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Affirming Ethical Options for the Terminally Ill

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Abstract

Eight states and the nation's capital have enacted laws that allow physician-assisted suicide. While proponents of these laws frame them in terms of relieving needless suffering for the terminally ill, physician-assisted suicide constitutes a major break with long-standing medical ethics embodied in the Hippocratic Oath. Many across the ideological spectrum agree that the normalization of medical killing poses a threat to the poor, disabled, and other vulnerable members of society. How can policymakers address the need to improve end-of-life care? On March 11, 2019, The Heritage Foundation hosted a panel of experts, including two medical doctors, to address this sensitive matter with its many pressing questions.

RYAN T. ANDERSON, PHD: Eight states and the District of Columbia have enacted laws allowing physician-assisted suicide.[1] Thankfully, earlier this year, such a law was defeated in Maryland. But it'll be back for debate there, and we can expect debates in states throughout the nation. Although it is sometimes proposed as a relief for patients undergoing pain and suffering, physician-assisted suicide constitutes a major break with the traditional medical ethics embodied in the Hippocratic Oath that calls on doctors to heal patients.

Many analysts across the ideological spectrum agree that the normalization of medical killing poses a threat to people who are poor, people with disabilities, and other vulnerable members of society. Several years ago, I wrote a report for The Heritage Foundation titled, "Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality."[2] Now, my colleague, Dr. Robert E. Moffit,

KEY POINTS

- Eliminating suffering by eliminating those who suffer is not a new temptation. It has always been part of medicine. It is because of this enduring temptation that doctors have committed themselves, for centuries, to the Hippocratic Oath.
- The emerging debate over physician-assisted suicide and end-of-life care in state legislatures around the country is a watershed moment.
- The normalization of medical killing poses a threat to the poor, the elderly, people with disabilities, and other vulnerable members of society.
- Public policy can encourage ethical alternatives to physician-assisted suicide, including advance directives, improved Medicare payment for palliative and hospice care, and personal choice of health plans and providers that respect patients' moral and religious convictions.

This paper, in its entirety, can be found at **http://report.heritage.org/hl1309**

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has taken the next step—from explaining why physician-assisted suicide isn't the answer to saying what the right answer *is*. And, what policymakers can do in offering an alternative to physician-assisted suicide.

We're gathered today with an expert panel to discuss Bob Moffit's new Heritage report, "End-of-Life Care: Expanding Patient Choice of Ethical Options."[3] Joining us today to discuss Bob's paper, and to discuss ethical choices at the end of life, are professors and medical doctors Farr Curlin and Kevin Donovan.

Dr. Curlin—a hospice and palliative care physician—is the Josiah C. Trent Professor of Medical Humanities at Duke Divinity School. He is also a professor of medicine at the Duke University School of Medicine. His research focuses on the patient–doctor relationship, the moral and professional formation of physicians, and the practices of care for patients at the end of their lives.

Dr. Donovan is the director of the Center for Clinical Bioethics and a professor in the Department of Pediatrics at the Georgetown University Medical Center. Kevin was the founding director of the Oklahoma Bioethics Center, and has three decades of experience in clinical bioethics and clinical medicine. He has been listed in Best Doctors in America and America's Top Doctors, has served on multiple ethics committees for hospitals and national organizations, and has chaired institutional review boards.

Finally, we'll hear from my colleague, Dr. Robert Moffit—PhD *not* MD. Go to him with metaphysical problems, not physical ones. He's a Senior Fellow here at The Heritage Foundation, and he's the former chairman of the Maryland Health Care Commission. Bob has long specialized in health care and entitlement programs, especially Medicare, and has testified frequently before congressional committees. He brings to the health reform effort his government experience as a Principal Deputy Assistant Secretary at the U.S. Department of Health and Human Services, and as a senior official in the Office of Personnel Management, where he served during the Reagan Administration. In 2010, *Modern Healthcare* magazine named Bob one of the 100 most influential Americans in health care.

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Restoring Trust Between Patients and Their Doctors

FARR A. CURLIN, MD: Thank you, Ryan. It seems to me that this growth in advocacy for physician-assisted death brings to light the fact that medicine is at a watershed moment. We're at a crucial point in the history of the profession.

Watershed Moment. Doctors are going to have to make a decision, and the public will also have to make a decision, about the profession of medicine. At issue is whether we will be a profession of healers who commit to acting only in a way that is consistent with the patient's health, or whether we will be reduced to a profession of "providers," who would be willing to make available any intervention that the law will permit—even if that intervention directly contradicts the patient's health.

