8-2002

John Dewey's concept of the good : a macro- and meso-application to the U.S. health system

Barbara Joan Russell
University of Tennessee

Recommended Citation

Russell, Barbara Joan, "John Dewey's concept of the good : a macro- and meso-application to the U.S. health system. " PhD diss., University of Tennessee, 2002.
https://trace.tennessee.edu/utk_graddiss/6299

To the Graduate Council:

I am submitting herewith a dissertation written by Barbara Joan Russell entitled "John Dewey's concept of the good : a macro- and meso-application to the U.S. health system." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Philosophy.

Glenn C. Graber, Major Professor

We have read this dissertation and recommend its acceptance:

John Hardwig, Charles B. Hamilton, Betsy Postow, Jonathan Kaplan

Accepted for the Council:

Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

To the Graduate Council:

I am submitting herewith a dissertation written by Barbara Joan Russell entitled "John Dewey's Concept of the Good: A Macro- and Meso-Application to the U.S. Health System." I have examined the final paper copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in philosophy.

Glenn C. Graber, Major Professor

We have read this dissertation
and recommend its acceptance:

John Hardwig
John Hardwig, Ph.D.

Charles Hamilton
Charles B. Hamilton, Dr.P.H.

Betsy Postow
Betsy Postow, Ph.D.

Jonathan Kaplan, Ph.D.

Accepted for the Council:

Vice Provost and Dean of
Graduate Studies

JOHN DEWEY'S CONCEPT OF THE GOOD:

A Macro- and Meso-Application to the U.S. Health System

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Barbara Joan Russell
August 2002

DEDICATION

This dissertation is dedicated to my parents

Hubert W. Russell

and

Mary (“Bette”) E. Russell

with much love and deep gratitude

for encouraging me to love learning, be resourceful, and try hard

ABSTRACT

This work stems from the debate about ethically reforming America's health system in response to the enduring scarcity of resources. There are at least three essential components to successfully instituting needed changes: a philosophically-defensible guideline, effectively-designed programs or legislation, and political willpower. This dissertation represents the first component.

Two distributive justice decisions are central to this dissertation. One decision is how to apportion resources among competing governmental programs such as Social Security, education, agriculture, and transportation. This is known as the macro-level. The other decision is how to apportion health-care resources to competing ailment or disease categories such as cancer, eye care, cystic fibrosis, and burns. This is known as the meso-level.

An ethical criterion or standard is needed with which to make such important decisions. Some proposals choose a consequentialist criterion in terms of the benefits resulting from health while others use a Kantian-like criterion of right action. Still other proposals focus on the notion of a good human life. The criterion selected for this dissertation comes from the philosophical work of John Dewey, an influential American philosopher in the first half of the 1900s. This criterion precedes the aforementioned criteria: it is the concept of the good itself.

Several philosophers have developed comprehensive theories about the good. I considered the theories of Plato, Kant, and Iris Murdoch as well as that of Dewey.

Dewey's theory is used herein because it has the greatest potential for engaging or examining the practical case of health-care reform. In other words, the theories of the other three philosophers are less able to evaluate and critique how societal goods and medical treatments are and are not good.

Dewey's concept of the good is applied to the practical macro-level programs of health care, national defense, education, and the arts in order to determine their relative goodness. Dewey's concept is also applied to the practical meso-level programs of prenatal care, kidney dialysis, and assisted reproductive technologies so as to determine their comparative goodness. The outcome of these comparisons is then examined in terms of the impact on distributive decision-making at a public policy level.

TABLE OF CONTENTS

CHAPTER PAGE

I. FIXING THE U.S. HEALTH SYSTEM: THE SEARCH FOR AN ETHICALLY DEFENSIBLE SOLUTION

II. COMPLEXITIES IN THE U.S. HEALTH SYSTEM: WHY THERE IS NO EASY SOLUTION

III. DEWEY'S THEORY OF THE GOOD

IV. DEWEY'S THEORY OF THE GOOD, HEALTH, AND HEALTH CARE

TABLE OF CONTENTS continued

CHAPTER PAGE

V. DEWEY'S THEORY IN MACRO-ALLOCATION AND MESO-ALLOCATION DECISIONS

LIST OF TABLES

LIST OF TABLES continued

TABLE PAGE

CHAPTER I

Fixing the U.S. Health System: the search for an ethically defensible solution

Introduction

In the first two years of President Bill Clinton's first term, the focus was to substantively revamp the country's health-care system. Elected representatives in the Senate and in Congress agreed, by and large, that the existing system continued to be costly, inefficient, and unfair. Likewise, hospital administrators and medical practitioners were frustrated in having to bear excessive economic risks for adequately treating ill or dying Americans who were indigent. Politicians, hospital administrators, and medical professionals formed a unified public voice calling for major changes. The proposed *Health Security Act* (1994) emphasized inclusion, choice, and competition: all Americans were to have some kind of comprehensive insurance coverage (including those who were unemployed and those with high-cost chronic conditions such as HIV/AIDS), available governmental health plans were to be differently structured, and an open marketplace for health plans was encouraged so as to maintain lower costs yet high quality.

Unfortunately this groundswell of support gradually evaporated as the work of various committees became swathed in secrecy and as the proposed legislation promised to make the system even more unwieldy. The proposed legislation did not survive political debate and thus was never voted on in either chamber.

Since the early 1990s, the need to control health-care expenditures has been led primarily by insurance and management companies, acting under the doctrine of managed care. The term "managed care" means:

> Any plan that finances and delivers health care through an organized network of providers. A broad term used to describe organizations that combine the financing and delivery of health care services to control costs and utilization (www.cff.org/publications04.htm), or

> A relatively new term coined originally to refer to the prepaid health care sector (e.g., HMOs[1]) where care is provided under a fixed budget and costs are therein capable of being "managed". Increasingly, the term is being used by many analysts to include PPOs[2] and even forms of indemnity insurance coverage that incorporate preadmission certification and other utilization controls (www.amso.com/terms.html).

This system is very different to the fee-for-service system of American medicine that was in place until the late 1980s. Under the fee-for-service system, what was provided to each individual patient was determined solely by the physician in terms of what she thought was medically best for her patient. Insurers reimbursed all reasonable

---

1. "HMO" means a health maintenance organization. It is typically a company offering health insurance and medical care at a set price to those people it covers. There are different kinds of HMOs: (1) a staff model wherein the HMO owns clinics and employs physicians, (2) a group model wherein the HMO contracts with different physicians and clinics to provide services, (3) an independent provider association model wherein the HMO contracts with such an association which, in turn, contracts with physicians, (4) a direct contract model wherein the HMO contracts directly with physicians, and (5) a mixed model made up of all of the above (www.amso.com/terms.html).
2. "PPO" means a preferred provider organization. It is a "system in which a payer [e.g., an insurance company] negotiates lower prices with certain doctors and hospitals. Patients who go to a preferred provider get a higher benefit—for example, 90 percent or 100 percent coverage of their costs—than patients who go outside the network" (Ibid).

costs without much question. Accordingly, decisions about what constituted good medical care were separate from decisions about whether the predicted benefits justified the costs and about who should be responsible for such costs.

With a managed care system, there are two parties involved in deciding what therapy is prescribed: the doctor who diagnoses and prescribes treatment and the insurance company that pays for such treatment. Reflective of its name, managed care incorporates an economic or business perspective in controlling (i.e., managing) a patient's treatment (i.e., care). Just as there are diagnostic risks and recuperative risks in medicine, there are economic risks. Economic risk arises in terms of the uncertainty of what effectively treating or responding to a disease or injury will ultimately cost. Is prescribing drug *A* at $*X* per month going to be more cost effective than, for instance, physiotherapy for *Y* months? Because each patient's condition, response, and adherence to treatment is individual, there is no certainty at the individual patient level as to what will be the total costs of treatment or assistance. As a result, the associated economic risks are shared among physicians through reimbursement incentives and discentives,[3] patients through deductibles and co-payments,[4] and insurance companies.

---

[3] An example of a financial incentive would be reimbursing a physician an added $50.00 if he prescribes a generic drug over a branded drug, given that the former is typically much less expensive than the latter. An example of a disincentive would be deducting $50.00 from his reimbursement payment because he referred a patient immediately onto a specialist instead of first trying to treat the patient himself. The disincentive is thus a type of penalty to the physician for making a decision that resulted in the insurance company incurring higher costs.

[4] Co-payments and deductibles are stipulated by health insurance companies. An example of a co-payment is that an enrollee must pay $10.00 to his physician for each and every visit. An example of a deductible is that an enrollee must pay the first $250.00 of costs incurred (which may be incurred over several visits) for the treatment of a medical condition.

Under the fee-for-service system, the financial risks were born by insurers only. Physicians were able to prescribed one medication or treatment modality and then change to another without personally bearing any of the economic costs of their medical decisions. Similarly, if a medically-sound treatment could be either an antibiotic pill or bed rest, when a physician opted for the former, she incurred no financial impact from her decision for the more expensive treatment. The situation was the same for patients in terms of bearing no or virtually no economic costs of treatment when under the fee-for-service system. Thus only the insurance companies or self-insured employers bore the financial consequences of a patient's health and adherence to a treatment regime and of a physician's treatment choices.

But now therapies and interventions available to enrollees in a particular insurance plan are restricted based on the financial resources of the total pooled group. There is subsequently an inherent balancing act in terms of what each member of the group actually receives: if treating *A* uses 60 % of the annual pooled funds, then *B* and *C* have only 40% of the total funds available for their health needs.

Yet managed care has not addressed all the problems. The initial reduction in the annual rate of expenditures has not lasted. Once again health-care costs exceed inflationary and population growth rates. There is significant earnings instability in the industry in that companies can post large profits one year and large losses the next. And the power of managed care organizations is seen by many people as excessive relative to the power of physicians and patients.

In light of these problems, several solutions come readily to mind. One solution might be to shift from a mixed system of public and private funding and go to a private system wherein all decisions are left to the marketplace populated by "buyers" (i.e., patients) and "sellers" (i.e., individual physicians or physician groups). Another solution to control costs could be to restrict expensive new technologies unless they deliver proportionally greater health benefits than less expensive, existing technologies. And a final suggestion might be to let the American public, rather than corporations, decide which interventions and therapies will and will not be made publicly available to whoever needs them.

Regrettably none of these three responses stands out as obviously superior to the other three. In response to the suggestion to shift all services to the demands and opportunities of a capitalistic marketplace, defensible standards for distributing health care are not limited to efficiency and control. Relevant ethical standards include decisions as to who is or is not responsible for whom in American society. Furthermore just because someone is willing to buy *X* at $*Y* does not mean that someone else is willing to make *X* or sell *X* at $*Y*. And vice versa. Accordingly, an open marketplace does not guarantee that every demand is met. When this is applied to the case of health care, it means that if there are inadequate profits in developing a treatment for a medical condition, no company is likely to bother with the necessary R & D or the necessary manufacturing and distribution costs. Thus there may be groups of patients whose needs remain unmet solely for economic reasons, a situation often labeled as "market failure."

With respect to the suggestion of increasing the "benefit threshold" of expensive new technologies, a new technology's benefits, burdens, and risks are learned over time. Thus medical progress is typically incremental and uncertain thereby frustrating definitive and timely cost-benefit analysis. And finally public consensus on the priority of different health interventions may be very hard to obtain. It can be very difficult to compare different interventions such as effective pain management versus preserved motor skills versus restored cognitive functioning. Further, people can have highly disparate views as to what counts as medically essential versus non-essential and medically urgent versus non-urgent. The elusiveness of consensus is based largely on the fact that medical interventions are often not simply about restoring biological processes that are objectively valued. Instead many interventions affect aspects of life that are idiosyncratically valued such as radical mastectomy for breast cancer, prescription drugs with very serious side effects, and placing a patient on a ventilator who may never be successfully weaned from it.

The debate over health-care reform has not just been focused on improving the system's efficiency or size. It has primarily been focused on the unjustifiable inequities or lack of fairness of the system. Access to medical care and procedures is determined largely by a person's ability to pay for such care or ability to be gainfully employed by an employer large enough to provide health insurance for its employees. At present, forty-three million Americans lack any or adequate health care insurance (*Statistical Abstracts of the United States 2001*). People who are wealthy have access to convenient and the latest health-care procedures while people of lower economic groups do not. But as illustrated by the three suggestions to revamp the system, easy programmatic or structural answers are not viable.

This dissertation's goal is to present and defend a viable answer. With this said, however, it is imperative to acknowledge that there are at least three components to actual change to the nation's health system. The first component is identifying a defensible guideline or means of prioritization with which to make allocation decisions among competing goods at the macro-level of society and among competing goods at the meso-level of health care. This dissertation focuses on this component only. In addition to a justifiable guideline, sound program and legislative policies must be instituted in terms of how the system will actually work and how responsibilities will be divided. And then willpower on the part of the politicians and the public is needed so as to ensure that the necessary legislation is successfully passed and the necessary agencies set up and funded. And so this dissertation represents the first step in a renewed effort to improve the U.S. health system so that is more ethically defensible.

The numbers: serious and urgent

In most discussions about health-care reform, some statistic is invariably employed to illustrate the troubled and troubling state of the American system. The numbers help confirm that the status quo is unacceptable. Statistics can identify telling symptoms of the immense structural problems in the American health-care system, problems both moral and mechanical. By "mechanical," I mean problems that are process-related or programmatic, such as inefficiencies and redundancies. In deciding which statistics of the seemingly infinite choices available to present in this dissertation, I focused on statistics about health care at a societal level, rather than at the level of the individual patient, practitioner, or institution.

Since the passage of Medicare and Medicaid legislation in 1965, the country's total health expenditures increased from $42 billion to $1,424 billion in 2001, an increase of 3,291% over thirty-six years (see Table 3[5]). Table 4 presents the annual rate of increase. Tables 5 and 6 present statistics on the country's population and its annualized rate of increase in a similar period. Table 7 shows the annual rate in increase in the consumer price index between 1965 and 1999. Comparing Tables 5, 6, and 7 with Table 3, a conclusion is that the increase in health-care expenditures cannot be fully explained by commensurate increases in the population (i.e., there are simply more people needing medical care) or in the costs of goods. In other words, relative to each person, more and more interventions and therapies are being prescribed and administered.

Arnold Relman, the former editor of the *New England Journal of Medicine*, employs a label to describe modern-day medicine which initially may seem misguided or mistaken: as a "medical-industrial complex" (1980, 963). However he is provocatively drawing our attention to the reality of medicine as big business. In the United States, health care constitutes one dollar out of every seven dollars spent in the nation's one trillion dollar domestic economy in 1997. Table 8 lists other major industries to confirm

---

[5] All tables cited in this chapter can be found in the Appendix.

the centrality of health care to our economy. Relman's challenge, I believe, is that it is naïve to continue to rely on the traditions of Hippocrates and Florence Nightingale as adequate guides for research and treatment. Beneficence is not a cornerstone of successful businesses in America. Private business, even if ethically driven, can contradict or frustrate these ethical traditions of health care.

Can the increase in total health expenditures be explained by a comparable increase in the American population? No, because the country's population itself has only increased 41.7% over approximately the same thirty-six year period. If the 1965 level of expenditures is multiplied each year by the annual consumer price index rate and the annual increase in the population, the 1965 expenditures of $ 42 billion would be roughly $ 450 billion in 2000. Yet the expenditures in 2000 were $1.3 trillion. This indicates that the amount of expenditures almost tripled over and above rising costs and a growing population base.

When compared to all the domestic economic activities from 1965 to 2001, (that is, the gross domestic product or GDP), health services and products have grown from 5.8% of the national economy to 14.3%. Projections suggest that at its present rate of growth and expected demographic changes, health care could represent 22% of the GDP by 2010, 26.5% by 2020, and 31.4% by 2030. That is, by 2030, almost one dollar of every three dollars spent within the U.S. will be health-related (see Tables 9 and 10).

The federal government's yearly budget has shown a comparable shift towards a greater and greater proportion directed towards health and away from other national priorities. In 1970, 6.2% of the budget was health-related; in 2001, the percentage was 20.5%. In comparison, education constituted 4.4% in 1970 and 3.4% in 2001; defense 41.8% in 1970 and 15.5% in 2001, and transportation-commerce-housing 4.7% and 2.3% respectively. Even Social Security, the social program deemed the bedrock of the U.S. social mandate, has grown at a slower rate than health care: as 15.4% of the federal budget in 1970 but only 22.5% in 2001 (see Tables 11 and 12). Given the division of social responsibilities, state and local government budgets have witnessed a dramatic a shift in the proportion of their budgets allocated for health care (see Tables 13 and 14).

As health-care costs constitute an increasing proportion of America's economy, whether it is in the form of research or in purchases of services and products, the outcome of this public and private financial investment reveals another problem. Relying on basic mortality and morbidity statistics, America's expenditures are a larger percentage of its economy in comparison to other developed countries and yet the health outcomes are primarily worse (see Tables 15, 16, and 17).

Moreover all of the seven other countries listed in Table 17 provide universal health coverage to their citizens. In the United States, however, approximately forty-three million have no insurance, be it privately- or publicly-provided. But private insurance should not be considered an obvious panacea.[6] First, the percentage of

---

[6] While the priorities of profits and fidelity to shareholders are commonly questioned today in the case of managed care companies, the same concerns arise with indemnity insurance companies that have been the financial backbone of the non-governmental sector of the health-care system up until the mid-1980s.

employees joining their employer's subsidized insurance plan is decreasing somewhat due to the increased premiums or deductibles they must now incur (see Tables 18, 19, 20, and 21). Second, the 1995 SUPPORT study[7] found that almost one-third of the families, which had a seriously ill or dying member, lost their life savings or major source of income because of a family member's serious illness. Of this group, 96% had medical insurance (Covinsky et al 1994).

In sum, these statistics affirm that (a) as a business, health care has become a major industry and driver of the American economy, (b) as one of many governmental initiatives, its hunger for funds appears insatiable, (c) as part of a societal mandate, its benefits have not been shared equitably; and lastly, (d) the bias in favor of scientific and technological innovation and cures has not produced similar direct gains in basic health measures in comparison to other countries' efforts.

Possible answers: Engelhardt, Callahan, and Daniels

In the biomedical ethics literature, there has been a robust and extensive debate about changing the American health system to increase its fairness. Proposals developed by H. Tristram Engelhardt, Norman Daniels, and Daniel Callahan are especially noteworthy for two reasons. First, each proposal is based on a sustained philosophical critique of the nature of both medicine and society. In other words, their

---

[7] The SUPPORT study was a landmark, five-year study of the medical care of patients at the end-of-life, meaning those who had six months or less of life left [see the SUPPORT Principal Investigators report, *JAMA* 274, no. 20 (1995): 1591-8.]

recommendations are not merely about adding or ending programs or agencies, but rather are about core commitments. The revisions proposed by Engelhardt are very different from those by Daniels and Callahan. This is the second reason to examine their recommendations: such disparity encourages a more rigorous debate. Accordingly, each theorist's recommendations for increasing the ethical basis of the U.S. health system will be analyzed and critiqued herein. Following this examination will be a discussion of the philosophical work that remains which, in turn, constitutes the overarching thesis of this dissertation.

In his widely read book, *The Foundations of Bioethics* (1986), H. Tristram Engelhardt frames justice around notions of freedom and possessions: "justice is first and foremost giving to each the right to be respected as a free individual in the disposition of personal services and private goods" (Engelhardt 1986, 354). In terms of the most defensible structure of America's health system, he supports having two levels of care. One level would provide basic care for all citizens; the other level would allow people to use their discretionary income to purchase more or better care if they so wished. Ethical justification for this dual system comes from the fact that:

> Not all property is privately owned. Nations and other social organizations may invest their common resources in insuring their members against losses

> in the natural and social lotteries.[8] On the other hand,…not all property is communal. There are private entitlements, which individuals may freely exchange for the services of others (Engelhardt 1986, 361).

In other words, any resulting inequality of care is defensible given its moral and factual inevitability. To appeal to "moral inevitability," Engelhardt holds that the ethical principles of beneficence and autonomy are foundational to health care. As a result, it is desirable to design a system that combines cooperation with privacy. And by "factual inevitability," he means that most developed countries already have a dual system which implies that no sweeping changes are needed. In other words, his recommendation is not so radical that it is unlikely to be adopted.

Yet in an article published over ten years after *The Foundations*, Engelhardt moves toward a much more libertarian stance. In "Freedom and Moral Diversity: The Moral Failures of Health Care in the Welfare State" (1997), he argues forcefully against governmental provision of any health care plan:

> Postmodernity as an epistemological predicament, not merely as a sociological fact, is the recognition that, outside of a revelation of a canonical standard, one cannot authoritatively choose among content-full understandings of moral probity, justice, or fairness without begging the question or engaging in an infinite regress (648).

---

[8] The natural lottery involves every human being in that each of us is subject to a specific genotype and phenotype. For instance, some people will have the genetic code to be tall and blonde (i.e., the Western stereotype for beauty), others will have the genetic code for a serious disease, and still others will innately be athletic. The social lottery also involves every human being in that each of us is born into a particular type of family, economic class, race, religious affiliation or lack thereof, and so on. In the case of both types of lottery, there is no personal responsibility (i.e., praise or blame); the associated outcomes are due to good or bad luck. The ethical implication is that people should be helped who have incurred the bad luck of a disadvantageous genotype or phenotype.

In a democracy, morality is secular, he says, which in turn "is procedural, and its legitimacy is limited by the consent of those who participate in common endeavors" (Engelhardt 1997, 649). Therefore any health policy is valid only if those it affects agree to it. As a consequence, the American health system must reflect and facilitate the wide diversity of opinions as to what constitutes a good life. America is highly pluralistic in terms of having "numerous competing moral accounts or narratives" (Ibid, 648). Moreover individual freedom and autonomy are of fundamental importance in this country. Thus the system should be made up of various health plans that reflect different moral commitments. Individuals then can chose which plan most closely mirrors their values regarding health, life, and death.

Engelhardt allows only three roles for government. One is to provide vouchers to those who are economically disadvantaged. These people can then decide autonomously whether to use the monies for health care and if so, select which plan meets their personal risk profile and health priorities best. Providing vouchers is optional, says Engelhardt, depending on whether a government sees itself as responsible for financially helping those in low economic groups. The next two roles are not optional, but are mandatory for a government of a democratic and capitalistic society. These two roles are to ensure that citizens have accurate and full information for good decision making and to ensure that the market does not restrict productivity, creativity, or quality of services and products.

This position is seriously troubling on four counts. First, Engelhardt prioritizes freedom too heavily. Imagine that a group of insurance companies decides to focus exclusively on enrollees who are nonsmokers, not overweight, and below age 50. If no other company is willing to cover those who do smoke or who are obese, these citizens will be responsible for all their medical bills. As mentioned earlier, relying on a capitalistic marketplace can result in market failure in that there can be unmet health needs. Privileging freedom is reminiscent of Darwinism: only the strong, whether strength is in the form of numbers, wealth, or power, will prevail.

As a way to counter paternalism by physicians, individual autonomy is desirable for three basic reasons. I am most likely to know my own goals and priorities better than anyone else. I am self-actualizing in terms of control of and responsibility for myself and my life. And I deserver a zone of privacy as to what my life is about.

Yet Leonard Fleck, an insightful philosopher of bioethics at Michigan State University, offers a practical cautionary note about autonomy by questioning how really robust is the autonomy of the poor, the dying, or the chronically ill. Engelhardt would ensure that their lives are not interfered with by others. But a more accurate way to understand what is happening is that "they are being ignored, left alone to cope with their own miserable conditions" (Fleck 1989a, 179). As such, autonomy seems like a concept that should not be defended vigorously. Autonomy is valuable only if a person has interests, goals, and resources. For instance, her autonomy is of immense value if she can choose to use her vacation time for foreign travel or for remodeling her home.

But it is bereft of value if she finds life boring, is physically unable to travel, or lacks the money to remodel. Freedom is not only an end in itself, it is also a means.

Engelhardt's conception of a person is also worrisome. In the mode of Kant, he holds that "it is because members of *Homo sapiens* are usually self-conscious, rational, and possess a moral sense that being a human is so significant" (1986, 107). He continues that not every human being qualifies as a person; for instance, infants, those who are mentally impaired, or those who are comatose. This excluded group of beings, however, does warrant some level of consideration because they are social beings. A social being is a being that has some relationship with a person. As a result, cruel treatment of someone with severe Alzheimer's disease is discouraged because such behavior may become habituated in the person and then it is more likely that those who are legitimately persons could be treated badly. For Engelhardt, disease and injury are to be remedied because they ultimately interfere with personhood.

Yet there is much more to worry about than reduced cognitive skills or self-consciousness. There are the psychological, emotional, and relational aspects of a person. Moreover ethically weighty concepts such as compassion, witnessing,[9] mercy, and patience are outside Engelhardt's viewpoint. Just as these ethical qualities are not central for him, Sharpe notes that "forms of neglect (which we ordinarily understand as *blameworthy* non-interference) will invite no moral censure" (1992, 306).

---

9. Witnessing is the opposite of abandonment. It is standing by another person who is in pain or dying and directly facing the reality of the situation as it is. A witness realizes that there is nothing to be fixed and no happy ending to pursue. To witness requires the virtues of attentiveness, honesty, patience, and courage (Frank 1991).

A fourth shortcoming in Engelhardt's position involves his libertarian emphasis on possessions or ownership. His suggestion that it is up to individuals to negotiate how to value and exchange services and products presumes medical services and products are privately held or owned. Yet a significant portion of medical training and remedies is the outcome of publicly-supported endeavors. Most medical and nursing schools are funded by public taxes. So too for the research and development of most treatment modalities, be they a new drug, a new suturing technique, or a new rehabilitation technique. Because this knowledge, skills, and interventions are public goods, distributive justice is imperative. As Fleck points out, "The good that physicians would hope to do for any one patient is legitimately constrained by the medical good that they *must* provide to other patients" (1989a, 177; italics added).

Therefore there is a legitimate role for government to monitor how the benefits (e.g., remedy, rehabilitation, and rescue) and burdens (e.g., taxation and participation in research studies) of medical care are distributed in American society. As Callahan notes, "The paradox of health is that it is both acutely personal and consumptively public" (1990, 103). "Consumptively public" means that consumption or use of services and treatments relies on a collective effort to research, manufacture or develop, and provide such services and treatments. Because of the extraordinarily large costs involved, contemporary health care must be a societal or communal enterprise.

In summary, Engelhardt's proposal to leave the provision of and access to medical care to the open marketplace and individual choice is ethically unsupportable. I now turn to the recommendations of another philosopher in biomedical ethics, Daniel Callahan. Callahan offers one of the most definitive or concrete ways to ethically revamp the U.S. health system. His position is developed across three books, *Setting Limits: Medical Goals in an Aging Society* (1987), *What Kind of Life: The Limits of Medical Progress* (1990), and *The Troubled Dream of Life: In Search of a Peaceful Death* (2000), each of which explores the role of medicine in our lives as well as the purposes of human life itself.

An important starting point is Callahan's claim that the most significant social effect of medical progress is "the way it reshapes our notion of what it is to live a life" (1990, 25). We now expect, he contends, to live longer and healthier, an expectation that includes the years of old age. Callahan judges such an expectation to be unrealistic and unsupportable in light of the financial limitations of the health system. He argues that a societal goal should be to help as many Americans as possible achieve a natural life span:

> A "natural life span" may then be defined as one in which life's possibilities have on the whole been achieved and after which death may be understood as a sad, but nonetheless relatively acceptable event (Callahan 1987, 66).

The kinds of possibilities that he countenances are having a family, travel, work, education, and aesthetic enjoyments.

From this position, he rejects provision of medical treatments to extend life beyond sixty-five or seventy years of age. In other words, publicly-financed research and insurance programs should investigate and provide life-extending modalities only for those below age sixty-five. Chemotherapy would thus not be offered to give an eighty-two year old woman with bone cancer another year of life. This does not mean, however, that Callahan is opposed to all medical treatment for the elderly. He would support provision of care that maintains the eighty-two year old woman's quality of life. Powerful analgesics would therefore be available as would nursing home care.

Callahan dismisses the popular image of the elderly pursuing lives of independent leisure; that is, the stereotypic images of playing golf and bridge, taking Caribbean cruises, and spending most of their time with friends. He sees such activities as being self-centered and hedonistic, and therefore ethically unimportant for public policy in terms of what medicine should and should not offer. So the justification for providing medical support aimed at quality of life stems from the special societal role Callahan does ascribe to the elderly: serving the young. To discharge their responsibilities of teaching, nurturing, and assisting the young, elderly people must not be in pain, cognitively disoriented, or communicatively impaired.

I have two major concerns with Callahan's proposal. First, Jecker (1989) points out that it is one thing to deem a person's death as not bad and quite another thing to say that person has no right to medical care. What Jecker is contrasting here are beneficence and rights, two very different ethical concepts. Callahan erroneously conflates rights with consequences, she notes. He asserts that if the death of a person is not bad, then that person has no right to certain kinds of medical care. In other words, only if a person's death is deemed bad, perhaps because there are young children involved, then the person can legitimately exert his right to medical treatment. Yet why should the badness or goodness of death affect whether a person has or does not have a right? For instance, the fact that an elderly person's death may be expected and regrettable (and therefore not bad) does not impact such basic rights as voting or free speech.

A second challenge against Callahan involves unacceptable discrimination. At the outset, discrimination means to carefully observe and differentiate between objects, events, or people. This then is about perception, comparison, and judgment and so is neither ethical nor unethical. Discrimination becomes unethical when the selected qualities are not applied consistently or are inaccurate or irrelevant and yet used for important decisions. Requiring a specific level of eyesight for airplane pilots is not unethically discriminatory because it is necessary for reading the plane's controls. But requiring a person to be able-bodied for a theatre ticket-taker job is unethical because walking is not necessary to competently perform the associated duties.

In the case of Callahan's denial of effective and standard medical treatments to those over sixty-five years of age, he ignores other groups of people and the kinds of treatments to which they should not have access. More strongly phrased, he seems to have targeted the elderly and placed the burden of "fixing" the U.S. health system at only their expense. This subsequently undermines his frequent appeal to community in that in a strong community, everyone shares and everyone sacrifices. His recommendation makes no demands of those who are not elderly.

Callahan could reply that his proposal is fair because at some point in time, everyone will become old and thus face age-based rationing. This reply does indeed mediate the apparent unfairness of his position. Yet a more fair system would be to apply his criteria of medicine assisting in the basic or universal goals or purposes of each stage of life and of medicine not assisting in idiosyncratic goals or purposes of each stage of life.

In conclusion, Callahan's recommendation to revamp the American health system is not adequately developed. He must apply the notion of what is the purpose of a particular stage of life to all stages of life before deciding the medical care that does and does not contribute to such purposes. Norman Daniels, the last philosopher in biomedical ethics to be engaged in this chapter, focuses on the human species in general as did Callahan.

In *Just Health Care* (1985), Daniels rejects need being the chosen criterion with which to decide what medical treatments are or are not offered to Americans. Need *per se* is too ambiguous and too elastic to establish firm constraints on expenditures. Delineating what a person needs can be an exercise that is far too subjective to be the basis of public policy design. Yet Daniels does not dismiss all types of need: "the needs which interest us are necessary to achieve or maintain species-typical functioning" (1985, 26). Species-typical functions are deemed objectively valuable in that "we need them whatever else we need" (Ibid, 27). Thus there is a level of equality in desirability here that helps to ethically ground his position.

Added ethical justification comes from the direct connection made between species functioning and opportunity, the latter clearly resonating with basic ethical principles in the United States. A person must be able to perform certain functions, such as communicating, thinking, walking, and seeing to be able to take advantage of possibilities presented to him. Daniels does, however, place a limit on opportunities. He suggests that publicly-funded health care is defensible only if it preserves or restores typical species functioning necessary for a normal range of opportunities for a given society. Such a range involves the types of life plans and goals that reasonable citizens have in the society.

While he embraces equality in the case of functions, he does not prescribe a kind of radicalized equality; that is, trying to make all people equal in all aspects. Instead Daniels demands that there be equality of opportunity for those who share similar abilities and skills. The opportunity range will then be markedly different for those who are artistically talented compared to the range of those who are of average intelligence and drive. In addition to not asking for radical equality, he does not demand equal successes, but only that equal ranges of opportunities are available to people.

There are three problems with Daniels' proposal to revamp the American health system. First, he focuses too exclusively on physiological functions and far too little on the tragedy of pain, suffering, and death (Stern 1983). Humans are not simply about action and achievements. As Stern notes, "To say that what is unjust about letting someone die for lack of health care is that it deprives him of opportunity is like saying that what is really wrong with killing people is that you are depriving them of liberty" (Stern 1983, 348). Furthermore, the close connection of functions and opportunity means that many standard medical procedures would not be funded. Birth control would be a private matter because it is counter to species functioning. Yet having children and controlling one's reproductive capacities is deeply tied to personal identity, not just species functioning. And since dental care does not affect opportunity significantly, it would also become a private matter.

A second problem surrounds the notion of species typicality. Daniels offers an inadequate explanation as to what counts as being typical for *Homo sapiens*. Is it the actual capacities of humans, such as, say, fifty percent of all people are literate? Or is it to be based on what the norm can be if certain social changes occur, such as making books and teachers available to all and then deciding what is typical (Jecker 1989)?

I have a further concern with Daniels' position. This concern involves the contextualizing of the range of opportunity, namely "for a given society." Societies can be very unjust as to what some groups of people are permitted to do and strive for versus what other groups are permitted to do and strive for. A classic example is the United States two hundred years ago when slavery existed. A more contemporary example is the mid-1900s, prior to the women's liberation movement, when women were restricted to the home and a handful of careers (e.g. nursing and teaching). It is very troubling to restrict health care to specific social structures. The result may be that health care helps reinforce social imbalances and the oppression of certain citizens.

The work by Engelhardt, Callahan, and Daniels of ways to revamp the U.S. health system is provocative and weighty and has generated further debate about an exceedingly important issue. Yet all three proposals have substantial shortcomings that need to be addressed.

This dissertation's structure: what and why

The issue remains of how to restructure the U.S. system so that it is a fairer system. For the purposes of this dissertation, fairness is defined as an ethically defensible distribution of benefits and burdens among those involved or affected. One possible way to address this issue would be to take the work of Engelhardt, Callahan, or Daniels and modify it so as to alleviate the problems discussed above. While such work could be worthwhile, this dissertation tackles health-care reform in a different way. John Dewey's work in ethical theory constitutes the theoretical analysis of this dissertation, followed by a practical analysis wherein his theory is applied to macro-level and meso-level health-care decisions. But prior to launching into Dewey's theory, an explanation is first needed as to why this dissertation's strategy is a justified approach for developing a viable candidate for health-care reform.

