The Philosophical Society of Texas

PROCEEDINGS

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OF THE ANNUAL MEETING

AT GALVESTON

DECEMBER 6-8, 1991

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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 Waverly 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. On December 5, 1936, formal reorganization was completed.

The office of the Society is located at 2.306 Sid Richardson Hall, Austin, 78712.

The Philosophical Society of Texas

One hundred eighty-two members, spouses, and guests gathered at the San Luis Hotel in Galveston on December 6, 7, and 8, 1991, for the Society's 154th anniversary. President William C. Levin had organized a splendid program with plenty of opportunity to enjoy being on the island as well. The Friday dinner in the Gulf Room of Gaido's Restaurant was a memorable affair, during which President Levin recognized 20 new Society members: Morris Atlas, George Fletcher Bass, Ronald Carson, Judith Lynn Berwick Craven, Gregory Curtis, Gilbert M. Denman, Jr., Richard Fisher, Elizabeth E. Hollamon, Barbara Jordan, Ben F. Love, B. J. "Red" McCombs, John Montford, Ewell E. "Pat" Murphy, Hugh G. Robinson, Robert Hoxie Rutford, Thomas Staley, Larry Temple, James Veninga, Sarah Ragle Weddington, and Joseph Irion Worsham.

Working with Dr. Ronald A. Carson, director of the Institute for Medical Humanities at the University of Texas Medical Branch at Galveston, President Levin had organized a thought provoking program for Saturday, "Turbulent Times for Health Care." The annual banquet was held Saturday evening in the ballroom of the San Luis with music provided by Ronnie Ginsberg. Dr. Marina L. Weiss, who was scheduled to speak on Sunday morning, was unable to attend.

At the business meeting, President Levin announced the names of 10 members who had died during the past year: George Beto, Jack Butler, Frank Ikard, William Owens, Edmund Pincoffs, Will Sears, Harlan Smith, John Tower, Donald Walker, and Peter Wells. The following officers were elected for the coming year: William D. Seybold, president; Robert C. Krueger, first vice-president; Steven Weinberg, second vice-president; James Dick, treasurer; and Ron Tyler, secretary.

After the organized activities, members and guests were able to take advantage of "Dickens on The Strand," an annual celebration that highlights the wonderful historic restorations throughout Galveston, but especially The Strand itself.

ATTENDANCE AT THE 1991 MEETING

Members registered included: Miss Hayes, Hill, Hollamon, Natalicio; Mesdames Brinkerhoff, Kempner, Krier, Randel, Rostow, Temple, Wallace W. Wilson, Will E. Wilson; Messrs. Anderson, Ashby, Barrow, Henry M. Bell, Jr., Paul Gervais Bell, Blanton, Boyd, Brown, Bryan, Caldwell, Carson, Clark, Cooper, Crim, Curtis, Denius, Dougherty, Dunagan, A. Baker Duncan, Charles W. Duncan, Jr., John H. Duncan, Farabee, Fehrenbach, Fleming, Joe J. Fisher, Richard Fisher, Frantz, Garrett, Gordon, Guest, Hall, Hargrove, Harrison, Harvin, Hershey, Hill, Hobby, Hoffman, Holtzman, Howe, James, Jordan, Kelsey, Kempner, Kilgore, Kozmetsky, Krueger, Law, LeMaistre, Levin, Lord, Love, Madden, Maguire, Margrave, McCall, McGinnis, McKnight, Mills, Mobley, Moody, Mullins, Murphy, Pope, Pressler, Edward Randall III, Risher Randall, Seybold, Shilling, A. Frank Smith, Spence, Staley, Storey, Sutton, Temple, Trotti, Tyler, Veninga, Wainerdi, Woodson, Worsham, Wozencraft, William P. Wright, Jr., Yudof

Guests included: Mrs. Thomas D. Anderson, Mrs. Lynn Ashby, Mrs. Thomas D. Barrow, Mrs. Henry M. Bell, Jr., Mrs. Paul Gervais Bell, Mrs. Jack Blanton, Mrs. Howard Boyd, Mrs. John R. Brown, Mrs. J. P. Bryan, Mrs. Clifton Caldwell, Thomas R. Cole, Mrs. John H. Cooper, Mrs. Billy Bob Crim, Mrs. E. Marc Cuenod, Mrs. Greg Curtis, Mrs. Frank Denius, Mrs. J. Chrys Dougherty, Mrs. J. Conrad Dunagan, Mrs. A. Baker Duncan, Mrs. Charles W. Duncan, Jr., Mrs. John H. Duncan, Mrs. Ray Farabee, Mrs. T. R. Fehrenbach, Mrs. Joe J. Fisher, Mrs. Richard Fisher, Mrs. Joe B. Frantz, Mrs. Jenkins Garrett, Mrs. William E. Gordon, Mrs. William F. Guest, Mrs. Jim Hargrove, Mrs. William C. Harvin, Mrs. Jacob W. Hershey, Mrs. John L. Hill, Mrs. Phil Hoffman, Mrs. Wayne H. Holtzman, Mrs. John P. Howe III, Sylvia Jackson, Mrs. Thomas N. James, Anne Hudson Jones, Mrs. Bryce Jordan, Mrs. Mavis P. Kelsey, Mrs. Harris Kempner, Jr., Mrs. Dan E. Kilgore, Mrs. George Kozmetsky, Joseph R. Krier, Mrs. Robert Krueger, Mrs. Thomas H. Law, Mrs. Charles A. LeMaistre, Mrs. William C. Levin, Mrs. Grogan Lord, Mrs. Ben Love, Mrs. Jack R. Maguire, Mrs. John L. Margrave, J. C. Martin, Larry Mathis, Mrs. Abner V. McCall, Mrs. Robert McGinnis, Mrs. William Mobley, Mrs. Dan Moody, Jr., Ellen S. More, Mrs. Charles B. Mullins, Mrs. Jack Pope, Mrs. Paul Pressler, Mrs. Edward Randall III, Mrs. Risher Randall, Walt Rostow, Vicki Saito, Mrs. William D. Seybold, Mame Shepperd, Mrs. Roy B. Shilling, Jr., Mrs. Ralph Spence, Louise Spurgin, Mrs. Thomas F. Staley, Mrs. Chuck Storey, Mrs. John F. Sutton, Jr., Ronald Thomason, Mrs. Robert S. Trotti, Harold Vanderpool, Mrs. Richard E. Wainerdi, David Warner, Sherra Wax, C. G. Whitten, Wallace W. Wilson, Will E. Wilson, William J. Winslade, Anne Fisher Winslow, Mrs. Benjamin N. Woodson, Mrs. Joseph Irion Worsham, Mrs. Frank M. Wozencraft, Mrs. William P. Wright, Jr., Mrs. Mark G. Yudof.

Saturday, December 7, 1991

WELCOME AND INTRODUCTION

WILLIAM C. LEVIN

I AM SO VERY PLEASED AND HONORED TO HAVE THE PRIVILEGE OF WELCOMING YOU to Galveston for the annual meeting of the Texas Philosophical Society. Today, I hope, we will all have opportunities to act a little bit like philosophers, because I can assure you that some of the issues to be presented are difficult. They are all difficult, and you will have the privilege and the opportunity to enter into active discussion. We have tried to structure the program in such a way that you can involve yourself very effectively in the discussion of the issues to be raised. And I encourage you to do so. From time to time in these meetings there has been some criticism that the Society has been lectured at. I hope that will not be the case today and tomorrow. Issues will be presented and ample time will be given for discussion of these opportunities by you philosophers. We welcome you.

Today is a very special day in the history of our nation. Fifty years ago, the United States was drawn into World War II by the bombing of Pearl Harbor by Japanese forces. I am certain that each of us who was around at that time can remember precisely what we were doing on that Sunday noon when we learned about the attack.

The beginning and the progress of World War II is very relevant to the issues to be discussed during this meeting of the Philosophical Society of Texas. Because it was during World War II that research addressing both scientific and technologic approaches to the care of the wounded and the sick proceeded at an accelerated pace.

Picture for just a moment the fact that at the beginning of World War II, the world had not yet been introduced to antibiotics in a clinically usable form. Anesthetic agents were primitive according to today's standards. At the beginning of World War II, the idea of operating on a patient's chest, particularly on a patient's heart, was almost inconceivable to patients and physicians alike. Chemotherapy as a treatment of malignant diseases had only barely begun to be explored. The suppression of malaria, something very important during World War II, and the management of malaria was dependent almost entirely upon the use of quinine, a drug not effective in the treatment of resistant malaria and a drug which often was not tolerated by many patients. We had many hundreds of thousands of forces in areas of the world where malaria was the most common disease.

A whole group of technologic developments had only recently begun to be studied. Computers, in the sense that we know computers today, were primitive, practically nonexistent. The computerization of a variety of

medical technologies had not even been dreamed of. X-ray methods were still in an era of darkness compared with today's sophisticated X-ray technology, which employs not only conventional X-ray examinations, but also the marriage of data regarding the transmission of X-rays with computer analyses. The state of blood bank technology at the beginning of World War II was almost nonexistent.

While the war cost millions of lives and drained the nation of many of its brightest and youngest people, and cost the nation multi-billions of dollars, it was also World War II that was responsible for tremendous advances in the development of new technologies and new scientific developments which could be applied to the diagnosis of disease and to the management of many diseases which prior thereto were considered to be death warrants once the diagnoses were established.

At the beginning of World War II, the physical principle of nuclear magnetic resonance had not even been discovered, much less applied to the imaging of organs of the living body for diagnostic purposes.

I have brought a couple of props this morning that I think will exemplify what I have been talking about. As an example of the explosion of knowledge in the medical techniques during and subsequent to World War II, this is the internal medicine textbook which I studied as a student. In this book, and I'm a hematologist, in this book, there are exactly 60 pages devoted to diseases of the blood-forming organs. That was 1941. This book was published in 1990. This is a textbook of hematology, somewhat incomplete, but nonetheless reasonably current. In another 10 years, it will probably take two volumes at least. The same comparison applies to almost any of the disciplines in medicine.

This brings us to the theme of the meeting, the present meeting of the Philosophical Society of Texas in 1991, precisely 50 years after the beginning of World War II and a hundred years after the establishment of the University of Texas Medical Branch as the oldest functioning medical school in the state. In the 1990s, patients with end-stage renal disease can be kept alive for years by dialysis, blood, and/or by kidney transplantation. Patients with severe disease of the coronary arteries can frequently be rehabilitated by the kinds of miraculous surgery which is now common among cardiac surgeons. By using computer enhancement of X-ray images and computer analysis of nuclear magnetic resonance phenomena, it is possible to visualize various human structures in the living body without any kind of invasion of that living body. Unheard of strides have been made in the extension of life in a variety of chronic diseases and in many malignant diseases. Newborn babies delivered very prematurely once died. Now they are kept alive by the application of scientific and technologic developments in the past 50 years.

Many diseases have almost disappeared. Smallpox has been eradicated as a disease throughout the world. Poliomyelitis, which was once a deadly scourge, can now be prevented if children are appropriately immunized early in life. On the other hand, patients chronically ill with incurable diseases can be kept alive by the application of various technologies which often extend life well beyond the time when such diseases would otherwise cause death.

Consequently, mankind, in general, and the health care professionals, specifically, are faced with unique, remarkable, and frightening challenges. On the one hand, there are opportunities for the prevention of disease and for the extension of life well beyond the traditional threescore years and ten. But, in accomplishing this, many debts are incurred by society. Such debts derive from a whole series of complex issues of a technologic and scientific nature balanced against the cost, the huge cost, for supporting such efforts and the cost of prolonging life in patients who frequently would choose to be relieved of the suffering attendant thereupon.

It is some of the latter issues that we will address today and tomorrow morning. It is my earnest hope that you, the members of the Philosophical Society of Texas, will be vigorous in your discussion of the issues that will be presented.

The program has been arranged by a rather remarkable philosopher, probably one of the few philosophers now in our . . . card-carrying philosophers . . . now in our organization. He has arranged the program and will provide the program overview as it gets started in just a moment. It is my very great privilege to introduce him to you. He's a good personal friend and one of the real stars of the faculty of the University of Texas Medical Branch, and I need to tell you a little bit about him.

Ronald Carson was educated in Indiana, New York, Germany, and Scotland. In preparing his Ph.D. dissertation at the University of Glasgow, he was a visiting scholar at the Nietzsche Archives in Weimar. Postdoctoral awards include fellowships from the Institute on Human Values in Medicine, the Council for Philosophical Societies, and the National Endowment for the Humanities. He is an elected Fellow of the Hastings Center and a recipient of the Society for Health and Human Values Distinguished Service Award. Dr. Carson is the author of "A Monogram on Sartre" and of many articles, chapters, and reviews in both humanities and medical publications. He is founder and coeditor of the journal, *Medical Humanities Review*, and is a contributing editor of the journal, *Literature in Medicine*. Dr. Carson is frequently called upon for membership on national grant review panels and has himself directed numerous research projects. He is currently serving on the advisory boards of two national projects, Georgetown University's Reference Center for Bioethics Literature and the Robert Wood Johnson

Program on the Care of Critically Ill Hospitalized Adults. He is in demand as a lecturer and consultant and recently served as inaugural visiting scholar at the University of Oslo's new Center for Medical Ethics. His current position is that of the Harris L. Kempner Professor in the Humanities and Medicine and director of the Institute for the Medical Humanities at the University of Texas Medical Branch in Galveston. Ron.

PROGRAM OVERVIEW

RONALD A. CARSON

GOOD MORNING. AND LET ME ADD MY WELCOME. AND LET ME BEGIN ON A PERSONAL note by saying that I am honored indeed to be welcomed into the midst of this august body as a member. I look forward to interacting with you over the coming years.

The topic for consideration at this meeting of the Philosophical Society of Texas is "Turbulent Times for Health Care," as Dr. Levin has told you. I don't think I need to do any more than assert that these are turbulent times for health care. I think all of us who follow the news and seek health care know that these are turbulent times for health, and we are going to be exploring today some of the reasons why that is so. Over the course of the next day and a half, we will selectively survey the scope of health care in late twentieth-century America. And I emphasize selectively—we can't do it all. It's a big, big enterprise. But we've selected out some topics that we think are of particular interest and particular concern.

Health care in this country is a vast professional, institutional, financial, and irreducibly personal enterprise whose shape is changing rapidly and in some quarters drastically as well. We will examine issues of access to the health care system and of equity across the generations. We will raise questions regarding the quality of relationships between doctors and other health professionals and the patients they care for. We will look at the character of institutions of care as both repositories of a vast array of impressive apparatus designed to fight disease and stave off death and institutions that are safe havens for the sick. Hospitals and nursing homes and long-term care facilities in this country are asked to do a whole variety of things and to strike that balance, to hold that balance between being a safe place to be sick and to die. And to fight disease and fend off death is sometimes a very hard balance to strike and to hold. Those of us who have been asked to make remarks from the podium look forward to engaging you in a discussion of these issues.

Panel I
Ray Farabee, Moderator

Ron has given an overview of the program, and I can't think of a more appropriate setting for this discussion of health policy issues. We are in one of the oldest cities in the state of Texas. We are one of the oldest organizations of this state. And Galveston is the site of the oldest public medical school in Texas, The University of Texas Medical Branch at Galveston (UTMB). UTMB has greatly expanded not only its program in the sciences, but its total view of medical and health issues. When the program committee identified this year's topic, it was an important issue; but no one perceived it would be as politically important as it is after the U.S. Senatorial election in Pennsylvania. As we look to the next presidential race in the United States, health care will be one of the principal issues. Many questions being asked are similar to those covered by our program this weekend. Some of the questions include: What type of health delivery system should this nation have? How much can we afford? Do we, or should we, ration health care services? Who should live? Who should be allowed to die? Who should make such decisions?

When I was in the state senate, I became interested in legislation then introduced in the state of California known as the "Natural Death Act." I authored the first "right to die" bill in the state of Texas, and we were the third state to have such legislation. Back then, 15 years ago, such laws were thought to be controversial. As an indication of how far we have come, nearly 40 states have similar laws, and the federal government recently made it mandatory that patients be advised of their rights to participate in such medical decisions.

This morning, as your moderator, I have three jobs. First, to introduce our distinguished speakers, Dr. Ronald A. Carson and Dr. Thomas R. Cole. Second, I wanted to tell you about the topic each speaker will discuss. Finally, I will moderate what I trust will be a spirited discussion characteristic of this organization.

Dr. Bill Levin has told you some facts about our first speaker. He is the Kempner Professor at UTMB and director of the Institute for the Medical Humanities at the University of Texas Medical Branch. Dr. Ronald A. Carson will address the topic of "Who should get decent health care?" Ron, I turn the program over to you at this time.

WHO SHOULD GET DECENT HEALTH CARE?

RONALD A. CARSON

WELL, WHO SHOULD GET DECENT HEALTH CARE? SENATOR FARABEE REFERRED TO the Pennsylvania state race, and that's exactly where I want to begin my remarks because I think it's a signal in ways that we all need to pay attention to because it's making a difference in whether health care is going to be high on the agenda in this coming presidential election. Whether it's high or not, it's going to be in every election forthcoming until we get the questions about the fair distribution of health care sorted out in this country.

But Harris Wofford's victory in the Pennsylvania senate race a few weeks ago was, I think, the opening volley in a battle that is heating up over the future shape of this country's system of health care provision. The three or four years prior to that victory had seen a score of national commission reports, countless federal legislative proposals, and grassroots projects in several states—perhaps the best known being the Oregon Health Decisions Project, which has spawned such projects in several other states around the country that are being watched very carefully. And a skirmish here and there over the rising cost of health care and the fate of growing numbers of Americans who are being priced out of the system—34 million, 37 million, and rising. Forty-six million if you take into account people who are paying for long-term care out-of-pocket. And so the numbers grow. Twelve million of these people are children—12 million of these people who have diminished access or no access at all to the health care system at all are children. I'll have some more to say about them in a moment.

As recently as May of this year, the New York *Times* was reporting that "prognosticators in both the administration and the Congress say that while momentum for [health care] reform will probably continue, no major action is likely until the end of 1992 . . . or early 1993." And, indeed, President Bush gave a major talk on domestic issues in June of this year in which health care was not mentioned. He was getting advice, I think, at this time, to steer away from it and that's not by the boards. But, this was May and June, and we were still not really talking about this issue in public on the national scene.

But it was also in May that Harris Wofford was appointed to succeed the late Senator John Heinz until an election could be held in Pennsylvania. Wofford hit the ground running on the issue of universal health care. The importance of this issue was brought home to him in a conversation he had had some months before with a Philadelphia ophthalmologist interested in contributing to his election campaign. Dr. Robert Reinecke had told Wofford of something that had bothered him for a long time, namely that the United States Constitution provides a right to counsel to someone accused of a crime

—Manuel Noriega was Dr. Reinecke's example—and yet there was no right to medical care. Wofford's experience in state government, about which I'll have a little more to say in a moment, made him very receptive to this view.

Wofford's campaign coordinators subsequently prepared a television ad in which the candidate said, "If criminals have a right to a lawyer, I think working Americans should have a right to a doctor. I'm Harris Wofford, and I believe there is nothing more fundamental than the right to see a doctor when you're sick." Within two weeks of the first airing of that ad throughout Pennsylvania in early September, opponent Richard Thornburgh's lead had been cut in half. On election day, the health care issue propelled Wofford to victory by a comfortable margin.

Now how this happened in a state where only 10 percent of the population has no health insurance is instructive. And I say only 10 percent, which is an unconscionably high figure in my view, but nonetheless a smaller proportion in Pennsylvania than is found nationwide, so one would not have expected that Pennsylvania would have been ripe for this kind of campaign.

During his four-year tenure as State Secretary of Labor and Industry, Harris Wofford's job was to mediate labor-management disputes and try to get people off welfare. On both fronts, health care was an all but insurmountable obstacle. Wofford is reported as saying that "virtually every labor-management logjam grew out of the rising cost of health care. Companies want workers to share the cost. Workers consider this an erosion of their compensation. It was also a major impediment to getting people off welfare." Again and again, he said, women on welfare were offered access to free training, job placement, and child care, but they had to turn it down because the jobs they were eligible for provided no health benefits. Whereas Medicaid at least provided coverage—the federal health insurance program for poor people.

And here, I really ought to head off a common misinterpretation. Medicaid is designed as a safety-net program, but it by no means catches everybody who falls toward it. In fact, only 38 percent of Americans living below the federal poverty limit are covered by Medicaid—38 percent. The federal poverty limit is defined as an annual income of less than $10,000 for a family of three. So, in other words, two-thirds of families of three who try to make ends meet on less than $10,000 a year are not receiving Medicaid benefits, although they are technically eligible for them. Working people with low incomes often have the worst health care coverage.

Well, as Wofford's campaign people began to take the public pulse in preparation for the Senate race, two things became increasingly clear. Middle-class people talked with great anxiety about their economic life falling apart, about the prospect of having to choose between their home mortgage, health care for their families, college tuition for their kids and a

decent old age for themselves. Not a happy choice at best; at worst, a frightening prospect for working people who don't believe that they should be having to face such a choice in the first place and who believe, furthermore, that government can make a positive difference in their lives, though not in its current stagnant state. The health care issue crystallized these fears and frustrations, and it also tapped the hopefulness that things could be different. Things could be better.

Now there is reason to believe that these sentiments are not contained within the borders of Pennsylvania. A recent opinion survey reports that a striking 89 percent of Americans see the U.S. health care system, and I keep emphasizing now, you'll notice, let me draw it out, this distinction between the system, the delivery system as we said, the system of provision, and satisfaction with your doctor. People tend to be satisfied with their doctors —that's not it. It's that they can't get access. So it's the latter, really, that is the subject of my discussion.

We have this plethora of riches, that Dr. Levin reminded us of, an increasing number of people can't get access to. Only 10 percent see their health care arrangements as working well. Many factors contribute to the growing dissatisfaction with the system. The means and methods of health care provision have changed so substantially in so short a time that the social meaning of fairness has become blurred. We must bring fairness back into focus. That is, we must come to understand medical care as a common good, as a valuable social resource held in common by us all and available to anyone who needs it, not of course in like measure—that would be impossible and in any case unnecessary—but certainly in a fair enough share to allow people to lead decent lives.

Now, why? Why should we focus on fairness? Because Americans place a premium on individual achievement. Achievement is fundamentally dependent on things we take for granted, like good health, like education, just to name two. In a society like ours, access to health services becomes central to considerations of fairness. In the absence of a fair chance to compete, achievement remains forever out of reach.

Well, these are troubling thoughts at a time when the gap between health needs and access to health care services is widening. They are especially disturbing in relation to children for whom access to health care services is life-enabling and impaired access is growth-stunting and life-threatening. Nearly 39,000 babies die each year in this country before they reach their first birthday. Approximately half of all black pre-schoolers are not fully immunized against preventable diseases. We know how to do it, we know how to prevent the diseases, and half of them are not immunized. Twenty percent of America's children are destitute. Government spending on poor children has

declined over the last 15 years, so that if you're under six years old in America today, you're six times more likely to be poor than if you're over 65. That makes us the first industrial nation in the world in which children are the poorest age group.

And although the situation with the nation's 33 million elderly citizens is not this stark, certain features of it are equally disheartening, and I'll just say a word about this because my colleague Tom Cole will have a good deal more to say. Medicare, the federal insurance program for elderly and disabled people, continues to be the fastest-growing major program in the federal budget despite a decade of aggressive efforts to control costs. And this has predictably prompted calls for setting limits on services. But cutbacks will be difficult as the number of elderly people increases at double the rate for the U.S. population as a whole and as the elderly population itself ages with a larger proportion made up of people over 75 years of age who require more care than those between 65 and 70.

And despite the fact that Medicare and Medicaid pay for one-third, a whopping one-third of the nation's hospital expenditures, there are still significant gaps in coverage. An increasing proportion of the cost of health care for people over 65 is paid out-of-pocket. Consequently, elderly people who cannot afford private insurance to supplement Medicare, so-called Medigap insurance, and are not poor enough to be eligible for Medicaid, put off going to the doctor until they're too sick not to and then drive up costs when they get there.

Between the children and the elders are the young and middle-aged adults who elected Harris Wofford, a growing number of whom are the working poor—those between jobs or in jobs that don't pay enough to permit them to buy health insurance for themselves and their families. Some of these people are too pinched to buy insurance and yet not poor enough to qualify for public programs. Others are uninsurable because of pre-existing illness. Still others have no health insurance because their employers don't offer it as a benefit. It's hard for small employers to make it these days. These are just some of the factors that governments at every level and private corporations and public agencies hard-pressed by rising health insurance premiums are considering as the U.S. system of health care provision comes under review.

The crisis of health care provision is widely thought to be primarily a crisis of cost. Who pays and how can costs be controlled? But dwelling on how to save money for corporations and governments is a miserly approach—lacking in generosity, the approach of old Scrooge if you will—welcome to Galveston on Dickens weekend—the approach of old Scrooge in modern dress. Certainly the financial questions are pressing and I don't want to detract from them, but they're getting a lot of good press, and I want to talk about something else which I think is probably as fundamental.

The financial questions are pressing, but because health care is so unavoidably personal, as I said in my opening remarks, the ethical issues are fundamental and pervasive. We can't discuss health care costs without thinking of them in relation to people who suffer and need care. The hue and cry about setting limits to services and containing costs has obscured the question that Americans worried about until the early 1980s—namely how could we insure every citizen access to a limited but fair system of health care provision adequate to his or her need?

In addition to the questions of who pays and how costs can be controlled, the question of what level of care is adequate is now open to national public debate. Raising the question of adequacy necessarily will lead to considerations of fairness and to the realization that the crisis is one of political will, organizational capacity, and social conscience as well as money.

Well, the pursuit of fairness alone cannot, of course, decide our health care policy, but on every previous occasion in this country when the subject of universal health care came up for serious discussion, and this is not the first time we're having this discussion, heaven knows, in the Progressive Era during the New Deal, in the post-World War II era, and again as a part of the Great Society program, each time the values of decency and adequacy were central to the discussion. And my purpose here, if there is a purpose, is to get that language back in there as we continue to think about cost containment and control.

President Truman told Congress in 1949,

> Action thus far taken falls far short of our goal of adequate medical care for all our citizens. If we are to deal with the problem realistically and in its true dimensions, action is required on a broad scale. Technical resources have been greatly increased, but as a nation, we have not yet succeeded in making the benefits of these scientific advances available for all those who need them. The best hospitals, the finest research laboratories, and the most skillful physicians are of no value to those who cannot obtain their services. Our objective must be twofold—to make available enough medical services to go around and to see that everybody has a chance to obtain those services. We cannot attain one part of that objective unless we attain the other as well.

Well, times have changed, but the objective, I would argue, has not. Many more medical services are now available at a much higher cost, predictably, but we still must decide how to distribute these services fairly to those who need them. To insure adequate medical care for all citizens now requires, as it did over 40 years ago, action on a broad scale.

A President's Commission of a decade ago recognized this requirement in its deliberations. Commissioned to study the ethical implications of differences and availability of health services among various groups in the United States, this commission put forward six principles after long deliberation and many hearings. This is kind of a framework, if you will, for thinking about the fair distribution of health care services. Here are the principles. Society has an ethical obligation to insure equitable access to health care for all. I emphasized before now, equitable, not equal, but fair, equity. Individuals, second, have an obligation to pay a fair share of the cost of their own care. Third, equitable access to health care necessitates that all citizens be able to receive an adequate level of care without bearing excessive burdens. Fourth, when private forces produce equitable access, there is no need for government involvement, although responsibility ultimately rests with the federal government to insure that society's obligations are met through a mix of public and private sector arrangements. Fifth, the cost of achieving equitable access to health care ought to be shared fairly at the national level. And, finally, the goal of cost containment should not focus on limiting the attainment of equitable access for those least well-served by current arrangements—in other words, it ought to be across the board. It ought not to create another welfare program.

Well, the third principle is the key one for our purposes in that it defines what is fair in terms of adequacy—adequacy of the level of care. Adequate was, you will recall, President Truman's way of putting it too. Unless this is a coincidence, it would seem that the question of what we as a society mean by adequate level of care is the question that we have yet to answer. It keeps dogging us—the question that we are now being pressed by economic forces to find a somewhat quicker answer to. In support of its claim that equitable access to an adequate level of health care for all citizens is a shared social responsibility, and that's where I began, medical care as a common good, the President's Commission argued: Health care can relieve pain and suffering, it can restore functioning, it can prevent death, it can enhance good health and improve an individual's opportunity to pursue a life plan. It can provide invaluable information about a person's overall health.

Beyond all these very important practical matters, the involvement of health care with the most significant and awesome events of life—birth, illness, injury, death—there is a symbolic aspect to health care. Health care is special because it signifies not only empathy in caring, but mysterious aspects of curing and healing. Was it the word mysterious? Health care can relieve pain and suffering and stave off death. But beyond this, there is a symbolic aspect that makes health care special and different from other things that we care about. It's not a commodity. It is special, and we've got to figure out a way to treat it as the special thing it is.

While people have some ability, through choice of life-style, through whether they fasten their seatbelts, or wear their helmets when they ride their bikes, or smoke or not, or drink in moderation or excessively, or all of these things that are now so much on our minds, while we have some ability through choice of life-style and through preventive measures to influence our health status, many of the health problems we encounter are beyond our control and therefore undeserved. They just happen. Finally, the incidence and severity of ill health is distributed very unevenly among people. Together, these considerations lend weight to the belief that health care is different from most other goods and services. In a society concerned not only with fairness and equality as we are in every realm of our ideological and professional and political life, but also with the redemptive powers of science about which Dr. Levin spoke so eloquently in his introduction. There was a felt obligation to insure that some level of health services is available to everybody who needs it.

Well, in sum now, as inequities in the present system of provision become more widely known, I imagine Americans will be less and less comfortable with the idea that most of us, most of us, get top-notch medical care simply by showing proof of insurance, while a significant, a growing minority, of our fellow citizens, including 12 million children, have diminished access or no access at all. We will not agree readily about where to draw the line between medical need and desire. That's a tough one in a system that can provide so much. We will not agree about how much of the system should be financed publicly and how much privately, but the subject of discussion is the right one, finally. What do we think is decent and, then and only then, how much of what is decent can we afford? If we can set our compass on this fixed point of social conscience, we will be able to steer a straighter course. The sailing may not be smooth, but the winds of profit and loss will not buffet us as they have so often as we've talked about setting limits. Instead, they will follow in the wake of care.

RAY FARABEE, MODERATOR

Thank you, Ron. Our next topic is related to the question discussed by Dr. Ron Carson. Because of demographic facts in our society, the problem to be addressed by our next speaker will become more intense. The topic is "Generational Equity: Health Care and an Aging Society."

As I thought about our topic, I recall when I first ran for public office in 1973 and 1974. I was not familiar with "AARP," i.e., the American Association of Retired Persons. I quickly learned about the AARP, and received many invitations to speak to this group. I understood quickly that senior citizens

vote. Children do not have a vote and yet they have important health needs. Because of physical and also political circumstances, the potential for competition between the generations within our society has emerged. We are privileged this morning to have a very qualified person to discuss this topic.

Dr. Tom Cole is associate professor and graduate program director of the Institute for the Medical Humanities of the UT Medical Branch here in Galveston. He is also author of the book, *The Journey of Life: A Cultural History of Aging in America*. It is a privilege to have and introduce Dr. Tom Cole.

GENERATIONAL EQUITY: HEALTH CARE AND AN AGING SOCIETY

THOMAS R. COLE

A SPECTRE IS HAUNTING AMERICA—THE SPECTRE OF OLD AGE. SINCE THE 1970s, awareness that America is an aging society has blended silently into fears of nuclear holocaust, environmental deterioration, military and economic decline, social conflict, and cultural decadence. The "first new nation," now a declining empire, no longer seems exempt from Old World destinies. The current mood of pessimism—the loss of faith in a secure and better future—is particularly strong among many who are now reaching middle age. Awakening from a privileged youth spent amidst the unprecedented prosperity that followed World War II, the baby boom generation (nearly one-third of the total U.S. population) today finds itself the first in American history that cannot count on surpassing its parents' station in life. Prohibitive housing prices, high interest rates, sluggish economic growth, and glutted job markets have turned confident expectations of upward mobility into a gloomy view of the future. This pessimism may not be unfounded: massive trade deficits, the continuing decline of the U.S. manufacturing sector, and the low wages paid to most workers in the growing service sector of the economy cast considerable doubt that today's younger workers will achieve anything like the rising standard of living their parents enjoyed in the 1950s and 1960s.

Beginning in the late 1970s, these frustrations and a growing disenchantment with welfare state liberalism supplied a new and surprising political color to images of aging and intergenerational relations. Critics of Social Security and Medicare blamed the deteriorating condition of children and families on the "graying of the federal budget" (more than half of all federal social spending goes to the elderly) and raised the spectre of intergenerational warfare between young and old. Since 1985, these views have been widely publicized by an advocacy group known as Americans for Generational Equity, which argues that society is displacing current costs onto future generations and ignoring its obligations to children and the unborn. The group trades on the image of a powerful gerontocratic lobby—ruthless in its pursuit of hard-earned tax dollars to buy mink coats, golf carts, and condos.

Until quite recently, the elderly enjoyed a privileged status among welfare state programs—built on an image of old people as poor, frail, and dependent. But as the generational equity campaign portrays them as politically powerful, selfish, and potentially dangerous, the dynamics of interest-group liberalism are now turning against them. Most of today's retired elderly enjoy generous public entitlements, while younger workers generally pay (directly or indirectly) one dollar in seven to the Social

Security system. According to recent polls, surprisingly few young people believe that the system will provide adequately for them when they reach retirement. They have heard forecasts of the future "bankruptcy" of Social Security. They know that there will be a smaller ratio of workers to retirees when they leave the labor force. Saddled with a staggering national debt, surprised by the unexpected longevity of their parents, frightened by the rising medical costs of an aging population, many feel as if they were *Born to Pay*.

For the first time in history, most people can expect to live into the "long late afternoon of life." Whereas American life expectancy in 1900 was about 49, today's children will live an average of about 75 years (71 for men, 78 for women). This increase represents two-thirds of all the gains in life expectancy achieved since the emergence of the human species! Since 1968, mortality among the elderly has fallen substantially, suggesting that we are not yet reaching the limits of the human life span. While individuals are living longer, they are also having fewer children, creating an older population. In 1920, 4.6 percent of the U.S. population was 65 years or older. In 1984, this figure had reached 11.8 percent. By 2030, when the baby boom cohort is passing through old age, at least one in every five Americans will be elderly.

Not only are more people living longer, in the American welfare state they are also healthier and more financially secure than ever. Since the 1960s, liberal Social Security benefits have reduced poverty among the elderly from an average of 35 percent to less than 14 percent. Thanks to Medicare and Medicaid, more older people are able to see physicians and to receive long-term care.

Nevertheless, the generational equity campaign's myth of the affluent elderly is seriously flawed; poverty and disease among the very old, women, and minorities remain more recalcitrant than ever. American aging policy does not meet the health or income needs of an important minority of elders. Still, it has been far more successful than programs designed for children and young families, and has avoided the deep funding cuts that other social programs received during the Reagan era.

Today aging policy faces a series of problems which neither liberal (more professional intervention, more entitlements, more taxes) nor conservative (marketplace solutions: more self-reliance, more savings) perspectives adequately address. Generational equity is only the most visible and widely-publicized of these problems, which are rooted in the decline of American military and economic power, the legitimation crisis of the liberal welfare state, and the aging of our population. In addition, the question of justice between the old and the young is also linked to the "spiritual situation of the

age"—in particular our culture's inability to provide convincing answers to deeper existential questions like the quality of life in old age, the unity and integrity of the life cycle, and the meaning of aging.

The current fiscal dilemmas of aging policy originated in the late 1970s, when high inflation (cost of living adjustments grew more quickly than anticipated) and slow economic growth rapidly drained Social Security trust funds. Social Security quickly lost its status as an untouchable "sacred cow." Emphasizing that the ratio of beneficiaries to workers had dropped from 1:40 in 1940 to 1:3.3 in 1980, neoconservatives raised the spectre of an aging society. Forecasts of intergenerational Armageddon and of Social Security's collapse made alarming headlines. The elderly lost their "favored" ideological status as "deserving poor" and increasingly were portrayed as a threat to the future.

In May 1981, the Reagan administration's first attempts to cut Social Security were soundly rebuffed. In 1982, Reagan appointed a bipartisan National Commission on Social Security Reform. In 1983, its recommendations—delayed cost-of-living increases, taxes on upper-income recipients, and gradually increasing the system's minimum retirement age in the twenty-first century—were adopted. As Achenbaum shows in *Social Security: Visions and Revisions*, policy-makers once again resorted to short-term tinkering with the system rather than face its long-term financial and ideological problems.

The 1983 amendments to the Social Security Act quieted voices of doom, but not for long. Soon after Reagan's reelection came rumblings of the next battle over old age security: the financial of health care. In the last several years, rising health care costs for the elderly have generated a new sense of alarm. Since 1965, the costs of Medicare and Medicaid have grown so rapidly (and are projected to rise even faster) that observers like Daniel Callahan now fear that the humane medical care for the elderly in the 1960s and 1970s will become a "new social threat in the late 1980's and 1990's." Total health care costs for people 65 and over are expected to grow (in constant dollars) from $50 billion in 1978 to $200 billion in 2000; during these years, the proportion supported by public expenditures will grow from $29 billion to $114 billion.

While epidemiologists disagree about the future health status of the aged, it is clear that longer life has brought with it an increase in chronic disease—a trend that could accelerate in the future. Regardless of which epidemiological forecast one prefers, the sheer growth in the number of older people is staggering. In 1985, the number of people over 65 in America exceeded the number under age 18; the fastest growing age group today are those 85 and over, whose numbers will double in the next 20 years. There is little doubt

that the elderly's need for health care, especially medical services (outpatient care, hospitalization, home care, hospice care, long-term care) will continue to increase dramatically.

These trends have led to considerable uneasiness (and not only among yuppies and neoconservatives) about the increasingly large share of health care dollars spent on the elderly. Like the "graying" of the federal budget in general, these trends raise questions of intergenerational equity and the social meaning of late life that welfare-state liberals, mainstream gerontologists, and aging advocates have preferred to ignore.

