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THE ETHICS OF MANAGED CARE:
A PRAGMATIC APPROACH

by

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A THESIS SUBMITTED
IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
DOCTOR OF PHILOSOPHY

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ABSTRACT

The Ethics of Managed Care: A Pragmatic Approach

by

Mary R. Anderlik

Standard approaches to the ethics of managed care fail to capture the complexity of the phenomenon. In particular, the view that managed care aligns with the business side of a fundamental dichotomy between medicine and business is an obstacle to nuanced analysis and to the construction of an ethic that addresses organizations. A version of pragmatism derived from the work of John Dewey is one basis for a more adequate analysis of the ethics of managed care: a method of inquiry oriented to practice, a compelling social vision of democracy and community, a moral psychology built around a holistic concept of individual character, and an appreciation of the importance of organizations as agencies of character formation. Dewey’s concept of character can also be applied to organizations, capturing the total complex of formal and informal structures in their internal relations, and in their relations with the external environment. Deweyan pragmatism provides the tools for an analysis of organizational virtues and an evaluation of organizational structures. This analysis is completed in a case study or “character study” of the way in which virtues are displayed and structures are fitted together in the life of a managed care organization, Kaiser Permanente. Kaiser is not free of ethical problems, but it illustrates some of the ways in which some forms of managed care might improve health and health care and contribute to the development of democracy and community.
Acknowledgments

In a world of fair exchanges, this project would never have reached completion; I have received much more than I have given. I owe a special debt of gratitude to Gerald McKenny, Elizabeth Heitman, and Sylvia Louie for wisdom generously dispensed over the past five years, to Gerald McKenny for guiding me through the dissertation writing process, and to my family members for their unvarying support.
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Introduction

My interest in managed care has biographical roots. Before taking up the study of ethics, I spent three years in the commercial banking transactions group of a corporate law firm. When I arrived, the group was busy documenting loans in connection with leveraged buy-outs or LBOs. When I departed, the group was busy documenting "work outs" of those loans. In other words, many of the deals consummated in the mergers and acquisitions frenzy of the 1980s had gone sour. As my original choice of practice reveals, I know the fascination of complicated transactions involving large sums of money.

During my tenure as a transactional lawyer, I also developed some skepticism concerning the existence of a hidden hand that inevitably weaves the social good out of the uncoordinated actions of individuals, rational self-interest, the profit-motive and so on. I saw how incentives operated in the rush to complete year-end deals, some of dubious quality, so that bankers could collect year-end bonuses. I noted the difficulty in assigning responsibility for effects that were difficult to locate in terms of individual actors. For example, the suggestion that we lawyers, as mere facilitators of transactions, should ponder and take responsibility for their social consequences seemed inappropriate or naive. It did not help that we were readily replaceable in an increasingly competitive environment. Health care, by contrast, seemed a field where matters of practical concern were routinely considered in moral terms.

I was not mistaken—witness the amount of hand-wringing over managed care among practitioners and the growing corps of professional medical ethicists. At the same time, two things are now clearer to me. First, health care is not a field insulated from wider social trends. Indeed, it seems that health care is now the favored arena for deal-
making activity. Second, the psychological and sociological phenomena I observed among bankers and lawyers are much in evidence here. Organizational structures shape conduct. Roles structure responsibility, but in a world increasingly dominated by large organizations, roles and the limits they set to responsibility are increasingly problematic. Actions have ramifications that extend beyond the individuals immediately involved, just as transactions among individuals are constrained by distant forces. Finally, it seems, we are becoming aware of the need for an ethic that takes account of organizations. How do organizations affect us? What is their moral status? How might they be assessed in moral terms?

We tend to think of organizations and the problems they raise as newly arrived to health care. Yet even in the days before managed care, physicians, and those cast in the role of patient, responded to incentives within a world dominated by organizations, by medical schools, hospitals, professional organizations, insurance companies and government agencies. Discussions of the ethics of medical practice going back to the Hippocratic corpus in the Western tradition, and the medical ethics movement initiated in the latter part of this century in response to new technologies and popular dissatisfaction with the paternalism of the traditional physician-oriented ethic, were and are a unique and valuable legacy. At the same time, the traditional ethic, and the newer ethic of patient autonomy, for the most part refrained from delving into matters of organization. And at one time these matters could, for the most part, be ignored. The incentives, it seemed, worked to the benefit of all concerned. The organization of health care on a fee-for-service basis, and relatively generous funding for health care, gave physicians incentives to do as much as possible. Since cost was largely invisible to them, patients had an incentive
to want as much as possible done to or for them. The traditional ethic, and the ethic of patient autonomy, told physicians and patients that it was good and right that they limit their concern to their immediate transactions with one another. If there was a weakness in health care, it was in the failure to extend the luxury of self-concern, and the beneficent attention of a devoted, and well-compensated, physician, to all who might occupy the role of patient.

The neglect of organizations is no longer benign, if it ever was. In the era of managed care, we can no longer afford to ignore the effects of organizations on conduct (and character), or the location of transactions between individuals within a social matrix. Those who cling to the traditional Hippocratic ethic, or the ethic of patient autonomy, are ill-equipped to grasp the problems made newly visible, if not created, by managed care. Managed care and related developments have provoked comment from medical ethicists and others, but few have taken up the challenge of constructing an ethic that speaks to organizations. By way of introduction, I will situate my project in relation to the literature, showing how efforts to this point have either failed to address or have inadequately addressed the organizational issues that I believe are central.

The debate over managed care has been dominated by the idea that there is a fundamental dichotomy between medicine and business, and the task is to choose sides. Ruth Macklin and Mark Waymack have both written on the ethics of managed care. Macklin charges that managed care is simply a euphemism for turning medical decisions into business decisions, with the further implication that this is an illegitimate conversion. She is particularly disturbed by the gatekeeping role assumed by physicians under some forms of managed care. Her criticisms of managed care resolve into concerns that
continuity of relationship and communication are being slighted and that commitment to patient welfare is being compromised. These are weighty concerns, but at each point consideration of a possible range of practices and justifications yields to a categorical judgment: "If the current system errs in providing incentives for ever greater numbers of referrals to specialists, the opposite error of providing incentives to primary care physicians not to refer, when it may be appropriate, is at least as bad." "A system in which bureaucrats at a distance make medical decisions and second-guess clinicians is a system that undermines the doctor-patient relationship and the ability of physicians to practice good clinical medicine in the best interests of their patients." "Physicians are educated and skilled to practice clinical medicine, not to carry out cost-benefit analysis for each and every patient." Managed care systems are "run by business managers whose main objective is to minimize costs." "The main objective of the physician should be to do what is best for the patient."¹ And so on.

While the judgments as phrased may be correct, one may question whether the conversation about the future of health care has been advanced very far. Do all managed care organizations offer incentives to discourage referrals regardless of their appropriateness? Do all "bureaucrats" work at a distance, and is all bureaucratic interference unwarranted, mere "second-guessing"? Do all organizations that employ cost-benefit analysis use the technique in the manner suggested by Macklin's comment? If many managed care organizations have ethical failings, is the only alternative a more tenacious embrace of the traditional way of doing things, even as it becomes less and less viable? Few would deny that the main objective of the physician should be to benefit the

¹Ruth Macklin, "The Ethics of Managed Care," Trends in Health Care, Law & Ethics 10, no. 1/2
patient. The question is what that entails. Is not "benefit" to the individual patient implicitly qualified by social considerations? Surely a physician is not required to steal a drug, even if that would benefit a patient. Should she bend a managed care plan's rules, or misrepresent a patient's condition to ensure more favorable treatment? Finally, Macklin, a strong defender of patient autonomy, would argue that benefiting the patient includes respecting patient choices. What, then, to make of a patient's choice of a plan?

By way of contrast, choice of a plan is the only thing that matters much in Waymack's view of the ethics of managed care. Waymack argues, in essence, that an adequate moral framework can be constructed using the consumer choice model. He compares forms of health care organization to automobiles. Traditional fee-for-service health insurance is a Mercedes, while the health maintenance organization (HMO) is a Ford. Waymack states that in many a consumer's judgment, the lower costs of the HMO will "more than balance out the restrictions involved with the service." According to Waymack, the kinds of conflicts that are generated within the context of HMOs are not a matter for ethical concern if the consumer "has willingly chosen to participate in this kind of health plan." He contrasts this "business" ethic, founded upon autonomy, with the traditional physician ethic, founded upon beneficence: "If the consumers buy into the HMO insurance plan, knowing its costs and conditions, it does not seem right to allow them to cry 'foul' when they (through pure misfortune) becomes [sic] the losers. Thus, when the physician acts as a gatekeeper, he or she is in an important sense acting in accord with the autonomy exercised by the patient when that health plan was selected."  

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For Waymack, ethical analysis is focused—exclusively?—on ensuring informed choice on the part of individual consumers.

Can health care be this completely assimilated to the automobile? Can ethical concern be narrowed to this isolated act of choice on the part of an individual? Do not the difficulties in bringing reality in line with the demands of the model suggest that it leaves too much out of the picture? First, there is evidence that consumers lack choice and information. At present, close to fifty percent of all Americans insured through their employers are offered only one health plan. In a large national survey conducted in 1995, sixty-three percent of respondents said that they did not have a good understanding of the differences between traditional fee-for-service and managed care plans. Close to twenty-five percent of those enrolled in managed care plans did not know that their choice of physician was restricted. Nearly three of ten respondents lacked confidence in their ability to make a good choice among health plans with the information available to them. Second, given the rapidly changing nature of medical technology and health care financing and delivery systems, "costs and conditions" can seldom be exhaustively detailed in contracts. Third and finally, many health care professionals resist the idea that they should act as stern enforcers of autonomous choice. We may resist it as well,

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5In a more subtle account, Haavi Moreim suggests that contractual justice must be supplemented by what she calls contributive justice. The argument is that in resolving ambiguities administrators must look at the implications of alternative interpretations for subscribers as a group. "[A]dministrators must look to the spirit of the agreement, the basic values governing health care and resource use that contractors hoped to achieve in signing on. These are the expectations that subscribers held *ex ante*, at the time they chose their policy, not what a few now wish they had, after events have defined their needs more clearly." E. Haavi Moreim, "Moral Justice and Legal Justice in Managed Care: The Ascent of Contributive Justice," *Journal of Law, Medicine & Ethics* 23, no. 3 (1995): 247-65 at 250. The problem with Moreim's discussion is her seeming failure to recognize that values and expectations, as well as provisions in written contracts, may be ambiguous, unsettled, or in conflict.
even if we see the potential injustice of allowing people to escape the consequences of their volitional acts. Imagine a world in which an argument that pediatric surgery by a skilled practitioner will save money in the long-run is met by “If you pay for a Ford, don’t expect a Mercedes.”* Is this really the paradigm we want to govern health care?

For Macklin, and for Waymack, the range of moral considerations is narrowly circumscribed. According to Macklin, the duty of the physician is to benefit the individual patient on his or her own terms, and the duty of the administrator or manager is to avoid interfering. Waymack draws the circle of moral concern even more tightly. The patient is to exercise his or her autonomy in choosing a health plan, and accept the consequences. The duty of the physician is to respect autonomy by holding the patient to the choice. Macklin uses a few anecdotes to illustrate how managed care is linked to violations of moral duties. Waymack spends even less time coming to grips with the reality of managed care. Further, given their interests and space constraints, neither Macklin nor Waymack has much to say about the range of social values implicated in managed care. What can or should the occupants of various roles, and the members of various communities, expect from one another? What kinds of contributions can they make to one another? For Macklin, the central values of health care are beneficence and autonomy. For Waymack, there is only autonomy. Waymack does suggest that we think about changing our understanding of the professional role, but he leaves the matter there. Neither has much to say about the complexity of human motivation, or the effects of organizations on character and conduct.

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*In real life, it was “If you pay for a Chevrolet, don’t expect a Cadillac.” George Anders, Health Against Wealth: HMOs and the Breakdown of Medical Trust (New York: Houghton Mifflin, 1996), 108.
The new (renewed) emphasis on controlling costs and the new demand for accountability on the part of health care providers have inspired others working in the field to begin feeling their way toward a new ethic. Two exemplary efforts in this area are E. Haavi Morreim’s *Balancing Act*, and Ezekiel Emanuel’s *Euds of Human Life.*

*Balancing Act* is one of the first serious, book-length treatments of the issues raised for medical ethics by medicine’s “new economics.” Morreim takes the evolving arrangements for the delivery of health care as given, and asks what kinds of changes must be made in moral and legal standards to bring them more in line with contemporary realities. She can adopt this approach because she believes that these arrangements are imperfect but not intolerable, and because she rejects the view that third-party payers and others outside the physician-patient dyad are “intruders.” She defines her project as an exercise in moral problem-solving. For Morreim, this means that one draws on the resources of theoretical normative reasoning only when practically necessary. Her distinctive contribution is a new framework for analyzing the duties of physicians. She argues that in the current environment we must recognize two new duties. First, physicians have a duty of economic advocacy for patients. Second, physicians have a duty to minimize conflicts of interest that may compromise their loyalty to patients.