Engelhardt holds that being able to do what one chooses with minimal governmental interference represents a good life. Callahan contends that a life of family, work, travel, and so on—the common parameters of a reasonable life—are what most humans should be assisted in accomplishing. And Daniels holds that having many opportunities to consider and possibly pursue is a good life. In each case, the underlying ethical question is "What is a good life for a human being?" Other answers are possible: for example, a life of spiritual or religious fulfillment or a life of happiness. From these alternative answers, analysis could ensue as to how health care can facilitate achieving such a good life.

In this dissertation, however, I want to begin with a meta-ethical question, namely "What is it for something to be good?" This question logically precedes the question "What is a good human life?" My interest in the concept of the good and its relevance to health-care was prompted by the work of Michael Walzer in *Spheres of Justice: A Defense of Pluralism and Equality* (1983). If something is valueless, then how it is distributed does not matter. But if something has a public value, then how, when, and to whom it is distributes matters. To have a public value is to be good, says Walzer. The point about public value versus private value can be illustrated as follows. Imagine that there is a large boulder on a riverbank, the result of geological and climatic forces. The boulder might be used for sitting by a passing hiker or for a lookout point by a small bird. Since the distribution of the boulder is not questioned here—and thus involves no public or communal relationships—it falls outside Walzer's concern about justice. Certainly the boulder has a value for the hiker, but it is a private value, not a public one. But if at some time the river area is to be purchased from the state, then the boulder acquires a public value because it is possible for the new owner to prevent others from making the boulder available to hikers.

The notion of public value comes from Walzer's intriguing characterization of distributive justice:

> The idea of distributive justice has as much to do with *being and doing* as with having, as much to do with production as with consumption, as much to do with *identity and status* as with land, capital, or personal possessions (1983, 3; italics added).

In other words, how things are distributed in a society says something significant about the citizens themselves in their inter-relationships with others. Walzer does not restrict his analysis to that which we readily think of as being distributed, namely consumer items such as computer, clothes, and cars. Instead he examines various "things" that humans carefully and often ritualistically distribute, such as love, divine grace, dangerous or arduous work, and public honor.

He argues persuasively that in any society, if access, acquisition, and allocation of something that has value is to be ethical, its nature must be first be understood before deciding on distributive systems and mechanisms. A good's nature is neither a brute fact nor mere physical attributes, occurring independently of its social and historical context. Pivotal to Walzer's thesis is the trenchant claim that a good's nature manifests in its communally-bestowed meaning and significance. As such, different natures necessitate different systems and reliance on only one system for every kind of good is disfiguringly Procrustean. For instance, Walzer argues that the good of money is its ability to facilitate exchanges and transfers.

Yet certain things are not supposed to be readily exchanged and thus should not be monetarized. An example might be human sexuality or children; they are to be distributed in other ways that are appropriate to their nature. The notion of appropriateness leads to Walzer's imagery of spheres of justice wherein it is ethical not to "break" the defined boundaries of a sphere of interaction and distribution by using the wrong distributive mechanism. Given what sexuality means or represents to most people in America, exchanging it for money is the wrong, and therein immoral, mechanism. But given what sexuality means or represents in the Netherlands, where prostitution[10] is legal, a monetary exchange is morally permissible. On behalf of Walzer, I think prostitution is not considered "right" or morally permissible in the Netherlands because it is legal. Instead because giving someone sexual pleasure is, in essence, simply providing a service, just as banking or housecleaning are services which can be exchanged for a fair price. Sexuality thus is not tied to personal identity or committed relationships. Thus since sex work is service work, it receives similar employment protection under the law as does other service work.

Walzer's conception of what it is for something to be good vis-à-vis distributive justice connects to the case of health care. As noted earlier, contemporary health care requires collective effort and resources. The involvement of a community or a society

---

[10] This use of the word "prostitution" is not accurate. In the Netherlands, women who exchange sexual pleasure for money are known as sex workers, not prostitutes. The word "prostitute" is pejorative and condemning, denoting socially-disapproved behavior. Walzer would suggest that goods can have different meanings based on cultural norms. Thus sexuality in America means something different than sexuality in the Netherlands and thus different rules of exchange are warranted.

means that fairness is an ethical concern. And so the question of what is the nature of health-care's goodness follows. This then prompts a meta-ethical question of what is it for something to be good. To answer this question, John Dewey's theory of the good is examined. Dewey's theory is selected on the basis that it will be most useful in exploring the good of health care. Other theories of the good developed by Plato, Kant, and Iris Murdoch were not chosen because I judged them less amenable to examining the practical case of health care. The appeal of Dewey's theory is reinforced by his commitment to pragmatism wherein emphasis is placed on gradual progress, compromise among the parties involved, and responding to specific situations (as opposed to relying on theories or abstractions). Given the urgent need for health-care reform in the United States, pragmatism is a promising approach to actually causing incremental changes to occur and to continue to continue. Paul Starr, a well-known economist, has argued that the most likely way to realize change in America is through incrementalism; in other words, through "small" compromises that are part of ongoing process of change (1992).

A weakness in Walzer's thesis is the possibility of relativism. Imagine a country that is very financially impoverished. Consequently, its government decides to rely on individual choice and resources for the distribution of health-care services. If a citizen is wealthy, he can purchase as much health care as possible. But since the majority of citizens are very poor, most will rely on home remedies to combat illness or mend an injury. Predictably, the general health of the population will be very poor. However if health-care's value is completely relative, then there is no basis for criticizing this result.

Prohibition of criticism relates to the philosophical theory of ethical relativism. Ethical relativism posits that what is morally right and wrong depends on an individual's or a community's interests and values. In other words, since Jehovah Witnesses reject the use of blood products in medical care on the grounds that to do so is immoral, then such use for them *is* immoral. But the Catholic community has no such objection to blood products and so to use them in surgery on a Catholic person is morally acceptable. Therefore use of blood products is morally impermissible for Jehovah Witnesses and morally permissible for Catholics and there is no inconsistency or contradiction in such a conclusion, says the ethical relativist.

But if ethical relativism is correct, there is a worrisome consequence: I am precluded from criticizing the values of another nation just as citizens of another nation are precluded from criticizing my country's values, on the grounds that the source of rightness comes from the group itself. Yet don't many Westerners believe that they can legitimately criticize, say, Islamic strictures on Afghani or Saudi women? And don't many orthodox Muslims want to legitimately criticize the materialism of the West?

Yet relativism can be challenged by asserting that there are some values that anthropologists hold to be fundamental to all human life such as truth-telling and a proscription against violence within the community (Palmer 2002). And so it is acceptable to make the normative statement that in all communities, membership and safety should be publicly supported. This still allows that there may be activities that are not universal and so could be within the parameters of ethical relativism. The ensuing issue then is accurately identifying what aspects of humans are universally important and what aspects are contextually or historically important.

Distributive justice involves two levels of society. There is first the question of what proportion of public resources should be allocated to competing societal projects, one of which is the physical and mental well-being of the populace. There is the subsequent question of what proportion of health-care resources should be allocated among competing patient groups, such as those with cancer, chronic asthma, and seriously impaired newborns. In work of Engelhardt, Callahan, and Daniels referred to above, they tackle the issue about allocations to particular patient groups, a meso-allocation issue. Yet in another chapter of Daniels' book, *Just Health Care* (1985), he asks: is health care special? By "special," he is wondering about health-care's worth relative to other social programs, a macro-allocation question. The consequence he would like to draw is that if it is, say, the most special, then it should garner the largest proportion of societal resources, be they financial, effort, time, and allegiance. Daniels does not answer this question in *Just Health Care*; presumably, posing the question was all that he wanted to do in the book.

Yet it is a critical question and one that will be directly taken up in this dissertation by comparing health care as a Deweyan good to three other societal endeavors: national defense, education, and the arts. Certainly there are other societal endeavors that are deemed good: income protection, voting, highways, Social Security, and environmental safety to name but a few. Yet national defense, education, and the arts are chosen because there are published financial statistics of the tax dollars they consume and, even more importantly, there have been and will likely continue to be recurring political debates as to whether they do or do not receive appropriate funding. Thus they are chosen because of timeliness.

Pursuant to this macro-level application of Dewey's theory, there will be a meso-level application. The three kinds of health-care intervention to be scrutinized are the treatment for end-stage renal disease (ESRD) is compared to prenatal care and to reproductive technologies. These three are selected because they represent very different kinds of intervention. Dialysis for ESRD is emblematic of intensive, technologically-rich medical care. Moreover ESRD is specifically included under Medicare for federal reimbursement. Prenatal care is emblematic of long-term, preventive care or public health care. And reproductive technologies demonstrate the creativity of medicine in control and manipulate what are often thought of as natural processes.

In conclusion, the American health system should be changed so as to increase its fairness. The status quo cannot be tolerated because health-care expenditures continue to rise at unacceptable rates and, in turn, threaten other valued social programs. To tackle this problem, the philosophical work of John Dewey is used to help us think of health and health care in a new way. Based on this theoretical work, the insights gained will be applied to macro-allocation and meso-allocation decisions. This application is valuable for two reasons. First, methodologies for comparing competing social goods have not yet been formulated by biomedical ethics theorists. Second, examination of how different rationing criteria would impact funding of different medical interventions has been absent in the literature as well. This dissertation's objective is to identify and defend an ethically-defensible criterion for decision making and then apply it to the kinds of distributive decisions that typify health care today.

CHAPTER II

Complexities in the U.S. Health System: why there is no easy solution

Introduction

Prior to delving into the writings of John Dewey, there are four issues I explore in this chapter: the nature and role of money in health care, the nature of rationing, replacement of the American system with that of another country, and the state of medicine today. Assuredly there are many other issues that illuminate and confirm that the health system is highly complex. But the aforementioned four are of particular interest here because from my reading on the subject of health-care reform, either they have not been discussed at all or I have new points to contribute to the debate.

Money emerges from the background

Historically the locus of attention and effort within medicine was the special dyadic relationship between a patient and his physician. The patient evinced suffering, mortality, and vulnerability while the physician represented expertise, remedy or rescue, and duty. Each of these features was seen as ethically weighty and complex. And so it made sense that the medical and philosophical communities scrutinized this relationship thoughtfully and critically. A physician was believed to have deep and binding responsibilities towards every patient. And a patient was believed to be able to trust his physician without limit.

However the primacy and insularity of the physician-patient relationship was tempered somewhat with the development of family practice medicine in the 1960s. No longer was a patient presumed to be akin to a free-floating Leibnizian monad in terms of being fully self-actualizing and self-motivating or as being unencumbered and detached. A patient came to be seen as closely tied to, and situated within, some familial[11] context. Accordingly the benefits and burdens of any medical intervention were recognized as not just impacting the patient in significant ways, but also as impacting the family unit and individual family members.

And no longer was the generalist physician presumed to be the sole professional responsible for patient care. Specialist physicians, nurses and other allied health professionals were acknowledged to be directly and substantively involved in patient treatment and rehabilitation. Thus the medical ethics literature since the 1960s has recognized that family members, specialists, and non-physician professionals are

---

11. Today "family" can be defined in multiple ways. The stereotype of the nuclear family (i.e., a married, heterosexual couple and their biological children) is now seen as out-dated and needlessly confining to the possibilities of supportive and committed relationships. In fact, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) defines family as "the person(s) who play a significant role in the patient's life, which may include a person(s) not legally related to the patient" (2001, 125).

important participants or stakeholders[12] in most medical encounters. In terms of "whose interest is at stake?" and "who should respond?" in any medical interaction, the aforementioned dyad was subsequently replaced by metaphors of a wheel or a web, illustrative of the multiplicity of interpersonal and inter-professional connections.

Since the end of the 1980s, the difficulties in balancing these competing interests and roles have been compounded by the monetary aspects of health care. The presence of money in health care is admittedly not new. But today, money's increased importance means that it is not simply one of many factors in an efficient health-care system. Instead money has emerged from the background to be now an overt determinant of *health* itself. Studies in the U.K. show that a person's economic class is one of the strongest correlates to personal health: the greater the income level, the better the health. Such strong and direct correlation was not found for such factors as education, age, gender, marital status, or geographic location (Lynch et al 2000; Marmot et al 1997; Arber 1996; Carr 1990).

Many politicians, employers, and individual Americans see major inadequacies, excesses, and injustices in the current system: too little, too much, not fair. The fact

---

[12] In the past ten years, various articles in the literature of business theory have challenged the traditional claim that a corporation's primary focus should be only its customers and/or its shareholders. The concept of a stakeholder reflects that a myriad of parties has vested interests or stakes in a company's decisions and operations. These parties can be as diverse as a governmental agency, a competitor, and a supplier. Accordingly this concept encourages discussions about the kinds of rights and duties that a company has vis-à-vis all of its stakeholders and about balancing such competing interests. Thus nurses are stakeholders in medical care because their involvement is legitimate and significant. They are owed certain recognition and treatment by physicians and patients. Thus "stakeholder" is an ethically richer concept than "participant" which admittedly conveys involvement, but no implication either of valued involvement or of duties owed by others.

that these worries are so widely shared across a highly pluralistic and heterogeneous populace attests, I believe, to their seriousness and magnitude. Moreover these problems have not simply appeared at the fringes of the system nor been restricted to only a few discrete areas. Instead they have come to permeate the entire health system.

Money and organization: multidimensional factors

It is informative, I think, to briefly examine how deep and how pervasive are these problems. Moreover such an examination helps explain why simply increasing the total amount of dollars flowing to health care would prove inadequate for addressing the monetary pressures and conflicts. I believe that only talking about "money" glosses over existing complexities of this side of health care. Consequently I first want to consider four kinds of monetary concern: (1) money itself, (2) business, (3) finance, and (4) economics, each of which, for my purposes, has a distinctly different meaning.

I define "money" as being the familiar medium of exchange, "business" as the typical demands and limitations of a capitalistic marketplace, "finance" as possible sources and uses of an institution's or program's funds (Cross 1999, 135-6), and lastly, "economics" as the optimization of resource inputs to outputs in the context of fulfilling people's material needs and wants (Knopf 1991, 89).

Second, I believe that it is helpful to examine how health care is delivered in this country by utilizing organizational analysis, again to underscore how the monetary problems arise in very different "places" in the system. My belief opposes the provocative claim made by Larry McCullough, a bioethicist at Baylor College of Medicine, wherein he holds that America has no health-care system. He contends that the word "system" denotes "a rationally organized, highly coordinated, and centrally controlled way of doing something" (1994, 484). This definition sets a high standard for what can qualify as a system. From McCullough's vantage point, the U.S. health system lacks such features and thus he concludes that in fact the country's "health care is a non-system" (Ibid, 485). Perhaps initially surprising, he does not lament the absence of systematization. Instead he applauds such a situation on moral grounds because it preserves pluralism of values and helps reduce paternalism.

I counter McCullough by allowing that a system need not be either monolithic or monovalent. The U.S. way of delivering health care is based on the premise that the funding comes from two primary sources: the public *qua* government and the private *qua* corporate. This *is* rational based on a belief in shared responsibility for medical care and progress. The system *is* coordinated in that there is clear separation of responsibilities: a patient "enters" the health system through one physician's office and then is referred further to treatments, examinations, and specialists. The same applies when a patient enters the system through an emergency department: she is subsequently admitted to the technology "rich" hospital and its specialists. Because the American health system is so advanced and has so many possibilities for treatment, it is very complex. But it is coordinated as evidenced by the familiar routine of appointments, paperwork, referrals, and so on.

As for McCullough's criterion of central control, I agree that that this accurate in the case for U.S. health care. But I want to challenge McCullough in that his version of control occurs only if there is a single administrative office. I suspect that the U.S. Postal Service would qualify as would the U.S. Mint. But such a standard excludes too many other organizations that have worked out national versus state versus local administrations (e.g., McDonald's, banks, and the Red Cross). Moreover there are other forms of central control: regulations, licensing, and professionalization. Each of these is prevalent in health care. And as a final rebuttal to McCullough, because the existing system does have numerous *kinds* of participants, heteronomy and dictatorial paternalism are reduced. In sum, I see American health care as a system, albeit highly complex.

I think a more illuminating way to understand how health care is delivered in this country is through an organizational approach. The concepts of micro-, meso-, and macro- levels are informative here. While the terms "micro-level" and "macro-level" are familiar in the mainstream bioethics literature, "meso-level" is still relatively new.

The connection among these three organizational terms can be illustrated progressively by moving from the narrowest perspective to the widest perspective on the delivery of health care. To speak about the micro-level in health care is to refer to particular or identifiable patient-professional interactions. Moving to a more generalized vantage point, the meso-level refers to institutional or bureaucratic settings for such interactions (e.g., an outpatient clinic or an acute care hospital). A macro-level perspective refers to society's explicit or implicit sanctioning of various health alternatives *contra* other societal goals.

So how do the different categories of money impact the different levels of health-care delivery? I begin by claiming that all four categories do not impact substantively all three levels. As reflected in Table 1 below, I see the micro-level as being affected most directly by the first two monetary categories: money and business.

First, money. Medicine tends to be among the highest paid occupations in this country. And wealth (i.e., having money) not only provides material benefits; it can also provide power. Recognizing such returns for services rendered, an immediate ethical question is whether, in caring for those who are vulnerable and suffering, a physician might be wrongly compensated at some point. In other words, fees may be so large that they cannot be considered fully earned, and so are not fully deserved. Moreover power, as a secondary gain, may be an inappropriate reward. A further question centers on money creating serious conflicts of interest for the physician in his role as an advocate for his patient. While the questions about desert and power have received minimal

Table 1. Relevancy of Kinds of Money to Levels of Organization in Health Care
(√ = is relevant)

	Money	Business	Financing	Economics
Micro-level	√	√		
Meso-level		√	√	
Macro-level			√	√

attention in the clinical literature, the question about financial conflicts of interest has consumed much of the debate over the morality of managed care and an unfettered marketplace (see Rodwin 1993).

In the case of business issues, a physician's private practice is challenged by the inherent demands of securing a customer base and generating adequate profits to sustain the practice. A quick review of such medical journals as *Medical Economics* confirms the importance and complexity of office management techniques for the private practice physician. In addition to being competent both in terms of clinical practice and in personal interactions, a physician must now be a skilled businessperson. But is it really possible for a physician to responsibly and capably wear two "hats," that of the physician and of the office manager or entrepreneur, when both are so dissimilar and are in conflict at times? In fact, such conflict can be so dramatic that it ultimately constitutes a deep betrayal of certain fiduciary duties (Ubel 1999, 1675).

Health care at the meso-level (i.e., in the clinic or hospital) faces ethical challenges from the second and third monetary categories, namely business and finance. Just like for-profit businesspeople, hospital administrators face a competitive and dynamic environment, as does an individual physician, in their decisions of what treatments and services a hospital will offer. Today, said treatments and services are often characterized as "service lines" and patients as "customers." These new labels cohere with the concept of commodification wherein goods are presumed to be price-able, fungible, and subject to property rights and participants are presumed to be prudent, informed “acquirers.” Institutional mandates shift from responding to and caring for the sick and dying to offering a package of financially-sustaining services. Not surprisingly, this recent change in labels represents a dramatic ethical shift in answering the questions of “what is at stake?” and “who is at risk?” in any medical encounter. The inevitability of such conflict has resulted in many individual physicians forming group practices and then employing office or business managers to handle the financial and administrative responsibilities.

There are numerous possible alternatives for institutional financing: for instance, insurance companies’ reimbursement rates, internally-generated revenues, governmental allocations, and local philanthropic contributions. Certainly a for-profit organization will pursue some different sources compared to a non-profit organization. But in either case, ethical concerns for institutional administrators include how “encumbered” is each source of financing and how stable is each source. The idea of being encumbered means determining whether the monies provided are restricted by any specific limitations as to their use (e.g., tied to a project for supporting unwed teenage mothers or for rehabilitation of spinal cord injuries). Regardless of whether funding flows from government-to-hospital or from patient population-to-hospital, stability denotes commensurate commitment. Predictable and longer term funding allows administrators to shift away from a financial crisis mode and thereby make a greater and more trusting commitment to the community the institution serves.

And lastly, I believe that both of the last two monetary issues, finance and economics, are particularly pertinent to the macro-level of health-care delivery. Financing involves state and federal governmental decisions about the amount and kinds of sourcing (i.e., taxation levels and lines[13]). In other words, who must contribute to the public coffers and how much must each contribute. Financing inflows are a separate governmental decision to the decision of who will receive said funds. Next are the questions of who will benefit and in what ways when the monies are "transformed" into medical procedures and services. An immediate ethical question concerning finances focuses on the fitting social balance between non-profit versus for-profit institutions in the delivery of health care and their operational freedoms and duties.

Economics involves optimizing the capacity of said public funds to fulfill society's competing priorities (e.g., the arts versus education versus the infrastructure). Ethically challenging is finding a defensible equilibrium between stimulating the health-care industry (such as promoting research) and controlling its unethical or illegal tendencies (such as patenting for economic gain). Innovation and service expansion can be part of the benefits while externalities[14] and market monopolization (e.g., patenting

---

[13] A tax line is the "what" of taxation as opposed to "how much." Property tax, income tax, alcohol tax, and a general sales tax are four examples of tax lines.

[14] An externality is the harmful consequence of person or company *Q*'s actions wherein the consequence is borne by those who (a) are not person or company *Q* and (b) have not sought nor received any commensurate benefit from *Q*. An example is a hog farm's toxic effluent that pollutes a nearby river system that is the water source for homes downstream from the farm. The polluted water qualifies as an externality because the agent or producer incurs none of the direct harms that result. The homeowners incur them. And if they are not employed at the farm and do not purchase any of its products, they then receive none of the farm's benefits. Moreover the homeowners likely never agreed to take on such burdens.

specific human genes) can be part of the burdens.

At present, one out of every seven dollars in the U.S. domestic economy is devoted to health care. There are no reasonable grounds to presume that more funds would not be required to meet all health needs or to provide benefits to everyone who could be so benefited. To support such a claim, six factors are salient: (1) the enduring existence of disease, injury, and suffering, (2) the difficulty in collectively prioritizing individually subjective health needs (e.g., the value of psychological counseling for post-partum depression versus the value of estrogen-replacement therapy with fewer bad side effects versus the value of IVF for an infertile woman), (3) our cultural fear of death, (4) the fact that people are living longer and longer and yet the rate of morbidity increases as we age, (5) our cultural trust in technological answers to social and personal problems, and (6) the industriousness of institutions (research and/or commercial) to develop new medications, therapies, and equipment. In other words, it is impossible to predict at what point the demand for more funds in health care would ever be sated. More bluntly, could health care use every available dollar if no restrictions were instituted?

Certainly use of the word "money" can serve as a kind of shorthand for the above monetary issues. However my contention that the monetary side is really of four kinds and that the loci of delivery is at three levels underscores why it is impossible to readily prevent and resolve the ethical problems generated by the role of money in health-care development, access, and delivery.

A new understanding of rationing

Despite the seemingly insatiability of demand and the intransigence of resource scarcity, many Americans believe that rationing in health care is a new phenomenon: a phenomenon courtesy of managed care. Just the opposite is true. Rationing has occurred for decades; it simply has remained hidden and thus unacknowledged. The fact that a percentage of the population has not been insured or has been underinsured, and who are too poor to cover their own medical expenses, is a form of rationing. This constitutes rationing at a societal level, not at the bedside. In other words, the decision of who would not receive any benefits or would receive less than they wanted is made by linking medicine with the ability to pay. Because of such an inability, people in need of care do not become patients (that is, they are not under a physician's care) unless in extreme cases of rescue. If a patient has the financial resources [be they from an employer's health insurance plan, a governmental health plan (e.g., Medicare or Medicaid), or personal resources], then once a physician-patient relationship develops, the physician would advocate on behalf of her patient. But if a patient lacks such financial resources, then no lasting relationship arises and no advocate is identified.

Why has rationing not been noticed? As noted by Asch and Ubel (1997), the health-care rationing debate has been confounded somewhat because the definitions employed have been inconsistent. They state that the majority of economists define rationing as "allocating goods in the face of scarcity" while other writers define it as cost-based limitations by treatment-type or by disease-type (1997, 1668). This range of definitions implies a lack of clarity as to what constitutes health-care rationing. If we do not know the defining criteria, then it is not surprising that actual instances are overlooked.

Distinct from the issue of inconsistency, the kinds of phrasing identified by Asch and Ubel are also, I believe, problematic because they are euphemistic. The fundamental problem with euphemisms is that they mask, thereby tempering conflict and concern and, in turn, rendering a topic or position tolerable. A euphemism is morally troubling because it can allow us to walk past when we should become involved in some way.

With these two concerns in mind, namely inconsistency and masking, I want to assume an ethically challenging stance. Accordingly I characterize rationing as being—at its core—about saying "no" to someone or to some people, despite their needs, their anguish, or their good reasons. "No" seems to intuitively require stronger criteria; in essence to "raise the bar" for what counts as adequate ethical justification. Moreover this connotation holds regardless of whether the specific monetary issue at hand is money, business, financing, or economics. At some point, a decline in physician income, a marginal profit margin, non-renewal of a philanthropic grant, or a comparably small benefit all translate into someone telling a patient or patient group "no."

Let me elaborate on this notion of needing more justification in the case of "no." An illustration of the asymmetry occurs in the case of informed consent. During the initial philosophical and legal discussions about what constitutes valid informed consent, the issue that consent had two "faces," namely assent and dissent, arose. When a patient agrees to the therapy that her physician recommends, it seems intuitively clear that the criteria for accepting her agreement should be few. Yet when she disagrees, it seems just as clear that the criteria for accepting her refusal should increase. What accounts for this apparent asymmetry?

The same situation occurs, I believe, when responding to a request from someone, *ceretus paribus*. If someone asks, "May I borrow your car?" my answer of "Okay" demands little explanation. But if my answer is "No," then there is a shared sense that some kind of explanation is warranted. Why might this be so?

"No" signals a thwarting or obstructing of someone's plan which is unethical, other things being equal. The charge of immorality is justified by Kant's position on the inherent and immeasurable dignity of humans as presented in the *Foundations of the Metaphysics of Morals* (1785). Flowing from such dignity, a person's plans have value such that they should not be hindered unless there is a morally adequate reason to do so. Furthermore Kant's privileging of individual autonomy means that the person is best able to decide what does and does contribute to her interests and well-being. And so when "no" is the reply to someone's request, it represents an obstacle to that person's chosen goals or preferences. Unless there is an adequate account forthcoming, the "no" is unethical from a Kantian perspective. In the example of refusing a physician's advice, a patient's refusal is questioned because it is presumed that the physician's advice will support her projects and interests. In the example of not lending the car, it appears that a plan is being obstructed.

With this said then, I think the demand for making "no" explicit accords with ordinary morality. The health-care system currently hides or masks the "no" it, in essence, says to the millions of Americans who have no health coverage. The importance of making this explicit can be underscored from another perspective. The local media often run a story of a person who has been turned down for a life-saving operation because of lack of funds or lack of available organs. In either instance, the issue is hard scarcity. The familiar response of readers and viewers is for the community to rally some kind of support such that the surgery is reimbursed or there is a directed organ donation. This kind of response reflects the power of what is labeled as an "identifiable life." An identifiable life is one where we know the person's identity; his situation becomes personal to us and thus it is easier for us to care.

In contrast are "statistical lives" wherein the medical situation involves a group of people who are never personalized, which is to say, their individual circumstances are never publicized and they never become "real people" to us. Our caring is less. Nonetheless statistical lives are the loci of health policy decisions such as whether to institute reimbursement coverage for prescription drugs under Medicare or to increase the number of reimbursed prenatal care visits for women on Medicaid. The relevant difference between identifiable lives and statistical lives here is that the public responds more compassionately to the former than to the latter. Yet are not the people whose well-being is being considered at the policy level (and so qualify as statistical lives) as needy or as deserving as those considered at the local level (as an identifiable life)?

Certainly rationing affects both kinds of lives, but the problem is that rationing at the policy level has traditionally remained hidden. Therefore an adequate definition of rationing must be able to make sense in terms of refusals to groups of patients as well as to individual patients.

Responding to the problems of inconsistency in definition and masking of its meaning, I have argued elsewhere (2002) that rationing's critical features are unmet demand, conflicting competition, shared and substantive valuation, and distributive control. Based on these features, I proposed that rationing be defined as: rationing is someone or some institution's deliberate decision to distribute a scarce good among competing persons. Complementing this definition, I proposed use of a description of rationing so as to more evocatively reflect the symbolism and experience of rationing. I believe the value of this description is that it accords better with what most Americans would say rationing is about:

> "Other people, as well as you, have asked us for *X*. But there's not enough for everyone. So we will have to decide whether you will either (a) get none of *X*, or (b) get less of *X* than you wanted."

It is possible that under a rationing scheme, some people will get all that they asked. Yet to my mind, anyone or any group who receives all that she or they want has not experienced rationing. The above definition of rationing is meant to underscore the experiential in its use of "you." What is personal can apply to both an individual and to a specific group because it is still the individual who experiences the absence or shortage. The ethical sub-text or symbolism of the above description is exclusion, being ignored, or abandonment, two responses antithetical to medicine's duties to those who are in pain, injured, or dying. Again, it is possible to exclude a group as well as an individual (e.g., people who are HIV positive as well as Mr. *X* who is waiting for a cadaver liver).

The growing role of managed care organizations in the structure of the country's health system has added to the sense of abandonment. When a patient is told "no" by a managed care organization with respect to reimbursement for a particular therapy or with respect to getting to access to a sub-specialist, she is being told by an organization. This adds, I think, to the sense of isolation because there is no personal relationship between herself and the MCO employee. Because it comes from an organization, there is a greater weight to the "no;" in other words, the patient sees it as more difficult to change an organization's "mind" than the mind of another person.

"Rationing" is not a new term. The most familiar example of it occurred during World War II when the availability of various foodstuffs and consumer goods were restricted for private use. I posit that public acceptance of such rationing came from benefits continuing to flow to the public (e.g., national security) as well as a sense of collective participation. In capitated managed care plans, enrollees do not share a sense of equal security. Rather an enrollee who is presently not ill knows that the finite resources of the plan are being drawn down today by those who are ill or dying today. And by those who will be ill or dying tomorrow. But the pivotal question for him is whether when he becomes ill or is dying, will there be anything left to cover his medical care? So with managed care, there is a sense of first-come first-served in terms of the associated benefits. Yet the burdens are equally distributed in that all enrollees must pay their monthly premiums. Thus the case of WW II rationing is starkly different from current health-care rationing and thus public support is commensurably different.

I suggest that it is the explicitness of the prospective “no’s” that has fueled much of the current public backlash against managed care. Certainly it has fueled the attendant emotions. The American public has rarely been told “no” directly and openly and the resulting psychological impact has been immediate, strong, and lasting. An article discussing the shortcomings of the British embrace of managed competition evocatively illustrates the experience of what rationing feels like when you are one of “those remaining,” obviously and unmistakably left at the curb:

> Inequalities are now more visible and more subtle: instead of an unseen wait in bus queues in another area, a taxi now stops and picks up selected people from the same queue in full view of those remaining (Powell 1996, 259).

Moving from the issue of how to best characterize rationing to the issue of how to ration, it appears that much of the literature on rationing frames it in terms of justice or fairness. Yet this is not the only way to frame the concept. There are numerous candidates for a defensible rationing criterion. From an ethical perspective, it is possible to conceive of a rationing policy—that is, a public policy that denies people what they normally received or obtained—that emphasizes, for instance, compassion or heroism. Such informing virtues could translate, I imagine, into strikingly dissimilar policies for health-care delivery. A heroic health system would privilege the notion of rescue wherein everyone who is facing immediate death or serious injury will be of primary importance. A compassionate health system would provide any person in American some basic level of healthcare to alleviate such fundamental human woes as severe pain, hopelessness, abandonment, and malnourishment. Use of the word "human" is meant to capture what is basic to being a human being or person and thus the examples are meant to be different from the physical bias of modern medicine.

Yet an ethical perspective does not exhaust the field of possible alternatives. From a business perspective, a viable candidate for a rationing policy could be efficiency, profitability, or even customer satisfaction. This plethora of criteria necessitates adequate justification for whatever criterion is finally chosen. Rather than appearing to presume that health care must be rationed fairly, arguments are needed as to why business considerations alone are not enough. And why justice is the central ethical virtue.

Selecting a criterion is a weighty choice. Bringing "no" to the foreground should sharpen our attention as to what limitation or scarcity really means: there is simply not enough for everyone and some or all must go without. The implications of saying "no" at the individual level ultimately redound to the macro or societal level. Considering first the foundations of our entire health system, Fierlbeck cautions us:

> But what is at stake is not merely the future of a healthcare system; it is *the legitimacy of a set of ideological claims* upon which the provision of healthcare is structured (1996, 544; italics added).

Shifting from the health system to society as a whole, the opening paragraph of *Tragic Choices* speaks of the magnitude and symbolism of our decisions not to help everyone in need:

> We cannot know why the world suffers. But we can know how the world decides that suffering shall come to some persons and not to others...For it is in the choosing that enduring societies preserve or destroy those values that suffering and necessity expose. In this way societies are defined, for it is by the values that are foregone no less than by those that are preserved at tremendous cost that we know a society's character (Calabresi and Bobbitt 1978, 17).

Replacing, not modifying, the U.S. health system

As mentioned in Chapter I, rationing has always occurred in the American health system. It has manifested in the guise of millions of citizens lacking or having insufficient access to standard and effective medical care. Yet all other developed nations have governmentally-provided health insurance for every citizen. Moreover the health status and outcomes in these nations is as good as or superior as that of Americans on certain primary indicators (see Table 17 in the Appendix). Yet these countries spend less, and in some cases significantly less, each year (Table 16).

In response to these results, demands made by theorists or by policy makers for the American medical system to improve its morality, its medical quality and effectiveness, and its productive efficiency have often appealed to the health systems of other countries as viable models. Scanning the mainstream academic literature of medicine, bioethics, and medical economics, I found that Britain and Canada are the countries most frequently identified as relevant alternatives to, or lessons for, America.

Although the populations of Britain and Canada are much smaller than that of the U.S.A., several attributes are shared among the three nations. The United States was founded by British subjects and much of the British political, legal, educational, and economic systems were instituted. This is also true of Canada.[15] Canada is commonly seen as being most like America in terms of language, culture, and geography.