How should we distribute limited health care resources between the old and the young? Is it fair to spend such a large proportion of our health expenditures on the dying elderly? Do these expenditures actually benefit them? Should we be devoting so much of our biomedical research and technology to the diseases of aging? Since none of us live behind the Rawlsian "veil of ignorance" but rather within particular historical and cultural circumstances, questions of distributive justice inevitably lead to questions of social meaning. How do we justify funds spent on a population that is not economically productive? What "good" are old people anyway? What do they contribute to the rest of society? Are there any special virtues or obligations particular to old age? Two moral philosophers have recently taken up these questions from different perspectives but with similar results. Both Daniel Callahan and Norman Daniels construct arguments attempting to justify the provision of a decent minimum of health care for the elderly, health care designed to relieve suffering and improve quality—not quantity—of life. Callahan's book, *Setting Limits: Medical Goals in an Aging Society*, has sparked a great deal of controversy, primarily for its recommendation that we should set limits to health care costs by withholding certain life-prolonging technology on the basis of chronological age. This is unfortunate, since the more important and enduring aspects of Callahan's book lie elsewhere. Callahan never makes clear how his scheme would save a significant amount of money. His call for relief of suffering and better long-term care could easily be more expensive than life prolongation. And at bottom, he is interested not only in cost containment but in philosophizing (in the best sense) about aging and the proper goals of medicine in the face of decline and death.

Callahan's book is fundamentally an attack on the indiscriminate use of biomedical technology to prolong life indefinitely. It is also an attempt to rethink the meaning of old age itself. Echoing several essays in *What Does It Mean To Grow Old?* Callahan deplores the absence of "a coherent, established, and meaningful place" for the elderly in our society. As a communitarian, Callahan thinks we should define the primary purpose of old

age as service to the young, rather than individual pursuit of pleasure. He has little patience for the retired couples travelling cross-country with bumper stickers that read: "We are spending our children's inheritance."

Like the old characters in Willa Cather's fiction, Callahan's ideal elders live primarily to benefit their grandchildren. When this communal obligation has been fulfilled, death can be understood as the completion of a natural life span rather than as a failed quest for immortality. This notion of living within the limits of natural life span calls to mind Thomas Jefferson's words. "It is reasonable we should drop off," he wrote to John Adams in their old age, "and make room for another growth. When we have lived our generation out, we should not wish to encroach upon another."

Once we have lived into our late seventies or early eighties (Callahan allows for variation based on individual biographies), society should not use up expensive resources trying to keep us alive. It should, however, guarantee us a decent minimum of palliative care. Callahan contributes two important arguments that are often overlooked in the controversy over his proposal for rationing life-prolonging technology: first, he makes the very un-American claim that old age is a biological limit that we should respect, rather than an "endless frontier" for biomedical conquest; second, he decries the impoverished social meaning of aging and calls for public debate about the nature and purposes of late life in the context of a "natural life span."

Norman Daniels is alarmed by the widespread talk of the young and old competing for resources. But he resists the knee-jerk liberal response of blaming the problem on the defense buildup or on attempts to roll back the welfare state. Daniels affirms that generational equity is a genuine moral problem in our aging society, albeit one that is susceptible to political abuse. In *Am I My Parents' Keeper? An Essay on Justice Between the Young and the Old*, he develops a philosophically rigorous argument for meeting the health care needs of all the elderly within a framework that is fair to other age groups.

While Daniels also uses the life span as a central category of analysis, he rejects Callahan's communitarian assumption that we can prescribe what is "good" or "right" for people at different stages of their lives. Instead, he argues that we should distribute resources to different age groups according to impartial principles that permit individuals to pursue their own opportunities. Daniels calls on us to stop thinking that different age groups must compete for resources in the here and now. Instead, we should realize that over a lifetime, resources are distributed *within stages of life*, rather than *between age groups*. From this perspective, age-based entitlement programs do not take resources from one age group to benefit another; rather, they are a vehicle for "savings" that provides a prudent allocation of resources to different stages of life (in his terms, a "Prudential Lifespan Account").

Like Callahan, Daniels urges us to reduce lavish expenditures designed to prolong the dying of terminally ill patients and to invest in long-term care (medical and mental health care, nursing care, rehabilitative therapy, personal-care services, and social services). He rightly stresses the moral importance of long-term care, which has long been the "neglected step-child" of our health care system. Poor patients in need of skilled care have difficulty finding nursing home placements. Others are prematurely institutionalized because federal policy will not pay for nonmedical home care services. Nursing home costs and the eligibility requirements for Medicaid drive many spouses into poverty. Families—largely women—providing long-term care receive little support and few services to ease their burden.

It is no accident that both the communitarian Callahan and the liberal-Rawlsian Daniels use the life span (or life cycle or life course) as a fundamental unit of analysis. Like others who have responded to the generational equity movement, Callahan and Daniels turn to this universal category as a way of undercutting the divisiveness enhanced by focusing on age-groups, cohorts, or generations. Daniels's "Prudential Lifespan Account" is particularly effective in disproving the assumption that because the elderly consume a disproportionately large percentage of health care they are receiving more than their "fair share."

In some ways, Daniels's book is really a philosophical and egalitarian version of the liberal ideology that has, until recently, legitimated Social Security. Individuals are encouraged to think that they are "saving" or insuring themselves against the vicissitudes of old age and disability. The primary justification for support or care for the elderly derives not from intergenerational obligations but from equal opportunity to pursue one's own life plan at every stage of life. Prudence leads people to support programs not out of commitment to a common good, but in which they have a common stake. And in a society characterized by mass longevity, a life course perspective *can* encourage a kind of solidarity between age groups. Growing up *and* old is both a fate and a privilege that virtually all of us share. The elderly are indeed ourselves or our future selves. Unfortunately, this kind of solidarity is precisely what is threatened by the "spectre" of old age.

But the centrality of the life course does not derive only from its abstract universality or its place in legitimating the liberal welfare state. Its unifying powers lies in an historical tradition that until recently provided widely shared images of the unity and integrity of the life course. Its social power lies in the chronically organized institutions built to regulate each individual's journey through the stages of life.

Daniels's account of justice across the life span actually builds on the traditional bourgeois ideal of a society ordered by the natural divisions of human lifetime. The life cycle has long functioned as a legitimating image

of this ideal. Born amidst the anxiety and upheaval of the Renaissance and Reformation era, the modern life cycle assumed an almost numinous quality amidst the European urban middle classes struggling for social and religious identity. Its burgeoning iconography played an important role in the emergence of urban individualism. Ministers, artists, and moralists exhorted people to imagine their lives as a series of age-linked roles.

This temporal perspective encouraged the development of individual virtues like self-control, thrift, and long-range planning. It also defused awareness of social inequalities based on class, wealth, gender, or political power. Eighteenth-century republicanism defiantly proclaimed the autonomy and equality of each mature generation. Jefferson's ideas about generational succession derived from his insistence that "the land belongs in usufruct to the living." French revolutionary moralists envisioned an ideal society where individuals would be divided only according to the natural order of ages; every individual could expect to run the course from dependent child to active adult to honored elder.

Set free from the older bonds of status, family, or locality, middle-class individuals over the last 150 years have increasingly viewed their own lives as careers—as sequences of expected positions in school, at work, and in retirement. This pattern of expectations has become both statistically and ideologically normative, constituting what Martin Kohli aptly calls a "moral economy of the life course." By the third quarter of the twentieth century, Western democracies had institutionalized this "moral economy" by providing age-homogeneous schools for youthful preparation, jobs organized according to skills, experience, and seniority for middle-aged productivity, and public-funded retirement benefits for the aged who were considered too slow, too frail, or too old-fashioned to be productive.

Hence the power of a life course perspective is not only existential, ideological, or moral—it is also institutional. The course of life today is an essential instrument for the maintenance of social order. Since the late eighteenth century, the structure of the "normal" life course has been created by changes in demography and family life, as well as the growth of age-stratified systems of public rights and duties. Demographically, age-at-death has been transformed from a pattern of relative randomness to one of predictability. Death now strikes primarily in old age, and with much less variance than in the past. Meanwhile, the experience of a "normal" family cycle (including marriage, children, survival of both partners to age 55, "empty nest," and widowhood) became increasingly common and chronologically standardized.

Over the last century, the social transition to adulthood (finishing school, first job, first marriage) has become more abrupt and uniform for a growing segment of the population. At the same time, the spread of universal age-

homogeneous public schooling and chronologically-triggered public pension systems have divided life into three "boxes": education, work, and retirement. This bureaucratized life course, supported by the state and administered by experts, is now an important means of social regulation. It is also under attack from those who call for an "age irrelevant" society, as well as from the generational equity movement. It is also increasingly experienced as a new form of domination and source of alienation.

The moral economy of the life course, then, forms the unspoken historical context of both Daniels's and Callahan's views about justice between the young and the old in an aging society. Both are aware of the need to rethink the moral obligations between age groups and to reformulate the moral economy of the life span in a new demographic context. Yet neither fully appreciates how much has been lost by secularization and modernization of the life course.

Amidst the decline of feudalism, the breakup of the Catholic church, and the emergence of urban commerce, early modern men and women turned to ancient understandings of the life cycle for a sense of stability and order. "Life's course is fixed," wrote Cicero in *De Senectute*. "Nature has only a single path and that path is run but once, and to each stage of existence has been allotted its own appropriate quality." In Ecclesiastes, they were comforted to learn that the natural divisions of a lifetime belong to the divine order of the universe: "To every thing there is a season, and a time to every purpose under heaven." Since the late Middle Ages, much Western medical, philosophical, and religious teaching has been predicated on this notion of the "seasonableness" or naturalness of the human life cycle. As we have seen, social divisions based on the stages of life have been considered natural and proper. In the late twentieth century, however, we have many doubts about this ancient truism—doubts connected to the growing feeling that old age may be a "season" without a purpose.

The ideal of a society legitimately ordered by the natural divisions of human lifetime is now under siege in large part because its view of old age is neither socially nor spiritually adequate and because the social meanings of life's stages are in great flux. The greatest threat to its legitimacy comes from the de-meaning of old age and marginalization of the elderly that emerged in the nineteenth century and became embedded in the bureaucratized life course of the welfare state. Herein lies the key to understanding the contemporary spectre of old age.

In our century, vastly improved medical and economic conditions of old age have been accompanied by a loss of cultural meaning and vital social roles for older people. The dominant liberal response has attributed these problems to "ageism"—a term that refers to systematic stereotyping of and discrimi-

nation against older people, analogous to racism and sexism. Over the last 15 years, we have witnessed a formidable effort to eliminate negative stereotypes of and prejudices toward older people. Academic gerontologists, humanists, health professionals, social workers, organized elders, and others have attempted to debunk "myths" of old age and to substitute positive images of aging for negative ones. This movement attempts both to redress the social conditions of old age and to reform cultural sensibilities toward aging. The campaign against ageism has done a great deal to free older people from outmoded cultural constraints; at the same time, however, it remains seriously limited.

In some quarters, the attack on ageism has so quickly achieved the status of an enlightened prejudice that its limitations have gone unnoticed. Not the least of these limitations is that the attack on ageism, uncritically invoked at the first hint of a negative feeling or idea about old age, is itself part of an historical pattern based on splitting or dichotomizing the "negative" from the "positive" aspects of aging and old age. Appreciating this historical pattern is essential to fashioning a satisfying culture of aging, and to rebuilding the moral economy of the life course.

Apart from its class bias and its empirical deficiencies, the attack on ageism perpetuates the existential evasiveness of its Victorian forebears. The currently fashionable positive mythology of old age shows no more tolerance or respect for the intractable vicissitudes of aging than the old negative mythology. While health and self-control were seen previously as virtues reserved for the young and middle-aged, they are now demanded of the old as well. Unable to infuse decay, dependency, and death with moral and spiritual significance, our culture dreams of abolishing biological aging.

While the middle-class elderly have become healthier, more financially secure, and politically potent, they nevertheless suffer from the cultural disenfranchisement imposed on old people in general. "Growing old," says a character in Anthony Powell's *Temporary Kings*, "is like being penalized for a crime you haven't committed." Having satisfied the social requirements of middle age and avoided many previously fatal diseases, older people are often able to live 10 or 20 years beyond gainful employment. But then what? Is there something special one is supposed to do? Is old age really the culmination of life? Or is it simply the denouement to be endured until medical science can abolish it?

We must acknowledge that our great progress in the material and physical conditions of life has been achieved at a high spiritual and ethical price. Social Security has not enhanced ontological security or dignity in old age. The elderly continue to occupy an inferior status in the moral community—marginalized by an economy and culture committed to the scientific

management of growth without limit. For the last 60 years Western observers have sensed this impoverishment of meaning in old age. But only recently have economic and political conditions turned this apparently academic question into an urgent public issue. In rebuilding the moral economy of an extended life course, we must not only attend to questions of justice within and between different stages of life, we must also forge a new sense of the meanings and purposes of the last half of life.

This will require a new and integrated appreciation of aging that transcends our historical tendency to split old age into positive and negative poles. Since the early nineteenth century, American culture has characteristically oscillated between attraction to a "good" old age (the health culmination of proper middle-class living) and repulsion from a "bad" old age (repudiating the dream of limitless accumulation of health and wealth). We can no longer afford this dualism, which feeds both the false pessimism and the superficial optimism in contemporary discussions of our aging society.

We must also break with our habit of using old age as a metaphor for the success or failure of various political and ideological agendas. This does not mean that our search for more adequate ideals of aging should be "value-free"—as if continued scientific research and technology could eliminate all conflict, mystery, and suffering in late life. Rather, we need more social criticism and public dialog aimed at creating socially just, economically sound, and spiritually satisfying meanings of aging.

We need, for example, to criticize liberal capitalist culture's relentless hostility toward physical decline and its tendency to regard health as a form of secular salvation. A good deal of the pathos that surrounds old age today derives from the instrumental perspective that pervades the scientific management of aging. The one-sided drive to alter, reverse, ameliorate, abolish, retard, or somehow control the biological process of aging intensifies the impoverishment of meaning instead of confronting it. So-called "positive" aspects of aging often turn out to be disguised forms of the effort to restore youth rather than appreciation of growing or being old as a fundamental dimension of human existence.

Until quite recently, Western culture emphasized the immutable limits and proper boundaries of the life cycle; it counselled individuals to transform their fate into a journey to self-knowledge and reconciliation with finitude. Contemporary men and women think of themselves not as fated creatures, but as active beings who can solve life's problems with science and technology. Yet this is clearly an illusion, since we now receive our fate at the hands of medicine. Our challenge in the future is to find a new synthesis, in which the ancient submission to natural limits is balanced against the modern drive to find a scientific solution to every problem.

Today there are encouraging signs that traumatic fear of aging is increasingly offset by awareness of its opportunities for inner growth. The assumption that full intellectual and emotional growth occurs in the middle years has been challenged by the view that human development is not chronologically bounded and that later life can be a time of transformation rather than mere adaptation. In literature and humanistic gerontology, we are seeing a resurgence of the view that old age is a period of unique capacity for wisdom, for understanding the experience of a whole lifetime, and (therefore) for service to the young.

To welcome the elderly back into the moral community, we need more than renewed appreciation for "the gifts of age." We need to understand the obligations and responsibilities as well as the rights and opportunities of old age. We need policies that eliminate the surplus dependency imposed on older people, policies that strengthen their ability to solve their own problems and contribute to their communities. This will require, as Harry R. Moody argues, a life span approach to human development. Just as public investment in the health and education of children is essential to their future productivity, so policies that stimulate self-help, lifelong learning, and social participation among the elderly are essential to maintaining their independence. Human services for and professional intervention with older people need not foster dependency.

Independence among the elderly is not only a matter of human services, it also requires incentives and opportunities for participation and productivity. Many experienced workers aged 50-75 leave the work force either because their skills are no longer needed or because they respond to employers' inducements to retire. While these people are generally vigorous, healthy, alert, and capable of making important contributions to the nation's economy and quality of life, their lives are primarily channelled into trivialized leisure and the consumption of professional services. In the year 2010, people aged 50-75 (which Alan Pifer hopes to popularize as the "third quarter of life") will comprise almost one-third of the U.S. population. We clearly cannot afford to continue excluding them from productive life.

Productivity in late life does not necessarily mean the continuation of full-time, paid employment. It means recognizing the contributions—whether in the form of full- or part-time, paid or volunteer work—made to the nation's economy or to its quality of life. Pifer suggests several ways of enhancing the productivity of older Americans. Both industry and government can open up retraining programs to workers over 50. Public and private pension programs can be changed to allow partial retirement. The federal government can permit older people to borrow against their Social Security benefits to finance retraining or enroll in new educational programs. As some have already done,

colleges and universities can devise special programs to meet the needs of older students. Public service employment programs for older workers can be expanded, providing modestly-paid work to unemployed older workers who want to defer retirement or supplement retirement benefits.

To accommodate an aging society (*and* to continue expanding protection for the poor for all ages), Americans will have to make substantial changes in the welfare state—but not of the sort that either interest-group liberals or neoconservatives envision. A half-century of Social Security history suggests that progressive reform (not abolition or privatization) is both desirable and politically feasible. Despite its limitations, Social Security remains, as Senator Bill Bradley has noted, "the best expression of community that we have in this country today." It rests not only on the principle of social insurance over the individual's course of life but also on an intergenerational compact that must be renegotiated as historical circumstances required.

The "spectre of old age" that seems to cloud America's future is actually a reflection of our impoverished ideas about aging and our reluctance to face the real but not insuperable challenges of generational equity. "It can only weaken the vital fiber of the younger generation if the evidence of daily living verifies man's prolonged last phases as a sanctioned period of childishness," Erik Erikson wrote in 1964. "Any span of the cycle lived without vigorous meaning . . . endangers the sense of life and the meaning of death in all whose life stages are intertwined."

The challenges of generational equity then involve the distribution of cultural meanings and social roles, as well as the distribution of social goods like income and health care. We have clearly entered a period in which the intergenerational compact underlying Social Security is being renegotiated. In this "conversation between the generations," there is good reason to believe that a new moral economy of the life course can be fashioned. If so, the "abundance of life" in our aging society can yet be channeled toward genuine human development and social well-being.

Questions and Answers
RAY FARABEE, MODERATOR

Thank you, Tom. (Ron, you can look at this group and tell there are no "geezers" in the Philosophical Society of Texas.) Now there may be a few of us who may qualify for the AARP. The last I heard, the threshold for membership was age 50, and they were thinking about going to 45. No wonder they can get *Modern Maturity* for life.

These discussions, and particularly after turning 59 last month, remind me of the epitaph on W. C. Fields's tombstone, which said, "All things considered, I'd rather be in Philadelphia." We can paraphrase that and say, all things considered, I'd rather be a part of an aging society.

Your papers to the group raised a number of questions and issues that are quite appropriate as we begin this meeting. I open the floor for questions to our two panelists if you have questions or brief comments concerning these two subjects. Mr. Hargrove.

James Hargrove: I think, in my experience in international areas, frequently what's being done in other places is better or cheaper or both than what's being done in the United States. I think it's certainly considered abroad that the costs of health care in the United States are fantastic, and no one really who is very prudent will come to the United States without some special sort of insurance to cover medical costs incurred while here as a tourist. We are spending a great deal more than other nations, I believe, on health care, but the benefits from that health care are not that apparent. Other nations seem to be doing a great deal better than we are in some areas, particularly infant mortality, I think, and I think that what is needed is some sort of a careful examination of comparative health systems in other nations comparable to ours. Canada is, of course, the one that's closest and the one that's mentioned most frequently in terms of our health system. What studies have been done with respect to comparative health systems and cost benefits and what can we do to further develop this comparison so that we can take advantage of what our friends in other parts of the world have developed?

Ray Farabee: Thank you. Ron, do you want to make the first response to a question concerning various health care systems as compared to our own?

Ron Carson: Well, you're quite right, it seems to me, in your observation that lots of other countries are doing it differently and better. If one wants to measure, or take as a standard of measure, access to the health care system, satisfaction with health care services, the delivery system itself, we do have information about this. We know this. Canadians are much happier with their system. The Germans are much happier with their system. The Swedes are much happier with their system, and so on. And I want to simply second your suggestion that we pay attention to those countries. Now, we can't duplicate systems from elsewhere because health care is personal, it's all woven into the culture fabric of a country, and so to simply adopt, to think that we could adopt a health care system from another country is foolishness. I think there's been quite enough of the sort of negative representation of health care systems

elsewhere. We know why the British system is not the one we want. For example, let me note the one that usually gets picked on, it's not even comparable. We shouldn't even be talking about that system. The British started over in 1945 and essentially built a system which now sort of muddles through, as Churchill said. We didn't do that. We should not be thinking in those terms. That scares doctors to think about a British system because here are physicians working for the government. Physicians in this country are not going to work for the government in that way. Canada, it seems to me, is in many ways an ideal model—not one that we can adopt in every aspect. But, we and the Canadians are more alike than we are different in terms of our cultural values, political values. So, increasingly, it seems to me, the pressure is on to take a look at what the Canadians are doing right. We know about the long waiting lines, we know for certain kinds of elective procedures, we know what's wrong with it. What's right about it? Does it make a difference that it's a national system regionally organized, that, for example, the provinces negotiate with physicians about the very questions we are talking about today—cost, access, etc.? Does it make a difference that there's a lot less high technology available? I mean, that's the reason for some of the waiting lines, for the long lines for the waits, you see. How much difference does that make in the big picture? It doesn't apparently hamper appreciably Canadians' satisfaction with their system. We ought to take a look at that system very closely. It's being done, of course, there are studies now galore. The question is the one of political will. Once we know enough, how do we feed that into the political system and get people to pay attention to it and come to some kind of understanding of how we can take the best of a system like that and make it work here?

Ray Farabee: Dr. Cole, would you like to make any response to that question? Next question.

Jon Fleming: I'm Jon Fleming, probably the most recent member of AARP in the room. We just got back from California and got a 25 percent discount on the Marriott Hotels out there. It's not a bad deal.

Two questions of Dr. Carson that are already in correspondence with our two senators and Senator Nunn. The first part of it is on the predicate that every physician in the United States has a larger or smaller streak of altruism in his or her life and that if we could create a structure that would grant tax credits to the physician and then extended tax credits to proprietary hospitals for the treatment, the primary treatment, of primary medical care, of indigent people, particularly children and older people, then we could make a substantial impact on the cost issue. Yes, we would be giving up tax income

in a way, but we would also create the carrot, as it were, for the physicians in our society to get with the people, treat them, help them, and provide care for them.

The second observation that's in this correspondence is that we live in urban war zones in the major cities and the trauma care is one of our largest cost issues and the systems of major trauma care, at least in Dallas, and I suspect in other cities in the United States, are imploding, and are in genuine essence, self-destructing. So that we could take and identify 30 or 40 major population centers, let the Department of Defense operate the trauma centers in the major cities, let the air force operate the life-flight helicopters and train the battle surgeons, the young men and women who are going to be the army's and air force's and navy's surgeons in the future in these trauma centers in an obvious physical infrastructure that's already there in the veteran's hospitals and begin to relieve this immense pressure on trauma care in the United States. Thank you.

Ron Carson: That was as much a comment as a question, but if I may, may I just respond briefly on each of the points. I'll defer to Governor Hobby and Dr. Warner and others tomorrow morning who will have a shot at some of the specifics, perhaps, of the kinds of things you're talking about—what mechanisms can we use to alleviate problems and get people access to the system? But, on your first point, I applaud anything that will enhance what you called physicians' altruism. Individual physicians continue to provide a share of uncompensated care, if you will, in all kinds of instances, in offices, in clinics, wherever it's still possible to do that kind of thing. I say, individual physicians. It has become increasingly difficult, delivery on one's altruistic instincts, as our system of delivery has become large and overweening and overburdening. So that, if you will, to draw stark contrast, it seems to me that physicians are often sort of required to spend time with paperwork that they could be spending taking care of people. That was the spirit, I take it, of your first remarks, and I applaud that. I'm not sure, regarding specific mechanisms, how we'd do that, but with our ingenuity and our intelligence, we ought to be able to figure that out. Again, for me, it's a question of social conscience and political will. Are we agreed that we want to tap, on the part of physicians, their good intentions toward patients? All in favor say aye, let's figure out how to do it. I mean, let's find a way to do that. Instead, we're throwing up roadblocks and obstacles, unwittingly, for the most part, but we've got to recognize that we're doing that and get those obstacles down.

On the second point, I don't know about this idea. I don't know whether you made it provocatively or seriously. I don't know how to take this question about taking over the trauma care. But, heaven knows the emergency rooms in this country, emergency rooms, trauma care centers, are burdened beyond

control. I mean they're just, and not least it seems to me, because there are a lot of people there who don't belong there. They're not there because they're traumatized, I mean, I'm not talking about the knife wounds and the gunshot wounds and the real trauma. I'm talking about all those poor people who are sitting around the emergency room of every major hospital in this country awaiting primary care. They've got an earache, or they've got a bellyache, or they've got something even more serious than that which needs attention, but certainly not in the emergency room of a major medical center. That's a mandate, it seems to me, not for manpower in the trauma centers, but rather an enhancement of training programs and incentives to draw people into prevention and primary care.

Ray Farabee: Next question.

Elspeth Rostow: I'm Elspeth Rostow. My attitude toward the medical fraternity—is that still a word? probably isn't—was determined when we spent a year in England and were assigned to a medical partnership. The two members of this partnership, both admirable men, were named Dr. Playfair and Dr. Strangeways. This prompts me to suggest a few variables that I haven't heard this morning that I think are relevant. One is the question of urbanization. We are sentimental about our past. Rural America of the nineteenth century did not provide very good medical care, but it had other institutions that could substitute for the lack of, let's say, a modern medical center. One of these was the family, and that's my second point. We have become an urbanized society at the same time, and it's not coincidental, that the family structure has been under strain, and in many cases, has disintegrated. And I'm thinking inner cities, I'm thinking about all the pressures that modern America produces for family structure. We now are in a transitional period when we have to define the community differently. I was glad to hear the word "community" come into it, because it seems to me that in this urban America with variously weak family structures, we have to define community responsibility in a fashion that will provide, not only the care, but will realize that this is a world where we can't necessarily send senior citizens out to the barn; we don't have enough troughs, but we also have the responsibility of taking care of the young, which used to be essentially a family function. So, to redefine the late twentieth century is to predict the problems of the twenty-first century, and they will not be the problems that we are accustomed to thinking of, so let's not be sentimental about the past, but let's realize that there are various structural differences that will determine how effective the community response will be.

Ray Farabee: Dr. Cole.

Thomas Cole: I appreciate those remarks, and let me make one comment about long-term care that does not take place, that takes place at home. The burden, although we're familiar with the burden on Medicaid of long-term care, it's important to remember that middle-aged women provide the bulk of the care for dependent elderly in homes, still. And I think, although I'm not familiar with the details of this kind of issue, I think it's not at all out of the question that we could consider finding incentives, financial incentives, tax incentives, to ease the plight, financial plight, of middle-aged female caregivers who are caring for their aged parents in the home at the same time as they are responsible for their children, which is another way of saying we need more family-based policies that can provide some kind of support for both the dependent older people in the homes and children.

Ray Farabee: Next question or comment.

Richard Wainerdi: We seem to see problems in isolation. One hundred and fifty years ago we said education is a problem in this country and decided that we were wealthy enough as a country to provide education to all children in every county or parish in the country, and we do that and sometimes at extraordinary cost. We have never decided that as a country we are wealthy enough to provide good health care for all children, and it seems to me that by cutting apart problems and keeping them separate—education, criminal justice, health care—we make a great mistake and fail to see their interrelation. We have jails for people who have a low IQ because they had problems in their nutrition and in their growth and who will never learn and who will never be part of society, and so we build more prison beds to house more people who have those kinds of problems. Instead of seeing that an investment in health care, which you have been talking about to a very large extent, is really illness care, and paying for illness care. A great deal more can be done in our society, it seems to me, by providing our children with an opportunity to be healthy. Thank you.

Ray Farabee: A response by either panelist. Ron Carson.

Ron Carson: I couldn't agree more. Access to the health care system is so on our minds that we do tend to think in isolation, and I appreciate your correction. You know of Head Start as a program that works very, very well

for the children at reading. It costs $3,000 a year and provides benefits that are incalculable, benefits of the sort, preventive benefits, if you will, of the sort that you have just described. Now that's in the realm of education.

Walt Rostow: First the question, how much of the decline in the health, or rise in the death rate of young children, the rise in our infant mortality, is a problem of the inner cities? How much of it is black and Hispanics? To what extent are the problems that we are talking about problems which, in the end, can only come from concerted programs which widen the options and bring the bulk of the populations over generations in the inner cities into the mainstream? Sixty percent of those in the underclass families, as formerly measured by the Urban Institute, have unmarried mothers as the only head of the family, and if there is any insight, it is the one that was suggested by the last speaker, last two speakers, which is that you've got to create a system in which you have continuity in care from birth control to prenatal care, postnatal care, Head Start, and as Pat Hays and George Kozmetsky and I were talking last night, begin to bring the young people into contact with the business world, the manufacturing world, so they can get prepared and conceive of their entering into the world of twenty-first century technology—all of which is quite possible, but it does take, as Elspeth said, a sense of community, interventions which cover the whole span, systematically, of the life of those now trapped in these circumstances. And it's quite a big population, and I think, statistically, it has quite a lot to do with the shape of the American statistics versus the Swedish, and so on. When you begin to look at it that way, and it has a lot to do also with mobilizing good will. My impression is that if you had organization, you could get the universities, the business community, all of the institutions of volunteerism, operating on a much vaster scale. Now it's a thousand points of light because there's not organization to make it a million points of light, but the will is there, and so what I'm raising with you is something that is missed if you talk in aggregate terms of statisticians. If you disaggregate and get at that part of our problem which stems from the disproportionate pathology of the inner cities, you might emerge with quite different ways of talking about, thinking about, and acting about this problem.

Ray Farabee: Dr. Carson?

Ron Carson: May I just ask you to elaborate on your claim that the political will is there? And I identify political will as one of the problems. I was talking about access to health care. I was talking about something more specific than you're discussing at the moment, Professor Rostow, but what's the source of

that political will? How can we mobilize it? I want to believe it's there, and I do believe with you that it is a matter of broad-gauged concern of the sort that I quoted President Truman as saying we needed in 1949. How do we do this? We seem to be stuck.

Walt Rostow: I remember a very similar problem and experience in 1960-1961. Not I, but someone else, suggested the idea of a Peace Corps to go out to the developing countries. I was working with then-Senator Kennedy on problems of development in India and elsewhere. He turned to me and he said, "If we made a Peace Corps proposal, would we get a response?" And I was then teaching at MIT, and I said with some confidence, "Yes, we'd get a response." And I knew this, not because I had some great insights beyond those of anyone else, but because the young people at MIT were trying to get at this problem through Operation Crossroads, which was a Quaker thing, there were a number of small operations, and I said I thought from my students and those that I had observed that if this was widened out, you widen the opportunities and gave them shape and leadership from the political process, you'd get a flood of people. I assure you that the flood that came was far beyond the most optimistic estimates. My feeling now is that there is a deep awareness in the country that the pathology of the inner cities in the widest sense is eating away at our capacity to educate the entrance into the workforce so, in a sense, we're living off the capital of children, infants born with potential talents which are never used, that are wasted, because we don't know how to deal with it, we don't give them health care. There's an awareness of this. The business community is aware that 40 percent to 50 percent of the entrants into the work force in the 1990s will be blacks and Hispanics, where the major dropouts are. And there's where you're getting IBM and other big firms truly concerned with this problem. And that may in the end help us. It's a bottom line problem. But from my knowledge of students in the University, I don't know how many thousands we could get into a systematic counseling program in the East Austin ghettos from the University of Texas—if we had it organized. My door is open to students, and I raise this with them because it's been on my mind for several years, and I don't think we've yet, the political leadership, has yet found a way to weave the potential volunteerism of this country, which is a strength that runs back as long as we've existed as a society, into the bureaucratic efforts to solve the problem. And there is another problem which may be the toughest of all—how you get bureaucracies to work together. There's a great definition Sol Levin had, that the cooperation of bureaucracies is an unnatural act conducted by unconsenting adults. And this is, it's a good joke, but it's black humor because it may prove to be the greatest block that exists to doing something.

And, I think, the way you put the question which is why we're not doing, that's one reason, because politicians are fragmented and this is tough to resolve. But I can give you no statistical evidence, but a certain amount of experience in dealing with the kinds of people and institutions which I think would put out a massive effort if there was a structure that promised hope. At the moment, both those in the inner cities and those outside are virtually hopeless.

Ray Farabee: Dr. Cole?

Thomas Cole: Let me just follow up with this discussion of the Peace Corps and ask the question about the possibility of the creation of an elder corps. If we ask the question of how many, we know the rates of retirement from age 55 to 75 are very high, we know most of those people are healthy, and why not find ways to put them to work as a form of public human capital in the kind of ghetto situation that you're talking about? Is this a feasible idea? Would there be a response to this? There could be a federally and locally coordinated program. And there's a lot of volunteering that goes on in the older population, but it's not coordinated, and there's no national way of bureaucratized financial commitment to this. Is this a feasible counterpart to the Peace Corps?

Walt Rostow: I'm sure it is, although I'm sure the social security system will have to be salvaged in the next century, first half of the next century, by just raising the age at which people retire so that a lot of them ought to be out there working. But, yes, I think there'd be a tremendous response. For those of you who know Lakeway, I bet I could get 25 percent of the people at Lakeway into your project.

Ray Farabee: Because of the balance of our program this morning, and our commitment to them, we're going to have to cut the discussion and comment at this time. But there will be, because of some similarity of issues, opportunities to bring forward some of the things that we didn't have an opportunity to cover.

Panel II
Wayne Holtzman, Moderator

It's obvious that the issues stirred up by the first panel this morning elicited a great deal of discussion during the coffee hour. Most of us are still ruminating about what this means for us personally, for our family, for our friends, for our society as a whole.

The issues are really staggering when you look at them in the health care field. It's clear that there are going to be momentous changes in the next five to ten years, if not in the next one or two years. Both the White House and Congress are vying for a position in defining health care for everyone in the country. It's rapidly becoming a universal right. Well, what does that right mean? Does it mean the right to see a physician whenever you want to, whenever you need to, whenever you're desperate enough that you must? Rights are very difficult to define in this context.

There are several things that have happened over the years that have transformed the doctor-patient relationship, the relationship between me as an individual seeking help and the expert who is an authority in the field of medicine and surgery who is advising me, doctoring me, providing me with nursing, whatever it may be as a health care activity. It used to be that we had two actors in this scene. Idealized, you had the family doctor, with his black satchel, who came out, charged you $1.50, and you received whatever he had to offer. And he knew you and you knew him. He might have even brought you into the world—he or she, although it was usually a he. That past probably never was quite up to the ideal image that many of us in our generation have of what the doctor used to be.

There are two additional major actors who have entered that scene, and they've entered it rather recently. First is the third-party payer, the insurer who provides managed care by the case-management worker. No longer is the relationship between patient and doctor strictly private. Today, in order to get reimbursement or permission for any kind of medical procedure, one goes to a remote outsider who is a case manager in some distant place, unknown to either the doctor or the patient, who decides whether the procedure can be reimbursed or not, whether the charges are appropriate. Have any of you had any problems dealing with a case manager who declines to reimburse you or the doctor from medical insurance? Have you felt sort of caught between the insurer out there and the doctor whose fees are challenged? Perhaps your insurer says you shouldn't even have that procedure. But the doctor says, "Look, I'm giving you the best medical care I can. How are we going to pay for this?" We've all had guilt feelings about the difference between what is set by the case manager and what the doctor feels is rightfully the fee for the many things that are done. The scene includes much

more than the doctor. There's an entire group, almost an industry out there, and most physicians are now in various kinds of firms or partnerships where they have a full-time claims adjuster. Unheard of in the past—a secretary or a clerk who keeps after the patient, provides a little distance between the doctor and the patient with regard to any guilt feelings about going after that last dollar that's due, or going after the third-party payer. This third force of managed care is a very real and permanent part of today's health care scene.

A fourth new actor on the scene is the litigious advocate, the attorney who files a lawsuit on behalf of the patient, often with good cause. As a result, the insurance rates go up and up while the malpractice insurance for the doctor skyrockets. What is the malpractice fee now for a high-risk area of medical practice? A hundred thousand a year? It's more than was the total income of that same physician not many years ago.

What is the impact of these two new forces upon what was a fairly close and intimate relationship between a doctor and a patient? Unfortunately, it has often driven a wedge between them. There is a growing distrust of the physician. There is a growing distrust by the physician of the patient. Defensive medicine is often practiced to protect the physician from a lawsuit. Various kinds of expensive high-tech diagnostic procedures are employed just to be safe, to avoid litigation, and the price of health care shoots way up. Concurrently there is a rise in dishonest claim-filing and kickbacks which is also destroying the doctor-patient relationship in many respects. Is a state dishonest when it establishes a kickback on Medicare and Medicaid from hospitals in order to maximize the federal dollars coming into that state? Is a physician dishonest when he accepts a kickback because he placed a patient into a particular hospital? Is it dishonest when the physician pads his bill in order to get those extra dollars that he feels he needs to run his operation because otherwise the third-party payer won't allow full reimbursement? In the old days, such practices would have been clearly dishonest. And the patient feels helplessly caught in the middle. As a patient, you have to be a pretty sophisticated accountant to deal with these issues.

Today's discussion by our panel is going to address some of the issues that arise in the doctor-patient relationship. Our first speaker will deal with the question of empathic expertise within the doctor-patient or nurse-patient relationship.

Ellen More comes into medicine in a way by the back door. She first studied British history, and then went on to obtain her Ph.D. in medical history at the University of Rochester. She was drawn into medicine through a Commonwealth Fund grant given her as a historian. More recently she has developed a special interest in the history of women physicians in American medicine.

Dr. More has been at the University of Texas Medical Branch in the Institute for the Medical Humanities since 1987. It's a pleasure to present Dr. Ellen More, who will speak to us on "Empathic Expertise."

EMPATHY, PRODUCTIVITY, AND THE CARE OF PATIENTS

ELLEN S. MORE

THANK YOU. IT'S A PLEASURE TO BE HERE. IT'S A SPECIAL PLEASURE BECAUSE ONE of my former medical students from the institute's first-year course in medical humanities is here today, sitting in the front row—quite a nice coincidence!

I'm going to speak to you today about the mixed message today's physicians receive from the public, the federal government, and even from certain sectors of the medical profession itself. The public wants its physicians to care more and charge less. We patients want our physicians not only to cure us, but to spend more time communicating with us. Communicating effectively, that is. At the same time, health care administrators, industry, government, and even patients (when it comes time to pay up), are insisting that medical costs be stabilized or even reduced. We are asking individual physicians both to deliver more cost-efficient care *and* to deliver it in a more "caring" way.