These duties are additional burdens on physicians. On the other hand, Morreim develops them in ways that lighten the load physicians have been made to bear by traditional moral and legal standards carried forward into changed conditions. In the area of economic advocacy, Morreim distinguishes between “gaming the system” and “pressing the system.” Shading the truth or lying to secure the desired treatment for

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7E. Haavi Morreim, *Balancing Act: The New Medical Ethics of Medicine’s New Economics* (Dordrecht:
one's patients would be an example of the former. Morreim brings forth powerful arguments against gaming, including principles of nonmaleficence, veracity, and justice. She proposes that the moral and legal standard of care which defines physicians' obligations to patients be divided into two components, a "standard of medical expertise" that demands the same level of knowledge, skill, and diligence in the care of every patient, and a "standard of resource use" that makes the level of resource use required for a patient a function of the particular resource arrangements in effect for that patient.

Morreim defends this departure from a unified and universal standard of care on two grounds. First, she argues that we are faced with the "new" problem of fiscal scarcity, as well as the familiar problem of commodity scarcity. Commodity scarcity requires us to make decisions about who will get a bed in the intensive care unit when the number of patients who would benefit exceeds the number of available beds. Fiscal scarcity requires us to consider that every dollar spent on the care of this patient is unavailable for other uses, within or outside health care, and that every dollar spent is a cost to someone. The one who does not pay as patient may pay as an employee, when the escalating costs of health benefits result in the loss of other benefits or a job, as a holder of stock, when corporate performance is affected by the high cost of employee health benefits, or as a taxpayer, when the bill for Medicare, Medicaid, and other public spending on health care must be paid. This argument suggests that even a "patient" might have reason to reject the traditional ethic that makes medical benefit to the individual patient the exclusive consideration in health care decision making. Second, she argues that a proper conception of autonomy must include responsibility for one's choices, including
one's choice of a health plan offering a defined level of benefits. Freedom is a prerequisite for autonomy, not its central meaning. In an era of resource constraints, says Morreim, "physicians must shift from an ethic of 'use it if it might help,' to 'don't use it unless it quite clearly will help.'"8 The duty to minimize conflicts of interest prompts Morreim to discuss some of the nuances of incentives. She calls upon physicians to be discriminating, not self-denying.

Like Morreim, I define my project as a practical one. Like Morreim, I reject the view that traditional standards must be preserved at all costs, and I resist the narrowing of moral concern to the physician-patient dyad, denuded of context. Unlike Morreim, whose focus remains on the physician, I will devote considerable attention to organizations. I will ask how the disciplines of psychology and sociology can inform our understanding of and response to the new developments we label managed care. Finally, I will make an effort to establish connections between health care, and health care ethics, and the contemporary debate over the meaning of social values such as democracy and justice. What Morreim states as a conclusion, that the "economic challenges we now face will force us to ask, openly and carefully, just what we prize," and to create a new order in more inclusive fashion,9 is one of my central concerns. New pressures may bring new opportunities for open and careful reflection on individual and communal ends. They may also bring division, and deception, and a cycle of license and reaction.

Morreim's conclusion is Emanuel's beginning. Rather than a work of problem-solving that largely dispenses with theory, The Ends of Human Life is a work of political

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8Morreim, Balancing Act, 99.
9Morreim, Balancing Act, 150.
theory that carries a particular political vision into practice. Emanuel’s point of departure is the impossibility of addressing the practical questions we face in health care without consideration of values and goals. He argues for a liberal communitarian social order in which the primary goal is to nurture democratic deliberation about the shape of the good life. Emanuel’s distinctive contribution is a proposal for the creation of a federated system of community health programs (CHPs) reflecting different conceptions of the good. Hence, Emanuel allows that there may be an Adam Smith CHP and a Jeremy Bentham CHP, as well as CHPs that instantiate conceptions of the good more identified with the liberal communitarian vision itself. CHPs will be limited to no more than 20,000-25,000 “citizen-members.” Basic financing for health care will be handled through vouchers issued to citizens by the federal government. Some CHPs may cater to those who want unlimited access to health care and are willing to pay to get it, while others may attract members by rebating some portion of the voucher amount. The CHPs will be regulated by state oversight boards under the purview of a federal oversight board. The distinctive conception of the good guiding each CHP will be reflected in its policies and mode of operation. As with Morreim’s prescription, this one reflects a particular view of autonomy. Here freedom or autonomy is not only the power “to choose and pursue one’s individual conception of the good life” but also the power “to shape the social and political structures in which these choices and pursuits occur.”

Like Emanuel, I inhabit a space that might be labeled “liberal communitarian.”

Like Emanuel, I am interested in problems of participation and scale. I, too, feel that we cannot address our present difficulties without considering what we value in life and why,
and that this process of sorting out values must be communal. Unlike Emanuel, I cannot envision a tidy pluralism. Emanuel’s account is pluralistic in that allowance is made for different conceptions of the good, but the ideal is a unified (although not necessarily homogenous) community with a coherent ethic. For Emanuel, communities are not fractured internally by a plurality of moral commitments and values, nor do persons have difficulty identifying themselves with a single community. Also, Emanuel, like Morreim, keeps the focus on the physician, and he has a stake in marking off some occupations, such as the practice of medicine, as “higher” than others. I will subject the medical profession and the professional ideal to greater scrutiny. Further, I am leery of Emanuel’s extension of the political model to health care, even if this extension is accompanied by an occasional acknowledgment that politics and political deliberation do not constitute the whole of life. I note that while Emanuel has much to say about the activity of citizen-members, he leaves the role of patient, of the recipient of medical services, largely untouched. Agency is concentrated in the citizen-member role. (It is significant that Emanuel’s paradigm case, chosen to anchor and guide reflection, involves an incompetent patient.) There is no consideration of possible alterations in the character of the relationship between physician and patient, or the relationships among providers of care.

Finally, the CHPs play a crucial role within Emanuel’s proposal for a truly federal health system, but they are considered as settings for civic deliberation and the resolution of quandaries—assignment of decision making authority, selection of medical interventions, and resource allocation—rather than as organizations with certain generic features. Hence, Emanuel does not address a problem that I believe to be highly significant in the managed care context, the tension between internal and external goods.
This tension does not exist for CHPs because Emanuel's ideal construct side-steps the problem of fiscal scarcity. The voucher system will provide CHPs with sufficient resources to provide adequate health care for all. Citizen-members will determine how resources are to be allocated in accordance with their particular conceptions of the good. For Emanuel, insecurity, and fear and greed, do not come into play at the organizational or individual level.

While I can identify points of disagreement with Macklin and Waymack, and Morreim and Emanuel, the larger point is that health care is such a complex subject that emphases are bound to differ. Although I owe a debt to Morreim and Emanuel, I hope to contribute to a pragmatic, organization-centered approach to the ethics of managed care. The method I will employ is a form of immanent criticism. I begin in the midst of the "problem" managed care poses to medical ethics. I consider the dominant approaches, and I conclude that these approaches lead to false choices that foreclose rather than advance inquiry. Alternative approaches are analyzed and tested for their capacity to cast light on the factors that have been neglected, such as the complex character of organizations. This process, which is pragmatic in the naive sense, i.e., directed to the solution of a problem in practical affairs, leads to a consideration of pragmatism as a critical project of bringing intelligence to bear on problems of social life. In the work of John Dewey, in particular, the activity of problem-solving becomes the model for inquiry. Central aspects of a pragmatic framework for analysis are laid out and tested for their capacity to speak to the role of organizations and address the other lacunae of the standard approaches. There is a kind of circle. The exploration of a particular problem occasions an interest in Dewey's work on method and lends Dewey's work some initial
plausibility. A method derived from Dewey's work is then employed in the fuller exploration and evaluation of the problematic situation, and this is both a practical activity directed to the solution of the problem and a test of the method. There is no foundational argument, but the circle is not a vicious one. There are tests, and they can be failed. I believe that the method is successful. At the conclusion of the inquiry a more comprehensive set of ethically relevant factors has been identified and analyzed, and a workable solution—a way of thinking about the ethics of managed care that takes account of the nature organizations and their possibilities and limitations—is offered.

In the first part of this dissertation, in Chapters 1 through 3, I review some standard approaches to managed care and some possible alternatives. In Chapter 1, I try to show that constructing the debate over managed care in terms of a fundamental dichotomy between medicine and business is unhelpful. I use an exchange of letters between Arnold Relman and Uwe Reinhardt to illustrate some of the deficiencies of this approach. I argue that those who defend traditional medical ethics and traditional medical practice, over against managed care (understood as a euphemism for the triumph of business over medicine), and those who defend the traditional business ethic and business practice and embrace managed care, suffer from a similar defect of vision, a kind of myopia. Some part of the social context is obscured; some moral considerations are removed from consideration. The limitations exhibited by Macklin and Waymack in their analyses of managed care are not idiosyncratic.

In Chapter 2, I present the story of one managed care organization's refusal to pay for a bone marrow transplant for a plan member diagnosed with advanced breast cancer. I try to demonstrate the inadequacies of the medicine-business dichotomy as a
framework for understanding what transpires. Further, I argue that an alternative approach to managed care, one that uses categories to frame analysis, also has its limits. The usual categories—choice, conflict of interest, and resource allocation—fail to address some of the morally significant features of the story. I suggest that we need a more complex, more social ethic to move beyond the limits of standard approaches to managed care. In Chapter 3, I review three possible candidates, utilitarianism, social contract theory, and communitarianism. I conclude that while each approach offers distinctive insights, none provides all the necessary tools.

In the second part of this dissertation, in Chapters 4 and 5, I develop my own version of Deweyan pragmatism as an alternative moral framework, with a distinctive method, understanding of social values (what I call "Deweyan democracy" and "pragmatic justice"), moral psychology, and "moral sociology." I borrow from the pragmatic tradition in the social sciences to construct criteria, consistent with this framework, for the evaluation of social arrangements in general and arrangements affecting health care in particular. I ask, first, what kinds of character or character traits institutions form, and second, what kinds of character traits they themselves display. I look at the meaning of virtues of justice, integrity, and responsiveness in the case of institutions. I also consider standards of efficiency and economy in pragmatic terms, and I comment on the place of the market, bureaucracy, and professionalism in the organization of health care services.

My aims throughout this section are practical, in keeping with the tenor of the dissertation as a whole. This is not a work of historical scholarship or analytic philosophy, a rigorous analysis of texts and contexts or a philosophical defense of Dewey. As a philosopher, Dewey has defenders and detractors, and as a non-
philosopher, I judiciously refrain from entering the philosophical debate. I take Dewey as a model for intelligent, engaged inquiry, not as a philosopher beyond criticism. I certainly would not claim that my borrowings from Dewey's work express established philosophical doctrine from which my conclusions follow as necessary truths. Rather, my goal, modest in conception but ambitious in breadth, is to explore the potential of a Deweyan social vision to aid in the identification of what is problematic in managed care and to assist in the evaluation of possible modes of response. The hope is that the reader will emerge with a fuller appreciation of some of the complexities and perplexities of managed care—enlightened if not converted.

I conclude this dissertation by emphasizing the essential diversity of managed care. In Chapter 6, I argue that some structures associated with managed care are valuable and others are not. I review and critique various policy recommendations, before suggesting that this kind of analysis must be completed by a more holistic approach. I argue that we need case studies or "character studies" of specific organizations. I pause to reflect on the virtues of pessimism. In studying organizations, we need to guard against an optimism that refuses to see the bad and a cynicism that distrusts every appearance of the good. In Chapter 7, the final chapter of the dissertation, I present a character study of the Kaiser Permanente, a managed care organization. I argue that on occasion significant individual and communal goods can be realized within the context of managed care. At the same time, the study reveals how difficult it is to find the appropriate balance in negotiating the various tensions of organizational life, especially in a time of rapid change. Finally, I look to the future.

A few points remain to be clarified. First, although I do not wish to minimize the
importance of individuals and governmental actors, my focus will be on ethics and organizations. Organizations are constituted by individuals and influenced by the legislative and regulatory environment, and it would be contrary to my understanding of pragmatism to attempt an ethics for organizations free of relations to individuals and to the larger social order; but, for purposes of my inquiry, individuals and society come in for consideration primarily as they affect or are affected by organizations. Second, my inquiry is limited to managed care as it has developed and is developing within the United States, both because managed care in the United States has distinctive features (as does managed care in England, Israel, New Zealand, and so on) and because the Deweyan framework is linked to the American experience. Third, even with the geographical restriction in place, there may still be confusion about what is meant by “managed care.” It is often a good idea to preface an inquiry with some description of the phenomenon to be submitted to analysis. Accordingly, I will conclude this introduction with a brief historical overview and an attempt at a definition.

Although some speak of managed care as if it were a recent innovation, "prepaid health plans" offering more or less comprehensive health services for a flat fee have been around for some time. The Sisters of Charity of the Incarnate Word offered a prepaid health plan in 1869. For $.25 a week, or $13.00 a year, one was assured care at St. Mary’s Infirmary in Galveston, Texas.11 The standard histories usually begin around 1929, when Dr. Michael Shadid established a farmers’ cooperative health plan in Elk City, Oklahoma. Shadid hoped to remedy some of the deficiencies of rural health care.

