

# Medical Humanities Report

This issue: Report from the Clinton Task Force

Summer, 1993

## Washington Update: Health Care Reform

*By Leonard Fleck, Ph.D.*

Some of my readers know that for the much of March and April for several days each week I was working in Washington D.C. for Hillary Clinton as one of the 511 secret agents charged with reforming our health care system. I served on Working Group #17 titled Ethical Foundations of the New Health Care System. There were about twenty-five of us who belonged to this group. It was, to say the least, an interesting mix: maybe eight philosophers, four religious ethicists, six physicians, three lawyers, several academics with degrees in various social sciences, a microbiologist ---all of whom are well known for their work in various dimensions of medical ethics with some attention to health policy. As nearly as I can tell, the reason I was chosen to be part of this group, apart from my published work on justice and health care policy, was the "Just Caring" project. The relevance of this project to the future of health reform will become evident later in this report.

Why was there an "ethical foundations" working group at all? My reading is that this will be one of the distinctive features of health reform under the Clinton Administration. That is, the Clinton Administration has embraced the fundamental premise of the "Just Caring" project, namely, that the problem of health reform is fundamentally a moral problem, and only secondarily an economic or organizational problem. The problem of health reform is not fundamentally a business problem or a cost

containment problem. Costs most certainly need to be contained, not primarily because there are huge inefficiencies in these escalating costs, but because escalating costs create escalating inequities throughout the system. Businesses at large, and insurance companies in particular, are strongly motivated to exclude from jobs and health insurance those individuals who can be prospectively identified as likely having the greatest health needs. This may be good business (because it protects profit margins), but it is bad ethics. Health reform that failed to address these kinds of gross inequities in our health care system would not be worthy of being called reform.

The specific charge that was given to our working group was to articulate the "moral vision" that was to guide health reform. We were to get beyond moral slogans, but we had to avoid complicated theoretical arguments. We were to articulate moral principles "with teeth" that would permit critical moral assessment of the various specific proposals that would emerge from other working groups. Needless to say, these same moral standards would be an integral part of the political debates that will occur after the full proposal is made public.

There were a total of fourteen "principles" that our working group articulated that seemed to capture the moral considerations most relevant to just health reforms. These principles will comprise the preamble to the actual legislation submitted to Congress and will also intro-

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duce several other documents that will be made public later. Many of you may be curious about the precise content of these fourteen moral principles, but we are supposed to keep confidential these details until the plan itself is publicly revealed. The broad details of the plan that is emerging have been widely discussed in The New York Times and The Chicago Tribune. There are a lot of hard decisions that remain to be made by the Clinton Administration, and, needless to say, there will then be congressional debate. What this means, practically, is that a lot remains open so far as the details of health reform are concerned.

Here are some of the main features of the Clinton proposal that have relevance to MHR readers. First, a critical defining feature of the Clinton proposal is that a very comprehensive package of health benefits will be guaranteed to all Americans. The moral objective here is to eliminate the two-tiered health system we currently have. There will be no Medicaid program for the poor, though it is likely the long term care portion of Medicaid will remain since only modest long term care reform is likely to be incorporated in the Clinton reform proposals.

Second, the vast majority of Americans will be receiving their health care through vertically integrated comprehensive managed care plans, now referred to as Accountable Health Plans [AHPs]. These plans, in turn, will be supervised by an entity known now as a Consumer Health Alliance, which will be both a purchasing agent for consumers and a strict quality assurance mechanism. It may also have some health planning responsibilities. For Michigan, there may be one to five of these Alliances in the state.

Third, risk-rating of individuals by these managed care plans will not be permitted. That is, consumers may join any health plan in their area, and they may not be discriminated against on the basis of prior or prospective health risks.

Fourth, the federal government will establish strict and detailed quality assurance criteria that AHPs must meet with special atten-

tion given to the quality of care provided to special populations that in the best have been underserved relative to their health needs.

Fifth, to control costs there will be global budgets established at the federal level, the state level, and the level of AHPs. This means that AHPs will be required to deliver that very comprehensive health package within the limits of the budget they have, determined mostly by the size of their enrollment. It is at this point that the "Just Caring" project has the most to offer a health reform effort.

Finally, though this is an effort at national health reform, the Clinton Administration will grant considerable flexibility to the states regarding how they achieve the goals of health reform outlined above. But the states will be strictly accountable for protecting equity (comprehensive benefits package must be guaranteed to all), protecting quality, and containing costs. By way of illustration, states can choose, if they wish, not to have AHPs, but to adopt a variant of a Canadian-style single-payer system.