Paradoxically, these demands occur at a time when the ratio of physicians to population is at its lowest point in at least half a century. Yet, rather than finding ways to utilize physicians more effectively, some analysts are calling for a reduction in the numbers of new physicians entering the profession as a way to cap the rising cost of health care. Despite our deliberate efforts since the 1960s to increase the numbers of physicians in practice, a recent article from the *Journal of the American Medical Association* asks, "How Many Physicians Can We Afford?"[1] Is it possible that a different approach might achieve better results—and at no increased cost?

Today I want to consider a first step toward reconciling our desire to cut costs while also improving the quality of care. I would like to suggest that providing physicians with incentives to communicate more effectively and empathically will contribute to both these goals. For, as we will see, these goals seem to conflict because, among many other factors, empathic care takes time and has effects that cannot easily be measured. Therefore, it seems inefficient. Nor do we reimburse doctors who "just talk" at the rate of those who perform procedures or tests. Simply put, we just don't reward physicians as highly for "care" as for "cure." Little wonder than an American Medical Association public opinion survey for 1991 reported that less than one-third of the public believes doctors spend enough time with their patients. According to studies cited by a recent *Wall Street Journal*, doctors spend, on average, seven minutes actually talking to patients.[2]

Yet considerable evidence exists that physicians and patients alike are showing renewed interest in empathic medicine, both for its benefits and its effects on cost. Here, for example, are some titles from a few of the recent articles devoted to the subject: one New York *Times* headline declared, "Doctors Find Comfort Is a Potent Medicine."[3] Another, in the *Journal of General Internal Medicine*, considered "Sympathy, Empathy, and Physician Resource Utilization."[4] And, in the prestigious *Annals of Internal Medicine*, a physician wondered "What Is Empathy and Can It Be Taught?" Perhaps a headline from the *Wall Street Journal* summed it all up by declaring, "Medical Science Seeks a Cure for Doctors Suffering from Boorish Bedside Manners."[5]

Invoking a tradition ultimately traceable to Hippocrates, Daniel Goleman began a recent article in the *Times* with the admonition, "Comfort always, cure rarely." Goleman was reporting on several studies designed to analyze the effectiveness of empathic medical care. In the first of these studies, conducted at the University of Pennsylvania, investigators examined the role of patients' emotions—and specifically their levels of optimism and pessimism—on the long-term outcomes of 122 men following a heart attack. Their state of mind was found to be a better predictor of death from subsequent heart attacks up to eight years later than any of the standard medical risk factors including degree of initial damage to the heart, arterial blockage, cholesterol levels, and blood pressure. Of the 25 most pessimistic men, 21 had died of subsequent attacks after eight years; of the 25 most optimistic, just six had died.[6] (This is good news for academics, by the way: most of us are incurable optimists.)

Another study, undertaken by psychologists at Johns Hopkins and Northeastern universities, examined the long-term effects on patient distress of training their physicians in the art of empathic listening. At Mt. Sinai Medical Center in New York, psychiatrists compared the length of hospitalization of elderly hip-fracture patients who had received psychiatric consultations during their hospital stays with those who did not. Dr. James Strain calculated that those who received the consults were discharged an average of two days earlier than those who did not, a savings of $178,572. He concluded that, "Physicians absolutely should take their patients' emotional states into account when they treat them for medical problems."[7]

Now, it is certainly true that these studies do not and can not *prove* that empathic care "causes" better outcomes for patients, whether measured in shorter hospital stays or longer lives. For one thing, pessimistic or depressed patients might have a physiological predisposition to depression that is also the underlying cause of their poorer outcomes. Such patients, too, may not comply as fully as the "optimists" with long-term medical advice regarding exercise, diet, and medication.

Nevertheless, regardless of the reason for these correlations between better outcome and greater attention to psychologically attentive medical care, the fact remains that patients who seek physicians to treat physiological complaints do not always reveal to them the emotional dimensions of their condition. Furthermore, even when they do try to broach such questions, their physicians are ill-equipped to provide the counsel and comfort they need. Not for lack of will, quite often, but for lack of training and time, young physicians quickly learn that the facts of medical life in today's health care system rarely include the art of listening: we pay lip service to "quality," but we reimburse and measure according to quantifiable measures of productivity and (sometimes) efficiency. One looks in vain for any measures of quality of care in studies of productivity.

Fortunately, the interest in teaching physicians the humane art of empathic listening has not disappeared. For, as anyone who has been part of the profession of medicine will realize, this is the core of the doctor-patient relationship. More to the point, improved communication leads to better decision making; better decisions produce better outcomes—and probably cheaper ones, too, in the long run.

I'd like to spend a few minutes, therefore, describing the work of one of the most interesting practitioners of the art of interpreting the meaning of illness, Arthur Kleinman, M.D., Ph.D. In 1988 Kleinman, a psychiatrist and anthropologist, published an exceptionally thoughtful book titled *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York, 1988). His work combines the techniques of psychiatry and ethnography to attempt an ambitious project: first, he seeks to convey to physicians and patients that from the standpoint of the patient, "illness has meaning." Second, he attempts to persuade physicians that they have the responsibility to help their patients discover that meaning for themselves.[8]

Not unlike the researchers described at the outset of this presentation, Kleinman is convinced by many years' experience interviewing and treating patients that the meanings patients assign to their illnesses actually can amplify the effects of their symptoms. For this reason, as Kleinman writes, "Witnessing and helping to order that experience [of illness] can have therapeutic value." He urges physicians to move from an understanding of disease to an understanding of the "innately human experiences of symptoms and suffering," that is, an understanding of the illness as experienced and interpreted by the patient. Kleinman calls this "empathic witness of the existential experience of suffering."[9]

Kleinman's recourse to the language of "empathy" is of signal importance to the success of his project. What he attempts can only proceed by the cooperative engagement of the physician, the patient, and the patient's family

working together. Only by a reciprocal "dialectic of healing" can the caregiver be brought into the "uncertain, fearful world of pain and disability," or can the patient be introduced into the uncertain world of therapeutic actions.[10] In short, this is a process of mutual engagement between patient and physician to which both must be fully committed.

It is also a process of mutual interpretation of symptoms—what we sometimes describe as a "negotiated settlement." Through the act of clinical listening the illnesses of particular patients become embodied in a "particular life trajectory . . . environed in a concrete life world." To truly understand, the physician must understand not only the disease, a biomedical entity, but also the meaning system by which the patient extracts key elements from his or her lifeworld and constructs an interpretation of her or his illness.[11]

To make his methodology more concrete, Kleinman offers examples from the experiences of his patients. One patient, in particular, impressed me deeply. Her name (fictionalized by Kleinman, of course) is Alice Alcott, and she is a middle-aged, white female. A diabetic, she was suffering from severe depression following amputation of her leg. Alcott's diabetes was a nearly lifelong condition; up till now, she always had coped successfully with her gradually accumulating series of bodily losses. Now, however, she was faltering in her ability to regain her self-assurance and overcome the new challenge presented by her disease. Kleinman was called in to help treat her depression, which was interpreted—quite appropriately—as a response to the recent amputation. By carefully listening to the narrative through which Alcott recounted and interpreted the meaning of her illness, Kleinman became aware that for her, the amputation of a limb carried a symbolic meaning far weightier than any of the earlier effects of her disease. In order to understand this, he needed to understand her life. The process by which Alcott and Kleinman gradually came to a deeper understanding of her deep mourning for her accumulating bodily losses, required a reciprocity of trust and communication best summarized as "empathic listening."[12]

Recently at UTMB our Psychiatry Department received a patient whose situation, her interpretation of its meaning, and the process by which we came to understand her interpretive system, will illustrate both the advantages and the difficulties of listening to patients' narratives of illness. This patient—I'll call her Mrs. W.—was a 73-year-old white female, a widow living alone in her own house in a small Texas town. She was brought to the hospital with a diagnosis of clinical depression. Thus far, she could be any one of thousands of elderly widows anywhere in the country. Mrs. W. recounted the outline of her life for an audience of about 20 medical students and three members of the faculty. As she spoke to us, however, she repeated one phrase three times during the course of her account, a phrase none of us immediately understood.

That is, we could only make sense of it by interpreting it from *her* perspective, from within the story she was telling. Three times during a 15-minute monologue she described herself as "working in public" in the aftermath of the three major crises of her life: the unhappy ending of her three marriages. As she put it, after the divorce, death, or disappearance of her three husbands, she was forced to *"work in public."* What, we wondered, could she possibly mean by that unusual phrase?

Perhaps some of you are familiar with the phrase, which I am told, is a usage heard occasionally in West Texas. For us, however, the words sounded discordant, strange, coming as they did from a rather timid and unworldly woman. What could "working in public" possibly mean to her? To us, her words conjured up the image of work in a public setting, perhaps as a product demonstrator, a salesperson, a model, or a television newscaster. This was so clearly an inappropriate interpretation that we were forced to dismantle our own associations with the phrase and start all over, this time from her point of view.

The meaning we discovered for Mrs. W.'s words helped illuminate her entire condition. As we considered the story told by this very modest woman, raised in a traditional rural setting with the typical expectations for a woman of her time and place, we began to understand that what she really meant was something like this: "Each time I experienced the calamitous end of my marriages, economic circumstances forced me to leave the privacy of my domestic sphere and *go out in the world to earn a living*." In other words, she was forced to "work *in public*." Her jobs were in no way extraordinary; she was not the anchorman on the six o'clock news. She was not, in the sense we understood it, working in public. But to Mrs. W., being forced to work outside the home was degrading, a kind of public humiliation, an exposure. Her sense of abandonment was, it turned out, central to understanding her interpretation of her depression.

Unfortunately, the process I have just described, of unpacking and trying to understand this patient's interpretation of her illness, did not occur in the presence of the patient. The fact is, our efforts at understanding took place in private, long after this patient interview was completed. But although this was not a successful instance of empathic doctor-patient communication, it is an example of the way that the humanities and social sciences are being used, at the Institute for the Medical Humanities and in many other medical schools, to help us move forward with the task outlined by Arthur Kleinman and many others: the task of interpreting the meaning of illness.

Yet there are many obstacles both to teaching and implementing the practice of empathic caregiving. Because empathy may not be terribly difficult to learn, but it is quite costly to practice, costly, that is, as an

expenditure of time. In fact, as I've already suggested, the desire to integrate empathy and expertise seems to run counter to that other demand on the health care system, the pressure to reduce cost. And, because physicians act as the gatekeepers to some of the costliest tests and procedures, one means of reducing costs favored by many analysts calls for reducing the number of new physicians and increasing the productivity and efficiency of those already in practice.

The pressure for productivity is not a new one, but it has intensified since the projection about 10 years ago of an apparent oversupply of physicians. Ironically, this "oversupply" has resulted from a deliberate national policy to counter a physician shortfall projected by federal studies conducted during the 1950s. In response to those projections, 41 new medical schools were opened between the 1960s and the 1980s while the class size of existing medical schools was increased substantially. According to most accounts, the ratio of practicing physicians to population increased by approximately one-third between 1976 and 1986, from 135:1000 to 181:1000. In absolute numbers, physicians have increased by 50 percent during the same period.[13]

Now, even while millions of Americans lack access to even minimal care, some analysts are targeting the supposed oversupply of physicians who, they contend, practice inefficient and unproductive medicine and fuel the steady rise in health care costs. This analysis thus defines the crisis primarily in terms of cost, claiming that high costs are what prevent millions of Americans from receiving adequate health care. But by emphasizing cost and deemphasizing structural issues such as the maldistribution of physicians and other resources, no attempt is made to creatively utilize the so-called glut of physicians already in practice.

What is more, and this is my particular concern today, if measures to increase physicians' productivity and efficiency do not also attend to quality, in the words of policy analyst Aaron Wildavsky, we will be "doing better and feeling worse."[14] Because people feel better *and* do better when they are *treated* better—as patients and as persons. But, when physician "productivity" is defined, as it is in most studies, as the number of hours worked per year and the number of patients seen per hour, quantity will edge out quality every time. Introduction of DRGs, MMIs (medical management information systems), decision analysis, and other ways to standardize decision making and improve outcomes can supply an appropriate and necessary rationality into diagnostic and therapeutic decisions. It will not, by itself, give patients or doctors better satisfaction with the outcome of their encounters.

Unfortunately, empathy does take time. But if it increases patient satisfaction and, by improving decision making, also improves outcome, it would be time well spent. Given our present oversupply and uneven distribution of

health care professionals, what is to keep us from building in a few more minutes per patient? To be sure, empathy isn't a "quick fix." But, a little empathy can go a long way.

Thank you very much.

NOTES

1. Kevin Grumbach and Philip R. Lee, "How Many Physicians Can We Afford?" *Journal of the American Medical Association*, 265:18 (1991), 2369-72; Roger A. Rosenblatt, M.D., M.P.H. and Denise M. Lishner, M.S.W., "Surplus or Shortage? Unravelling the Physician Supply Conundrum," *Western Journal of Medicine*, 154:1 (1990), 43-50.

2. Howard B. Beckman, M.D. and Richard M. Frankel, Ph.D., "The Effect of Physician Behavior on the Collection of Data," *Annals of Internal Medicine*, 101:5 (1984), 692-696; AMA study cited in "Medical Science Seeks a Cure for Doctors Suffering from Boorish Bedside Manners," *Wall Street Journal* (March 17, 1992), B1.

3. Daniel Goleman, "Doctors Find Comfort is a Potent Medicine," New York *Times* (Nov. 26, 1991), C1.

4. Stephen D. Nightingale, M.D., Paul R. Yarnold, Ph.D., and Michael S. Greenberg, M.D., "Sympathy, Empathy, and Physician Resource Utilization," *Journal of General Internal Medicine*, 6 (Sept.-Oct. 1991), 420-423.

5. Howard Spiro, M.D., "What Is Empathy and Can It Be Taught?" *Annals of Internal Medicine*, 116:10 (1992), 843-846; *Wall Street Journal* (March 17, 1992), B1.

6. Goleman, "Doctors Find Comfort is a Potent Medicine".

7. Ibid.

8. Arthur Kleinman, M.D., *The Illness Narratives: Suffering, Healing and the Human Condition* (New York: Basic Books, 1988), pp. xxi, xiv.

9. Ibid., xii, 3, 10.

10. Ibid., xiv.

11. Ibid., 39-41.

12. Ibid., 39.

13. Gregory C. Pope, "Physician Inputs, Outputs, and Productivity, 1976-1986," *Inquiry*, 27:2 (1990), 151-160.

14. Aaron Wildavsky, "Doing Better and Feeling Worse: The Political Pathology of Health Policy," in John H. Knowles, M.D., *Doing Better and Feeling Worse: Health in the United States* (New York: Norton, 1977), 105-123.

Wayne Holtzman, Moderator

Thank you, Ellen. Our second speaker on the panel, Anne Hudson Jones, also comes into medicine by the back door. She received her undergraduate training in French and did her dissertation as a doctoral candidate in comparative literature at the University of North Carolina. She comes to us as a professor in the Institute for the Medical Humanities, where she has been since 1979. Currently serving as editor-in-chief of *Images of Nurses: Perspectives from History, Art and Literature*, Dr. Jones will speak to us today about listening to the voices of patients, in particular the voices of mental patients, in "Asylum—From the Patient's Point of View."

ASYLUM—FROM THE PATIENT'S POINT OF VIEW

ANNE HUDSON JONES

THE PAST THIRTY YEARS IN THIS COUNTRY HAVE CERTAINLY BEEN TURBULENT TIMES for *mental* health care. The trend toward deinstitutionalizing mental patients —that is, discharging them from mental hospitals to "the community," which all too often has turned out to be a euphemism for "the streets"—had begun already by the late 1950s. Deinstitutionalization accelerated in the 1960s and the 1970s, so that by 1980 the census of patients in mental hospitals in this country had dropped to 140,000 from a peak of 558,000 in 1955.[1]

By the end of the 1980s, however, I think it was obvious to even the most casual lay observer of the plight of the homeless in this country that deinstitutionalization, as a policy of mental health care, was a failure. Indeed, watching frankly psychotic people trying to fend for themselves on the streets, one could only wonder how such a practice—or policy—could ever have seemed sensible. It is not my main purpose here today to give a history of deinstitutionalization, but I think it's important to sketch briefly the reasons that are usually cited. Some are conceptual, even idealistic; others are unabashedly pragmatic. They include the attacks upon the concept of asylum by prominent sociologists, psychiatrists, and historians, including R. D. Laing and Michel Foucault; the general distrust of authorities that reigned in the 1960s; the vigorous efforts of civil rights advocates to free institutionalized mental patients; the development of palliative chemotherapy, the psychotropic drugs such as Thorazine, which came on the market in this country in May 1954; and, last but not least, the perceived economic advantages to the states. In February 1954, a National Governors' Conference on Mental Health was convened, at which representatives from all the states agreed that their states would go bankrupt unless something could be done with the chronically mentally ill other than support them for life in state mental hospitals. The availability of Thorazine three months later showed them a way to return the mentally ill to "the community."[2]

There is another component that bears mention. That is the role of writers and filmmakers in shaping public attitudes. For example, Ken Kesey's *One Flew over the Cuckoo's Nest*—the best-selling novel from 1962, the film from 1975—is the apotheosis of a muckraking subgenre that exposes the abuses of mental patients by their caretakers, who often seem more in need of psychiatric help than the patients themselves. Because my field is literature, I was especially curious about the images of asylum presented in twentieth-century American autobiographical accounts of mental illness. Before I began systematically reading a selection of these works, I expected to find prevailingly negative images that would help explain how our society

came to value deinstitutionalization above asylum. Although I did find negative images, I also found something I did not expect: an overwhelming affirmation of the concept of asylum, even in muckraking works explicitly written for the purpose of reform. The works I read document and expose abuses, but they also demonstrate the powerful positive values of asylum and lead to an obvious conclusion: the fact that the concept of asylum can be abused does not mean that it should be abandoned. I'd like to remind you of the original meaning of the word *asylum*, from the Greek: a safe place of refuge or sanctuary, a place that is inviolable. So strong is this sense of inviolability in the meaning of asylum that in Greek society it was considered a sacrilege against the gods to force anyone to leave an asylum against his or her will.

The works on which I base my presentation were published between 1908 and 1969. Some are autobiographies; others are autobiographical novels. Some are by women; some are by men. The authors have all been through the experience of mental illness, been institutionalized in an "asylum" of sorts, recovered, and written about their experiences. They are experts on asylums from the inside, and there is remarkable agreement among them about four major points: first, the need for asylum; second, a corollary, the need to be with other mentally ill patients; third, the need for a significant human relationship with someone in the asylum, either another patient or a member of the staff; and fourth, the need for the medical professionals to have "heart as well as head."

Because of time constraints today, I obviously can't discuss all the works that I have read, but I do want to mention three briefly, to demonstrate for you some of the evidence on which I base my claims. I'll speak briefly, then, about three works, one from the first decade of this century, one from the 1940s, and one from the 1960s.

The first work that I want to discuss is chronologically the first work by an American mental patient to receive any significant attention. It is Clifford Beers's autobiography, *A Mind That Found Itself*, which was first published in 1908. In the epigraph, Beers says: "This book is written by one whose rare experiences impel him to plead for those afflicted thousands least able to speak for themselves."[3] In one way or another, this sentiment is repeated by the authors of all these works. They are very much aware that they are the lucky ones who recovered and that they must speak for the thousands of other patients who were never able to speak for themselves.

After an inept and unsuccessful attempt at suicide, Beers was confined in a series of three mental institutions for a period of several years, with diagnoses of depression, dementia praecox, and ultimately mania. He was first confined for eight months in a private proprietary (for-profit) hospital,

Stamford Hall, in Stamford, Connecticut. Next he was committed for fourteen months to a private corporate (nonprofit) mental hospital, Hartford Retreat, also in Connecticut. From the Hartford Retreat, he was transferred as an indigent patient to the state, or public, hospital, Connecticut Hospital for the Insane, in Middletown, where he stayed for almost a year. Thus, Beers had experience in the three different kinds of mental hospitals that were available in the United States in the first decade of this century.

Beers documents abuses in all three; ironically, it is in the state hospital where he is cured, albeit more in spite of his treatment than because of it. Yet, even given the abuses he observed and suffered himself, Beers profited from his stay in the asylum, and he knew it. When he first arrives at the Hartford Retreat, for example, he attributes his new feelings of contentment "to an environment more nearly in tune with my ill-tuned mind. While surrounded by sane people my mental inferiority had been painfully apparent to me, as well as to others. Here a feeling of superiority easily asserted itself, for many of my associates were, to my mind, vastly inferior to myself."[4] What Beers expresses as a feeling of superiority, others express as a feeling of belonging, of at last being at ease when they are out of the world of the sane and in the asylum. Despite Beers's explicit muckraking purpose, near the end of his book he affirms again his belief in the concept of asylum: "Realizing that my detailed account of abuses may disturb relatives and friends of the inmates of our hospitals for the insane, I feel it my duty to express again my belief that most insane persons are better off in an institution than out of one."[5] And Beers offers specific advice to physicians: "Physicians throughout the country engaged in work among the insane may profitably take this observation to heart,—and 'heart' I use advisedly, for it is the quality of heart rather than the quantity of mind that cures or makes happy the insane."[6] This advice is repeated by many of the other authors in much the same words.

The second work that I want to give some attention to is Mary Jane Ward's 1946 autobiographical novel *The Snake Pit*, based on her own nervous breakdown and nine-month stay in a state mental hospital with a very large patient population. This popular novel, a selection of the Book-of-the-Month-Club for April 1946, was reprinted in part in *Harper's Bazaar*, condensed in *Reader's Digest*, translated into five languages, and made into a Hollywood film that was released in 1948.[7] The film bears little resemblance to the original work, changing its focus entirely to depict a successful Freudian analysis that did not take place in the novel. I'll discuss only the novel and not the film.

The novel's protagonist, Virginia Stuart Cunningham, is a professional writer. She has suffered a nervous breakdown for reasons that neither she, her doctor, nor the reader ever understands, and has entered a state mental

hospital because her husband cannot afford to send her to a private one. In Juniper Hill Hospital overcrowding and understaffing are the main causes of dehumanizing conditions and poor care of patients. For example, Cunningham is allowed to shower only twice a week; there are two shower stalls to accommodate forty to fifty women. There are no doors on the toilet stalls, no toilet seats, and frequently no toilet paper either. There are not enough food, sheets, pillow cases, covers, even beds. There are not enough doctors, nurses, or attendants to provide good care for the multitudes of patients, and some nurses and possibly a doctor suffer breakdowns of their own as a result of the terrible conditions in which they have to work.

Cunningham considers Juniper Hill Hospital a snake pit of the old variety, but with some modern refinements: The disturbed ward stinks of paraldehyde, and Cunningham, like other patients, has to endure repeated shock treatments. Despite these wretched conditions, when Cunningham finds herself on the worst ward yet, she is oddly pleased. Her account makes clear the importance of being able to descend to the lowest layer of the self. She says:

> . . . the hopelessness that had been hounding her had lessened and for the first time she dared to believe that she might get well. Perhaps her foundation for this beginning of optimism was childish or, terrifying thought, perhaps it was the start of delusions. However, when you realize you aren't the sickest in your ward, it does something for you. . . . Shock treatments. Why bother with insulin, metrazol, or electricity? Long ago they lowered insane persons into snake pits; they thought that an experience that might drive a sane person out of his wits might send an insane person back into sanity. By design or by accident, she couldn't know, a more modern "they" had given V. Cunningham a far more drastic shock treatment now than Dr. Kik had been able to manage with his clamps and wedges and assistants. They had thrown her into a snake pit and she had been shocked into knowing that she would get well.[8]

It is the experience of the most disturbed and hopeless ward that leads Cunningham back to mental health. And even as she is leaving the asylum she so despises, she realizes that "Juniper Hill, the shelter patients devoted their sane moments to hating, was indeed a shelter."[9] Reforms are needed, yes, but the asylum has served its purpose for her, and she realizes that it does so for other patients as well. What is needed most of all is money to hire more staff.

This need for asylum—even when the asylum offered looks horrifying to nonpatients, that is to family and friends—is nowhere better depicted than in *I Never Promised You a Rose Garden*, the 1964 autobiographical novel of Hannah Green, pseudonym for Joanne Greenberg. The teenaged protagonist of this novel, Deborah Blau, is brought by her parents to a private mental hospital after she has tried to commit suicide. Deborah's diagnosis is schizophrenia. Although the hospital is a red-brick, run-down Victorian house in the country, it has bars on its windows, and the high, hard scream her parents hear from one of the barred windows makes her father, especially, want to take Deborah home again. Deborah's mother prevails, and they leave Deborah at the hospital.

All wards of the hospital offer two important privileges: "starkness and crudity."[10] After Deborah rakes the insides of her arms with the top of a tin can until her arms are a gory, bloody mess, she is moved to the Disturbed Ward. Deborah is at first terrified to be on the Disturbed Ward:

> Women were sitting bolt upright in bare chairs, and sitting and lying on the floor—moaning and mute and raging—and the ward's nurses and attendants had big, hard, muscular bodies. It was somehow terrifying and somehow comforting in a way that was more than the comfort of the finality of being there. Looking out of a window barred and screened like a fencer's mask, she waited to find out why there seemed to be some subtle good about the frightening place. . . .
>
> . . . and Deborah suddenly knew what was good about D ward: no more lying gentility or need to live according to the incomprehensible rules of Earth.[11]

It is not until she is well again that Deborah really appreciates what her parents have given her by allowing her to stay such a long time in the asylum, on the Disturbed Ward, with no sign of progress. They have given her the opportunity to fight her way back to sanity. At least one patient was not so lucky. The patient, named Carmen, is admitted to the Disturbed Ward, but then is taken home by her millionaire father the first time he visits. The patients read about Carmen's suicide in the paper.

Deborah is blessed in her psychiatrist, an internationally known analyst named Dr. Fried, who is based on the real analyst Freida Fromm-Reichmann. Dr. Fried is warm and caring, but also tough and honest. She makes no false promises, but assures Deborah of her own inner strength and potential mental health. Dr. Fried is described by another analyst as "a fine doctor," by which

he means one with brains. Another analyst answers that although Dr. Fried is brainy, "'after you know her a while, you'll find that with little Clara Fried, brains are only the beginning.'"[12]

In summary, the implications of these narratives are clear: first, the concept of asylum, a place of shelter or sanctuary from the world of the sane, is the most important thing of all in the healing process for the patients depicted in these works. An important aspect of such an asylum is that it provides Disturbed Wards where mentally ill patients can be free to experience and fight their illness. Second, being with other mentally ill patients is also a crucial element in these patients' experiences. Whether it simply provides the basis for elemental human bonding or whether it shocks like the snake pit and brings the patient back to health, being with other patients is an important part of the cure. A third important factor is having a significant human relationship with someone, whether it be doctor, nurse, attendant, or patient. Who it is doesn't matter nearly so much as that it is. To realize that often the significant person in a patient's return to mental health is another patient may be very threatening to health care professionals. Fourth, and finally, for professionals in mental health care, the most important thing to be learned from these books is that heart matters as much as head. A warm, caring person can be more effective than the brainiest cold, impersonal one.

In conclusion, as we make decisions and policies about future care of the mentally ill in this country, we should be instructed by mental patients who have experienced institutionalized care in the past. Although those mental patients who have recovered and written about their experiences are a small number of the whole, still their accounts must stand as testimony for those who did not recover and who have no voice. If the burden of these patients' stories is that asylum was a critical component of their recovery, then we must rethink our practice of deinstitutionalization and restore the concept of asylum in our care of the mentally ill.

NOTES

1. See Ann Braden Johnson, *Out of Bedlam: The Truth about Deinstitutionalization* (New York: Basic Books, 1990), 115, 274 n. 1.

2. Ibid., 40.

3. Clifford Whittingham Beers, *A Mind That Found Itself: An Autobiography* (New York: Longmans, Green, 1917), n.p.

4. Ibid., 64.

5. Ibid., 255.

6. Ibid., 91.

7. Leslie Fishbein, "*The Snake Pit* (1948): The Sexist Nature of Sanity," *American Quarterly*, 31 (1979): 645.

8. Mary Jane Ward, *The Snake Pit* (New York: Random House, 1946), 216-17.

9. Ibid., 275.

10. Hannah Green, *I Never Promised You a Rose Garden* (New York: New American Library/Signet, 1964), 47.
11. Ibid., 53-54.
12. Ibid., 188.

Questions and Answers

Wayne Holtzman: We have a few minutes for comments or questions. Please step to the microphone and give your name so that it will be on the record for our proceedings.

Henry Bell: Henry Bell from Tyler. I'd like to ask Ms. Jones—having personally been involved with the East Texas MHMR Center for about 15 years in one capacity or another—what comments she would have on the quality of care of these MHMR community centers as well as the quantity and economy. Thank you.

Anne Hudson Jones: I don't mean by what I have said here today to defend bad institutions. There's no question that the institutions many, if not most mental patients, have been in are bad. I think the concept of community care is very important. Had there been community-care centers that could have served as a place of refuge for mental patients who were released from the large institutions, I think that deinstitutionalization might indeed have succeeded in fulfilling the ideal that many thought it would. But the monies, the facilities, have just not been there in the numbers that are needed. I'm also aware that what these patients have presented is not an economic answer; it's a conceptual answer, a cry to tell us what they need. Yet economically, if we can provide a form of care that allows patients—more patients—to recover, then we'll ultimately save money—as well as lives.

Wayne Holtzman: Mark?

Mark Yudof: I'm Mark Yudof from Austin. This is to Dr. More. I guess what I want to say is I have some skepticism about your view of all this, and I'll just explain it. I suppose that part of the problem is that empathy costs money because empathy takes times and time is money for a professional. And I remember being particularly annoyed when it took me three months to get in to see my G.P. only to discuss the flowers and local politics and the birds the first half-hour, and I had the feeling I would have been better off with a six-week wait, rather than a three-month wait, with less empathy and less conversation. But I'm a lawyer, so . . . I guess what I would say is the way your argument is constructed, it's both sort of instrumental and deontological. It is to say that this is the best of all worlds, that empathy is virtuous, that it

gets patients well, that it employs unemployed doctors, that it allows you to engage in a sort of feminist philosophy because you listen to human voices instead of just scientific rules, that it fits in with symbiotics because you interpret signs from people, and it also is amenable to expertise, empathic expertise, meaning that it is a learned characteristic rather than just one which people have, perhaps, like being good actors or people who are good at athletics, where it's partially learned and partially capable. I'm very skeptical that all that is true. It would be very convenient if it were true. Suppose, this is my question to you, suppose it turns out upon further study that empathy doesn't make people get well better. Suppose it turns out that the optimism that some people have is generated by internal physical characteristics which physicians yet cannot measure and ascertain, that is, they are optimistic because they are, in fact, likely to live longer. Would you still take the position that you do, that empathy should play such a major role, if it could not be shown to be in the best interest of the patient, in the instrumental sense of making them better more quickly or improving their prospects or whatever?

Ellen S. More: Well, I would say, first of all, I hope the tape was on because you've done a fair and concise job of describing the virtues of empathy. Now, I myself did say that the claims of those studies reported in the *Times*—I have not read the actual studies themselves—are not solid enough for me to say, "Empathy *made* this happen." And in fact, as I also said, with reference to the role of optimism or pessimism, a suppressed immune system, for example, might be at work; it is not yet possible to say what was "cause" and what was "effect." So I clearly agree with you that that requires far more psycho-immunological study than we have done, although those kinds of studies no doubt are being undertaken.

I also said that I think perceiving empathy as a quick fix is to miss the point. The point is that patients are suffering in more ways than one and this is one way to address that suffering. But the other side of the coin is that I think physicians are suffering, too. I think physicians would like to provide more empathic care. I also think, in regard to your own experience, that if you had to wait for three months and then spent half an hour talking about—I don't think you said "the birds and the bees," you probably said "the flowers and the trees"—but whatever it was, if it didn't seem relevant to you, that was not empathy on the part of your physician. It was clearly not a case of his accurately assessing your needs at the time. Therefore it was surely not an example of empathic care. In general, I would have to say that I am always skeptical, but I based my comments on my perception that today, when physicians and patients emerge from their encounters, neither one seems terribly pleased with the results. Empathy is part of the answer.

Wayne Holtzman: Bryce, can you step to the mike?

Bryce Jordan: I'm Bryce Jordan from Austin. When one talks about the empathetic care of the ill, one's mind leaps ahead almost immediately to the education of the caregiver. And some of us know a great deal about the very pioneering work that's been done in your institute here in Galveston, and I've had a tie with another medical school whose work in that field stemmed almost directly from Galveston. Many lay people don't understand the importance of humanistic, as well as humane, education for the physician. I wonder if one of you would comment on that just very briefly as to the importance of this kind of education in the curriculum.

Wayne Holtzman: You're at it longer than she is, Anne. Why don't you take that?

Anne Hudson Jones: Okay. I think that the things that Ellen More was saying earlier in her talk are to the point, that most of the premedical training that students get is very technical, it's very scientific. They come into medical school as excellent students who have worked very hard in the sciences, but many of them have never been sick themselves, many of them have never cared for sick people, perhaps, have never even been with sick people. When they move onto the wards in their third year and start seeing patients, they're seeing human beings who are sick, as opposed to seeing disease entities in the laboratory or reading about them in the textbook. To try to help them understand the experiential world that sick people live in is a large part of what we try to do. There are many ways to do that, but, since my field is literature, among the things that I think work is having students read accounts of what it was like for someone to be ill, to learn from someone who's been through the experience if they haven't been through it themselves. For example, the stories that I've talked about today—the stories of mental patients—have much to teach us.

Wayne Holtzman: As a medical educator and recent president of the university, I'm going to ask Bill Levin to comment on that particular question, if he would.

William C. Levin: I'm going to comment as an oncologist because I was, and still am, I hope, a hematologist oncologist. In dealing with people who have very serious illnesses, particularly incurable malignancies, I think that the empathy is absolutely essential to care for the whole patient. I'm not speaking now about the surgical procedures that sometimes are huge. I'm not speaking

about the use of chemotherapy or radiation therapy which invariably produces additional illness. But it is absolutely essential, in my opinion, that empathy be an important part of the management of that patient from the standpoint of the responsible physician. All too often, it is my observation that very young physicians who have never been ill themselves, who become oncologists, fail to use empathy, I think sometimes because they are fearful of injuring their own psyches, their own sense of well-being, by admitting that they are dealing with a very trying human problem, and here is a very practical area in which empathy plays a most important role. And I hope, Dr. More, that you would be willing to accept the importance of empathic expertise with respect to physicians dealing with very ill patients.

Ellen S. More: Absolutely. Not only do I accept it, but I would add just one additional point to the comments you've made: the fear of violation of ego boundaries, or losing oneself and losing one's sense of self (as you've just described it), is perhaps at the heart of why novice physicians hold back in their relationships with their patients. This fear is addressed in the medical education literature of the 1950s and sixties under the heading of "detached concern" or "distanced caring." It is interesting to note that as we've become more interested in this phenomenon and in reassuring medical students that they need not be afraid that empathy will compromise their sense of personal integrity, the literature has begun to convey a different message. We now address the issue, these fears, by acknowledging that for empathic communication, it is necessary to momentarily lose one's sense of self, but that one regains it again almost immediately. I think Dr. Levin's point is absolutely true.

The other point I would make is that empathy is more than just "heart." It is "heart" and "head" together. It is affective and cognitive. It doesn't work if you're just being emotional, if you're just "feeling into" (the literal translation of the term "empathy" from the German). I didn't want to get into the technical history of the interpretation of empathy, but this last point is essential to an understanding of the concept.

Wayne Holtzman: Yes?

John Cooper: John Cooper. I'm an educator. I share the points of view that have been expressed here that empathy is tremendously important, not only in the medical field, but in the educational field. One of my concerns relates to the fact that I see this whole problem of health as part of a much larger whole. It's part of the global condition of our society, and it seems to me that that must be approached seriously with new and innovative procedures,

methodologies. I think schools have a role in this regard because one of the great names of the large school system, and I think one of the reasons that we have such a high incidence of problems in big-city schools, is that they are made up of great bureaucracy, and bureaucracies are by nature, I think, cautious in the development of new practices. And so I would see the, I would bring us back to the point that was made this morning. Dr. Rostow and I went to the same high school, the Hill House High School in New Haven, Connecticut, and we had an excellent education. I suggested to him that he ought to go back and look at Hill House High School today. He would not recognize it. The doors are locked, the police are there, it's a declining kind of condition. And so I would say that whatever we can do that would encourage new developments, new practices, they should be done, but they should be done keeping in mind the global condition that we are in, all of these things seem to interlock. I thank you.

Wayne Holtzman: Dr. Howe?

John Howe III: I have an observation and a question. The observation is that after listening to the testimony for the past two or three hours, it is with some trepidation that I come before you to admit that I'm a physician—a doctor. And the second is a question, in the spirit of this morning, is it okay to share some good news? And that is, as I was listening this morning to the comments of altruism, sense of community, quantity of heart, empathy, etc., and at the same time, the comments that all of this is going to be recorded, I think that before we break for lunch, I just wanted to share three quick stories that I think underscore what is happening in Texas today.

One is the story of a recent Board of Regents meeting in which Dr. LeMaistre told the story of South Texas having the highest rate of cervical cancer in the country and that the physicians at M.D. Anderson are doing something about it. Whether you're poor or whether you're rich today in South Texas, and you have a pap smear, the doctors at M.D. Anderson will read that. Secondly, at the same Board of Regents meeting, I heard Dr. James tell Regent Temple, among others, that in fact there is primary care in East Texas today at two sites, thanks to the physicians at Galveston. And, most recently, at the Cameron County Courthouse, I was given the opportunity by Dan Morales to be examined and cross-examined for two hours as part of the Maldef suit and had a chance to talk about the $42 million of free care given by the 400 physicians at the Health Science Center in San Antonio and the 29 physicians that are practicing in the small towns in the Valley as a result of our family practice program in McAllen.