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He noted that the high cost of a serious illness put decent comprehensive health care beyond the reach of many hard-working farming families. He also saw a connection between poor medical care, in particular, unnecessary surgeries that often resulted in death, and the combination of severe economic conditions and the incentives associated with fee-for-service payment. He remarked the neglect of prevention and means of early detection and treatment for serious conditions such as cancer. Finally, he argued that solo practice was becoming obsolete as a mode of organization due to advances in technology and knowledge. For the sum of $50, a family joining his cooperative would receive a share in a state-of-the-art hospital and a discount on all health care. In 1932, the cooperative implemented a prepaid health plan.12

Also in 1929, two Los Angeles physicians created a group practice prepayment plan and contracted to provide comprehensive health services to approximately two thousand water company employees. The Group Health Association in Washington, D.C., was established in 1937, Kaiser-Permanente Medical Care Programs in 1942, the Group Health Cooperative of Puget Sound and the Health Insurance Plan of Greater New York in 1947, and the Group Health Plan of Minneapolis in 1957. These developments were not necessarily welcomed by organized medicine. Indeed, the "corporate" practice of medicine was strenuously opposed by many county and state medical societies,13 and

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13For example, Donald Light has described the efforts of the profession to suppress "contract medicine," which involved competitive bidding for contracts to provide health care to the employees of large businesses. County and state medical societies conducted studies and reported on the (allegedly) awful conditions under which contract physicians labored, although published remarks of contract physicians stressed the advantages to physicians of guaranteed income and the opportunity to build up a private practice. In addition, some medical societies sought to shame physicians who did contract work by putting their names on a list; the names of members who promised not to enter into competitive contracts were entered on an "honor roll." Others threatened expulsion or censure, no idle threat given that medical
for much of the century managed care was largely a regional phenomenon.

In 1969, with concerns about increases in health care spending on the rise—the rhetoric of "crisis" is nothing new—these prepaid group health plans or "health maintenance organizations" attracted attention as a way of controlling costs. As the term suggests, the original idea was to keep people healthy. Health maintenance strategies were expected to provide benefits to individuals and society in the form of greater well-being and productivity, as well as benefits to the HMOs themselves, and third party payers, in the form of savings on sick care. At that juncture, escalating health care costs were mainly a concern of the federal government. Then as now, the federal government paid for a good portion of health care directly under Medicare and Medicaid (a federal-state partnership), and indirectly through employer tax deductions for health care benefits to employees and the exclusion of these benefits from employee income. In the 1970s Congress passed legislation to make HMOs more attractive, but throughout the 1970s and 1980s HMOs had a rather small, albeit growing, share of the market.

Costs have continued to increase, and in the last decade or so large employers, as well as federal and state governments, have become increasingly aggressive in seeking to control costs. Many believe managed care achieves this objective, although the evidence suggests that some costs are simply being shifted to other parts of the system. Whatever the ultimate verdict on the cost issue, managed care is clearly in the ascendancy. The

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societies in many cases controlled access to hospitals. Societies also lobbied for legislation prohibiting the corporate practice of medicine, i.e., the employment of physicians by non-physicians. Donald W. Light, "Reforming America's Health System: Origins and Dilemmas," transcript of lectures delivered November 14-18, 1994 at the University of Texas-Houston Health Science Center (HPI Discussion Paper No. 7) (Houston: Health Policy Institute, University of Texas-Houston Health Science Center, 1996), 13-14.

Shadid, who was careful to distinguish his cooperative idea from contract medicine, recounted his many battles with the medical societies in Crusading Doctor. The story of how colorful Oklahoma governor "Alfalfa Bill" Murray saved Shadid's license to practice medicine is particularly entertaining. Shadid, Crusading Doctor, 116-22.
percentage of workers in private firms who are enrolled in some form of managed care rose from twenty-nine percent in 1989 to seventy percent in 1995.\textsuperscript{14} While it would be disingenuous to assert that cost containment is not the primary factor behind the recent turn to managed care, other reasons are offered in favor of managed care. Traditional fee-for-service payment gives providers incentives to overutilize medical resources. Evidence of variations in practice patterns across regions and providers, without evidence of any correlation between intensity of treatment and the health status of affected populations, leads to skepticism concerning physician's judgments of medical necessity. It is not merely a matter of dollars. Most medical interventions are associated with very real risks to patients. If managed care decreases utilization of certain health care services, this is not necessarily a bad thing. Further, many HMOs provide comprehensive care and devote a greater portion of their resources to preventive care.

A commonly cited definition of managed care comes from an article by John Iglehart, which appeared in the \textit{New England Journal of Medicine} in 1992:

\begin{quote}
[A managed care system is one] that integrates the financing and delivery of \textit{appropriate} medical care by means of the following features: contracts with \textit{selected} physicians and hospitals that furnish a \textit{comprehensive} set of health care services to enrolled members, usually for a predetermined, monthly premium; utilization and quality controls that contracting providers agree to accept; financial incentives for patients to use the providers and facilities associated with the plan; and the assumption of some financial risk by doctors, thus fundamentally altering their role from serving as agent for the patient's welfare to balancing the patient's needs against the need for cost control.\textsuperscript{15}
\end{quote}

\textsuperscript{14} Etheredge et al., "Health System Change," 94.

This kind of definition commands agreement in the technical literature, but as David Mechanic and others have noted, the term is used quite promiscuously. Managed care may designate any kind of utilization review, and even more broadly, any form of cost-cutting or cost-consciousness. When I speak of managed care I mean the kind of system described by Iglehart, but I also recognize that the public perception of managed care is shaped by the loose usage of the term.
Chapter One: Managed Care and the Medicine-Business Polemic

"Managed care" is a euphemism for transforming medical decision making into business decisions.

—Ruth Macklin, Enemies of Patients

[Just as, when our own resources are not infinite, we may willingly choose the sturdy Ford over the crafted and polished Mercedes with the real leather interior, the compact disk stereo and anti-locking brakes, so we may willingly choose the inexpensive but serviceable HMO over the more generous fee-for-service plan.

—Mark Waymack, "Health Care as a Business"

1. The Medicine-Business Polemic

For Ruth Macklin and others, managed care is a tool of interests hostile to medicine. Given the prevalence of the view that managed care aligns with the "business" side of a fundamental dichotomy between medicine and business, one cannot simply ignore this construction of the problem. But neither ought this construction to be uncritically accepted. I will begin by describing the cultures and values of medicine and business as represented in much of the current debate. I present two portraits—my renderings of the way in which many participants in these two spheres of activity portray themselves and, to a large extent, one another. I label these portraits "ideologies" because they are used to defend certain prerogatives. The explicit or implicit threat is that any departure from the dictates of the ideology is dangerous. I readily concede that the portraits I paint are caricatures. Few express belief in the ideology of business or medicine without qualification, and it is doubtful whether even their behavior is totally consistent with belief. Still, these particular caricatures have shaped much of the debate over managed care. Polemics in which one caricature is opposed to the other dominate
discussion, curtailing reflection and deflecting attention away from projects such as the development of a health care ethic addressed to organizations.

By way of illustration, I present a detailed analysis of an exchange of letters between a physician, Arnold Relman, and an economist, Uwe Reinhardt. I have selected this exchange for analysis because the presentation of the issues is typical, and because Relman and Reinhardt are both prominent in their fields and prominent in the public debate over managed care. I try to show how Relman is trapped by his need to defend the image of the physician as a disinterested philanthropist. Reinhardt, in turn, devotes his considerable rhetorical skill to shattering this image. Having done so to his own satisfaction, he offers physicians (and other health care providers) no standard or ideal other than that of the generic purveyor of goods and services motivated by self-interest. A host of issues that seem to merit further reflection are passed over in the drive to undercut physicians' claims to moral superiority. The Relman-Reinhardt debate illustrates the perils of remaining within the confines of the medicine-business dichotomy. If we fail to move beyond this way of framing the issues, we throw away the opportunity to shape the future by means of a discriminating analysis that draws attention to what is morally desirable in managed care, even as it warns of possible dangers.

The ideology of medicine

Central to the ideology of medicine is an ethos of disinterested philanthropy. The distinctive features of medicine usually cited by practitioners include the special vulnerability of the patient and the noble character demanded of those who "volunteer" to care for those in this pathetic condition, not to mention exposing themselves to the risk of
contagion. Medicine also lays claim to a specialized moral as well as technical vocabulary, arising out of a certain interpretation of the Hippocratic tradition. The ethical physician acts primarily, if not exclusively, for the benefit of the immediate patient. The individual physician has the burden and privilege, at least initially, of determining where that benefit lies. Politics, and economic and social organization, are peripheral concerns, except to the extent that these are asserted to interfere with what is in fact the preferred or ideal form of organization, the autonomous practitioner within an autonomous profession. Fee-for-service payment and solo practice are favored precisely because they seem to secure autonomy and render organization invisible to practicing physicians.

Organized medicine has promoted the image of medicine as philanthropy and defended the autonomy of the profession and the individual physician in its codes of ethics and policy statements. A recent statement of the Council on Ethical and Judicial Affairs of the American Medical Association (AMA) on managed care stresses the primacy of the physician in the health care system as the one who advocates for the patient, and the primacy of the patient's interest in the motivational structure of the physician: "Without the commitment that physicians place patients' interests first and act as agents for their patients alone, there is no assurance that the patient's health and well-being will be protected."1 The theme of devotion to patient welfare has long been intertwined with claims for professional independence. The first Code of Ethics of the AMA, dating from 1847, makes the private conscience of the individual practitioner the final court of appeal: "A Physician should not only be ever ready to obey the calls of the sick, but his mind ought also to be imbued with the greatness of his mission, and the

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1Council on Ethical and Judicial Affairs, American Medical Association, "Ethical Issues in Managed Care,"
responsibility he habitually incurs in its discharge. Those obligations are the more deep and enduring, because there is no tribunal other than his own conscience, to adjudge penalties for carelessness or neglect."2

The Preamble to the 1957 "Principles of Medical Ethics" clarifies that the principles are "not laws but standards by which a physician may determine the propriety of his conduct."3 These duties are self-imposed and are, as it were, at the disposal of the individual physician. By 1980, a direct assertion of physician autonomy has been added. Paragraph VI states that, except in emergencies: "A physician shall ... be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services."4 Paragraph VI reflects the strand of traditional medical ethics that Albert Jonsen has dubbed the Lockean ethic of rights.5 As Jonsen notes, this philosophy has undergirded the claim that physicians have a right to control the context of practice, the disease, and the patient. It has guided resistance to prepaid group practice and the "interference" of administrators and other "third parties." Solo practice, on a fee-for-service basis, has been considered the optimum social and economic arrangement for the contract between physician and patient.6

The field work of medical sociologist Eliot Freidson confirms that at the time

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3American Medical Association, "Principles of Medical Ethics (1957)," in Ethics in Medicine, 38-39 at 39.
4American Medical Association, "Principles of Medical Ethics (1980)," in Ethics in Medicine, 40.
5Perhaps the best-known statement of the Lockean ethic comes from a 1971 opinion piece by Dr. Robert Sade, published in the New England Journal of Medicine. Sade writes: "In a free society, man exercises his right to sustain his own life by producing economic values in the form of goods and services that he is, or should be, free to exchange with other men who are similarly free to trade with him or not." Robert Sade, "Medical Care as a Right: A Refutation," New England Journal of Medicine 285 (1971): 1288-92 at 1289.
these principles were articulated they accurately reflected the beliefs of physicians about themselves and their profession. In a study of physicians in a prepaid group practice dating from the 1970s, he found that "[c]hecking up was associated with 'kindergarten teaching,' 'dossiers,' and even 'gestapo' and 'Big Brother.' … 'Thou shalt trust physicians' was the basic commandment, justified by a particular conception of physicians as special people especially deserving of trust." Even these physicians, who had chosen a group practice, stressed independence and self-sufficiency: "Most of the physicians emphasized above all other sources of motivation to perform well the physician himself as an individual, believing that he performs more or less independently of the situation he is in and, particularly, independently of the social pressures connected with that situation. Like his basic medical training, his basic character was seen as a more or less permanent and only minimally changeable part of him…. The physician was visualized as someone who is guided only by his unchangeable inner needs. He works the way he does because he has no other choice." 7

The ideology of business

In contrast to medicine, business makes no bones about being an interested activity. Moreover, in business interest is equated with self-interest, which is identified with material self-interest for the individual and profit maximization for the "firm." Business also has its own specialized technical (managerial) vocabulary—one which increasingly intrudes into the health care field or "industry." The moral claims of business are reflected less in a specialized moral vocabulary than in claims to efficiency and effectiveness. The proof of performance—production targets met or dollars saved—

seems to render words superfluous. Beyond this, the businessman exhibits a cheerful amorality. Indeed, he incurs something like moral disapproval if he allows moral concern to influence the operation of the firm and thus usurps the role of the market in achieving the maximal satisfaction of interests. The corporation is the natural milieu of the business type, be he entrepreneur or manager, but issues of organization and the broader social background are as remote for the businessman as they are for the solo practitioner of medicine.

The classical business ideology is reflected in the work of Milton Friedman. Friedman's essay, "The Social Responsibility of Business Is to Increase Its Profits," is a spirited defense of this image of the businessman and its propriety. Friedman is a thorough nominalist. He begins by declaring that only persons can have responsibilities. In a free enterprise system, the primary responsibility of people who serve as corporate executives is to the corporation's owners, and "[t]hat responsibility is to conduct the business in accordance with their desires, which generally will be to make as much money as possible while conforming to the basic rules of society." An argument for "social responsibility" can only be a claim that an executive should act contrary to the interests of his employer. Friedman equates social responsibility with the exercise of state power. For Friedman, there is no "public" space between the purely private, the realm of individuals pursuing their own interests, and the state.