For more than 2,000 years, since the Hippocratic reform movement, physicians in the West have maintained a firm commitment to care for those who are sick, irrespective of their other characteristics, and seek to preserve and restore their health. In order to sustain that commitment, doctors have recognized that there are some things physicians must never do. Chiefly, they must never kill or intentionally damage or destroy a patient's health. Now, does that mean doctors ignore suffering? Of course not.

As Ryan said, I practice palliative medicine. My regular clinical practice is caring for those who are suffering pain and breathlessness and any number of other difficult symptoms that often accompany advanced illness. And I can tell you that we now have measures to treat pain, breathlessness, and other difficult symptoms more effectively than we have ever had before. And we can do that while respecting ethical norms that have guided the profession of medicine for centuries.

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1. California, Colorado, Hawaii, Montana, New Jersey, Oregon, Vermont, Washington State, and the District of Columbia.
2. Ryan T. Anderson, "Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality," Heritage Foundation *Backgrounder* No. 3004, March 24, 2015, https://www.heritage.org/health-care-reform/report/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak.
3. Robert E. Moffit, "End-of-Life Care: Expanding Patient Choice of Ethical Options," Heritage Foundation *Backgrounder* No. 3377, January 31, 2019, https://www.heritage.org/node/10816331/print-display.

Again, chief among those guidelines is that a physician would never intentionally cause or hasten a patient's death. The moves for assisted suicide highlight the way that this issue is consequential for solidarity and trust. I have met many patients who are wary of, and even firmly resistant to, palliative medicine, or hospice; patients on the South Side of Chicago, and patients in Durham, North Carolina. They are resistant and wary because they're worried that doctors today are falling prey to a temptation to get rid of suffering by getting rid of those who suffer.

> Many patients are wary of, even firmly resistant to palliative care—because they are worried that doctors are falling prey to the temptation to get rid of suffering by getting rid of those who suffer.

The Hippocratic Oath. Eliminating suffering by eliminating those who suffer is not a new temptation. This always has been part of the practice of medicine and caring for those who are grievously ill. And it's because of this enduring temptation that doctors have committed themselves, for centuries, to the Hippocratic Oath, which states, in part, "I will neither give a deadly drug to anybody who asks for it, nor will I make a suggestion to this effect." Or in the American Medical Association's (AMA's) code of ethics, where the AMA has maintained, since its founding, that physician-assisted suicide is fundamentally inconsistent with the physician's professional role.

Note also that the World Medical Association has opposed assisted suicide and euthanasia since it was formed. The prohibition is also repeated in the Declaration of Geneva, issued just after World War II. This prohibition has been consistent across the profession in the West for all of these centuries. The commitment to never kill creates a boundary within which patients can entrust themselves to physicians' care when they are too sick to care for themselves. And crucially important, it gives physicians the freedom to treat patients' symptoms decisively and effectively, accepting the side effects of such treatment when there is good reason to do so, when there is proportionate reason to accept those side effects.

Restoring Trust. While advocates for physician-assisted suicide say that it is needed to relieve suffering, in fact, the practice of assisted suicide makes it harder to relieve suffering. I will tell you: It has already made it more difficult for me to relieve the suffering of patients, because it erodes the trust that patients must be able to place in their physicians in order for physicians to effectively treat their pain and other symptoms. I want to say this again: Physicians cannot practice causing the death of their patients without undermining the trust on which the practice of medicine depends.

*—**Farr A. Curlin, MD,** is Josiah C. Trent Professor of Medical Humanities at Duke University.*

> Physicians cannot cause the death of their patients without undermining the trust on which the practice of medicine depends.

And because of that, I would encourage Americans to ask their physicians a question that they probably thought they could take for granted. But ask them: "Are you a physician who is willing to kill? Or are you a physician who is committed only to healing?"

The notion that we can have these two things together—killing and healing—is mistaken. We're either going to have one or the other. I hope that we will offer sufficient resistance within the profession and without, so that we preserve a profession that patients can trust when they are gravely ill; when they need someone to care for them without worrying that their physicians might be willing to end their lives in order to end their suffering.