But let me also at the same time tell you a story of just two days ago, in visiting with, and this will get back to Dr. Rostow's comments, the heads of all of the student organizations at the Health Science Center—about 20 or 25. Five years ago, when I met with them, they complained about parking and they complained about library hours. Not so this time. What they wanted to do was to tell me that they had participated in a program in San Antonio overseen by Mr. Menez to give 17,000 dinners on Thanksgiving to the poor of our community. Our students participated in that, and there were other things as well. But, equally importantly, as we look to the future, Dr. Mullins could report to you that this year, there were 2,800 young people that applied for the 800 positions for next fall for the UT medical schools, and those kiddos are bright, young, aspiring, choosing to come into medicine, when in fact there are turbulent times. So I would just end by saying that as we look to the future, indeed there are challenges over the past two or three years, but I think thanks to Governor Hobby, Senator Farabee, Senator Krier, there are some things in motion here in Texas that I think are very, very positive. Thank you.

Wayne Holtzman: Judy?

Judy Yodof: I'm Judy Yudof from Austin. I'm not a physician, but the last 15 years, I've been a volunteer, primarily in my community in mental health, and I wouldn't like to end on a sad note, but I don't see the future of mental health in the state of Texas from a very positive perspective. Dr. Jones, I appreciate your impressions from the patients' point of view because I think the policymakers ought to be more concerned about patients' point of view. However, the biographical sketches that you drew for us, I believe under today's funding, those patients could not be seen in the bulk of institutions. And, although I know you know that, I wanted to be sure everyone else in this room knew that, and my personal prejudices that perhaps we ought to bite the bullet on the care of the chronically mentally ill, the people that are at the extreme end of the spectrum, who we can perhaps do very little to help, and start considering preventing people from becoming part of the population of the chronically mentally ill. Now mental health professionals may think that there's a naivete to my comments, and perhaps we can't prevent all those people who are before crisis from becoming part of that census of chronically mentally ill, but I would like to think that we could prevent some of them from joining that population. And I don't see how we're ever going to get out of this revolving-door syndrome at our state institutions unless we work to reduce the number of people who are going to become part of that pool. And I think that the state of Texas has perhaps taken an amoral position in deinstitutionalization because it hasn't just been to put people in a less

restricted environment, but it has been instead to follow a court order to reduce the ratio of staff to patients, and there has never been an investment in this state in the community resources. So we are putting people who perhaps have no families to go back to, very little support in the community, literally on the street waiting for them to be sick enough, stay alive to be sick enough, to be seen again in our institutions. I have enormous problems with that as a lay person, as a potential consumer of any of these services. We are putting them at risk, and we are putting other innocent people at risk by putting these people who have so few coping mechanisms and so few family and societal support systems to depend on to help them out. Thank you.

Wayne Holtzman: Did you want to comment on that, Anne?

Anne Hudson Jones: I think your comments were eloquent, and I entirely agree with you. I personally don't think I'd do very well living on the streets in Houston. And when I see the mentally ill living on the streets—like you, I despair. I'm surprised that they can survive at all. Thank you for your comments.

Wayne Holtzman: We have time for just one more comment. Ralph Spence has been waiting to say something.

Ralph Spence: Ralph Spence, from Tyler, yessir. I was intending to join the previous speaker and was quite moved by her and show my own mental illness by being willing to talk to you folks after following her. But I did want to be the good news part. We were talking about access and availability, and we have our regent, Miss Ellen Temple, here, so I wanted to report and get in the record that the University of Texas Health Science Center in Tyler has a program of call-a-nurse 24 hours a day, so that mamas with sick children or anybody who feels sick can call this nurse and talk about their symptoms and what they're doing and get advice or get reference. And I think that's a great service of access and availability, and I want to record it for the UT Health Center. Thank you very much.

Wayne Holtzman: There is obviously more good news to share among ourselves, but we'll have to do it informally since time is up. I'm sure Stella Mullins has in mind some things going on the mental health field as well. And I would like to invite anyone who wishes to pursue this further to contact any of us in the mental health field. We're very eager to share some of these new ideas with you. Many of you are aware of the work of the Hogg Foundation for Mental Health and of the Mental Health Association in Texas, in moving the state toward community-based care for the mentally ill. Thank you all. We are now ready for lunch.

Panel III
William Seybold, Moderator

May I ask you to come in and take your seats please so we can get this session started?

Thank you. I'm Dr. William Seybold. I come out of retirement today to moderate this panel at the request of our president Bill Levin. It is my privilege to do so. This is a fine program he's planned for us. We're changing our plans a bit for the afternoon, for medical reasons. Dr. Stanley Joel Reiser of Houston, listed as our first speaker, became ill with the flu yesterday, so it was too late to fill in for him. We're going to expand the assignment of each of our speakers but shorten our program, and instead of going until 4:00, I've asked each speaker to limit his comments to 30 minutes. We'll have 30 minutes for discussion, or maybe longer if needed, and plan to end our discussion about 4:30 instead of 5:00.

This afternoon's session is to be a symposium on technology and its influence on medicine. We're all aware it is a major factor, not only in the success of medicine, but in producing some of the problems of modern medicine: the problems of the relation of the physician and the patient, the problems of the cost of medical care, the problems of organizing medical care, and a lot of the attendant problems that have been the result of our revolutionary changes in medical technology. I think you all will be interested and amused to be reminded that 10 years ago the Society addressed itself to health and medicine in the eighties when Mickey LeMaistre was president of the organization and the meeting was in Dallas. So, here we are again, 10 years later, when circumstances have changed, times have changed. The basic problems haven't changed, but some of the problems in the context of today's society have changed, and we are addressing some of these problems of health and medicine again.

I'm convinced that there are no serious human concerns that ever get finally settled. We analyze them, we study them, we debate them. We debate them in the context of the current times, our current society, our current mores. We try to inform ourselves so that we can hear the various expressions about these very basic problems. The best we can hope is make judgments about how to address those problems and outline some course that can be tried that sounds sensible and that has to be tentative because the world does change. So here we are again in 1991, 11 years later, talking about health and medicine. And no doubt our successors and those attending years from now will be talking much about the same things.

As we all know, a lot has changed in our society, in general, and a lot has changed in the health care scene in particular in the last 10 years. The MRI (magnetic resonance image) is an example of some of the technological

innovations that are tremendously expensive and tremendously productive. That is only one example. There was a story in the *Wall Street Journal* about a week or two ago about a new drug that's just been produced that is capable of saving lives of young people with a particular kind of bacterial infection, and I believe a single dose costs $3,000. And the question is, can we afford it? If used in a widespread manner, what will that do to the cost of medical care, and will the cost, with the limited resources, take something away from some public health services to the young or to the elderly? With the world of limited resources and infinite demand, there are some hard choices that we are addressing today.

I saw an expression recently that I rather liked, comparing Americans to children in toy stores: we wanted everything we saw, but we didn't have the money to pay for them. Our problem is to try to find, as the term was used this morning, what's decent, what's fair, within the limit of our resources, and the same time, because our resources, we all are learning, are limited, have always been limited, and, now even more than in our past as a nation, promise to be limited in the future.

The concerns we are addressing this afternoon deal with not only this impact of technology, that was what Dr. Reiser was supposed to address primarily, but with some of the other moral and ethical concerns that we have not touched on, or that were not touched on in this morning's meeting, concerns that involve all of us, concerns that you have read about, concerns for which we have no pat answers, but, again, those that do invite our intelligent discussion and argument and, hopefully, we can address and have a better understanding of, and solve in a better manner than we have in the past.

Before I stop to introduce our first speaker, let me review briefly a list I got from Dr. Reiser's paper that he has been unable to deliver to us. He goes considerably into the history of the instrumentation and technology of medicine, and he listed the instruments that were developed in the nineteenth century that had a great deal to do with the improvements of medicine in the nineteenth century. And I'll compare those, not to a list of what's happened in the twentieth century, I wouldn't be capable of giving a complete list without considerable study nor in a time frame that you would find enjoyable. But, in the nineteenth century, we had such innovations as the stethoscope, which I expect in its most costly version was not over $10 or $20; a laryngoscope to look down our larynx; an ophthalmoscope to look at the retina of our eyes; a microscope; and, of course, some chemical agents and chemical apparatus which was not limited to use in medicine but in many of our sciences, the sphygmomanometer (a blood pressure machine), the electrocardiograph in its infancy, and the clinical thermometer, and that's

about the total list of technology of the nineteenth century. And none of you could count the current introductions in your lifetime, even the younger ones I see in the audience, on the fingers and toes. All these things have revolutionized medicine and revolutionized some of our problems.

Well, so much for all the technology. Some of our problems are not only due to the cost of medical care, some are due to our life-style, which we're all quite aware of, and which were referred to this morning. And I'll leave life-style to recitation of a cartoon that I saw several years ago in one of the medical magazines where the fellow was sitting on the end of the examining table talking to his doctor and he said, "Doctor, I didn't come to you to be told that I was burning the candle at both ends. I came for more wax." And so, that's what most of us do. We continue our life-styles and go to the doctor for more wax. We do need to change our life-styles, because we bring on many of our own ills, but that won't solve all the problems we are addressing today.

Our first speaker this afternoon is Dr. William J. Winslade, who is a lawyer and a doctor of philosophy. He is the James Wade Rockwell Professor of Philosophy of Medicine at the University of Texas Medical Branch here in Galveston. He is a Cullen Professor of Law at the University of Houston Health Law and Policy Institute. He's an author and a psychoanalyst, editor of *Personal Choices and Public Commitments*, published by the Institute for the Medical Humanities and the Texas Committee for the Humanities. Dr. Winslade.

CHOOSING LIFE OR DEATH

WILLIAM J. WINSLADE

THANK YOU, DR. SEYBOLD. I'M GOING TO MENTION A COUPLE OF OTHER CARTOONS that I've seen recently that are appropriate to my talk. One of them shows a man being wheeled into the operating room and he says, "$15,000 and that's my last offer!" The second cartoon I saw, which is a little more directly related to what I'm going to talk about, is the doctor comes into the hospital room, the patient is connected to all sorts of machines, and the patient looks up to the doctor and says, "I have a gun."

I have been following the problems of terminal care medicine since, before really, the Karen Quinlan case in 1976. And after several years of writing and lecturing about the topic of death and dying, I got too depressed to keep talking about it and changed to other things. Now I thought after the late 1970s I wouldn't have to talk about death and dying again, at least for a while, but in recent years the flood of current problems that have captured the attention of people, not only in the United States, but around the world, has drawn me back into thinking about some of these issues, and today I want to talk to you about some facts, some feelings, and a couple of cases, not the ones that are best known, but a couple of cases, one of which is a court case and one of which really is an astounding story.

The facts are that more than a half million people have purchased Derek Humphry's recipe book for suicide, *Final Exit*. Why? Why does Dr. Jack Kevorkian, an assistant suicide vigilante, attract so many supporters? Why did Dr. Timothy Quill, whose moving account of his patient Diane, whom he helped to die, win so much public praise? I mean, even the New York *Times* liked what he did. Why have public attitudes about suicide, assisted suicide, and euthanasia shifted away from rejection toward tolerance or even endorsement? Polls, numerous polls, in recent years have revealed to us that eight or nine out of every ten persons say that they would not prefer to continue living if they were in a persistent vegetative state or permanently unconscious with no prospect of recovery.

Last year, and effective on December 1 of this year, Congress passed the Patient Self-Determination Act, that many of you probably read about in the paper recently, that requires all hospitals and home-care agencies that receive federal funds, to advise patients on admission or before the receipt of home care that they have a right under whatever state laws are relevant to their care to sign any kind of advance directive or living will or durable power of attorney that is permitted in their state. Now we've had these statutes since the mid-1970s and nearly every state has some kind of recognition of the rights of patients to refuse in advance life-sustaining care which would only

prolong their dying process or postpone the moment of death, but only 10 percent of the eligible population have bothered to sign these documents. Maybe, with an educated and streetwise group like you folks, we have a higher percentage, now I'm not going to embarrass you by asking you how many of you, or refute what I'm about to say, by asking you how many have signed advance directives. But even if you've signed them, that doesn't mean that anybody's going to know about it, because a study that is being conducted under the auspices of the Robert Wood Johnson Foundation found that out of 5,000 seriously ill and critically ill patients that are being studied in hospitals around the country, 800 of them, which is a little higher than the usual percentage, had some kind of advance directive, and these are people who are being treated in hospitals and in intensive care units and for serious medical illnesses. Out of those 800 people who had advance directives, how many of them, do you think, had any indication of that in their medical records? Take a guess. Thirty-eight out of 800. So I'm just making the point that it isn't enough just to say that anybody has the right to say what they want with respect to artificial life-support at the last phase of life, it's going to take a lot more change than we've experienced in the last 15 years for these changes in our rights to become implemented.

Now I want to turn from some of these facts to some of our feelings, but, before I do, I just wanted to mention in passing that the research that I've been doing and some of my colleagues have been doing, and we will continue to be doing over the next several years, have been supported by not only the Texas Committee for the Humanities that Dr. Seybold mentioned, but also the University of Texas Chancellor's Grant and the Harris and Eliza Kempner Fund have provided us with funds to explore some of these issues, only a fragment of which I can tell you about today.

Let me turn from some of these facts to some feelings. Most of us are uneasy, even fearful, about losses, and particularly loss of control and self-image, abandonment, and ruptured relationships. When one is in great pain or suffering, and especially when terminally ill, severely depressed, or irreversibly disabled, awareness of alienation from others and from oneself is often heightened. For many people, the prospect of being barely alive, but totally alone, cut off completely from what one values, is more frightening than the idea of death itself.

Our ambivalence toward death and dying produces indecision and uncertainty about whether to hasten death or to prolong dying. Janet Adkins, you remember her, committed suicide with Dr. Kevorkian's assistance because she did not want to suffer the prolonged indignity of Alzheimer's disease. Many terminally ill patients seek the security of knowing that suicide or euthanasia are options, even if never exercised. Most of us hope to avoid an

insensate "life" in a persistent vegetative state like Karen Quinlan or Nancy Kruzan. Yet nursing homes become the penultimate destination for many severely demented patients with biological tenacity, but no conscious life. Hospitals prolong the dying of many patients lost to themselves because we, physicians, families, others, judges, can't let go. Courts deliberate about the fate of permanently unconscious patients often long after the patients have already died. Fifteen years after Karen Quinlan's respirator was removed, we still lack sensible policies about how to deal with permanently unconscious patients. Despite a growing consensus that such a fate is worse than death, we remain paralyzed by our ambivalence.

The new federal Patient Self-Determination Act that I mentioned earlier is a step in the right direction in terms of recognizing people's rights, encouraging them to make choices, and possibly, over the next several years, providing ways to implement some of these rights. But this bureaucratic notification, which can easily become only a perfunctory performance, fails to address the real issues. And I work in a hospital now and I've worked in hospitals for the last more than 15 years, and I spent some time last week talking with doctors who have to carry out the Patient Self-Determination Act, and I can assure you that many of my colleagues, scientific experts that they are, excellent clinicians that they are, don't know how to deal with, and don't want to deal with the Patient Self-Determination Act, and find it difficult to deal with it.

But, as I said, the Patient Self-Determination Act isn't the real issue. When we become patients, we want reassurance, not regulations. We want to know that if we give up control of our bodies or minds to physicians and hospitals, we will not be abandoned to a mindless limbo or a life in which survival is a form of torture. And we want reassurance that if we remain conscious, our relationships with others and our options will not be cut off.

Such reassurance is difficult for physicians and hospitals to provide for several reasons. And I think, in defense of my colleagues in the medical community, we have turned to physicians for things that they can't provide, and we expect hospitals to give us things that they can't deliver. Our health care system is stymied by patients whose lives can be saved, but whose functioning cannot be restored. Patients we can't help make us feel helpless. It's tempting to turn away from them and, in fact, it's well known in the hospital communities that the terminally ill patients, and, in particular, the permanently unconscious patients, nobody knows what to do with them, and they often skip them when they make rounds.

Second, physicians and hospitals lack effective means to sustain intimate relationships ruptured by illness and disability. Our health care system itself often strains relationships between patients and their loved ones. Economic

factors, institutional rules, intimidating bureaucracies, legal obstructions, and psychological insensitivity often make patients feel loss of control over their lives beyond that caused by illness.

They may, then, be tempted to preserve self-determination by being sure that they have their own way out. That's part of the answer to why 500,000 people have purchased *Final Exit*. As an author, I can't imagine selling a cookbook in that many numbers for ending people's lives. I mean somebody that would write a book about empathic expertise would not be selling 500,000 copies of the book, and yet that's a much more important topic than knowing how to commit suicide.

Except for a few enthusiasts, no one thinks of suicide, assisted suicide, or euthanasia as something good. They are only, and at best lesser, evils. Health care professionals need not be intimidated by Derek Humphry or Dr. Kevorkian or others, but the health care professionals need to provide reassurance that we will help patients retain as much control as possible over their lives. We will not abandon them or force them to suffer unwillingly, and we will not allow our own sense of helplessness and futility to dominate our treatment of patients on the brink of death. Patients do not need, in my view, more legal rights or forms to sign. Required, instead, are sensitive and well-timed conversations, realistic reassurances, and thoughtful attention to individualized needs from health professionals. If we all want to retain, regain control of the technologies and the bureaucracies that dominate our lives, we must remember that loss of control in itself, abandonment and ruptured relationships, not death itself, are what most of us fear the most.

Now having said that, I want to briefly remind you of the course of the development of the treatment of permanently unconscious patients from Karen Quinlan, who you all remember, to Rita Green, who you've probably never heard of. Karen Quinlan, Paul Brofey, Nancy Kruzan, Brother Fox, and many other permanently unconscious patients have become well known to lawyers and to people in the medical community as people who have been in a persistent vegetative state and decisions needed to be made about whether or not to continue the respirator, whether or not to continue artificial nutrition and hydration, as in the case of Brofey and Kruzan, or, more recently, whether Mrs. Wangley's respirator had to be continued.

And I want to talk a little bit about Mrs. Wangley, because it's a more interesting case than any of the others. For years, people have been beating on doctors and hospitals for keeping people on respirators far too long, or keeping them alive far too long. Now Mrs. Wangley, in December of 1989, fell and broke her hip. She was then 87 years old. She had, in addition to the broken hip, chronic lung disease, and she could no longer be cared for at home, and, after she broke her hip, and her hip was repaired, she had bronchial

problems that made it necessary for her to be treated at the Hennepin County Hospital in Minneapolis, the teaching hospital of the University of Minnesota. For six months she was treated in the hospital for her lung problems and a respirator was necessary to assist in her breathing. During this time, she was conscious and intermittently competent, and able to communicate with her family, her husband, and her two children. And nobody ever questioned the appropriateness of the use of the respirator in that setting. But it was clear that the acute care hospital where she was a patient really had nothing more to offer her once they had cleared up the bronchial infections and they believed she was respirator-dependent, though conscious and able to interact. And so it was recommended that she be transferred to a chronic care facility where she would remain on the respirator. She was transferred in June of 1990, and she was weaned from the respirator at the chronic care facility. They were able to control her breathing without the use of respiratory support, but two weeks after that had occurred, she suffered a cardiac arrest and was rushed to a hospital where she was resuscitated, and the people at the hospital said that the damage to her brain and the irreversible condition of her lungs made the continued use of the respirator not medically appropriate and they recommended that the respirator support be discontinued. But the family felt that they should get a second opinion, and they took her back to Hennepin County Hospital. At Hennepin County Hospital, the physicians there responded to the family's insistence that she be thoroughly evaluated and, after another couple of months, they agreed with the hospital that had resuscitated Mrs. Wangley and began to talk to the family about the fact that the respirator really wasn't providing anything other than support for her organic life, that she was permanently unconscious, had no mental life, and this wasn't going to change. But the family wanted her kept on a respirator. The hospital complied. Another couple of months went by. Then the physician who came onto the service in October reviewed the case and said that it wasn't medically appropriate to keep her on the respirator. It wasn't—respirators are supposed to be used to provide supportive care during surgery or if somebody has a lung infection or emphysema. There are lots of different proper uses of respirators and uses for which we can be very grateful, but keeping somebody alive in a persistent vegetative state isn't one of them. And so the doctors who have, for years, been accused of keeping people alive inappropriately with life support said this isn't appropriate. But the family insisted that she be kept on a respirator because they believed that her life should not be shortened in any way. It wasn't clear whether she believed this or not, she hadn't indicated what her preferences were, and finally, the hospital, in frustration, went to court, and there's more details to this story than I want to go into, but the hospital recommended that the court appoint a conservator who was neither

a representative nor of the family to independently evaluate the situation and make a recommendation to the court. And the court said it would consider that alternative, but then when the litigation finally settled out, and this is now seven months after Mrs. Wangley has been permanently unconscious, the court decided that Mr. Wangley, her husband, was in the best position to make decisions for her, even though he wasn't at that time technically her legal guardian. And so the court said that the hospital couldn't discontinue the respirator, even if they wanted to, and they hadn't even asked to do that at this point. They just asked to have somebody review the case who was neither committed to one side or the other. And at that point, Mr. Wangley was appointed his wife's guardian, and then she died, and the case was over.

But the problem hasn't been solved. The problem hasn't been solved because Mrs. Wangley was not that unusual. There are many people in persistent vegetative states, it's hard to know exactly how many, but we're talking about somewhere between 5, 10, or 15,000 people around the country in hospitals and intensive care units suffering from head injuries or heart attacks or terminal cancer. And the families, once a person is in a persistent vegetative state, by and large, don't hear what the doctors are saying. The families, in many cases, think a miracle is going to happen, or they believe, as the Wangleys did, in vitalism—the idea that life is valuable at all cost.

And so the physicians in the Wangley case were criticized a great deal by the legal community and by lots of other people who have said, well, this is really a matter of personal preference. This should be up to the individual. Of course, we didn't know what Mrs. Wangley wanted, because she hadn't told us, and that's the case with most people. And if you remember I pointed out that of the 800 people who had said what they didn't want with respect to life support, only 38 of them had any mention of this in their medical records.

Well, we haven't decided what to do since 1976 with Karen Quinlan, we haven't been able to resolve the problem with the permanently unconscious patients where we don't know what they want, and even if Mrs. Wangley had told us what she wants, now we have to do what her husband says, or what she would say, and in her case the $800,000 medical bill was paid by Medicare and a private insurance policy. The insurance companies and the hospitals have been very silent about this because they don't want to look like they're not wanting to treat people, but when we total up the amount of money that's being spent on just this one small category of patients in our intensive care units in the United States, we're looking at a very astronomical number.

I'm just going to turn now to one more case that illustrates this in an extraordinarily dramatic way. And I know in Texas we like to think that we have the record holders—football and basketball and baseball—and here's one record I'm glad that we don't have. The record holder for life in a

persistent vegetative state is Rita Green. She has now been in a persistent vegetative state for 40 years. When she was 25 years old, she was a nurse in Washington, D.C., and she got tuberculosis. She was recovering from the tuberculosis, but they wanted to do one more evaluation and they wanted to do a bronchoscopy and check that spot on her lung. And so, before they did it, they sprayed the back of her throat with an anesthetic to make it easier to put the tube down, and she had an anaphylactic reaction to the anesthetic and went into cardiac arrest and the intern who was working that day was up in the doctor's lounge shaving. This was 1951. They called him and he grabbed a razor blade that he'd been using to shave and ran down to the emergency room and cut open her chest with the razor blade, manually massaged her heart, and got her heart to start beating again. Now at age 25, she was otherwise pretty healthy. Her heart has continued to beat for 40 years. One nurse has been taking care of her for 35 years.

Nobody has questioned the millions of dollars that have been paid for her care over the years. She has collected disability payments every month since 1951, and her bank account is now 800,000 and something dollars. The only legal battle that Rita Green has been involved in was a conflict between the hospital that had been taking care of her for nearly 40 years and her brother in West Virginia who wanted her transferred to a nursing home nearby. And the hospital resisted making the transfer. I mean they became very possessive of Rita Green, and, in fact, as I've studied this case, which hasn't been in the courts, people who take care of patients like this begin to believe that they really communicate with them. And so the nurse that's taken care of Rita Green doesn't agree that she's in a persistent vegetative state, although the medical evidence seems to be that she really is.

We have a more complicated problem than simply signing an advance directive. We have the problem of deciding whether to sign advance directives, which ones to sign, and then to figure out how to make them work. Because just as there are some families that don't want to recognize that the functional life has ended, there are some physicians who don't want to carry out the directions of patients who don't want artificial life support. Just as there are some physicians who don't want to carry out patient's directives, there are some families that don't want to do what the physicians recommend when they do want to stop life support. And I mention the Wangley case and the Rita Green case to illustrate the other side of the coin, because in both of these cases, the families have no desire to end life support, and Rita Green's brother said, I'm not going to have her be a Nancy Kruzan.

But the obviously important public policy here is, why do we do this when we know how much it costs? Dr. Seybold mentioned the expensive antibiotic that can save lives, and here we're spending thousands and millions of dollars,

total up what it would cost to support 10,000 in a persistent vegetative state at several hundred thousand dollars or even a million dollars a year. You don't need your calculator to know that it's a large number.

But we have not solved this problem, and we've been talking about it and thinking about it since the Karen Quinlan case in 1976. We need to solve that problem, we need to face the hard questions, and we need to provide the reassurances to people as they enter hospitals or as they deal with terminal illnesses that they're neither going to be abandoned psychologically when they're conscious, nor left in limbo when they're unconscious. But all of us, patients, physicians, lawyers, and policymakers alike, have to address this problem, and I'm astonished that we haven't been able to do it. I'm making a small effort, with the help of some colleagues, to come up with some practical proposals. And I hope that in the next year, we'll see others addressing these issues and moving away from simply agonizing and being ambivalent to actually figuring out what we ought to do and how to do it. Thank you very much.

WILLIAM SEYBOLD, MODERATOR

I THINK YOU ALL RECOGNIZE THIS PROBLEM OR THESE PROBLEMS THAT DR. Winslade recited as byproducts of modern technology and modern knowledge. Not many years ago, we weren't faced with these problems because we were unable to keep patients alive indefinitely.

Our next speaker, Dr. Harold Vanderpool, is also a Ph.D., a professor at the Institute for the Medical Humanities at the University of Texas Medical Branch. He is an author, lecturer, a poet, and coeditor of *Ethics and Cancer*, an annotated bibliography which has been published under the auspices of the National Cancer Institute. Dr. Vanderpool is going to talk to us about "Caring for People with Cancer." Dr. Vanderpool.

CARING FOR PEOPLE WITH CANCER

HAROLD Y. VANDERPOOL

THE FIRST HINT THAT THE FORMER NEW YORK YANKEES BASEBALL STAR, BABE Ruth, was seriously ill surfaced in January of 1947, when newspapers reported that he had undergone a serious operation of the neck. Throughout 1947, the papers continued to speak of his slow recovery and poor health, which they frequently attributed to the bad weather that winter and spring. None of the many articles that year on the 52-year-old Sultan of Swat specifically mentioned that the Babe might have cancer.

In July of 1948—a year and a half after his illness was first publicized—Ruth entered New York City's Memorial Hospital for radiation treatment. Within a month, his seriously deteriorating condition was receiving front-page coverage in newspapers across the U.S. Some 13,000 letters and telegrams swamped the mailroom of the Memorial Hospital where the Babe was struggling to stay alive. News accounts reported that now and then sandlot baseball players would interrupt their games for prayers on behalf of one of their great idols. By then, official explanations for Ruth's disease centered on the phrase "pulmonary complications." Only after his death on August 16, 1948, was the awful secret of the slugger's demise revealed. He had succumbed to the ravages of throat cancer. The malignancy that had eaten away at this six-foot frame and made his famous round face seem strangely hollow.

Most importantly, although all America was privy to the truth after Ruth's death, the star himself was never told. Neither Ruth's family nor his doctors wanted him to know he had cancer. With a pride that strikes us now as somewhat strange, his obituary said that his having cancer was "one of the best kept secrets in modern times."[1]

This vignette is representative of many features of cancer care in America in the 75 years between 1890 and 1965. By assuming that the word "care" as applied to medicine includes both the science and art of medicine, we can use the saga of Babe Ruth's struggle with cancer as a backdrop for identifying fundamental features of cancer care in America today. This is my purpose—to identify prominent features of cancer care in America today by comparing and contrasting present-day care with that of the late 1940s and early 1950s. As I begin to make comparisons and contrasts, I will do some ethical evaluating.

Note what I am assuming about the nature of medical practice. On the one hand, I assume that it consists of scientific knowledge and technology. On the other, I assume that regardless of whether they are accented or not, medical care inherently includes psychological, social, ethical, and even metaphysi-

cal dimensions of human existence. This is in keeping with the underlying assumptions of our required medical ethics course at UTMB—a course that I direct. In that course we hold that every medical intervention is ethically invested, even if most of those interventions are not ethically controversial. In the Institute for the Medical Humanities we thus regard our medical ethics course as a course in medicine—a course that focuses on important and ever-present non-biophysiological elements of medical practice and decision making.

Regarding medical science and technology in the late 1940s, it is notable that Babe Ruth received the two standard and best treatment modalities of the time—surgery and radiation. Even if it might have helped, chemotherapy and the subspecialty of oncology as we know it today were virtually nonexistent before the mid-1950s when the cancer chemotherapeutic research program mandated by the U.S. Congress in 1953 began to bear some fruit. Even after adjuvant chemotherapy was advocated as a therapeutic supplement to surgical resections in the late 1950s, however, its use was skeptically regarded by most of the physicians and researchers of the time.[2]

The uses of surgery—including heroic or highly mutilative surgery—for the cure of cancer was the gold standard at the time. In the mid-1950s surgery offered five-year cure rates for approximately 33 percent of persons diagnosed with serious cancers—that is, cancers other than those responsible for easily cured skin lesions. This was a significant improvement over the approximate 20 percent survival rates of the 1930s.[3] The 13 percent increase in these survival rates was primarily indebted to the dramatic advances in surgery during World War II—in particular, refinements in blood transfusions and the use of antibiotics to combat infections. Ruth's fate, of course, rested with the unfortunate 70 percent majority of patients who died of cancer's ravages.

Because I can find no detailed account of Ruth's cancer treatment, I can only surmise that his throat cancer was too invasive for successful treatment. We know that there were many successful surgical cures of head and neck cancers in the 1940s and in prior years. For example, as early as 1893, Grover Cleveland had successful surgery for cancer of the jaw while he was still in the president's office. The surgery was performed under the cloak of secrecy as Cleveland and his surgeons were aboard a yacht at sea. Although two teeth and most of his upper left jaw were removed, the incisions were made from within his mouth, leaving no visible scar. Fitted with a vulcanized rubber jaw, neither the public nor Congress ever knew what happened. Cleveland's decision to conceal his having cancer stemmed both from personal reticence and his worries that a cancer diagnosis for the president would create great consternation at a time when the U.S. economy faced financial panic and depression. Cleveland died of heart problems 15 years after his operations.[4]

Although Babe Ruth entered Memorial Hospital for radiation treatment, it is questionable how effective that treatment might have been either as a curative modality or as a palliative measure that might have eased the baseball great's suffering and freedom of breathing. Not until the 1950s was radioactive cobalt put to use as a means of delivering high-energy rays for deeper body penetration.[5] Before that time, X-radiation could indeed destroy shallow neoplasms, but not without danger of skin burns and tissue damage.[6]

The Babe's penchant for mingling with famous Americans of all walks of life extended to his being admitted to New York's Memorial Hospital, the first and most renowned institution in America devoted to cancer care and research. Beginning with the generous donation of the chairman of Phelps-Dodge Copper Mining Company, James Douglas, whose daughter had died of cancer, philanthropic gifts from many foundations were given to Memorial for cancer research. A champion of radium therapy, whereby the element radium was put in glass beads or other substances from which it would emit continual radiation, Douglas commissioned Memorial to unleash the power of radiation against the scourge of cancer. He created a radium salve which he would rub on his wife's feet—I'm not sure why—kept a pitcher of radium-charged water on his desk for drinking, and eventually died of pernicious anemia.[7] Generous gifts from Alfred P. Sloan, Jr., and Charles Kettering, both of General Motors, fostered the building of the Sloan-Kettering research complex near Memorial. Sloan-Kettering opened in the year of Ruth's death. Like Ruth, those who could afford it in the late 1940s and 1950s customarily entered hospitals for end-of-life cancer treatment and care.

As for federally funded research, the National Cancer Institute in Bethesda, Maryland, was founded in 1937 with a yearly budget of $400,000.[8] After the war, NCI's budget expanded exponentially—from $500,000 in 1945, to $14 million in 1947, to $110 million by 1961.[9]

Similar to Babe Ruth, the majority of Americans at the time were never told of their dire diagnoses. Talk of cancer was taboo, an unmentionable, a forbidden topic of discussion between most family members and the majority of doctors and patients. Why the secrecy and concealing? First of all, cancer connoted death, terrible and prolonged suffering, guilt, filth, and punishment. Asked what disease or illness would you dread most, 67 percent of Americans in 1947 responded "cancer." The books of the time called it a vicious invader, a horrible crab-like disease, a loathsome scavenger slowly and inexorably consuming you alive.[10]

Second, in keeping with a long-standing tradition in western medicine, bad news was usually concealed from patients. The physicians of the time believed that it was morally acceptable, if not morally mandatory, to conceal dire diagnoses from patients if the truth would harm them, which they believed it surely would in the case of cancer. Out of benevolent paternalism,

deception was both practiced and recommended throughout the 1940s and 1950s, as numerous articles bear out. [11] In a masterly survey of physician beliefs and practices published in the American Medical Association's *Journal of the American Medical Association* in 1961, Donald Oken revealed that almost 90 percent of the 219 physicians questioned had a strong or general tendency to conceal cancer diagnoses from their patients. Fifty-six percent of these said they never or very rarely revealed the truth, while only 4 percent said that they often told. Nearly all said they strictly avoided using terms like "cancer" or "malignancy," but instead used terms like "lesion," "mass," "growth," or "hyperplastic tissue."[12] Oken reported that behind these practices lurked fear—fear that if told, patients would become psychotic, suffer severe and prolonged depressions, or commit suicide. No wonder the Babe was never told.

Unfortunately, time does not allow me to explore how and why standard cancer care in the 1940s metamorphosed into that of the 1990s—an intricate and fascinating story of change in only 50 years. For us Texans, that story would have to include another great athlete named Babe—Babe Didrikson Zaharias, born in Beaumont and treated at Galveston's University of Texas Medical Branch. Unlike Ruth, Zaharias and her doctors freely spoke about her malignancy, including her being operated on for a rectal malignancy in 1953. As James T. Patterson says in his superb book on cancer and modern American culture, "the readiness of Zaharias and her doctors to talk openly of her disease and its location was little short of astonishing for that day and age"—a true testimony to Babe Zaharias's strength and winning spirit in the face of adversity.[13]

While not attending to the hows and whys, we can nevertheless contrast and compare what has transpired. First, cancer patients have a larger number of treatment options today, and, in general, treatment is less mutilative.

Consider the treatment of breast cancer. Fifty years ago, the standard treatment of breast cancer consisted of radical mastectomies—the surgical removal of the breast, the major and minor pectoral muscles, and the ancillary lymph nodes. Now, breast cancers are, first of all, carefully classified according to size and invasiveness. Next, smaller and non-invasive cancers are surgically removed so as to leave the breast intact (called lumpectomies), while the more invasive ones require removal of the breast tissue, while preserving the pectoralis muscles and some of the ancillary lymph nodes.[14] Finally, breast reconstruction is accented a great deal today so as to minimize scarring and restore breast size and its natural contours.

Though there was research being done strictly within surgery, the primary moving force behind less radical surgery was impelled by the development and provable effectiveness of radiation and chemotherapy either as exclusive

treatment modalities or as supplemental to surgery or to each other. Radiation's therapeutic advances mushroomed during the 1950s and 1960s with the development of cobalt and high-energy or supervoltage machines. Dramatic discoveries proved that 70 percent of patients with Hodgkin's disease were curable by means of radiation therapy.[15] About half of the approximately 1 million newly diagnosed cancer patients each year are said to be treated now with some form of radiation therapy. Some 100,000 of these are treated with radiation alone.[16]

The limited success of, but enormous fascination with, chemotherapy began after an American ship laden with mustard gas was blown up by the Axis powers near the end of World War II. Discovering that nitrogen mustard suppressed white blood cells, curious researchers began to explore whether patients with certain forms of leukemia, in which red cells and platelets are often suppressed, and white cells are sometimes massively accumulated, might be cured. Beginning in the 1950s, several chemotherapeutic agents were producing impressive cure rates for children with acute lymphatic leukemia, for women with metastatic choriocarcinoma, for patients with Hodgkin's disease, and for those with prostate cancer.[17] Unfortunately, many of the high, at times, ecstatic hopes about magic-bullet drugs for numerous types of cancers remained unfulfilled. In 1986, official figures from the National Cancer Institute indicated that only some 2 percent of patients diagnosed with cancer each year are being cured with chemotherapy alone.[18]

All the while, cancer research has been massively funded—a total of $2.2 billion in 1986 alone. The budget of the National Cancer Institute grew from $110 million in 1961 to $1.3 billion in 1986—a 12-fold increase over those 25 years.[19] Overall, five-year survival rates of serious cancers increased from 33 percent in 1955 to approximately 45 percent in the mid-1980s. This gain of some 12 percent over 30 years compares with a gain of 13 percent during the 20 years before 1955.[20] The disappointing news is that cancer has proven itself to be an exceedingly tough, many-faceted adversary. Numerous persons, time and time again, over the last 75 years, have claimed that cancer's eradication is just around the corner. You may remember seeing the drop of interferon on the cover of *Time* magazine with words to the effect of its being a breakthrough cure. In fact, our victories have been partial. Far more than gross statistics, however, the lives of the individuals who have been cured comprise our primary ethical justification for cancer research expenditures.[21] Medicine's incremental victories over cancer during the last 50 years still constitute the greatest similarity between our age and that of Babe Ruth 50 years ago. Lamentably, the majority of patients struck with this disease will not survive.

In a more positive vein, the silence and embarrassment over cancer five decades ago is, thankfully, history—or, for the most part, history. The change from concealing to revealing is illustrated by the degrees to which Ronald Reagan and his physicians never attempted to hide the fact of the president's malignancy and colon surgery in 1985.[22] TV coverage all but give us photographs of the colon. Thanks to the work of humanists, ethicists, and concerned physicians, Americans after 1965 became acutely aware of the extent to which we all had been curtained off from genuine interaction with our dying loved ones. In the face of loss and tragedy, family members increasingly wanted to relate to each other more honestly. Countering the silence of previous years, a death and dying movement began in the late 1960s, a movement determined to reacquaint us Americans with the toughness and wisdom of our eighteenth- and nineteenth-century forebears, a movement set on ending the pretending.