Friedman goes on to sing the virtues of the market as the great disciplinarian. Private competitive enterprise "forces people to be responsible for their own actions." "In an ideal free market resting on private property, no individual can coerce any other, all

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cooperation is voluntary, all parties to such cooperation benefit or they need not participate." Friedman allows that people are free to be socially responsible with their own property, but he expresses a general skepticism concerning those who affect to act "for the public good." He even objects to the efforts of owners to advance a social agenda through voting their shares. Such efforts are apparently coercive in ways that putting forward and voting for, say, a slate of directors who have announced their total dedication to profit is not. In effect, not only are corporate executives bound by fiduciary principles to maximize the profits of the corporation, but owners have a similar obligation to make increasing their wealth the object of the business. And what about those who undertake activities that benefit the corporation, and the community, and describe what they do as an exercise of "corporate social responsibility"? Friedman is morally outraged. He labels this kind of conduct "hypocritical window-dressing" that "harms the foundations of a free society." Friedman seems to argue that business people have a social responsibility to avoid voluntarily taking on any social responsibilities, within a conceptual scheme that does not allow for the existence of "society," except as an aggregation of individuals.

It may be objected that Friedman does not speak for business people in the same way that the AMA may, with some qualifications, be said to speak for physicians. It is important, then, to consider some empirical work on the moral world of business. The findings of an exhaustive study of the ideology of business dating from the 1950s are very much in line with Friedman's views. The conclusions of a 40-year-old study must be appropriated with caution, but the consistency between the findings of this particular study and more contemporary reports is striking. In their discussion of the "business

creed," Francis X. Sutton and his colleagues conclude that:

The entire classical strand of the business creed can be viewed as an expression of individualistic values, and in particular as an argument for the social virtues arising from the pursuit of individual self-interest. The model shows that maximum satisfaction and distributive justice result from individual egotism. Certain moral qualities of the individual are essential to the operation of the model: integrity in transactions; willingness to live up to one's commitments and to accept the consequences of one's actions. But a whole range of possible moral responsibilities to others are [sic] excluded.... If a transaction is carried out honestly, the individual need not ask whether he is morally justified in getting the best possible terms from the other party; the acceptability of terms to the other is a matter solely for his own judgment.... The argument for the model is that it is precisely this sort of egotism which assures the benefits of the system.9

Many of the same themes emerge in a more recent study of the moral world of corporate managers, conducted by sociologist Robert Jackall. Among other things, Jackall finds that managers need to develop an armor that enables them, psychologically, to make the "hard choices" that business is said to demand. They are reassured by the creed, which tells them that the proper role of business is "to give the public what it wants," adopting the market "as the final arbiter not of values, which are always arguable, but, more importantly, of tastes, about which there can be no reasonable dispute."10

**Overcoming myopia**

Although the ideologies of medicine and business are opposed, in the sense that they incorporate different moral ideals and operate according to different moral codes, they also have something in common. They have both been labeled "individualistic" by

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9Francis X. Sutton, Seymour R. Harris, Carl Kaysen, and James Tobin, *The American Business Creed* (Cambridge: Harvard University Press, 1956), 254. The authors note that the classical view might well be called the "dogmatism of egoism," borrowing a phrase used by Jeremy Bentham to describe political economy.
critics. Certainly, the physician and the business person take note of the significance of organization and organizations in practice, and each regards at least one organization as immensely powerful and threatening, i.e., the federal government, but neither has an ideology displaying any sociological sophistication. At the same time, the label of individualism does not quite capture what is problematic in the ideologies of medicine and business.\textsuperscript{11} I believe that an ethic that neglects the social and organizational levels of analysis is flawed. At the same time, I would find an ethic that focused exclusively on the interest of the collective just as unsatisfactory. It would be nonsense to say that such an ethic was individualistic, but not that it was \textit{myopic}, that is, that it excluded a field of possible ethical relevance from consideration.\textsuperscript{12} In the ethics shaped by the ideologies of medicine and business, some fields are outside awareness, while others are actively suppressed. Under the sway of ideology, neither physicians nor corporate executives seem aware of the degree to which their roles are socially and legally constituted. Physicians believe they have an obligation to ignore consequences that extend beyond the medical interests of present patients. Corporate executives believe they have an obligation to ignore consequences that extend beyond the financial interests of the present owners of the business.

\textsuperscript{11}Friedman does not want corporate executives to pursue their own interests; he wants executives to fulfill their fiduciary duties to owners. And even Friedman acknowledges that markets have a legal and social structure, although at times he speaks as if the market were natural rather than artificial. The picture for medicine is similarly complex. A profession as thoroughly organized as medicine cannot be individualistic in any simple sense. A physician can lament the power of managed care organizations and argue that the ultimate duty and power of decision rests with the individual physician, and then immediately turn around and state, "Realistically, however, no single physician or institution can stand up to the juggernaut of managed care." Randall J. Lewis, Letter to the Editor, \textit{New England Journal of Medicine} 333 (1995): 1220.

Even if we adopt a more nuanced way of characterizing the narrowness in the medical and business ideologies, we are still at some risk of oversimplifying matters. Neither medicine nor business is monolithic. Moving beyond an acknowledgment of that essential diversity, we may be led to ask whether there is a physician anywhere who truly subscribes to what Robert Veatch calls the "Hippocratic principle." Is there a physician who truly believes that her sole responsibility is to the immediate patient considered in isolation, without reference to the patient's family, other patients or users of the health care system, or other segments of society, and that the ultimate court of appeal on what will benefit the patient is her own conscience? If there is, how likely is it that she will be able to sustain that narrowness of focus in practice? Is there a business person out there who conforms to Friedman's portrait of the scrupulous profit-maximizer? Veatch and Friedman have been widely repudiated for having offered up caricatures. Yet caricatures come from somewhere—they work on the principle of exaggeration rather than pure invention. There is also evidence that the basic themes or ideas that emerged in our examination of the caricatures still shape much of the debate over managed care and related developments in health care.13

13Of the seven letters printed following an editorial on managed care in the New England Journal of Medicine, two incorporate free market themes and two emphasize the dedication to patient benefit that distinguishes physicians from all others. Almost all locate blame for the changes they abhor outside the profession. The Lockeans are sure that managed care is the consequence of government meddling. Those who cling to the Hippocratic tradition are eager to distinguish themselves from the corporate interests. One writer thinks it significant that "insurance company executives take no oath whatsoever, and their 'morality' is purely profit driven." Sam J. Sugar, M.D., Letter to the Editor, New England Journal of Medicine 333 (1995): 1220. This is the preamble to an argument that physicians are held to a higher moral standard, but this should be no bar to vigorous action on their part to secure "fair compensation" for their efforts. His colleague is more of a purist: "By agreeing to serve the interests of...anybody other than the patient, we are giving up the moral high ground—the singleness of motivation that has generated the trust of our patients and society. When we cooperate with managed-care companies and the managed-care agenda, we are reducing ourselves to the level of businesspeople.... It is ultimately individual physicians who must determine what is in the best interest of their patients." Lewis, Letter, 1220.

There is little doubt that the ideas given expression by Friedman continue to exercise considerable influence. In the first instance, they affect the way in which physicians portray business and business people. They also shape the world view of some business people who have turned their attention to health
2. The Relman-Reinhardt Debate

Even those who address managed care with a great deal of sophistication seldom question the basic tenets of the ideologies that shape their thinking. Hence, it is important to submit the polemical use of the medicine-business dichotomy to critical scrutiny. The central issues can be explored through an analysis of an exchange of letters between Uwe Reinhardt, an economist, now James Madison Professor of Political Economy at Princeton University, and Arnold Relman, a physician, Editor-in-Chief Emeritus of the New England Journal of Medicine, and Professor Emeritus of Medicine and Social Medicine at Harvard Medical School.\(^\text{14}\) The subject is for-profit enterprise in health care and, more generally, the nature and future of health care and health care providers. Both men were members of an Institute of Medicine committee on for-profit enterprise in health care, and the work of that committee is the context for the exchange of letters. My approach in exploring these texts might loosely be termed "rhetorical analysis," as it has to do with identifying the strategies employed to persuade, and the "common topics" or reservoirs of social belief on which they draw.

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Relman initiates the correspondence. Apparently, Relman and Reinhardt have taken opposed positions on a very general issue, whether health care is the same or different from other spheres of human endeavor. For Relman, for-profit enterprise introduces a new and corrupting element into health care. For Reinhardt, the motivational structure of for-profit enterprise is not far different from that which has always governed physicians and hospitals. The role of the newly prominent for-profit enterprises is to shake up providers, grown complacent thanks to the disinterest of payers and consumers. Relman has just finished reading an article by Reinhardt, and he wants to test some of its claims. In good rhetorical fashion, Relman poses a series of questions which seem to admit of only one answer. "Do you really see no difference between physicians and hospitals, on the one hand, and 'purveyors of other goods and services' on the other?" he asks. Relman cannot in charity believe that his audience (Reinhardt) would be so obtuse as to deny a difference or differences, yet to be specified, that must be obvious. Further, although it is not stated explicitly, it is clearly assumed that "difference" must be situated in terms of a hierarchy in which some occupations have a higher moral status than others. As the series of questions continues, Relman appeals to themes of service and community responsibility in articulating, in an exploratory way, wherein difference might lie: "Where does the professional commitment to service fit into your view of medical care? Do hospitals have no responsibility to serve the community?" (209) Once again, the phrasing of the questions seems to force a choice between two alternatives that appear, to the author, as clear-cut. Either one neglects the role a "commitment to service" has played in the constitution of the profession of medicine, and denies that hospitals have any

Academy Press, 1986), 209-223. Page numbers for specific quotations will be incorporated in the text.
responsibility to the community, or one accepts the different, and higher, moral status of health care providers.

Despite the earlier suggestion that the difference he defends should be plain to everyone, near the close of his first letter Relman implicitly recognizes that perspectives may vary according to the situation or experience of the observer:

As an economist, you may not see any distinction between the practice of medicine and a business, but that point of view would be strongly contested by many people outside of economics, including the great majority of health professionals. It would also be contested by almost anyone who has had a major personal encounter with medical care. Sick or frightened patients do not regard their physicians as they would "purveyors of other goods and services," nor do they think of the hospital where they go for the treatment as simply another department store. (emphasis added) (209-10)

Relman only wishes to suggest that socialization in the discipline of economics may blind one to significant qualitative distinctions, but if the point has force, it would seem to apply more generally. If the perspective of the economist is shaped by a process of socialization, and if that process highlights certain distinctions and obscures others, the same could be true of the physician. But the insight is not deepened into a consideration of socialization or ideology.

Note that Relman offers the patient's perspective as a sort of trump. He makes an appeal to the experience of illness and anxiety for validation of his argument. And, in so doing, he attempts to engage the emotions of the audience. The manner in which this appeal figures in Relman's discourse may be illuminated by the classificatory scheme for the rhetorical arts derived from the work of Aristotle. In classical rhetoric, there are three modes of "artistic" proof, that is, evidence internal to a speech. The three artistic proofs
are *ethos*, *pathos* and *logos*, roughly corresponding to the three universal factors in any rhetorical or persuasive situation, a speaker, an audience, and a discourse. Ethos or character refers to the credibility the speaker establishes through his or her work. Pathos refers to the emotional reactions the speaker is able to elicit in the audience. Logos refers to the logic of the argument within the discourse. Relman attempts to use pathos to break through the economist's cool rationality. He invites his audience to relive an experience of seeking out and receiving medical help in time of need, or at least to identify with the experience of others.

Were one to treat Relman's appeal to patient experience as a logical argument, one could point out obvious flaws. Sick or frightened and hence vulnerable patients are among the persons least capable of rendering a considered judgment on the character and conduct of those on whom their fate may wholly depend. Patients as a group may believe that their physicians are exceptionally dedicated to their well-being, saviors even, but this does not establish that physicians have a "commitment to service," let alone a unique moral status. Further, this portrayal is highly contestable as an empirical matter. The "almost" in "almost anyone" signals the weakness. Who would testify that "medicine" and "business" are two different things? Ninety-five percent of patients? Forty-five percent? And what would be the meaning of this testimony? How would the terms be defined? Along the lines of our two caricatures?

Logic, however, is not everything—at least in the world of rhetoric. Pathos appeals to persons as fully embodied, emotionally responsive historical beings, rather

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than disembodied intellects. Experientially, we "feel" that there is a significant difference between the complex of activities, relationships and emotions involved in buying a toothbrush and buying a kidney transplant. At the same time, that difference need not presuppose or entail a higher moral status for physicians. In other words, Relman's appeal may not achieve its purpose, even if we allow that *pathos* is a valid mode of argument. If Relman's audience is caught up in the emotion of gratitude, reliving with particular vividness the experience of benefiting from the extraordinary dedication to service displayed by physicians in a personal health crisis, then all this is mere quibbling. But if experience is more ambiguous than that—if it fits less neatly with the *logos* of a discourse about the special moral qualities of physicians—then the appeal to experience is likely to fail. Any appeal to fully rounded experience may meet with the disapproval of the logicians, but beyond that the very perplexities of experience may raise questions which the rhetor would rather ignore.