Going back to the role of the "Just Caring" project under the most likely Clinton proposal, the Princeton health economist, Uwe Reinhart, is quoted as saying in The Wall Street Journal (April 22), "The whole idea of managed competition is to delegate these painful decisions [about resource allocation for very expensive, marginally beneficial life-prolonging medical care] into the dark corners of the HMO.... This is a smart way of delegating painful decisions from the government to the private sector." Now Reinhart is correct in saying that this is something that could happen to AHPs operating under global budgets. And if this were to happen, then this would be seriously unjust because, as I have argued elsewhere in a number of papers on the

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topic of invisible rationing, this approach violates a core element of our shared conception of justice, what John Rawls refers to as the "publicity condition." What the "Just Caring" project offers is a way of meeting the requirements of the publicity conditions, and more generally, the requirement that there be fair procedures in establishing health priorities and just cost containment mechanisms within the context of a limited budget. The term "rationing" is one that triggers negative reactions in the minds of most Americans. Part of this has to do with the suspicion on the part of many that rationing cannot be done fairly, that there will always be those who game the system and thereby escape the sacrifices that are expected of everyone else. What will prevent these suspicions from being realized within AHPs? There are three things that are crucial.

First, a lot will depend upon the moral integrity of physicians and their commitment to fair treatment for all their patients. Within health care physicians are the primary allocators of access to health care. No one can obtain any significant health services without the cooperation of physicians. If there are rationing protocols within an AHP that make explicit the sorts of non-costworthy marginally beneficial health services that should be denied to all members of that AHP, then it is the moral responsibility of physicians to implement those protocols honestly and fairly. If they are tempted to game the system in favor of the patient before them now (in the name of compassion), then they need to be reminded that in a closed system with a fixed budget they are effectively denying those resources to other patients that are their patients also who have health needs that make a stronger and more just claim to those resources---and these other patients are as deserving of compas-

sion as the patient before them.

Second, physicians will not be disloyal to the interests of the patient before them or lacking in compassion if the rationing protocols within that AHP are a product of a public moral conversation that has occurred among the members of that AHP. That is, if the members of that AHP have imposed these rationing/ cost containment protocols upon their future selves because they have made the judgment that there are other health needs that have greater priority for the limited resources available to that AHP, then the

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patient before this physician is among those who have endorsed these limits for himself. Further, the likelihood is that this patient has already benefitted from this more rational deployment of limited health resources, which is then another moral consideration that speaks against cooperating with this patient to circumvent these rationing protocols.

Third, the argument might be made that (as is very likely) these rationing protocols will vary from one AHP to another, and this is inequitable. Here we need to be reminded that there are broad principles of health care justice that must not be violated by any rationing protocol in any AHP. Thus, there would be no moral justification for a rationing protocol that denied ICU care to an AIDS patient who had less than a 10% chance of surviving this hospital stay; but it would be morally permissible for the members of an AHP to agree that anyone with any terminal illness who needed ICU care and who had less than a 10% chance of surviving

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this ICU stay would be denied access to an ICU. Any one of us is likely to come under the scope of this rationing protocol in the future, and none of us can now game the system by agreeing to this protocol since we are all likely ignorant of our future in this matter, and all of us can agree that there are much better uses for those terminal ICU care dollars---all of which would motivate each of us to agree freely and autonomously to such a protocol.

To speak more directly to the equity concern of varying rationing protocols among the AHPs, we need to note that there is a vast gray area in the choice of rationing/ cost containment protocols that are all "just enough" so long as they are freely and democratically chosen by the members of a given AHP. Thus,

it is easy to imagine that some AHPs will choose to save money by denying bypass surgery to patients with single-vessel coronary disease and less than 70% occlusion. That saves \$40,000 per case, and 20% of the bypass surgery we now do in the United States falls in this category. This is marginally beneficial care, though some AHPs may provide these anyway and cut costs elsewhere.

There are lots of possible trade-offs. What is morally critical to protect fairness is that these trade-offs be made in ways that are public, accountable, and a product of informed democratic deliberation within the AHP. The "Just Caring" project can be an enormous source of help in providing a model of how this might be done.

## Balancing Politics and Philosophy in Health Care Reform

*By Howard Brody, M.D., Ph.D.*

In March, 1993 I attended two sessions of the working group on "Ethical Issues in the New Health Plan," one of 35 working groups assembled by Hillary Rodham Clinton's Task Force on Health Care Reform to advise the Administration on its proposals, which are now expected to be submitted to Congress in early June in hopes that Congress can act on them before the end of the year. In all, 511 people, primarily Washington government staffers and academics, made up these working groups.

Our working group gave us a bit of a glimpse into the political tradeoffs involved in the "100 days" process. We spent a certain amount of time in working group meetings reminding ourselves of deadlines; a certain amount of time dropping what we were doing to respond to some other "crisis," real or imagined, elsewhere in the system of working groups;

and a certain amount of time berating ourselves for being seduced by a crisis-and-deadline mentality rather than sticking by our intellectual guns and doing what we thought needed to be done. (I will pass over the spectacle of philosophers trying to philosophize to meet a deadline.) All of this could evoke the comment: it's taken several decades for the U.S. to screw up its health care system; isn't it arrogance and naivete to think that a group of "the best and the brightest" could fix it up in just a couple of months? Why didn't we, as academics, simply tell the White House that they were creating a process destined for either failure or mediocrity, and refuse to be a part of it under those conditions?