The tributaries to this cultural stream were many. Beginning with the seminal study by Erich Lindemann in 1944, physicians began to recognize that the great majority of patients did not respond catastrophically to news of dire diagnosis. Study after study indicated that centuries of tradition about the traumatizing effects of cancer diagnosis were vastly overblown.[23] By 1961, the psychiatrist Donald Oken issued a manifesto—fears of revealing cancer diagnosis apparently reside far more in the hearts and denial mechanisms of physicians than in the psyches of patients. As a physician, Oken could make that charge, and it would be taken very seriously. Numerous studies in the 1970s bore out the truth of Oken's convictions, and these studied called for far more training in the psychological, social, and spiritual dimensions of caring for critically and terminally ill patients.[24] Meanwhile, an increasingly vital and visible bioethics movement was underway, a movement that accented the right of patients and families to choose what to hear and what to do in the face of medical technology and an expanding array of therapeutic alternatives.

By 1979, a study by Dennis H. Novack and others made it clear that a cultural transformation had taken place. Using the same questionnaire employed by Oken 18 years earlier, Novack and his fellow researchers revealed that 98 percent of their physician respondents reported that they generally reveal cancer diagnosis to their patients in contrast to the 90 percent who hid the diagnosis in 1961. Two-thirds of the group surveyed in 1979 said that they never or very rarely made exceptions to their approach.[25] Our forebears' powerful intimacy with the unsavory sides of human sickness was being recaptured.

Finally, accompanying these changes, numerous concerned professionals and lay persons were revisioning and revising the social settings and circumstances in which cancer patients found themselves at the end of life.

Similar to Babe Ruth, ever-increasing numbers of persons now enter hospitals for critical cancer care. But thanks to important changes over the last two decades, patients who are diagnosed as terminally ill—or even desperately ill—have greater options. On the one hand, once standard therapies have failed, many patients now have the option of being enrolled on a cancer research protocol, protocols that are conducted by many cancer centers across the U.S. On the other hand, persons who are terminally ill can turn to a variety of other possibilities—from hospital-based palliative care units where patients are not neglected as if "nothing more can be done with them," to in-house hospices, to hospice-sponsored home visitation programs.

This note about options is a fitting point at which to end these remarks. Our having options and our expanding these options testifies to the freedom and tenacity of the human spirit. Even in the face of the direst of diagnoses, thankfully, we now have more options. Socially, we can choose to "go for it" therapeutically to the very end, to rest among like-situated humans surrounded by caring professionals, or to go home. Internally and existentially, we can fight, flee, or, here in Galveston anyway, go fishing. We can, as Dylan Thomas urged in behalf of his dying father, "not go gentle into that good night." Or we may, like the mortally wounded Stonewall Jackson, say to those surrounding us, "Take me across the river and let me rest beneath the trees." Thank you.

NOTES

1. James T. Patterson, *The Dread Disease: Cancer and Modern American Culture* (Cambridge, Mass.: Harvard University Press, 1987), 152-153. The account of Ruth's death given here is deeply indebted to Patterson's description.

2. Michael B. Shimkin, "Neoplasia," in John Z. Bowers and Elizabeth F Purcell, (eds.), *Advances in American Medicine: Essays at the Bicentennial*, (New York: Josiah Macy, Jr., Foundation, 1976), 233-234.

3. Patterson, *The Dread Disease*, 191, 233; Vicent T. DeVita, "Modern Cancer Therapy," in Arthur I. Holleb (ed.), *The American Cancer Society Cancer Book*, (New York: Doubleday, 1986), 84.

4. Patterson, *The Dread Disease*, 36-37.

5. Willis J. Taylor, "Radiation Therapy," in Holleb (ed.), *The American Cancer Society Cancer Book*, 141.

6. Ibid.

7. Patterson, *The Dread Disease*, 65.

8. Ibid., 114, 131.

9. Ibid., 171-172.

10. Ibid., 160. This and the points that immediately follow are taken from Harold Y. Vanderpool, "Should Cancer Diagnosis Be Concealed or Revealed? The History and Meaning of a Dramatic Change in American Medicine" (in press).

11. Vanderpool, "Should Cancer Diagnosis Be Concealed or Revealed?", 8-9.

12. Donald Oken, "What To Tell Cancer Patients," *Journal of the American Medical Association*, 175 (April 1, 1961), 1120-1128.

13. Patterson, *The Dread Disease*, 154.

14. Henry M. Keys et al., "Breast Cancer," in Philip Rubin et al. (eds.), *Clinical Oncology* (6th ed.; American Cancer Society, Inc., 1987), 120-125.

15. Shimkin, "Neoplasia," 233.

16. Taylor, "Radiation Therapy," 140-141.

17. Shimkin, "Neoplasia," 234-234.

18. DeVita, "Modern Cancer Therapy," 84.

19. Patterson, *The Dread Disease*, 171-172, 297.

20. DeVita, "Modern Cancer Therapy," 85.

21. Harold Y. Vanderpool, "The Ethics of Clinical Experimentation with Anticancer Drugs," in Steven C. Gross and Solomon Garb (eds.), *Cancer Treatment and Research in Humanistic Perspective* (New York: Springer Publishing Company, 1985), 34-36.

22. Patterson, *The Dread Disease*, 36, 298.

23. Vanderpool, "Should Cancer Diagnosis Be Revealed or Concealed?", 11-12.

24. Ibid., 12-13.

25. Dennis H. Novack et al., "Change in Physicians' Attitudes Toward Telling the Cancer Patient," *Journal of the American Medical Association*, 241 (March 2, 1979), 897-900.

Questions and Answers

William Seybold: Thank you, Dr. Vanderpool. I believe you used the figure that in one recent year $2.2 billion were devoted to cancer research. When I was a young surgical resident in the state of Minnesota, 50 years ago, one of my mentors made the comment that more money was being spent on forestry research in the state of Minnesota than was being spent nationally on cancer research. Indeed, we have come a long way due to the tremendous boost research has received in the last 50 years. And I'll add this additional comment, that it's my impression that one of the big benefits, social benefits, that came out of World War II was the realization of what research could do, what it had done in our military service, in improving our ability to fight and what it had done during the war years for the massive production of penicillin in the early forties. It was produced in quantities of a few grams and in a very short time, due to a tremendous research program, the science that resulted, we were producing it in the tons. The realization of this by the public, I think, enabled us to have our government support the tremendous biomedical research that has meant so much to our improved health, our ability to control disease. Thank you, again, Dr. Vanderpool.

Before I open up the floor to questions, let me ask a question. You made reference to some of the ethical problems of cancer treatment—chemotherapy—would you speak briefly about the ethical and moral considerations and some of the protocols of treatment, so-called double-blind studies of the effectiveness of cancer treatment?

Harold Y. Vanderpool: I think I could give a lot of Dr. Reiser's speech because he was one of my mentors in my post-graduate program, but the ethics of cancer research or the issues and questions there are somewhat similar to the ethics of biomedical research in other fields, a whole host of issues involving at least three dimensions. One is a very accurate as possible determination of the relative harms and benefits of what the research is. And that calls for a variety of things by the biologist. The second issue involves fully informed consent. And the third has to do with justice, so that there is one population of patients who will not bear the burdens of research from which another population of patients who bear no such burdens might benefit. There are, I'm assuming Dr. Seybold is talking about randomized clinical trials, and there are questions dealing with randomized clinical trials, namely, when you have a double-blind trial, Section A will be getting one type of drug or drug combination, Part B will be getting another. One of the ethical problems that is raised by that is what if the data starts showing you that treatment A is significantly more effective than treatment B? Should you continue on with that protocol? And both biostatisticians and biomedical researchers now have ways of alerting, of being alert to the discrepancies between two treatment modalities so that one will not prove at least far less life-extending than another. There are a host of issues to this effect. I think my own concerns have to do, as much as anything, with the degree to which cancer research, because it is big business—that's only part of what it is, but it is big business—becomes a standard suggestion to a variety of patients who are in desperate circumstances, rightly so, as long as these patients are fully informed.

Phase I cancer research protocols, for example, cancer research, chemotherapeutic research, is divided into three phases, Phase I, II, and III. Phase III has to do with comparing a standard therapy with a new therapy or comparing two therapies that are known to be efficacious. Phase I simply is bringing on line a new hopeful cancer drug. When you bring a new drug on line, though, you have rat, and possibly dog and monkey, models to suggest that it's somewhat efficacious. But, basically, you're not going for efficacy, you're basically going for a measurement of toxicity. You began with a low dosage of that drug and you raise it up to the point at which the body can't stand it any more. And many of you know that cancer chemotherapy keys off of the notion that we can get the rapidly growing cells in the body without killing the more permanent ones. That's why the hair follicles and internal lining of the mouth and intestines often ulcerate, or fall out, because these are rapidly growing cells. The hope is that cancer chemotherapy will get those rapidly growing cells, including the cancer, before the heart or the liver or something else will go. Well, the Phase I, to my knowledge, there is no good data concerning the efficacy of Phase I research. Basically, there are

anecdotes that cancer researchers can tell about a physician who suddenly turned around with a Phase I new drug coming on line protocol, but we don't really have good data about that, and so it strikes me, and what you're going to do is raise that drug dose to a toxic level, and then you'll start comparing it with other drugs in Phase II. Phase II actually involves taking that top toxic limit and trying it out on different forms of neoplasm.

The whole question bristles with a variety of issues, but I think the key is to have thoroughly informed consent, fully informed consent. And it seems to me informed consent is not just talking about the drug, but the researchers, doctor researchers, being able to spell out the different options that this patient has. I think patients need to see what the options are of going for it with a Phase I research versus other options. And I said, you can go for it and fight, as one, but fleeing and fishing are other options. And patients sometimes get locked into that battle with cancer, and of course it's a vicious battle, and I hate to think that patients really have no chance, yet take the chance thinking they do have a chance, when their lives could be more enriching in other respects.

William Seybold: Thank you, Dr. Vanderpool. We'll open the floor to questions, and I hope you'll identify yourself at the microphone because it will be recorded. Jack?

Jack Blanton: I'm Jack Blanton. Dr. Winslade, I believe we have in Houston four, I think they're called either Level 3 or Level 1 pediatric ICUs. Two of them are in public institutions, and many of the patients, babies, in those ICUs are those born to usually very young mothers. Frequently, some of those, I'm told, from 1-1/2 to 2 pounds, that we can save. I think the answer to the question do you save them is easy to many of us, but the question is can society handle it where it is costing us from perhaps $100,000 to $200,000 to save these babies? Many of them arrive, I understand, with other problems because various drugs relate to some of them. Of those that are not so burdened, Ralph Fagan at Texas Children's tells me that we can save somewhere around 95 percent of those babies, and we will have usually a baby that has every opportunity for a very normal growth. This relates, a little bit, I can relate it to, that basically is my question, to an ethicist because things such as this play absolute havoc with a Harris County Hospital District budget. The question is really what do we do about this? If I may relate this a little bit with a commentary to this morning's session of access to medical care, because this is not, while solely a problem of the inner-city, it predominantly is an inner city problem, and it basically begs the question of what we do about the cause of this. It has been disappointing to me that we really haven't seen the medical profession join hands with our secondary educational leaders because I really

feel that the major influence we're going to be able to make in correcting some of this, at least the best way of doing it, is to overcome the lack of communication that these young people receive about what they ought to do about prenatal care and the many other attendant problems. But we obviously need to do a much better job about both of those. And I would be interested in your observations about the way that society ought to approach it.

William J. Winslade: Well, thanks for giving me an easy question. I guess there are several things that occurred to me as you were articulating what is indeed a terribly difficult economic, political, social, legal and ethical issue, and I'm going to disappoint you by saying there are even more dimensions to it that make it even more complicated.

One of them is that we do believe that children who are born deserve a chance. And in this country, we have made a mistake, I think, in our neonatal and pediatric intensive care, particularly in the neonatal area. We go in with a full-court press and then we keep it on. I think that's one of the problems that we have. In England, the doctors have more discretion about whether or not to stop the full-court press if they really think that clinically there's not much that can be done. In Sweden, the doctors wait a little bit before they try the full-court press, and if the baby survives long enough to warrant it, then they try it, and then they sort of go for broke. So, I think, and we've had a history since 1970, of the problems of too much discretion with physicians and families to stop too soon and not provide life-saving care of infants that don't have serious problems, or who are maybe handicapped because of Down's syndrome. And then we have the history of the Baby Doe controversies in the eighties that push in the other direction for life-saving care but no follow-up care. We have the further problem that you brought up and alluded to—low birth-weight infants with young mothers who may be undereducated or self-abusive—but we have the problem that the treatment of damaged infants has been caught up in the interminable controversies about abortion.

And so it's even more complicated because of all of these other ideological battles, political battles. I really think, though, in answer to your question, that I would prefer to give an infant—an innocent infant with no previous opportunity to have a chance of life—I would be more inclined to spend my money there than at the other end of life. And, but that doesn't mean we should do it pointlessly, when it's futile. And we're ambivalent as a society because the Americans with Disabilities Act is a response partly to all of those infants we have saved that now have lots of disabilities, and there are going to be more of them. So, fortunately, as an ethicist, I have no power, I have no influence, I have no money, I just have lots of problems. But I think we all have to deal

with them, and one of the things that I hope we can do collectively in our society is deal with them better than we have for the last 20 or 30 years. We have to do that.

Harold Y. Vanderpool: Could I comment also on this set of issues? I think we need to do something really soon about some of them along the lines of great expenditures of preventative medicine. I mean, I am pro-research, and I have two brothers who are M.D.s, and was pre-med myself, so some of my best friends are doctors. But I think a lot of money was wasted on chemotherapeutic research. Not wasted if we had it to spend, but in terms of priorities. What we're talking about in some of these allocation issues of what are your top priorities and what are your secondary priorities, what are your tertiary priorities, it seems to me that prevention in terms of the kind of prenatal care you're talking about is one of the first priorities. But I want to go beyond that. I think we need to do thoroughgoing research on these underweight compromise infants. My psychiatrist brother told me on the golf course the other day —see, you can always question the accuracy of information just as you're about to putt—but he said there's been a recent study to show that those infants that are compromised and they're underweight and spend a lot of time in the bassinets have a much higher suicide rate as they grow up. And I said, well why do you say that? And he said, well, because there's no bonding. They just have this feeling within that life is not worth living. And I say, well, you have parents, you have this, you have that. I know, but I just don't feel life is worth living for me. Well, I don't know the study, I haven't read it, probably need to chase it down, I do need to chase it down, but I think we need good data on this.

Secondly, I think we're way too lax on anybody and everyone's being able to have kids. And what we do about that, I think we have to have much more stringent issues about the rigor of parenting in America, and I, now you get in the thick of the law and so on, but unless we, in some way, restore our feel for the tremendous work it takes to be a decent parent, then we're in trouble. And so I think educational programs, and so on, are very much in order on that score. And to expect the hospital to suddenly pick up these social problems is expecting too much. The doctors are there, they've got the technology, they're in the thicket of ethical and legal issues on these things. I think the rest of us, what I'm saying in part, the rest of us need to give the hospitals and doctors a lot of help prior to the time these babies ever get born and/or make it in the hospital.

Teresa Hershey: I'm Terry Hershey. I have two questions. One is relatively simple and I think one is unanswerable. It's left over from this morning, but I think it fits in now, too. The simple question is what is the gap in communication that allows only 38 people out of 800 that have expressed some desire to be able to depart with dignity? Is it, I was under the impression, if you sign these things, which I have, and give them to your doctor, which I have, and pass them around in the family, which I have, that somebody would be around to say, hey, this person has signed something. What happened between 38 and 800?

Harold Y. Vanderpool: Okay. Let me answer that for you with a simple answer. I think that we have an illusion that a signed piece of paper does anything, even if everybody has it. And that's why the most significant advance and most important change that's occurred in this area occurred in Texas in 1989 when we passed the Durable Power of Attorney for Health Care Act, which says that you can designate another person to decide for you if you're not able to decide for yourself, and in every bureaucracy I've ever dealt with, whether it's hospitals or the driver's license bureau, it's people rather than paper that make a difference. And so if you've got a person who has the authority to speak for you, they can carry the piece of paper that you signed too, but they're going to get somebody's attention, and they're more likely to get results than if you rely on simply a piece of paper doing the work. That's the simple answer.

Teresa Hershey: So the mistake was giving it only to the doctor, the family, and friends. You should give it to your lawyer and designate who you want and give that to your lawyer.

Harold Y. Vanderpool: Yeah, probably not your lawyer, though, because he has a claim against your estate.

Teresa Hershey: But just be sure he has the paper. The other question we, as a species, and particularly in America, which was a recently discovered continent, have had a wealth of resources for the taking. And we have lived through an extractive society which will be increasingly limited as we come up by resource overconsumption. And if, as indicated, we are concerned with keeping people alive, not only longer but at all with the new treatments available, how can we avoid the issue of population control when we discuss health care? And not many people have mentioned population control as an overriding thing. For instance, we can't depend on hazards anymore. For instance, in Bangladesh, they lost 100,000 people in the floods, and they pick

up three times that much yearly with their population increase. So people are forced down into those floodplain areas because there is no more area upon land. And so, even though you lose 100,000, you pick up 300,000 in one country. We try to get rid of wars, and if there was ever a Holy Grail contest, that's it, but just the same, if we get rid of wars, we still have more people. So the question is when does triage set in? When do we decide who's going to get pushed off the lifeboat so somebody can stay on?

William Seybold: Terry, I don't know whether either of these fellows are prepared to answer that.

Harold Y. Vanderpool: I'm going to jump.

William J. Winslade: Well, I'll say this. You know, Bill's right, I tend to walk where angels just wouldn't tread whatsoever sometimes. But I think triage needs to start with the persisting vegetative, persisting coma patients. I really do. I think we need very good, we've got to have good diagnostic measures. But just because you get a twitch every now and then when you say a certain thing in a room does not seem to me to warrant the kind of expenditures we're spending on these approximately 10,000 people who are in persisting vegetative comas. I just don't see it. I mean, it seems to me that although we're not now talking about triage in a terrifying sense, we need to start talking about triage much more seriously in an incremental sense. I mean, I agree with Woody Allen to some degree, and that is that my neocortex is at least my second favorite organ, and that may be irreverent, but if the neocortex is gone, it seems to me that that's it, and one of the issues in the Wangley case involved, if they can pay for it, the individuals can pay for it, perhaps they can keep someone like that alive. But I hate for the public to have to pay for Mrs. Wangley and the insurance company, lawyers, and so on, would need to get together and ask whether that's a person or not, according to the constitutional law. But it seems to me the insurance companies shouldn't have to pay for it either.

W. G. Hall: I'll have to share this experience with these distinguished ladies and gentlemen that occurred two days ago when the insurance company vice president, the one that carries the insurance for our bank, was explaining to me an incident that occurred to him in Austin recently. His chief counsel, and a bank customer, were going to a meeting, and they got in the car and they didn't notice that one wheel was about off. They went past the insane asylum as the wheel rolled off. They were in a quandary as to what to do. And the wheel was there but they had the car jacked up. They had no nuts for the wheel. There was a man mowing grass inside. And so the lawyer, obviously speaking first, asked this man, he said, you don't know how far it would be before we

could find a garage that might be able to come and help us get this wheel back on? And he said, well, is that all the problem? He says, yes. He says, why don't you borrow a nut from one of the other wheels and put it on there and go on down the road? You'll find that garage, it's only about a mile. That they did. And then this lawyer said to his banker friend, he says, that's a hell of a note. Here, we're two educated men, and we don't know the solution, but that man at the insane asylum, he solved the problem. He said, the man could tell us, how is it that you're in an insane asylum and you know the answer, and we're educated people and don't? The man in the insane asylum said, well, mister, I'm crazy, but I ain't stupid.

Now then, that causes this man who I was talking to, to ask me, you're going to be with a bunch of real medical experts. Yes. Now see if you can get them to derive some way that I can tell the difference between a man in an insane asylum and a lawyer and a banker. I said, well, I'll submit that to them. Now, that's your problem, so how do we tell?

William C. Levin: Mr. Chairman, I'm not here to ask a question. I'm really here to address the members of this Society and the wider citizenry of our state and our nation. I want to be sure that everyone understands that the development of conclusions regarding ethical questions, insofar as medical practice is concerned, should not be left to physicians. It is our responsibility, as a society. And I hope that the membership of this Society will become involved in at least thinking about the various issues and will join together at some point in the halls of the legislature or the halls of the Congress to assist in the development of appropriate policies that are ethically, reasonably ethically, sound. It's not up to the physicians alone. It's not up the lawyers, I hope. It's up to society.

William Seybold: Thank you. Any other questions? Well, I would close, after thanking our two speakers for their fine presentations, by saying that I like what Dr. John Cooper said this morning about global change in our society. Some of these ethical and moral problems go so deep, are so complex, involve so many aspects of our society, that there are no simple answers, and we haven't faced up to the fact that we have limited resources and unlimited demands for what we'd like. And I don't believe anyone can yet make the decisions about triage or finally settle these ethical and moral questions.

I started this panel this afternoon by saying that I don't know that we ever solve these human problems. We address them, hope we learn something in addressing them, apply what our current mores are, and understanding are, and hope we can deal in the future with them a little more intelligently. But I don't believe we can come to any final solutions.

That ends this session, but I want to ask the members to remain for a business session which will follow immediately. Thank you all very much.

Sunday, December 8, 1991

SYMPOSIUM

WILLIAM C. LEVIN, MODERATOR

GOOD MORNING, LADIES AND GENTLEMEN. PLEASE COME IN AND BE SEATED. THIS is the second year that the Philosophical Society of Texas has met on a Sunday morning. The original intent of these Sunday morning meetings was to provide an opportunity for the members of the Society to discuss what was presented the day before, to discuss whatever they wish to discuss. Because the subject this year centers on health care delivery, it seemed appropriate to pull together, both from the Society and from without the Society, some experts in various aspects of the health care delivery system to get this discussion started this morning.

Unfortunately, the participant that we had hoped would be here called me Friday to tell me that she would be unable to attend. I'm speaking of Dr. Marina Weiss, who is chief analyst for health and human services for the U.S. Senate Committee on Finance. She formerly served as legislative assistant to Senator Bentsen, as a member of the faculty at Texas A&M University, and on the staff of the Senate for Urban Programs. I think that Marina is one of the most knowledgeable people in the country with respect to funding of health resources at a public level. But, unfortunately, the Congress didn't adjourn as we all expected it to, as she expected it to. And she told me on Friday that because of this, because hearings will start early tomorrow morning in Washington, that she would be unable to attend, and she sent her regrets.

But we fortunately have some people who are most knowledgeable about issues in Texas, particularly, and about the whole issue of health care delivery in public policy in general. And I'm so very pleased that Bill Hobby is here and Dave Warner. You know both of them, but I guess as chairman, I should be more formal and introduce them.

Bill Hobby, as you know, at least in my opinion, is the most distinguished lieutenant governor that ever served the state of Texas. He presently is chairman of the board of H&C Communications, Inc., and holds the Sid Richardson Chair in Public Affairs at the LBJ School of Public Affairs, and currently is the Tsanoff Professor of Public Affairs at Rice University and at the School of Public Health in Houston is adjunct professor of health policy.

Dave Warner is professor of public affairs at the LBJ School at UT Austin, is professor at the University of Texas School of Public Health, member of the education committee of the Texas Medical Foundation, member of the editorial board of the *Journal of Health Policy Politics at Law*, and a former board member of Brackenridge Memorial Hospital in Austin.

We have really a very broad coverage of various considerations of the health care delivery system. Dr. Carson is standing by in case he's to be called upon. I'm going to make a few general comments before calling on—Bill, will you be the first?—we're calling on Dave to make a few comments, and then Bill Hobby will make some comments, and then it's up to you, the members of the Society, to proceed with the important part of this morning's program.

During the sessions which were held yesterday, most of the discussion centered upon some of the major issues which health care professionals, ethicists, members of the legal profession, and the community at large are grappling with, both in the abstract and in day-to-day encounters.

Economic issues have been touched upon, but this morning we hope that the discussion will center upon economic issues and will, at least in discussion, deal with some of the hard decisions facing the nation with respect to the costs and the methods to deal with these escalating costs in the health care delivery system of our nation.

Hardly a day passes without news stories and editorials appearing in the lay press and in the professional journals addressing these issues. And I'm going to refer to just a few of these, and they range through the whole gamut of problems affecting the health care delivery system of our nation.

On November 17 of this year, the New York *Times* had an article, "Washington Tries to Sort Out Health Insurance Proposals." Last week's New York *Times*, November 24, I think that was last week, two weeks ago, first page, "Mental Hospital Chains Accused of Much Cheating on Insurance." The *Wall Street Journal* on November 12, an article by Milton Friedman, and just to be provocative, let me read one sentence from his article. "The inefficiency, high cost, and inequitable character of our medical system can be fundamentally remedied in only one way—by moving in the other direction toward reprivatization of medical care." So the range of opinions being expressed is quite remarkable. Arthur Andersen, Inc., publishes a Washington health care newsletter and the newsletter, October 1991, deals with a number of major issues.

The last publication that I should like to refer to, to sort of set the stage for the discussion this morning, appeared in the *New England Journal of Medicine*, September 19, 1991—an article by Dr. Arnold Rellman. Dr. Rellman was once professor and chairman of the Department of Medicine at the University of Pennsylvania Medical School, and then for many years thereafter until he recently retired was the editor-in-chief of the *New England Journal of Medicine*. He gave a lecture at the annual meeting of the Massachusetts Medical Society in May of this year. It's called the Shadduck Lecture—"The Health Care Industry—Where Is It Taking Us?" He makes

a number of points—some very frightening ones. "What we see now," and I'm quoting, "is a market-oriented health care system spinning out of control. In 1965"—I'm again quoting—"we spent about 6 percent of our gross national product on health care. In 1975, approximately 8 percent. In 1985, about 10-1/2 percent, and last year, over 12 percent." So, in the course of 15 years, I beg your pardon, my arithmetic is poor, 25 years, the amount of the GNP devoted to payment for the health care of our nation doubled. And very recently I came across an article that suggested that for 1991 it probably will reach 13 percent. Again quoting from Dr. Rellman's article, "At least 15 percent of Americans have no health insurance and probably at least an equal number are inadequately, or only intermittently, insured. Evidence of inefficiency, duplication, and excessive overhead is everywhere apparent. Administrative costs have recently been estimated to make up between 19 and 24 percent of the total spending on health care—far more than in any other country." And then, the last two or three quotations from the same article, he addresses the issues of,

> How have these developments affected the practice of medicine? In the first place, they have resulted in more regulation of the private practice of medicine by third-party payers. Second, doctors are increasingly threatened by malpractice litigation as a strictly business relationship begins to replace the trust and mutual confidence that traditionally characterized the doctor-patient relationship. Thirdly, the courts, which formerly kept the practice of medicine out of the reach of antitrust law, now regard the physician as just another person doing business, no longer immune from antitrust regulation.

Those are just a few of the problems. And I would make one, give you one more quotation from Dr. Rellman's article, his concluding statement, and then I shall sit down—"what our health care system needs now is not more money, but different incentives and a better organization that will enable us to use available resources in a more equitable and efficient manner to provide necessary services for all who need them. We can afford all the care that is medically appropriate according to the best professional standards. We cannot afford all the care a market-driven system is capable of giving."

Now, Dr. Warner, those are just a few of the issues that I am sure you will resolve for us this morning.

David Warner

Thank you, Dr. Levin. Driving down here, Governor Hobby and I were talking and decided that we would both try to be provocative and then he suggested that I should go first. But mature reflection has led me to think that perhaps I'll be less provocative than I might have been if I had gone second.

Also, I learned on Friday that Marina Weiss wouldn't be here. Accordingly, I've tried to address her topic of health care in the U.S. in the year 2000 and beyond. When asked to look into the future, one tends to adopt the rhetoric or the mantle of Buck Rogers, or perhaps Jeanne Dixon, or even Martin Luther King. Buck Rogers because there is always the temptation to point to the gee-whiz technology that has become and will be available. Jeanne Dixon because it is always fun to predict significant change in the status or the life-style of the rich and famous. And Martin Luther King because it is very important to have a dream of what may be achieved in an improved and more equal society.

With regard to this topic, all three perspectives are important and are interrelated. I will first discuss some of the roles which technology, the emergence of new disease and even demographics will play in shaping and determining the health care system of the future. Next, I will discuss the role of hospitals, physicians, other practitioners, and the patient in the future. Finally, I will discuss some of the current shortcomings of the U.S. health care system, and some of the initiatives being proposed to increase access and equity and to control cost.

Technology and Disease

The vast new technologies alluded to by Dr. Levin in his introductory remarks yesterday are truly awesome. Biomedical research has been a very valuable investment; and I think that Texas has been wise to invest in this technology, especially during a period when the federal government has been generally supportive. Science has developed new limbs and artificial organs. Physicians can now transplant many organs, manipulate the immune system, and clone new forms of life. With regard to some of yesterday's comments on rationing, there is a fairly well-organized federal system of allocating cadaver organs. In fact, certain priorities as to who shall live do rest in committees at the regional level now, although I think with very little public oversight or understanding of exactly how they work. *Jurassic Park*, a recent book by Michael Crichton, shows what may be possible with science—a dinosaur park is developed for dinosaurs which have been cloned from genetic material which has been found in frozen specimens by paleontologists. But the book also illustrates the unpredictable way in which life survives

and humans miscalculate. Walt Rostow will appreciate that the most insightful character is a mathematician from the University of Texas who is a specialist in chaos theory.

Optimism that science will take us to ever higher levels of wellness or control over our own health was best summarized, for me at least, in a radio interview I heard with Timothy Leary, where he expressed the belief that, for immortality, we just need to eat right, let our feelings out, and replace organs when needed. A more cautious version of this was stated 20 years ago by Lewis Thomas, who believed that through heavy investment in high science and molecular biology we can develop efficacious interventions for virtually every disease. While halfway technologies palliated syphilis and typhus, for example, the development of definitive interventions turned these dread diseases to easily-managed conditions. He believed most, if not all, major human diseases are approachable scientific problems which will be solved fairly soon. He also believed that as diseases are conquered, most persons will live longer and will be more likely to have an old age like that of Bertrand Russell, who lived in good health until he was in his nineties, whereupon all systems collapsed and fell apart at once, rather like Oliver Wendell Holmes's "One Hoss Shay."

By contrast, René Dubos, in *Mirage of Health*, sets forth the proposition that disease is in large part a natural outcome of man's attempted adaptation to changing social conditions. He relates that plague was serious in the Middle Ages because of the prevalence of the black rats who carried the flea which transmitted it to humans. When the more dominant brown wander rats emigrated across the Volga, carrying a different flea which did not transmit the disease, the plague ceased to be a problem. He states that in Europe leprosy was prevalent in the fourteenth century, plague in the fifteenth, syphilis in the sixteenth, smallpox in the seventeenth and eighteenth centuries, scarlet fever, measles, and tuberculosis in the nineteenth century. He points out that no one was prepared for the virulence of the 1919 influenza epidemic. Furthermore, he predicted in 1959 that cancer, environmentally-generated diseases, and mental illness would be among the major problems facing us in the late twentieth century. And he predicted that new diseases would also emerge as indeed they have with a vengeance.

Methods of dealing with disease are as much determined by the underlying social arrangements as is the generation of new diseases. Dubos noted, for example, that the village fool, who used to be an accepted member of any rural setting, the semi-senile oldster who was expected to spend his last years rocking on the porch of the family homestead, and even the timid soul who escaped competition by retiring into a sheltered home atmosphere are likely now to become inmates of mental institutions or nursing homes (or more contemporaneously the streets) because they cannot find a safe place in the crowded high-pressure environment of modern life.

A commonly-stated objective for health planners is to reduce mortality and morbidity due to conditions such as diabetes, prematurity, head injury, and heart disease. However, mortality and morbidity are not necessarily reduced together. In fact, as several speakers have noted, when we reduce mortality, we often increase morbidity, sometimes at high cost to society. The goal of health systems in poor societies is to reduce mortality. In rich societies, with increases in long-term chronic conditions, it will be necessary to find ways to reduce the cost of maintaining people with some limitations in society. With many early retirees expecting to spend nearly as much time in retirement as they spent on the job, it should be clear that the long-term productivity of the whole society will have to increase.

The Health Care Industry

Since the enactment of Medicare and Medicaid in 1965, revenues have poured into the health care sector. Total health care sector expenditures in 1992 in the United States are estimated to exceed $800 billion annually, nearly $3,000 per capita. This represents about 13 percent of GNP. Other industrialized nations spend between 6 percent and 10 percent of GNP on medical care even though they guarantee universal access to basic health benefits. In Texas, in 1991, best estimates are that we will have spent roughly $40 billion on medical care.

In spite of the increasing number of physicians, many Americans believe they now have less access to primary physicians or to continuity in their care. By 1991, the number of physicians in the United States had increased to more than 600,000—an increase of 75 percent since 1970. There is now one physician for every 420 Americans, while there was one for every 641 in 1970. Partly because of reimbursement incentives, the relative number of physicians going into primary care has declined. Physicians' incomes and their relative incomes have also increased to the point where the median physician income exceeds $160,000. Certain specialists, such as ophthalmologists, some orthopedists, and cardiac surgeons are paid as much as $800,000 or more. By comparison, junior high science teachers earn about $30,000-$35,000, although both ophthalmologists and teachers are paid largely from tax revenues. One consequence of such high physician incomes and high relative pay has been the attraction over the last 25 years of a disproportionate share of the smartest and most able students into medicine. Because of these artificially high relative incomes, society's ability to attract capable people into a variety of different professions has been attenuated. Medicine, law, and perhaps investment banking have attracted highly capable students to the detriment of many other professions in which we desperately need very able persons if we expect to have a society that can compete in the world.

Hospitals' expenditures have increased even more rapidly. Each hospital seems to aspire to be a small medical school, with campuses, training programs, and all conceivable technology, as well as CEOs, CFOs, and more accountants than General Motors. The development of trauma care, ICU units, and all sorts of diagnostics have led to new levels of cost. Although much of this care is efficacious it is surely more than most citizens would choose if they could reallocate some of the tax and insurance funds spent on health care to other public uses. For instance, with the public school budget, the school board has to raise taxes to everybody if it plans to increase expenditures. Funds for health care are pulled out of many revenue sources and payers if an eligible patient has a reimbursable condition, and if all of the payers ante up insufficient funds, the provider can go after the patient for the balance. This is not to say that the way we fund schools necessarily leads to high quality. The way we allocate funds to medical care has created a system which few politicians dare to touch and has led to some very unusual arrangements, with tremendous waste and little or no local or consumer control.

A related issue is whether we are not over-medicalizing what are essentially social problems. The problems of infant mortality seem, in the United States, not to be lack of access to high-tech medicine. Indeed, the United States has the best infant mortality rate by birth weight in the world. The problem is that too many of the babies born are low birth weight. This is partly a function of our recording many very low birth-weight births as live births whereas in some other nations, births below 750 grams may be defined as still births. More important initiatives to combat low birth-weight births are the reduction of teenage pregnancy, the provision of adequate prenatal care, and incentives for adequate care. In a recent study, C. Arden Miller found that 10 European countries were achieving better results in infant survival than the U.S. by establishing easily understood and readily available provider systems. These nations then "link prenatal care to comprehensive social and financial benefits that enable pregnant women and new mothers to protect their own well-being and to nurture their infants."

Similarly, the care of the chronically mentally ill and the elderly unable to care for themselves is often more a housing and social support problem rather than a medical one. Fees for service reimbursement, which may occasion good focused effort for some provider-oriented practice, have had the impact of driving out those broader functions which are not reimbursed. This has become true in social work and psychology as well as in medicine, with perhaps even more unfortunate results. Even in the public sector, the Texas Department of Human Services has gone from providing child welfare services to providing child protective services, and it is only able to serve

about half of the cases of proven child abuse. A fortunate consequence of expanded funding for mental health services under Medicaid will be more revenue. The downside may be more attention to billable events than to the kinds of supportive services needed.

There was a brief period when health planning was mandated in the United States, in which all interests were represented. There were physician representatives, insurance companies, and consumers. But it did not work very well. One of the biggest problems was that the professionals were involved in this process not for their expertise, but really to represent their economic interest. One of the greatest health policy problems in the United States over the last 20 years is that physicians generally have let professional societies represent them rather than coming forward with standards of care and also priorities for care at the community level. Dr. Kitzhaber, who is the leader of the Oregon Initiative and is also president of the Oregon Senate, is a physician. It's because he's a physician and speaks with some knowledge of clinical issues that citizens have had some comfort in being able to discuss some of the issues related to rationing. People in public policy have, in a sense, been shadowboxing. They have not had the technical expertise or legitimacy to raise these issues. Professional groups and advocacy groups have responded to serious debate on priorities with the view that if one person dies, that would be too many. In fact, in any conceivable state of the world, many persons will die, either because they didn't get treatment, due to rationing, or because they didn't have access.

In addition to setting priorities for care, we must develop efficient, high-quality medical services. Lawrence Weed, in a classic article in the *New England Journal of Medicine*, posed the question, "What is the best combination of systems, tools, and people for solving any health care problem in the context of the individual patient's life?" He concluded that physicians and other health care professionals using computers, protocols, and feedback loops should function as a team along with the patient in facilitating his or her own health care and treatment plan. Weed believes patients should receive a copy of their medical record. Weed is the father of the problem-oriented medical record in which the practitioner describes the medical problem and sets forth the proposed treatment plan, identifying what the patient needs to do and what the physician needs to do. That's a level of communication which I think is often lacking between patients and physicians.

Weed concludes that under our present licensing and credentialing system, which focuses on training rather than on performance through one's professional life, there is too much reward for doing simple things or doing many complex things poorly. He believes that in the selection of health providers, natural skills and interpersonal relations, manual dexterity, dedication, and

a sense of responsibility to others should far outweigh the present emphasis on memorized knowledge and extensive backgrounds in formal education. Medicine is the only one of the principal medieval professions which appropriated the mantle of science. And the statutory constraints on the practice of medicine continued to be delineated in nineteenth-century medical practice acts. The medical systems of the future will have to take into account the productivity and quality-enhancing possibilities that information technology and new forms of practitioners can provide.

Providing Care for All

Finally, as a consequence of the rapidly escalating cost of the increased medicalization of society's problems, and of a financing and entitlement system that allocates services based on age, place of employment, and family income, most Americans believe that the U.S. health care system must be reformed. The basis for this belief is concern for the increasing number of uninsured, the rapid escalation of insurance costs, the lack of available coverage from many employers, and the fear held by almost all Americans of catastrophic expenses and loss of coverage, either due to illness or to the loss of the job which provides coverage.