Granting such critical similarities, it is rather surprising that each country has noticeably different health-care system. Difference here centers not on the level of scientific advancement. In all three countries, reproductive technologies, transplant surgery, genetic screening, and high-intensity neonate care have become increasingly routine. Nor does the countries' differences center on the technological mix of medical facilities. All three have primary, secondary, and tertiary care facilities.[16] Instead difference centers on how medical resources, be they services or products, are made

---

15. I allow that the geographic areas that came to be known as the United States and as Canada were not discovered by Caucasians. Numerous aboriginal and Inuit tribes or First Peoples lived on the continent for centuries prior to the influx of Caucasians. However the United States and Canada became federated countries only with the immigration of white people.

16. Primary care is provided by a general or family medicine practitioner, typically in her office, with a special focus on prevention and long-term relationships. The presence of specialists or the need for surgery implies secondary care wherein the setting is usually a clinic or a hospital's outpatient wing. And finally, tertiary care implies sub-specialists as well as specialists, experimental medicine, emergency wards, and high-tech equipment typically found in acute care or teaching hospitals.

available and distributed to their citizens.[17]

A brief description of the evolution of the British and Canadian health systems is included in the Appendix. I see such descriptions as highly informative in that they illustrate how a health system reflects a national ethos. In other words, the design of a health system in a country, or lack thereof, reveals societal priorities of what is the good life such that all its citizens know that of *X*, *Y*, and *Z*: *X* and *Z* are guaranteed to all of them and that *Y* is left to individual preferences and effort. Furthermore these two descriptions describe other countries' ongoing struggles with the challenge of ethically rationing health care. These struggles underscore that returning to the fundamental question that drives this dissertation is a timely exercise because there are no ready programmatic "fixes" to the rationing challenge.

In response to recommendations that the United States adopt the British or Canadian health system, I say "no." As one Canadian health economist noted, "'Nations do not borrow other nations' institutions'" (Iglehart 1986, 779). As revealed in the above descriptions of these two countries' systems, there are critical societal values at

---

[17] Deber (1993) provides a useful characterization of the differences:

	Financing	Delivery
U.S.A.	private	private
modification	*private/public*	*private/public*
U.K.	public	public
Canada	public	private

The above modification to Deber's chart is mine. In my opinion, it represents a more accurate picture of the American system. Because governmental funds constitute over one-third of all health expenditures, some mention of public financing is warranted.

stake. In Britain there is national unity around the essentialness of a basic level of health care to a good *British* life. As evidenced by their reconsideration of the privatization and competitive changes, I posit that health care represents security over body and mind. The importance of such personal security is similar for all Brits: there is consensus that all British citizens are reasonably, although not maximally, protected in something so fundamental. There is no demand that every technological advance be made available to as many as possible. This is compatible with the national image of Britain: stoic, reliable, communitarian, and unglamorous. And so I see that paying higher taxes, in part, to ensure that all Brits can rely on having a basic but comprehensive level of health care to all Brits is justified in their minds because they see themselves as duty-bound to provide such security to their fellow citizens.

Something similar can be said of Canadians. Health care is one of the unifying and identity-conferring aspects of Canadian life. This has become even more pronounced over the last decade with the recognition of how very different is the American system. In other words, for Canadians, their health system is one obvious way that they are different from Americans. Since the late 1970s, there has been ongoing efforts to try to maintain the national differences so as not to be "swallowed up" culturally by the United States.[18] Moreover the health system is a societal, governmental program of which Canadians are particularly proud and just like the efforts to remain

---

[18] In the late 1970s, for example, the federal government passed legislation mandating that a certain percentage of programs on television and radio must be Canadian, whether they included Canadian actors, directors, producers, or musicians. This legislation was in response to the growing incursion of American programming and the concern over the loss of Canadian culture and identity.

different, the Canadian system is an indicator that Canadians can do some things better than the Americans.

The American system does not have such societal values under girding it. Its informing values, I contend, are innovation, autonomy (be it of the patient or the physician), and options. Such values are deeply reflective of the United States itself and are not at the core of the national identities of the U.K. or Canada in my opinion. Hence my claim that it would be misguided for the U.S. to discard its system's structure and institute that of one of the other two countries. My claim incorporates much of Walzer's arguments wherein basic values or goods are culturally defined to a large extent. Moreover the chosen institutions and systems that govern a societal good reflect various communal priorities and commitments. More simply put, the means that are selected reflect the worth or urgency of the end being pursued.

Two concerns about contemporary medicine

I believe that substantial changes to the health-care system have been elusive in part due to a failure to clearly understand the state of medicine today. To help evocatively illustrate this failure, I want to characterize contemporary medicine as being conflicted and as being totalitarian.

First, the case of conflicted identity. The notion that American health care has successfully remained outside the vagaries and paradoxes of American society—that as a science, it is value-neutral and free from political mandates—is convincingly refuted by

Paul Starr's much lauded book, *The Social Transformation of American Medicine* (1982). Especially noteworthy is his choice of the word "transformation" to describe medicine's progress in this country. If the level of scrutiny is restricted to, for example, interactions between caregiver and patient or to a specific disease and treatment modality—in essence, micro-level scrutiny—then medicine's progress typifies Darwinism; that is, continued segmentation and specialization. However as reflected by Starr's work, if scrutiny is directed to health care as a whole—a macro-level perspective—then I suggest that the field has been subject to major transformations.

Current challenges facing American medicine arise in part, I believe, because its identity has become unclear which is troubling because resources may be misdirected and expectations may be unfulfilled. By "identity," I mean: what is medicine all about? What are its defining priorities and commitments? Because medicine taps into human possibility and the complexity of human nature, it should be expected that there is more than one candidate for its identity.

In fact, I propose that there are five competing identities. These identities are not mere gradations or refinements of each other, but instead differ strikingly in their basic values. To help crystallize each of the five, I have included certain personae or familiar role models as heuristic devices. As Iris Murdoch contends, greater benefits occur by going beyond mere description: "'images should not be resting-places but pointers towards higher truth'" (Ramanathan 1990, 226).

Hippocrates and the code of conduct attributed to him constitute a clear starting point to Western for medicine's evolution. A guiding motive behind the Oath, written in approximately 500 B.C.E., was to formally distinguish what was acceptable from what was unacceptable in terms of medical treatment, behavior towards a patient, and behavior towards other practitioners. Thus the oath specified various kinds of obligations owed to a patient, other practitioners, and to the discipline itself. In addition, written codification implied legitimacy. Accordingly those who complied with the code could be considered reliable practitioners while those who did not could be labeled charlatans or quacks.

The Hippocratic Oath is relatively brief and written in a simple, yet direct, style. Such simplicity and directness imply, I feel, that there are certain fundamentals or minimums below which medicine must not sink. The Oath details such duties as fidelity, nonmaleficence, beneficence, and confidentiality, respectively:

> To him who has taught me this art [I will consider him] as equal to my parents...
>
> I will keep them [the sick] from harm and injustice...
>
> I will come for the benefit of the sick...
>
> Whatever I may see or hear in the course of the treatment... I will keep to myself holding such things shameful to be spoken about....
> (Edwards and Graber 1988, 40).

The Hippocratic Oath can be understood as beginning the differentiation among and legitimating certain practitioners. Since then, the first shift away from it came in the late 1800s. The new paradigm had two aspects: common-sense care and compassion. By "common-sense care," I mean cleanliness and bed rest as ways to minimize the external demands on the body so that it could marshal its own natural defenses against disease and death. Compassion was shown by not abandoning the suffering or the vulnerable. Florence Nightingale saw the practicality and logic in simply washing her hands and any medical instruments prior to patient contact. She also demonstrated heroic selflessness in putting herself in harm's way due to contagion. And by remaining at the bedside, she affirmed the obligation of presence, of being ***with*** another person, and through vigil, the value of witnessing suffering itself. Thus an outcome of this new identity for medicine was to move away from concern for public legitimacy and to emphasize a selfless caring for, and binding loyalty to, each patient. Furthermore the presence of mass media attention on Nightingale helped entrench this purpose among the public's expectations.

About the same time as Nightingale and continuing thereafter, a third paradigm appeared: the discipline of science. The promise of recovery through individual and local succor was herein replaced by the promise of prevention through science. Praxis was overshadowed by theory; trial-and-error by discipline. "Good" science demanded repetition, systematization, and control, and its preferred setting was the sterile, equipment-laden laboratory. And the guiding objective was a reductionist understanding of human physiology and its interactions with the external environment. Accordingly focus on *this* ailing individual was replaced by a focus on cells, chemicals, and microorganisms. In a way, concern for the immediately-present human being changed to a concern for the unseen, the atomic, and the formerly hypothetical. Any resulting benefits were expected to flow to the general public rather than to an identifiable person. Scientists, such as Jonas Salk and Marie Curie, were publicly applauded for the coolness of their search for knowledge: impartial, methodical, yet rigorous.

The next and fourth paradigm that I see as pivotal to medicine's purpose incorporates the idea of intervention as first embraced by Hippocrates. But here intervention is framed by another development, namely technology. The work in the 1970s by Drs. Christiaan Barnard and Robert Jarvik typifies this period. Their work highlighted the impact of both technology and aggressive intervention into the body's workings. Hence the former paradigm of prevention was replaced by dual promises of rescue and of cure. The case of the first successful heart transplant in 1968 by Dr. Barnard exemplified rescue while the first artificial heart[19] in 1969 exemplified cure. At this time, breaking through limitations or boundaries was no longer a question of "if," but a question of "when." The institution of medicine became the great hope for all Americans' well-being, present and future.

And, finally, since the late 1980s, increasing attention has been on the money side of health care. From the demand side, the public's desire for medical treatment and services appears unquenchable. From the supply side, financial returns appear to range from millions of dollars in profits to bankruptcy. Consequently a debate has arisen as to

---

[19] The publicity surrounding the Jarvik heart in 1978 has led some people to believe it was the first artificial heart. However the first fully mechanical heart was developed in 1969 and kept its first recipient alive for sixty-five hours until a human heart could be obtained (Bruno 1997).

whether medicine is rightly situated in a capitalistic marketplace and thus not require the government to be involved as either a supplier or buyer of health-care services.[20] The goals of choice, efficiency, and customer satisfaction have meant that patients are best understood as consumers and that medical services are best characterized as product lines. Similarly a focus on maximizing the returns for each health dollar spent has opened discussion as to how to aptly value added years of life or repaired abilities. As such the fifth paradigm shift substituted the promises of rescue and of cure with the promises of consumerism and competition and the persona informing these dynamics is economist Adam Smith.

In summary, medicine has embraced five different identities as it has progressed: (1) the duty-bound practitioner, (2) the devoted and gentle caregiver, (3) the patient, but detached, investigator, (4) the action-oriented rescuer, and (5) the entrepreneurial producer. But which one is, or ones are, most fitting for medicine as the new century begins? The entrepreneur is very different from the duty-bound practitioner and the rescuer is very different from the caregiver. Can medicine successfully do it all? Do medical schools adequately train physicians about each role and what it requires? My greatest concern is with patients. By this I mean that patients may not understand how each role involves different, often conflicting, priorities and virtues. More specifically, I am concerned that patients are still so trusting and so hopeful that they will presume that their welfare is always first and that the physician they have is the kind of physician they

---

[20] Over the past ten years, roughly 40 % to 45 % of the dollars spent annually on health care in the United States have been from local, state, or federal coffers (*Statistical Abstracts of the United States*).

need.

The second issue that supports the importance of this dissertation's motivating question centers on medicine being totalitarian. What I am pointing to with such a characterization is that public health, mental health, and familial care-giving have each been eclipsed or marginalized by physical[21] medicine in America. Admittedly there is nothing inherent in medicine *per se* that makes totalitarianism inevitable. Nonetheless if only mass media reports and personal testimonials are relied upon, an easy conclusion would be that "health" and "health care" are exhausted both by what is physical and by physical medicine as situated within the institutional and bureaucratic setting of the acute care hospital. As a result, both concepts are very narrowly defined.

Yet human beings are not merely bodies living in isolation from each other. Humans are composites of body and mind, living their lives within the bounds of family and home and within the bounds of some community or society. Overlooked too much by clinicians and governmental agencies alike, public health, mental health, and home care are examined below in terms of both their relevance to human health and their marginalization within health care.

Public health differs from medicine in several ways. Its focus is on human

---

21. "Physical" medicine contrasts with "behavioral" or "psycho-emotional" medicine such that the former type's focus is the physiology of the body while the latter type's focus is the mind or personality.

behavior, human interactions, and social organization.[22] Medicine, on the other hand, tends to focus on discrete individuals, its arena is technology, and its primary model is the biomedical model of disease. This model is reductionistic and mechanistic in its perspective (Brandt and Gardner 2000). A charge of reductionism is detrimental in that it is asserting that something has been "stripped down" to a bare minimum and as such, is not an adequate representation or characterization. And a charge of mechanism can be pejorative when what is being described as mechanistic is actually a living organism. Such a description is therefore inaccurate.

The benefits resulting from public health measures have been dramatic since the late 1800s. Sanitation, clean water, and immunizations have prevented more deaths and extended Americans' life expectancy far more than mainstream medicine (Sagan 1987; McKinley and McKinley 1977). As shown in Figures 1 and 2, below, there is a sizable inequity between impact on human health and financial support. The first figure presents the varied contributions to health by four areas: (1) the environment, (2) personal lifestyle choices, (3) human biology (e.g., heredity), and (4) mainstream medicine (or "health-care delivery"). The second figure presents the proportionally differing allocations of public funds to each of the four areas.

---

[22] The following strategies and fields, now part of public health, attest to the breadth of its current mandate: "health promotion...health education, social marketing, epidemiology, biostatistics, diagnostic screening, immunisation, community participation, healthy public policy, intersectoral [voluntary organizations, governmental departments and agencies, agencies and private sector businesses] communities or populations, its arena is political, and its preferred model accepts the interdependence of health, environment, collaboration, ecology, health advocacy, and health economics" (Petersen and Lipton 1996, 5).

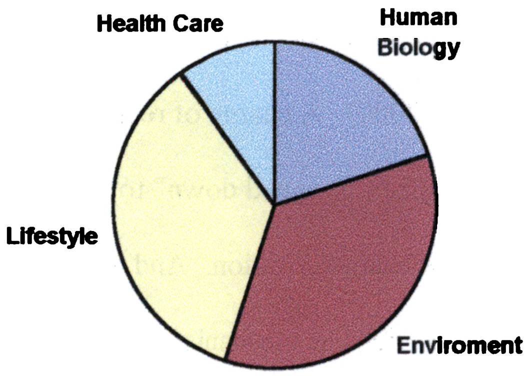

Figure 1. Relative contribution to human health
(Ng and Davis 1981, 15)

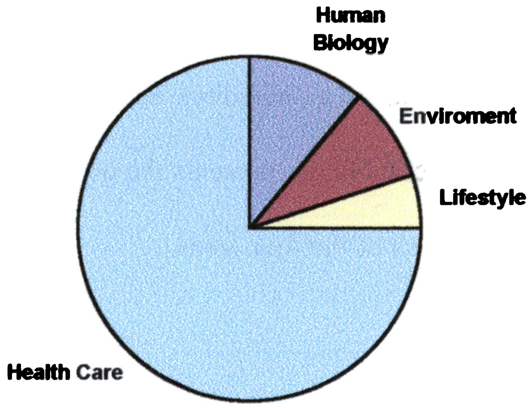

Figure 2. Relative financial funding
(Ng and Davis 1981, 15)

According to governmental publications of annual expenditures in America, of the total funds spent on health, roughly 1 % is typically funneled to public health while 99 % goes to medicine and medical research (*Statistical Abstracts of the United States*).

What might account for such a large disparity? Based on the aforementioned differences between medicine and public health, many people see medicine as more controllable or manageable, reliable, and impartial, which is to say that medicine is an efficient, effective, and fair response to pain and illness. In sharp opposition, public health is seen as "*tainted* by politics, advocacy, individual noncompliance, and social diversity" (Brandt and Gardner 2000, 711; italics added).

The different objectives of medicine versus public health also help explain the inequity between benefits and funding. As suggested earlier, in recent decades, medicine has promised both rescue and cure, which are much more psychologically and emotionally gripping in comparison to a promise of prevention. Rescue and cure imply heroics, a virtue that resonates strongly with the American psyche, while prevention implies avoidance. Thus prevention, depending on how it is framed or the vocabulary employed, can reflect tentativeness and even fear. And finally, another boost to medicine's allure comes from science and technology. They are now standard mechanisms for its advancement, each of which clearly represents possibility and action, which, in turn, signal optimism and human ingenuity.

Public health has focused on sociological and epidemiological studies, few of which have caught the public or media's attention. At the same time, effective programs to, say, reduce childhood obesity or dental disease rely upon long-term, incremental education initiatives or changes to public utilities (e.g., adding fluoride to public drinking water). No flashy fixes or shiny new machines here. Concurrently the focus on communities or "statistical lives"[23] means that no compelling individual testimonials are relevant. And finally much of public health emphasizes behavioral change for obtaining health improvements, something that is very difficult for people to do in comparison to taking a pill or having a one-time surgical procedure. Based on these points, I suggest that public health does not have the conflict in its identity or guiding purpose that medicine does, as posited by the five models. Instead public health has a popular identity of the social engineer in terms of monitoring water systems, air systems, and food distribution systems, and so on. The issue instead is that public health's role in the public's well-being is not adequately appreciated by the most Americans in comparison to traditional medicine.

Turning now to the case of mental illness in America, mental health programs and facilities have generally been accorded lower priority in comparison to physical health programs and facilities. Insurance plans typically limit the number of annual therapy sessions with a psychologist or psychiatrist, require co-payments of 50 % of the billing

---

23. "Statistical lives" refers to the aggregate number of people impacted; "identifiable lives" refers to particular individuals. For example, debating whether General Motors should provide full employee-insurance coverage for the new male birth control pill would involve discussing its 55,000 male employees (i.e., as statistical lives). Yet GM's coverage could also benefit machinist, John Doe, (i.e., an identifiable life) who has personally asked the company for special consideration in reimbursing his prescription.

fee, and even "carve out" certain psychiatric services from their coverage.[24] These restrictions are more severe than those usually applied to physical health coverage. Yet it is now acknowledged that a mental illness or disorder affects one in three Americans sometime in their lives. At present, one in six citizens has a mental illness which, in turn, translates into approximately forty-one million Americans enduring and suffering from one or more of these conditions (Boyle and Callahan 1993).

Several reasons explain society's ongoing disregard of mental illness and mental health care. While largely aware of the limited treatment options available, the public is not aware of how very beneficial some of the treatments are (e.g., psychotropic drugs).

Moreover since the 1970s, there has been a "trend toward remedicalization" of mental health and illness (Barney 1994, 21). Medicalization implies that traditional physical medicine can adequately investigate and respond to mental illnesses; what are then minimized are family, culture, and socio-politics. Admittedly some psychiatric conditions are organic conditions of the brain or are genetically based. As such, they should be addressed by the same disciplines and institutions as conditions such as gastric ulcers (i.e., an organic condition of another organ) or some forms of breast cancer (i.e., related to the BRCA-1 and BRCA-2 genes).

But many mental illnesses that are listed in the *Diagnostic and Statistical Manual of Mental Disorders* (1994), the primary diagnostic reference for American psychiatry, are better understood as being social (i.e., a matter of not "fitting in" in a community or

---

[24] When specific treatments or procedures are overtly excluded from an insurance plan's coverage, particularly when the plan is deemed to be comprehensive, it is labeled as a "carve out."

society) or as being interpersonal (i.e., not "fitting in" in a family or with other people) (Szasz 1997; Edwards 1997). As Thomas Szasz contends, if a person who currently does not fit in wants to improve his life, medicine may treat only the symptoms and not the root problems. To treat the root problems may require adequate education, adequate employment, adequate housing, and so forth; in other words, social initiatives. Similarly the root problem may be a lack of tolerance for people who behave differently yet pose no threat to others; in other words, interpersonal relationships. But the trend towards re-medicalization means that some situations that are illegitimately characterized as "problems" will be addressed by medicine and some situations that are indeed problems will be addressed by medicine which can only tackle the symptoms, not the underlying causes. In this way, what is considered to fall under medicine's jurisdiction increases.

Mental illness is incompatible with the customary paradigm for physical medicine for another reason: the former is often judged to be the patient's responsibility to a greater degree than a physical illness. Boyle and Callahan insightfully identify a paradox in the public's opinion about mental illness:

> Treatment of mental illness is seen as something patients can do without, since, on the one hand, remedies for the severe and persistently ill are perceived to be almost futile, and on the other, relief for the "worried well" is thought to be discretionary (1993, S4).

More simply put, medical remedies are judged to be either useless or not to be medically urgent. Any kind of clinical or societal duty to provide or make such remedies readily available therein dissipates: there is not much we either can do or should do.

Despite the attention devoted to hospitals and out-patient clinics, care that is delivered in the home constitutes approximately 80 % of all care rendered to ill, injured, or dying people. The change in 1983 in federal reimbursement formulas (from fee-for-service to diagnostic-related groups[25]) encouraged hospitals to discharge patients sooner so as to reduce costs. With this impetus to discharge patients earlier, greater importance was placed on the home as the preferred site of recovery and routine medical care. Between 1987 and 1994, national expenditures for home care rose by an average of 27.5 % each year while total health expenditures rose only 11.5 % (Arno, Bonuck & Padgug 1994).

Two ethical concerns emerge from this trend. As a starting point, the home is expected to be a place of safety, comfort, and intimacy, and thus discharge from a hospital can be welcomed by patient and family alike. But the increased discharge of sick or recovering patients has resulted in the "hypermedicalization of the home" (Arras and Dubler 1994, S20). Hypermedicalization occurs because high-tech equipment must be in the home for the continued care of the patient and family members must become knowledgeable and skilled in using said equipment. The home becomes

---

[25] A diagnostic-related group, or DRG, designated the amount of money to be charged for a particular medical service or product. In the late 1980s when DRGs were instituted as the amounts that the U.S. government's Medicare and Medicaid plans would reimburse for any medical interventions. The advantage to this system was to cap prices and thus control costs, to standardize what physicians in one part of the country charged compared to that charged by physicians in another part, and to impose a measure of equity in terms of what a medical generalist charged compared to what a specialist or sub-specialist charged for their services. Because Medicare and Medicaid are major reimbursers of health-care costs, their imposition of DRGS meant that DRGs became the standard for payments for mostl private insurers or employers.

hypermedicalized as it changes from providing bandages, a cool cloth for a burning forehead, and rest in one's own bed to providing TPN-feedings, hemodialysis, and confinement to a rented hospital bed. The institutional realm of medicine thus encroaches upon the formerly private and idiosyncratic realm of the family.

As Ruddick comments, illness or injury has a transformative quality. Illness can change significantly a patient's self-image and interpersonal relationships: "the person who comes home from the hospital may not be the person who left home for the hospital" (1994, S13). Illness can also alter a home to the point that "what was home may no longer be home" (Ibid). In fact, a transformed home may actually be less supportive and inviting than a hospital, given the burdens and demands that illness or dying can place on untrained caregivers and residential facilities.

The other ethical worry about home care stems from what I characterize as technology's oppressiveness. Despite popular anecdotes about "Mr. Mom," care giving continues to be provided mostly by women, irrespective of whether the patient is her child, her husband, or her parent. Thus women, not men, provide necessary care and sustenance and typically must sacrifice to a disproportionate degree their own time, energy, and projects in so doing. This injustice is exacerbated by the fact that high-tech medical devices can render a woman isolated, disconnected from outside friends and colleagues. She must be at the bedside to monitor machine settings... or to suction...or to clean a central line. And since patients now go home sicker, she is tied to the home longer.

Reasons for the lack of clinical and public attention to the issue of home care are twofold. First, the historical inattention by American society towards women continues in terms of their presumably inescapable responsibilities for caring for patients in the home. And second, the traditional American view that the family and the home should be beyond the government's reach has meant that any internal injustices are not society's concern.

Admittedly traditional medicine has made many important contributions to human well-being. But I see it falling victim to its successes and glamour in that it continues to promise "more and better things" and to ignore its failures and shortfalls. And in light of the general distrust of government and business, the public wants to believe that some societal institution cares about them when they are most vulnerable. A candid and public discussion of what is the purpose and role of medicine in our society (i.e., clarifying its identity) relative to other societal endeavors (i.e., ending its totalitarianism) is overdue. Absent such a discussion, hopes and resources will continue to be directed towards medicine and it will remain unrestrainable.

CHAPTER III

John Dewey's Theory of the Good

Introduction

One objective of this dissertation is to tackle the issue of health-care reform in the United States by beginning with a philosophical starting point. Some writers who propose ways to make the American system more just start with the premise that health care has a specific overarching purpose. In *Setting Limits* (1987), Callahan holds that health-care's purpose is to contribute to a person's ability to live a reasonably full life. Daniels states in *Just Health Care* (1985) that its purpose is to help people pursue available opportunities. In contrast, Engelhardt suggests in *The Foundations of Bioethics* (1986) that its purpose is not singular. Instead it is multi-purposed and the purposes depend solely on the opinions and priorities of individual citizens: some think health-care's focus is easing pain and suffering, others think it should be saving lives, and still others point to its ability to overcome the "shortcomings or mistakes" of nature (e.g., genetic therapy wherein a person's genetic make-up is manipulated so as to block the expression of, say, Huntington's chorea).

Rather than immediately propose another practical purpose for medicine and then consider how it affects distributive justice decisions, I chose a meta-ethical approach whereby I examine the nature of the good or of goodness itself. Guiding this examination is the philosophical work of John Dewey which was chosen for three reasons. First, he has a developed theory about the good. Certainly many philosophers have debated different things that do or do not qualify as being good, but many of these discussions are relatively brief or cursory. I sought a sustained and carefully thought out theory, expecting that it would offer more content to work with when applying it to the specific case of health care at the macro-allocation level and at the meso-allocation level. John Dewey is among the very few philosophers who developed a robust theory of the good.

Another reason to adopt a different approach is that there is a critical difference between knowing which things are and are not good and knowing what the good is. This difference is nicely illustrated in one of Plato's dialogues, namely *Euthyphro*. In this story, Euthyphro is confident that turning his father over to the police for the death of a servant is a morally right—and thus required—act. In conversation with Socrates, he is eager to justify his confidence in light of such a seemingly unloving act. He appeals to the virtue of piety and what it demands of human conduct. Assuming his customary position of knowing nothing himself, Socrates asks to be enlightened as to what are the definitive distinctions between the holy and the unholy. Despite Euthyphro's sincere efforts to answer, Socrates eventually chastises him:

> Bear in mind that I did not bid you tell me one or two out of all the many pious actions but that form itself that makes all pious actions pious, for you agreed that all impious actions are impious and all pious actions pious through one form (*Euthyphro* 6d).

What Socrates is seeking is the nature of holiness itself or the definitive criteria by which to correctly label something as either being holy or unholy.

Third, Dewey is well known for his work on pragmatism, a philosophical theory about human behavior and interactions (a further description appears in the next section). Pragmatism seems to be a fitting way to approach the question of health-care reform. It has a strong practical focus: it deals with ends *and* means, strives for incremental progress over the long-run, and accepts compromises (as opposed to maximums or absolutes). One lesson to be learned from the failure to legislate the Clinton health plan in 1994 may be that achieving sweeping reform of a program of such large dimensions may be impossible. As discussed earlier, health care is an immense economic institution in this country. And being ill, seriously injured, or dying has just as significant import to a person. Thus an approach that embraces incremental progress promises to be useful in the ongoing debate on reforming the health system.

Background notes

John Dewey (1859-1952) wrote prodigiously: more than fifty books, over seven hundred journal articles, and more than two hundred entries to encyclopedias (Dewey 1977). He lectured often in other countries and was invited to teach at foreign universities. During the decades when his career was at its peak, Dewey was not only well-known by other academics, but also by the American public. In addition to his work in philosophy, he was actively involved in education and social reform.

In his academic career, he completed a Ph.D. degree in 1884 at Johns Hopkins University. His doctoral dissertation focused on Kant's psychology. Upon graduation, Dewey joined the philosophy department at the University of Michigan where he remained for ten years. From 1894 to1904, he chaired the department of philosophy at the University of Chicago. During this period, he became active in Hull House, a center for social activism, and began the Dewey School, a center for studying education and psychology. In 1904, he left Chicago to go to Columbia University's department of philosophy where he remained for twenty-six years. While at Columbia, Dewey began Teachers' College so as to research methods of teaching.

While he was at Johns Hopkins, three professors were especially influential to Dewey's development. First, he studied under C.S. Peirce, who is credited as originating the theory of pragmatism. Next, he studied under G.S. Hall, an experimental psychologist, interested in scientifically investigating human behavior and motivation. And lastly, G.S. Morris was one of Dewey's professors and he was interested in Hegel and idealism. In an autobiographical article, Dewey explains that he was drawn to Hegel's work because of its abilities to progressively synthesize, to unify, and to include cultures and communities (1930a). In my reading of various works by Dewey, the appeal of these abilities can be explained as follows: progressive synthesis is valued because it denotes activity, improvement, and harmonious integration. The ability to unify is worthwhile because in comparison to traditional philosophy's penchant for identifying mutually exclusive dualities,[26] unification more accurately captures what life is really like. And in comparison to the view that people are detached, ahistorical individuals, Dewey considers it is more realistic to acknowledge the role of context when studying human development and behavior. Also at this time, Charles Darwin's *The Origin of Species* (1910), which described the intricate interactions between organisms and their environments, was challenging traditional positions within the sciences.

When he moved to the University of Chicago, Dewey's interest in human behavior vis-à-vis its organic, interactive nature deepened. At the same time, he became increasingly disenchanted with Hegelianism's privileging of a transcendental state (i.e., the One) for three reasons. Holding the One as the pre-destined ideal marginalized the importance of daily life and daily struggles. The ontological "distance" between daily life and the One meant that they were so different from each other as to be irrelevant to each other. And perfection constituted an unreachable goal.

In addition to his work on the philosophy of education, Dewey is best known for his work on pragmatism. This philosophical theory was very influential in the United States during the first part of the 1900s. More than one philosopher was involved in developing and expanding the theory: Peirce, William James, Dewey, and Schiller. In

---

26. Throughout Dewey's work, he rejects standard dualisms found in philosophical inquiry: mind-body, reality-appearance, subjective-objective, the knower-the known, idea-experience, theory-practice, cognition-sensation, thinking-activity, and individual-society. His rejection is based on what results: one part of each pair is considered superior to and dominant over the other. In contrast, Dewey wants to allow for the presence of both parts of each pair: "nature induces and partially sustains meanings and goods, and at critical junctures withdraws assistance and flouts its own creatures" (1929a, 341).

Philosophy and Civilization (1931), Dewey offers an overview of pragmatism as it developed under Peirce, James, and himself. He rejects the common description of pragmatism wherein it emphasizes ends over means. He also rejects the claim that it "glorif[ies] action for its own sake" (1931a, 16). Instead means are as important as ends and the role of action is to assign meanings to ideas. Dewey's own version of pragmatism, which he labeled instrumentalism, advocates logical inquiry into all aspects of the world, humans, and life:

> Logic, therefore, leads to a realistic metaphysics in so far as it accepts things and events for what they are independently of thought, and to an idealistic metaphysics in so far as it contends that thought gives birth to distinctive acts which modify future facts and events in such as way as to render them more reasonable, that is to say, more adequate to the ends which we propose for ourselves. This ideal element is more and more accentuated by the inclusion progressively of social factors in human environment over and above natural factors; so that the needs which are fulfilled, the ends which are attained are no longer of a merely biological or particular character, but include also the ends and activities of other members of society (Dewey 1931a, 31-2).

In this definition are words that repeatedly appear in Dewey's writings: realistic, act[ion], future, reasonable, social, members, environment, and fulfilled.

Foundations to Dewey's philosophy

It is necessary to explain four foundational positions within Dewey's work as they help justify his particular theory of the good, which will be explained in the following section of this chapter. These positions are: (1) philosophy's purpose, (2) the relationship between science and philosophy, including ethics, (3) human experience and its importance, and (4) the nature of being human or the "human condition."

An impetus to philosophy since the ancient Greek Stoics has been a search for reality, truth, and certainty. Dewey sees this as largely misguided:

> I find that the retention by philosophy of the notion of a Reality feudally superior to the events of everyday occurrence is the chief source of the increasing isolation of philosophy from common sense and science (1917, 59).

Admitting that people live in "a world of hazards," Dewey posits two possible avenues for their guidance: relying on an external power and authority or changing the world through their own actions (1929a, 3). The former avenue is well-represented by religion, which Dewey claims has been a major part of philosophy. And so in earlier times, philosophy was looked to for answers to people's worries and fears. But no longer. Dewey provocatively states that when the sciences became a systematized, communal effort (as opposed to an idiosyncratic and individual effort), they constituted a crisis for philosophy (1931a, 29). He applauds the sciences for their effectiveness in solving people's ordinary problems in living.

Furthermore Dewey criticizes modern philosophy as having a "deplorable deadness of imagination" in that problems that originated in ancient Greece or during the Middle Ages continue to be examined (1930a, 18). Moreover philosophers should not be content to talk only to each other, challenging and refining one another's arguments, he argues. In place of such "academics," "philosophy recovers itself when it ceases to be a device for dealing with the problems of philosophers and becomes a method cultivated by philosophers, for dealing with the problems of men" (Dewey 1917, 66-7). Philosophy should be "a study, by means of philosophy, of life-experience'" (1929a, 34). With experience as foundational, philosophy becomes useful when it explores "the *interaction* of our judgments about ends to be sought with knowledge of the means for achieving them" (1931a, 37).

In recapturing philosophy's relevance, Dewey dismisses the idea that the sciences are antithetical to philosophy. Rather they are similar in important ways: they explore the world and life as they are experienced: temporal, situational, problematic, and changing. Science recognizes that some areas of nature are determined and thus establish boundaries or impose constraints. It also recognizes that many areas can be controlled and manipulated to make human life better.

So too for philosophy, says Dewey. In this light, he describes his overall philosophical stance as empirical naturalism. He recommends that philosophy adopt a methodology similar to that of science. This methodology forms the basis of his version of pragmatism, namely instrumentalism, as described earlier. Accordingly philosophy, including moral philosophy, changes from a discipline focused on only affirming antecedent, fixed beliefs and refining "antecedent existences and essences" to a discipline focused on future possibilities and experimentation (Dewey 1929a, 71):

> In experiment, everything takes place above-board, in the open. Every step is overt and capable of being observed. There is a specified antecedent state of things; a specified operation using means, both physical and symbolic, by which the conclusion is reached that such and such a judgment of an object is valid is overt. It can be repeated step by step by any one (1931a, 289).