In defense of the Clinton team, one must hypothesize that somebody who understands both presidential and Congressional politics reasoned that there was a discrete window of

opportunity for presenting a plan which would have a serious chance of being passed whole, rather than taken apart and amended to death. Lose that window and you blow your chances for four years.

So far, I'd argue that the Clinton hypothesis has been borne out by the success of the planning process in capturing the attention of the media. One of the activities of our Center this spring has been teaching the new Humanities course in the College of Human Medicine; and one of the medical-history teaching exercises involves the fight between Truman and the AMA in 1945 over national health insurance. Truman, in his message to Congress introducing his plan, included the words, "This is not socialized medicine." The AMA replied, predictably, that it was just that; and from that point on the debate was framed: Should the U.S. adopt socialized medicine? So far Clinton has been far more successful than Truman in controlling how the debate is framed in the media. To see this, one has to recall what the media was saying about health reform only 6-9 months ago. A proposal that we should do very little about the health system and basically trust the free market, maybe giving insurance vouchers to the poor, would at that time have been treated as a serious proposal. Now, no one bats an eye when reading a news story which argues whether a payroll tax is more fair than a value-added tax to finance health care, or whether Medicare should be kept separate or combined with the overall national system. The Task Force process has succeeded in changing the "should we?" question into the "when and how?" question. It has also made it more difficult for those who will oppose the President's plan to paint themselves as being for something substantial. Either they will appear to be "for" their own selfish financial interests, or they will be "against" the plan with nothing better to offer.

That doesn't mean that any of the details of the proposal will have a free ride through Congress; and that in turn highlights some of the silliness of the debate over the "closed" process

engaged in by the Task Force. Various groups miffed at not having been invited to meetings with Hillary (which thereby suggested that they were nothing more or less than "special interests") argued that the final plan was sure to be flawed because everything was being done secretly and all the people who would actually be affected by the plan hadn't been heard from. On reading those charges back in March, it was easy to forget that the entire plan would have to go through both houses of Congress, where all the lobbyists and special interests would take their knives to it and where all the usual horse-trading would still occur. Demanding to be there when the proposal was being assembled is a little like demanding to see, not only the proposed legislation, but also all of the discarded rough drafts. Moreover, as the process evolved, the sense of the working group was that an atmosphere of openness largely prevailed. As we were completing our tasks, two new panels of experts (one of clinicians, the other of lawyers) were being brought in specifically to try to tear holes in what had been proposed so far.

An interesting question arises for moral philosophers involved in this political process. It is fairly likely that the plan which will ultimately be recommended, or the plan which will emerge after the first few rounds of Congressional horse-trading, will significantly fall short of some of the moral principles our working group articulated. And yet the plan might still be significantly better, or at least somewhat better, than the present mess that passes for the U.S. health care system. Does the philosopher compromise her principles and work to support the less-than-ideal plan, or stick to her guns and run the risk of passing up a real chance for reform? Obviously the answer is "it depends"; but what it depends upon, and where in the sand one feels forced to draw the line, are likely to be subtle and challenging questions.

## Literature in Review

**Humility** By Norvin Richards, Temple,  
1992. xvi + 224 pp. \$37.95 cloth

*By Judith Andre, Ph.D.*

Most of my students do not think of humility as a virtue. They have the Oxford English Dictionary on their side; if to be humble means to have "a low estimate of oneself," how could it be a good thing? For Norvin Richards, the OED and my students have it wrong. Humility "involves having an accurate sense of oneself, sufficiently firm to resist pressures . . . to think too much of oneself. . . ." (p.5). [emphasis added] Humility is above all a clear view of oneself, a sense of perspective.

What does this mean in practice? The humble person may, indeed should, recognize when she has been mistreated, and take umbrage; but proportionately. The slights and offenses she suffers have no more weight than those that others endure. Taking oneself too seriously is a sure road to misery, and one recommendation for humility is that it blocks that road. Similarly for envy and jealousy: the humble person will not exaggerate her deserts.

Richards' discussion sheds light on several topics central to medical ethics. Paternalism, for instance, will repel the humble person, who understands the limits of his abilities and, more often to the point, the limits of his moral standing. It is enlightening to see paternalism treated as a lack within oneself as well as a violation of the rights of others. The author makes a number of interesting and original points here. Not all paternalism, for instance, is motivated by concern for others. Some of it arises from a kind of aesthetic sense: we may give nutritional advice, or suggest a particular surgical procedure, simply because we believe

there are right ways to do these things.