As Ron Carson reported, the uninsured have increased from roughly 26 million reported in 1977 to 31 to 38 million in 1987. In 1987, the National Medical Expenditure Survey found that 47.8 million people lacked insurance for all or part of the year, of whom between 34 and 36 million were uninsured on any given day, and 24 million were uninsured throughout the year. This does not include persons with Medicaid or Medicare who are considered to be insured. The small group health insurance market has eroded badly, and many employers are unable to arrange affordable group insurance for their employees without unacceptable exclusions and limitations.

Even with coverage, many persons are not able to earn enough to pay premiums for their families and do not qualify for other coverage. With increasing employment insecurity, there is concern that coverage will be not available if jobs are lost. Troubling aspects of the current system include the increasingly dual nature of care available to those who are not insured. Many of those who are uninsured are covered by a public system in overcrowded emergency rooms and clinics. This two-tier care may be expanding to differentiate between those with public coverage under Medicaid and perhaps Medicare, which increasingly limit reimbursement to physicians and hospitals, and those with private coverage, which is developing other methods of limiting access to and reimbursement for care.

The poor level of entitlements to young families and children is a continuing problem not only for health care, but also in education, nutrition programs, day-care, and job training. Without healthy and productive young

families, the capacity of the society to prosper will surely be at risk. I am not going to review the different health insurance proposals that have been developed; many members of Congress since the Pennsylvania election have submitted something. It does seem clear that a guarantee of basic health services to all Americans is a necessity for us to have a society that works. And if it is a guarantee that is combined with some sensible idea about the reasonable constraints on treatment and payment of providers, there is no reason why it should bankrupt the economy.

Robert Alford has characterized the American health care system as "dynamics without change." We go back and forth between an ideological attachment to bureaucratic and market-based solutions without fixing on a system of oversight or entitlements that work. I read an interview with a Congressman last week who said that it may be true that 70 percent of the American public want change, but a lot of people are employed in the industry and until it gets to 90 percent, he wasn't too sanguine that change would come about.

Ironically, the current Kennedy-Waxman Basic Health Benefits for All Americans Act (1989) is very similar to Richard Nixon's Employee Health Care Insurance Plan proposed in 1974, which was dismissed by Congress. My 12-year-old son, who disapproves of the radio station I listen to when taking him to school, asked me one day, "What do you get when you play a Country-Western record backwards?" With some trepidation, I said, "Well, what?" He said, "Well you get your wife back, your job back, and you get sober." Now, I don't think we could run the record back to 1974, nor do I think we want to, but I think we really are going to have to do some very serious thinking about where we go from here.

WILLIAM C. LEVIN, MODERATOR

THANK YOU, DAVE. GOVERNOR HOBBY.

WILLIAM P. HOBBY

I'D LIKE TO TAKE THE SECOND SPEAKER'S PRIVILEGE TO AMEND SLIGHTLY WHAT Dave opened with about who was going to be provocative about what. The arrangement was that he was going to make statements so provocative that they would stir up enough comment to more than fill the time allotted to this discussion. Well, the corollary of that is that if he hasn't been provocative or outrageous enough to do that, then I've got to be even more provocative and outrageous.

Bill Levin was kind enough to mention in his introduction that I am the Ratoslav A. Tsanoff Professor at Rice. The founder and funder of that chair is a member of this Society, Walter Hall, who is here this morning. Rice thanks you, Walter.

The policy research project that Dave and I are conducting on health care cost and access came about because of a member of this Society, our boss, Max Sherman, dean of the LBJ School. More than a year ago, Max asked people from the Governor's Office, Lieutenant Governor's Office, and the Speaker's Office if there was a single public affairs project or subject that they would like to see become the subject of a pretty thoroughgoing research by the LBJ School. And the unanimous reply was health care and access. There wasn't anything else in second place. And this PRP was also planned to work in conjunction with the Governor's Commission or Interim Task Force on Health Care, which held its first meeting earlier this week. The fact that Bill Levin had the foresight to devote this program to this subject, the fact that a major effort on the part of the LBJ School is being devoted to this subject, the recent senatorial election in Pennsylvania, the governor's naming a task force, the many articles that Bill Levin referred to, the fact that you can't go to a newsstand and not see some magazine whose cover story relates in some way or another to health care, is indicative of the concern that this issue now raises.

It might be interesting to mention the specific charge that Governor Richards has given to her Texas Health Policy Task Force. There are six elements to the charge. They are: define a basic health care service package for Texans emphasizing preventive and primary care; propose a health insurance benefits package or other health care financing mechanism (and I think that is very significant, health insurance package or other health care financing mechanism) for Texas that is not necessarily tied to place of employment, and includes recommendation for state regulation of health insurance or other financial plan; third, provide a range of options for small businesses to assist with health care benefits for their employees; fourth, recommend cost containment and financing options for health services; fifth,

recommend a coordinated health care delivery system with special emphasis on rural health care and trauma health care; and sixth, delineate the responsibilities and the commitments of consumers, providers, insurers, employers, and government at local, state, and federal levels for high quality and affordable health care.

Now as you can see from the specific charge from the governor to the Task Force, and from the mission of the LBJ School research project, there is great concern about cost of health care and access to health care costs.

And following a conversation that Ted Fehrenbach and I have had several times, but most recently out in the hall just before this session started, in our culture, particularly in this country, we commonly refer to certain things as problems, the problem of access to health care, the problem of health care costs, the problem of whatever. And referring to something as a problem, rather than a situation, somehow carries with it the idea that somewhere out there, if somebody is just smart enough, there is a solution that will make everybody well and will reduce cost, and that is not the case. In fact, one of the best surveys on the health care situation in Texas so far has been done by the Texas Research League, specifically by a former student of Dave's, an LBJ graduate named Anne Dunkelberg, which shows that Texans who have health care coverage of whatever sort, whether through Medicare or Medicaid, or through health care insurance arising from employment, make use of the medical system 1.28 times as much as those without coverage, which is exactly what you would expect. But the point is that under present arrangements, the more that we increase access, which is a goal shared by us all, under the present system, costs are going to increase very sharply with access.

Do we really have, as set out in the article Bill Levin referred to, a market-driven health care system? I think we don't, and that's one of the problems with the system (and also a source of difficulty with the system). We don't have a market-driven system in the same way that the market drives and sets costs for the professional services—legal services, architectural services, accounting services, and so forth—because a very high percentage of the payments are through third-party payers. We don't shop the market for medical services as we do for other services because under the existing system there is not the incentive to do so. So I would argue that one reason for our very high cost (medical inflation runs now about 15 percent a year, twice that of inflation in other parts of the economy) is that the current arrangements do not give us an incentive to do the same kind of shopping that we do for other services.

Both Bill and Dave referred to the very familiar fact that opens almost any discussion of this kind, that we have in the last 20 years or so doubled the proportion of GNP going to health care from 6 percent to 12 percent. The

alternative system most widely discussed is the Canadian system. In Canada, costs have increased too, but their GNP percentage devoted to health care is 8 percent.

But two things need to be put into perspective to make it clear that this gap is even more striking than it first appears. We spend 12 percent of GNP on health services, and yet we have about 38 million people in the country who are outside the health care coverage system. Canada spends 8 percent of GNP, and nobody is outside the basic system. Ralph Spence, I believe it was yesterday, was asking have studies been done on the Canadian system? Yes, there have been. I personally think that moving toward that system is the way that we ought to move as a national policy basis, though it is certainly not importable or reproducible immediately into this country.

The system is a source of immense pride and satisfaction within Canada. Ron Tyler told me yesterday that he recently tried to recruit a potential employee from Vancouver and was not able to do so because that person does not want to leave to bring his family to the United States and take away the benefits of the Canadian health care system. I personally know one other person whose parents, who are American citizens, live in Canada for exactly that reason. All the Canadian opinion polls show a high level of satisfaction. Opinion polls in the United States show a very low level of satisfaction with our system.

A criticism of the Canadian system is that it does not provide access to as much or as high technology as the American system does. Some Canadians who can afford to come across the border to Rochester, to various health care facilities in Michigan, and so forth, to get access to high technology—CAT scanners, MRIs, etc.—that are not yet as readily available in Canada as they are in this country. There is inevitably flow both ways across the border.

Of course, in addition to the high physician income, one characteristic of our system which Dave mentioned is its tremendously high administrative costs. The administrative costs in Canada are substantially less because you have the single-payer system. The government is the payer there.

The problem of new diseases has been referred to. New diseases means generally, the first one that we all think of in this room is AIDS. There is another one on the horizon and new disease is not the right word, but a condition, new in the past decade, that is going to have implications I think none of us can really grasp at this time, and that is the impact on society of babies who were addicted to one substance or another, but, more particularly and more recently, to crack. Crack babies are about the size of your hand when they are born. They are convulsive from the moment they are born. They are not subject to comforting and nurturing in the way that ordinary babies are. What I suspect all this means is that they are sociopaths from the minute they

are born. They cost about $2,500 a day to keep alive. The first of these are now about six or seven years old, just about normal age for entry into school. I think there's very little prospect that any substantial portion of these unfortunate children can ever be integrated into society in any real way, and I suspect that we are seeing the beginning of a wave of problems, medical and social as well, that are going to be with us for a very long time.

Have I been outrageous enough? Thank you very much.

Questions and Answers

William C. Levin: Thank you, Bill. Ladies and gentlemen, you've been provided with a great deal of material to discuss. The floor's open. Would you please come to the microphone and give your name, because this is being recorded and will be included in the proceedings. Dr. Mullins?

Dr. Charles Mullins: Charlie Mullins, University of Texas System. Let me make a couple of comments about the cost of the health care delivery system. It's a very personnel-heavy industry. In 65 to as high as 80 percent of the health care delivery system the cost is personnel driven, personnel salaries. Over the last two decades, there's been a progressive increase in the salaries of the nursing staff and technical staff system that provides the medical care. Health care workers, two decades ago, were notoriously underpaid in comparison with other workers in the industry. That has now shifted, and that's part of the reason that the health care, you see the market, escalation of health care expenditures, because of the drive for nursing personnel, technical personnel, to have what we now consider probably appropriate salaries. So, that's one of the reasons that the GNP, perhaps, has increased more rapidly in the last two decades than it has in the past.

Secondly, it is driven by technology, we've discussed that, but to give you some insights into it, a cardiac catheterization lab costs about $3 million to build now, that's for the equipment and technology within the lab, not the structure itself. An MRI unit cost a million to $3 million, depending upon what type of unit you buy. CAT scans cost $1 million to $1 million and a half just for the equipment, not including the housing of the equipment. It requires high-technology technicians to operate that equipment. It's a very expensive operation and in five to seven years it's outdated technologically and has to be replaced. That's the drive for the health care industry. The second, in my estimation at least, in terms of the cost.

I'd like to make another comment, and I'd like the panelists to address this particular question, rather than just a comment, but how much does the American public, how much is it willing to spend of its GNP on health care

delivery? How much does it spend on entertainment? And I think we need to put this in context. I don't know what we can afford, I have no idea. But maybe 12, 14, 16 percent of the GNP is not inappropriate. It's an economic drive. It provides jobs. It is an industry, just like General Motors is an industry. I think we need to think of that in that context, to some degree.

Now I certainly agree with what Governor Hobby said about the third-party payers being a market group in economy. In my estimation, health insurance should have been a catastrophic insurance program rather than one that pays for the first aspirin or the first bottle of nose drops that somebody has to have, because then it's an unthinking process, that somebody else is paying for that type of medication. That may be enough to get things going, and I'll be glad to discuss the Medicaid program in the state, too, if you'd like to get more depth in the Medicaid program.

David Warner: I think the concern is not relative to entertainment, I think it's relative to the fact that for really low-income workers right now, or even medium-income workers, somewhere between 10 percent and 20 percent of their payroll may be going to pay for health care for persons other than themselves. They are paying, everybody's paying 2.90 percent up to about $110,000 for Part A of Medicare. They're paying significant taxes for Part B of Medicare. They're paying state and federal taxes for Medicaid, even if they have no health insurance for themselves. They are paying for the health portion of workers' compensation and automobile insurance, and in their local taxes for charity hospitals and medical education. Young persons are generally subsidizing older coworkers who are using the system more intensively. To a certain extent, what we're doing, partly through the way we finance medical care and partly the way we allocate the resources, is we're making it very difficult for young families to be viable. The comparison I made between how much we pay a junior high school science teacher and an ophthalmologist, I think, is very relevant. Although the junior high science teacher is paid an order of magnitude less, he or she has more to do with whether we'll compete in the world over the next 30 years than the ophthalmologist does. And actually, it would be a pretty nasty society in which we spend significantly more on medical care when we are sick than we do on entertainment over our whole lifetime, both sick and well.

William C. Levin: Governor Hobby, do you have a comment?

William P. Hobby: Yeah. Charlie had a question about the MRI and CAT scan costs, which are always, of course, adduced as a driver in medical inflation. But, Charlie, is there any way of getting at how much cost those non-invasive things save in the way of surgery? Is there any way to make a stab? I have no idea.

Charles Mullins: I don't have that information, but I do know that some of the leading diagnostic devices that have come on board in the last couple of decades have been very important to medicine, especially in the arena of head trauma. It's made a difference, it certainly has made a difference in terms of surgery, because the surgeon can see, with great detail now, what he needs to operate on now. Back surgery is a classic example. They can in almost pictorial fashion outline where one might have a disk. They can see it in great detail within a half a millimeter of where that disk has ruptured and what it's compressing. So it's made, from a technical standpoint, it's improved the quality for surgery, and, I would guess, eliminated certain unnecessary operations because of the lack of diagnostic techniques in the past. But I don't have that in hand, the economics of it in hand.

I didn't mean to make a comparison just with entertainment. I mean, that is a major section of GNP, and how much do you pay football teams, for instance, pro football teams, not college football teams? And how much is it worth?

Ronya Kozmetsky: I'm Ronya Kozmetsky and I want to say that it's awfully important for us to realize that none of these things are going to happen unless we pay for them. We've been dancing around that issue for the two days that I've been here. And once we get to that point, we sort of veer off because it's so painful. Well, I don't think we have a choice anymore in our society. We must be our brother's keeper or we're going to lose it. We cannot keep our society going the way we're going without taking the responsibility. And when we take this responsibility, thank you, Dr. Mullins, thank you for saying that we must pay for it. But we must pay for it willingly. And that's the point that we're not at, and that's where I think we're making a . . . I think we're making a mistake because the first thing we have to do is change the attitude of the community to their responsibility. Because until we do that, we are not going to have good health care. And I'm saying we should start with our most endangered species, as you mentioned, the children, the crack baby, the AIDS baby—but, more than that, the ordinary baby, the ones from zero to five. In our last legislative session, we didn't have a . . . nobody argued about spending $1 billion for jails to put these babies into when they grow up, but not a dime for child care so that they wouldn't go into prisons, and they wouldn't get rickets, they wouldn't get all these diseases. We must change the attitude of our community. We have not choice, or we are not going to be a leading nation in anything but war.

William C. Levin: Any response?

Ronya Kozmetsky: I want to commend Governor Hobby because he had the courage to tell us how we were going to pay for it. I commend you because you were one voice who said, yes, let's raise our taxes for the good of the people.

T. R. Fehrenbach: I'm T. R. Fehrenbach. And when we started this, the comment was made it was supposed to be provocative, and I think some provocative things were said, but one of the interesting things about this whole conference was there's very little really provocative—we've kind of danced around it. But two things I just want to reemphasize that each of our speakers have said. One, Dr. Warner brought out something, and the last speaker here touched on this, there's a big spectrum of opinion out there, not among the elites, but among what we call the amorphous middle class, that many of these so-called medical problems are social problems. Dr. Warner brought this up. A crack baby is not seen as a medical problem, it's seen as a social problem. The trauma, the tremendous problem, as someone mentioned yesterday, you know, the trauma center, shooting, stabbings, whatever, are seen as social problems, and many people in the community say, why should I pay taxes, you see what I mean, to cover all of those things? Agreed, we should spend money on solving those social problems. The problem is nobody knows how to spend any money effectively to solve those, at least at the moment.

The other thing I'd like to say is Bill Hobby, I think, should be emphasized, yesterday, speaker after speaker after speaker talked about a market-driven medical system. I'm not nearly as tactful as Governor Hobby. I say it's nonsense that we don't . . . a market-driven system is like the market for Lamborghinis or Cadillacs. In other words, you price people out of the market and the market has so much. We had a market-driven medical system maybe in 1930, but anybody who's on group insurance, or anybody who's on any of the government programs, which I imagine most of us are, this has nothing to do with market. It combines the worst vices of the market with the vices of the governmentally-supported program, which we're discovering. But cost is a problem, I'll say this, because, Governor Hobby, despite holding three chairs, is also a businessman and understands markets.

Recently, in a business that I own, we have had to drop our small group coverage, and this was with the consent of the employees. We made other arrangements. Premiums, it's an aging group, I mean our whole population is aging, the employees are aging, with the premiums for our small group coverage were pushing 50 percent of salaries. That's not uncommon today. And that's why employees are just bailing out of this right and left. Now, is that too high? We're still not mentally adjusted, you know, to support this kind

of thing. And I'm not alone. I know many other employers, probably Governor Hobby knows that too, employers that are having this problem. I don't know what the solution is, but, yes, you're approaching a, on cost, you're approaching a pressure cooker-point in which private industry is no longer going to play in the system. Somebody else is going to have to do it. Thank you.

William C. Levin: Any comment?

Walter G. Hall: I want to commend you for having the guts to even touch on this particular problem and to bring this Society into focus on it. You're touching on a thing, of course, that is of increasing importance to all of us. As a small businessman with some 150 employees, the health care cost is becoming, as the gentleman just before me outlined, a tremendous burden for us to carry. And yet we have to carry it because we are concerned about the welfare of our employees. It's also important because it's a competitive matter that good folks will not stay with us or come to us if our benefits are not, shall we say, competitive. It's been dismaying to me what has happened to the public feeling about doctors in the past 25 years. Now I have seen no study anywhere about how much profit hospitals are really making. When a person gets a bill, I swear they're charged $1 or $2 or $3 for an aspirin. It's hard to defend that hospital. And yet I know of no study that's been made to show whether the great hospital firms, like Humana and so forth, are making exorbitant profits. I have seen no study recently about what the average income of the upper 10 percent of physicians make on down the line. The public is damning the doctors. At one time, they were, as you know, they were the highest regarded group in the whole society. I think now they're afraid to submit to a poll. I think they'd be almost as sorry as bankers. And that would be very, very bad. But, you see, when the people read about a doctor being sued, then they'll read the detail. They'll see that a good doctor has testified one way on a lawsuit, a good doctor has testified in another way in a lawsuit. That tends, of course, to feel that they don't know what the hell they're talking about, one or the other. Now, it's important for us to have faith and confidence, as well as respect, for our doctors. We put our lives in their hands, the lives of our family and our employees. And we do things beyond understanding at a very time when our society has become highly stratified. We now have those with no collars, blue collars, solid white collars, on up to starched collars. And the public doesn't realize that, and they don't see the significance, generally, of our opening the gates and literally have millions of folks coming in, immigrants, who the great majority of, in a matter of a few years, become social charges. Now the doctors deserve a commendation,

shall we say, of trying to take care of them at a fee, but they do not do much in the way of informing people just what goes on. A friend of mine whose son is a doctor at one of the big Harris County hospitals said that he knew that his son as a doctor delivered a child, the fourth child, all fully on charity, for a 14-year-old girl. Now that brought on discussion among the group that I happened to be in, and two of them were very able doctors. Would there be an acceptable proposal for cases of that sort for medical care, if it's available, to limit the capacity of that 14-year-old girl to continue to have a baby every year? Now that's very, very unacceptable to most societies. Our people would rather have no collars or whatever. They think that anybody in our country is entitled to the most costly medical care that is available, and that is, as you know, in some cases, very, very costly. Now, it's a problem I don't have any answer to. I'm confused. I'm a damn sight more confused now than I was this morning, but I'm not confused about the problem or the possibility, and indeed the responsibility, of the medical profession finding out and telling to the public, our hospital is making undue amounts of money. Are all doctors getting rich? Is there any justification for charging what some hospitals charge? And the whole thing, you see, if they do itemize it, that's what causes a lot of hell. But the point I'm making, sir, while you have been, your profession has been providing outstanding services and improvements, the pharmaceutical business and AIDS, everything, and I'm using the term broadly, and treatment of our illnesses, we have not kept, you have not kept, you have not made any effort to keep the public advised as to why you have to charge so much to get the service, we're too altruistic, our people. We're too humanitarian. We want to see everybody have the best that's available, whether it's a $150,000 hospital bill or whether it's a $25 visit to a charity ward. I say to you that if the medical profession will start paying one-tenth as much attention and cost in advising the public, and to do it in a medical pact, we'll be better off.

William C. Levin: For the record, that was Walter Hall. Governor Hobby.

William P. Hobby: Walter, you said one thing which every employer in this room is very much aware of, that the cost of your health coverage, whatever your arrangements are, and there are probably two—HMO and a conventional insurance plan as well—are rising at a tremendously rapid pace, along with workers' comp costs, and are really putting an insupportable burden on employers. I don't want to lead the witnesses as they are the students in this policy research project, but I believe that an employment-based health coverage is very foolish for two reasons. First of all, employers can't pay the cost of all the health care in the country, and employers are paying a great deal

more of it than is incurred by their employees, because hospitals, and providers of all sorts, engage in cost-shifting, which they must, despite all the efforts that are made to curb that practice. It certainly goes on. So employers are paying a disproportionate share of the cost of the system. The other fault of it is that it doesn't cover everybody. The figure of 38 million is commonly used for the number of people who don't have coverage. Only about half of those are unemployed. About half of them are employed by employers who don't have the coverage. I think it needs to be a universal system, not based on employment, for just the reasons that you have mentioned.

Robert Krueger: Bob Krueger. Back in 1975 when evidently the health care cost made up 8 percent, according to what I'm told, of GNP versus now, I think Bill Levin said, perhaps 13 percent, I was in Congress. And I was one of those who, at that time, felt that we needed to try to bring the market into controlling health care costs. I really think we should forget about that. I don't think that health care is governed by market circumstances. What is different, and Ted Fehrenbach mentioned Lamborghini or the Cadillac, or we could mention the Geo or the Chevrolet, we can go to those dealers, we can know the cost of the product in advance, we can compare and we can make a judgment, we can do that all in sort of rational terms, we think. But the relationship between a health care provider, let's take the extreme, the physician and the patient, is not a relationship among equals. It is a relationship among one person who is subservient and comes at a dependent moment and another person who is in, by definition, a superior position. You go to a physician when you are ill, when you are suffering, and you do not go as an equal. You go at a time of great need. And this other person is to provide an answer to that need. You are not even psychologically inclined to consider what the cost is, but if you want to consider the cost, you have no basis for comparative cost. I don't suppose that anybody in this room has ever consulted three different ophthalmologists to see which one would do, whatever, eye surgery, on a comparative cost basis. Now, I was talking to one individual here who just had five people bid on his house. But if he was going for health care, you're not going to go, Walter, to get bids on health care. It doesn't work that way. So I think we really need to set aside this marketplace notion. It is so fundamental in America that we think of ourselves as a marketplace economy that we tend to apply that paradigm to health care, and I think it doesn't work. I don't know exactly what the answer is, but I don't think it's going to be through the marketplace. Because this is not a place where the marketplace works, not that there's necessarily collusion among physicians or health care providers to maintain, keep costs high, although there may be some, I don't know that there is, but there doesn't have to be collusion, because there is no

real comparison of costs. And it seems to me that to think in terms of marketplace is to think in the wrong terms, and we have to think in something else. What that is, I'll be glad to hear from the panel.

David Warner: Well, I can testify. Milton Friedman wrote a very famous article arguing that we shouldn't license physicians at all. He believed we should just let the market work and freeing up access to the profession is maybe what you'd have to do to have the market work. In any case, another fellow and I wrote an article to the *New England Journal of Medicine* 18 years ago advocating giving patients copies of their medical records. I sent a copy of it to Milton Friedman. He read it and wrote back. He said, "Thank you for sending me your article on giving patients a copy of their medical records, but surely that's a matter of free choice between the physician and his patient." But it is such an unequal relationship in terms of knowledge and in terms of everything else that I realized that pure market solutions would need some very substantial structuring to say the least.

Dr. William Schwartz in the Washington *Post* several months ago said, well, even if we pay doctors much less, even if we control hospital costs, even if we get rid of all unnecessary procedures, we're still going to have to ration care. And I think that speaks to what Dr. Mullins is speaking to, in that those MRIs are expensive and those other things are expensive, but there is going to have to be some rationing of care, and it's going to be even care that is efficacious. This really should not be surprising since we ration nearly all other goods and services in society.

William C. Levin: Dr. James.

Dr. Thomas N. James: I'd like to return to the matter of market driving. I think saying something is market-driven, the comments I hear, assuming that market driving is an orange, and all market driving processes are oranges, market driving's oranges and apples and bananas and maybe fruitcakes. The market driving that Bud Rellman is referring to is not the process of competing to reduce costs, and that's what Governor Hobby is referring to, that is a form of market driving. What Dr. Rellman is referring to is market driving to increase desire, to increase demand, and that's a pernicious process. Charlie Mullins referred to the value of MRI—there's no question about that. There are some things that could never have been done in the past and others that have been done in the past can be done much better now because of the precision that can be obtained with that new technology, very expensive. But the manufacturers of that equipment, the hospitals that have that equipment, and some less scrupulous physicians, perhaps, who engage

in the operation of that equipment, could use at some times much cheaper new technology that would be just as adequate, maybe even superior. And a specific example is regarding abdominal masses. MRIs are too often done to assess to presence or nature of an abdominal mass when a simple sonar which costs a fraction of an MRI procedure would be just as effective, or even better. For some years it was illegal for pharmaceutical companies to advertise prescription medications. Now, today, you see pharmaceutical companies advertising prescription medications and insisting that the patient go see their doctor and get that medicine. The new antihistamines are a perfect example of that. The level of competition between hospitals, which is marketing process, has reached an egregious state in many communities where you have to have certain prerequisites in order to have patients come to your hospital, but who pays for those prerequisites. That drives costs up.

The ophthalmologists to whom reference has been made already send vans to old people's homes. They publish they pick up patients to have eyes tested for presence of cataracts and the likelihood of correcting those. They publish these pathetic photographs of what a grandmother could see of her grandchildren before the cataract was removed and after the cataract was removed, not making mention of the fact that a significant percentage of those removals were for marginal indications, the grandmother wasn't having that much difficulty seeing. A technically present cataract wasn't functionally important. In my own field, there's no question that we do far more coronary artery bypass grafts than are necessary. We're the only country in the world that does a percentage of those procedures in relation to patients who have coronary disease compared to all the other countries in the world, including First World countries. So, I would say that market driving is a pernicious force, and it isn't that for one form of it, we don't have enough of it, that is competitive reduction of prices. But for the other form of creating demand, by patients, by physicians, by hospitals, it is a very bad influence on health care costs.

William C. Levin: Any comments from the panelists? Senator Krier.

Sen. Cyndi T. Krier: I'm Cyndi Krier from San Antonio, and after the role John Howe played yesterday, you'll think we're all incurable optimists there. But I do think it's important that we balance the provocative discussion with a little focus on some of the limited good news that's existed. And far be it for me to defend a lot of what went on in the last legislative session, but one of the things that was proposed was the billion-dollar bond package, and that was submitted to Texas voters and overwhelmingly approved by them. And while that was perhaps in the public carried as 25,000 more prison beds, in reality 10,000 of those beds are to be set aside for MHMR, for substance abuse

programs, trying to deal with what caused the people to commit the crimes to be in prison in the first place. And that has moved Texas, that one bond issue, from dead last in the country to first in the country in the amount of resources that we have specifically targeted at the underlying causes of crime and trying to wrestle with them. And while that's not the children that we do need to focus on, it's 20-year-olds who are out there committing serious crimes and who, if we don't break that cycle of violence, are either going to give birth to the crack babies or be around to harass us rather than to contribute to society for the next 50 years of their lifetimes. And I think that's an important part so that you all don't go home thinking, gosh, nobody in Austin is aware of any of these problems or trying to do anything to make even incremental progress to dealing with that.

But that's the adults, and I wanted to turn it over to Stella because she's taken over where the legislature stopped in terms of also trying to do some creative things to deal with the next generation in health care and in some other ways. So I wanted her to get to share that because we ran out of time yesterday.

Stella Mullins: I'm Stella Mullins. I'm with the Mental Health Association in Texas. And I do live in Austin and have wonderful exposure to a lot of state agencies. I know we do a lot of bureaucracy bashing, so I just want to tell you one thing that has happened as it relates to nine state agencies coming together benefiting children in all of Texas. By way of telling you that, I would like to just quickly say that statistics tell us that in the state of Texas we have, between birth and 18, upon any given day, 325,000 children and adolescents who are considered seriously emotionally disturbed. Fortunately, about 250,000 of those children do get some kinds of services. And 100,000 of those children who have no way of getting the services they need except through the public sector—child welfare services, MHMR (mental-health mental-retardation) services. As we began to look at what the state of Texas was doing, we found that, in fact, we were spending upwards of $60 million a year on mental health services for a number of children, but not nearly as many children as we thought that, if the agencies coordinated and cooperated with their services, that we could be serving. As it turned out, in 1989, the state of Texas did, in fact, spend that $60 million on 3,500 children. The proposal that for a period of a year the state agencies worked on was to develop a 10-year plan, and I think that's the important piece of it, that all of us who pay taxes want to know that our money is being spent in a planned and organized way. They did work very diligently for about 12 months to come up with this 10-year plan, as I said. The price tag for that, for the first biennium, was $44 million. We did go to the legislature. In the very last hours of that final special

session, they did, in fact, the legislature did, in fact, fund $22 million. At this time, I'm happy to say that the RFP went out, the Request for Proposal went out to 45 regions in the state of Texas, 43 regions submitted proposals, and those are in. They're being read and by January 1, at least 16 sites in the state of Texas will have money to have their children's mental health services. And this is all in cooperation with the schools and other agencies at the local levels. And it's the local levels who are making determinations about how they want to spend that money. And I think all children in Texas need to say a special thank you to Governor Hobby because he's the one who supported us in this whole process, to make sure that the legislative budget board staff would work with the agencies who wanted to do this. Thank you.

William C. Levin: Stella, thank you for some good news. There's been very little of it this morning.

Bill Wright: I'm Bill Wright. I understand that in the state of Hawaii, they have developed a state program that encompasses an integration of business, public support, the federal programs, and, you know, a lot of what we've been talking about presumes a new federal act, or a convulsive change in the system. They have apparently done something at the state level that has been effective. Would you care to comment on that?

David Warner: Yes, Hawaii developed their program before the federal Employee Retirement and Income Security Act (ERISA) was enacted, so they're the only state in the country that has exemption from ERISA. An employer with an ERISA-qualified pension plan can also self-insure for health coverage, which preempts them from state regulation. In fact, in Texas, most large and medium-sized employers have their own self-funded plan under ERISA so they don't have to provide all of the benefits that are mandated by the state. They don't have to pay the insurance tax to the insurance board, and they aren't subject to a number of regulations regarding freedom of choice of provider or adequacy of reserves. Employers in Hawaii are subject to pay-or-play schemes which mandate that employers provide health insurance or contribute to a public fund which does. Hawaii has some other more expansive add-ons to Medicaid to cover some other groups, so, in effect, Hawaii covers all but 2 percent of the population, and the 2 percent they don't cover tend to be homeless or very difficult to cover for one reason or another. One of the problems that many people have raised is that Hawaii is an island. It's not quite the same as where people have traditionally moved back and forth between Texas and Oklahoma, for instance, depending upon the social services they require and employment opportunities. And there are

many more large employers as a percentage in Hawaii than in, for instance, Texas. Agriculture is quite corporate in Hawaii. In Texas, currently, estimates are that there are between three to four million persons who are not insured, and that includes Medicaid.

Basically, it's a very difficult situation now. So I think in Texas, and we will know more about this in a few months, but I think it will be very difficult without federal assistance, certainly in getting rid of ERISA, but also, just in terms of costs, to provide more than the very most basic benefits. I mean, that's the other piece of it: which benefits do you include? You obviously, probably, can't include the kinds of benefits that Medicare, or even Medicaid, cover. It would be probably too expensive to provide.

William P. Hobby: I think there's another consideration on the Hawaii plan. As Dave mentioned, because Hawaii is an island, it's not as easy to move back and forth as it is between Oklahoma and Texas, for example. But another aspect of that is that companies, employers in Hawaii, are not subject to the same cost competition that employers in Texas and Oklahoma are. You have a much higher-cost, employment-driven or employment-based system, let's say, in Texas than in Oklahoma. The bad results of that would be immediately apparent, and those pressures are not quite as present in Hawaii because of the geography.

William C. Levin: This morning, we've spoken a great deal about dollars and about employers and about governmental, the role of government in providing access to health care. But I'd like to ask a question of Dr. Warner and to Hobby or to anyone else. I have the impression that there are a large number of sick folk or people who should stay well out there who do not access health care because of certain, what I call, cultural blocks. It is my impression, and I have no hard data to support this, it is my impression that in the cities of Galveston, Houston, San Antonio, Dallas, El Paso, Lubbock, wherever there are medical schools or public hospitals which provide excellent health care resources, that there is a significant number of people who should be users of these resources who fail to take advantage of this access for cultural reasons, or, I say cultural reasons for lack of a better term. Dave, would you . . . .

David Warner: Well, I think that's certainly true. It's partly that, and it's partly the way in which the services are available also. With prenatal care, it still takes a month to six weeks for your first prenatal visit from the city health clinic in Austin. Whereas everyone seems to agree that that's the most important visit, outreach is not what it should be, nor is the system of delivery very flexible. I think the two groups that are most in need are, on one hand,

the pregnant women and young children and, on the other, there is a large group of persons in Texas, some of whom have coverage and some who don't, who are in their forties and fifties and already have a chronic disease, or are at clear risk of developing a chronic disease. These persons really would be able to keep working, and providing for themselves and their families, with relatively inexpensive and efficacious ongoing treatment. Without the treatment they are much more likely to become disabled early and to leave the labor force at which time they become entitled to Medicaid and eventually Medicare. However, they aren't in the system, and it's partly financial, partly lack of a provider, and I think cultural as well. Mexican Americans, in particular, are very low utilizers of medical care.

William P. Hobby: I trust that what Dave said of the cultural reasons that Mexican Americans are low users is basically what you were referring to. There are some other health care arrangements available in Texas which are either completely or largely unused. I should recall these details better than I do, but, Dave, I bet you do or, Cyndi, are you still here? What is a health services district, Cyndi, as opposed to a hospital district? Dave, do you know what kind of arrangement I'm referring to? Multi-county arrangement—actually it was passed for South Texas.

David Warner: Right, but it has never been implemented. There are a couple of joint health departments which are in that. I think Newton and Jasper counties had got a joint arrangement. I think there are about five counties out in West Texas that . . . I guess the idea was to provide funding for public health services . . . .

William P. Hobby: It was a South Texas initiative, but nothing was ever . . . .

William C. Levin: Dr. Mullins?

Charles Mullins: Bill, I'd just like to comment that there is a tremendous network in the state of Texas to support individuals who don't have health care insurance, indigent health patients, basically. The 11 teaching hospitals in this state, and they're in hospital districts, delivered more health care to indigent patients this last year, and have for several years, than the direct care budget of Department of Human Services through the Medicaid program. I think that's important for people to understand. There is a tremendous conduit of care through the medical schools and the teaching hospitals in the state. The University of Texas System, with its three hospitals and four medical

schools and two dental schools and seven nursing schools, delivered over a half a billion dollars in charity care this last year. Medical schools are a conduit for a lot of the charity care that the Medicaid program never picked up. Now, fortunately, we're enhancing the Medicaid in this state, and, eventually, we hope it'll be a much better solution to the problem of indigent health care than currently exists at the moment. But a lot of the burden for the health care of the indigent in this state is carried by local hospital districts, i.e., local counties like Harris County, Bexar County, Dallas County, the counties that El Paso and Lubbock are in, and I think that's an important concept to understand. And so there's a differential tax burden in many of the metroplexes to help support the indigent health care in those communities.

William P. Hobby: Charlie, since you're on that issue and time is running out, could you do, for the benefit of this audience, two or three minutes on disproportionate share and what that means to the state?

Charles Mullins: You bet. There's a new program that started with federal legislation in HICKFA, and that's Medicare/Medicaid program, roughly four years ago, and Texas began to take advantage of it about two years ago, called disproportionate share, a Medicaid program. The disproportionate share terminology came from the fact that certain hospitals give a disproportionate share of charity care and Medicaid care in which Medicaid patients are charity patients that have the state/federal program, obviously that's underfunded, but still does give some support. That particular legislation brought in two new programs called Disproportionate I and Disproportionate II to the state of Texas, and we're currently applying for another one called Disproportionate Share III program. The Disproportionate Share I program was a combination of the major teaching hospitals in the state actually giving money back to the state of Texas Department of Human Services, who then send it forward, and it's administered out of the Department of Human Services, to the federal government for federal match. And that particular program, and I don't, give me the license on the numbers, I think right about, somewhere about $9 million the first year and, subsequently last year, about $18 million of additional federal money back to the state via the Department of Human Services to the hospitals that provide charity care and Medicaid in large numbers to the citizens of the state. The University of Texas, through its three state hospitals, has a matching program called Disproportionate Share II which has brought $160 million for the last two years back to the state, $42 million of that go to the three teaching hospitals, the remainder of it goes to the Department of Human Services to fund the broad-based Medicare program throughout the state. And the Disproportionate Share III programs

approved by the federal government, it has the potential of bringing in somewhere between $600 and $700 million of new federal money to support the Medicaid program and will finally maybe get this state out of the 48th rank from the bottom back up to hopefully mainstream in the nation, if we can support that. Difficulty is, it's a major raid on the federal budget. It's not just the state of Texas, there are 36 states now that are taking advantage of this particular program, and it's estimated to cost the federal government, when fully implemented, at least $5.5 billion. That would put the federal budget into deficit spending and trigger in sequestration, cost sequestration, which could cause some major problems in federal budgeting, and that's what Dr. Brandon Weiss is going to discuss here I think. But currently, that's been put in abeyance, the current programs have been approved by Congress right now until 1993. So the state of Texas certainly has major benefits from that program and will have. And we hope it continues, but it is a major funding problem in the federal budget.