Ethical theorists are expected to explore hypotheses about the kinds of behavior and interactions that achieve desired outcomes in specific circumstances. Recognizing that behavior and interactions are inherently particular and historical, what is sought is specificity and timeliness. Ethical rules and principles can serve, at most, only as general guidelines as to what has been effective in the past in similar situations. Rules are retrospective and so are typically not definitively applicable to most prospective ethical problems (e.g., "What do I do in *this* situation right now?").

Dewey dismisses the notion that decisions of what to do can be made based on moral intuition, since he concludes that no such capacity exists. Instead people rely, consciously or unconsciously, on analysis, memory, and imagination. They scrutinize the presenting problem, recall what worked in the past, and imagine different possible responses and their consequences. And then based on what will bring about the most preferred outcome, a judgment is made and an action taken. This is reminiscent of Mill's utilitarianism in terms of calculating utility over disutility. But Dewey does not demand calculating the maximum net balance or an exclusive focus on consequences. Instead he includes consideration of the kind of person the agent will be when making a decision and thereafter.

Traditional philosophy has typically offered people a kind of knowledge that Dewey labels as "spectator knowledge" wherein "the real object is the object so fixed in its integral aloofness that it is a kind to any beholding mind that may gaze upon it" (1929a, 23). Spectator knowledge involves claims that the external world exists completely independent of people and so their epistemological worry is how accurately their sense perceptions and ideas represent the world. Truth therefore depends ultimately on the world's reality. Rejecting such intellectualism, Dewey sees experience as the ground or foundation of everything. Dewey cautions that "experience is not slipping along a path fixed by inner consciousness;" in other words, experience is not just knowing (1917, 25). In saying this, he rejects the atomistic or reductionistic view of humans found in much of traditional philosophy. More specifically, philosophers have emphasized cognition and reflection and minimized other human activities such as enjoyment, suffering, and doing. As Boisvert suggests, "experience is always wider than knowledge" (1998, 26).

When he writes about experience, Dewey consistently refers to its embeddedness in nature, interactions between human *qua* organism and environment, and society as part of the environment. To be embedded is to be inextricably living within a family, a community, society, and a time in history. For example, experience is described by Dewey as "the intercourse of a living being with its physical and social environment" (1917, 23). Or,

> Experience is *of* as well as *in* nature. It is not experience which is experienced, but nature—stones, plants, animals, diseases, health, temperature, electricity, and so on. Things interacting in certain ways *are* experience; they are what is experienced. Linked in certain other ways with another natural object—the human organism—they are *how* things are experienced as well. Experience thus reaches down into nature; it has depth. It also has breadth and to an indefinitely elastic extent. It stretches... (Dewey 1929a, 4).

Phrased differently, but making the same points, experience is "an undergoing of an environment and a striving for its centre in new directions [which are] pregnant with connections" (Dewey 1917, 23).

The word "connections" implies relationships. Dewey's portrayal of human beings begins with the fact that they are necessarily situated in relationships, be they with specific individuals or with a community. This relatedness involves benevolent reciprocity wherein a person has concern for the welfare of his community as well as his own welfare. Further the community is concerned with its members' welfare as well as its own. People need each other just as they need the traditions of a community and its cooperation:

> Right, law, duty, arise from the relations which human beings intimately sustain to one another, and that their authoritative force springs from the very nature of the relation that binds people together (Dewey 1938, 238).

Dewey sees the positive mutuality between the collective and the individual as both a factual claim and a normative statement. Admittedly a society or an individual could benefit greatly by exploiting or undermining each other in the short run. But Dewey's focus is on the life of a person, as opposed to only a particular episode, and on the continuance of a society, as opposed to a brief period of luxury. He values progress and endurance. When a society flourishes over the long-term, Dewey contends that this is due to a large extent to the collective's concern for its members. And when an individual flourishes over the long-term, he is usually concerned about his community as well as himself.

Dewey sees democracy as the most appropriate form of governance for most of our interactions. Democracy recognizes that citizens are both individuals and members and supports collective inquiry as per pluralism. In a sense, pluralism mirrors Darwinism in that diversity is advantageous to a species' survival.

The image of the human condition is very dynamic. At its core is activity which Dewey asserts is the object of every desire. "Self-conscious creatures...know that they act and know that their capacities are realized through their activities" (Welchman 1995, 79). This emphasis on activity helps explain Dewey's frequent characterization of a person as an organism: an animated, responsive, and responsible entity interacting with its particular environment on a variety of levels such as the physiological, psychological, and social. "'Life' is an interpenetration of organism and environment" (Boisvert 1998, 17). Being an organism, humans are as much a part of nature as are other mammals; they only exhibit different behavior patterns.

For centuries, traditional philosophy has debated the operations, purpose, and nature of the human mind and will. Dewey sees both as ultimately related to activity. The role of the mind is "to project new and more complex ends—to free experience from routine and from caprice...to liberate and liberalize action" (Dewey 1917, 65). Dewey argues that the more one is involved with and in one's surroundings, the more attention one devotes to what is happening and what are possible alternatives, then the greater is one's freedom. On his behalf, Welchman describes the will as actively directing one's attention, emotions, and energies to a course of action and by so doing "we effectually identify ourselves with the modified self that wills the outcome" (Welchman 1995, 80). Similarly means are just as revelatory as ends for Dewey. What one chooses to pursue will be influenced in part by the means available. One thus assumes responsibility for "the what" and "the how" of action. As a result of making a decision and acting, a person invariably affects her surroundings which, in turn, affect her. This ongoing back-and-forth explains why there is no reified or fixed self, just as there is no static reality. Just as nature is always in process, so too are human beings because they are of and in nature.

To summarize these four issues or topics, Dewey is a realist, a moderate, and an optimist. The four issues are: (1) philosophy's purpose, (2) the relationship between science and philosophy, including ethics, (3) human experience and its importance, and (4) the nature of being human or the "human condition." All aspects of life warrant equal consideration at the outset because everything is part of nature. Nothing is privileged or deemed superior. Everything that is living strives to flourish. In the case of human beings, their intellect is one instrument by which to live a fulfilling life as a participant in multiple relationships and in a community. Human beings are not simply creatures with superior intellects and reasoning capacities; that is not how a person understands herself or others. Instead human beings are about living in the form of experiences: joys, challenges, frustrations, dreams, losses, and so on. Thus Dewey's philosophy centers on investigating how life is actually lived, reflecting on the possibilities for beneficial change, and actuating opportunities for self-expression and development. Philosophy, in the guise of instrumentalism, offers people an ongoing methodology to continuously examine life critically and carefully, to act imaginatively and wisely, and to achieve harmony within natural and social ecosystems.

Dewey's theory of the good

Prior to explaining Dewey's theory of the good, I think it is informative to highlight his comments about three significant ethical theories: hedonism, Mill's version of consequentialism, and Kant's version of deontology. Dewey frequently refers to them while explaining and defending his own ethical theory. Examining what he sees as correct and incorrect in these alternative theories will provide further and deeper insights as to why he felt it necessary to develop his own theory.

Hedonism holds that what is good or of value is my pleasure and so what is morally right for me to choose or do is whatever brings me pleasure. As a guide for someone else, hedonism holds that she is ethically justified in choosing whatever brings *her* pleasure according to *her* own standards. Hedonism begins with a factual claim that every desire experienced and every action chosen is ultimately about bringing pleasure to the agent. Pleasure thus is good and as such constitutes a good or desirable life.

Dewey criticizes valuing pleasure on two counts. First, Dewey dismisses the notion of pleasure and pain *per se*. Instead what can be examined is only a specific pleasure or pain felt as a result of a certain end obtaining at a certain time and in a certain set of circumstances. Each pleasure or pain is particular and thus must be critiqued accordingly. Dewey also rejects the claim that every pleasure is valuable, though he allows that any pleasure may be valued. To be valu*ed* is to be desired. This is a statement about someone's wants or wishes. But to be valu*able* is to be judged worthy or something that is acceptable to desire. A vicious person will see lying or cheating as pleasant: "pleasantness and unpleasantness are accordingly signs and symptoms of the things which at a particular time are congenial to a[n]...organism" (Dewey 1938, 213). It is one thing to be pleased with breaking a promise to a friend in order to obstruct his success. It is another thing to be pleased with breaking a promise so that the friend learns the value of thriftiness. So the pleasures experienced here are not the key issue, according to Dewey. Instead "we have set the man's existing character as the criterion" (Dewey 1938, 208). What we should instead be interested in is the person's character in terms of what he approves and disapproves of. If he approves of not keeping commitments, what he should be criticized most harshly for is being the wrong kind of person, not that the pleasure he feels is inappropriate. Consequently what is ethically salient here is a person's character and not the pleasures he enjoys.

Second, pleasures and pains just "*happen* to us," notes Dewey (Ibid, 213). They come and go without careful reflection, conscientious judgment, or purposeful action. Dewey views pleasure as a brute or immediate response to some object of experience. Given his emphasis on investigation, criticism, and chosen action, it is understandable why he deems brute responses as not important in human behavior and interactions. The situation is different when Dewey critiques happiness being deemed the good as per a common rendering of Mill's consequentialism.[27] This version of Mill's theory, as presented in *Utilitarianism* (1861), holds that what is good is happiness and what is evil is unhappiness. The morally prescribed decision or action is then the one that produces the greatest net balance of happiness over unhappiness for all those affected. Dewey rejects Mill's theory when happiness is nothing more than pleasure as described above. Mill's theory is more acceptable if happiness is defined as Dewey suggests:

> Happiness is not to be sought for, but is something now attained, even in the midst of pain and trouble, whenever recognition of our ties with nature and with fellowmen releases and informs our natures (Dewey 1930c, 265), and
>
> Happiness is a stable condition because it is dependent upon the standing disposition of the self (1938, 213).

These two quotations hold that my happiness is ultimately about my character and my relations with my surroundings, which include my physical environment and other people. It is also not a transitory experience, but is stable as reflective of my character.

But Mill does not propose such descriptions of happiness, says Dewey. He comments that Mill's theory "seems to find good from a result which is not in organic relation with anything in the agent" (1900, 19). Since "individual judgment is an act, an expression of interest, habit, and ultimately of individual character," acceptable moral guidance must consider personal integrity and commitments (Koch 1991, xvii). Dewey grants weight to happiness only because it connects to individual character and to certain non-agent relative values. For instance, if I master a complex piano piece and such

---

[27] Other renderings or interpretations of Mill's theory describe the good and the evil as pleasure and pain, utility and disutility, or satisfaction and dissatisfaction.

mastery and artistry are valued in my community, then my happiness says something very different about me than if I am happy about saving money by cheating on my income taxes. In the former instance, the happiness is laudable because it reflects my sharing of communal values and my concern for the state of my character. In the latter instance, the happiness reflects non-social values and likely no consideration of my character. And so Dewey contends that morally required action must illustrate something about the person and how she sees or interprets her life in a communal setting. In this way, natural goods are prudentially valuable but included in prudent considerations are her welfare within an interactive community, her understanding of herself, and her image that she wishes to project to others.

Yet to be fair to Mill, he does countenance different kinds of happiness and unhappiness. One way that he proposes for making such a distinction is in terms of the quality of happiness. For example, Mill would agree that the happiness felt from learning to overcome one's fear of heights is qualitatively greater than the happiness felt from winning a $10 grocery gift certificate. Bentham proposed a "calculus"[28] for utilitarianism. Mill commended this careful scrutiny of what is relevant to comparing outcomes or consequences. Concerned that cultural pleasures would not be weighted more heavily than base pleasures, Mill held that the pleasure experienced from a high

---

[28] Mill adopts Jeremy Betham's original version of consequentialism which included a kind of "calculus." Bentham suggests using seven factors characterize happiness. The seven factors can be used to then compare strikingly dissimilar causes of happiness such as spending forty dollars for a lobster dinner versus donating forty dollars to Save the Children's Fund. The factors that Bentham appeals to are: duration, intensity, extent, purity, fecundity, probability, and timeliness. (Bentham 1838).

quality activity (e.g., reading a Shakespearean play or listening to the opera *La Boheme*) translates into greater happiness which, in turn, translates into greater ethical weight in comparison to the pleasure experienced from a baser quality activity (e.g., drinking alcohol). I think on further reflection, Dewey would applaud Mill in making such a distinction which could allow that a person's relationships with family and his self-respect count more than his enjoyment of a practical joke.

Dewey also offers a common criticism against happiness being deemed the primary end. Happiness is experienced because of other events obtaining. In other words, happiness is a by-product of, say, being honest or being adventuresome. A person does not experience happiness pursuing happiness itself, but in pursuing something else. And so happiness itself cannot be an end; it is simply a desirable "accompaniment" to the kind of action and character Dewey extols. "Man would never have happiness, satisfaction, unless he could feel his activity" (Dewey 1900, 31).

Kant's ethical theory seeks an objective process which can provide firm guidelines as to what is and is not ethical behavior. By being objective, it will consistently and equally guide human decisions. In *The Foundations of the Metaphysics of Morals* (1785), Kant develops what is known as the categorical imperative. Such an imperative imposes binding duties on people and thus is deontological. This theory is starkly different from a consequentialist theory such as Mill's because in using the imperative, possible outcomes are of utmost central importance. Kant contends that what is morally right and wrong does not depend on contingencies or particularities such as outcomes. This underscores that his standards for a valid moral theory are that it apply equally and consistently to all people in similar situations.

Three formulations of the imperative are said to be presented in *Foundations*, but the most important two are: (1) act only by that maxim which, at the same time, you can will to be universalized so as to apply to all people, and (2) act only in a way that treats humans, other people as well as oneself, as ends and not as means only. As a result of these two formulations, Kant's theory holds that "You must always keep your promises" and "You must develop your innate abilities and skills" are duties imposed on every person.

Kant's version of deontology is rejected by Dewey for two reasons. First, Dewey does think that human reason and choice are important morally. But he sees Kant as overemphasizing reason and will over all other aspects of experience and human nature. Cognition and will are only *as* important, not more important, as caring, ambition, fidelity, flexibility, and so on. Moreover reductionism, wherein two attributes are most special in humans, distorts the human *persona* because it discounts the innate complexity of people.

Second, Kant ignores context and embraces abstraction in order to derive an objective methodology for ethical decisions and actions. "It is [a] fallacy [to suppose] that because something can be derived from experience that it is in itself real apart from the circumstances with which it goes" (Dewey 1900, 27). Dewey doubts the applicability of an abstract rule to the peculiarities of any real situation. In my reading of

Dewey, he believes that responding ethically to the nuances and subtleties of any situation is the ethical challenge. To set aside such actual particularities as specific relationships (e.g., my mother and I are not getting along right now), feelings (e.g., I resent my sister's recent promotion), and self-images (e.g., I see myself as a generous person) is to distort the situation, at a minimum, or to "empty" the situation of its content, at a maximum.

Further, Dewey sees character and consequences as mutually bound up in any situation; more simply put, character does matter morally as do consequences: "the self is not a mere means to producing consequences because the consequences, when of a moral kind, enter into the formation of the self and the self enters into them" (1938, 316). A human is not just an agent who has no responsibility for the outcomes she purposively brings about. Dewey holds people responsible for their ability to imagine alternatives, predict outcomes based on past experience, reason, use their bodies, to choose effective means, and so on. Certainly there may be factors that people are not responsible for and they can be carved out so as to be fair and accurate in evaluating characters.

In conclusion, Dewey finds hedonism, Mill's utilitarianism, and Kant's categorical imperative unsatisfactory as compasses for moral human conduct. Dewey looks for moral ascriptions of goodness to connect in some way with a person's self-identity and to be connected with the ordinary demands and opportunities of daily living. In this vein, his ethical philosophy is less about the correctness or incorrectness of discrete decisions and more about people as both unique individuals and as social creatures. From this position, I now turn to his theory of the good and relevant features of his general ethical theory.

In his *Lectures on Ethics* (1900-1), Dewey proposes three categories of good: (1) natural, (2) ideal, and (3) moral. These three goods connect to ordinary experience in that a natural good relates to immediately-desired states of affairs, ideal goods relate to long-term states of affairs, and moral goods involve changes that must be made. Described another way, these three goods relate to different kinds of transactions or interactions that Dewey sees as natural to our world: the physio-chemical, the psycho-emotional, and the social. The relationship with the natural world is central. All of these goods arise or occur within the dynamics of living. They are not merely linguistic conventions (i.e., a way to denote my approval or liking of something) or entities that are part of some transcendental or immaterial realm (e.g., as in Hegel's the One or in Plato's Form of the Good). Dewey also develops a conception of the good which unifies and harmonizes the three kinds of good.

Natural goods are "those [goods] which appeal to immediate desire" (Dewey 1938, 224). Natural goods are also labeled as "immediate goods" and as "material goods" by Dewey. They are material in the sense that what is desired is a discrete object or idea. Desire signals a lack or shortcoming in my present circumstances: "there is no desire except there is obstacle...and conditions of effort" (1901a, 170). Desire and prospective effort both occur in what is experienced. The stimulus of a particular desire is a particular object or idea.

In the *Psychology of Ethics* (1901a), Dewey uses the example of a child and a bowl of sugar to illustrate what are natural goods. When the child sees the sugar, she recalls a past experience of tasting its sweetness. She realizes that she lacks having such an experience at this moment; the obstacle is that she does not have something sweet immediately at hand.[30] Also experienced, in terms of the conditions of effort, is the motivation to go to the sugar and dip in her finger.

Dewey contends that every experience, no matter how simple or how complex, involves a judgment. "The sensation of pleasure or pain is a sign by which we [judge] the value of experience" (1938, 178). When I experience shooting pain from an abscessed tooth, I judge the situation as one that I should to try to end. When I experience relief as I mail my annual income tax papers just thirty minutes before the filing deadline, I judge that I should not repeat my actions next year. Judgment involves valuation, says Dewey; that is, we continually estimate, appraise, and assign value:

> We do not content ourselves with a purely external statement about the weather as it is measured scientifically by the thermometer or barometer. We term it fine or nasty: epithets of value. Articles of furniture are judged useful, comfortable, or the reverse (1938, 290).

Importantly, Dewey makes a distinction between noting that "I want *X* because I like painting" and "I want *X* because it helps me display my artistic abilities." As will be seen

---

[30] If she was eating a sweet candy at the time of seeing the sugar, she would probably not desire the sugar because she experiences no absence of sweetness.

shortly, the concept of judgment is central to Dewey's view of humans being as active participants vis-à-vis their surroundings and their social groupings and the importance of being responsive and responsible.

Returning to the situation with the child and the bowl of sugar, the natural good is the sugar. It can effectively satisfy the immediate desire for sweetness. But once the sugar is tasted several times, the child no longer experiences a "lack" and so she removes her finger. Her immediate circumstances, all other things being the same, have returned to a kind of harmonious equilibrium. At the same time, the sugar at issue no longer qualifies as a natural good since it is not desired by anyone; it is no longer an end-in-view.

In the case of a Deweyan natural good, there is no accompanying doubt or confusion in the child. The child acts deliberately and confidently: seeing the sugar reminds her of the experience of sweetness, she knows she lacks this experience at that moment, she judges that that particular sugar can eliminate the lack, and she judges that she is able to get to the sugar. But what if the sugar is actually cornstarch and so her desire will not be fulfilled? She will still act deliberately, but since her desire will not end, the cornstarch does not qualify as a natural good. And what if she is unsure as to whether the substance in the bowl is sugar or cornstarch; won't she be confused? When she thinks that it is sugar, it will prompt the desire for sweetness as she remembers the last time she tasted sugar. But when she thinks it might be cornstarch, which she recalls tastes like flour, no immediate desire for that taste arises. With such competing judgments (i.e., sugar promises sweetness, cornstarch promises an uninteresting flavor), she approaches the bowl not in a confused frame of mind. Instead of just dipping her finger into the bowl and putting her finger immediately into her mouth, she acts differently. She first looks carefully at the texture of the white substance because she remembers that sugar is usually granular while cornstarch is powdery. Thus her behavior is appropriate for intelligently fulfilling her desire for sweetness. In realizing that the two past experiences are relevant to the situation at hand, there is no confusion.

When Dewey says that a natural good can be an idea, a practical example might be: a man works the night shift and so must sleep during the daytime. He remembers that it is hard for him to sleep when the bedroom has too much light. The sun shines directly into his bedroom window in the afternoons. The idea that prompts a desire for thick curtains is the wish to be rested. But what can be said if the curtains do not help him to actually sleep soundly? Certainly he will continue to desire rest. Armed with the new knowledge that it is not only daylight that prevents him from sleeping, he remembers that he cannot abide outside or street noises. The desire for rest now prompts him to purchase ear plugs. And so "thick-curtains-and-ear-plugs" constitutes a natural good for him because with them, his desire for rest will be satisfied.

Can we say that he was confused in the beginning? No, because he was clear on what he desired. Can we say he was mistaken? Yes, because the curtains were a necessary but not a sufficient condition. A person will not be confused about his desires as immediately experienced, according to Dewey. So too for not being doubtful about his desires as they are experienced. In other words, the man was not confused about wanting rest. And at the time, he was not doubtful about the benefit of the curtains prior to hanging them nor about the benefit of the ear plugs prior to buying them. If he had been doubtful about the curtains, his thinking would have been: "Now they will help but not completely. What else do I need so that I can sleep?"

"Only a self of complete rigidity in nature, plus a purely stable world, could possibly yield ready-made and unalterable goods" (Crissman 1928, 630-4). Since a natural good is the content of *this* child's or *that* man's action, which is in response to *her* or *his* desire, each natural good is unique. The irreducible connection to actual desire means that this kind of goods is particular, circumstantial, and contingent. Similarly there is no set or correct hierarchy of natural goods; no *summum bonum*. And because of the uniqueness of each agent-situation, rules and principles are unhelpful. For instance, sugar can be infested with insects or can require too much effort to obtain (e.g., in the case of the child, if the sugar bowl is stored far out of reach though still in sight) and so she cannot always act on a general rule such as "Eat sugar."

The second type of good is labeled as an ideal good:

> The ideal must be the projection or anticipation of a unified experience which contains in its unity what we have already presented to us in scattered and more or less opposed forms. What we have got is particulars and they are made particulars by the fact that they do not organize. In that very consciousness of discrepancy there is a vague, undefined consciousness of a possible unity or harmony. And that conception is what we mean by the ideal (Dewey 1900, 59).

Dewey notes that an ideal good has a "beyond-ness" in that it is "an instance in which a man throws himself ahead" (Dewey 1900, 60). In contrast, a natural good is about here-and-now with a specific means identified. An ideal good has three functions: it is a process for "illuminating actual existing conditions," it is a process for unifying experiences, and it is transformative (Ibid). An example is timely here. Dewey offers the case of social justice as an ideal good and the specific experience I will use is submitting my annual income taxes to the federal government. The ideal "illuminates" or brings to the foreground of my thoughts what I know other people pay in taxes and their incomes, what public programs I use and do not use, and what programs other people use and do not use. These separate conditions are brought together and unified into my experience of social justice in America. Suppose that social justice means proportional distribution of benefits and burdens among the members of a community or society. In examining the actual conditions, I find that there is a lack of proportionality. One factor that obstructs fairness from manifesting is my preference to be independent and as a result, my use of public programs is minimal. I can change this personal propensity into a means if I begin writing my elected representatives to modify the tax rules so as to reward independence. In this way, "obstacles [are transformed] into means" (1900, 43).

An ideal good must be attainable at some point in time, says Dewey repeatedly. Ideals that demand human perfection are unattainable because humans are fallible, finite creatures. If recognized as unattainable, a particular ideal good will not adequately motivate a person and then his striving towards a particular end will cease. For instance, if an ideal good is suggested to be making no mistakes on examinations (i.e., to earn a perfect score) then it will not motivate most students. In place of that ideal good, the ideal good that students should perform to the best of their abilities and talents is what motivates students to try to attain the highest score possible. This second ideal good is effective in unifying the various “actual conditions” (e.g., students studying hard, trying sample questions, and getting enough sleep the night before) to explain the experience of taking a major examination. It is important to note that Dewey sees ideal goods as socially bound which is to say that an ideal good is not a private or idiosyncratic good. Ideal goods relate to the psycho-emotional level of transactions between the human organism and its environment. The psycho-emotional parts of life always involve mutual interactions and connections with other people, whether they are family members, friends, or strangers in special roles (e.g., my bank’s loan officer or my own clients). “Doing the best one can” is a shared value in American society; “making no errors on an exam” is not.

Unlike natural desire and natural goods, there are no definitive criteria as to what constitutes a specific ideal good. Though not phrased in the language of good by Dewey, his notion of a standard is relevant to further delineate the content of an ideal good. The major difference between a standard and an ideal good is “a difference of the degree of consciousness in use” (Dewey 1900, 69). A standard is a:

> Valid ideal, or the ideal which has been consciously conceived as ideal with reference to its capacity to [act as a principle of interpretation on the psychological side, and as a method of control or direction on the practical side] is the standard (Ibid).

In the example above, the standard of social justice is the definition given. Admittedly there are other definitions. But the notion of validity means "whether the ideal will work" (1900, 70) in the present circumstances: does it unify? Does it help change obstacles into means? Dewey acknowledges that there can be some ambiguity or flexibility in an ideal good in terms of what standard is legitimately applicable to the situation under consideration. In seeing the actual consequences of using a certain standard, a person may modify how important the ideal is. If seeking proportionality repeatedly results in strife within the community I live in, then I may judge social justice to be of less value. Or I may find that the specific standard I have been applying fails to capture all that I think is reflective of justice, and so I will adopt a different definition.

"The particular ideal of good at a given time and what we take as our standard of good need not… coincide with each other. They are always modifying each other" (1901a, 186). What is noteworthy in this claim about mutual modification is that Dewey is once again underscoring the contingent dynamics or give-and-take of a complex organism (i.e., a human being) living within complex systems (e.g., a society and the natural world). Accordingly no ideal can ever be considered absolute and no standard can ever be considered definitive.

A moral good "exist[s] only when something has to be done. The fact that something has to be done proves that there are deficiencies, evils in the existent situation" (Dewey 1920, 169). Key here is the obligatoriness of action: of identifying the end to bring about and the means to be successful. A natural good creates no duties;

neither does an ideal good. But a moral good has a sense of urgency associated with it: the current situation cannot continue. But the ensuring question is how does a person or a group of people know when something must change. This is the function of the good itself. When the good is being undermined, then a person must act.

Dewey defines the good as:

> a system, an organism, something which pervades a variety of different forms of value and which holds them together in such a way that the good *cannot* be realized except as these goods can be realized…the idea of a harmonious and harmonized, inclusive unity is necessary to the good (1900, 49).

Dewey also offers a more condensed characterization of the good: it is growth which involves increasing (1) one's abilities for adaptive living and (2) the meaningfulness of one's experiences. Growth fits with Darwin's emphasis on the mutual interactions between organism and environment. For Dewey, a human being does not have a static essence that must be perfected. Kanne notes, "There are no fixed self-enclosed finalities…life is interruptions and recoveries" (1988, 217). And Dewey also holds that humans are not reducible to a handful of special abilities. And finally a human being is not an isolated, self-determining creature. Instead he sees humans as multifaceted, living as multifaceted, nature as multifaceted, and society as multifaceted. Moreover humans, nature, and society change and evolve and as a result, living changes. These dynamics are underscored in the concept of growth:

> the process of growth, of improvement and progress, rather than the static outcome and result, becomes the significant thing…The end is no longer a terminus or limit to be reached. It is the active process of transforming the

> existent situation. Not perfection as a final goal, but the ever-enduring process…is the aim of life (Dewey 1920, 176), and
>
> the rectifying of present troubles, the harmonizing of present incompatibilities by projecting a course of action which gathers into itself the meaning of them all (1930c, 210).

When Dewey describes growth as "the consummatory value," he is not claiming that it is the highest good (1901b, 370). Instead he is saying that it integrates and harmonizes diverse but critical elements of life. Crissman explains this point by noting that the "good becomes coextensive with *all* of life's significant concerns" (1928, 598).

A very evocative characterization of the Deweyan good comes from Gouinlock in his book, *John Dewey's Philosophy of Value* (1972). He sees the good as ultimately artistic in that its meaning or significance exceeds itself:

> Intelligent and imaginative concentration on resolution of the existing problematic situation augments the forces of growth by deliberately converting agencies of conflict and frustration into effective powers. When conduct is art, the problematic situation is resolved by discerning its active tendencies and anticipating its possible outcomes, and also by drawing liberally on the past. If there is successful resolution, and consummatory experience ensues, it is clear that such experience is at the same time a fulfillment of the past and portentous of the future….the *situation* becomes consummatory by the organic and functional interaction of its constituents (1972, 250).

The aesthetic here is the balanced integration of the actual and the possible, the past and the future.

The iterative dynamic between oneself and the environment has two very significant outcomes. First, the self becomes more defined and refined in terms of successful habits for living. This involves the idea of being more responsive to one's surroundings; in Darwin's terminology, more adaptable. To be more adaptable is to have increased abilities, habits, relationships, resources, and knowledge.

This increase, however, is not meant to mirror the adage "more is better." Recall that growth is directed towards attaining a harmonious unity in one's life. So greater abilities are not desirable because they allow for greater power with which to conquer or oppress others. It is pivotal to note that Dewey believes that a good life involves cooperation with other individuals and the community-at-large over the long-run. People must rely on each other and so cooperation is necessary.

But imagine that someone suggested that having three cars contributed to adaptability more than having one car just as having an immense hard-drive on a personal computer is superior to having a moderately-sized hard-drive. The concern here is that if Dewey agrees that these do contribute to adaptability, and thus qualify as good, then consumerism will be embraced which, in turn, places pressure on health care producing more and more and more. I believe that Dewey would criticize rampant consumerism on the grounds that it does not promote cooperation. Much of the energy within consumerism is, I suggest, competition; that is, to have "bigger, newer, faster" when other people do not. Materialism can also be an outcome of ego wherein a person finds self-worth in possessions. Dewey would reject such a source of self-value and in its place recommend self-worth based on mutual, long-term relationships with others plus a feeling of resiliency and agency because of living in a complex, dynamic environment.

Even more importantly, Dewey posits that "'apart from the social medium…the individual would never "know himself," he would never become acquainted with his own needs and capacities'" (Welchman, 1995, 165). In this vein, it is imperative that a person maintain a place for herself in society in which she can be the kind of person she is and the kind of person that the community can allow. Dewey rejects egoism on a factual basis in that no person, or very few, can do well in society if concerned only with self-interests. Similarly he rejects the idea of radical self-creation wherein everything one values and chooses is created by the individual herself. Dewey claims that facts support his statement that peoples' behaviors are socially conditioned. The "facts" of which he is thinking are:

> others do take account of what we do, and they respond accordingly to our acts. Their responses *do* affect the meaning of what we do…All the actions of an individual bear the stamp of his community as assuredly as does the language he speaks (Dewey 1930c, 317).

As a consequence, Dewey considers it to be obvious that every citizen, if intelligent, will act in ways that are compatible with society just as society will structure itself so that growth in every citizen is possible. This still leaves room for progressive change as both citizens and society evolve in concert.

A second outcome is that experiences themselves become increasingly meaningful. What does Dewey mean by this claim? As a starting point, in *Experience* *and Nature* (1929b), Dewey defines meaningfulness as "things in their immediacy are subordinated to what they portend and give evidence of" (108). And "meaningfulness" is not simply symbolism or importance, but rather is "the acquisition of significance by things in their status in making possible and fulfilling shared cooperation" (Ibid, 149).

It is critical to note that such cooperation is reflective of shared understandings, values, identities, and commitments. This is the source or basis of a claim that meaningfulness occurs in the form of cooperation. Cooperation therefore is not just about congenial exchanges of objects or information. And the notion of cooperation is important for Dewey because he does not wish to privilege or allow for exclusive self-advantage being the criterion for goodness. He contends that each person is inextricably linked to other people in intimate, highly significant relationships and that both parties benefit by maintaining strong relationships. Moreover my opinion of myself is not "private" by which I mean that, for Dewey, my self-image is in part dependent on others' opinions of me.

An example of meaningfulness is my donation of one hundred dollars to a non-profit organization with a mission of reducing illiteracy by offering reading programs. My donation increases the meaningfulness of my life because I am connecting myself to those who are less fortunate than I.

There is one passage in *The Psychology of Ethics* (1900) in which Dewey seems to say that experience is greater than growth:

> The whole process of experience is more of a good, and a deeper good than the good itself. That which we formulate as the good is a phase of the whole process of the development of experience itself. And it is the good which it

> is simply because of the part which it plays in this experience (Dewey 1900, 25).

Is Dewey saying here that it is experience that qualifies as the good, not growth? A straightforward answer is not evident so I will begin with an analogy using the case of justice. If I said that trial by jury was more just and a deeper justice than justice itself, what am I saying? I am pointing out that a real trial actualizes or operationalizes the concept of trial. From this, I suggest that an actual instantiation of something surpasses the associated concept in terms of reality. In the instance of the trial, what it "looks like and feels like" is richer than its associated concept. In being "richer," there are more details involved than could ever be captured in a concept's definition. In other words, to see and hold a kitten is much different experientially and epistemologically than memorizing the definition of kitten.

Returning to Dewey's quote about experience and the good, I interpret him to say that experience is the phenomenological foundation of everything connected to humans. Growth is not a foundation of all that exists, but rather it directs us to what we should pursue, given the kind of creatures we are, the kind of context we are in, and the kind of interactions we rely upon.

Conclusion

This chapter's over-arching goal is to identify what John Dewey considers to be the good in his moral philosophy. The Deweyan good is growth which has two components: adaptability and meaningfulness. This concept will be applied in the next chapter to the practical biomedical ethics case of the health-care system in America to ascertain in what ways, if any, does health care qualify as good.

Dewey's moral psychology is heavily infused with his pragmatism. He does not seek perfection of human nature or some glorious transcendent realm. Instead his theory incorporates the past, the present, and the future. The past is relevant because we have knowledge of the consequences of prior decisions. For Dewey, knowledge involves not just reasoning abilities. It involves reflecting, remembering, weighing, analyzing, and so: aspects of what can be labeled as "critical thinking." It is, however, just as important that such knowledge informs action. Knowledge that has no effect on an agent's decisions and actions is of no interest to Dewey.

The present is relevant because of the kind of person the agent believes himself to be. The present is also salient because a problem has been identified such that action is needed. And the future matters because of the possibilities for improvement, for solving the problem, and for re-establishing a harmonious balance.