In any event, Reinhardt's discourse is characterized by a playfulness and gentle irony that effectively neutralizes Relman's attempt to elicit an emotional response. Reinhardt, merely by his tone, intimates that emotional appeals are inappropriate to the occasion, an exchange of views between academic colleagues on an issue of public policy. Relman's specific appeal to the experience of the sick or fearful patient to establish the distinctiveness of medicine is passed over. Reinhardt chooses to focus his counterarguments on the conduct and character of physicians and not-for-profit health care institutions. Reinhardt refuses to engage Relman on the abstract question of whether physicians *ought* to be committed to service, or hospitals *ought* to have any responsibility to serve the community. Rather, he suggests that the question is what
physicians actually do. The appeal is to the historical record. "What," Reinhardt asks, "in the history of the American medical profession, aside from that profession's own rhetoric, should lead a thoughtful person to expect from physicians a conduct significantly distinct from the conduct of other purveyors of goods and services?... And what in the history of mainstream American medicine would you have serve as a role model for the emerging for-profit institutions delivering health services?" (211) Reinhardt does not neglect the role of commitment to service in the constitution of the medical profession, or not-for-profit health care institutions, but he suggests that it has figured in talk rather than action. If Reinhardt can make good on his promise of an exposé, it would seem that we have reason to view the espousal of such ideal standards with suspicion, and ask what purposes purported commitments to service may serve.

Note that Reinhardt is making his own kind of appeal to experience. His approach is an empirical one. Of course, consistent with the role of social scientist, it is limited to certain aspects of reality. Rather than personal experience or the particular experience of other persons, he appeals to "the history of the mainstream." Reinhardt studiously avoids the kind of emotional appeal that closed Relman's first letter. On the other hand, one may perceive a shift in the posture Reinhardt assumes from student of history to prosecuting attorney. Gentle raillery sometimes verges on sarcasm. Reinhardt insists, however, that he is not attempting to establish the moral perfidy of physicians, only the failure of efforts by physicians to distinguish themselves from other economic actors, "other purveyors of good and services." He simply remarks the absence of any evidence that physicians have acted in ways that set them apart from, in a favorite phrase, "ordinary mortals." Of course, that phrase seems intended to needle Relman by
suggesting that Relman, in arguing for difference, is aligning himself with some of his professional brethren who claim the status of demigods, if not the Almighty Himself.

Reinhardt offers four examples of physician conduct inconsistent with the ideal of service. First, physicians have vigorously defended a form of payment, fee-for-service, that seems intended to maximize revenue rather than encourage good patient care. Second, physicians have consulted their own desires and interests, rather than patient or societal need, in choosing where to practice. Third, physicians claim a degree of autonomy in choosing whom to serve that strikes Reinhardt and other observers as inconsistent with a commitment to service, in particular, a commitment to charity care. Fourth, physicians as a collectivity have ruthlessly pursued their interests in the political arena and have jealously guarded each of their prerogatives and privileges. A mere itemization scarcely conveys Reinhardt's skill as a rhetor. It also fails to reveal some of the tensions that appear in the argument of particular points. For example, Reinhardt's comments on fee-for-payment are a classic example of deflation:

Surely you will agree that it has been one of American medicine's more hallowed tenets that piece-rate compensation is the sine qua non of high quality medical care... We have here a profession that openly professes that its members are unlikely to do their best unless they are rewarded in cold cash for every little ministration rendered their patients. (211-12)

Certain phrases are carefully chosen to convey the profession's image of itself at its most solemn and fatuous, while others brutally undercut that image. The high-sounding "hallowed tenets" is juxtaposed with the bald industrial term "piece-rate compensation," rather than the more dignified "fee-for-service," and this term is succeeded by the even
bald "cold cash for every little ministration." The passage is quite effective
rhetorically, even though in an obvious or literal sense it is quite false. Physicians have
never defended their favored mode of payment under the description "piece-rate
compensation." That physicians "are unlikely to do their best unless they are rewarded
in cold cash for every little ministration" is precisely what is not openly professed. And
so much, Reinhardt might add, to physicians' discredit. They have been attempting to
pass off the proverbial sow's ear as a silk purse.

Reinhardt stresses that it is physicians' pretensions to moral superiority that he
finds most irksome. In pursuing his point about the moral ordinariness of physicians, he
asks, "Do you really believe that physicians are more civic in their behavior than the rest
of us? Do you think they could come even close to members of the voluntary fire
brigade?" (212) Unlike some of his brother and sister economists, Reinhardt appears to
recognize human motivations other than narrow self-interest. He does not deny the
possibility of civic-minded behavior, only the medical profession's claims to a
disproportionate share in it.

Reinhardt's discussion of charity care is worth considering for the insight it
provides into Reinhardt's social ethic. Reinhardt denies that physicians and other health
care providers have a role-related duty to provide charity care. If there is no moral duty,
then failures to exhibit any special generosity in this area are not to be condemned, even if

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16 A shocking phrase indeed. Then again, physicians are apparently unique among occupational groups in
demanding cash for their opinions. A 1993 survey of doctors found support for health care reform. That
was interesting, but so was this comment in the article reporting the findings: "This poll was different
from most surveys of doctors in that the respondents were not paid to participate. Such payments, virtually
unheard of in most public opinion polling, are usually provided to doctors because poll takers have found
that many will not answer questions except for money." Adam Clymer, "Poll Finds Doctors Backing
might argue that they are exceptionally busy, but that would lead one to expect that they would simply
refuse to answer questions.
some of the profession's own rhetoric suggests a higher standard. The moral duty to provide health care to the poor lies with society. "Society" is, however, a large abstraction, and Reinhardt suggests that charity begins with the federal government. The problem with this resolution is that charity seems to end where it begins; in relieving providers of a burden that is clearly too large, too little attention is paid to the need for its continuation in more modest forms if the larger social project is to succeed. Reinhardt offers real estate developers as an example of a group that has "done much for the poor since federal funds began to pay them for it." (213) However, the reference to federal housing programs may also serve as a reminder of scandals at the Department of Housing and Urban Development, exposés of fraud and corruption in connection with particular projects, and reports of developers' eagerness to rid themselves of their poor tenants at the earliest opportunity. No doubt many reformers would welcome the disappearance of "charity care," with the strains it places on providers and the stigma it places on recipients. On the other hand, if we do away with the sense of obligation we might call "charitableness," we are likely to end up with a world in which health care providers in truth offer their best only when they are paid "in cold hard cash for every little ministration"—and carefully monitored. The dichotomy between individual (or professional or institutional) responsibility and societal responsibility seems a false one.

Reinhardt concludes his treatment of organized medicine with a comment on the economist's reading of the human comedy. He writes, "Economists are neither shocked

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17What I have in mind is similar to what William F. May terms "public spiritedness." In an essay on the virtues in professional life, May argues that the responsibility to distribute professional services to meet basic human needs is both society's (through the state) and the professions'. He writes, "When the state alone accepts responsibility for distributive justice, a general sense of obligation diminishes, and the social virtue upon which distribution depends loses the grounds for renewal." William F. May, "The Virtues in a Professional Setting," *Soundings* 67, no. 3 (1984): 245-66 at 261.
nor surprised by such a posture nor, however, does it persuade them that physicians
stand much apart from the rest of mankind." (214) Whether intended as such or not, this
passage is a counterpoint to Relman's suggestion that the discipline of economics induces
in its practitioners a certain insensitivity to qualitative differences. Here Reinhardt seems
to be claiming for his profession an ethos which incorporates something like the virtue of
equanimitiy—economists are not "resigned" to the less-than-ideal conduct of physicians,
because they have eliminated the desire that the world be otherwise. At the same time,
this passage suggests that human nature is relatively fixed, and it is this fixity that renders
"mankind" predictable for the economist. Surprise, like shock, is absent from the
economist's emotional repertoire. Were Reinhardt's account less lively, one might be
tempted to assert that the world of the economist is flat.

Reinhardt also takes up the distinction between for-profit and not-for-profit
hospitals. According to Reinhardt, if Relman is to make his case against for-profit
institutions as such, he must "at least" present "a testable theory according to which the
ethical standards of essentially unsupervised, self-employed, fee-for-service physicians
affiliated with non-profit hospitals can withstand even the severest economic
pressure...in the face of ample opportunity to be venal, while the ethical standards of
physicians affiliated with for-profit hospitals, or employed at a salary by the latter, will
wilt at the mere suggestion by some corporate officer to set aside medical ethics for the
sake of corporate profits that do not even accrue, dollar for allegedly corrupt dollar, to the
allegedly corrupt M.D." (215) Here we have here another case of glorious rhetoric that
seems to force the opponent to make an impossible argument, or raise the white flag. The
mere fact of not-for-profit status must cast a mantle of absolute moral purity and
involuntaryity to economic pressures over the institution and all who are affiliated with it, while the opposite status must so corrupt an institution that those affiliated with it "wilt" at a "mere suggestion." This is a rather demanding standard and burden of proof. Reinhardt seems to rule out consideration of subtler influences and outcomes that become more (or less) likely according to organizational type, while still far from inevitable (or impossible). Certainly, a distinction between for-profit and not-for-profit institutions may be too crude to capture what is significant. While there is a tradition that links not-for-profits with a particular ethos, a particular scale of values, a substantial number of institutions will cross the line whenever this ensures a more favorable financial picture.

Further, there is no reason to expect that either not-for-profits or for-profits will fit a simple profile. We have no reason to expect that all not-for-profit corporations to be the institutional equivalents of Mother Theresa. It is unlikely that virtue in institutions can be identified in simple fashion. Indeed, it is likely that difference will often be exhibited at the margin. Not, for example, in never turning away indigent patients or laying off employees, but in always making sure that every patient that is turned away has someplace decent to go, and never suggesting that an employee laid off because the institution was in financial difficulties was actually discharged for incompetence. Given the great variability to be expected, it would not be surprising if a comparison between not-for-profit and for-profit institutions found little difference on such dimensions as costs or uncompensated care. The same considerations would apply to comparisons of "managed care organizations" and the collection of alternatives. At the same time, who can blame Reinhardt for setting Relman such a hard task, when the adversaries of for-profit enterprise have tended to favor global judgments over more nuanced appraisals.
The way in which Reinhardt presents the "allegedly corrupt" M.D.'s dilemma deflects attention from more likely scenarios. As Reinhardt paints the scene, the corporate officer attempts to seduce the physician into abandoning his ethical principles in order to bring about some increase in corporate profits. The suggestion is that, even were the physician a greedy fellow, he would view any eventual economic returns to himself from a general improvement in the corporate bottom-line as too remote to warrant the sacrifice, and presumably, the increased risk of malpractice suits associated with scrimp on patient care. But most for-profit corporations do not ask physicians to sacrifice their ethics to increase corporate profits; they give a physician a direct financial stake in the performance of the unit or division affected by that physician's conduct, or tie compensation as closely as possible to that physician's profit-generating capacity. There is nothing remote about it. And even the physician who is not driven by greed may weaken if threatened with the loss of a good portion of his or her practice.

Reinhardt concludes this section of his letter with a judgment that, in effect, physicians have sown the wind and are now reaping the whirlwind. Reinhardt's rhetorical skill is apparent in the way he puts the language of heroism to ironic use: the profession has fought "valiantly" to guard its monopoly over the profit-generating potential, as well as practice, of medicine, but control is slipping away. It is too late to rail against the venality of physicians or the corporate barbarians who have stormed the gates. Reinhardt presents the current situation of health care entrepreneurism "for all" as a fait accompli. And so, "[w]e are left with the search for incentives that make our for-profit or for-income or for-honorarium providers of health care do good by doing well." (215) As in his comments on real estate developers, Reinhardt-the-realist here displays considerable
faith in the power of incentives to manipulate persons and organizations in accordance
with policy makers' good intentions.

It is interesting that Reinhardt closes his letter by sharing a personal reminiscence.

Reinhardt's anecdote does not concern a health crisis. There is no attempt to evoke
powerful emotions. Nevertheless, Reinhardt's use of narrative to round out his letter may
be accounted an implicit recognition of the importance of pathos to persuasion.

During my student days at Yale I did develop a certain disdain for
physicians, but I write that off as a lack of maturity. You see, until those
days I had thought of physicians as people somehow apart and above the
rest of us. Naively, I had accepted the imagery physicians like to project
of themselves. It was the dissonance between this imagery and the
empirical record all around me that pained me enough to lash out in anger
at your profession. Now I have mellowed. Years of both casual and
careful empiricism have persuaded me that physicians really are not very
different from other "purveyors." If one accepts them on that level, they
come across as truly fine purveyors—expensive, to be sure—but truly
fine, nevertheless. (216)

Reinhardt concludes his story, then, with an invitation for Relman and others to join him
in the kind of balanced appraisal of which he now finds himself capable. Reinhardt
invites us to accept that physicians do not belong to a race of morally superior (or
inferior) beings. He suggests that if we lower our expectations, and physicians lower their
aspirations, there will be no cognitive dissonance, no disillusionment, no prod to moral
outrage, and no impassioned criticism from within or without. The new ideal for the
physician will simply be the "truly fine purveyor." But perhaps more than professional
hubris is lost in this transition. There is a suggestion that in the moral leveling the generic
standard replaces the particular. Does the annulment of hierarchy truly require the denial
of difference? Does failure to achieve the ideal render it meaningless? William F. May
suggests another way of understanding the tension between ideal and reality. He has written, "Just because an ideal hovers beyond our reach in the sense that we can seldom directly realize it does not remove it to the realm of the merely optional. One may live under a double responsibility—both to respect the ideal but also to recognize the unavoidable difficulties in the way of its even partial realization in an imperfect world."\textsuperscript{18} I would add that the ideal itself is not beyond criticism, as May has demonstrated so well in his work on the philanthropic ethic in medicine.