William Gordon: Thank you, Bill. I'm Bill Gordon from Rice University. I'm very pleased that I have the opportunity to make a choice as an individual about the use of heroic means to prolong my life, should I get in a position where the prognosis is sufficiently bleak, and I've made that choice, and I appreciate the fact that society, and the legislature that underpins it, has given me that permission.

It has a bearing both to me and my family, which perhaps is overriding, but it seems to me it also has some bearing on the allocation of health care resources. I've seen people suffer for almost endless times, maintained essentially as a vegetable when those resources surely have better use. I think society has progressed a great deal by giving me that permission, and the question is, will society progress to the point—and considering health care allocations, where others who have prognoses that are at least as bleak as mine might have been, for example, the case that's been brought up of the crack babies—will society get to the point where it's prepared to make a decision with regard to cases where the prognosis is just completely bleak?

William C. Levin: Dr. Carson, I think that's yours.

Ron Carson: We have a very difficult time in this society saying no. And especially in the face of great wealth really, I mean, comparatively in the world. But we are learning how to say no, and I think the Patient Self-Determination Act that was discussed yesterday at some length is a sign of this. It's reminding people, it's really, if I may take issue with just one thing you've said, it's really not giving people rights, but reminding people of the

rights that they have, encouraging them to exercise them, and providing mechanisms for the exercise of choices which you and I so value. At the policy level, it's a lot tougher. We have, for example, invested a great deal of money in our society in rescuing, trying to rescue all of the perishing at both ends of life as a relatively recent development. And while we're not going to roll back the commitments we have, I think we have become more sophisticated about how to go about making policies that will allow us to say no. We are going to have to raise, as a policy issue, the question whether it is desirable and feasible, for example, to try to rescue all of the perishing at the beginning of life—the low birth-weight babies, the crack babies. We are just beginning, really, to do so-called clinical outcomes research which will give us some data on which to base sound decisions about clinical decision making in these very tough situations. But I think we're on our way, and I think, just to enter my own view in here, I think we must begin to say, look, on the basis of dire prognosis, we, as a society, are simply going to have to come to some consensus about the limits we put on providing resources for rescuing people that don't have a shot at a decent life, either at the beginning or at the end. Now, notice that by doing that at the policy level, we're not being ungenerous. We're being fair. And we're getting doctors off the hook. Doctors don't want to be in the position of having to make what boils down to judgments of social merit at the bedside. Those judgments are misplaced at the bedside. They are imperative at the policy level.

William C. Levin: Ladies and gentlemen, we've been at this for two hours. Are there any other philosophers who wish to inject their opinion or questions? Bill, do you have any closing comments?

William P. Hobby: No, I'd just like to observe, on the right-to-die legislation, that legislation exists in Texas because the members—is Ray Farabee still here?—Ray introduced the first such act in Texas and amended it a time or two to make it even more effective, so we owe that debt to Ray.

William C. Levin: Dave, do you have anything?

David Warner: No, I just think I've learned a lot from various comments.

William C. Levin: Ladies and gentlemen, I think that about closes the meeting of this Society for this year. I want to thank you for coming to Galveston and for participating. I look forward to seeing you in Dallas next year.

NECROLOGY

CLINTON STANLEY BANKS
1892-1990

CLINTON STANLEY BANKS, SON OF EDWIN GRAY BANKS AND LILA EDWARDS, WAS born in Caldwell, Texas, on October 6, 1892. His father was a lawyer, county judge, and Confederate veteran. His mother's ancestors came to Texas with Stephen F. Austin.

Banks attended schools in Caldwell and Lufkin, and in 1911 the Banks family moved from Lufkin to San Antonio. Banks "read law" in the office of his father and was licensed to practice law at the age of 20. During World War I Banks served two years in the United States Army. On December 31, 1919, he married Ann Eleanor Sutcliffe, and they were parents of four children.

Banks was identified with the practice of law in San Antonio for 72 years and helped write the original city charter. He also was instrumental in the establishment of the San Antonio Junior College District (now the Alamo Community College District). In recognition of his many years of service to San Antonio, he was selected in 1972 to be honorary grand marshal of the 77th Battle of Flowers Parade.

History, Banks once said, was his only hobby. As a lawyer specializing in land titles, he developed an interest in Texas history and collected in his home a library of more than 2,000 volumes. When he celebrated his 90th birthday he said, "I'll go to work, go home, and read my history books." He was an organizer and president of the San Antonio Historical Society, a longtime member of the Texas State Historical Association, and gave the major address at the golden anniversary dinner of the Association. For 17 years he served as a member and chairman of the Texas State Library and Archives Commission. Banks was a member of the Sons of the Republic (a Knight of San Jacinto) and assisted the Daughters of the Republic as legal advisor for many years. His Texas history books were placed in the library of the Daughters of the Republic at the Alamo.

Banks was an active member of Laurel Heights Methodist Church and with Pat Ireland Nixon wrote *Laurel Heights Methodist Church, 1909-1949* (1949) and *A Crowning Decade, 1949-1959: Laurel Heights Methodist Church, 50th Anniversary* (1959). With Grace Taylor McMillen he edited *The Texas Reader; An Anthology of Romantic History, Biography, Legends, Folklore and Epic Stories of the Lone Star State* (1947) and *The New Texas Reader* (1960, 1961).

Banks was elected a member of the Philosophical Society in 1947. He died at his home in San Antonio on January 23, 1990, at the age of 97.

D. H. W.

George John Beto
1916-1991

In the loss of George John Beto on December 4, 1991, this Society and the people of Texas lost a friend of all of us and without doubt the leading light in the entire criminal justice field in Texas and in the nation.

A member of this Society since 1973, George Beto was born in Hysham, Montana, on January 19, 1916, the son of a Lutheran pastor. He grew in up North Dakota and Lena, Illinois, and then attended Concordia Lutheran Seminary for two years before enrolling at and graduating from Valparaiso University in Indiana in 1938. In the fall of that year, he returned to Concordia Seminary and graduated in 1939, then coming to Austin as an instructor at Concordia Lutheran College. He became president of the college in 1949, and served in that position until 1959. He received both the Master's degree in history in 1944 and the Ph.D. degree in education in 1955 from the University of Texas at Austin.

In 1952 he was appointed to the Texas Board of Corrections. Convinced that what the inmates of the prison system most needed was the opportunity for an education, he was instrumental in developing the Wyndham School District as a vehicle for that instruction.

In 1959 he left Texas for Springfield, Illinois, to become president of Concordia Theological Seminary. For the year 1961-1962 he served as a member of the Illinois Parole Board. During the same period he served as chairman of the Committee to Evaluate the Illinois Youth Commission. In 1960 he conducted a survey of prisons in Germany, France, England, Denmark and Holland. Then in 1962 he came back to Texas to accept appointment as director and chief of chaplains at the Texas Department of Corrections.

His performance in this post for the next 10 years was not only outstanding; it was nothing short of marvelous. He was educator, mentor and friend to inmates and all with whom he came in contact. From his habit of strolling through the prisons to observe conditions the inmates called him "Walking George." In 1964 he conducted a survey of prisons in Japan. He served from 1966 to 1969 as a member of the National Advisory Council on Correctional

Manpower and Training, from 1971 to 1978 as a member of the American Bar Association's Commission on Correctional Facilities and Services, and from 1972 to 1973 as a member of the National Advisory Commission of Criminal Justice Standards and Goals and as a contributor to that organization's *Manual of Correctional Standards*. In 1970 he was the United States Delegate to the Fourth United Nations Conference on Prevention of Crime and Treatment of the Offender in Kyoto, Japan, to the Fifth such Conference in 1975 in Geneva, Switzerland, and to the Seventh Conference in 1985 in Milan, Italy. In 1969-1970 he was President of the American Correctional Association, of which he had been a member since 1953 and was a lifetime member. In 1971 he was a member of the President's Crime Commission and, through the years, was a consultant in corrections to the National Governor's Conference and to numerous state governments.

One of Dr. Beto's most significant achievements while he was director of the Department of Corrections was to induce the Texas Legislature in 1963 to develop a program of excellence in criminal justice at Sam Houston State University, specifically to develop undergraduate and graduate degree programs in criminal justice, to develop continuing education programs for criminal justice professionals, to conduct research on the problems of crime and the administration of justice and to provide technical assistance to the state's criminal justice community. The George J. Beto Criminal Justice Center and its outstanding reputation and programs are the result. Included are a Police Academy, the state's first Probation Training Academy, a Correctional Training Academy, and an Alcohol and Drug Program. It is the site of the College for New Judges and the certification program of the Texas Association for Court Administration.

In 1972 he left the Department of Corrections to become Distinguished Professor of Corrections at Sam Houston State University in Huntsville. During his 19 years there, he served on two occasions as Dean of the Criminal Justice Department pending the filling of vacancies in the deanship. At the invitation of the United States Army in 1974, he conducted a survey of military government correctional facilities in Germany and in 1976 he evaluated rehabilitation facilities sponsored by the United Nations Department of Health, Education and Welfare in Warsaw, Poland, and Cairo, Egypt. At the same period he inspected law enforcement served in the Arab State of Qatar. From 1975 to 1987 he was a member and Chairman of the Texas Youth Commission Board. At the time of his death he was Chief of Chaplains and Board Member Emeritus.

From 1973 to 1974 he was a member of the Texas Constitutional Revision Commission. In 1976 he was appointed by United States District Judge Frank M. Johnson and served for a year as one of two monitors of the court-ordered

dramatic changes in the Alabama Prison system. He also served as a consultant to the Human Rights Committee appointed by the judge. Later, in 1983 he again was one of two representatives on a court-approved committee which oversaw prison improvements through 1988. He was named a Distinguished Alumnus of the University of Texas in 1971 and later as a Distinguished Alumnus of Valparaiso University. In 1989, he was awarded an honorary Doctor of Divinity degree by Concordia Lutheran Seminary in St. Louis, Missouri. In 1990 he was named a Takeuchi Fellow in Japan.

Active in the Lutheran Church throughout his life, from 1980 to 1983, he served as a member of the Board of Managers for Pension Funds in the Missouri Synod of the church and from 1984 to 1987 as a member of the Synod's Board of Social Ministry. He retired as Distinguished Professor of Criminal Justice in September, 1991, and returned to live in Austin. His death of a heart attack occurred in December of that year and his body was buried in the State Cemetery.

But a man like George Beto will not die until those who knew and respected him and his accomplishments are also gone. His influence in Texas criminal justice and in the lives of those who were privileged to know him will be life long.

Only some evidence of this respect and regard is in the fact that the Criminal Justice Center at Sam Houston State University bears his name as do two separate units of the Texas Prison System, a building on the campus of Concordia College in Austin and a youth facility operated by the Texas Youth Commission. The Justice Center houses the College of Criminal Justice and the Institute of Criminal Justice, and the building itself is constructed of materials made by the inmates of the prison system during Dr. Beto's tenure as director. Only 10 institutions in the United States, of which this is one, offer the doctoral degree in criminal justice.

George Beto left surviving his wife, the former Marilynn Knippa, his sons, Dan R. Beto of Bryan and Huntsville, and Lieutenant Colonel Mark D. Beto of Berlin, Germany, and his daughter, Beth O'Donnell of Austin. Another daughter, Lynn Vann, died in 1978. He was also survived by a brother, Dr. Louis Beto of Danville, Kentucky, a sister, Dorcas Lobell of Lena, Illinois, and 5 grandchildren.

J. C. D.

Howard Taney Boyd
1909-1992

Howard Taney Boyd, a prominent Houston lawyer and businessman, died in Houston on February 10, 1992, and is buried at Forest Park Westheimer Cemetery. He was born on June 5, 1909, in Woodside, Maryland, one of four

children of Howard Boyd and Mary Violet Stewart. For several generations this family has produced a number of important lawyers and jurists in Washington, D.C. In 1935 Howard married his only sweetheart, Lucille Belhumeur, who survives him, along with two children, Dennis Boyd and Sharon Boyd Rodriques, and five grandchildren. A daughter, Deborah Boyd Fitch, is deceased.

Howard was educated at Georgetown University in Washington, graduating from the Preparatory School in 1938; the College in 1932, Magna Cum Laude; the Law School in 1935 at the head of his class; and finally receiving an honorary LL.D. degree in 1971. Howard was inspired to be a lawyer by his father, who was a Georgetown law graduate and professor. Howard was sitting in the front row of a class being lectured by his father, who suddenly fell dead at the lectern. This was a shock to Howard who admired his father greatly.

Howard's first employment was with the Department of Justice as an assistant attorney. Several years later he resigned to join a private law firm. In 1952 he won a landmark case against the secretary of interior who wanted to block a major pipeline to California. This success led to an invitation to join the El Paso Company, where Howard eventually became chairman and chief executive officer from 1965 to 1979. Here he made several major innovations, some well ahead of their time, including taking a directorship in the U.S.-USSR Trade and Economy Council in an effort to bring then-much-needed gas to Europe and America. As a world leader in the liquefied natural gas industry, he was for years president of the Groupe International Des Importanteurs de Gas Natural Liquefie.

After retirement from the El Paso Company, Howard became a partner in a leading Houston law firm for several years.

Howard served as director of several major corporations. He was a trustee or other officer for Georgetown University, the University of Southern California, and Texas A&M University. He was an officer in numerous professional and charitable organizations.

Among his many honors Howard was commissioned a Chevalier of the French Legion of Honor. As a devout Catholic he was made a Knight of Malta.

More important to Howard than publicized honors was a life filled with many quiet and unsolicited acts of personal kindness and charity. Howard was a gentleman in every sense. He was noted for his courtesy, his eloquence, his patriotism, and his intense devotion to his family and friends.

M. P. K.

Joe Ewing Estes
1903-1989

Senior Judge Joe Ewing Estes died on October 24, 1989, of pneumonia on his 86th birthday. He was born in Commerce, Texas. He received his LL.B. from The University of Texas Law School. At law school he was president of his class, and in recognition of his scholastic attainments he was selected as a chancellor and member of the Order of the Coif. He received an LL.D. from East Texas State University School of Law in 1974.

He was admitted to the Texas Bar in 1927 and practiced law for 28 years thereafter, except for service as a lieutenant commander in World War II. President Eisenhower appointed him U.S. district judge in Dallas in 1955. He later became chief judge of the U.S. District Court, Northern District of Texas, where he served for 13 years, and thereafter became a senior judge and judge of the Temporary Emergency Court of Appeals of the U.S., where he served for 15 years ending in 1987.

Judge Estes was a pioneer in the field of pretrial procedure. Early in his judicial career he became interested in improving judicial administration in that trials could be abbreviated, and justice better served, if the lawyers carefully prepared and fully disclosed claims, defenses, and evidence prior to trial. With this as his thesis he instituted the pretrial order, now fully embedded in the federal courts and the Federal Rules of Civil Procedure.

Survivors include his wife, Carroll Virginia Cox Estes, Dallas; son, attorney Carl Lewis Estes II and wife Gay Gooch of Houston; daughter, Dr. Carroll Lynn Estes and husband Dr. Philip R. Lee of San Francisco, California; sister-in-law, Margaret Estes Davis; and three grandchildren.

R. T.

John Holmes Jenkins III
1940-1989

On April 16, 1989, Texas lost one of her outstanding sons. John Holmes Jenkins III's body was found floating in the Colorado River, the needless victim of a homicide as maintained by his friends or the subject of a suicide as stubbornly maintained by the Bastrop County Sheriff's Department. The cause of his death is not as important as the tragic loss of one of the more gifted Texans of our time. He was Texas's best rare book dealer, and his life was truly a provocative, entertaining, and unfinished first edition. There is a Texas

tale in his birth and death. He was born on March 22, 1940, a good month for Texas and Texans. It is the month of Sam Houston's birthday and Texas Independence Day. He died near the site where his great-great-grandfather had been killed in 1890.

John's forefathers came to Texas six generations ago. What they planted over the years in sweat, blood, and sacrifice bloomed in 1940 into one of the state's most talented and complex figures—book dealer, book publisher, author, gambler, and, most importantly to us and to him, Texas historian.

It is hard to put navigational instruments on what lay ahead in John's life. With an impish grin at the consequence, he too often went down the least traveled road. There is a strong sense that in his contribution to Texas history, the best was ahead, not behind him. He accomplished enough, however, in the 49 years he shared with us to serve several lifetimes of achievement. He published 300 books with the Pemberton Press and the Jenkins Company, mostly related to the history of Texas and the Southwest. He developed a small, insipid book and coin company at 912 Congress Avenue in Austin into one of the largest rare-book businesses in the United States and made himself the Alcalde of Texana. Under his own authorship, he issued over 30 titles. Each of his books was better in form and substance than the last. His most recent publication, *Basic Texas Books*, was a brilliant success that served both a commercial and personal purpose. Its publication and subsequent recognition as a valuable research book made each of the books mentioned in it immediately collectible—a good result for a dealer with a large inventory of such books. It also answered years of creditable criticism that John gave disdainful attention to scholarly detail. *Basic Texas Books* was rigorously researched by Johnny with an uncommon religious fervor.

Christmas brought a special literary greeting from Johnny, usually an episode in John's career presented as a historical vignette, which said more about John's unusual spirit than the spirit of Christmas. Someday those items will be the elusive treasures for future generations of Texas collectors.

There is no arguing with the statement that John Jenkins was a genius. He got an early start on that distinction. He was the youngest published author in the history of the United States. Upon graduation from high school, he published the recollections of his great-grandfather, John Holmes Jenkins. He was an Eagle Scout, president of his senior class, and valedictorian of his high school. How he chose to apply his genius was his only failing; not a failing in terms of his personal enjoyment but a failure to use his indefatigable energy and talent to further our selfish interest as Texas historians and Texana collectors.

John shared his genius with many organizations. He was a member of the executive council of the Texas State Historical Association from 1976 to 1980 and a fellow of the Association since 1967. He resigned from the executive council in 1980 to serve on the board of the American Antiquarian Bookmen's Association and later as its president.

John was also a servant to many other audiences, but he was not play-acting in his role as a Texan. Although small in stature, when he stood on his knowledge and love of Texas, he became a man of immense proportions. His indiscretions and character contradictions are part of the tabloid that has distinguished generations of notable Texans. As his critics, we observe the tapestry of John's life and pay homage to how he wove excitement into the commonplace. For many of us he truly made Texas history and Texana collecting sources of high adventure.

Much is known of his purchase of the famous Eberstadt Collection and subsequent sale of a substantial part of it to The University of Texas. Less may be understood of his lifelong talents as a trader that made such a transaction possible. John could bargain with all the talents of the best West Texas horse trader. He would have been the perfect subject for a Ben K. Green book entitled *Rare Book Trading*. His sense of value and the recognition of the limits of his clients' lust made him as formidable a trader as has ever come on the Texas scene. He could see value where others saw only verse. What others achieved in their imaginations, he accomplished through his industry and energy. When he exercised all components of his trader's talents, he had no equal. For 30 years I traded and bought books, coins, and artifacts from John Jenkins. His death has assured me that I will never best him in such a transaction. I suspect that it was that talent more than any other that was the source of his problems, his poverty, and his prosperity. It caused jealousy and consternation among his competitors and complaints from his clients, but it made him, without challenge, Texas's best Texana salesman and spokesman.

We have been left one last product of John H. Jenkins III's talent. Two days before his death, he completed *The Life of Edward Burleson*. He had worked on this project for most of his adult life. This book fills a dry socket in Texas history as there is no decent work on this early Texas warrior and leader of the Second Regiment of Volunteers at San Jacinto. Also, we will be favored with a final look at John Jenkins, the author. I still enjoy his first book, *The Recollections of John H. Jenkins*, but I revere my recollections of John H. Jenkins III, Texas book trader, Texas historian, and Texan.

J. P. B.

Mary Moody Northen
1892-1986

Mary Moody Northen, a longtime member of the Texas Philosophical Society, holds a special place in the hearts of the Society and all Texans. Her activities and interests gave her a special status that will continue for generations to come. Her philanthropic interests, combined with her love of history and culture, led her to make her own unique mark on the Texas experience.

A lifelong resident of Galveston, she was a daughter of one of the families that gave direction to modern Texas, the Moodys of Galveston. Although involved in business, like her father and grandfather, she found her special fulfillment in the support she gave to Texas cultures.

As the eldest child of W. L. Moody, Jr., she gave direction to the activities of the Moody Foundation, which he had established in 1943, focusing its support in the fields of education, preservation, and history. From college campuses across the state, to the schoolchildren who benefited from her interest in the Junior Historians, to the museums that serve both Texans and visitors, her influence was to be found.

Galveston, her home, was special to her, and it benefited from her interest in many ways. The Rosenberg Library, Ashton Villa, the Samuel May Williams House, the Moody Memorial Medical Library, the Tall Ship *Elissa*, the Center for Transportation, and the Galveston Historical Foundation are just a few of the institutions that benefited from her interest and insight.

She served her community and her state in many ways, participating in and directing such agencies as the Texas Historical Commission, the Texas Historical Foundation, and the Texas Committee on the Arts.

Her vision led her to establish Mary Moody Northen, Inc., a private foundation that supports her own projects in Texas and Virginia. In addition to grants supporting historic and educational projects, the foundation has restored the Moody home at 2618 Broadway, making it into a nationally-recognized historic house museum offering special insights into the cultural life and business history of twentieth-century Texas.

Mary Moody Northen, in her own quiet way, enjoyed Texas and the Texas experience. To share her special joy, she found new ways to bring the meaning of Texas to all its peoples and gave us a legacy that will long survive.

E. P.

William A. Owens
1905-1990

William A. Owens, son of Charles and Jessie Ann (Channault) Owens was born in Blossom, Texas, on November 2, 1905. He rose from a poverty-stricken childhood to become an educator and an important Texas writer. His early education was continually interrupted because he had to help his family earn a living. His autobiography, *This Stubborn Soil* (1966), describes his passion for obtaining an education and the harshness of life on a farm as a cotton picker.

Owens never completed high school but entered Southern Methodist University after passing a special entrance examination. He took the B.A. degree in 1932 and the M.A. in 1933. He did postgraduate work at The University of Texas at Austin in 1936 and earned a Ph.D. at Iowa State University in 1941. During World War II (1942-1945) he was in the army and was awarded the Legion of Merit. On December 23, 1946, Owens married Ann Slater Wood, and they were parents of two children, Jessie Ann and David Edward.

Owens joined the faculty at Columbia University (1945), where he taught for 28 years. He became full professor in 1966. He was director of the summer session from 1959 to 1969. He retired in 1974 with the titles of dean and professor emeritus.

Owens taught in the public schools of Texas and was writer-in-residence at Texas A&M University (1976) and visiting professor at The University of Texas at Austin (1978). Author of 16 books on subjects dealing with folklore, slavery, the oil industry, the Big Thicket, history, and fiction, Owens was made a fellow of the Texas Institute of Letters in 1982. He died in Suffern, New York, on December 9, 1990.

D. H. W.

Edmund Lloyd Pincoffs
1919-1991

When Edmund Pincoffs died in November 1991 at the age of 72, the Society lost not only an internationally-recognized philosopher but also a stalwart defender of human rights. Courtly in manner and gracious in speech, Dr. Pincoffs did not reveal to the casual observer the intensity of his convictions about what constitutes the just society. To those who knew him, however, he embodied the classical concept of civic virtue: concern with the community twinned to the highest ideals.

To understand Edmund Pincoffs, it helps to realize how he became a philosopher. Born in Chicago and schooled in Houston and Pennsylvania, he entered the Coast Guard immediately after graduating from the University of North Carolina in 1941, serving as an officer in the Caribbean and Western Pacific on anti-submarine and assault landing-vessels. He returned to civilian life as a partner in his family's export-import firm, Maurice Pincoffs Co., in Houston. After four years with the firm, the young businessman made a remarkable career change. At 31, already married to the talented painter Mary Elizabeth Zimmerman and a father, he entered the doctoral program in philosophy at Cornell, receiving his Ph.D. in 1957.

The academic career of Dr. Pincoffs began in the mid-1950s at the University of Houston, where he rose to be chairman of the philosophy department from 1959 to 1965. His first book, *The Rationale of Legal Punishment*, appeared in 1966, a year after he had joined The University of Texas at Austin as associate professor. When he became full professor in 1967, it was already apparent that Pincoffs was no ivory-tower philosopher. A UT colleague, Paul Woodruff, explained: "Dr. Pincoffs was concerned to bring philosophy out of the classroom and into a public arena where it could affect peoples' lives. He pursued this goal in teaching, in his writing, and also in a devotion to public service rare among academics." In 1976, Pincoffs was quoted as saying that "no one in his right mind craves academic administration these days .... [However] I regard departmental chairmanships as civic duties. . . ."

By the time Pincoffs became chairman of The University of Texas Philosophy Department (1976-1980), he was known as a key exponent of "virtue ethics"—calling for a return to the ancient conceptions of virtue and human excellence. A few months after his retirement in 1989, a conference at The University of Texas honored Pincoffs's distinguished career. The two-day session, "The Future of Virtue Ethics: Its Political Relevance," drew colleagues from within the university as well as participants from around the country and abroad. Shortly before his death, he was elected vice president of the American Philosophical Association (Central Division), scheduled to be president in 1992. The journal *Social Theory and Practice* devoted an entire 1991 issue to Dr. Pincoffs's contributions to ethical theory. The recipient of many awards, fellowships, visiting professorships, and grants—and an admirable teacher of both undergraduates and graduates—he was nonetheless always accessible to students and colleagues, and patient and gentle with those outside his discipline.

This was, in sum, an unusually creative and significant human being. At a time when so much discussion about ethics focuses on quandaries and moral dilemmas, how refreshing it was to have a scholar instead emphasize the need

to return to an expanded view of the field. His major work, *Quandaries and Virtues: Against Reductionism in Ethics*, (1986) summed up his convictions persuasively. Pincoffs was also a significant contributor to the philosophy of law. (See his *Philosophy of Law: A Brief Introduction* [1991], or his thoughtful editing of *The Concept of Academic Freedom* [1975].) Many will remember Pincoffs's reasoned defense of due process in 1974 after Society member Stephen Spurr was dismissed by the regents from the presidency of The University of Texas at Austin. Unable to remain passive when he believed that correct procedure had been violated, Pincoffs headed a faculty inquiry into the murky details of the Spurr firing.

Not your run-of-the-mill philosopher, Ed Pincoffs. Devoted to his country and insistent on its capacity for self-improvements, he could be equally at home speaking at an international gathering or reading to children in the library in Castine, Maine, where the Pincoffs spent their summers. Devoted to his family—three children and eight grandchildren—he listed his hobbies as tennis, travel, swimming, and farming. Violently attacked by youths when walking near his home in Austin toward the end of his life, he never gave up his faith in the educability and potential for virtue in human beings.

Edmund Pincoffs was, in short, that rare individual—a moral man who lived his life in accordance with (or, if you prefer, in the pursuit of) virtue. The Philosophical Society of Texas, created "for the Collection and Diffusion of Knowledge," has lost a prime "Collector" and skilled "Diffuser." Although a member of the Society for a bare three years, we are fortunate that at last he came our way.

E. R.

Katharine Risher Randall
1901-1989

Katharine Risher Randall, a longtime resident of Galveston, died on April 14, 1989, after a lengthy illness. Born in Waco, Texas, the daughter of Harry Cooke and Agnes Peel Risher, she was a graduate of Waco High School and The University of Texas where her long association with the Pi Beta Phi Sorority began. She moved to Galveston in 1926 as the bride of Dr. Edward Randall, Jr., the two having met earlier at a Mardi Gras function in the Grand 1894 Opera House. Over the years she was active in the National Society of the Colonial Dames of America, Gunston Hall, Daughters of the Republic of Texas, Ashton Villa, Galveston Historical Foundation, Galveston Orphan's

Home, Grand 1894 Opera House, Rosenberg Library, Trinity Episcopal Church, Trinity Episcopal School, William Temple Foundation, Philosophical Society of Texas, University of Texas Chancellor's Council, UT College of Arts and Sciences, UTMB Development Board, and UTMB President's Club.

Katharine Randall was known for her vivacious personality and love of life and laughter. She was devoted to her family, the Galveston community, and her many friends there. She was preceded in death by her husband, Dr. Edward Randall, Jr., president of the Philosophical Society of Texas in 1965; her daughter, Laura Randall Schweppe; and her granddaughter, Katherine Randall Schweppe; and is survived by her son Edward Randall III and his wife Ellen; her son Risher Randall and his wife Fairfax, all of Houston; and 10 grandchildren: Martha Randall Galbraith, Laura Randall Bacon, Helen Wicks Randall, Edward Randall IV, Risher Randall, Jr., Hally Randall Carver, David Crow Randall, and William Edward Randall, all of Houston, and Anne Schweppe Ashmun and Mary Jane Schweppe of Austin; and five great-grandchildren.

She was an enthusiastic and vigorous supporter of public education and higher education. She served as a role model in a variety of leadership positions, and greatly influenced these activities at both local and state levels.

W. L.

Woodrow Bradley Seals
1917-1990

Judge Woodrow Bradley Seals's death on October 27, 1990, at the age of 72, cut short a life of continuing exceptional deeds and accomplishments in three separate fields: in the law and its judicial improvement; in dedicated religious work in his church; and in active political leadership up until he became a judge, and in wise governmental counsel to people in high places later in his judicial career.

Judge Seals, senior United States district judge for the Southern District of Texas at the time of his death, was born on Christmas Eve 1917, at Bogalusa, Louisiana, the son of Charles B. and Ruby Hughey Seals. The date of his birth might later have been thought to be prophetic of Woodrow Seals's concern for the welfare of people during the most active and influential years of his life.

To present this sketch of Judge Seals's active life, I will quote verbatim the next seven paragraphs extracted from the biography printed in the Houston papers, and condensed, printed, and distributed to those attending the memorial service on November 3, 1990, in St. Stephen's United Methodist Church in Houston.

> Judge Seals served as a pilot in Europe during World War II, and he retired as a lieutenant colonel in the Air Force Reserve. In 1942, he married the former Daisy Newman of Yazoo County, Mississippi. He is survived by his wife, their son Bradley, an attorney in Austin, a brother Charles Seals of Bogalusa, Louisiana, a sister Geraldine Underwood, also of Bogalusa, and a brother Robert Seals of Lake Charles, Louisiana.
>
> Judge Seals is loved and known not only for his courageous rulings, but for his efforts for his fellow man in the United Methodist Church and in the many civic organizations he worked in or actually founded.
>
> Judge Seals held most of the offices of his local congregation, St. Stephen's United Methodist Church, and taught an adult church school class for over 30 years. In the mid-sixties, he founded the Society of St. Stephen, an organization to help the needy, which is now established in Methodist congregations across the country. He also founded a Peace Advocate program in the United Methodist Church in 1984.
>
> Judge Seals's awards and honors include the Papal Medal 'Beneremenți' presented to him by Pope John Paul II in 1979, the Medal of Honor from the Daughters of the American Revolution in 1985, and the Jefferson Award for community service in 1986. In 1987, the World Methodist Council presented him with its Peace Award, the second time it has been given to an American, the first being to former President Carter. In 1984 he received an Honorary Doctorate of Humanities Degree from Wiley College in Marshall, Texas.
>
> Judge Seals's current civic affiliations included being a Community Associate of Hanszen College at Rice University; chairman of the Committee to Celebrate the Bicentennial of the United States Constitution for the Southern District of Texas; the Houston Philosophical Society; and the Philosophical Society of Texas.

He was founder and past president of the Juvenile Court Volunteer Services of Harris County; past president of Big Brothers/Big Sisters of Houston; a founder of the now-defunct Community Service Option Program for offenders on probation. He served on the Board of Directors of the Star of Hope Mission, the Volunteer City, the Houston Chapter of the United Nations Association, and the Houston Chapter of Planned Parenthood, and as chairman of the local Boy Scouts Council Division of Scouting for the Handicapped.

Other civic and charitable boards include the Houston Public Library, the United Way, the Community Council, the Council on Human Relations, the Mental Health Association, the United Services Organization, the South Central YMCA, Volunteers in Technical Assistance, Houston Metropolitan Ministries, The Shoulder (halfway house for ex-prisoners), the Chinquapin School (for deprived and disadvantaged children), the Alley Theatre, and the Candidate Advisory Service of the Air Force Academy.

While Judge Seals had lived a sizeable segment of his life in Mississippi, he received his juris doctorate degree from The University of Texas Law School in Austin in 1949 and moved to Houston to practice law. The law degree from UT Austin seemed to be the catalyst that catapulted him into a dedicated service to humanity.

During the fifties, he became Harris County Democratic chairman, and was so dynamic that he was selected as John H. Kennedy's campaign manager for Harris County in 1960. He was active in the State Bar of Texas, and served as chairman of the Committee on Criminal Law and Procedure and as a member of the Grievance Committee and the Committee on Professional Ethics.

In 1961 Senator Ralph W. Yarborough nominated and President Kennedy appointed him as United States attorney for the Southern District of Texas. As United States attorney he hired the first black secretary in a U.S. attorney's office in Texas, as well as hiring the first black assistant U.S. attorney in the South, Carl Walker, now a state district judge. In 1966, Senator Yarborough nominated and President Johnson appointed Judge Seals to the federal bench as United States district judge.

His eminent service as judge included the writing of at least three of the greatest U.S. district court judicial opinions in Texas written during his years of service.

Certain school districts in Texas sought to deny children of persons who were not citizens of the United States, or were not legally admitted aliens, admission to the public schools. One district even levied a one thousand dollar tuition per year on children of illegal aliens in the district.

In his landmark opinion in *In Re Alien Children Education Litigation*, 501 F. Supp. 544 (S.D. Tex. 1980), a statewide class action suit, Judge Seals held that the state statute could not prohibit the use of state funds to educate children whose parents were not citizens of the United States or legally admitted aliens, and that such a statute was unconstitutional. The court permanently enjoined the Texas Commission of Education from implementing this statute, and from then on children of illegal aliens in this state were able to sit in the public schools of Texas and receive the essence of American democracy, which would be one of their greatest influences in life.

In the case of *Medrano v A. Y. Allee*, 347 F. Supp. 605 (S.D. Tex. 1972), the United Farmworkers Union was striving to unionize the Mexican American farm laborers in the Lower Rio Grande Valley and brought a class action suit to enjoin the Texas Rangers and state officials from interfering; for the first and only time, the Texas Rangers were placed under a permanent injunction. Judge Seals held unconstitutional the several state statutes that the Rangers and state officials were using as a basis for the action against these labor organizers.

In two related cases, *Cisneros v. Corpus Christi Independent School District*, 324 F. Supp. 599 (S.D. Tex. 1970) and 330 F. Supp. 1377 (S.D. Tex. 1971), actions on school desegregation cases, Judge Seals held that Mexican Americans were entitled to be treated as any other school children, and not segregated and discriminated against in the schools, as they had been for a long time.

Woodrow Seals was one of the judicial pioneers for human rights in Texas, and particularly in South Texas where Hispanics had been denied those human rights.

In addition to the personal services that Judge Woodrow Seals rendered to his church as outlined above, he rendered a greater personal service to his religious belief and faith. On Saturdays and Sundays, he would go alone to areas of Houston where he knew there was a large percentage of people who did not attend church. He would knock on door after door, and when they answered, he would explain that he believed in his church and his faith, and he would ask them if they belonged to or attended any church. If their answer was that they had once belonged to a certain church or denomination, he would urge them to go back there. If they answered that they had no church membership or affiliation or leaning, he would urge them to look at the

churches near their home, pick one that appealed to them most, and start attending, assuring them that they would probably find life more pleasant and rewarding.

In my 89 years of life, I have never heard of any other judge or non-professional religious person who sacrificed his time and his life on Saturday and Sunday, week after week, in such an unselfish service to his fellow man for their spiritual benefit.

On another score, I knew of an extremely valuable service that Judge Woodrow Seals rendered to the Democratic Party, the people, and the nation. It was in the 1960 presidential campaign. Woodrow Seals, not then a public officer but John F. Kennedy's campaign manager for Harris County, came to Washington to urge me to do something. He said that Kennedy's Catholic Church membership was doing him in and that he would be defeated if something dramatic wasn't done. Kennedy was coming to Texas for a three-day campaign rally in September, and Woodrow Seals had an idea to have him invite the Protestant ministers of Houston to a meeting to answer their suspicions and to allay their fears. I thought it risky, but he said that if it wasn't done Kennedy would lose Texas and probably other southern states.

I then agreed with him, told him to go see Bobby Kennedy, whom he knew and who was his friend, and get approval and proceed. Woodrow Seals told him there was a Presbyterian minister in Houston, the president of a Protestant ministers' group in Houston, who was for Kennedy and would cooperate with him.

Woodrow saw Bobby Kennedy, got his approval, and went back to Houston to plan for the confrontation between John F. Kennedy and the Protestant ministers. It occurred in the Rice Hotel ballroom. Under the agreed ground rules, Kennedy was entitled to have only one aide present, no other staffers or supporters. The large ballroom was packed by the ministers. Not admitted to attendance, I walked along the hotel hall outside the ballroom, and to my good fortune, one person in the ballroom, I think a member of the press, left hurriedly leaving the front doors slightly ajar. Through the resulting crack, standing in the hall, I could see Kennedy at the podium, answering the inquisitions. I marvelled at his calm mastery, and his great knowledge of theology. He won the confrontation, and after it was over Woodrow Seals told me that the overwhelming majority of the Protestant ministers were satisfied and that he believed that John F. Kennedy could carry Texas. He did, and was elected to the presidency. The role of Woodrow Seals in that turning of the presidential campaign from defeat to victory is little noted, but it was a landmark in American presidential history.

Had Woodrow Seals lived in the days of the Republic, his brilliance would have placed him in the original founding circle of Texas history. As it is, the Society honored him by making him a member (he did not solicit it; I was one of the numerous nominators), but he honored the Society greatly with his membership.

I personally know of some of his private, unpublished benefactions, some of them over $400 a month, made over and over, and made without solicitation. Charity and kindness were only two elements of this great person.

Faithful to every duty, Judge Woodrow Seals was a thinker and a doer. He created the St. Stephen's Society in the Methodist Church for aid to the poor, against difficulties and the Peace Society of the Methodist Church, advocating bringing the war in Viet Nam to a settled conclusion.

When he was made a member of the Philosophical Society of Texas, he said that it was the greatest honor of his life, next to his two presidential appointments. And, when we examine his record in life, we members of the Society will be compelled to admit that he honored us when he accepted membership with us.