Just as he embraces this "fullness of time," Dewey emphasizes the complex richness and diversity of human life as well as its interconnectedness. Growth is not a definitive term that sets rigid criteria for everyone. It is to be thought of as a process that accommodates the heterogeneity of characters, talents, and circumstances.

Admittedly Dewey's moral theory does not sanction everything and anything a human might do at a particular moment. An individual is not a supreme sovereign.

Instead Dewey holds that a person lives deeply connected to other people, to a community-at-large, and to his physical environment. As such, he has responsibilities to others as well as to himself which demand nurturing and moderation if they are to endure over the long-run. This emphasis on the ethical significance of context reflects the organic naturalism of Dewey's moral theory.

Dewey's pragmatism is a provocative contrast to other philosophical theories that privilege the individual, the faculty of cognition, consequences, or that establish absolute rules, or that strive to find "Truth and Reality." His inquiry into the natural world, human beings, and their interactions seems much more realistic and humble. He seeks to accept humans as complex social creatures that care about relationships and character. Moreover these creatures strive to be intelligently attentive and responsive and in so doing, accept responsibility for the practical means they utilize to bring about the ends they choose. The concept of the good encompasses all these points and accordingly promises to be a very useful mechanism with which to evaluate the goodness of health care, a societal endeavor focused on improving the lives that Americans lead. Similarly, the fact that Dewey's theory can be described as empirical naturalism affirms its synergies with health care which relies heavily upon the sciences' investigation of human physiology. In other words, Dewey's theoretical work can shed light on the practical case of the health-care system.

CHAPTER IV

Dewey's Theory of the Good, Health, and Health Care

Introduction

This chapter represents this dissertation's shift from theory to praxis or, more specifically, the application of theory to practical problems. There are many problems and challenges in reforming the U.S. health system. However the practical problems to be addressed herein are of two kinds. One problem is how to ethically allocate scarce resources among competing social programs. The resources under examination here are funds obtained by the government through taxation. These resources are scarce in that there has been, and continues to be, inadequate funding to cover the costs of assisting all citizens who need the help of others so as to have a reasonably good life. Articles and reports in the press are frequently about a government's budgetary woes, whether it is a reluctance of politicians to support new or increased taxes or a looming shortfall in funds to cover promised services.

"Social programs" means programs accepted through legislative action to be the government's responsibility, such as sanitation, income protection, utilities, education, the military, police and fire departments, and so on. For the purposes of this dissertation, "government" includes federal, state, and civic governments. Some social programs are the exclusive responsibility of the federal government (e.g., Social Security and the military) and others will involve shared responsibility with states or cities (e.g., highways and education).

The division of responsibility is not critical here. What is important is that these programs rely on tax dollars to cover most or all of their operating expenses. When a program is funded through taxation, this means that the costs are borne by the general public. Another way to phrase this is that the associated burdens are borne by the public. What follows from this is the ethical claim that the public should then have some measure of involvement in the decision of how the funds will be distributed. In other words, this is the decision of who will benefit and how much.

The second problem is distributive, too. It is how to ethically allocate scarce resources among competing medical interventions. This decision is "closer to the patient" in that the kinds of choices to be made are the level of funds directed into, for example, cancer treatments, well-child check-ups, and psychological counseling. As such, these are meso-allocation decisions.[30] Again, insufficient tax dollars are available to cover the costs of researching, manufacturing, and providing all therapies that Americans who are ailing, injured, or dying could use. Of the 1.4 trillion dollars spent on health care in the U.S. in 2002, 44 % came from public coffers (e.g., tax funds) and 56 % from private coffers (e.g., employer insurance plans or individual savings)

---

30. "Micro-allocation" is sometimes used to refer to decisions relative to individual patients; for instance, a physician choosing whether to treat, and then to what extent, a woman with gastric reflux disease versus a man with a peptic ulcer. Both patients "use" the physician's billable time. And if both patients belong to a managed care insurance plan, the physician knows that there is a definite limit on available resources to be shared by all enrollees of that particular plan. The term "meso-allocation" is being used in this dissertation to reflect distributive decisions among groups of patients, not between individual patients.

(*Statistical Abstract of the United States* 2001). It is worth noting that the private contributions are overstated because the government allows corporations to shield health benefits from taxation. In this way, the government underwrites private insurance.

The objective of this chapter is to examine how Dewey's theory informs public policy decisions that involve rationing. Prior to exploring this dissertation's two allocation problems, a discussion as to what constitutes health is needed for two reasons. First, there has been a debate in the biomedical ethics literature concerning how to accurately define "health." Second, we are not interested in health care, whether it is in the form of medical or public health measures, just so as to have health care. Rather, health care is considered valuable because it contributes to human health. Its value is derivative to that of health itself. And so before tackling the practical side of health care, it is necessary to understand what constitutes health or being healthy by means of scrutinizing definitions of health and deciding which is most persuasive or strongest. Then Dewey's notion of the good will be applied to health itself to affirm that it is indeed a good thing after which will follow a comparison of health as defined and evaluated in this dissertation to health as defined by Daniels and Callahan. The objective of this comparison is to underscore the impact of Dewey's philosophical work to the practical issue of health-care reform. In other words, what might Dewey say in examining Daniels' and Callahan's recommendations for rationing health care?

Defining health

The debate as to what is health revolves around two basically opposed viewpoints: health is a biological notion (which includes body and mind) and health is a sociological notion. Phrased differently, what is at issue is objective fact versus subjective value. To say it is sociological or subjective means that being healthy is determined by what a society decides it needs its population to be able to do and to be permitted to do and to what extent. For instance, if a society's economy depends heavily on taxation, then the longer people can work and pay income taxes, the better. A healthy citizen would then be someone who works until age 80 or so and is not absent more than the average employee who is in his 30's or 40's.

Resolving the debate about the nature of health has two advantages. Discussions are more productive when there is agreement about terminology. And responsibilities for improving or preserving health can be appropriately assigned once we are clear on what health involves. If health is biologically based, then medicine and public health should be involved because they can more readily affect what a person's body and mind can do. They are based heavily on empirical studies and human physiology. But if health is sociologically based, then other agencies, disciplines, or enterprises must be involved (e.g., schools, public transportation) because they can affect what opportunities and roles a person can fulfill.

Let me begin with Christopher Boorse's classic biological characterization of health (1975). He first notes that "organisms are vast assemblages of systems and subsystems which…work together harmoniously in such away as to achieve a hierarchy of goals" (Boorse 1975, 551). This hierarchy of goals starts at the cellular level and progresses to the level of organs and eventually to the entire organism itself. Boorse continues on to define health in a simple way: it is the absence of disease. Disease, in turn, is "deficiencies in the functional efficiency of the body…when they are unnatural, and they may be unnatural either by being atypical or by being attributable mainly to the action of a hostile environment" (Ibid, 552-3). Although the definition does not specifically mention the mind, the references to functional efficiency and the body can be interpreted as covering mental abilities in that the brain is a part of the physical body whose functions are cognitive.

To illustrate this definition, a person is not healthy if, for instance, she has endometriosis, paranoid schizophrenia, melanoma, or the flu. Endometriosis and paranoid schizophrenia qualify as diseases because they are not statistically normal for the human species. Skin melanoma and the flu qualify as diseases because they are caused by "a hostile environment." Boorse adds that the value of health comes from "nothing but the value of conformity to a general excellent species design" (Ibid, 560). Since his explanation of health refers to functions, efficiency, statistics, and the species, it is considered a biological or objective characterization of health. And given this perspective, medicine and public health would be assigned responsibility to intervene. Yet by Boorse's lights, medicine and public health's goal is thus not to maximize or optimize individual capabilities beyond what is normal for the species.

Boorse suggests that the value neutrality of his definition is a positive feature. In this case, being value neutral means the definition does not include any particular prescription as to the kind of lives humans should lead or the goals they should pursue. No mention is made of promoting happiness, preserving a self-image, or even ending suffering. Neutrality is considered advantageous because it promotes the likelihood of people agreeing as to what is and is not a disease.

Boorse describes illness as also being free of values. Illness is the presence of a disease that is unwanted or undesired by the afflicted person and that provides "a valid excuse for normally criticizable behavior" (Boorse 1975, 555). The kind of behavior he means is not fulfilling one's responsibilities, poorer personal hygiene, being less communicative, and so on. If someone carries the HIV virus, he would be deemed to have a disease and not healthy because the virus is atypical. Yet if he continues to follow his daily routine and discharge his normal duties, he is not ill. But when his body weakens to the point of having to perhaps work only on a part-time basis, then he qualifies as being ill.

This definition of health is unacceptable because it does not countenance problems in a person's psychology, emotions, or behavior. A depressed person, suffering from organic depression as opposed to situational depression,[31] would not be considered ill or unhealthy and neither would a person who is addicted to shopping. And confusion surrounds the claim of value neutrality and the claim that goals are organic.

---

[31] Depression is considered to have two causes. One is a biological dysfunction of the brain. The other is dysfunction in interpersonal relationships.

To illustrate my point, consider the fingers which are part of the "system" known as a hand. The fingers' purpose is for holding, manipulating, or picking up objects. Yet it is not just any object that a person desires to hold or pick up; it is certain objects. For instance, I want to hold a writing instrument so that I can write notes during my university class lectures, be subsequently more likely to earn a university degree, and then be more employable. It is not enough to say that holding itself is important because the subsequent question is "What do you need or want to hold?" so as to determine the range of movement and strength of the fingers. The reason I want the dexterity to hold a pen or pencil rather than a fire hose is my career aspirations. Thus a discussion of values is necessary.

Daniels (1985) begins just as Boorse does: health is the absence of disease. Daniels defines disease as deviations in natural functions, mental or physical, that are normal for a member of our species. The inclusion of "normalcy" means a rejection of maximizing or perfecting human abilities. By Daniels' definition, exceptional intelligence is not considered a disease because it does not prevent an organism from functioning normally. A person with a "genius IQ" is still able to make coherent choices, look after his physical well-being, and interact effectively with other people. However infertility counts as a disease because reproduction is a normal function of any species.

Daniels' evaluative move occurs when he argues that the value of being healthy is to take advantage of opportunities. He notes that he has been influenced by John Rawls' seminal work on social justice (Daniels 1985, 40). Opportunities are valuable for self-expression, agency, happiness, or whatever the agent desires for himself. Daniels constrains opportunities by adding a "normal range" of opportunities to the definition. Daniels defines this range as "the array of life plans reasonable persons...are likely to construct for themselves" (1985, 33). The constraints are in two forms: societal and innate talents (as opposed to learned abilities). In other words, a healthy person can pursue a set of opportunities that are delimited by the society or community she lives in and by her skills and talents. So if a woman lives in a highly patriarchal society, the responsibilities and activities deemed "normal" for her will be very different from those expected of her in a liberal or egalitarian society. Similarly the normal roles and activities that can be pursued will be very different for a woman who is mentally handicapped or is 70 years old compared to those for a woman who is athletically-skilled or is 22 years old.

From this characterization of health, the purpose of medicine is limited by species' functioning, societal expectations and "permissions" (in terms of what a person is expected and permitted to do), and innate abilities. This counters contemporary medicine's focus on the individual as unique, autonomous, and self-creating. Most physicians today continue to see themselves as devoted advocates for each of their patients. Thus they are expected to fight tenaciously for each of their patients' best interests, exclusive of all their other patients.[32]

---

32. The advent of managed care challenges the primacy of the individual patient as discussed in Chapter I. There is growing pressure on physicians now to try to balance the competing interests of multiple patients.

Daniels' position mirrors the definition developed by renowned functionalist sociologist Talcott Parsons:

> the state of optimum *capacity* of an individual for the effective performance of the roles and tasks for which he has been socialized (Parsons 1958, 69).

Parsons' focus here moves to the individual but the invocation of what socialization demands of him means that the individual is not free to do or pursue whatever he wishes. Just as Daniels limits health to what is normal within a particular society, Parsons limits the range of activities also to what a particular society expects of its members.

I reject Daniels' and Parsons' definitions on the grounds that they place excessive authority on society for setting boundaries as to what is normal. Imagine a country that oppresses its women. As a consequence, women would have a highly restricted range of opportunities to them. What is then deemed worthy of medical intervention would likewise be limited. Afghanistan under Taliban rule is a ready example. Afghani women who experienced serious eye strain due to reading would be denied corrective eyeglasses but not if the eye strain is caused by close needlework.

An example "closer to home" illustrates the point further. Writers on feminism have vigorously debated research in and techniques for assisted reproduction. Case in point: processes such as in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and intracytoplasmic sperm injection

(ICSI) are now familiar clinical interventions to overcome infertility.[33] Yet an ethical concern with their development is that such ordinariness can mean that an infertile woman feels pressured to pursue such interventions so as to become pregnant. Yet if a woman is not willing to do "whatever it takes" to be pregnant, then she may be judged selfish or judged a weak-willed mother.

Many feminist writers worry that assisted reproductive technologies (ARTs) reinforce the enduring social stereotype that motherhood is not only natural to a woman but also largely defining of womanhood (Warren 1988). Referring back to Daniels' and Parsons' perspectives, ARTs would be readily available because motherhood continues to be a socially-prescribed role for women, irrespective of individual priorities. The further point here is that fatherhood is not as consuming a definition for men and hence there is an unjust reproductive double standard. And so Daniels' and Parsons' positions are unable to obviate societal or cultural discrimination, which is an unacceptable limitation.

Other definitions of health have been developed which place a greater focus on the personal:

a person's psychophysical capacity to act or respond appropriately (in a way

---

33. IVF involves adding sperm to a Petri dish that has unfertilized ova and then several fertilized eggs are placed inside the woman's uterus. GIFT involves placing an egg and sperm in the fallopian tube with the expectation that fertilization will occur there. ZIFT combines IVF and GIFT: an externally fertilized egg or zygote is placed in the fallopian tube. ICSI is the process of manually injecting a sperm into the center of an egg. GIFT, ZIFT, and ICSI are viewed scientifically as improvements over IVF because of increased control over various natural steps in the reproductive process. The presumption is that the greater control, the greater the likelihood of a pregnancy (this presumption has not yet borne out).

> that is supportive of the person's goals, projects, and aspirations) in a wide variety of situations (Whitbeck 1981, 620),
>
> a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization 1942, 83), and
>
> the experience of well-being and integrity of mind and body (The Study Group[34] 1996, S9).

The definition proposed by Whitbeck includes the psychological condition of humans as well as the physical and references dreams and priorities. Thus this definition is more holistic in its conception of health and its purposes. Whitbeck also stops short of demanding success in whatever a person attempts (hence its use of only "capacity") or in every situation. Health relates to *available* capacities. It does not relate to the outcomes of using said capacities or to a demand that the person does use them.

The World Health Organization's (WHO) definition is frequently referenced in the bioethics literature because of its clear invocation of the mental and social in addition to physical aspects of human life. Moreover it often praised because it is seen as acting on behalf of people everywhere and their interests. With its political power, it represents a voice against governments that do not put their citizens' welfare first and it represents a voice of support for governments that struggle to care about their citizens' welfare.

I see the definitions proposed by WHO and the Hastings Center Study

---

34. "The Study Group" was a group of philosophers and bioethicists at a premier bioethics think tank in America, the Hastings Center, who developed a position paper on the contemporary goals of medicine (1996).

Group as being standards that are impractical, unrealistic, and excessive. I doubt whether *complete* well-being is ever possible for a sustained period of time. And “well-being” is much more than health in that I believe that it includes feeling safe, happy, respected, loved, and challenged. Accordingly, neither definition is likely to actually effect positive change. So they remain conceptually intriguing at best.

Of the above list of candidate definitions, Whitbeck’s definition is preferred, but with some modification. As a reminder, Whitbeck posits that health is:

> a person’s psychophysical capacity to act or respond appropriately (in a way that is supportive of the person’s goals, projects, and aspirations) in a wide variety of situations (1981, 620).

A concern with this definition is the person whose goals or hopes are deemed unethical. For instance, think of the woman who seeks revenge on a colleague by sabotaging her work over a two month period. If she has the physical stamina and the mental acuity to work sixteen hours days and to keep track of a myriad of small details so as not to get caught, do we want to say she is healthy? We would likely say she is healthy if her goal was to raise money for survivors of a tornado. Stamina and acuity are desirable for most people. It is a separate issue as to what a person decides to do with her body and her mind. Someone can be healthy yet a morally praiseworthy person just as someone can be healthy and blameworthy. Health is about physical, emotional, cognitive, and psychological capacities. Therefore I propose modifying Whitbeck’s definition to:

> a person's psychological, emotional, cognitive, and physical capacities to act or respond intelligibly in a wide variety of situations.

What is implied by the word "intelligibly"? Inclusion of this qualifier ensures that a marginal or minimal ability to act or respond is insufficient to denote being healthy. Similarly it ensures that the kind of action or response matters. For instance, if during a conversation a casual acquaintance asks me "Would you like to get a cup of coffee?" and I respond by turning and running away, this is unintelligible at first sight. If I do not want to go, simply saying "No, thank you" is an intelligible response. If running away is explainable because of paranoia and as such, I am unhealthy. But if running away is due to an error in translation because the other person speaks a different language, then I am not unhealthy. What is intelligible will depend on the particular situation and the explanation provided. Inclusion of intelligibility in the definition is warranted so as to disallow just any action or behavior being indicative of health.

A possible challenge to "intelligibly" is that it is redundant to Whitbeck's inclusion of goals and aspirations but I disagree. "Goals, projects, and aspirations" tend to imply the long-term and the significant and thus not able to consider an immediate, simple desire not to have coffee with an acquaintance at this. To say "It is my goal or my project or my aspiration not to have coffee with *X*" seems arrogant. The definition does not guarantee that a desired outcome will happen. Factors outside a person's control, and thus not responsible for, help determine actual consequences. A conception of health should not include accidental factors or independent factors.

Health and Dewey's concept of the good

For the purposes of this dissertation, health is "person's psychological, emotional, cognitive, and physical capacities to act or respond intelligibly in a wide variety of situations." Definitions are highly condensed summaries of what something is. Yet to ensure understanding, an explanation is often needed in order to describe the nature of something more fully. I see this being the case relative to the chosen definition of health.

With this said, I begin explaining what health is by noting that people are not one dimensional. They interact and respond on many levels. Therefore being healthy involves mental, emotional, psychological, and social capacities of a person. Further, people live in a complex environment or in complicated situations that change. So to be healthy, it is not enough to be able to respond intelligibly to a handful of situations or to only a few kinds of situations. However in being healthy, there is no accompanying guarantee that a particular goal will actually be realized, that happiness will be found, or misfortune always avoided. Health is a means to reaching various, not all, ends.

Based on this expansion of the concept of health, does it qualify as a good thing by Dewey's concept of the good? The Deweyan good is growth so whatever supports growth will be judged to be a good thing. Growth is defined as that which adapts to these surroundings and that which finds meaningfulness in its surroundings on an ongoing basis and over the long-term. More simply put, the greater the adaptability and the greater the meaningfulness, the better. So based on the earlier explanation of healthy or being healthy, it does indeed qualify as a good thing according to Dewey's work because it contributes to both adaptability and meaningfulness.

In more general terms, Dewey would accept this definition of health for several reasons. A person is conceptualized holistically rather than reduced to a few special traits and is realistically accurate. Emphasis is on responding and acting, which accords closely with Dewey's focus on activity. He believes that experience always involves activity, either as response or as action. Our activity in the world and in our communities confirms our existence and agency. Appropriateness means that there are standards and rules. Not every response or action is valuable or good.

Just as we "fit" in the natural world, so we "fit" in our society and in our communities. Moreover appropriateness means fitting for the intended purpose which, in turn, requires knowledge. Dewey wrote repeatedly about thinking in activity. And lastly, everything is situational because humans are situated in a particular society at a particular point in time. The definition of health does not demand perfection in terms of being able to act in all situations. Dewey would accept this on the basis that nothing is perfect and to set a standard at perfection is to produce negativity and pessimism. His theoretical outlook is very optimistic as shown in his pragmatics: progress, endurance, and cooperation.

Competing views of health as good

Just Health Care (1985) presents Daniels' development of an ethically-justified health system. He acknowledges that financial funding remains insufficient to help all Americans in need of health care. His criterion for judging whether a specific individual is healthy or is unhealthy incorporates the concept of species-typical functioning, a range of life plans *qua* opportunities, parameters of what the individual's society or community supports and sanctions in terms of life plan, and the individual's innate skills. For a man who is talented in the industrial arts (e.g., carpentry, metal working) and who lives in a society that wants beautiful furniture or highly efficient machinery, the range of opportunities that he will be supported in pursuing would include being a carpenter or machinist, or teaching carpentry or metal working. But consider another man who lives in the same society, but who has no special skills in working with his hands. Although he is eager to learn, he would not be medically supported in the same way as the man with the natural skills, according to Daniels. This would then result in a rationing decision wherein if both men's hands are badly damaged in an accident, the medical therapies offered to the first man would be much more extensive than those offered to the second man. The amount of coordination and dexterity in the first man's fingers will need to be much greater than in the case of the second man.

If Daniels focused on species-typical functions exclusively, I think that Dewey would find his position very problematic. Dewey privileges experience as being foundational to all that exists and is known in human life. It is individuals who have experience although since human life is inescapably communal—i.e., there are no private interpretations, languages, or symbols, according to Dewey—experience connects a person to one or more communities. But experience is only "had" by a person, not by a community. I think Dewey would also point out that there is a salient difference between people and *Homo sapiens*. What I mean by this is that I rarely relate to other people as being fellow members of the same species to which I belong. Instead I relate to them as, perhaps, fellow sufferers of pain or searchers for self-fulfillment. Thus Dewey would judge the importance that Daniels places on species to be excessive.

Dewey would concur, however, with Daniels' recognition that humans are social creatures. People need other people, whether it is for such obvious reasons as being raised from infancy, exchanging products and services, or learning in school. At a deeper level, a person needs others for her personal identity in terms of her heritage, values, beliefs, language, and membership. Additionally relationships are valued for the feelings they generate (e.g., love, tenderness) as well as the benefits that accrue. And lastly, relationships are a medium of self-expression: I can manifest or realize my virtues of patience and creativity respectively by actually being patient with someone else and by hosting a Murder Mystery dinner party, for example. The same applies for some kind of affirmation of my existence and who I am. By this I mean that we value family members and longstanding friendships partially because these people know the person we have been over time; they can testify to our triumphs, struggles, and endurance.

Daniels is also "correct" in that he conceives of people living according to life plans. This avoids any tendency to represent people as decision makers wherein decisions are discrete activities. A "life plan" signals integration of the past, present, and future and an image of oneself (e.g., as a parent or a good Catholic). Thus Daniels' position has a robust view of human beings and so would be praised by Dewey.

Initially, it would seem that Dewey would challenge Daniels on his use of species typical functioning. Each person has only a handful of innate skills or talents and Daniels does not make much room for skills learned through years of practice. It seems that if I believed I was a competent bookkeeper, though admittedly not an expert bookkeeper, this would not matter. The chosen standard for evaluating my bookkeeping abilities, as with most of our abilities, will be our species' functions. The fact that someone derives great pleasure from downhill skiing is irrelevant with respect to the question of whether the government should reimburse medically-needed orthopedic surgery expenses. The reason is that skiing is not a standard activity nor can it be deemed a function of our bodies. Yet surgery would be paid by the government so that a person could walk without assistance because mobility is a normal function of our natural physiology. Dewey's emphasis on the organism could imply that individual organisms matter hence his criticism of Daniels' focus on species.

Yet I think Dewey would agree that an inability to ski is not reflective of poor health, but his reasoning would be that it does not really impact the city dweller's ability to respond to her environment nor does it harm cooperation. Imagine that the concern is not the ability to ski, but a desire to prevent another pregnancy because of an inability to adequately look after all her responsibilities as well as herself. Here again Dewey and Daniels would concur, albeit for different reasons: Dewey on the grounds that birth control pills increase the ability to manage her environment; Daniels on the grounds that it is typical for our species to care for its offspring.

As discussed earlier, the delineation of what qualifies as a "normal" range of opportunities is troubling in terms of possible societal prejudices and injustices. Dewey's focus is admittedly on the individual as being deeply situated in a society or in communities. I'll use the example of a thirty-year old African American man who lives in the United States in the early 1900s, when segregation was still in force. For Daniels, this man's normal opportunities would exclude being a mathematician in an academic or research setting, even though he is a math whiz. Imagine that he develops a brain tumor that obstructs his calculative and conceptual skills, but he can still adequately perform an unskilled laboring job. Based on Daniels' position, he does not have a disease because the basic calculative functions typical for the human species are still present.

Dewey would reply that if the tumor is removed and his math skills restored, he will be more adaptable in terms of being able to handle financial matters better, for instance. Will meaningfulness also increase? Likely not, except in the rare situation that he teaches children who struggle with mathematics because this prompts shared cooperation. Based just on Dewey's statements about adaptability, making surgery available would be ethically justified. Thus similarities do exist between Daniels' and

Dewey's views about health as a good and the consequences that flow from them. Yet the issue about society's standards is a serious disagreement between them.

I turn now to Callahan's characterization of health, as presented in greatest detail in *Setting Limits* (1987), to consider how Dewey might respond. Callahan holds that health is important because with it, we can achieve a reasonably good life. A good life includes such major accomplishments as being educated, having a family and friends, working to provide for one's needs and for self-fulfillment, and enjoying some leisurely pleasures. When a person successfully accomplishes such goals, then continued life or more time no longer matters as much.

Callahan suggests that the appropriate role for elderly people is to share their knowledge and experience with the young so that the young are more likely to have a good life. In other words, the more people who live long and skillfully enough to achieve these major goals, the better. If an elderly person fulfills this advisory and pedagogical role, Callahan recommends reimbursing health-care costs for him. But if the elderly person chooses to live a different kind of life or fill other roles, then the governmental does not have a duty to offer life-extending medical interventions (e.g., chemotherapy or trauma care). At most, the government's responsibility is to offer him only quality of life care (e.g., pain management, maintenance of organic process such as digestion and respiration) on the grounds that compassion cannot abide suffering and pain.

Just as he would appreciate Daniels' inclusion of life plans, Dewey would appreciate how Callahan "fills in" what constitutes a good life. Callahan includes significant events such as relationships, knowledge, and employment. Callahan's listing is not meant to be exhaustive, but only illustrative. Dewey would recommend adding some reference to participating in society or in a community as another part of a desirable life. Moreover Dewey would support Callahan's comprehensive perspective in terms of looking over the entirety of a life. That is, he looks for integrating and harmonizing the possible richness of life. This contrasts with a perspective that only scrutinizes discrete events or looks at life as a sequence of detached phases.

It is reasonable to suggest that Dewey would reject Callahan's claim that elderly people are valuable because they have responsibilities towards others: "recognizing that [the elderly's] primary orientation should be to the young and the generations to come, not to their own age group" (Callahan 1988, 655). Callahan holds that this group of people has a responsibility to share their wisdom and experience with those who are younger and less experienced. It is imaginable that Dewey would criticize the unilateralness of this arrangement: from elderly to the young. Dewey repeatedly stresses mutuality in relationships because mutual relationships are typically stronger and last longer than unilateral relationships.

But in Callahan's defense, I think he does countenance a greater degree of reciprocity. He notes that in our current society, people who are retired usually are relegated to spending their remaining years entertaining themselves (e.g., golf games, Caribbean cruises, and bridge games). He advocates substituting entertainment with the more important work of nurturing and guiding the younger generations. The benefits that subsequently flow to the elderly will be respect and inclusion in the mainstream of an active society. The elderly thus move from the margins to the center of everyday communal life.

Dewey would commend this idea because he wants people to be vital, responsive, and responsible organisms in a changing environment. Assigning this new role to the elderly population signals optimistic progress: knowledge of the past will be used today to benefit future outcomes. At the same time, this is a pragmatic response to today's problems of using "resources" already at hand.

In closing, applying Dewey's theory of the good to the case of health affirms that health is good on philosophical ground. Qualifying as good thus makes health worthy of protection or pursuit. And it has been shown that Dewey's theory can be used to examine the very important contributions Daniels and Callahan have made to the current health-care reform debate. I believe that Dewey would find strengths in both philosophers' positions. As argued above, Dewey would find Callahan's general proposal to be defensible. At the same time, I think the problem about potential or actual social injustice would render Daniels' position to be, in the end, unacceptable from Dewey's vantage point.

Health care as a good

In this final section of Chapter IV, there will be a closer examination of health care and its goodness. As noted earlier, health care's purposes are to preserve, protect, and restore health. As such, health care qualifies as good instrumentally in that it contributes to another instrumental good, namely health. Another way of justifying that health care is an instrumental good is that we would not want surgery, vaccinations, or home health visits just to have surgery, vaccinations, or home health visits. So health care is not an intrinsic good. It is informative to herein consider how Dewey's concept of the good "connects" with the purposes of the three components that comprise health care. This then is another way in which the philosophical work of Dewey is newly applied to practical situations. These three components are medicine, public health, and home care.

With this said, a recent trend in public health policy challenges my position wherein I equate health care with "medicine + public health[35] + home care." This trend began with empirical findings that showed a person is healthier—as measured by rates of sickness and injury—the more education, the more leisure time, the safer the neighborhood and job, and the higher the disposable income he has. Studies in Britain reveal that the strongest correlate with health is social class: the higher one's social

---

35. Public health is a multi-faceted or vast enterprise because it can include everything that impacts citizens' health. But it can be separated into governmental programs and community health programs. Community health typically includes private or philanthropic health organizations, community outreach programs established by hospitals or clinics, and professional associations.

standing, the healthier one is (Lynch et al 2000; Marmot et al 1997; Arber 1996; Carr 1990).

What follows from this expansion of contributing factors or obstacles to health is that other programs warrant the same or comparable attention as that traditionally accorded to medicine. If it is true that completing university or college results in less morbidity, then isn't it just as sensible to assist people to attend college as it is to continue developing new pharmaceuticals or surgical techniques? I think the answer is "yes." Further empirical studies are needed as to learn all the factors that impact health and to what degree, and then based on the findings, to modify public policy decisions about spending and access. But until there is more comprehensive information on contributing factors, health care will encompass medicine, public health, and home care for the purposes of this dissertation.

In applying Dewey's work to public health, home care, and medicine, the central question is how they do or do not contribute to adaptability and meaningfulness. Beginning with public health, it is defined for this dissertation as governmental programs directed towards "protect[ing] the community against the hazards engendered by group life" (Fairbanks and Wiese 1998, 5). Hanlon and Pickett concur that the focus is on the collective or the community, not on identifiable individuals. They provocatively describe how an individual is seen: "as a social and community integer, a member of a family or social group." An integer is likely best understood to be a whole number (e.g., a number lacking a fraction). But it is also defined as a "unit of measurement or reckoning" or as “a thing complete in itself” by *The New Shorter Oxford Dictionary* (1993) which implies that the individual is an integrated unit. When used in the context of public health, the reference to membership is paramount in that humans are not detached or isolated individuals.

Public health services evolved as we recognized that it is unreasonable to hold each person fully responsible for her own health. Look at the reality of how we live. People live in collectives, be they a family or a town. People are highly interdependent, whether through employment or shared water systems. And people remain vulnerable to the forces of nature or the climate, as in the case of major blizzards or earthquakes. Diseases are transmittable. And the actions of others such as continuing to be in public when contagious with, for instance, tuberculosis or a dangerous strain of influenza, can substantially impact other people. These other people can be considered unknowing and thus not responsible for becoming ill. Similarly the “carrier” may not realize she is infectious and thus not adjust her ordinary behavior to avoid spreading the disease.

Public health has several general purposes: (1) preventing epidemics and the spread of disease, (2) protecting citizens against environmental hazards, (3) preventing injuries, (4) promoting healthy behaviors by the populace, (5) responding to disasters and assisting communities in recovery, and (6) maintaining the quality and accessibility of health services across the country (Fairbanks and Wiese 1998). Reflective of the magnitude of these responsibilities, the national PHS is multi-dimensional. It includes the Centers for Disease Control and Prevention, Centers for Medicaid Services, Food and Drug Administration, National Institutes of Health, Human Resources and Services Administration, Indian Health Service, Substance Abuse and Mental Health Services Administration, Agency for Toxic Substances and Disease Registry, and the Agency for Healthcare Research and Quality.

All of the six purposes of public health support Dewey's notion of adaptability in terms of preventing, restoring, or maintaining peoples' (as opposed to a particular individual's) capacities to live well in a dynamic environment. For instance, mandating safe working conditions means that fewer people are injured in the workplace. And responding to help those who are affected by natural disasters involves restoring their asset or economic base (e.g., repairing home, replacing destroyed vehicles, or restoring businesses). Such remedies increase the victims' abilities to respond to their environment.

Home care contrasts with institutional care. Home care is prescribed for both acute and chronic conditions. After the rescue efforts of an emergency department and intensive care unit for a person injured in a motor vehicle accident, a patient will likely be discharged for further care in the home. Or after an episodic crisis in a chronic disease, such as asthma or sickle cell anemia, a patient will again be discharged for ongoing maintenance care at home. Home care is provided in two ways: by family members or by various health professionals. In an effort to reduce costs over the past ten years, hospitals have discharged patients sooner and sooner. As a result, they leave sicker and must be cared for longer in the home. In fact, Arras and Dubler (1994) suggest that approximately eighty percent of all medical care is delivered in the home. Their insightful article, "Bringing the Hospital Home: Ethical And Social Implications Of High-Tech Home Care," describes the consequences of altering the home so as to accommodate a seriously ill or terminal patient; altered in many instances to the point of the home no longer being a home.

Home care is an extension of medical care that is provided in a hospital or clinic setting. Thus much of what is discussed below with respect to medicine applies directly to home care services. Yet there is a special factor surrounding home care that warrants consideration. When someone is cared for at home, there can be deeper connections made with family members as they express their concern and love for one another. The daughter who tends to a temporarily bedridden mother can demonstrate her loyalty, compassion, and kindness. In turn, the mother can reveal her gratitude and patience to her daughter. In such a situation, their relationship is reciprocal with both giving and receiving. The relationship thus strengthens. Therefore home care can be an opportunity to increase meaningfulness in people's lives. With this said, however, the demands of home care can frustrate, embarrass, and exhaust those involved and therein damage relationships. There is then no guarantee that home care offers important benefits for living; in some situations, tending to patients in their homes will indeed qualify as a Deweyan good, and in other situations, it will not qualify as a Deweyan good.

And finally medicine's focus can be therapeutic, preventive, or palliative. By therapy, Hanlon and Pickett mean "diagnosis and treatment of damage already done" (1984, 5). They note that this includes recovery (where a patient is restored to his previous level of functioning) or rehabilitative (where he is restored to a lesser level).