Even 'soft' paternalism can be arrogant: Restraining someone 'only' long enough to ensure that they know what they're doing can violate someone's preference for spontaneity and risk. Even the advancement of logical argument can be, in some situations, an arrogant imposition. A right to intrude depends not only on knowing better than the other, but (at least ordinarily) on having received some implicit invitation to decide for her.

On the other hand, Richards wonders whether claims to have complete sovereignty over one's own life might also be unhumble. He concludes that in most circumstances it is not. While my life is not my property, nor something on loan to me, my claim to make decisions about it stems from a number of powerful interests, including the needs to understand and to evaluate oneself.

Humility is a competent, clear discussion of an important topic. There are moments of quiet insight, as when the author remarks that "an unwillingness to judge oneself by any but the very highest standards can reflect, not humility, but its opposite. . . . A conviction that one belongs in a higher league" (p.7). In spite of its strengths, however, the book is not always engaging, nor in the end satisfying.

What is missing, I think, is the intensity and depth that the best interdisciplinary work would provide. (It's notable, for instance, that Richards' many references to literature are ordinarily so brief. He uses them to illustrate his points rather than as sources of understanding.) I would like to have seen the author tangle with the human complexities here. How does one become humble? What are the barriers to clear sight? Are these barriers moral defects, psychological problems, both? Why has humility come

to be understood as low self-esteem? How is all of this connected to American society, classless in its mythology, highly stratified in fact?

Richards suggests, but does not say, that humility is a strengthening and healing virtue. Bill Moyers' superb PBS series "Healing and the Mind" dealt one evening with people learning to live with chronic pain through the practice

of Buddhist meditation: of mindfulness. Mindfulness and humility, I suspect, have a lot in common. The Buddhist tradition offers a way of becoming mindful; learning from it could be one rich source from which to develop Richards' valuable beginning discussion.

## Notes and Announcements

### Center Director Honored

Howard Brody was honored at the College of Human Medicine commencement ceremonies on May 15 with the Distinguished Alumni Award from the Michigan State University Alumni Association. Brody had received the Distinguished Alumni Award from the College of Human Medicine in 1991, and the College then placed his name in nomination for this all-University award.

Howard Brody has been named Senior Scholar in Residence at the Agency for Health Care Policy and Research by the American Academy of Family Physicians for 1993-94. He plans to spend a sabbatical period (September 1993-May 1994) working part-time at AHCPH in Rockville, MD, studying the interfaces among health policy, primary care medicine and research, and medical ethics.

### Publications and Presentations

Judith Andre's "Beyond Moral Reasoning: A Wider View of the Professional Ethics Course," was published in Teaching Philosophy, Vol. 14:4 (Dec 1991) 359-373. She was a panelist for the Central Consortium on teaching: "Teaching Student Relativists" this past April at the Central division of the APA. Dr. Andre spoke to Alpha Epsilon Delta (pre-professional Society for Health Careers) on "Uncooperative

Pregnant Patients" and to Jackson County Public Health Department nurses on "Medical Ethics: Non-compliant Patients, Non-compliant Institutions".

### Handicapper Advocate Judy Gentile Dies

The staff of the Center were saddened to learn of the death, at age 46, of Judy Gentile, director of the MSU Office of Programs for Handicapper Students, on April 28. Judy held a number of important state and national posts and was widely known as an advocate for handicappers.

Many of us had occasion to encounter Judy at various public presentations and hearings. We often found ourselves in disagreement with her on policy matters such as patients' rights to refuse life-sustaining medical treatment and on health care reform and rationing. Judy was unfailingly polite and cordial in expressing her views, and unswerving in her advocacy for the perspectives of patients with disabilities. I think that all of us, over time, were educated by her to a level of greater awareness about the needs and perspectives of handicappers. We will certainly miss her contributions to the ongoing dialogue about these important matters at Michigan State University.

# Coming Events

*The Center for Ethics and Humanities is an academic unit whose faculty teach, write, and consult about bioethics and the other medical humanities. Staff members frequently conduct public discussions about a variety of such topics and we encourage our readers to attend and participate in these forums.*

June 24-5: **Marian Gray Secundy, Ph.D.**, of Howard University's School of Medicine will visit us. If you would like an opportunity to meet with Professor Secundy, please call the Center.

July 10-16: **Third Annual Intensive Skill Building Workshop: "Medical Ethics for the 90's."** Conducted by Center faculty with nationally known guest speakers. For further information, please call the Center.

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July 29: **Thomas Cole**, Pulitzer nominee for The Journey of Life, will give the keynote speech for the conference "Aging and Learning." (Fee; Sponsored by the Institute for Research on Teaching Adults and the College of Education.) For further information call Steve Weiland (355-2395). If you would like to meet with Professor Cole, please call the Center.

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