Proportionate and Compassionate Care

G. KEVIN DONOVAN, MD: It may come as no surprise that I agree with Dr. Curlin. Quite frankly, the onset of physician-assisted suicide intruding into our culture, and Western culture in general, is something I find quite frightening. It is frightening primarily for the patients involved, but also for the profession of medicine. Proponents have said, "Why don't you let those who want this pursue it, and the rest of you just stay out of it?" But when "the rest of you" includes practicing physicians who have no interest in pursuing this harmful practice, and think it's bad for their patients, they find that they are not being allowed to stay out of it. We have seen that in some venues physicians are frequently not only encouraged, but even required, to participate in physician-assisted suicide, or refer their patients to someone who wants to participate in either physician-assisted suicide or euthanasia where it is legal.

Social Harm. I find this development quite disturbing. We must remember that whatever is permissible in medicine becomes habitual. Whatever is habitual becomes standard of care, and then standard of care becomes a requirement, and this is where we are now. We're on the threshold of that in this country as it has occurred elsewhere, such as Canada, the Netherlands, and Belgium.

You will notice in this discussion that you will hear no religious arguments from me or the other panelists. These are not really required to highlight the concerns here, or to oppose the spread of assisted suicide. Nevertheless, some might be wary of presenting themselves to their Creator unbidden, following an action that is harmful to themselves and others. The question then is, is it harmful? Yes, harm is involved. Harm is clearly involved, I think, when anyone kills himself, no matter what his motivation. I also think that it's arguably a harm, not just to the patient involved who commits suicide, but also to those who have no interest in the situation except for the harm done to society.

I don't think this is a victimless crime any more than other actions described as such, like prostitution. That's perhaps the only connection between the two, but I think it's a very serious one.

Whatever is permissible in medicine becomes habitual. Whatever is habitual becomes the standard. Whatever is the standard becomes a requirement.

Before delving more into this, I think we ought to consider and clearly respond to the question: Don't doctors already kill their patients? You could go into an ICU any week in any hospital, and somebody's being taken off the ventilator at the end of life. Are we *killing* them when that happens, and they subsequently stop breathing? Is there a difference between stopping those life-sustaining treatments and just deliberately ending a life in another way? And the closely related question would be: Are *withholding* and *withdrawing* therapy different, or are they the same?

Proportionate Care. Let's briefly consider that. The standard dictum for some time has been that if you withhold or withdraw a life-sustaining intervention, these actions should be considered morally equivalent. I would agree that, yes, that dictum should hold, when occurring in the same set of clinical circumstances. Although it often doesn't feel the same, a decision not to initiate a life-sustaining treatment or, alternately, to initiate it; then, to see that it doesn't seem to be beneficial anymore, and to then discontinue it, should be looked at in the same moral sense. However, that isn't to say that there is no distinction between killing and letting die. There is no moral obligation to employ measures near the end of life, or at any other time, that offer insufficient benefit to the patient, and at the same time would cause excessive pain, excessive inconvenience, or cost to the patient, or to his family, or even to society. Once we accept this principle, then we can say, "Well, maybe withholding or withdrawing can be a way to deal with the issues that concern us," as long as are not actively killing these patients.

How do we know the difference? One of my colleagues at the Edmund D. Pellegrino Center for Clinical Bioethics at Georgetown came up with the formulation that I believe is very helpful. We can distinguish killing versus letting die primarily by considering whether we are introducing a new lethal state at that time. As we've already heard from Dr. Curlin, to introduce a lethal state intentionally goes against everything that a physician is taught in the traditional ethics of medicine. But, if there is already a lethal state, then all we may be doing is allowing that pre-existing lethal state to take its natural course. At times, that may be a perfectly moral act. You could also envision when it may not be, when there might be an intention to kill more than to remove burdensome interventions, but that still would be in contrast to the situation in which a new lethal state is deliberately introduced.

However, when you write a prescription for lethal medications, or inject something into the veins of a patient that causes his heart or breathing to stop, you create a new lethal state with the intention of bringing about the end of that person's life. This is not *allowing to die*—this is killing.

These are things that doctors certainly find problematic in the practice of medicine. The vast majority of patients feel the same way. In contrast to physicians' willingness to do a patient harm by prescribing lethal doses of medications, it must be noted that many patients are still afraid of end-of-life treatments *not* being withdrawn. In the past, it has been seen that once you are placed in an ICU on a ventilator, or on dialysis, or similar interventions, it seems to be almost like a runaway train that nobody seems able to stop, and you are in for a life of suffering until the moment of your death. Now, unfortunately, it can look that way, and sometimes it has turned out that way. This scenario has supported the mindset of some seeking control through physician-assisted suicide. It certainly doesn't have to be that way.