In his second letter, Relman attempts to defend his position by invoking the special characteristics of the doctor-patient relationship, not the special characteristics of health care providers alone. He writes:

That relation is based on trust by the patient and a commitment by the doctor to serve the patient's interest first. The fact that most doctors are also interested in being well paid for their services, whether by salary or on a fee-for-service basis, doesn't change the primacy of their ethical commitment to the patient. This commitment is unfortunately being more and more eroded by new economic forces, but it is still there, and it is one of the several reasons why health care is different from other economic goods and services. Other reasons include the virtually total dependence of the consumer on the advice of the physician, and the often intimate and immediate relation of health care to the quality and quantity of life. (217)

The morally significant features of health care are portrayed as relational, rather than wholly internal to certain individuals or roles. The provider's commitment to the patient is still of the highest importance, but now that commitment is linked to patient trust. Also, commitment has to do with the priority rather than purity of interests. Having admitted the complexity of interests, however, Relman does not seem to allow that interests may interpenetrate. The interest in serving the patient's interest is in one

\textsuperscript{18}May, "The Virtues in a Professional Setting," 252.
compartment, and the interest in material gain is in a separate and subordinate compartment. The means of satisfaction of the interest in gain, Relman seems to say, is a matter of moral indifference. Where Reinhardt concludes that we can look only to incentives to achieve our goals, Relman implies that incentives are not all that significant.

The continuation of Relman's argument dances around Reinhardt's empirical claims about physician behavior. Although no studies are cited, Relman asserts that the physician's ethical commitment to the patient is "still there." It may, however, be rather hard to detect, as it is being steadily eroded by new economic forces. Relman does not tell us when these "new" forces came into play. It is rather likely that the tension between interests has been there all along. This is not to deny that significant changes have occurred in health care in recent years, but merely to assert that economic pressures, and debates over how to define health care vis-à-vis business, are perennial. At the close of the progressive era, a paper on the reorganization of Brooklyn's hospitals prompted a prominent surgeon to comment that "[o]ur charitable hospitals have become businesses and are...wolves in sheep's clothing."19 Here are Relman and Reinhardt circa 1910:

(Question) "You can not put doctors and ministers who are engaged in the distribution of sweet charity in the line of men who are managing Standard Oil and the Sugar Trust."

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19Ernest Codman, responding to a paper read by Robert L. Dickinson before a meeting of New York's Taylor Society and the Harvard Medical Club, quoted in David Rosner, A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885-1915 (Cambridge: Cambridge University Press, 1982), 61. Rosner chronicles the transformation of hospitals in Brooklyn from neighborhood institutions serving the worthy poor without charge, into temples of science (and scientific management) accountable to central agencies and oriented toward the needs of paying patients and their physicians. As usual, there are few clear heroes or villains. The forces behind change included the "upstart" industrialists and businessmen who became trustees of the newer hospitals—such as the Jewish Hospital of Brooklyn founded in 1903—following the crisis in hospital financing that accompanied the depression of the 1890s. "[Abraham] Abraham and other trustees of this newest hospital did not feel that careful business management needed to conflict with the hospital's caring function. From their perspective, care could be provided only if the hospital were financially stable. But for many trustees reared in the older ideals of stewardship for the poor, the idea of a hospital that was not as poor as its clients was incongruous; hospitals were, by definition, in debt and dependent on charitable contributions." Rosner, Charitable
(Answer) "I think human nature is the same."

Further, some of the strongest empirical evidence against the claim that physicians always put patient interests first dates from the 1970s. In *Doctoring Together*, Eliot Freidson describes how etiquette, as an expression of occupational solidarity, is given priority over efforts to realize the ideals of dedication to service and technical proficiency in a group practice. In other words, some of the "forces" that have long undermined physician commitment to patients are professional rather than economic. So, as an empirical argument, the claim that economic forces of recent vintage are eroding a previously uncompromised commitment to patient welfare is rather weak. Relman also asserts that health care affects the quality and quantity of life intimately and immediately, and, we may infer, to a greater extent than other goods and services. But Relman does not choose to pursue the point. He does not, for example, distinguish health care from health. Some have argued that it is health, not health care, that should concern us, and that increasing expenditures for health care may not be best way of decreasing morbidity and

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Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989) (epigraph from hearings in the Pennsylvania legislature on state aid to nongovernmental hospitals). Stevens traces the changing relation, sometimes supportive, sometimes antagonistic, between voluntarism and business across the century. She sees health care institutions as flexible and adaptive in serving an array of interests. She argues that the true voluntary ideal was only developed in the 1930s, and represented an adjustment to the conditions of the Great Depression. The traditional ideal of voluntarism as charitable giving by benevolent elites (including wealthy capitalists, some of whom were the most ardent opponents of any intrusion of business considerations into hospital operations) shifted mid-century and became more democratic and participatory. In the 1960s, a major question was whether hospital administrators should be trained in business schools or schools of public health. In the 1970s, "nonprofit" hospitals became "not-for-profit," a change that simultaneously acknowledged that hospitals were indeed making money (profit) and denied that they were "in it for the money." Government funding of hospitals and health care lessened the financial dependence of hospitals on local communities, including wealthy donors. The inclusion of capital costs in reimbursable costs of patient care was especially momentous: between the late 1960s and the early 1980s debt levels doubled, from approximately forty percent of total capital financing to eighty percent. Stevens, *In Sickness and in Wealth*, 299-300.

In particular, Freidson found that the rules of etiquette blocked transmission of information about abusive behavior toward patients, negligence and fraud. Freidson, *Doctoring Together*, 165.
mortality in a population. 22

Reinhardt opens his reply with some miscellaneous observations. He argues that the changes in health care captured by the term "commercialization" are "American adaptations to an underlying change in the technology of health care: the increasing reliance of modern medicine on sophisticated and expensive capital equipment." (218) Any analyst of health care must take account of the implications of recent technological developments; the need for capital, absent acceptance of a dramatic alteration in the technological style of modern medicine, cannot be wished away. At the same time, a simple model in which changes in the technological infrastructure trigger and unilaterally determine changes in the ideological superstructure is scarcely adequate. The development of PET scanners and similar devices depends in part on the prior acceptance of an ideology that favors expensive capital equipment over less costly technologies. Reinhardt believes that forms of adaptation that avoid some of the ethical failures of the commercialization of health care are not real options for the United States. Short of an improbable revolution along the lines of the Swedish system, we are stuck with certain unfortunate conflicts of interest. Reinhardt does not see the seeming triumph of the "business" approach to health care as simple progress. Although he generally favors HMOs, he comments that "[o]ne unfortunate feature of an HMO is that, by 'meshing' the physician's and the HMO's incentives in one direction, the physician may lose independence in his/her role as the patient's ombudsman." (219) If Relman, as Reinhardt

22The question of whether medical care makes any difference in the overall health of a society began to be seriously debated in the mid-1970s. Paul Starr has a good, succinct discussion of the issues. Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, 1982), 408-11. See also Donald W. Light, "Escaping the Traps of Postwar Western Medicine," European Journal of Public Health 3 (1993): 281-89. Of course, it may be that medical care is more than a technology for producing "health." As Freidson says, responsiveness and recognition may constitute (at least some part of) the service and its
believes, has tacitly accepted that "the physician's professional ethics are apt to be malleable," Reinhardt has tacitly accepted that the changing structure of health care organizations is altering the doctor-patient relationship, and that the relationship as traditionally conceived did, in general, work to the benefit of patients.

This admission in no way causes Reinhardt to retreat from his position that physicians are no different from other purveyors. He denies that the necessary existence of an agency relationship between physicians and patients confers the distinctiveness Relman claims for physicians and other health care providers: "The craftsmen who repair our cars and homes perform a similar agency role." (219) After pressing the analogies between medicine and the crafts of automobile and home repair in an egalitarian spirit—and granting client relations with mechanics, electricians, plumbers, and business people, the dignity of words like "integrity" and "trust"—Reinhardt chooses to focus his attention on the medicine-business dichotomy.

You and Dr. Donald M. Nutter, in a recent piece in your journal, contrast the presumably venal "business ethic" with your profession's presumably more lofty code of ethics. If you ever sat in on the board meetings of large corporations, you would be surprised to learn how often business people forego easy profits for the sake of ethical standards and you would be surprised to learn what they could get away with, if they were as venal as is implied in your use of the term "business ethic." I honestly believe that a corporation has as much concern over the decency with which it treats its customers as physicians have over their patients.... They [physicians] are as decent as other human beings, and just as frail under severe economic pressure. (219)

Reinhardt suggests that Relman and his colleague, Nutter, have been guilty of speaking out of ignorance. In effect, they have exhibited a kind of bigotry. They condemn benefits. Freidson, Doctoring Together, xii. We may still ask whether medical care as we currently have
medicine's "other," business, with little notion of how actual business people conduct themselves. Reinhardt makes an appeal to experience, his own experience of business practice. Reinhardt opens the way for a consideration of business on terms other than those of the business ideology. Robert Solomon, a philosopher interested in business ethics, describes business as a practice, a form of ongoing, cooperative social activity.23

Note that in the course of Reinhardt's exposition there is an unheralded shift from business people to the corporation. Reinhardt treats the corporation as a person who has "concern" for and interacts with customers. He does not acknowledge the complications introduced by offering an organization as a moral agent. Earlier in the correspondence, Reinhardt suggested that some organizations conform to the simple model of economic self-interest (the AMA), while others (the volunteer fire brigade) are models of civic virtue. His account of human nature is considerably more complex, if one can glue together the various fragments. Human nature is fixed in its central tendencies, but malleable. Human beings are "decent" when (economically) secure, but "frail" under severe economic pressure. If we credit this account, then the degree of economic pressure associated with alternative forms of health care organization should be of utmost concern. This concern should motivate us to develop a more nuanced appraisal of "corporate nature."

Reinhardt recognizes the hazards of too great an emphasis on market discipline, as in his comments on HMOs, but he seems inclined to slight such considerations in his drive to destroy medical "exceptionalism." And so, rather than pursue these issues further, he returns again to probe the weak points in Relman's presentation of the case for

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it is the best way of securing "responsiveness and recognition."
Frankly, I remain a little puzzled by your own views on medical ethics. Sometimes you seem to suggest that physicians are endowed with a strong commitment to ethical conduct. If that is true, why do you worry so? At other times you lament the erosion of medical ethics in the face of capitalist medicine. If medical ethics erode so easily, what then does set physicians apart from "other purveyors"? (219-20)

Although this puzzlement, real or affected, is very effective rhetorically, the presentation of Relman's position is a little unfair. In the course of the correspondence, Relman has as much as admitted that medical ethics may be eroded by economic pressures. Relman has begun to search for a way to articulate a difference between health care and other fields that depends on the quality of the relation between physician and patient and the special goods they may each be seeking in and through that relationship. If he has not arrived at mutuality, he is at least moving away from a model in which the physician graciously bestows his services on patients reduced to abject dependency by need. And he has hinted that fragility is not incompatible with high value. Relman seems to realize that he need not defend (implausibly) the moral incorruptibility of physicians in order to argue that a virtue or commitment to principle that is fragile and always in peril ought, for that very reason, to be protected. In any event, it should not be subjected to further strain without serious reflection.

Reinhardt concludes his second letter by elaborating on his earlier suggestion that commercialism in health care is inevitable given the combination of technology and the values to which Americans are committed. Early in the correspondence he suggests that

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we face a moral crisis, not a cost crisis. Near the end he returns to this theme:

Most societies treat health care not as a consumer good, but as a community service that is be distributed on an egalitarian basis, on the basis of medical need. While this lofty goal may not always be attained, it is at least espoused. It is my sense that Americans have now decided to treat health care as essentially a private consumer good of which the poor might be guaranteed a basic package, but which is otherwise to be distributed more and more on the basis of ability to pay. What I personally think about this ethic is uninteresting. In thinking about policy recommendations for the United States, I must take the prevailing ethic as a state of nature. (220)

Reinhardt adopts a form of social constructionism. The question is not whether health care somehow considered in itself, apart from social context, "is" a commodity, a private consumer good or a community service. The important question is how a particular society defines and orders health care. If a "commodity" is something exchanged for money, then in the United States, health care is a commodity. If commodity suggests exchange without social regulation, or fungibility, health care begins to look less like a commodity. As Michael Walzer would say, goods always have social meanings. Reinhardt differs from Walzer in his (Reinhardt's) acceptance of the political process to date as definitive. Walzer argues that where there is conflict over or among social values, the proper resolution in matters of distribution must somehow honor that conflict. Is Reinhardt correct in interpreting legislative failures in the area of health care as a decision by the public to treat health care as a private consumer good, or is the public mood at present one of profound ambivalence?

24The "crisis before us" is "an apparent unwillingness of society's well-to-do to pay for the economic and medical maintenance of the poor. It is not an externally imposed economic or cost crisis; it is a moral crisis." (210)
This kind of analysis can be extended to the question of whether medicine is or is not a business. If “business” suggests the exchange of money, goods, and services, or attention to financial performance, then, in the United States, medicine is undoubtedly a business. At the very least, it is an activity with business aspects. If business requires that financial performance be the first and last consideration, if it precludes one from seeing the patient in need of care and reassurance behind or beyond the operating margin, or demands the surrender of all claims to distinctiveness, then medicine is not yet a business in any uniform sense. When proponents of managed care label medicine a business, they usually mean business in the first sense. Physicians and other health care providers are usually paid for their services; they exchange them for money and they aim to bring in revenues in excess of expenses. When opponents of managed care dispute the business label, they may be revealing their obliviousness to reality, but they may also be thinking in terms of business in the second sense. They resist the reduction of the practice of medicine to an activity for generating income or profit.