The specific goals to be examined herein were developed by a group of philosophers and bioethicists. Six years ago, a group of bioethicists and philosophers gathered at the Hastings Center, a well-known bioethics "think tank," to debate the goals of contemporary medicine. This project was prompted by two developments. First, medical research and technology seem able to erase the barriers as to what medicine can do. Medicine's promise is brilliant in terms of its ability to control for or compensate for "Mother Nature" or bad luck. Second, in light of the increasing options to intervene, the associated costs have escalated such that the American system is more financially unstable and more people are excluded.

These two developments appear contradictory: medicine is unlimited in terms of what it can accomplish, yet, at the same time, it is limited in terms of whom it could help. Hence the project of answering the question, "Today, what is medicine for?" Their answer included four goals: (1) prevention of disease and injury, (2) alleviating pain and suffering, (3) caring for people who cannot be cured, and (4) helping people achieve a peaceful death ("The Goals of Medicine" 1996).

Does prevention of disease and injury support an organism's adaptability? Given the earlier discussion about disease *contra* illness, it is illness that is of interest here.

Disease is a statistical anomaly while illness is the negative outcomes such as loss of needed function and discomfort. Injury can be defined as "harm, detriment; damage, esp. to the body" (*The New Shorter Oxford English Dictionary* 1993, 1371). Disease and injury reduce a person's abilities to respond to her surroundings and thus a goal of preventing illness and injury connects to the concept of adaptability.

Pain and suffering seem like obviously negative events and it seems uncontroversial to state that alleviating them is obligatory. I would temper this statement somewhat though. Pain can have a good side. There is a genetic condition wherein a person does not feel pain due to inadequate neurological development. As a result, if he is cut or burned, he feels no pain and thus there is no physical "alert" to remove his hand from the knife blade or from the boiling water. His life is thus additionally risky or dangerous compared to a person who does not have this condition. Pain is therefore bad only when it continues beyond its initial warning phase because it serves no purpose and is an undesirable experience. Eric Cassell, a bioethicist known for his intensive examination of the nature of suffering, defines it as damage or a loss of any aspect of personhood. Examples of these aspects include:

> the lived past, the family's lived past, culture and society, roles, the instrumental dimension, associations and relationships, the body the unconscious mind, the political being, the secret life, the perceived future, and the transcendent-being dimension (Cassell 1991, 43).

The consequences of unrelieved suffering are loss of identity, diminished relationships, self-doubt, confusion, and so on.

So I hold that suffering and gratuitous pain undermine adaptability because they distract a person from pursuing opportunities or, more seriously, they can terminate such pursuits. When a woman has chronic migraine headaches that prove untreatable, she is less able to respond to her circumstances, whether they are employment or education-related. This is the same for depression wherein a man is unable to hold onto his job in the wake of, for example, the death of his child.

The third goal of medicine refers to care of those who cannot be cured. I consider care important by Dewey's theory because it increases meaningfulness. When someone tends to the daily needs of a bedridden patient, a deeper connection can often result (though as discussed in the section on home care, not always). When we attend to a person as vulnerable, discomforted, or worried, we demonstrate virtues of compassion, empathy, and sincerity. Moreover to care is to be responsive to the other person or to attend closely to them as persons. And it is to be responsible in terms of accepting one's duty to act as a moral agent (Benner et al 1996). "Care is about recognizing difference" as to how people experience their illnesses (Frank 1991, 40). Our actions say that the person's experience and the person matters to us, that we want to alleviate his anxiety, and that we want to make him comfortable. More simply put, he is of value and his loss or suffering is not inconsequential to me. I concur with Arthur Frank's position that illness and injury must be accepted because they are real and they are part of a person's life: "Illness is the experience of living through the disease and what happens to my body happens to my life" (1991, 13).

Returning to the medical goal of a peaceful death, it can be re-framed as the concluding chapter of a person's life. As such, it carries special weight in that it ideally should tie together and integrate all the preceding chapters. As illustrated by great literary works, the final chapter is what the earlier chapters are leading towards. A superficial conclusion or a disjointed one is dissatisfying to read; it puts into question all that went before. But a memorable and integrative chapter seals the intelligibility of the entire story. And so striving to help a patient achieve a peaceful, dignified death is ripe with meaningfulness.

In summary, the preceding section has examined whether contemporary health care can be said to be good using a philosophical theory of the good. The chosen theory of the good is that of John Dewey wherein the good is an organism's growth which has two features: adaptability and meaningfulness. Prior to making such a philosophical assessment, health care was defined as being constituted by medicine, public health, and home care. The outcome of this assessment is that each component is good from a philosophical theory approach.

This chapter represents the conjoining of theory with practice in that the theory of the good developed by John Dewey is applied to the case of health and health care. After critiquing several definitions of health, it was concluded that the most reasonable definition holds that health is a multifaceted ability of a person to interact with his surroundings. Health care is defined as efforts to maintain or restore health. Dewey's good, when applied to health itself, found that health qualifies strongly as a good because it is needed if a human being is going to be able to successfully interrelate with his surroundings over the long-run. Similarly health care qualifies strongly as a good because it also contributes to better interrelations and more successful interactions with the environment.

The next and concluding chapter tackles the macro-allocation question of whether health care is more, less, or equally good when compared to other societal programs. Additionally, the meso-allocation question is tackled; the question asks whether specific types of medical treatments are more, less, or equally good. Predicated on this comparative philosophical work using Dewey's notion of the good, there will be a discussion as to how the findings can influence public health policy decisions. In this way, a philosophically-justified way to ration scarce financial resources for health care is identified.

CHAPTER V

Dewey's Theory in Macro-Allocation and Meso-Allocation Decisions

Introduction

Engelhardt, Daniels, Callahan agree that being healthy is good. Engelhardt suggests that the reasons justifying such an evaluation are highly individualistic. Daniels and Callahan disagree and each philosopher offers a specific reason: pursuing opportunities and accomplishing major life goals, respectively. Based on Dewey's work, the reason is pragmatic interactions, a phrase I see as more informative than "growth" to represent Dewey's concept of the good. As explained in the previous chapter, health-care's goodness stems largely from its positive impact on health. Examples were used to illustrate how, for instance, home care does actually promote pragmatic interactions.

This concluding chapter tackles macro-allocation and meso-allocation decisions. "Macro-allocation" reflects the kind of decision making, either explicit or implicit, that occurs at the public policy level wherein governmental representatives work on budget or cost-related decisions. Moreover macro-allocation decisions are implicitly or explicitly part of the political campaign platforms and political rhetoric that politicians use to affirm that they understand the wishes of the public. For the purpose of this dissertation, "meso-allocation" reflects decision making of those working in institutions. The kinds of institutions I have in mind are hospitals or those involved in health insurance. Insurance coverage is provided by private or for-profit companies, self-insured employers, or governmental agencies.

In "Rational Fools: A Critique of the Behavioral Foundations of Economic Theory" (1977), Amartya Sen, a well-respected professor of economics, considers how best to understand people's behavior. He states that contemporary economic models employ a characterization of a person that can be labeled as *Homo economicus*. An "economic man" acts as a "self-seeking agent. It is possible to define [his] interests in such a way that no matter what he does, he can be seen to be furthering his own interests" (Sen 1977, 322). Personal welfare is considered identical with personal choice (Ibid, 329). Moreover the consistency of "economic man's" behavior denotes rationality.

Sen refers to the ongoing debate in the literature of economics concerning optimally distributing public goods. A private good, he suggests, is something that only one person can consume or use; for instance, a glass of orange juice.[36] In contrast, a public good is something that can be used by more than one person. In the aforementioned debate, a common characterization of people is as "gains-maximizers" wherein they want a system or program that promises to give them the largest returns or greatest benefits possible, but to which they have to contribute the least (Sen 1977,

---

[36] 36. Sen illustrates what a private good is with the example of a piece of pie. Unfortunately, based on this single example, it is not completely clear whether the definitive criterion for privacy is that the good is completely used up and/or that the good can be used by only one person at a time. For instance, is an automobile a private good by Sen's definition? Only one person can drive it at a time. But more than one person can be transported in it at a time. Or is the crux here ownership in that only one person (typically) owns a car and then from ownership comes the ability to decide what happens to it and who else benefits from it.

325).

Yet many theories of morality, Sen notes, are universalized systems wherein collective welfare is more important than individual welfare. Utilitarianism and Kantianism are examples of what Sen means by "universalism." In other words, the individual is expected to care about others and occasionally (though certainly not always) act so as to benefit others at his own expense. As a consequence, standard economic theories and familiar moral theories disagree significantly as to fundamental traits of ordinary human beings.

Sen's challenge against the classic economic conception of human behavior is that "the *purely* economic man is indeed close to being a social moron" (1977, 336) or a "rational fool" (Ibid, 344). The reference to "social" is critical in these comments. Since humans do interact with each other and are mutually dependent, if a person is totally self-interested, he would be a social moron, inept at collaboration and cooperation. Further, he may have admirable cognitive skills, but if unable to understand what is real—namely, that he lives in a community or amongst others—other people will see him as a fool.

Sen argues that in addition to self-interest, other factors can help explain actual behavior. The two factors he considers in this article are sympathy and commitment. A person will often forego maximizing personal gain in response to feeling concerned or sympathetic towards another person. If there are no such feelings and yet she does want to help the other person, Sen says she has some type of commitment towards the person.

He holds that commitments are tied closely to personal morals and to relationships with various groups and individuals.

Given that people's behavior can be explained by more than one factor, Sen recommends re-examining the structure of economic theory which has, by and large, allowed for only one factor, egoism. Dismissing a dualistic structure comprised of moral choices (i.e., non-egoistic) and actual choices, he advocates a system in which preferences are ranked, a system he calls "meta-ranking" (Sen 1977, 33). With this said, quantifying self-interests, sympathy interests, and commitment interests may not be possible. Accordingly, he recommends an ordinal system such that interests are ranked in terms of "equal," "more," and "less."

The approach of comparing various social and health-care goods in this chapter will use an ordinal meta-ranking system. If a cardinal system was employed, a conclusion might be "National defense is 2.6 times more ethically-significant than the arts" or, perhaps, "Kidney dialysis is 1.3 times as important as prenatal care." Such quantitative exactness is not possible with Dewey's concept of the good for two reasons. First, he does not include such exactness in his own explanation of goods, be they natural goods, ideal goods, or the good. Second, the components of growth, adaptability and meaningfulness, are themselves qualitative notions in the context of human life and interactions.

Prior to applying Dewey's concept of the good to competing social programs and medical interventions, consideration is needed as to how the meta-ranking will be used.

In other words, once the ranking has been done, how will it translate into specific funding decisions, given that there are different cost structures involved? The following decision model illustrates what is of concern here.

Imagine first that the only health-care intervention developed, manufactured, and available in America is childhood vaccinations. In 1997, the CDC spent 840 million dollars to vaccinate 78 % of the children who needed to be vaccinated (Center for Disease Control 2002). Therefore assume that 100% of children are actually vaccinated; the associated costs would be 1.1 billion dollars. Next, assume that the only national defense weapon is the B-52 Stratofortress planes, a plane developed for nuclear deterrence and able to drop every type of bomb in the military's inventory. Currently there are eighty-five such planes owned by the Air Force; each one has cost 54 million dollars (U.S. Strategic Air Command 2002). Assume further that since they are the *only* military equipment available, the number of planes must be doubled so as to provide minimally adequate protection geographically, costing a total of 9.2 billion dollars in purchase and maintenance costs.

Turning now to ranking the two social goods using a philosophical basis, imagine that national defense is judged to be better or "more good" than vaccinations. How would this conclusion then be used for budget purposes? First, national defense becomes the first priority; the one hundred seventy bombers are purchased. After that if there are tax monies still available, as much vaccine is purchased as possible until all that is needed is bought. This scenario is acceptable as long as there is between 9.2 billion and 10.3 billion dollars available (i.e., being able to purchase all the planes needed or all the planes and all the vaccines). But what if the maximum amount of tax revenues is 7.4 billion dollars in a particular year? Is *80 %* military coverage better than *full* health coverage? Or should the vaccines be purchased and administered now and then the airplanes be purchased next year when the cumulative funds are 13.7 billion dollars?[37]

These questions illustrate the challenge of estimating of *how much* better national defense is compared to health care. It is possible that gross or rough comparisons could be made; that one is, for instance, twice as good or twice as better as another. But finer distinctions will likely prove increasingly tenuous. Therefore I would concede that using rough comparisons is the most that can be asked of this methodology. Yet this methodology still helps guide policy decisions such that the amount of funds allocated to diverse programs will be commensurate with their ordinal goodness.

I now move from the issue of different cost structures (e.g., "How much money is needed for basic vaccinations versus basic defense?") to the principle of diminishing returns. This economic principle holds that for most products and services, there will not be a fixed rate of benefit delivered for each and every added unit of input. For instance, a physics student reads a book of fiction (the unit of input) after having spent an entire semester reading nothing but scientific textbooks and reference books. The enjoyment (the benefit) she experiences will probably be substantial. But when she reads the fourth fiction book, her enjoyment will probably decline, although certainly she still

---

[37] The amount of the cumulative funds, 13.7 billion dollars, is based on: ($7.4 billion in tax revenues – $1.1 billion for vaccines in year *1*) + ($7.4 billion tax revenues in year *2*).

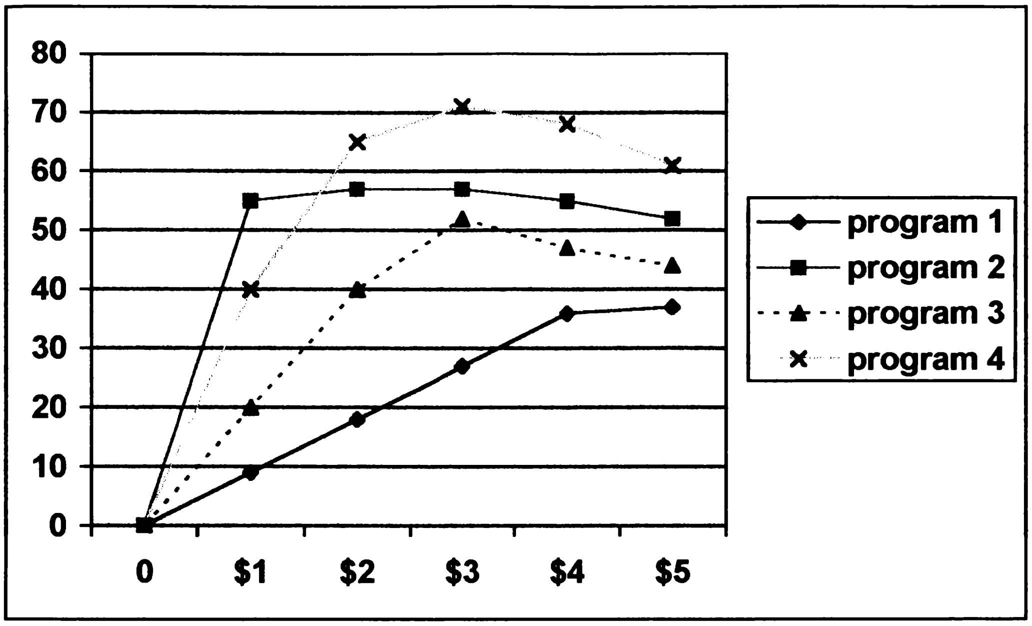

Figure 3. Illustrative Diminishing Rates of Return
($ = one hundred billion)

prefers reading it to a textbook. The import of this principle for decision making is that each added fiction book she reads provides incrementally less and less enjoyment. At some point in time, it is conceivable, perhaps with the fourteenth book in a row, that she will not find it enjoyable at all. Simply, this underscores that "more is not necessarily always better."

How does this principle apply to comparisons of social goods, such as education and the arts, when a decision is to be made as to how much of each should be provided? Figure 3, above, is meant to illustrate how the principle actually supports Dewey's position; the figure is not meant to be accurate as to the rates of return of benefit from each social program.

First, Figure 3 needs some elaboration. The vertical axis measures the benefit gained (e.g., human adaptability) of every additional dollar spent for each program (e.g., health care, the arts). The horizontal axis is the amount of funds in a government's annual budget. The principle of diminishing returns is that, at some point, each added dollar spent on a particular program produces less incremental benefit. Imagine that I receive 5 units of pleasure by spending one dollar on an activity, 9 units by spending two dollars, and 12 units for three dollars. The associated rates of pleasure are 5, 4.5, and 4 respectively. Each incremental dollar delivers less and less pleasure; its rate of return is diminishing. And different goods can have different rates of return as illustrated in the above figure.

This principle will apply to the case of national defense, the arts, health care, and education. As more and more funding is pumped into each, the incremental change will decrease at some point. Referring to the previous figure, if three dollars were spent last year on program 4, but this year four dollars are available, what would be the best way to allocate the four dollars? If all of it goes to program 2, the benefit is 68 units. But if three dollars goes to program 2 and one dollar to program 1, the total benefit is 80 units.

Figure 3 is not meant to reflect the actual rates of return of health care, education, the arts, and national defense on human adaptability. It is strictly illustrative of the complexities to be anticipated in making discrete distributive choices. From another perspective, I believe Dewey would support the idea of allocating funds to more than one program based on his conception of humans. To rely on only one program runs counter to Dewey's position: adaptability involves flexibility. Being the deadliest or the most intelligent flouts the inherent complexity of being human and of our surroundings (e.g., the natural world and our communities). Thus the objective is to strike a balance among the programs, first, of basic minimums of each (recall that there can be thresholds of adequacy as in the case of half of a B-52 bomber being unusable), and thereafter, of incremental amounts above such minimums.

Competing social programs vis-à-vis health care

Three socially-supported programs will be examined in this section in terms of Dewey's theory of the good: national defense, education, and the arts. The macro-allocation question being examined here is the comparative goodness of health care relative to other valued social programs. Over the past few years, American health care and these three programs have been funded from public coffers as shown in Table 2 on the next page.

First, a few explanatory notes about the above statistics. The figures for health care exclude personal or private expenditures as do the figures for education and the arts. Education covers elementary, high school, and university/college. The figure for the arts includes the National Endowment for the Arts and the National Endowment for the Humanities.

Recall that health care fits with Dewey's theory of the good in terms of

Table 2. Comparative Spending on Four Social Programs

	Public Expenditures ($)					Public Expenditures Relative to Health Care				
	1990	1994	1995	1999	2001	1990	1994	1995	1999	2001
Health care	282b		458b		631b	1.0		1.0		1.0
Education	412b		458b		520b	1.5		1.0		0.86
National defense	299b		272b		299b	1.1		0.59		0.50
The arts	311m	314m		179m		0.001	0.0007		0.0003	

Source: *Statistical Abstract of the United States*, 2001.
(b= billion; m = million)

promoting both adaptability and meaningfulness for humans. Does national defense qualify as a Deweyan good? To answer this question, the same process is employed as that used with health care. Health-care's purpose is its contribution to health; its value is instrumental. As a result, it was health itself that was examined relative to Dewey's concept of the good.

Accordingly the immediate question is about the purpose of national defense. First, it is pertinent to note that no single citizen, or even a few citizens, can effectively deter or defeat another country's military. The cost of maintaining sufficient weaponry is exorbitant. So there is no real alternative to having a military force that is sponsored by a government, if the country exists in the midst of other aggressive or potentially-aggressive nations. A military force can act defensively or offensively. In either case, the purpose of national defense is protecting the lives of Americans from outside aggressors and, if invaded, fighting to restore the country's independence.

Yet if another country or group attacked America, will it really affect the citizens' adaptability? Consider the terrorist attacks on the World Trade Center and the Pentagon on September 11th, 2001. How did the attacks affect Americans' adaptability? First, they were more informed as to how various groups and nations really judged them. There were people who hated America and Americans to the point of wanting to kill them and topple the country. Knowledge increases adaptability because it is obviously critical to be accurate in "how the world is" so as to be able to respond effectively to risks and opportunities. Second, the attacks resulted in a loss of activity and energy in the people. Fear produces tentativeness and pessimism. The U.S. Stock Exchange value fell dramatically, the Gross Domestic Product (a common indicator of how optimistic or pessimistic the citizens are about their nation) declined, and the value of the American dollar (a common indicator of how optimistic or pessimistic people in other countries are about the United States) decreased. Therefore adequate national defense contributes to adaptability because individuals can go about their daily lives confidently and optimistically.

Yet wouldn't it be better to have the largest and most technologically-advanced military in the world? Dewey would counter "no" and would appeal to the idea of mutual deterrence. There is no real guarantee that a country can prevent every attack. Case in point is the terrorist attacks of September 11th on the U.S. Dewey's perspective is long-term, not short-term; this is one reason why he rejects egoism

A further argument in support of adaptability is that if a country is unable to protect itself from invasion by other nations, then nothing else matters. In a sense, the argument holds that national defense is something needed before anything else. I question this claim by drawing upon an analogy. It is often said that liberty is the most important human right. Yet if a person is in pain, afraid, hungry, or alone, then freedom is like an empty shell. Freedom is valued largely because my actions are not interfered with by other people. But if I have no realizable goals because I am too ill to act or I have no significant relationships that motivate me to act, then "all the freedom in the world" does not ensure I have a tolerable life. Other aspects of life must be in place before liberty has much substantive importance in terms of the kind of life that the person can expect. The same holds for national defense. It certainly is an important enterprise, but I would contend that it need not be in place before any other good is obtained.

But national defense is not just about deterring invasions. The military is also a vehicle for foreign policy in terms of assisting other nations in their political struggles. Consider the war between Kuwait and Iraq or the Tutsi-Hutu conflict in Rwanda. In the case of Kuwait and Iraq war, relationships were strengthened between the United States and various countries in the Middle East. These relationships centered around the production and sale of petroleum, a mutually beneficial relationship and so in accord with

Dewey's emphasis on shared cooperation. In the case of the Rwandan conflict, America's eventual involvement was part of a humanitarian effort to end genocide. This fits too with shared cooperation because it improves the relationships that other countries have with the United States in that they believe that they can count on the U.S. for moral support. This benefits the U.S. in the form of increased foreign trade as a result of the U.S. being seen as a virtuous nation. Based on this brief analysis, it is clear that national defense does preserve adaptability and does boost reciprocity between parties. Therefore national defense qualifies as a Deweyan good in that it contributes to adaptability and meaningfulness.

Education connects with Dewey's theory on two levels: adaptability and meaning. By finishing high school and continuing on to university, a person gains many benefits: knowledge, skill development, self-understanding, socialization, and employability. Skill development, knowledge, and employability directly relate to adaptability. If a person gains more skills and knowledge, he is able to attempt or try more things, able to cope better with change, and more accomplished.

In addition to increasing knowledge and skills, schooling is a primary way that our society socializes its children, adolescents, and young adults. They learn about teamwork, independence, role differentiation with strangers (student-teacher), different perspectives and belief systems, and commitments to non-intimates or to causes (school loyalty or volunteering to clean up a local river). Socialization and self-understanding I see as being about meaningfulness in a person's life. Because a student learns about other possible ways to live and other things to be committed to, he is able to establish pragmatic or mutually-beneficially relationships with other people. Learning how values infuse his choices, he relates and how he relates to others. Self-understanding accords with meaningfulness in that he knows how his upbringing and past experiences have resulted in the person he is today. He also knows that he may choose to be otherwise in the future if he finds that the person he is right now is not who he wants to be. Such self-understanding positively and directly affects his relationships with others in terms of honesty and authenticity. Therefore education clearly qualifies as a Deweyan good because it fits with both adaptability and meaningfulness.

The arts, by which I mean museums, theatre, orchestras, and dance, may not seem to link closely with Dewey's notion of adaptability. Certainly in a few instances, people who have gained careers in dance or music have become more adaptable because they are more independent and self-sufficient as a result. Yet the arts do influence human adaptability by stimulating both our emotions and imagination. The result can be increased abilities to cope with both success and tragedy in terms of emotional health. Creativity prompts new opportunities to be discerned and problems solved in innovative ways.

Meaningfulness intuitively seems to have an even stronger connection with the arts than does adaptability. Dewey holds that meaningfulness is shared cooperation; this is not the standard definition of meaningfulness. But on his behalf I suggest that the arts' purpose is expression which presupposes other people. Two reasons can explain this point. An artist wishes to share his vision, ideas, perceptions, and insights with others. Or an artist wishes to either use or challenge normal descriptions and symbols. These descriptions and symbols come from communities of people because, as Dewey believes, language and symbols cannot be privately or idiosyncratically created.

Health care's purpose is to preserve and protect health. National defense's purpose is to maintain sovereignty or independence and provide humanitarian aid. Education increases knowledge and skills and is a vehicle for socialization. The function of the arts is to encourage expression and imagination. All four programs qualify as good by Dewey's theory because all four contribute to human adaptability and meaningfulness, or growth.

The next step is to rank the four in terms of these contributions. Dewey does not prioritize adaptability over meaningfulness or vice versa. Both are of equal importance. To be responsive to and responsible for one's surroundings requires shared cooperation. The notion of pragmatic interactions is critical here. A person will not be successful in solving problems if she insists on being totally self-sufficient. Life is too complex and humans too fallible and inadequate to be independent for any length of time. Moreover being part of relationships, be they familial or communal, is necessary for human well-being. In other words, Dewey points to our unavoidable connectedness with others. We must connect and we should connect with others because relationships involve identity and belongingness.

It would be ideal to be able to fund all four social goods to their maximal contribution points. But given scarcity of funds, this is not possible. In ranking the four, I believe education is the most important, then health care, then national defense, and finally the arts. "Important" here means having the most impact on growth. The rationale for this ranking begins by holding that knowledge and skills are essential for an organism to thrive in a changing, competitive environment. Yet education also involves socialization so that a person belongs somewhere and among other people as opposed to being alone and isolated. Health care helps preserve our physical and cognitive capacities so that a person can be attentive, active, and cooperative. Deciding whether education is more important than health care can seem a bit like the chicken-and-egg question of which came first. But I contend that education precedes health care in the above ranking because knowledge and skills are most important in all, or virtually all, human endeavors. By means of knowledge and skills, answers to poor health, security breaches, and boredom can be found. Yet I would add that health-care's goodness is only somewhat less than that of education.

National defense is important given the reality of America's current situation. It would be far preferable if "we could start over" and begin new international relationships. Then greater efforts could be spent on diplomacy and cooperation as opposed to power and expediency. But that is not possible at this time. I believe that even if a new approach in international relations was employed today, it would still take years or decades to achieve the kind of harmonious balance that Dewey imagined.

Accordingly, military defense is needed because America has enemies that would almost certainly take advantage of any military vulnerability. Similarly the military can effectively help humanitarian initiatives around the world. And lastly, the arts are less good than national defense at this time because of the ongoing tensions around the world.

Part of the public and political debate on health-care reform is the macro-allocation question of *how* special is it compared to other beneficial social programs. This is a question that even Daniels and Callahan have not tackled directly although Callahan has written extensively on new ways to accept our human limitations (e.g., death, serious accidents, diseases) without falling into despair. If Dewey's philosophical work is applied to health care and the other three programs or initiatives, I contend that the highest priority is education, followed by health care, national defense, and the arts. This ranking should then inform decisions about public funding for each program. As discussed above, the amount of tax revenues will directly influence the actual amount of funds distributed to each. The fact that programs have disparate cost structures must also be taken into account, as illustrated above in establishing minimum programs. From Dewey's perspective, it is also desirable that monies be allocated to all four programs so as to maintain diversity, as described above.

The next step in transforming this initial proposal into concrete allocation decisions would include applying Dewey's good to every social program that is part of governmental mandates. Then there should be a comprehensive comparison of social goods so as to reach a new meta-ranking of priorities. Next, an economic analysis of what constitutes "adequate" for each programs is needed. Part of this analysis should be considerations of time: what allocation ratios will result in optimizing the funds over a full legislative term, rather than simply considering one-year "snapshots." The longer perspective will capture efficiencies of scale and timing. This proposed process illustrates that the philosophical and analytic work in these chapters is only the beginning of the needed process for health reform.

Competing medical interventions

The final section of this chapter will examine actual medical procedures to illustrate the effect of Dewey's theory of the good. This is the meso-allocation decision to be scrutinized. For this purpose, three therapies or medical interventions are chosen: prenatal care, kidney dialysis for end-stage renal disease, and assisted reproductive technologies. Each represents a different kind of intervention. Prenatal care is preventive medicine, kidney dialysis is rehabilitative medicine (i.e., a patient is not "as good as new" with dialysis), and assisted reproductive technologies are compensatory.

Dialysis costs several billion dollars annually (*Statistical Abstracts of the United States*, 2001). If dialysis is prescribed so as to mitigate the damage of end-stage-renal disease (ESRD), the associated costs are covered by Medicare, irrespective of a patient's age. ESRD is the only specific disease that is specifically designated for federally-associated reimbursement assistance. Prenatal care is far less funded from public coffers.

I see prenatal care as qualifying as preventive care while dialysis is rescue care. From the perspective of cost-benefit analysis, prenatal care has a far smaller ratio than dialysis which is to say that relative to its benefits, prenatal care involves much lower costs.

Kidney disease is caused by a variety of factors, including genetic conditions and diabetes. The kidneys become progressively less able to process body fluids to extract the normal toxins and produce urine for expulsion from the body. End-stage renal disease (ESRD) means that the individual's kidneys are almost exhausted and if no medical intervention happens, she will die.

In 1972, President Nixon signed legislation to modify Medicare so that any person requiring kidney dialysis would have the associated costs reimbursed under this federal health insurance plan. Prior to this amendment, Medicare's comprehensive health coverage was limited to citizens aged sixty-five and older. Yet coverage for ESRD was available irrespective of age. What prompted this change in eligibility was the expectation at the time that a national health insurance plan would soon be legislated (Nissenson and Rettig 1999). Moreover the costs for this additional coverage were projected never to exceed one billion dollars annually.

Medicare's kidney dialysis coverage "is as close as anything in American medicine to a universal entitlement" (Ibid 162). Today the costs are roughly eight billion dollars annually (Ibid). The ballooning expenditures are due to the huge increase in patients diagnosed with ESRD and the continuing inadequate supply of donated kidneys.[39]

Prenatal care involves a variety of monitoring and educational programs for a pregnant woman. These include monthly check-ups by an obstetrician-gynecologist, ultrasound and amniocentesis tests as needed, blood work, counseling on nutrition, weight gain, discomfort exercise, coping behaviors, and parenting skills. The purpose of this care is for the woman to be as healthy as possible physically, psychologically, and emotionally, both for her own well-being and for the well-being of the gestating fetus. Prenatal care is considered preventive medicine in that studies confirm that women who receive good care tend to have less complicated deliveries, continue the pregnancy for the full-term more or less, and have healthier babies.

Various cost-benefit ratios associated with prenatal care helps affirm its contribution to such consequences: for every dollar spent on prenatal care for low-income women, three dollars are saved in medical costs during the infant's first year of life. And for every dollar invested in a smoking cessation program for pregnant women, six dollars are saved in neonatal intensive care costs and long-term care associated with low birth weight babies (www.APHA.org). Although statistics on the total monies spent on prenatal care are not part of governmental reporting yet, the percentage of American women who do receive this form of care is recorded: eighty-three percent in 2000

The phrase "assisted reproductive technologies" spans a wide range of medical

---

[39] Roughly 13,300 kidney transplant operations were performed in 2000, yet 51,000 patients were waiting for a donated kidney as of the beginning of 2002 (www.unos.org).
(*Statistical Abstract of the United States* 2001).

interventions, from birth control pills to Viagra to IVF to sex selection to cloning. The past twenty years have witnessed incredible development as scientists have been able to intervene further and further into the human reproductive process or to side-step certain steps altogether. From a medical perspective, the purposes of technologies include to a large extent overcoming infertility in a woman or man, lessening the likelihood of an "at-risk" newborn, and providing greater personal control over one's sexuality.

Let's now turn to Dewey's concept of the good as being comprised of adaptability and meaningfulness. I see the goals of prenatal care as involving adaptability. The therapies and monitoring programs increase the likelihood that both the woman and the fetus respond more strongly to their current circumstances as well as their circumstances post-delivery. What is meant by "respond more strongly" is that the woman is not excessively limited by her pregnancy and the fetus is able to use its environment for successful development in the womb. And after birth, prenatal care should help the woman recover fully from the sacrifices her body has made in carrying the fetus to term.

In terms of meaningfulness, I would posit that it is not as strong here as adaptability. Yet prenatal care does contribute to meaningfulness. Recall that for Dewey, meaningfulness means shared cooperation tied to significant relationships. I do not see pregnancy as involving cooperation. Instead it involves the sacrifice to a woman's body and often her mind. Moreover a fetus is not a conscious being or an agent, two qualities central to Dewey's emphasis on reciprocity and cooperation. At most, however, Dewey could accord some measure of meaningfulness to pregnancy based on the fact that the woman has other relationships to preserve. The most obvious ones are those with her partner and/or immediate family. Prenatal care that allows her to maintain supportive relationships with them would support meaningfulness.

Dialysis's purpose to keep a critically ill person alive until such time as a suitable organ donor is located. By being alive, the person is able to remain active, however limited, within her natural environment and community. Yet a tension may arise when meaningfulness is considered. If a dialysis recipient is so ill that she is unable to look after her relationships and thus becomes a "drain" on them (i.e., harms them), then Dewey would say that meaningfulness is undermined. Dewey does not set a minimum for adaptability. Yet on his behalf, I would posit that "being barely alive" is not adequate for the kind of active participation at the core of Dewey's pragmatic interactions. And so I can imagine that if deliberative activity is not feasible, he would suggest that dialysis does not qualify as good. This suggestion could only be tempered by, for instance, the patient wanting to remain alive for significant reasons such as found in religious belief system. Religious beliefs count as meaningful under Dewey's theory because they reflect membership within a long-standing and committed community.

The assisted reproductive technologies, as mentioned, are very diverse yet their primary purposes focus on helping people control their sexuality and the formation of families. How do these purposes relate to adaptability and meaningfulness? If these two purposes are evaluated relative to adaptability, the results are inconclusive. An argument could be made that by having children, a person has more resources with which to respond and take advantage of his surroundings. Children are able to assist a parent in a multitude of ways. An opposing argument could, however, be made that having children reduces one's resources as time, effort, emotions, and material resources are diverted to the upbringing of a child. Accordingly to be able to reasonably judge child-bearing as contributing or hindering adaptability, the specific intentions of the parent and her or his situation would have to be taken into account.