Advance Planning. One of the things that make a difference here is when the patients themselves take steps to avoid that scenario. This is where letting people know what you want, and making sure they know what you don't want, can be very useful. The best way to do that, I think, is through some form of an advance directive. There are two parts to them. One is called the living will, where you stipulate all the things that you would or wouldn't want if you couldn't speak for yourself. Most often they are put only in the negative, unfortunately, and do not emphasize those interventions you might prefer or desire. The other component of an advance directive is called a proxy appointment, surrogate appointment, or durable power of attorney for health care. All these terms mean essentially the same thing: that you are selecting someone to speak for you when you are unable, because of your illness, to speak for yourself.

I will also admit at this point that I have a strong preference for one over the other. As a physician, I don't really get enthusiastic about living wills, because they tend to be typically too vague. You know, they tell us what people's aspirations might be, but they don't really give us enough information to make the decision about one particular patient with one particular intervention at a particular point of time with a particular illness. Some people have tried to overcome that aspect, and those of you who live in states that have Medical Orders for Life-Sustaining Treatment (MOLST) or Physician Orders for Life-Sustaining Treatment (POLST) may be familiar with them. MOLST and POLST forms can be very specific, perhaps too much so. On Maryland's form, you may not only be asked to accept or reject things like CPR or ventilators at the end of life, but may need to indicate your acceptance of endotracheal tubes, antibiotics, and decide whether they should be oral or intravenous!

Now, when I start telling people about this, they start to snicker a little bit, saying, "You're really telling me that patients are supposed to be deciding this for the doctors in advance, not even knowing what the situation might be?" I think you can see some of the problems involved. You don't have to be working in the ICU to see how this could be problematic.

But, what if there were someone who knows exactly who you are, and what you value, and what you fear, and might be willing and able to discuss this with the medical team, and have the power of making decisions for you? That is what a surrogate or proxy appointment consists of. It could work very well if you have a surrogate and if you have told that surrogate exactly how you feel about things, and he or she can use those values and apply them flexibly as necessary to a particular end-of-life situation.

I think that this approach can prevent the feeling that we have to be able to do something much more drastic near the end of life to satisfy the patient's needs. I think patients need not be over-treated. I think that patients need not be kept in pain, but I think they do need to have attention paid to their medical needs, their psychological needs, their spiritual needs; and these things can be handled without pushing them toward an early death. What would be highly appropriate would be to have policies in the United States that also matched society's prescriptions and proscriptions. I think that it would be useful to look at what we have, and perhaps what we should have, in the realm of policies to make ethical options for the terminally ill work better. More than just physicians alone, this is a role for the policy expert.

*—**G. Kevin Donovan, MD,** is Director of the Center for Clinical Bioethics, and professor in the Department of Pediatrics at Georgetown University Medical Center.*

A Limited—But Vital—Role for Public Policy

ROBERT E. MOFFIT, PHD: The emerging debate over physician-assisted suicide and end-of-life care, not only in the Maryland General Assembly, but also in other state legislatures around the country, is, as Dr. Curlin said, a watershed moment. The national debate also presents us with an opportunity. It's an opportunity not only for leaders of civil society—private and professional medical organizations and religious institutions—but also for policymakers. It is a chance for us to change the facts on the ground, pre-empt opponents of traditional medical ethics, and redefine the terms of the debate in the right way. How can we affirm the inherent dignity and the value of human life? How can we secure the best and the most humane treatment for those who are aged, or frail, or seriously ill until their time of natural death?

As I emphasized in my Heritage *Backgrounder*, end-of-life care is an area where the role of government is, and should be, inherently limited. Most, if not all, of the key decisions in this sensitive area should be made by individuals and families, patients in consultation with their physicians, and the institutions of civil society. Religious authorities especially have a powerful role to play in this arena. While recognizing that the primary role in end-of-life care is largely a matter best left to the institutions of civil society, public authorities can pursue and secure some very positive policies.

Advance Directives. Dr. Donovan just mentioned advance planning, particularly advance directives. Without specifying the content of such directives, the legal documents themselves, federal and state policymakers can do some very positive things to encourage their adoption and use, giving individuals the opportunity to authorize a trusted person to act as their proxy, usually a friend or a family member. Such persons are given a power of attorney, and are thus authorized to make decisions concerning end-of-life care on behalf of a loved one, whether family or friend. This is a profound responsibility. The most important thing is to make sure that these advance directives, when they are drawn up as legal instruments, are compatible with the patient's ethical, moral, and religious convictions.