Commodities, and business, are usually linked to markets. “Market,” seldom defined, may have many meanings. For the political philosopher, the market may be the default position, the empty space defined by the absence of state intervention. To the extent that the political philosopher finds state intervention without justification, he or she will tend to favor the market in this sense. Considered from the perspective of the economist, markets are understood with reference to laws that describe how, given certain conditions, the uncoordinated actions of willing buyers and sellers come to exhibit certain marvelous properties, e.g., supply is aligned with demand, prices converge on marginal cost, and so on. The market as a place for the exchange of money, goods, and services
becomes a mechanism for the efficient exchange of information about desires and costs. To the extent that the appropriate conditions are present, economists will tend to favor the market in this sense. The business ideology has a tendency to merge these two meanings of market, assuming the identity of an absence of government regulation and the achievement of "efficiency" as a free-floating term for the economic good.

For the sociologist or anthropologist or social philosopher, the market is anything but empty space. In actual markets that we can observe, such as the stock market or the commodity exchanges, the state structures transactions even where it does not direct them, through tax laws, securities laws, the regulation of weights and measures, farm subsidy programs, and so on. Further, the "uncoordinated" actions of buyers and sellers are nevertheless rule-governed. Robert Solomon argues that "the market must be understood not as an empty unstructured space in which free agents voluntarily test their skills against one another but as a preexisting community with a network of values and needs... and a system of rules that define and constrain the nature of negotiation and the sorts of things that can be negotiated."26 If one understands "the market" as a global term for a certain class of social institutions, one will tend to evaluate the market, or actual markets, according to one's general criteria of social desirability.

By relating the appropriate principle of distribution for health care to an interpretation of social meanings, Reinhart looks to criteria that are not strictly economic as decisive. Finding a social consensus in favor of leaving the distribution of health care to the market in the economic sense, that is, to the uncoordinated actions of willing buyers and sellers, Reinhart returns to the role of economist. Even if reliance on the market to

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distribute health care is the approach most consistent with American social values, the
economist must ask whether the conditions are present for appropriate functioning of this
market. In particular, the theory of the market assumes that consumers are sovereign. In
Reinhardt's words, individuals must have sufficient power "to fend for themselves" in the
face of market forces. If patients prove unable to fend for themselves, if their
expectations concerning the behavior of health care providers are disappointed, this may
have profound ethical as well as economic significance. There are few words as
emotionally loaded and charged with a sense of injury as "betrayal."

Relman is allowed the last as well as first word in this correspondence. He returns
to two themes, the doctor-patient relationship and the question of social values. As to
the first, Relman is at least clearer about what he is not claiming: "Of course there many
services which, like medical care, consumers are technically incompetent to judge. And,
of course, physicians are not inherently more virtuous or honest than business people, or
maybe even than corporations." (222) In this passage, Relman also signals that he has
reservations about corporations as such, but no more than Reinhardt does he choose to
analyze the nature or effects of corporate structures. He implies that corporations are
something alien that must be held at arm's length. Where Reinhardt uses "business
people" and "corporation" interchangeably, Relman suggests that role and organization are
separate. Relman seems to equate "corporation" with "for-profit corporation"; otherwise
it is hard to see how he could cherish such a high opinion of the traditional voluntary
hospital.

I have noted that some of Relman's views seem to change in the course of the
correspondence. Yet as Relman proceeds to contrast the business ethic with the
physician ethic, he appears to revert to his initial stance and the simple medicine-business
dichotomy. He views the business ethic as relatively straightforward: "The ethical
obligations of a car mechanic or any other purveyor are to be honest in his business
dealings, and to offer a good product or service, if the customer wants it enough to pay
the price." There are clear limits to obligation, and the relation is established based on
consumer desire. Things are far different with the physician ethic:

An ethical physician's obligations to his patient go far beyond that. The
sick patient must rely on the physician to ensure that he gets the services
he needs, and to make choices for him, upon which the quality and
quantity of his life may depend. Financial considerations are secondary.
There are some superficial resemblances, but no one who has ever been
really sick would take your analogy between a car mechanic and a
physician very seriously. (222)

The physician ethic must be strenuous, heroic; the obligations of the physician to the
patient go "far beyond" what is required of the crafts person or business person. The
relation itself is established on the basis of need rather than desire. Further, to be in need
of a physician's attention is to be a patient, a status once again equated with dependency.
Finally, Relman once again expresses his conviction that his position will receive
existential confirmation.

I will conclude this analysis with Relman's rebuttal to Reinhardt's claim that
society has chosen the market, and that it is not the role of policy advisors to challenge
the collective will. Relman writes: "I believe the issue hasn't been discussed or analyzed
sufficiently to say what the American people really do believe. It is certainly true that
we have been drifting towards a marketplace mechanism for distribution of health care,
but the public hasn't given its approval of that trend, and many people haven't even
thought about it." (222-23) Relman questions whether a "public" of those affected has yet awakened to the urgency of the situation. He assumes that the kind of public approval that should carry weight cannot be identified with the outcome of the political process. He is personally convinced that when people do begin to reflect seriously on the problems associated with health care financing and delivery, egalitarian sentiments favoring communal provision according to need and without regard for profit, occasionally expressed in action, will prove stronger than sentiments favoring the market.

I have selected these letters for detailed analysis because the presentation of the issues is characteristic, and because Relman and Reinhardt are such prominent figures in the current debate over managed care and the future of health care in the United States. The exchange illustrates how the caricatures of medicine and business shape and limit the debate over health care policy. We never get far beyond the issue of whether physicians are disinterested philanthropists or "pursuers of goods and services" who by and large pursue their narrow self-interest. Attention is diverted away from consideration of how character and interests and expectations and social values are related, how these may be affected by organizations, the moral status of corporations, and the significance of the multi-layered character of social life. The personal virtue of physicians is vigorously debated. The same is true of the commitment to service of traditional not-for-profit institutions. Attention is diverted away from the significance of the fragility of virtue and moral commitment, and the complex relationship between virtue and social and institutional context. We never learn how organizations might nurture fragile virtues and moral commitments, whether certain kinds of economic pressures are more likely than others to injure (or benefit) persons and relationships, and when the structuring of
incentives crosses the line and becomes manipulation. Responses to the correspondence may simply reproduce these limitations. For example, Albert Jonsen, surely among the most insightful practitioners in the field of medical ethics, has called the Relman-Reinhardt exchange "a tremendous debate" poising "economic logic against ethical conscience." Of course, Relman is "conscience" and Reinhardt is "logic." Once again, the medicine-business dichotomy shapes the discourse.

In conclusion, let me review some of the sources of frustration in the contemporary debate. We are presented with either/or's that bring premature closure. Defenders of the ideologies of medicine and business wish to force a choice: Are you with us or against us? Even those whose views are more subtle fall prey to the dichotomizing tendency: Are physicians and voluntary hospitals heroic benefactors of patients and communities or generic purveyors of goods and services? Is health care a unique social good or a commodity? The social vision that might orient and guide moral reflection is never fully worked out. Further, we are left with some troubling questions concerning human nature. We are a long way from adequately accounting for the behavior of physicians, administrators, and consumer-patients. We would benefit from a more nuanced understanding of character and character defects, choice, self and interest (as in self-interest), and motive (as in profit-motive). Much more needs to be said about incentives and the broad range of influences Reinhardt refers to as "market forces."

Finally, it seems impossible to separate the individual entirely from the social, and managed care renders the atomistic view even more suspect. Managed care is above all a

\[27\text{Albert Jonsen, "Barbarians at the Gates: Medicine, Money, and Morality," } Ophthalmology \text{ 99 (1992):}\]
phenomenon of organizations. We cannot continue to speak of corporations as if they were interchangeable with persons (Reinhardt), or alien creatures (Relman). We must begin to develop criteria for evaluating specific practices, and specific organizations, in moral terms. At this point, we know only that any satisfactory criteria must go beyond the for-profit/not-for-profit distinction.
Chapter Two: The deMeurers Case

In medical ethics, it is customary to use a case to lend concreteness to the discussion of significant moral issues. I will use a case to lend concreteness to my discussion of managed care, and also to show how the portrayal of managed care in the popular press reflects the interpretive framework of the medicine-business dichotomy. For a number of journalists, the story of Christine deMeurers has served as an emblem of managed care. The following narrative is based on accounts that have appeared in a widely-read weekly magazine, a daily newspaper, and a journalist's book on managed care, and reflects the characteristic issues and concerns, and limitations, of such perspectives.1 My use of these sources follows from my interest in the manner in which these perspectives are shaping the public perception of managed care. Given the nature and limitations of the sources, the statements that follow concerning the events and actions that occurred should be treated as allegations.

DeMeurers and her family were members of a network model HMO called Health Net. The Health Net plan happened to be the least expensive of the three options offered by deMeurers's employer. Family members appeared to be in good health at the time of enrollment, and neither deMeurers nor her husband, Alan, paid much attention to the details of the contract, received after they enrolled in the plan. In late August of 1992, less than two months after she enrolled in Health Net, deMeurers was diagnosed with breast cancer. She was referred by her primary care physician to an oncologist, Mahesh Gupta. She underwent a radical mastectomy, radiation therapy and chemotherapy. Nevertheless, the cancer spread, and she was later classified as having Stage IV metastatic

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breast cancer.²

Given the limits of standard therapies, Gupta referred deMeurers to a specialist he knew for consultation concerning a bone marrow transplant. On her sister's recommendation, deMeurers also sought a consultation on her own with another transplant specialist, Roy B. Jones at the University of Colorado. After the consultation with Jones, deMeurers decided to pursue a transplant. Although there is as yet no solid scientific evidence establishing that transplants for patients with metastatic breast cancer prolong life or improve the quality of life, reports suggest that such transplants are considered standard of care by many specialists, and approximately three out of four insurers pay for them.³ Health Net denied coverage on grounds that a transplant in deMeurers's case would be experimental and hence excluded under its contract. Many managed care plans cover "medically necessary" services, but not "experimental" treatments and procedures. What is experimental can rarely be specified in detail given the rapidity with which change occurs in medicine and the lack of consensus among physicians in many areas. Hence, contracts tend to be ambiguous and open to conflicting interpretations. The Health Net contract was especially ambiguous on the subject of

²At Stage I, breast cancer is localized in the breast tissue. A lumpectomy or treatment with radiation may cure the disease at moderate cost; the ten year survival rate is around ninety percent. At Stage IV, the most advanced stage, the cancer has metastasized to other regions of the body. Chemotherapy may slow the progress of the disease, but the treatment itself often makes the patient violently ill.
³A meta-analysis of the effectiveness of bone marrow transplants for advanced breast cancer concluded that transplants were of zero value, and possibly had negative effects on length and quality of life. See Emergency Care Research Institute, High Dose Chemotherapy with Autologous Bone Marrow Transplantation and/or Blood Cell Transplantation for the Treatment of Metastatic Breast Cancer, Technology Assessment Custom Report Level 2 (Plymouth Meeting, Pa.: ECRI, March 1994). Information on coverage comes from E. Haavi Moreim, "Moral Justice and Legal Justice in Managed Care: The Ascent of Contributive Justice," Journal of Law, Medicine & Ethics 23 (1995): 247-65 at 259, n. 26. Moreim also points out that insurer willingness to cover such unproven treatments hampers the conduct of clinical trials that might establish their safety and effectiveness, or ineffectiveness. Relatively few women are willing to enter scientific trials, in which they may be assigned to a control group receiving standard treatment, when their insurer will pay for an unproven treatment described by practitioners as "promising"
bone marrow transplants. 4

According to the published reports, Gupta agreed to make a referral for a second local evaluation, but later told deMeurers that he was not authorized by Health Net to make the referral. DeMeurers petitioned for a new oncologist. The new oncologist, Stanley Schinke, suggested that deMeurers go to the University of California-Los Angeles (UCLA) Medical Center for an evaluation. Thereafter, Sam Ho, Health Net’s medical director, allegedly called Schinke to tell him that a transplant was not indicated in a case like deMeurers’s. In the meantime, deMeurers, again acting on her own, had sought out John Glaspy, a transplant specialist at UCLA. She did not tell Glaspy or anyone at UCLA that she was a Health Net plan member. The deMeurerses feared that the UCLA physicians would attempt to dissuade them from proceeding with the transplant if they knew of the connection to the HMO.

DeMeurers appealed the Health Net decision to deny coverage, and was again denied. The deMeurerses agreed to pay UCLA $92,000 for a transplant; their lawyer, Mark Hiepler, prepared to sue Health Net. In a Time magazine cover story, the fund-raising efforts of relatives and friends are reported in poignant detail—the deMeurerses’ eight year-old daughter contributed a sign for a yard sale that said "MONEY GOES TO A MOTHER WITH CANCER." The $17,000 raised was sufficient to cover the harvesting of deMeurers’s bone marrow, the first stage of the transplant procedure.