But with this said, sexuality and families are strongly connected to Dewey's idea of meaningfulness. First, procreative liberty involves "control over whether one reproduces…is central to personal identity, to dignity, and to the meaning of one's life" (1999, 416). When Dewey writes about adaptability, he emphasizes the dynamic, unpredictable circumstances of a living organism in its environment. Being a parent or helping others to become parents is an ethically-rich role or task in terms of connections to other individuals. Controlling one's sexuality is also ethically-rich in terms of relationships that ensue. So these technologies can fit Dewey's theory of the good when they promote meaningfulness in a person's life.

But a note of caution is warranted here. Based on experience of the kinds of outcomes that result from such medical interventions, not every case increases meaningfulness. Three medical cases, which were widely publicized in the mainstream media but by no means the only such dramatic cases, help affirm the serious complexities involved in the assisted reproductive techniques. The case of *Davis v. Davis*, a

Tennessean legal case in the late 1980's, involved a divorced couple which fought over possession of several frozen embryos that had not been implanted into Mrs. Davis's womb during the marriage (Clayton 1992). In the early 1990s, there was the case of Mary Beth Whitehead and the Sterns. They battled over acquisition of the right to be rearing parents to a daughter, Baby M. Mr. Sterns and Ms. Whitehead were her genetic parents, and Ms. Whitehead was also the gestational mother (Bartels 1990). And in the late 1990s, the birth of the McCaughey septuplets was controversial because superovulatory drugs were used even though Mrs. McCaughey was young and had had a daughter only eighteen months before. Also at the time, there were no medical data on the likely risks associated with septuplets. Moreover a few of the children were born with physical and cognitive impairments (Steinbock 1999; Klotzko 1998).

These cases demonstrate the significant difficulties we have today in understanding the multiple competing and often conflicting relationships that can be created by assisted reproductive technologies and the burdens or risks taken on by one party (i.e., the parent) that may befall another, but innocent, party (i.e., the child). Undermining relationships is indicative of lost meaningfulness. Unfair treatment is indicative of seeing another person as being of less importance and therefore as having less meaningfulness or value. As a result, I see the technologies as raising just as many ethical problems as the number they solve and so I am ambivalent as to whether they do qualify as a Deweyan good.

Reviewing the application of Dewey's concept of the good to the medical interventions of kidney dialysis, prenatal care, and assisted reproductive techniques produces the following conclusions. Providing kidney dialysis contributes to the adaptability of the recipient as long as the kind of life being lived is not so impoverished that sustaining relationships is not possible. Prenatal care fits strongly with the value of adaptability and supports meaningfulness to a lesser extent. And the assisted reproductive technologies can contribute to adaptability to some extent, but their value, I suggest, comes from the possibility of enhancing meaningfulness in a person's life. Yet this possibility is fragile and the "down side" of these techniques is worrisome.

How might these three interventions be meta-ranked based on Dewey's work? The consequence of this ranking will be to help guide distributive decisions at the meso-level. Prenatal care supports adaptability strongly and it does contribute to meaningfulness. Therefore it is a viable candidate for program funding when meso-allocation decisions are being made. But harms are imaginable when dialysis and assisted reproductive techniques are made available. Depending on the situation, dialysis does help the patient to be more responsive to his surroundings just as reproductive assistance helps the recipient find greater meaningfulness in her connections with others.

With this said, however, the worries about dialysis and reproductive assistance are not worries about the techniques themselves. Instead the fundamental problems stem from people's mixed feelings and perceptions about mortality, sexuality, and intimate relationships. For instance, in Western society people's reluctance to accept their mortality is evidenced by the "youth culture" that continues to inform much of our social norms and expectations. Similarly I think that American society sends mixed messages about the worth of parenthood and children. On one hand, public and political rhetoric extols the wonder of children and the deep feelings and virtues involved in parenthood. One the other hand, though, social programs that are for children are not adequately funded (e.g., school lunch programs, funding for programs in the arts, surveillance of foster homes) and child neglect or abuse rates continue as unacceptably high levels. Until we honestly face the fact that we die and discuss candidly our feelings and fears about it and until we attain some consistency as to the status of parenthood and childhood, the value of associated medical interventions treatment will remain unclear.

Dewey demands both adaptability and meaningfulness for something to qualify as being good. To participate in an environment that lacks important human relationships is, I suggest on his behalf, not a desirable or supportive life for a social species such as *Homo sapiens*. Similarly to have significant relationships with other people and groups of people and yet be inactive and unthinking is not desirable. Thus dialysis and assisted reproductive techniques can qualify as good, and thus be candidates for funding, but only if they actually do contribute to the person's adaptability and meaningfulness.

Dewey's work assists in making ethically-defensible distributive decisions in that it provides criteria for deciding under what conditions the remedies are and are not made available. With respect to the issue of a scarcity of funds such that not all three programs can be covered to help all those who could benefit from them, the following meta-ranking is suggested. The intervention that is of highest priority is prenatal care because it can help every pregnant woman and every newborn. In this way, it helps everyone for, at a minimum, everyone was once developing fetus *in utero*. I see no clear way to differentiate between dialysis and the reproductive techniques as each can maintain or increase adaptability and meaningfulness. Their purposes are important because on one side, what is at stake are life and death and, on the other side, what is at stake are intimate relationships. If the comparison had been between, for instance, dialysis and regular dental check-ups or a first-degree sun burn, then dialysis would have been found to be a greater priority for public funding.

Using Dewey's work, this then is the guide for ethically rationing the multitude of health-care services and products. Those that contribute less to human growth, Dewey's term for the good, are of less priority when compared to those which contribute more. The outcome will be, I think, a publicly-funded range of programs that serve as basic health care wherein *major* physical, emotional, psychological, and mental capacities are preserved and protected. It is the consequence of a disease or injury that is decisive here. The kinds of treatment that maintain or restore reason, sensation, and communications would be included in a publicly-funded program, for instance. But if an impaired ability results in no significant loss in the ability to participate actively in one's environment, then treatment would not be covered by public funds. The types of care that would not be publicly reimbursed would include those that could correct slight or minimal reductions in abilities.

Conclusion

When I step back from the practical exercise of applying Dewey's notion of growth to public policy decisions, four points are telling. First, it is telling that his conception of the good is growth which he holds has two critical factors, capability and meaningfulness. The inclusion of capability results in his position mirroring much of what Daniels described under the label of "species-typical functioning." Harkening back to Darwin's work, a fundamental instinct of any species is surviving successfully in its environment. But Darwin saw survival as also involving exploiting an environment to optimize its living conditions and well-being. Dewey concedes that Darwin did influence his thinking about human nature as situated in a complex ecosystem of reciprocal interactions with the natural world and with the social or communal world. Just as lower-order animals attempt to make the most of their innate abilities, humans attempt to do likewise as part of their natures, notes Dewey. Since people naturally have higher intelligence and a wider range of emotions, they are expected to integrate them into their daily activities. Dewey does not see human beings as being superior to other creatures or perfect creations; instead, humans are merely different.

A marked difference between Dewey's and Daniels' positions concerns what counts as the focal point. By this I mean that Daniels allows for individuality by allowing for consideration of personal talents and skills in determining what medical treatments would be made available. As mentioned earlier, this still leaves most of a person's abilities being compared to whatever is deemed typical for the human species.

Dewey focuses on individuals in another way. Certainly he does not contend that a person is a completely autonomous, self-creating creature. Context matters significantly. His emphasis on familial relationships, communal relationships and societal relationships reveals his presupposition that humans are inherently and deeply situated in relationships. Moreover he contends that to thrive, a person must maintain and encourage supportive and reciprocal relationships with others or groups of others, just as a community must maintain and encourage supportive and reciprocal relationships with its members. Relationships exist over the long-term and thus people must respond and act in ways that promote the longevity of these connections.

This then rules out egoism wherein what is normative is whatever the individual decides is best for himself. Concurrently other forms or manifestations of individualism are ruled out: consumerism, materialism, and economic monopolization. There are, of course, people who would reject Dewey's descriptive claim that all humans need to maintain a variety of relationships as well as his normative claim that all humans should maintain the well-being of such relationships. But I think he would agree that there may be "free riders" who can successfully capitalize on the fact that the majority of people do follow social conventions so as to maintain a harmonious balance with other people. But being a pragmatist, he could add that perfection is not the standard for a viable theory of human nature and interactions. A sound theory need not accurately describe every person, but only most people.

I see this emphasis on relationships in Dewey's work to be what is missing from Daniels' work. Admittedly Daniels does include consideration of the society in which a person lives in terms of what she can reasonably expect to be part of a normal range of opportunities for her. But this idea deals more with what choices she is permitted to make in her life than with inescapable relationships' responsibilities and duties. I do not mean to imply that making choices and having alternatives are trivial. What I do mean is that Daniels does not accord sufficient ethical weight to relationships in comparison to Dewey. Thus I see using Dewey's position for characterizing the kinds of health care that should be provided publicly as more ethically-justified than using Daniels' position.

Dewey's work is also superior to that of Callahan in my estimate. I am very much concerned that Callahan has not considered which medical interventions can be deemed unjustified for people who are not elderly. Dewey's work has no set limitations to particular groups of people. Moreover Dewey would dismiss scrutinizing one particular group and not all other groups on the basis that society is itself a kind of ecosystem. As such, all groups are equally important at the outset and each has a legitimate place. Dewey would recommend to Callahan that he needs to equally consider all groups so as to ensure that each is appropriately bearing the burdens of resource limitations. Certainly this is something that is not out of reach in Callahan's work. Thus criticism of his proposal centers on its incompleteness, not necessarily its invalidity, in that the burdens of scarcity exclusively fall to the elderly and inadequate arguments are presented to support this position. More simply put, it is hard to believe that the medical treatment of those who are not elderly provides significant benefits or benefits that support achievement of major life goals.

However with this said, there remains the problem of how to "translate" the criteria for goodness into usable guidelines for discrete decision making at the policy level. As argued above, rough guides may be all that can reasonably be expected because what is being examined is difficult to quantify. Yet Dewey's work does offer criteria with which to make rough comparisons in terms of the value of the purposes of different programs and specific treatments.

This is reminiscent of the work that ensued when the state legislators of Oregon re-structured the distributive basis of the state's Medicaid program in the mid-1990s (Broome 1993; Eddy 1991; Fleck 1990). The legislators decided to select specific criteria as to what counts as value or being good and then apply the criteria consistently to all available medical treatments. The first attempt resulted in counter-intuitive rankings in certain cases, but what was learned in the initial phased contributed to a more defensible second attempt. This parallels the work in this dissertation. Dewey's philosophical work on understanding human nature and the human condition provides a defensible characterization of the good. This then is useful beginning the needed process of comparing valued programs and interventions when, in light of resource scarcity, distributive choices are being made at the macro-level and at the meso-level of society.

REFERENCES

REFERENCES

"A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients." *JAMA* 274, no. 20 (1995): 1591-8.

American Specialty Organization, Inc. web site. http://www.amso.org.

Arber, S. "Integrating Nonemployment into Health Inequalities." *International Journal for Health & Safety* 26, no. 3 (1996): 445-81.

Arno, Bonuck and Padgug. "The Economic Impact of High-Technology Home Care." *Hastings Center Report* 24, no. 5 (1994): S15-9.

Arras, John D. and Nancy Neveloff Dubler. "Bringing the Hospital Home: Ethical and Social Implications of High-Tech Home Care." *Hastings Center Report* 24, no. 5 (1994): S19-28.

Asch, David A. and Peter A. Ubel. "Rationing By Any Other Name." *New England Journal of Medicine* 336, no. 23 (1997): 1668-71.

Badgley, Robin F. "Regionalization of Health Services in Canada." *Israel Journal of Medical Sciences* 18 (1982): 375-83.

Barer, Lomas, and Sanmartin. "Re-Minding Our Ps and Qs: Medical Cost Controls in Canada." *Health Affairs 15*, no. 2 (1996): 216-34.

Barney, Ken. "Limitations of the Critique of the Medical Model." *Journal of Mind and Behavior* 15, nos. 1 & 2 (1994): 19-34.

Bartels, Dianne M. (editor). *Beyond Baby M: Ethical Issues in New Reproductive Techniques*. Clifton (NJ): Humana Press, 1990.

Bentham, Jeremy (1838). *An Introduction to the Principles of Morals and Legislation* edited by J. H. Burns and H. L. A. Hart. London, Athlone Press, 1970.

Blaug, Mark. "Where Are We Now in British Health Economics?" *Health Economics* 7 (1998): S63-78.

Boisvert, Raymond D. *John Dewey: Rethinking Our Time*. Albany: State University of New York, 1998.

Boorse, Christopher (1975). "On the Distinction between Disease and Illness" in *Concepts of Health and Disease*, edited by A. L. Caplan, H. T. Engelhardt, and J. J. McCartney. London: Addison-Wesley Publishing, 1981, pages 545-60.

Bowden, Peta. "Ethical Attention: Accumulating Understandings." *European Journal of Philosophy* 6, no. 1 (1986): 59-77.

Boyle, Philip J. and Daniel Callahan. "Minds and Hearts: Priorities in Mental Health Services." *Hastings Center Report* 23, no. 5 (1993): S1-23.

Brandt, Allan M. and Martha Gardner. "Antagonism and Accommodation: Interpreting the Relationship between Public Health and Medicine in the United States during the 20th Century." *American Journal of Public Health* 90, no. 5 (2000): 707-14.

Broome, John. "Rationing America's Medical Care: The Oregon Plan and Beyond" *Bioethics* 7, no. 4 (1993): 351-8.

Bruno, Leonard C. *Science & Technology Firsts*. Detroit: Gale Research, 1997.

Buchanan, Allen. "Trust in Managed Care Organizations." *Kennedy Institute of Ethics Journal* 10, no. 3 (2000): 189-212.

Bulger, Roger. J. "Covenant, Leadership, and Value Formation in Academic Health Centers" in *Integrity in Health Care Institutions: Humane Environments for Teaching, Inquiry, and Healing*. Edited by Ruth Ellen Bulger and Stanley Joel Reiser. Iowa City: University of Iowa Press, 1990.

Calabresi, Guido and Philip Bobbitt. *Tragic Choices*. New York: W.W. Norton & Company, 1978.

Callahan, Daniel. *The Troubled Dream of Life: In Search of a Peaceful Death*. Washington D.C.: Georgetown University Press , 2000.

Callahan, Daniel (1988). "Aging and the Ends of Medicine" in *Ethical Issues in Modern Medicine* edited by John D. Arras and Bonnie Steinbock. Mountain View (CA): Mayfield Publishing, 1998, pages 652-62.

Callahan, Daniel. *What Kind of Life: The Limits of Medical Progress*. Washington DC: Georgetown University Press, 1990.

Callahan, Daniel. *Setting Limits: Medical Goals in an Aging Society*. New York: Simon and Schuster, 1987.

Cambridge Dictionary of Philosophy, edited by Robert Audi. Cambridge: Cambridge University Press, 1995.

Carr-Hill R. "The Measurement of Inequities in Health: Lessons from the British Experience." *Social Science & Medicine* 31, no. 3 (1990): 393-404.

Cassell, Eric J. *The Nature of Suffering*. New York: Oxford University Press, 1991.

Catley-Carson, Margaret. "Global Considerations Affecting the Health Agenda of the 1990s." *Academic Medicine* 67, no. 7 (1992): 419-24.

Center for Disease Control. http://www.cc.gov/od/oc/media/fact/c11.htm.

Church, John and Paul Baker. "Regionalization of Health Services in Canada: A Critical Perspective." *International Journal of Health Services* 28, no. 3 (1998): 467-86.

Clayton EW. "A Ray of Light about Frozen Embryos." *Kennedy Institute of Ethics Journal* 2, no. 4 (1992): 347-59.

Coleridge, Samuel Taylor. *The Rime of the Ancient Mariner*. New York: Atheneum, 1992.

Covinsky, Goldman, Cook et al. "The Impact of Serious Illness on Patients' Families." *JAMA* 1272, no. 23 (1994): 1839-44.

Crissman, Paul. "Dewey's Theory of the Moral Good." *Monist* 38, no. 4 (1928): 592-619.

Cross, Wilbur. *Dictionary of Business Terms*. Paramus (NJ): Prentice Hall, 1999.

Cummiskey, David. "Contractualism, Consequentialism, and the Dignity of Persons." Paper given at the Department of Philosophy, University of Tennessee, Knoxville, November 9, 2001.

Cystic Fibrosis Federation web site. http://www.cff.org

Daniels, Norman. "The Articulation of Values and Principles Involved in Health Care Reform." *Journal of Medicine and Philosophy* 19, no. 5 (1994): 425-33.

Daniels, Norman. *Just Health Care*. Cambridge: Cambridge University Press, 1985.

Darwin, Charles. *The Origin of Species by Means of Natural Selection: or, The Preservation of Favored Races in the Struggle for Life.* New York: A. L. Burt, 1910.

Deber, Raisa B. "Canadian Medicare: Can It Work in the United States? Will it Survive in Canada?" *American Journal of Law and Medicine* 19, nos. 1 & 2 (1993): 75-93.

De Coster, Carolyn A. and Marni D. Brownell. "Private Health Care in Canada: Savior or Siren." *Public Health Reports* 112, no. 4 (1997): 298-305.

Dewey, John (1900). *Lectures on the Logic of Ethics* in *Lectures on Ethics: 1900-01: John Dewey*, edited by Donald F. Koch. Carbondale (IL): Southern Illinois University Press, 1991, pages 3-96.

Dewey, John (1901a). *Lectures on the Psychology of Ethics* in *Lectures on Ethics: 1900-01: John Dewey*, edited by Donald F. Koch. Carbondale (IL): Southern Illinois University Press, 1991, pages 99-263.

Dewey, John (1901b). *Lectures on Social Ethics* in *Lectures on Ethics: 1900-01: John Dewey*, edited by Donald F. Koch. Carbondale (IL): Southern Illinois University Press, 1991, pages 267-445.

Dewey, John (1917). "The Need for a Recovery of Philosophy" in *On Experience, Nature, and Freedom: Representative Selections*, edited by Richard J. Bernstein. New York: Minton, Balch, & Company, 1962, pages 19-69.

Dewey, John (1920). *Reconstruction in Philosophy*. Boston: Beacon Press, enlarged edition, 1948.

Dewey, John (1929a). *The Quest for Certainty: A Study of the Relation of Knowledge and Action*. New York: Minton, Balch & Company, 1929.

Dewey, John (1929b). *Experience and Nature.* La Salle (IL): Open Court Publishing, 1929.

Dewey, John (1930a). "From Absolutism to Experimentalism" in *On Experience, Nature, and Freedom: Representative Selections,* edited by Richard J. Bernstein. New York: Minton, Balch, & Company, 1962, pages 3-18.

Dewey, John (1930b). "Context and Thought" in *On Experience, Nature, and Freedom: Representative Selections*, edited by Richard J. Bernstein. New York: Minton, Balch, & Company, 1962, pages 89-110.

Dewey, John (1930c). *Human Nature and Conduct: An Introduction to Social Psychology*. New York: Modern Library, 1930.

Dewey, John (1931a). *Philosophy and Civilization*. New York: Minton, Balch, & Company, 1931.

Dewey, John (1931b). "An Empirical Survey of Empiricisms" in *On Experience, Nature, and Freedom: Representative Selections*, edited by Richard J. Bernstein. New York: Minton, Balch, & Company, 1962, pages 70-88.

Dewey, John and John Tufts. *Ethics*. New York: Henry Holt and Company, 1938.

Dewey, Robert E. *The Philosophy of John Dewey: A Critical Exposition of His Method, Metaphysics, and Theory of Knowledge*. The Hague: Martinus Nijhoff, 1977.

Diagnostic and Statistical Manual of Mental Disorders: DSM-IV. Washington, D.C.: American Psychiatric Association, 1994.

A Dictionary of Philosophy, edited by A.R. Lacey. London: Routledge & Kegan Paul, 1976.

Dictionary of Philosophy & Religion: Western and Eastern Thought, edited by William L. Reese. New Jersey: Humanities Press, 1980.

Donelan, Blendon, Schoen, Davis et al. "The Cost of Health System Change: Public Discontent in Five Nations." *Health Affairs* 18, no. 3 (1999): 206-16.

Drummond, Michael and Alan Maynard. "Efficiency in the National Health Service: Lessons from Abroad." *Health Policy* 9 (1988): 59-74.

"Dying Well in the Hospital: The Lessons of SUPPORT," *Hastings Center Report* 25, no. 6 supplement (1995): S1-36.

Eddy, David M. "Oregon's plan. Should It Be Approved?" *Journal of the American Medical Association* 266, no. 17 (1991): 2439-45.

Edwards, Rem B. "Mental Health as Rational Autonomy" in *Ethics in Psychiatry: Insanity, Rational Autonomy, and Mental Health Care*. Amherst (NY): Prometheus Books, 1997, pages 50-61.

Edwards, Rem B. and Glenn C. Graber. *Bioethics*. San Diego: Harcourt Brace Jovanovich, 1988.

The Encyclopedia of Philosophy, edited by Paul Edwards. New York: The Macmillan Company & the Free Press, 1996.

Engelhardt, H. Tristram, Jr. "Ideology and Etiology." *Journal of Medicine and Philosophy* 1, no. 3 (1976): 256-66.

Engelhardt, H. Tristram, Jr. *The Foundations of Bioethics*. New York: Oxford University Press, 1986.

Engelhardt, H. Tristram, Jr. "Freedom and Moral Diversity: The Moral Failures of Health Care in the Welfare State." *Social Philosophy and Policy* 14, no. 2 (1997): 180-96.

Enthoven, Alain C. "Internal Market Reform of the British National Health Service." *Health Affairs* 10, no. 3 (1991): 60-70.

Evans, Robert G. "Canada: The Real Issues." *Journal of Health Politics, Policy & Law* 17, no. 4 (1992): 738-62.

Evans, Lomas, Bauer et al. "Controlling Health Expenditures: The Canadian Reality." *New England Journal of Medicine* 320, no. 9 (1989): 571-7.

Fairbanks, Jo and William H. Wiese. *The Public Health Primer*. Thousand Oaks: Sage Publications, 1998.

Fierlbeck, Katherine. "Policy and Ideology: The Politics of Post-Reform Health Policy in the United Kingdom." *International Journal of Health Services* 26, no. 3 (1996): 529-46.

Fleck, Leonard M. "The Oregon Medicaid Experiment: Is It Just Enough?" *Business & Professional Ethics Journal* 9, no. 3 & 4 (1990): 201-17.

Fleck, Leonard M. "Just Health Care: (I): Is Beneficence Enough?" *Theoretical Medicine* 10 (1989a): 167-82.

Fleck, Leonard M. "Just Health Care: (II): Is Equality Too Much?" *Theoretical Medicine* 10 (1989b): 301-10.

Frank, Arthur. *At the Will of the Body: Reflections on Illness*. Boston: Houghton Mifflin Company, 1991.

Frankena, William. *Ethics*. Englewood Cliffs: Prentice Hall, 1973.

Ginsberg, P., J. Gabel, and K. Hunt. "Tracking small-firm coverage, 1989-1996." *Health Affairs (Millwood)* 17, no. 1 (1998):167-71.

Glaser, William A. "Doctors and Public Authorities: The Trend toward Collaboration." *Journal of Health Politics, Policy and Law* 19, no. 4 (1994): 705-27.

"The Goals of Medicine." *Hastings Center Report* 26 (1996): S1-25.

Goddard, Maria and Russell Mannon. "From Competition to Co-operation: New Economic Relationships in the National Health Service." *Health Economics* 7 (1998): 105-19.

Gorman, Christine. "Playing the HMO Game." *Time* July 13 (1998): 22-8.

Gouinlock, James *John Dewey's Philosophy of Value*. New York: Humanities Press, 1972.

Grisez, Germain and Russell Shaw. *Fulfillment in Christ.* Notre Dame: University of Notre Dame Press, 1991.

Hamlin, Alan P. "The Normative Status of Consumer Sovereignty" in *Rationality, Individualism & Public Policy*, edited by Geoffrey Brennan and Cliff Walsh. Canberra: Australian National University, 1990, pages 1-18.

Hauerwas, Stanley. "The Significance of Vision: toward an Aesthetic Ethic" in *Vision and Virtue: Essays in Christian Ethical Reflection*. Notre Dame (IN): University of Notre Dame Press, 1981, pages 31-47.

Health Care Financing Review. Washington DC: U.S. Health and Human Services Department, 1992.

Iglehart, John K. "Canada's Health Care System: Part II." *New England Journal of Medicine* 315, no. 12 (1986): 778-84.

Iglehart, John K. "Canada's Health Care System Faces its Problems." *New England Journal of Medicine* 322, no. 8 (1990): 562-8.

James, John. "Reforming the British National Health Service: Implementation Problems in London." *Journal of Health Politics, Policy and Law* 20, no. 1 (1995): 191-210.

Jecker, Nancy S. "Should We Ration Health Care?" *Journal of Medical Humanities* 10, no. 2 (1989): 77-90.

Jost, Hughes, McHale et al. "The British Health Care Reforms, the American Health Care Revolution, and Purchaser/Provider Contracts." *Journal of Health Politics, Policy and Law* 20, no. 4 (1995): 885-908.

Kanne, Marvin E. "John Dewey's Conception of Moral Good." *Journal of Economic Issues* 22, no. 4 (1988): 1213-23.

Kant, Immanuel (1785). *The Foundations of the Metaphysics of Morals*, translated by Lewis White Beck with critical essays edited by Robert Paul Wolff. Indianapolis: Bobbs-Merrill, 1969.

Kassirer, Jerome P. "Doctor Discontent." *New England Journal of Medicine* 339, no. 21 (1998): 1543-5.

Klotzko, Arlene J. "Medical Miracle or Medical Mischief? The Saga of the McCaughey Septuplets." *Hastings Center Report* 28, no. 3 (1998): 5-8.

Knopf, Kenyon A. *A Lexicon of Economics*. San Diego: Academic Press Inc., 1991.

Koch, Donald F. "Introduction" in *Lectures on Ethics: 1900-01*, edited by Donald F. Koch. Carbondale (IL): Southern Illinois University Press, 1991, pgs xi-lvii.

Labour Party. "Renewing the National Health Service: Labour's Agenda for a Healthier Britain." *International Journal of Health Services* 26, no. 2 (1996): 269-308.

Llamzon, Benjamin S. "Toward a Wholistic Approach in Moral Decisions (through Kant and Dewey)." *Listening* 18 (1983): 23-9.

Lynch J.W., Smith, G.D., Hillemeier, M. et al. "Income Inequality and Mortality: Importance to Health of Individual Income, Psychosocial Environment, or Material Conditions." *British Medical Journal* 320, no. 7243 (2000):1200-4.

Margolis, Joseph. "The Concept of Disease" *Journal of Medicine and Philosophy* 1, no. 3 (1976): 238-55.

Marmot, M., Ryff C.D. and Bumpuss L.L. "Social Inequalities in Health: Next Questions and Converging Evidence." *Social Science & Medicine* 44, no. 6 (1997): 901-10.

May, William F. *Testing the Medical Covenant: Active Euthanasia and Health Care Reform*. Grand Rapids: Eerdmans, 1996.

Maynard, Alan. "Can Competition Enhance Efficiency in Health Care? Lessons from the Reform of the UK National Health Service." *Social Science & Medicine* 39, no. 10 (1994): 1433-45.

McCullough, Laurence B. "John Gregory (1724-1773) and the Invention of Professional Relationships in Medicine." *Journal of Clinical Ethics* 8, no. 1 (1997): 11-21.

McCullough, Laurence B. "Should We Create a Health Care System in the United States?" *Journal of Medicine and Philosophy* 19, no. 5 (1994): 483-90.

McKinley, J. and S. McKinley. "The Questionable Contribution of Medical Measures to the Decline of Mortality in the Twentieth Century." *Milbank Memorial Fund Quarterly* 55 (1977): 405-28.

Mechanic, David. "The Americanization of the British National Health Service." *Health Affairs* 14, no. 2 (1995): 51-67.

Mhatre, Sharmilla L. and Raisa B. Deber. "From Equal Access to Health Care to Equitable Access to Health: A Review of Canada's Provincial Health Commissions and Reports." *International Journal of Health Services* 22, no. 4 (1992): 645-68.

Mill, John Stuart (1861). *Utilitarianism*, edited by George Sher. Indianapolis: Hackett Publishing, 1990.

Moore, G. E. *Principia Ethica*. Cambridge: Cambridge University Press, 1903.

Moskowitz, Ellen H. and James Lindemann Nelson. "The Best Laid Plans." *Hastings Center Report* 25, no. 6 (1995): S3-5.

Nelkin, Dorothy and Lori Andrews. "*Homo Economicus*: Commercialization of Body Tissue in the Age of Biotechnology." *Hastings Center Report* 28, no. 5 (1998): 30-9.

Nelson, James Lindemann. "Measured Fairness, Situated Justice: Feminist Reflections on Health Care Rationing." *Kennedy Institute of Ethics Journal* 6, no. 1 (1996): 53-68.

Newhouse, Joseph P. "US and UK Health Economics: Two Disciplines Separated by a Common Language?" *Health Economics* 7 (1998): S79-92.

The New Shorter Oxford English Dictionary. Oxford: Oxford University Press, 1993.

Nissenson, Allen R. and Richard A. Rettig. "Medicare's End-Stage Renal Disease Program: Current Status and Future Prospects." *Health Affairs* 18, no. 1 (1999): 161-79.

Ng, Lorenz K.Y. and Deura Lee Davis. *Strategies for Public Health: Promoting Health and Preventing Disease*. New York: Van Nostrand Reinhold Co., 1981.

Noddings, Nel. *Caring: A Feminine Approach to Ethics & Moral Education*. Berkeley: University of California Press, 1994.

Nordenfelt, Lennart. "Concepts of Health and Their Consequences for Health Care." *Theoretical Medicine* 14, no. 4 (1993): 277-85.

On Experience, Nature, and Freedom: Representative Selections, edited by Richard J. Bernstein. Indianapolis: Bobbs-Merrill Company, 1962.

O'Neill, Michael A. "Health as an Irreversible Part of the Welfare State: Canadian Government Policy under the Tories." *International Journal of Health Services* 26, no. 3 (1996): 547-59.

The Oxford Companion to Philosophy, edited by Ted Hondenrich. Oxford: Oxford University Press, 1995.

Palmer, Donald. *Does the Center Hold?* Boston: McGraw-Hill, 2002.

Paris, John J. and Stephen G. Post. "Managed Care, Cost Control, and the Common Good." *Cambridge Quarterly of Healthcare Ethics*. 9, no. 2 (2000): 182-188.

Parsons, Talcott (1958). "Definitions of Health and Illness in the Light of American Values and Social Structure" in *Concepts of Health and Disease*, edited by A. L. Caplan, H. T. Engelhardt, and J. J. McCartney. London: Addison-Wesley Publishing, 1981, pages 57-81.

Petersen, Alan and Deborah Lipton. *The New Public Health: Health and Self in the Age of Risk*. London (UK): Sage Publications, 1996.

Philosophical Dictionary, edited by Walter Brugger and Kenneth Baker. Spokane: Gonzaga University Press, 1972.

Plato. "Euthyphro" in *Plato: Complete Works*, edited by John M. Cooper. Indianapolis: Hackett Publishing Co., 1997, pages. 1-16.

Plotnikoff, Gregory A. "Spirituality, Religion, and the Physician: New Ethical Challenges in Patient Care." *Bioethics Forum* 13, no. 4 (1997): 25-30.

Powell, Martin. "The Ghost of Health Services Past: Comparing British Health Policy of the 1930s with the 1980s and 1990s." *International Journal of Health Services* 26, no. 2 (1996): 253-68.

Propper, Carol. "Agency and Incentives in the National Health Service Internal Market." *Social Science & Medicine* 40, no. 12 (1995): 83-90.

Rainbolt, George W. "Competition and the Patient-Centered Ethic." *Journal of Medicine and Philosophy* 12 (1987): 85-99.

Ramanathan, Suguna. *Iris Murdoch: Figures of Good*. New York: St. Martin's Press, 1990.

Rationality, Individualism and Public Policy, edited by Geoffrey Brennan and Cliff Walsh. Canberra: Australian National University, 1990.

Rawls, John. *A Theory of Justice*. Cambridge: Harvard University Press, 1971.

Reiser, Stanley J. "Medicine and Public Health: Pursuing a Common Destiny." *JAMA* 276, no. 17 (1996): 1429-30.

Relman, Arnold S. "The New Medical-Industrial Complex." *New England Journal of Medicine* 303, no. 17 (1980): 963-70.

Robertson, John. "The Presumptive Primacy of Procreative Liberty" in *Ethical Issues in Modern Medicine*, edited by John D. Arras and Bonnie Steinbock. Mountain View (CA): Mayfield Publishing, 1999, pages 415-25.

Rodwin, Marc A. *Medicine, Money, and Morals: Physicians' Conflicts of Interest*. New York: Oxford University Press, 1993.

Rorty, Richard. *Contingency, Irony, and Solidarity*. Cambridge: Cambridge University Press, 1989.

Ruddick, William. "Transforming Homes and Hospitals." *Hastings Center Report* 24, no. 5 (1994): S11-4.

Russell, Barbara J. "Healthcare Rationing: Critical Features, Ordinary Language, and Meaning." *Journal of Law, Medicine & Ethics* 30, no. 1 (2002): 82-7.

Sagan, Leonard A. *The Health of Nations: True Causes of Sickness and Well-Being*. New York: Basic Books, Inc. 1987.

Samuelson, Robert J. "Secrets of Success." *Newsweek* (Winter 1997-1998 Special Edition): 79.

Schaffner, Kenneth F. "Coming Home to Hume: A Sociobiological Foundation for a Concept of 'Health' and Morality." *Journal of Medicine and Philosophy* 24, no. 4 (1999): 365-75.

Schrader, George A. "Autonomy, Heteronomy, and Moral Imperatives" in *Foundations of the Metaphysics of Morals*, translated by Lewis White Beck., *with Critical Essays*, edited by Robert Paul Wolff. Indianapolis: Bobbs-Merrill Company, 1969, pages 117-33.

Sen, Amartya. "Rational Fools: A Critique of the Behavioral Foundations of Economic Theory." *Philosophy & Public Affairs* 6 (1977): 317-344.

Sharpe, Virginia A. "Justice and Care: The Implications of the Kohlberg-Gilligan Debate for Medical Ethics." *Theoretical Medicine* 13 (1992): 295-318.