Medical professionals entrusted with the treatment of persons at the end of life will then have a guidepost of what is morally acceptable for that person and what is not. We know from survey research that most Americans realize that they should undertake such planning. The reality, however, is that most simply do not do it. Of course, it is not an easy thing to ask people to start thinking about their own death, or to ponder their very last days or hours on Earth. And then ask them, further, to anticipate and specify to some extent what medical treatments or procedures would or would not be acceptable to them at a future time when they might not be able to communicate their wishes. There's an emotional response to that.

Nonetheless, there are ways that public officials can encourage such planning. They can encourage it, for example, through regular public communications about our health care system. Medicare beneficiaries, for example, have the highest death rate among Americans in any given year. Whenever a person is newly enrolled in Medicare, policymakers could encourage that person to consider taking out an advance directive and designating someone to act on his behalf. Medicare officials could do that by spelling out in *Medicare and You*, the program's handbook, the many advantages of such planning for every senior and disabled person enrolled in Medicare, as well as for each enrollee's family members. Today, in *Medicare and You*, enrollees can learn what their hospital and outpatient benefits are, what payments they face, what kind of care options they have in the program, and they can get information that allows them to determine whether they want to stay in traditional Medicare and buy private supplemental coverage, or whether they want to go into Medicare Advantage, the alternative system of competing private health plans.

Federal officials could also test out various payment options for end-of-life care. Under current law, that is done through the Centers for Medicare and Medicaid Services' Center for Medicare and Medicaid Innovation (CMMI). The agency conducts demonstrations on a variety of Medicare-related issues, such as payment and care-delivery reforms. Medicare officials could test whether or not economic incentives would encourage people to voluntarily take out an advance directive. There are various ways that this could be done. For example, Medicare could provide a select group of newly enrolled beneficiaries with a premium discount if they were to take out an advance directive, provide proof of that transaction or submit a copy, subject, of course, to all of the patient-privacy protections of current law.

Premium discounts or cost-sharing reductions are economic incentives that exist today in private health insurance to encourage employees' enrollment in wellness or preventive health programs. Applying this same approach in the Medicare program to encourage a take-up of advance directives might help reverse the inertia that exists today.

Whatever we decide to do in the area of end-of-life care—at a policy level—we should not rush into it. That is why I think it would be a good idea for CMMI to experiment with economic incentives for advance directives. We need to see whether such an approach would actually work, how many people would sign up, how such a program would perform in achieving a more widespread use of these legal instruments. In the end, hopefully, people would gravitate toward this commonsense method of self-protection, and do the right thing on their own behalf, as well as for their physicians and their loved ones.

The Role of Religion. Advance directives should not simply be transactions limited to a client and a lawyer. Religious institutions can play a vitally important and concrete role in developing and promoting advance directives. Faith-based or religious organizations should develop guidelines or templates for advance directives, reflecting their moral or religious convictions, on behalf of their congregants, either for Medicare beneficiaries or for any other patients, spelling out what the ethical guidelines should be in governing such documents. For many people, this would raise their comfort level about end-of-life-care planning, and for many others it would secure peace of mind. As many of you know, often from firsthand experience, there is sometimes a great deal of confusion about what is, or is not, appropriate, proportionate, or disproportionate in end-of-life care.

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As Dr. Donovan pointed out, some clinical situations are not crystal clear. Nonetheless, some of the best thinking of religious leaders, philosophers, and moral theologians can be brought to bear in helping future patients to develop advance directives.

Improving Palliative Care. Dr. Donovan and Dr. Curlin both mentioned the positive impact of palliative care. Such care provides relief from pain and comfort, and it routinely encompasses social, psychosocial, and spiritual services.

Palliative care is often curative, hospice care is not. Under Medicare law, hospice care is reserved for persons who have a prognosis of six months or less to live. Only those persons are qualified for Medicare's hospice care benefit.

Medicare finances palliative care. If you know anything about Medicare's administrative payment system, however, you know that it is complex, inflexible, and often fragmented. Palliative care services are provided to patients under Part A, the hospital part of Medicare, and also Part B, the part that pays for physicians and outpatient medical services. So, in the case of palliative care, the payment from different parts of the Medicare program is disjointed, and the care is fragmented. Medicare's complex administrative payment system is incompatible with the kind of team-based care that is appropriate for the holistic delivery of palliative care.