Judge Woodrow Seals was one of the best of men. Let us properly mark his passage; our words are not too many to mark our book.

His life is worthy of a biography. Truly, he is one of God's Noblemen.

R. W. Y.

Hyman Judah Schachtel
1907-1990

It was on a long-ago Friday night that I first met Hy Schachtel. My father, himself a distinguished minister, apparently had decided that my religious education needed broadening. I couldn't have been more than 10 years old as Dad drove us across Houston in his Chevy coupe and parked before an imposing building on Holman Street. The building was embellished with a strange star and candelabra. We walked up the steps and entered (me for the first time) a Jewish synagogue. I don't remember the service, but I do remember the dignity of the night and the warmth of the man they called Rabbi. In a real sense I do not remember not knowing Rabbi Schachtel. For almost 50 years his and his family's lives have been entwined with ours. His life and ministry brought blessings to hundreds of thousands of people, but we feel particularly blessed in having known him and Barbara in such a special way, and for so long a time.

Dr. Schachtel was born in London, England, on May 24, 1907. He died in Houston on January 11, 1990. When he was 11 years old his family moved to the United States, crossing on RMS *Lusitania*. His father was a renowned cantor and operatic singer who enjoyed a long and distinguished career.

From his early years Hy felt drawn to the ministry, and after finishing the Lafayette High School in Buffalo, he matriculated in the University of Cincinnati. Taking courses for his bachelor's degree in the morning and studying for the rabbinate in the afternoon, he achieved both his degree from the University of Cincinnati and ordination from the Hebrew Union College in May of 1931. Upon graduation he became the assistant rabbi at the venerable West End Synagogue in New York City. There, he served successive posts and was eventually elevated to chief rabbi of the congregation. While serving the West End congregation, he found himself in Lake Placid, New York, for an appointment with a colleague. This brief visit proved pivotal in his life, for while there he met and began dating Barbara Levin. They were married in 1941, and their union was blessed with two children: Bernard, himself a rabbi, and Ann, a communications consultant. The Schachtels have one grandson who just this year entered the University of Denver.

In 1943 Rabbi Schachtel was called as chief rabbi to Congregation Beth Israel in Houston. From the outset of his rabbinate, his became a major voice in the affairs of the city. After World War II, while Houston was entering its greatness as a city, Hy helped shape its modernity through his prophetic preaching, penetrating writing, and thoughtful teaching. He was arguably one of Houston's five or six most influential clergymen who tirelessly worked with the lay leadership of the city to grapple with the city's "coming of age." This was so particularly in the ministries to the poor and mentally ill of Houston and Harris County and in race relations. His strict moral code, coupled with a sense of humor that never allowed him to take himself too seriously, soon led to his involvement in affairs of the state and the nation. He became the good friend of several presidents and particularly of two. At this point a wonderful story emerges.

Hy was a Democrat, although he was careful not to broadcast it so as not to offend his friends and parishioners who were otherwise persuaded. When President Johnson was inaugurated in 1965 Hy was asked by the president to be one of the reverend clergy to bless the proceedings. He did so with his customary grace and dignity. Another dear friend of his, and our colleague in the Society, was elected president in 1988. Rabbi Schachtel and Mr. Bush had known one another since shortly after the time the Bushes moved to Houston in the 1950s. Their correspondence contains "Dear Hy" and "Dear George" letters. The admiration each had for the other is evident in even a

casual perusal of such. Hy *knew* (and even remarked to a close friend or two) that it was likely that he would be asked to deliver the blessing for the Bush inaugural just as he had for the Johnson ceremony. The invitation never came. As inaugural day 1989 approached, he commented to Barbara Schachtel about the apparent oversight. Dr. Barbara, in her quick fashion, retorted, "Oh for heaven's sake, Hy, you're a Democrat!". . . and that was that.

His ministry was a living testament to a modern ecumenical spirit, broadly defined, which made generous room around the Throne of Grace for all of God's children. He regularly preached in Protestant pulpits and often lectured in and was honored by Protestant and Roman Catholic universities. Until the time of his death he was a permanent lecturer at Saint Luke's United Methodist Church in Houston. His only qualifier for inclusion in a such a fellowship was that one love and honor God. In so doing, he believed, we could not escape loving and honoring one another. It logically followed, in his relentlessly logical mind, that in this was the only real hope for the radical improvement of life on earth. When I was a boy, I once asked him if he was a Christian. His response, which seemed perfectly normal to a 12-year-old Methodist: "You bet I am." I suppose what he was trying to say, with that snappy answer, was that, "we all belong in our Father's house, the one filled with many mansions, each in our own way and each for our own reasons." He never asked me the reverse question, "Are you a Jew?" If he had, particularly later, I would have responded in kind to him.

His life was a kaleidoscope of activity and honors; the latter were heaped upon him by a grateful community, state, and nation for his tireless and selfless service to other people.

Aside from his earned doctorate taken with the faculty of the University of Houston, he was honored with a doctorate of divinity from Hebrew Union College and a doctorate of humanities from Southwestern University. He was the recipient of the Coronet Medal from Saint Edward's University—a Roman Catholic institution.

He was a member of Phi Delta Kappa, a national educational honorary fraternity. His board memberships included the Houston Grand Opera Association, the National Foundation for Ileitis and Colitis, the Prisoner Services Committee of the Houston Metropolitan Ministries, and the executive board of the Central Conference of American Rabbis. He was a past president of the Houston Rabbinical Association as well as the Mental Health Association of Houston and Harris County. In 1982 the Rabbi was named by the College of Education of the University of Houston as Outstanding Alumnus. In May of 1987 the Mental Health Association of Houston and Harris County chose Dr. Schachtel to receive the Ima Hogg Award for distinguished service in the cause of mental health.

He was the author of several thoughtful books, the last of which, *How to Meet the Challenge of Life and Death*, was published in 1980. He was a published composer of liturgical music, including two Sabbath services and five hymns. In 1928 he composed the *Alma Mater* of Hebrew Union College.

He loved the Philosophical Society of Texas. He and Barbara were faithful attenders of its affairs and meetings. This should come as no surprise to his colleagues and friends, for he had a lifelong love affair with things of the mind. He was not only a formal philosopher, in the sense that most of us are not, but he was a natural one as well. He was equally "at home" with his friends Alfred North Whitehead and Frank Dobie. Again, that should come as no surprise, for he loved knowledge and the good that knowledge and wisdom, regardless of their idiom and dialect, could work in the world.

The Rabbi's own words appropriately end this. They come from the last paragraphs of his book, *The Real Enjoyment of Living* (New York: E. P. Dutton & Co., Inc., 1954), and are as alive today as they were in 1954 when first put to paper. Remember, they were written by a Jewish rabbi who once told a little boy that he was a Christian.

> Lift up your head and be proud that you are a human being. No matter what happens, don't lose faith in the human race, nor in yourself. The jungles tried to destroy us and we survived. The tyranny of thousands of years tried to crush our faith and love and yearning for freedom, but all these violent attempts have been in vain. Slowly, painfully, sacrificially, proudly, the human race has come up from the jungle, from slavery, from feudalism, into wars and out of wars—sometimes slipping back, but not all the way back—onward and upward, fighting and struggling to be free.
>
> For what is there to fear when we believe in the eternal power of God, the eternal truth of love, and the everlasting presence of idealism and self-sacrifice within the human mind and heart!
>
> You can't have everything in this life, but you can, through believing in God and in yourself and in mankind and in freedom, come into a world of the mind and the spirit which is satisfying, which despite the storms and troubles of life can provide you with a fortress within, a mental world in which you do have everything that really counts for the real enjoyment of living—your faith, your courage, your undying love, your wisdom, your appreciation of beauty, your inner peace (pp. 191-192).

J. H. F. & D. F.

Preston Shirley
1912-1990

Preston Shirley, 77, born on November 14, 1912, in Fort Worth, Texas, died in Galveston, Texas, on October 18, 1990. Educated at Texas Christian University and The University of Texas, he was an associate professor of law at The University of Texas School of Law, Austin, 1940-1941, and served in World War II 28 months overseas in the CBI Theater. Following that, Mr. Shirley was a practicing attorney with a long and distinguished career. A partner of Mills, Shirley, Eckel & Bassett, he was a Fellow of the American College of Trial Lawyers; Fellow, American Bar Foundation; Fellow, American College of Probate Counsel; past president, Texas Association of Defense Counsel; past president, Galveston County Bar Association; member, Committee on Administration of Justice, State Bar of Texas, 1952-1972; member, Philosophical Society of Texas; distinguished alumnus, University of Texas, 1982; Outstanding Fifty-Year Lawyer, Texas Bar Foundation, 1983; Outstanding Alumnus of The University of Texas Law School Association, 1985; and recipient of The University of Texas School of Law Faculty Award, 1986. He was a member of the American Bar Association; State Bar of Texas; Galveston County Bar Association; International Association of Defense Counsel; Association of Defense Trial Attorneys; Texas Association of Defense Counsel; Order of the Coif (Law School); Chancellors (Law School); Phi Delta Phi (Law School); and Phi Kappa Psi (Social).

Mr. Shirley was active in community and business affairs, having served as chairman of the Board and chairman of the Executive Committee of First Hutchings-Sealy National Bank of Galveston, 1981-1982, and senior chairman of the Board and chairman of the Executive Committee of Inter-First Bank Galveston, N.A., 1982-1987; director, American Indemnity Financial Corporation, Galveston; director, American Indemnity Company; director, American Fire & Indemnity Company; director, Texas General Indemnity Company. He was also director and executive vice president of Sealy & Smith Foundation for the John Sealy Hospital, Galveston; member and twice chairman, The University of Texas Development Board, Austin; member of the Board and past president of The University of Texas Foundations Nos. 1 and 2, Austin; member of the Development Board of The University of Texas Medical Branch, Galveston; and chairman of Life Trustees, The University of Texas Law School Foundation, Austin.

He is survived by his wife, Elizabeth Hodgson Shirley, his three daughters, and their children.

J. E.

Joseph Royall Smiley
1910-1990

A professor of French, a Chevalier of the French Legion of Honor, and an authority on Denis Diderot, the eighteenth-century French materialist philosopher, encyclopedist, satirist, and dramatist, Joseph Royall Smiley's career was divided between his love for the language and literature of France and his talents for administration in higher education.

A native of Dallas, Smiley earned his B.A. degree in French and German and his M.A. in French literature at Southern Methodist University, and his Ph.D. in French at Columbia University. He taught at Arkansas A&M College, North Texas State College, Columbia, and the University of Illinois, at the latter institution rising in the period 1951-1958 to the rank of professor of French, chairman of the French Department, and dean of the College of Liberal Arts and Sciences.

Smiley's administrative work included the presidencies of The University of Texas at Austin (1961-1963) and the University of Colorado (1963-1969). (During his presidency at Colorado, his work with UNESCO and his contributions to the study of French language and literature earned him the French Legion of Honor.) And he had the distinction of serving twice as president of the University of Texas at El Paso (1958-1960, when the institution was known as Texas Western College, and 1969-1972).

Upon his retirement as president of UTEP in 1972, he was appointed H. Y. Benedict Professor of French and president emeritus.

Known for his urbanity, wisdom, and keen sense of humor, Smiley left significant marks on UTEP in his two presidencies there, including the establishment of the first endowed professorship, significant increases in library holdings and in private gifts, and the launching of a full-scale nursing degree program.

Smiley was married to the former Mary Fincher, who predeceased him, and is survived by his daughter Anne, son Steve, and five grandchildren.

Joseph Royall Smiley died at age 80 on May 25, 1990, in El Paso.

D. N.

Harlan Smith
1924-1991

Dr. Harlan Smith, one of the country's leading astronomers and a longtime director of The University of Texas at Austin's McDonald Observatory, died on October 17, 1991, at Seton Medical Center in Austin. He was 67.

Smith, who had been undergoing treatment for cancer, retired as McDonald director in August of 1989 after 26 years. He was born in 1924 in Wheeling, West Virginia.

In July, Smith received the NASA Distinguished Public Service Medal at a ceremony in Austin. The citation for that award reads: "For a lifetime of service to the astronomy and space communities, students, and public through teaching, research, public speaking, and leadership of advisory and oversight groups."

Smith earned B.A., M.A., and Ph.D. degrees from Harvard University, and honorary doctoral degrees from N. Copernicus University in Torun, Poland, and Denison University in Ohio.

Dr. Carl Sagan said that Smith was one of the pioneers of planetary radio astronomy, and would be missed from the astronomical community.

"Harlan Smith was an extraordinary scientist, notable in his intellectual breadth, organizational ability, and humane perspective," Sagan said. "He offered me advice and encouragement from the beginning of my scientific career.

"Knowing full well the nature of his illness, he was courageous and optimistic to the end. His last words to me, in a letter written just a few weeks ago, were 'Here's to the future.' I personally feel his loss very deeply."

Smith was appointed to the Yale University faculty in 1953. He joined The University of Texas at Austin faculty in 1963, when he left Yale to become director of the McDonald Observatory in West Texas.

As director of the McDonald Observatory and chairman of the Department of Astronomy, Smith was responsible for the development of an internationally-recognized astronomy program. While at UT Austin, he expanded the astronomy department from four faculty members to its current faculty of 23. The department now supervises 50 graduate students and teaches 6,000 undergraduates a year.

He directed the construction of the McDonald Observatory's 107-inch telescope and The University of Texas Radioastronomy Observatory in Marfa, and developed the plans for the 8.5-meter Spectroscopic Survey Telescope to be built at the McDonald Observatory.

Smith had a zeal for bringing the message of astronomy to the public. He was legendary for his enthusiastic lectures to any group that invited him. He also developed the StarDate radio program that is now heard worldwide. He strongly believed in the destiny of mankind to explore space and supported that goal in any way he could.

As a researcher, Smith was credited with discovering the variability of quasars, the influence of solar wind on radio emissions from Jupiter, and the existence of a class of variable stars known as dwarf Cepheids (also known as Delta Scuti stars).

His later research interests included analysis of planetary atmospheres, quasars, variable stars, photometry, and instrumentation. In addition to his research, he served on many national scientific committees of NASA, the National Science Foundation, and the National Research Council, and was chairman of the Board of the Association of Universities for Research in Astronomy.

Smith was among the first astronomers to realize the importance of ground-based observations in the planning and support of space missions. In the 1960s, he convinced NASA to fund the McDonald Observatory 107-inch telescope for that purpose, and NASA still supports planetary research on the 107-inch telescope today. It also opened the door for other NASA-funded telescopes, such as the 88-inch telescope, the 3-meter infrared telescope, and the future second 10-meter Keck telescope, all at Mauna Kea Observatory in Hawaii.

He was involved in the early promotion of space telescopes in the late 1960s, a project that eventually resulted in the Hubble Space Telescope. As chairman of the NASA Space Science Board Committee on Space Astronomy and Astrophysics, he was responsible for proposing the Great Observatories series of orbital telescopes, which includes the Advanced X-ray Astronomy Facility (AXAF), the Gamma Ray Observatory (GRO), and the Space Infrared Telescope Facility (SIRTF), as well as the Hubble Space Telescope.

Smith was also chairman of a national committee that recommended that NASA support the Search for Extra-Terrestrial Intelligence (SETI) program.

As Harlan Smith said in his acceptance speech for the NASA Distinguished Public Service Medal, "I suddenly realized what the medal almost certainly really is for—and that's for figuring out more ways, perhaps than any other scientist has, to help NASA spend money."

He was author of numerous articles for astronomical and physics journals, and was also the developer of the *Story of the Universe* educational film series, which earned first-place awards in 1959 and 1961 at the New York Film Festival.

His interests in international scientific cooperation and world peace were reflected by the many scholars from around the world whom he hosted at The University of Texas McDonald Observatory, and at his home.

Increasingly, international cooperation in space and on Earth was the focus of his research. At the time of his death, he was working on the return of humans to the moon and the establishment of lunar astronomical observatories. It was Smith's dream that the coming decades would see increasing numbers of telescopes on the surface of the moon, probing the universe from the ideal conditions the lunar environment affords.

Smith was always an active man, filled with energy and vitality. He founded the "Walk-up Club," always taking the stairs to his fifteenth-floor office and encouraging others to join him. His other activities included windsurfing, swimming, and beekeeping.

He is survived by his wife, Joan Greene Smith; children, Nathaniel, Julie, Theodore, and Hannah; three grandchildren; and his brother, Kenneth.

The family asks that contributions be sent to the McDonald Observatory, The University of Texas, Austin, Texas 78712, in order to establish an endowment in his name at the observatory.

W. H.

Zollie C. Steakley
1908-1992

Former Texas Supreme Court Justice Zollie C. Steakley died in Austin on March 24, 1992, at age 83. He was secretary of state for Texas from January 15, 1957, to January 3, 1961. He was then appointed by Governor Price Daniel to the Supreme Court in 1961. He resigned after 20 years of service on the Court on December 31, 1980.

He was born in Rotan, Texas, on August 29, 1908. He was named for his father, who was named for a former Tennessee congressman and Civil War general, Felix Zollicoffer. The name Zollicoffer became Zollie Coffer Steakley.

Zollie was an excellent baseball player at Hardin Simmons, from which he received his bachelor's degree, and later an honorary Doctorate of Laws. He was also named one of its distinguished alumni. He also had to decide whether or not to accept a professional baseball contract.

His choice was for the law school at The University of Texas. There he was student editor of the *Law Review*. He was a member of the Order of the Coif, and he graduated with his law degree in 1932.

He practiced law in Sweetwater from 1932 to 1939. He was married to Ruth Butler of Sweetwater; she survives him.

Judge Steakley was an assistant attorney general under both Gerald Mann and Grover Sellers.

After Pearl Harbor, Zollie went on active duty in Naval intelligence, from which he was discharged a lieutenant commander in 1945. He began practice in Austin in 1946, which continued until January 1957 when he became secretary of state.

Zollie was a man of many talents. He was a fine athlete and a good golfer. His playing partners, outside of the members of the Court, included Tom Kite, Sr., and his famous golfer son. He was an outstanding churchman. He taught the large Men's Downtown Bible Class of the Austin First Baptist Church. Zollie's message was carried each week by radio to a large area of Texas. In civic affairs, he was a very large Lion, president of the Austin Downtown Lions' Club and district governor. He was a trustee of Hardin Simmons University and on the Executive Board, Capitol Area, Boy Scouts of America.

After retirement, he served as special assistant attorney general to Mark White and Jim Mattox, particularly on opinions of the attorney general. He continued to be of such assistance to the present attorney general, Dan Morales, until shortly before his death. Governor Mark White used Judge Steakley as his legal counsel.

Zollie and I worked together on the Supreme Court for 20 years. He was a careful and studious scholar. He wrote well and was always prepared. When former Governor Price Daniel was proposed for appointment by Governor Preston Smith, there was some opposition that this would create a "Daniel wing" on the Court. Zollie and I were close to Price, and he appointed both of us. The opponents did not know Price, and they did not know Zollie or me. Each was independent. The three of us served on the Court together eight years. Zollie was a pleasure to work with, a fine and honorable man. He deserves to be remembered as a distinguished member of the Philosophical Society.

J. R. G.

John G. Tower
1925-1991

Statesman, member of the Philosophical Society of Texas, and former United States Senator from Texas, John G. Tower died on April 5, 1991, in a commuter airline crash near Brunswick, Georgia. Tower, whose daughter Marian also was killed in the crash, was en route to an event promoting his book, *Consequences: A Political Memoir.*

The son and grandson of Methodist preachers, Tower was born in Houston and grew up in a number of East Texas communities. He served with the U.S. Navy in World War II, received a bachelor's degree in political science and history at Southwestern University in Georgetown, completed a master's

degree in political science at Southern Methodist University, and pursued graduate studies at the London School of Economics and Political Science. From 1951 to 1961, Tower taught political science at Midwestern University in Wichita Falls.

Tower was credited with changing the political landscape of Texas in 1961 when he became the first Republican elected to statewide office in 84 years. By winning Lyndon Baines Johnson's former U.S. Senate seat, Tower forged a path that would make Texas a two-party state. Reelected in 1966, 1972, and 1978, he eventually chaired the Senate Armed Services Committee and the Republican Policy Committee, also serving on the Banking, Housing, Urban Affairs, and Budget committees. Tower retired from the Senate in January 1985. He was then appointed by President Ronald Reagan to serve as U.S. negotiator on strategic nuclear arms, with rank of ambassador, at the negotiations on nuclear and space arms with the former Soviet Union in Geneva. He resigned that post one year later to enter private business and teach at Southern Methodist University.

In 1987, President Reagan appointed Tower to chair the President's Special Review Board to study the role of the National Security Advisor and the National Security Council and its staff in the Iran-contra affair. The board and its subsequent report became known as the Tower Commission. In addition, Tower served as a member and chair of the President's Foreign Intelligence Advisory Board from 1987 until his death.

Tower served as chair of the boards for Brassey's, Inc. (U.S.) and the *Armed Forces Journal International*. He was a director of British Aerospace, Inc., and Macmillan, Inc. He had served as a member of the Southwestern University Board of Trustees since 1968, and the Tower-Hester Chair in Political Science is named for him. Tower was chair of the board of John Tower & Associates, Inc., an international consulting firm. Tower was a 33rd Degree Mason and Shriner and was a member of the American Legion, the Texas State Historical Association, and the United Methodist Church.

In 1982, Tower designated Southwestern University as the repository of his papers. The collection is housed in the John Goodwin Tower Library of the A. Frank Smith, Jr., Library Center on Southwestern's Georgetown campus.

Tower is survived by two daughters in Dallas, Penny Cook and Jeanne Cox.

R. S.

Peter Boyd Wells, Jr.
1915-1991

Peter Boyd Wells, Jr., a "lawyer's lawyer," died on September 16, 1991, at Beaumont, his home for 45 years, where he volunteered and served as principal officer in a wide variety of civic and community organizations. He lectured and wrote widely in law but additionally pursued biblical and historical studies. He was survived by his wife, Betty, two married children, and six grandchildren.

Peter was born and reared in Austin. His ancestors came to Texas in 1828 as members of Stephen F. Austin's second colony. His grandfather was a chairman of the Board of Regents of The University of Texas. He was distinguished for his opposition to the Ku Klux Klan. Peter graduated from the university in 1936 where he had been named to Phi Beta Kappa. His law degree was granted by Harvard in 1940.

During World War II Peter served four years in the army, saw action in the Battle of the Bulge, was awarded four battle stars and the Bronze Star, and was discharged in 1945 with the rank of major.

After beginning his law practice in Beaumont, specializing in taxation, estate, and trust law, Peter began his own firm in 1958 with the late George Duncan and Charles Beard. The firm had 18 lawyers at the time of his death.

Time Peter dedicated to his community included service on the Beaumont Port Commission and on the boards of the Beaumont Chamber of Commerce, Beaumont Community Foundation, Lamar University Foundation, and the Texas Gulf Historical Society. Peter was a past president of the Beaumont Rotary Club and the Neches River Festival, of which he was chosen King in 1988.

In search of archaeological evidence, Peter travelled widely in the Middle East, studying Old Testament sites. Dr. Harland Merriman, Peter's pastor and one who had collaborated on occasion with him in his biblical studies, spoke in his funeral eulogy of Peter's dedication to *veritas* (truth), Harvard's motto, as the guiding principle in all his endeavors, vocational or avocational.

Long active in the Sons of the Republic of Texas, Peter was named by them a Knight of San Jacinto. He donated the Texana that he had carefully accumulated over many decades to the John Gray Library at Lamar University. This donation became the cornerstone of a special collection for which he underwrote the cataloguing and, with wife Betty, endowed to provide for future purchases.

The life of Lorenzo de Zavala was a special focus of Peter's Texas studies. By happy coincidence a description of the admired de Zavala, written by his contemporary, Mirabeau Lamar, neatly fit Peter himself: he "was a little less

than average height, well formed, a full face, handsome features, and an open countenance. He was dignified in carriage, courteous in manner and temperate in his habits. In a single sentence: he was all that a gentleman ought to be."

G. D.

Everett Donald Walker
1922-1991

Last year the Philosophical Society lost a most valued and valuable member. He had been in good health except for a troublesome knee, and his death unexpectedly resulted from a circulatory complication following knee surgery.

E. Don Walker, the name he most often used, was born on April 27, 1922, lived his early years in Livingston, Texas, and, except for military service, remained in Texas until his death on May 1, 1991.

He served in the United States Air Force from 1942 to 1947 with primary duties as a test pilot, but served also in the China-Burma-India and Alaska theaters of operation. He was discharged with the rank of major. In 1943 he married Kathryn Marie Keneaster, and their only child, Don, Jr., was born in 1946.

After military service, he completed his education at Sam Houston State University, with a bachelor of science degree in business administration in 1948, and at The University of Texas in Austin with a master of business administration degree in 1949. Southwestern University in Georgetown awarded him an honorary doctor of laws degree in 1976.

After serving as auditor at both Sam Houston State University (1950-1951) and Texas Tech University (1951-1955) he joined The University of Texas System for a distinguished career, which is summarized as follows: The University of Texas Medical Branch at Galveston, business manager, 1955-1959; business manager and comptroller of hospitals, 1959-1964; and associate director, 1964-1965; The University of Texas System, director of facilities planning and construction, 1965-1966; vice-chancellor for business affairs, 1966-1968; executive vice-chancellor for business affairs, 1968-1970; deputy chancellor for administration, 1970-1975; deputy chancellor, 1975-1977; president and chief operating officer, 1977-1978; chancellor, 1978-1984.

It was in the System Office of The University of Texas that he made his mark on the entire system. He was the right man at the right time, for he held the right positions serially during an unprecedented expansion of the

University System. New components were added, enrollment in all units increased, and it was necessary to mount a truly monumental building program to house this expansion. At one point in time, over six hundred million dollars of construction was under way. Don Walker was at first in charge of planning and building these new facilities and then, as chancellor, was the chief operating officer of the university. His great strengths for this task were his outstanding financial talents, his political expertise, and his extraordinary ability to choose and work with people. A colleague who worked closely with him stated that his financial acumen was almost beyond belief and that he had few peers in working with the legislature and the Governor's Office.

For his achievements, he received many honors and awards. He was a distinguished alumnus of Sam Houston State University (1978) and was also listed in the Hall of Honor there for his outstanding basketball career, which included being named an All-Conference player. He was a member of many governing boards, including that of the Lyndon Baines Johnson Foundation, and a member and officer of many civic and community organizations.

Following his career with The University of Texas, he became president of the Hermann Hospital Estate, 1984-1988. In that capacity he continued working with the several University of Texas components in Houston.

In recent years he has served on the Alumni Board of Directors of Sam Houston State University and was chairman of the Distinguished Alumni Committee the last three years.

His beloved wife Katy predeceased him in October 1990. He is survived by his son, Don, Jr., his daughter-in-law, Denise, and two granddaughters, Kelly and Casey.

Don will be remembered as a man of integrity, of outstanding ability and endeavor, and as a warm and true friend. We will miss him.

F. H.

OFFICERS OF THE SOCIETY

For the Year 1992

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WILLIAM D. SEYBOLD

First Vice-President
ROBERT KRUEGER

Second Vice-President
STEVEN WEINBERG

Secretary
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WILLIAM D. SEYBOLD 92
ROBERT KRUEGER 93
STEVEN WEINBERG 94
WILLIAM C. LEVIN 91
FRANK MCREYNOLDS WOZENCRAFT 90
J. CHRYS DOUGHERTY 89

88 JOHN CLIFTON CALDWELL
87 ELSPETH ROSTOW
86 WILLIAM PETTUS HOBBY
85 — JOE R. GREENHILL
JENKINS GARRETT

PAST PRESIDENTS

*Mirabeau Buonaparte Lamar 1837-59
*Ira Kendrick Stephens 1936
*Charles Shirley Potts 1937
*Edgar Odell Lovett 1938
*George Bannerman Dealey 1939
*George Waverley Briggs 1940
*William James 1941
*George Alfred Hill, Jr. 1942
*Edward Henry Cary 1943
*Edward Randall 1944
*Umphrey Lee 1944
*Eugene Perry Locke 1945
*Louis Herman Hubbard 1946
*Pat Ireland Nixon 1947
*Ima Hogg 1948
*Albert Perley Brogan 1949
*William Lockhart Clayton 1950
*A. Frank Smith 1951
*Ernest Lynn Kurth 1952
*Dudley Kezer Woodward, Jr. 1953
*Burke Baker 1954
*Jesse Andrews 1955
*James Pinckney Hart 1956
*Robert Gerald Storey 1957
*Lewis Randolph Bryan, Jr. 1958
*W. St. John Garwood 1959
George Crews McGhee 1960
*Harry Hunt Ransom 1961
*Eugene Benjamin Germany 1962
*Rupert Norval Richardson 1963
*Mrs. George Alfred Hill, Jr. 1964
*Edward Randall, Jr. 1965
*McGruder Ellis Sadler 1966
*William Alexander Kirkland 1967
*Richard Tudor Fleming 1968
*Herbert Pickens Gambrell 1969
*Harris Leon Kempner 1970
*Carey Croneis 1971
*Willis McDonald Tate 1972
*Dillon Anderson 1973
*Logan Wilson 1974
Edward Clark 1975
Thomas Hart Law 1976
*Truman G. Blocker, Jr. 1977
Frank E. Vandiver 1978
*Price Daniel 1979
Durwood Fleming 1980
Charles A. LeMaistre 1981
Abner V. McCall 1982
*Leon Jaworski 1983
Wayne H. Holtzman 1983
Jenkins Garrett 1984
Joe R. Greenhill 1985
William Pettus Hobby 1986
Elspeth Rostow 1987
John Clifton Caldwell 1988
J. Chrys Dougherty 1989
Frank McReynolds Wozencraft 1990
William C. Levin 1991

*Deceased

MEETINGS OF THE PHILOSOPHICAL SOCIETY OF TEXAS

December 5, 1837 - Founded at Houston
January 29, 1839 - Austin
January 18, 1936 - Chartered
December 5, 1936 - Reorganizational meeting - Dallas
January 29, 1937 - Meeting and inaugural banquet - Dallas
December 4, 1937 - Liendo and Houston
1938 - Dallas
1939 - Dallas
1940 - San Antonio
1941 - Austin
1942 - Dallas
1943 - Dallas
1944 - Dallas
1945 - Dallas
1946 - Dallas
1947 - San Antonio
1948 - Houston
1949 - Austin
1950 - Houston
1951 - Lufkin
1952 - College Station
1953 - Dallas
1954 - Austin
1955 - Nacogdoches
1956 - Austin
1957 - Dallas
1958 - Austin
1959 - San Antonio
1960 - Fort Clark
1961 - Salado
1962 - Salado
1963 - Nacogdoches
1964 - Austin
1965 - Salado
1966 - Salado
1967 - Arlington
1968 - San Antonio
1969 - Salado
1970 - Salado
1971 - Nacogdoches
1972 - Dallas
1973 - Austin (Lakeway Inn)
1974 - Austin
1975 - Fort Worth
1976 - San Antonio
1977 - Galveston
1978 - Houston
1979 - Austin
1980 - San Antonio
1981 - Dallas
1982 - Galveston
1983 - Fort Worth
1984 - Houston
1985 - College Station
1986 - Austin
1987 - Kerrville
1988 - Dallas
1989 - San Antonio
1990 - Houston
1991 - Galveston
1992 - Dallas

MEMBERS OF THE SOCIETY

(NAME OF SPOUSE APPEARS IN PARENTHESES)

ADKISSON, PERRY L. (FRANCES), chancellor, Texas A&M University System, distinguished professor of entomology, Texas A&M University ..... *College Station*

ALLBRITTON, JOE LEWIS (BARBARA), lawyer; board chairman, Riggs National Corporation ..... *Houston*

ANDERSON, THOMAS D. (HELEN), lawyer ..... *Houston*

ANDREWS, MARK EDWIN (LAVONE), president, Ancon Oil and Gas Company; former assistant secretary of the navy ..... *Houston*

ARMSTRONG, ANNE LEGENDRE (MRS. TOBIN), former U.S. ambassador to Great Britain ..... *Armstrong*

ASHBY, LYNN COX (DOROTHY), editor, Houston *Post*; member, Houston Philosophical Society and Houston Economic Development Council; author ..... *Houston*

ASHWORTH, KENNETH H., commissioner of higher education, Texas College and University System ..... *Austin*

BAKER, JAMES ADDISON, III (SUSAN), U.S. secretary of state; former U.S. secretary of the treasury; White House chief of staff ..... *Houston* and *Washington, D.C.*

BAKER, REX. G., JR., lawyer ..... *Houston*

BARROW, THOMAS D. (JANICE), vice-chairman, Standard Oil Company (Ohio) ..... *Houston*

BARTON, DEREK HAROLD RICHARD (CHRISTAINE), professor of chemistry, Texas A&M University; Nobel Prize in chemistry ..... *College Station*

BELL, HENRY M., JR. (NELL), senior chairman of the board, First City Texas, Tyler N.A.; chairman of the board, East Texas Medical Center Foundation ..... *Tyler*

BELL, PAUL GERVAIS (SUE), president, Bell Construction Company; president, San Jacinto Museum of History ..... *Houston*

BENNETT, JOHN MIRZA, JR. (ELEANOR), member, University of Texas Centennial Commission and Texas Historical Records Advisory Board; director, Texas and Southwestern Cattlemen's Association; Major General, USAFR ..... *San Antonio*

BENTSEN, LLOYD (BERYL ANN; "B.A."), United States senator ..... *Houston* and *Washington, D.C.*

BLANTON, JACK S. (LAURA LEE), president, Scurlock Oil Company ..... *Houston*

BOLTON, FRANK C., JR., lawyer; former head of legal department of Mobil Oil Company ..... *Houston*

BOYD, HOWARD TANEY (LUCILLE), retired chairman, The El Paso Company; College of Business Administration Council of Texas A&M University; regent emeritus, Georgetown University ..... *Houston*

BRANDT, EDWARD N., JR. (PATRICIA), physician—medical educator; executive dean, Oklahoma City Campus—Health Sciences Center, University of Oklahoma ..... *Oklahoma City, OK*

BRINKERHOFF, ANN BARBER, chairman, Liberal Arts Foundation, University of Texas at Austin ..... *Houston*

BROWN, JOHN R. (VERA), judge, Fifth Circuit Court of Appeals ..... *Houston*

BRYAN, J. P., JR. (MARY JON), president, Schroeder Torch; former president, Texas State Historical Association ..... *Houston*

BUSH, GEORGE (BARBARA), president of the United States; former director, Central Intelligence Agency; former ambassador to United Nations; former congressman ..... *Houston* and *Washington, D.C.*

CALDWELL, JOHN CLIFTON (SHIRLEY), rancher; former chairman, Texas Historical Commission; director, Texas Historical Foundation ..... *Albany*

CALGAARD, RONALD KEITH (GENIE), president of Trinity University ..... *San Antonio*

CARMACK, GEORGE (BONNIE), former editor, Houston *Press*, *Albuquerque Tribune and Travel*, and editorial writer San Antonio *Express-News* ..... *San Antonio*

CARPENTER, ELIZABETH "LIZ," former assistant secretary of education, Washington correspondent, White House press secretary; consultant, LBJ Library; author ..... *Austin*

CARROLL, MARY JOE DURNING (MRS. H. BAILEY), lawyer; board member, *Texas Law Review*; ed. staff, *Handbook of Texas* (1952); former parliamentarian, Texas Senate; Governor's Committee, 1969 Codification of Texas School Laws ..... *Austin*

CASEY, ALBERT V., former United States postmaster general; chairman and C.E.O., AMR Corp. and American Airlines, Inc.; director, Colgate-Palmolive Co. ..... *Dallas*

CAVAZOS, LAURO F. (PEGGY ANN), former secretary of education; former president, Texas Tech University and Texas Tech University Health Sciences Center ..... *Washington, D.C.*

CHRISTIAN, GEORGE (JO ANN), writer and political consultant; former press secretary and special assistant to President Lyndon B. Johnson ..... *Austin*

CISNEROS, HENRY G. (MARY ALICE), former mayor, San Antonio, faculty member, Trinity University ..... *San Antonio*

CLARK, EDWARD, lawyer; former secretary of state of Texas; former United States ambassador to Australia ..... *Austin*

CLARK, RANDOLPH LEE (BERTHA), former president, University of Texas System Cancer Center M.D. Anderson Hospital and Tumor Institute ..... *Houston*

CLEMENTS, WILLIAM P., JR. (RITA), former governor of Texas; former chairman, SEDCO, Inc.; former deputy secretary of defense ..... *Dallas*

CONGER, ROGER N. (LACY ROSE), retired executive; former mayor of Waco; former president, Texas State Historical Association ..... *Waco*

COOK, C. W. W. (FRANCES), company director, former chairman, General Foods Corp. ..... *Austin*

COOPER, JOHN H. (DOROTHY), headmaster emeritus, KinKaid School; educational consultant ..... *The Woodlands*

COUSINS, MARGARET, writer and editor ..... *San Antonio*

CRIM, WILLIAM ROBERT (MARGARET), investments ..... *Kilgore*

CROOK, WILLIAM HERBERT, former U.S. ambassador to Australia; former president San Marcos Academy; commissioner, U.S.-Mexican Border Development ..... *San Marcos*

CUNNINGHAM, WILLIAM H. (ISABELLA), president, University of Texas at Austin ..... *Austin*

DARDEN, WILLIAM E., president, William E. Darden Lumber Company; former regent, University of Texas ..... *Waco*

DEBAKEY, MICHAEL E., surgeon; chancellor, Baylor College of Medicine ..... *Houston*

DECHERD, ROBERT W. (MAUREEN), president, A. H. Belo Corporation ..... *Dallas*

DENIUS, FRANKLIN W. (CHARMAINE), lawyer; former president, University of Texas Ex-Students' Association; member, Constitutional Revision Committee ..... *Austin*

DICK, JAMES, founder-director of the International Festival-Institute at Round Top; concert pianist and teacher ..... *Round Top*

DOTY, EZRA WILLIAM (ELINOR), emeritus professor of music and founding dean of the College of Fine Arts, University of Texas at Austin ..... *Austin*

DOUGHERTY, J. CHRYS (SARAH), attorney; Honorary French Consul in Austin; trustee, St. Stephen's Episcopal School, Austin; University of Texas Law School Foundation ..... *Austin*

DOYLE, GERRY (KATHERINE), former chairman, foreign trade committee, Rice Millers Association ..... *Beaumont*

DUFF, KATHARYN, communication consultant, author ..... *Abilene*

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