Shifrin, Leonard. "Health Care System May Be Facing Most Important Federal Election in 30 Years." *Canadian Medical Association Journal* 149, no. 6 (1993): 866-8.

Silversides, Ann. "Role of Private Insurance in Public System Source of Debate at CHEPA Conference." *Canadian Medical Association Journal* 153, no. 6 (1995): 827-8.

Starr, Paul. *The Logic of Health-Care Reform*. Knoxville: Whittle Direct Books, 1992.

Starr, Paul. *The Social Transformation of American Medicine*. New York: Basic Books Inc., 1982.

Statistical Abstract of the United States 2001. Washington DC: U.S. Department of Commerce, 2000.

Statistical Abstract of the United States 1998. Washington DC: U.S. Department of Commerce, 2000.

Statistical Abstract of the United States 1998. Washington DC: U.S. Department of Commerce, 1998.

Statistical Abstract of the United States 1997. Washington DC: U.S. Department of Commerce, 1997.

Statistical Abstract of the United States 1992. Washington DC: U.S. Department of Commerce, 1992.

Statistical Abstract of the United States 1988. Washington DC: U.S. Department of Commerce, 1988.

Statistical Abstract of the United States 1985. Washington DC: U.S. Department of Commerce, 1985.

Statistical Abstract of the United States 1980. Washington DC: U.S. Department of Commerce, 1980.

Steinbock, Bonnie. "The McCaughey Septuplets: Medical Miracle or Gambling with Fertility Drugs?" in *Ethical Issues in Modern Medicine* edited by John D. Arras and Bonnie Steinbock. Mountain View (CA): Mayfield Publishing, 1999, pages 375-7.

Stern, Lawrence. "Opportunity and Health Care: Criticisms and Suggestions." *Journal of Medicine and Philosophy* 8, no. 4 (1983): 339-62.

Strategic Air Command. http://www.stratcom.af.mil.

SUPPORT Principal Investigators. "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients. The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)." *Journal of the American Medical Association* 274, no. 20 (1995): 1591-8.

Szasz, Thomas S. "The Myth of Mental Illness" in *Ethics in Psychiatry: Insanity, Rational Autonomy, and Mental Health Care*. Amherst (NY): Prometheus Books, 1997, pages 22-32.

Trotter, C. Griffin. "The Medical Covenant: A Roycean Perspective" in *Pragmatic Bioethics*, edited by Glenn McGee. Nashville: Vanderbilt University Press, 1999.

Tumulty, Karen. "Let's Play Doctor." *Time* July 13 (1998): 28-32.

2001 Hospital Accreditation Standards. Oakbrook Terrace (IL): Joint Commission on Accreditation of Healthcare Organizations, 2001.

Ubel, Peter A. "Physicians' Duties in an Era of Cost Containment: Advocacy or Betrayal?" *JAMA* 282, no. 17 (1999): 1675.

UNOS web site. http://www.unos.org.

Walzer, Michael. *Spheres of Justice: A Defense of Pluralism and Equality*. New York: Basic Books, 1983.

Warren, Mary Anne. "IVF and Women's Interests: An Analysis of Feminist Concerns." *Bioethics* 2, no. 1 (1988): 37-57.

Webster's Encyclopedic Unabridged Dictionary of the English Language. New York: Portland House, 1989.

Welchman, Jennifer. *Dewey's Ethical Thought*. Ithaca: Cornell University Press, 1995.

Whitbeck, Caroline. "A Theory of Health" in *Concepts of Health and Disease*, edited by A. L. Caplan, H. T. Engelhardt, and J. J. McCartney. London: Addison-Wesley Publishing, 1981, pages 611-26.

Wilsford, David. "States Facing Interests: Struggles over Health Care Policy in Advanced, Industrial Democracies." *Journal of Health Politics, Policy & Law* 20, no. 3 (1995): 571-613.

World Health Organization (1942). "Constitution of the WHO" in *Concepts of Health and Disease*, edited by A. L. Caplan, H. T. Engelhardt, and J. J. McCartney. London: Addison-Wesley Publishing, 1981, page 83.

Wyman, Freeley, Brimacombe et al. "Core and Comprehensive Health Care Services: 4. Economics." *Canadian Medical Association Journal* 15, no. 10 (1995): 1601-4.

APPENDIX

TABLE 3. U.S. Total Health-Care Expenditures ($ billions)

1965	1970	1975	1980	1985	1990	1993	1995	1997	1999	2001 proj
42.0	74.9	132.1	247.5	428.7	699.5	895.1	991.4	1,092.4	1,211	1,424

2010	2020	2030
3,787.8	7,839.4	15,696.6

Sources: For 1965 to 1985, *Statistical Abstract of the United States* 1998. For 1985 to 2001, *Statistical Abstract of the United States* 2001. For 2010 to 2030, *Health Care Financing Review*, 1992.

TABLE 4. Average Annual Growth Rate in Health-Care Expenditures (%)

1965-1970	1970-1975	1975-1980	1980-1985	1985-1990	1990-1993	1993-1995	1990-1995	1995-1997
15.6	15.2	17.4	14.6	12.6	9.3	5.4	8.3	5.1

1997-1999	1999-2010	2010-2020	2020-2030
5.4	8.8	10.7	10.0

Source: calculations based on Table 3.

TABLE 5. U.S. Population (millions)

1965	1970	1975	1980	1985	1990	1993	1995	1997	1999	2000
194.3	205.1	216.0	227.7	238.5	249.9	258.1	263.0	268	272.9	275.4

2010	2020	2030
302	320	333

Sources: For 1965 to 1985, *Statistical Abstract of the United States* 1998. For 1985 to 2001, *Statistical Abstract of the United States* 2001. For 2010 to 2030, *Health Care Financing Review*, 1992.

TABLE 6. Average Annual Increase in Population (%)

1965-1970	1970-1975	1975-1980	1980-1985	1985-1990	1990-1993	1993-1995	1995-1997
1.1	1.1	1.1	0.9	1.0	1.1	0.9	1.0

1997-1999	1999-2010	2010-2020	2020-2030
0.9	0.9	0.6	0.4

Source: calculations based on Table 5.

TABLE 7. Annual U.S. Inflation Rate (or Consumer Price Index) (%)

1965	**1970**	**1975**	**1980**	**1985**	**1990**	**1993**	**1995**	**1997**	**1999**	**2000**
1.6	5.7	9.1	13.5	3.6	5.4	3.0	2.8	2.3	2.2	3.4

Sources: For 1965 to 1985, *Statistical Abstract of the United States* 1998. For 1985 to 2001, *Statistical Abstract of the United States* 2001.

TABLE 8. Breakdown of the 1999 Gross Domestic Product by Major Sector

	$ billion	$ billion	% of Total	% of Total
Private activity:	7860.7		88.6	
services		1772.6		20.0
financial/real estate/insurance		1692.1		19.1
manufacturing		1529.4		17.2
retail		847.3		9.5
wholesale		709.3		8.0
construction		361.1		4.1
transportation		272.4		3.1
utilities		216.3		2.4
communications		264.6		3.0
agriculture/forestry/fishing		150.9		1.7
mining		121.9		1.4
other		77.2		0.9
Public (governmental) activity	1015.1		11.4	
TOTAL	8875.8		100.0	

Source: *Statistical Abstract of the United States* 2001.

TABLE 9. U.S. Gross Domestic Product ($ billions)

1965	1970	1975	1980	1985	1990	1993	1995	1997	1999	2000
719.1	1,035.6	1,583.9	2,784.2	4.213	5803.2	6642.3	7400.5	8318.4	9289.2	9963.1

2010	2020	2030
17,238	29,594	49,936

Sources: For 1965 to 1985, *Statistical Abstract of the United States* 1998. For 1985 to 2001, *Statistical Abstract of the United States* 2001. For 2010 to 2030: *Health Care Financing Review*, 1992.

TABLE 10. National Health-Care Expenditures as a Percentage of Gross Domestic Product

1965	1970	1975	1980	1985	1990	1993	1995	1997	1999	2000
5.8	7.2	8.3	8.8	10.2	12.1	13.5	13.4	13.1	13.0	14.3

2010	2020	2030
22.0	26.5	31.4

Source: calculations based on Tables 3 and 9.

TABLE 11. Federal Budgets Allocations by Sector ($ billions)

	1965	1970	1975	1980	1985	1990	1993	1995	1998	1999	2001 est.
Social Security	17.5	30.3	64.7	118.5	188.6	248.6	304.6	335.8	381.7	390	433.6
Income Security	9.5	15.6	50.2	85.6	128.7	147.0	207.3	220.5	239.4	237.7	262.6
Medicare[a]	-	6.2	12.9	32.1	65.8	98.1	130.6	159.9	198.1	190.4	219.3
Health[a,b]	1.8	5.9	12.9	23.2	33.5	57.7	99.4	115.4	131.8	141.3	175.3
Defense	50.6	81.7	86.5	134.0	252.7	299.3	291.1	272.1	264.1	274.9	299.1
Education	2.1	8.6	16.0	31.8	29.3	38.8	50.0	54.3	55.1	56.2	65.3
Transportation	5.8	7.0	10.9	21.3	25.8	29.5	35.0	39.4	41.5	42.5	51.1
Commerce & housing	1.2	2.1	9.9	9.4	4.3	67.6	(21.9)	(18.8)	3.5	2.6	(0.8)
Veterans' benefits	5.7	8.7	16.6	21.2	26.3	29.1	35.7	37.9	43.1	43.2	45.4
Other[c]	18.1	20.9	38.1	93.9	158.8	200.9	240.2	254.7	263.1	324.1	305.3
Total Outlays	112.3	187.0	318.7	571.0	913.8	1216.6	1372.0	1471.2	1621.4	1702.9	1856.2
Undistributed	5.9	8.6	13.6	19.9	32.7	36.6	37.4	44.5	46.4	52.1	68.9
Total Budgeted	118.2	195.6	332.3	590.9	946.5	1253.2	1409.4	1515.7	1667.8	1755	1925.1

a. If the expenditures for Medicare and Health are combined ($ billions):
1.8 12.1 25.8 55.3 99.3 155.8 230.0 275.3 329.9 331.5 394.6

b. Health is mostly Medicaid or its predecessor programs.

c. Includes interest on federal debt.

TABLE 11. Federal Budget Allocations by Sector ($ billion) continued

Sources: For 1965, *Statistical Abstract of the United States* 1980. For 1970 and 1975, *Statistical Abstract of the United States* 1985. For 1985, *Statistical Abstract of the United States* 1988. For 1993, *Statistical Abstract of the United States* 1997. For 1980, 1990, and 1995, *Statistical Abstract of the United States* 1998. For 1997 and 1998, *Statistical Abstract of the United States* 2001.

TABLE 12. Federal Budget Allocations as a Percentage of Yearly Total Budget

	1965	1970	1975	1980	1985	1990	1993	1995	1998	1999	2001 est.
Social Security	14.8	15.4	19.5	20.1	19.9	19.8	21.6	22.2	22.9	22.2	22.5
Income Security	8.0	8.0	15.1	14.6	13.6	11.7	14.7	14.5	14.4	13.5	13.6
Medicare[d]	-	3.2	3.9	5.4	7.0	7.8	9.3	10.5	11.9	10.8	11.4
Health[d]	1.5	3.0	3.9	3.9	3.5	4.6	7.1	7.6	7.9	8	9.1
Defense	42.8	41.8	26.0	22.7	26.7	23.9	20.7	17.9	15.8	15.7	15.5
Education	1.8	4.4	4.9	5.3	3.1	3.1	3.5	3.6	3.3	3.2	3.4
Transportation	4.9	3.6	3.3	3.6	2.7	2.3	2.5	2.6	2.5	2.4	2.7
Commerce & housing	1.0	1.1	3.0	1.6	0.5	5.4	(1.6)	(1.2)	0.2	0.1	(0.4)
Veterans' benefits	4.8	4.4	5.0	3.6	2.8	2.3	2.5	2.5	2.6	2.5	2.4
Other	15.3	10.7	11.5	15.9	16.8	16.0	17.0	16.8	18.5	21.6	19.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

d. If the expenditures for Medicare and Health are combined (% of total annual budget):

1.5 6.2 7.8 9.3 10.5 12.4 16.4 18.1 19.9 18.8 20.5

Source: calculations based on Table 11.

TABLE 13. State and Local Government Expenditures ($ billion)

	1965	1970	1975	1980	1985	1990	1993	1995	1997	1998
Education	28.6	52.7	87.9	133.2	192.7	288.1	342.3	378.3	418.4	450.4
Highways	12.2	16.4	22.5	33.3	45.0	61.1	68.4	77.1	82.1	87.2
Public welfare	6.3	14.7	27.2	45.6	69.6	110.5	167.1	193.1	200	204.6
Health[a]	0.8	1.8	4.4	8.4	13.7	24.2	32.6	38.0	42.2	44.4
Hospitals[a]	4.5	7.9	14.4	23.8	36.0	50.4	62.6	67.9	68.3	70
Sanitation	2.4	3.4	7.4	13.2	17.4	28.5	35.6	38.6	41.3	41.8
Police protection	2.5	4.5	8.5	13.5	21.0	30.6	36.4	41.1	47.4	50.5
Fire protection	1.3	2.0	3.5	5.7	8.9	13.2	15.4	17.0	19.3	20.3
Housing & community development	1.3	2.3	3.5	6.1	10.4	15.5	18.8	21.5	23.5	24.7
Utilities	6.9	7.8	17.3	33.6	57.0	75.0	81.4	91.2	96.3	99.5
Parks & recreation	1.1	1.9	3.5	6.5	9.2	14.3	16.2	17.9	20.7	22.4
Other	18.8	32.7	68.1	109.4	175.2	261.3	333.3	366.0	397.2	410
TOTAL	86.7	148.1	268.2	432.3	656.1	972.7	1210.1	1347.7	1456.7	1525.8

[a] If Health and Hospitals are combined:

5.3	9.7	18.8	32.2	49.7	74.6	95.2	105.9	110.5	114.4

Sources: For 1965, *Statistical Abstract of the United States* 1980. For 1970 and 1975, *Statistical Abstract of the United States* 1985. For 1985, *Statistical Abstract of the United States* 1988. For 1993, *Statistical Abstract of the United States* 1997. For 1980, 1990, and 1995, *Statistical Abstract of the United States* 1998. For 1997 and 1998, *Statistical Abstract of the United States* 2001.

TABLE 14. State and Local Government Expenditures as a Percentage of Total Expenditures

	1965	**1970**	**1975**	**1980**	**1985**	**1990**	**1993**	**1995**	**1997**	**1998**
Education	33.0	35.6	32.8	30.8	29.4	29.6	28.3	28.1	28.7	29.5
Highways	14.1	11.1	8.4	7.7	6.9	6.3	5.7	5.7	5.6	5.7
Public welfare	7.3	9.9	10.4	10.5	10.6	11.4	13.8	14.3	13.7	13.4
Health[b]	0.9	1.2	1.6	1.9	2.1	2.5	2.7	2.8	2.9	2.9
Hospitals[b]	5.2	5.3	5.4	5.5	5.5	5.2	5.2	5.0	4.7	4.6
Sanitation	2.8	2.3	2.8	3.1	2.7	2.9	2.9	2.9	2.9	2.7
Police protection	2.9	3.0	3.2	3.1	3.2	3.1	3.0	3.0	3.3	3.3
Fire protection	1.5	1.4	1.3	1.3	1.4	1.4	1.3	1.3	1.3	1.3
Housing & community development	1.5	1.6	1.3	1.4	1.6	1.6	1.6	1.6	1.6	1.6
Utilities	8.0	5.3	6.5	7.7	8.7	7.7	6.7	6.8	6.6	6.5
Parks & recreation	1.3	1.3	1.3	1.5	1.4	1.5	1.3	1.3	1.4	1.5
Other	21.5	20.3	24.8	25.5	26.5	29.7	27.5	27.2	27.3	27
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

b. If Health and Hospitals are combined:

6.1 6.5 7.0 7.4 7.6 7.7 7.9 7.8 7.6 7.5

Source: calculations based on Table 13.

TABLE 15. Medical Research and Development Expenditures by Country for 1995 ($ billions)

COUNTRY	$ billion	Ratio to U.S.A.
Japan	82	0.46
Germany	38	0.21
France	27	0.15
U.K.	21	0.12
TOTAL	168	0.94
U.S.A.	179	1.0

Source: Samuelson, 1997-1998: 79.

TABLE 16. National Health-Care Expenditures of Developed Countries as a Percentage of Gross Domestic Product

	1980	**1985**	**1990**	**1995**	**1999**
U.S.A.	9.2	10.7	12.4	13.9	13.7
U.K.	5.8	5.9	6.2	7	7
Canada	7.4	8.4	9.5	9.5	9.5
France	7.6	8.5	8.9	9.8	N/A
Germany	8.4	8.5	8.3	10.2	10.5
Sweden	9.4	9	8.6	8.4	N/A
Australia	7.3	7.7	8.2	8.2	N/A
Japan	6.6	6.7	6.7	7.2	N/A

Sources: For 1980 to 1990, *Statistical Abstract of the United States* 1997. For 1995 and 1999, *Statistical Abstract of the United States*2001.

TABLE 17. National Health Statistics of Developed Countries for 1997 and 2001

	1997		1997		1997		2001		2001		2001	
	death rate[a]	Ψ	infant mortality[b]	Ψ	life expectancy[c]	Ψ	death rate	Ψ	infant mortality	Ψ	life expectancy	Ψ
U.S.A.	8.8		6.6		76.0		8.8		6.8		77.3	
U.K.	11.2	+	6.3	-	76.6	-	10.4	+	5.5	-	77.8	-
Canada	7.2	-	6.0	-	79.3	-	7.5	-	5.0	-	79.6	-
France	9.0	+	6.0	-	78.6	-	9.1	+	4.5	-	78.9	-
Germany	11.1	+	5.9	-	76.1	-	10.4	+	4.6	-	77.6	-
Sweden	11.3	+	4.5	-	78.2	-	11.1	+	4.4	-	78.5	-
Australia	6.9	-	5.4	-	79.6	-	7.2	-	5.0	-	79.9	-
Japan	7.9	-	4.4	-	79.7	-	8.3	-	3.9	-	80.8	-

Ψ indicates whether U.S.A. ratio is better (+) or worse (-) than that of the other country. For instance, compared to the U.K. in 1997, the U.S. death rate is lower in the U.S.A. and thus is better.

a. deaths per 1,000 people
b. deaths per 1,000 infants
c. calculated at birth, the number of years he is expected to live

Sources: For 1997, *Statistical Abstract of the United States* 1997. For 2001, *Statistical Abstract of the United States* 2001.

TABLE 18. Number of Americans Covered by Insurance or a Health-Care Plan (millions)

	1980	**1985**	**1990**	**1993**	**1995**	**1997**
Governmental	53.6	59.4	56.6	64.8	66.6	64.6
Private	137.3	174.6	182.1	182.4	185.9	188.5
Not covered	36.8	34.6	34.7	39.7	40.6	43.4
Total population[a]	227.2	234.0	248.9	259.8	264.3	269.1

a. Because an individual may have both private and governmental coverage, each column will exceed the total population.

Sources: For 1997: *Statistical Abstract of the United States* 2001. For 1985 to 1995: *Statistical Abstract of the United States* 1997. For 1980: *Statistical Abstract of the United States* 1992.

TABLE 19. Number of Americans Covered by Insurance or a Health-Care Plan as a Percentage of Total Population

	1980	**1985**	**1990**	**1993**	**1995**	**1997**
Governmental	23.6	24.9	22.6	25.1	25.3	24.1
Private	60.4	73.2	72.9	70.7	70.6	70.3
Not covered	16.2	14.5	13.9	15.4	15.4	16.2
Total	100.0	100.0	100.0	100.0	100.0	100.0

Source: calculations based on Tables 5 and 18.

TABLE 20. Number of Americans Enrolled in a Health Maintenance Organization Program

	1980	**1985**	**1990**	**1993**	**1995**	**1997**
Number (millions)	9.1	21.0	33.0	38.4	46.2	66.8
As % of total covered	4.8	9.0	13.8	15.5	18.3	26.3

Sources: For 1997: *Statistical Abstract of the United States* 1998. For 1985 to 1995: *Statistical Abstract of the United States* 1997. For 1980: *Statistical Abstract of the United States* 1992.

TABLE 21. Employee Enrollment in Employer-Subsidized Insurance Plans

	1989	1996
Small employers (less than 200 employees)	72%	66%
Large employers (more than 200 employees)	73%	67%

Source: Ginsberg, Gabel, and Hunt 1998.

Abbreviated Description of Britain's Health System

Prior to 1948, health services were provided either by salaried professionals working at large hospitals or by independent professionals working out of private offices. Costs were covered by fee-for-service or by philanthropic donations and there was little regulation beyond the licensing of practitioners. By 1948, three major problems faced the system: (1) erratic introduction of new techniques and products, (2) inequitable access to whatever treatment modalities were available, and (3) an absence of innovation or of responsiveness to patient needs. Moreover the lack of coordination and cooperation among providers made care more expensive because of a failure to realize economies of scale in terms of sharing facilities and equipment as well as harmonizing purchasing agreements. Characterized as part of "what ought to comprise modern citizenship," the 1948 Labour government instituted the National Health Service (NHS) (Fierlbeck 1996, 530).

The NHS's mandate was comprehensive, universal, and equal (as per medical need) health care. Each year, the government specified a fixed proportion of general tax dollars to be allocated to the country's health system. This pool of funds was then distributed to hospitals, virtually all of which were owned by the government, and to general medicine practitioners to cover their expenses in caring for the population. Most specialists and sub-specialists remained salaried employees of the hospitals. No user charges were levied against any citizen requiring any form of medical or public health care. And district and regional health authorities (DHAs and RHAs) coordinated virtually all health services.

By the mid-1980s, public and political criticism focused on the lack of sufficient services, resulting in unacceptable waiting lists, some of which were known as "'never-never lists'" (Powell 1996, 256). The public and the opposition Labour party demanded a substantial increase in governmental funding. But the British economy had been in a long decline and tax revenues had decreased commensurably and yet the NHS had grown into the largest employer in Western Europe (Le Grand and Bartlett 1993). Some influential members of the Conservative government believed that the NHS had become highly inefficient and moribund. The government therefore chose to revamp the system, rather than boost funding, in hopes of directing funds away from wasteful projects and of increasing the productivity of existing allocations.

With reform in mind, input was sought from Alain Enthoven, a Stanford University economics professor who had developed the concept of "managed competition" to address the growing financial stresses within the American health system. Pursuant to Enthoven's analysis of the British system and confident of its political majority, the Thatcher government passed the *NHS and Community Care Act* in 1990, with no pilot or testing of its radical recommendations. The *Act* emphasized competition to weed out inefficiencies and stimulate innovation, professional and administrative incentives and disincentives to control costs and improve quality, and bureaucratic decentralization to promote accountability. The only explicit resource-rationing involved kidney dialysis for end-stage renal disease. If a patient was age 65 or older, this expensive treatment would not be offered to him.

Four reforms were most controversial. First, an internal or quasi-market[36] was created by administratively separating providers from purchasers. Second, although still owned by the government and operated on a non-profit basis, all hospitals became autonomous providers. Third, since funding was to "follow the patient," all general medicine practitioners, or GPs, were to eventually become fundholders or GPFHs (James 1995, 195). As a fundholder, a physician received an enhanced capitation fund from the government with which she would contract with any provider all non-emergency medical services for her patient group.[37, 38] As such, GPs became "gatekeepers" to the entire national health system. If a citizen did not wish to be part of a GP's practice, his care could be handled by two other forms of purchasers: a DHA or a Family Services Health Authority (or FHSA).[39] And fourth, contracts between providers and purchasers became the operational mechanism for all medical care.[40] Thus capitalism, independence, restricted access, and legally-binding contracts became part of the British health system.

---

36. A quasi-market has several key features. On the supply or provider side, the primary goal is not to maximize profits, but, for example, to achieve high quality of products, universality of access, or safety of the products. Suppliers are typically publicly owned. On the demand or consumer side, purchasing is centralized and decisions are made by a third-party, not by the end user. Yet a market does indeed exist due to the presence of multiple providers and purchasers negotiating contracts for the best package of services (Le Grand and Bartlett 1993).
37. Once a GPFH's patient's annual care reached £5,000, all added expenses are directly covered by the NHS (Mechanic 1995).
38. Any financial savings or efficiencies realized by a GPFH can only be reinvested in the practice; they could not constitute part of the GPFH's direct income (Ibid).
39. A patient cannot be refused care or de-listed by a DHA or FSHA on the grounds that the expected medical costs would be high (James 1995).
40. Pricing was regulated by the government: contracts were to be based on average costs, a maximum 6% return on capital, and no cost-shifting (Propper 1995). And to promote cooperative relationships, the contracts cannot be enforced through the court system. Instead disputes were to be resolved through binding arbitration (Jost, Hughes, McHale et al 1995).

After eighteen years of Conservative majorities, a Labour government was elected in 1997. The country's health system has once again fallen under severe criticism. The multiplicity of providers and purchasers has driven up the percentage of funds consumed by bureaucracy and administration, and thus away from direct patient care. The system has become inequitable and, hence, unjust. The shift towards privatization[41] has been substantial and "instead of money following the patient, the patient follows the contract"[42] (Labour Party 1996, 275). Admittedly, Britain has witnessed considerable technological progress, but an enduring concern remains in "'not letting the best be the enemy of the good'" (Blaug 1998, S72). In other words, technological progress must not be at the cost of society's overarching values. In the case of Britain, these values stress inclusion of all citizens and equality of consideration over cutting-edge technology and competition.

---

[41] Prescriptions, dentistry, optical/opthamological care, and long-term care of the elderly are handled by the private sector. As such, costs are covered by out-of-pocket user charges or through private or employer-paid indemnity insurance (James; Powell 1995). Today, 81% of total health-care funding in Britain comes from general taxes, 14% from payroll taxes, and 4% from direct user charges (Maynard 1994).

[42] The system is seen as now being two-tiered. The care of patients who "belong" to GPFHs is superior, in terms of higher quality and shorter waiting times, to that of patients seen by non-GPFHs, DHAs, or FSHAs.

Abbreviated Description of Canada's Health System

Prior to 1966, the ten provinces and two territories had total jurisdiction over the health care of their residents. The country's constitution, the 1867 *British North American Act* (*BNA*), stipulated that health was a provincial and territorial responsibility, except for the care of military personnel, native Canadians, and the Inuit. After the signing of the *BNA* and until the mid 1960s, Canada's health system was typified by non-profit, privately-owned facilities[43] and fee-for-service, independent physician practices. Each province partially funded medical treatments and facilities to help lower the final billings of hospitals and physicians to their patients.

Provinces cannot directly tax the income of their residents or the profits of corporations. Instead taxation remains a federal responsibility as per the *BNA*. Annual tax revenues are apportioned either to federal or to provincial departments to provide services to their respective residential and corporate base. Because Canada's population is very unevenly distributed just as its natural resources are unevenly distributed, the economic base is also distributed unevenly from province to province. To mitigate large differences in federal funding to the provinces, funds are equalized. This means that prior to actual payment, some of the funds earmarked for the highly populated or "have" provinces are re-directed to the less populated or "have not" provinces. Thus economic or demographic prosperity in one region is shared with regions not so

---

43. "Privately-owned" here means, first, that a provincial government does not own a hospital or clinic's assets. Second, it means that the assets are owned by the facility itself. And third, most of these privately-owned facilities are managed by community or local boards.

advantaged, rather than allowing emergent disparities in lifestyle and opportunities to increase over time. This idea of equalization has informed much of the evolution of the country's health system.

In 1966 the Liberal federal government passed the *Medical Care Act* for three reasons: (1) to deliver on its party's ideological platform of expanded social programs, (2) to lessen intra-provincial differences in health-care provision, and (3) to acquire a legitimate voice in an area of constitutionally-defined *provincial* responsibility. Health care was viewed as a common good for every Canadian "cradle to grave." The *Act* supported the creation of provincially administered insurance plan[44], each of which was to focus on five objectives: universality, accessibility, comprehensiveness, portability, and non-profit management of all health facilities and programs. In recognition of this focus, the federal government agreed to match each province's funding allocations to health care.

The Canadian system, nationally known as Medicare, provided unlimited, unrestricted access to all specialties and facilities with no charges to patients. Physicians retained full professional autonomy over their patients' treatment and care. Cost control was achieved by means of capped budgets. Each year a hospital or clinic petitioned its provincial ministry of health for adequate funds to covers its operating and its capital budget.[45] And every year, unions or associations representing physicians

---

44. Canada therefore has "'socialized insurance,'" not socialized medicine as is commonly alleged by American commentators (Evans 1992, 741).

45. Separate negotiations of these two budgets contributed to effective cost control by limiting costly technological acquisition and facility construction without necessarily restricting day-to-day operations. Furthermore it was difficult for a hospital to successfully circumvent cost control by diverting annual operating funds to highly expensive equipment or building projects.

negotiated fixed fee schedules with each provincial health ministry.[46] Admittedly shortages at the end of the year were carried forward into the next year's funding request. Thus deficits were eventually covered but did generate considerable scrutiny of hospital operations. In this way, no patient was denied treatment but there was a general atmosphere of fiscal conservatism.

By the early 1980s, several trends came together to prompt further federal health-care legislation. Canada's recession proved recalcitrant despite efforts to stimulate the economy, and so general tax revenues continued to decline. Yet overall health-care expenditures continued to increase much faster than any other sector. This growth, coupled with expenditure increases in other social programs, transformed the federal deficit into an economic and political millstone. Furthermore decreased tax revenues meant that hospital budgets and physician fee schedules either remained static year-to-year or any negotiated increases were far below the inflation rate. Many physicians responded by directly charging patients user or office visit fees. Cognizant that the public would reject tax increases, provinces gradually excluded some medical care from coverage and waiting periods for various treatments grew. As a consequence, private insurance companies began to offer competitive comprehensive insurance plans to individuals and employers.

The Conservative federal government tackled these worrisome trends by passing the 1984 *Canadian Health Act* (*CHA*). The *Act* replaced the federal-to-provincial cash

---

46. As an illustration of the incomes physicians can earn under a capped fee system, Saskatchewan and Quebec allow income levels of $ 300,000 to $ 400,000 per year before reimbursement for medical services is at progressively reduced rates (Barer, Lomas, and Sanmartin 1996).

transfer policy and it revoked the promise of 50-50 sharing of Canadians' health-care costs. Instead the federal government stated that it would begin transferring not cash, but tax percentages[47], to the provinces. Federal funding participation would be allowed to drop as far as zero, depending on annual tax revenues.

The *CHA* also established an "'all in or all out'" relationship between physicians and provincial insurance plans (Evans 1992, 744). If a physician chose to extra bill her patients, she would be summarily interpreted as choosing to totally opt out of every provincial plan. As a further measure to prevent the emergence of a two-tiered system in Canada, private insurance plans were prohibited from covering services already covered by a provincial plan. And yet coupled with these significant changes, the *CHA* emphasized anew the five core principles of the initial Medicare legislation.

Today Canada has the second most expensive system in the world in terms of the percentage of GDP allocated to health care; first is the United States. 75 % of the nation's total health expenditures are covered by public insurance; of this percentage, only 40 % is covered by federal tax allocations to the provinces (Catley-Carlson 1992; Wilsford 1995). No provincial insurance plan continues to reimburse all care: dental, most prescription drugs, ophthalmology, physiotherapy, and elective surgery are not covered. 70 % of Canadians have private insurance through their employer's benefit plans (Silversides 1995). Two provinces require monthly premiums to be paid by all residents. One province has levied a payroll tax. Two provinces have allowed private

---

[47] As of 1977, the federal government had transferred 13.5 points of personal tax and 1 point of corporate tax to the provincial tax formulas (O'Neill 1996).

eye and MRI clinics to be set up. Complaints about excessive waiting times and overly slow introduction of the latest equipment and procedures fill frequent newspaper headlines.

Recently there have been repeated calls for increased federal involvement to stem "the balkanization of health-care benefits across the country" (Wyman, Freeley, Brimacombe et al 1995, 1601). From the perspective of most Canadians, health care remains a "sacred" social program. As Shifrin notes, Medicare "ranks with the Charter of Rights as a declaration of the inviolable essence of Canadian citizenship" (1993, 1868). At the 1997 annual conference of the Canadian Medical Association, a resolution in support of a private health system appeared likely to pass. But after much heated debate, which I expect was fueled in part by acknowledging Medicare's relevance to national identity itself[48], physicians opted to help lead the country's efforts to repair the existing system so as to once again fulfill the five defining goals of the initial 1966 concentrated pockets of population, two national languages, and various separatist movements. Continual financial pressures at the provincial level have been addressed over the past five years primarily through organizational change, namely regionalization.[49] Authority and responsibility over provincial-federal funds now resides with regional boards as per a process labeled "devolution": some authority has shifted downwards from the provincial health ministries and some authority has shifted upwards from local hospital and health boards. The advantages seen in regionalization

---

48. Evans (1992) suggests that Medicare has been one of the most effective mechanisms to unify Canada, a country that continues to deal with the divisive forces of immense geography, concentrated pockets of population, two national languages, and various separatist movements.

are increased responsiveness to patient needs and technology demands, greater economies of scale, and enhanced community involvement in health policy decisions and tradeoffs. Badgley (1982) argues that, in actuality, these early regional bodies had virtually no authority and no input concerning local needs. Serving only as "storefront dressing," they were expected only to support and institute provincial health policies.

---

49. A few provinces instituted regionalization in the 1970s albeit on a very limited scale.

VITA

Barbara J. Russell was born in Calgary, Alberta on July 10th, 1953. She attended schools in the public system of Calgary. She attended the University of Calgary in the fall of 1971 and earned a Bachelor of Commerce degree in May 1975. In the fall of 1981 she began a M.B.A. degree program at the University of Calgary's evening program which she completed in the spring of 1986. She was employed in the Canadian petroleum industry from 1975 until two years after the completion of her M.B.A., working in such areas as marketing, financial accounting, and human resources. From 1990 to 1992, she traveled through various developing countries in Africa, Asia, and South and Central America. In the fall of 1992, she returned to the University of Calgary to earn a Bachelor's degree in Religious Studies and Applied Ethics. Thereafter she attended graduate philosophy programs, specializing in biomedical ethics at the University of Tennessee, Knoxville. In the spring of 1994, she earned a Master degree in Philosophy and in the summer of 2002, a Ph.D. in Philosophy.

After graduation, she will be working at the University of Alberta Hospital in Edmonton, Alberta, Canada as the in-residence clinical ethicist.