The good news: The Trump Administration is considering new payment models for palliative care. The Administration is examining proposals that would integrate payment and the delivery of care, possibly something like a "bundled" payment system for those Medicare patients who need palliative care.

Hospice is very different from palliative care. In the Medicare program, hospice is reserved, as I noted earlier, for people who have six months or less to live. It is team-based care. It provides a continuum of services for people at the end of life. Almost half of Medicare patients take advantage of it.

Expanding Hospice Options. Hospice care for Medicare patients, however, can be improved. The best way to do that is to open up the system and allow Medicare Advantage plans to offer a hospice benefit.

The Medicare Advantage program, a system of competing private health plans, covers over 36 percent of the total Medicare population right now. Under current law, Medicare Advantage plans can provide palliative care, but not hospice care. This legal restriction is unnecessary. Medicare Advantage plans have pioneered case management and care coordination, and they often deliver high-quality care in a very effective way for people suffering from chronic illnesses. It would make perfect sense to allow the Medicare Advantage plans to offer hospice care, just like they offer palliative care and various other types of care not available in the traditional Medicare program.

Finally, I'll just mention one other thing, a major problem. It is this: By law and regulation, we have health care arrangements today where all the key decisions, the big decisions, are basically made by third, and even fourth, parties. That is to say, what kind of benefits you get, what kind of plans you get, what kind of medical treatments and procedures you get are determined by other parties, such as your employer, managed-care executives, or various state and federal government officials. Consumers do not make these crucial decisions.

The American paradox is this: We have a great market economy that is powered by fast and efficient personal choices, increasingly facilitated by apps on our electronic devices, but we are saddled with a set of clunky industrial-era health care arrangements that are largely insulated from consumer decision making. Most notably, Americans still do not have a consumer-friendly health insurance market. My colleagues at The Heritage Foundation, along with nationally prominent economists, have been highly critical of these arrangements for more than three decades.

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It's well past time that we start thinking about health care financing and delivery in an even broader way. It's not simply getting the best value for money that we have to think about now, we also have to think about value in a much broader sense. What do we value most in life, and what do we value at the end of life? Do the health care institutions, the big insurance companies, the government health programs, the hospital systems, respect and accommodate your ethical, or moral, or religious convictions at the end of life?

Expanding Personal Choice. Today, I offer a very simple principle: the principle of consumer choice. If a medical institution, a health plan, or a medical professional rejects your moral values in these sensitive areas, such as end-of-life care, you should have an absolute right to reject their values and their business.

You should have the right to enroll in health plans, and contract with doctors and other medical professionals who respect, promote, or will, at the very least, accommodate your ethical, or moral, or religious convictions in this sensitive area. In the context of broader health care reform, to achieve the goal of personal empowerment would require some very, very big changes in the organization of American health insurance markets. This would require changing the way in which the health insurance markets function, including a change in the federal tax treatment of health insurance, thus creating equity among consumers and a level playing field among different types of health plans and care delivery options.[4]

Before closing, in that same spirit, I suggest one other policy proposal. Today, we have consumer-based programs administered by the federal government: the Medicare Advantage program and the Federal Employee Health Benefits Program (FEHBP). Washington policymakers ought to encourage religious and faith-based organizations to sponsor health plans in these programs, just like unions and employee organizations today sponsor health insurance plans in the FEHBP. Such plans could offer a whole continuum of care delivery that positively affirms the fundamental values, ethics, and the moral and religious convictions of the people who choose to enroll in them.

There's a lot more to say, and our discussion can illuminate these issues even more. We have only skimmed the surface today. Thank you very much.

*—**Robert E. Moffit, PhD,** is Senior Fellow in Domestic Policy Studies, of the Institute for Family, Community, and Opportunity, at The Heritage Foundation.*

The transcript of this discussion has been edited for clarity.

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[4] Robert E. Moffit, Jennifer A. Marshall, and Grace V. Smith, "Patients' Freedom of Conscience: The Case for Values-Driven Health Plans," Heritage Foundation *Backgrounder* No. 1933, May 12, 2006, https://www.heritage.org/health-care-reform/report/patients-freedom-conscience-the-case-values-driven-healthplans.