As it turns out, Glaspy served on the Health Net advisory committee that decided to deny coverage for transplants for patients with deMeurers’s level of disease, although

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4 The Health Net pamphlet containing coverage information listed bone marrow transplants as a covered treatment, with the exclusions for experimental or investigatory procedures appearing many pages later. The company later modified the pamphlet to alert readers to the fact that covered items were subject to
he personally voted in favor of coverage. Glaspy eventually learned that deMeurers was a Health Net plan member, and he agreed to sign a declaration in support of her suit.

Later, at the request of Health Net's lawyers, he signed a declaration in opposition. As an advisory committee member, he had pledged to serve as an expert witness on Health Net's behalf in any litigation over the twenty-page policy guide that resulted from the panel's deliberations (the "grid").

Sometime between Glaspy’s two declarations in the deMeurers-Health Net litigation, Clifford Ossorio, Health Net's associate medical director, called Glaspy’s superior, Dennis Slamon, chief of UCLA’s division of hematology/oncology. According to the Los Angeles Times, Slamon has a memory of pointed questions about "why Glaspy was recommending a transplant for a Stage IV patient despite UCLA’s commitment to supporting the grid." Ossorio has contended that he was merely smoothing ruffled feathers at UCLA. In any event, the call reportedly led to a dispute between Slamon and Glaspy over whether the harvest of Christine deMeurers's bone marrow obligated UCLA to pay for the transplant. Slamon saw the harvest as a pledge by UCLA to complete the treatment. Glaspy was familiar with cases in which a harvest had been undertaken pending resolution of other issues, and he felt that Slamon did not understand the situation. Moreover, the cost of deMeurers’s treatment would come out of his unit's budget.

Slamon prevailed. On September 23, 1993, deMeurers entered UCLA for a bone marrow transplant at UCLA's expense. Since HMOs notoriously do not want their members to receive services that they do not offer (it draws attention to their coverage exclusions. See Anders, Health Against Wealth, 119, 124.
limitations, and it suggests that the services provided are "medically necessary" rather than "experimental"), this alone might have been sufficient to strain UCLA's relationship with Health Net. Further, although the deMeurers were at first "elated" by the news that UCLA would pay for the transplant, they had grown suspicious. Alan deMeurers told the Los Angeles Times that with UCLA paying, "We were worried we'd get compromised care. How would we know if she was getting the best? There was no standard we could hold them up to."

Christine deMeurers died on March 10, 1995. After the transplant she enjoyed four apparently disease-free months, falling ill again by the spring of 1994. Before she died, the family took a trip across the country to build memories for the children, and the family had one additional Christmas together. Alan deMeurers believes the quality of that family time made all they went through to get the transplant worthwhile. He believes the outcome proved Health Net was right. In October of 1995, an arbitration panel determined that Health Net should have paid for the transplant. It also found that the company had interfered with the doctor-patient relationship by telephoning Christine deMeurers's doctors. The panel awarded $1.2 million to Alan deMeurers.

Soon after the decision in the deMeurers case Health Net changed its policy on bone marrow transplants. If a case falls outside the grid, it is forwarded to an outside agency in Virginia. That agency sends the case on to three independent experts. If even one is of the opinion that a transplant is warranted, Health Net pays for it. The reporter for the Los Angeles Times speculates that Christine deMeurers might consider this a victory. He quotes Alan deMeurers: "After Christy got her transplant from UCLA, the question from Health Net was why were we pursuing the case against them... She always
replied it was to make it easier for the next person." In September of 1994, the Federal Employee Health Benefits Program mandated that all its health plans cover bone marrow transplants for advanced breast cancer. Coverage of bone marrow transplants is also required under a number of state laws, including one passed in California.

Health Net is a very large corporation. In 1995, the company, the second largest HMO in California, received two billion dollars in premium payments for 1.2 million "covered lives." It is worth noting that Health Net is the kind of HMO that many Americans may be offered as a low-cost option. Health Net is not a "fly-by-night" operator. It converted to for-profit status during the period of Christine deMeurers's struggle with cancer, but it traces its roots to Blue Cross of Southern California. Further, in December of 1995, Health Net received a one year accreditation from the National Committee for Quality Assurance.5

Many media accounts juxtapose stories of personal tragedy with stories of the financial machinations of managed care organizations and their executives. This is certainly true of accounts of the deMeurers case. At the time of its conversion to for-profit status, Health Net was acquired by a smaller competitor, QualMed. The chief executive officer of Health Net, Roger Greaves, and the chief executive officer of QualMed, Malik Hasan, both became executives of Health Systems International (HSI), a holding company. In 1994, Greaves and Hasan ranked third and fourth, respectively, in terms of cash compensation for chief executives in the "HMO industry." Greaves

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5 Larson, "HMO," 46. The National Committee for Quality Assurance or NCQA was founded in 1979 by the Group Health Association of America and the American Managed Care Review Association, the major trade associations of the "managed care industry" (now merged into the American Association of Health Plans). In 1990, it was "spun off" as an independent not-for-profit. The chief activity of the NCQA has been the development and refinement of the "outcome" measures which constitute the Health Plan Employer Data and Information Set (HEDIS). The NCQA is the managed care equivalent of the Joint
received $8.9 million, while Hasan received $8.8 million. Uwe Reinhardt has suggested that these figures should not be cause for general concern. He argues that the cash filling the coffers of managed care organizations, and managed care executives, comes from the socially beneficial activity of “putting the squeeze” on providers and drug companies:

"[Rather than driving up the costs of health care, these pay packages are being financed by] the doctors and nurses and pharmaceutical companies on whom they put the squeeze... As long as the patients are happy, why should they care that Malik Hasan is going to be able to buy a new airplane every year?"

Peter Boland, a managed care consultant, is less sanguine about the social benefits of the transfer of funds from providers to managed care organizations. Boland looks at what HMOs are doing with the money, aside from rewarding executives. He asserts that the dominant strategy in the industry is to buy market share, "to grow as quickly as possible through external acquisition, rather than pumping money back into the company to achieve higher levels of patient satisfaction and performance." In 1995, HSI announced plans to merge with WellPoint Health Networks to create the nation’s second-largest for-profit managed care company. WellPoint, a subsidiary of Blue Cross of California, planned to acquire HSI for stock worth $1.89 billion. The deal would have increased the value of Greaves's stockholdings from $300,000 to $31.8 million. Hasan would have held shares worth $175.9 million as a result of the deal. Unfortunately for Greaves, Hasan, and the other shareholders, the merger with WellPoint collapsed in

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Commission for the Accreditation of Health Care Organizations.

6These figures do not reflect compensation in the form of stock or stock options.


December of 1995. The failed transaction cost HSI $20.2 million. To preserve its profit margin, the company has reduced payments to providers and frozen salaries across the board, “even for senior managers.”

Another HSI transaction in 1995, while less rich, may be nearly as significant. The Connecticut State Medical Society’s M.D. Health Plan was considered one of the success stories in physician attempts to mount a professional challenge to aggressive, multi-state managed care organizations. Society members raised $7 million to start the plan and marketed it with the slogan: “WE DON’T WANT ANYTHING TO COME BETWEEN YOU AND YOUR PHYSICIAN.” Participating physicians agreed to a discounted fee schedule, rather than relying on a system of gatekeepers to reduce costs. The plan became the second-largest HMO in Connecticut. It also had the lowest profits and the smallest percentage of premiums going toward administrative expenses. The plan eventually attracted the attention of HSI, which purchased it for $101 million. The plan's 1,500 stockholders received a $56,000 return on a $3,000 investment. Although the plan's leaders say they needed access to capital to remain competitive, "[s]ome observers see the deal as evidence that doctors are as likely as anyone else to take the money and run when the opportunity arises."

Obviously, economists and financial consultants disagree on the desirability of such corporate behavior, judged purely in terms of economic impact. From a broader social perspective, it is relevant that Health Net spends no money on medical research,

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and defends its practice by citing its fear of engaging in unlawful discrimination by favoring one disease over another—as well as the exigencies of competition. On the other hand, Health Net can point to the California Wellness Foundation, and its $300 million endowment, as its continuing contribution to the good of society. When the company converted to for-profit status, it set up a not-for-profit foundation to meet the requirements of a California law. Critics believe that the sale price was too low, and hence the amount contributed to the Foundation was less than it should have been.\textsuperscript{12} Be that as it may, the Foundation is currently quite active. In 1994, the Foundation launched a five-year, $24 million "Violence Prevention Initiative" targeting young people.\textsuperscript{13}

Malik Hasan, formerly a practicing neurologist, has become a public spokesman for for-profit managed care organizations. In an opinion piece in the \textit{New England Journal of Medicine} entitled "Let's End the Nonprofit Charade," he concludes:

The energy and entrepreneurial spirit that have made America a leader in all aspects of the world economy are doing the same in health care. Investor-owned plans are spearheading this change in the health care system with improved access, a strong emphasis on preventive care, affordability, and demonstrable quality. The conversion of the remaining nonprofit plans into investor-owned plans will provide funds that can be used for activities outside the scope of the market [e.g., in separate not-for-profit institutions established solely as sites for indigent care, medical education, and testing of experimental procedures]. The time has come to enact these changes and allow the marketplace to continue its

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comprehensive reform of the American health care system—a reform that benefits every American.\textsuperscript{14}

The ideology of medicine prepares us to see struggles between virtuous physicians and venal executives, with the patient as helpless bystander in the battle of titans. Journalistic accounts of managed care tend to adopt this framework. The ideology of business prepares us to see virtue in the venality of executives. The patient is (or ought to be) a knowledgeable consumer who regards her needs and wants in relation to health care in the same light as her needs and wants in relation to transportation. No longer a victim, she is, according to the model, the true sovereign. Organizations sit awkwardly within either ideology. What does a critical assessment of the behavior of the principle characters in the story of Christine deMeurders reveal concerning these two sets of assumptions?

There is some evidence that some physicians failed to display the imperviousness to social pressures required of them by the ideology of medicine. They are not quite the unblemished heroes, even in the media accounts. In the media, Hasan and Greaves tend to be portrayed as the villains, profiting from human suffering. However, their venality (such as it is) can scarcely be attributed to the world of "business" in any simple fashion. Hasan is a physician, and Roger Greaves spent his early career running a not-for-profit health care organization. Further, they are not alone in their desire for material gain. Consider the physician-stockholders of the M.D. Health Plan. Is avarice any less avaricious on a smaller scale? The leaders of the plan cite increasing capital needs as a reason for selling the enterprise. Is this credible, or are they simply less honest than

Greaves and Hasan? As for the managers, they seem to caught in the middle. They stand between patients and the treatments those patients, advised by specialists, so desperately want, and they are caught in the tension between the ideologies of medicine and business. Are they servants of individual patients or corporate profits, or something else?

And what of "the patient"? Or rather, what of the patient and her husband and her lawyer? Is Christine deMeurers a passive victim, someone reduced by need to abject dependency on her personal physician, or a consumer seeking to satisfy her preferences? As the second question implies, the patient in this case is not a monad; she has the support of a family and the legal system. Further, she herself is clearly an agent. Hence the picture of total dependency is not quite adequate. At the same time, all of the people with whom she interacts help to shape her expectations and choices. It is impossible to label her victim or sovereign. She experiences what she and her husband perceive to be betrayal by some of the physicians and by Health Net, but she and her husband are also perceived as betrayers, deceivers, by Glaspy. Once deMeurers is allowed to be a moral agent, her character and her choices become subject to ethical scrutiny. Is she selfish or altruistic? Her husband says that she continued her suit against Health Net past the point where it made any difference to her own treatment "to make it easier for the next person."

Since litigation is emotionally and physically draining, there was real sacrifice involved. On the other hand, the verdict and the change in Health Net policy that it brought about only made things easier for the next patient with Stage IV metastatic breast cancer or similarly advanced disease who wants a bone marrow transplant of questionable benefit. The change in policy may actually make things worse for other patients affected by the redirection of funds to expensive, borderline treatments.
Finally, it seems clear that problems of organization, problems of hierarchy and coordination, affect for-profit managed care organizations and academic medical centers, strongholds of "business" and "medicine." This is only to say, once again, that matters are complex and there is a good deal of ambiguity. Virtue and venality are not distributed as neatly as the medicine-business dichotomy would suggest. Physicians, managers, and patients, have complicated motivational structures. It is no simple matter to press oneself into the mold of philanthropist or *homo economicus*. The philanthropist finds it difficult to conform to a code that demands a character impervious to economic considerations and organizational pressures. *Homo economicus* feels compelled to justify his conduct in moral terms. Behavior exhibits enough diversity to cast doubt on the assumptions behind the medicine-business dichotomy. Further, this diversity suggests something of the range and complexity of the influences we must address. Talk of "pressures" and "influences" may suggest too great an exteriority. The organizations we participate in clearly affect our understanding of our own interests and those of others. Present realities demand a more comprehensive and discriminating analysis.

Not all moral evaluations of managed care are framed in terms of the medicine-business dichotomy. There is another common approach that ignores the polemic, the call to take sides. Instead, a category or series of categories guides the selection of material for discussion and serves as the standard for evaluation. Proceeding in this mode, the analyst of managed care may organize her discussion in terms of choice, conflict of interest, allocation of resources, and similar categories. Does the "standard categories" approach remedy the deficiencies of the medicine-business dichotomy as a framework for analysis? The story can once again serve as a test.
The usual assumption is that, once identified or elicited, the choices of patients or consumers are relatively unproblematic. I do not mean to minimize the value of analysis in these terms, but I believe it needs to be placed within a larger frame. The point is not that someone other than the patient or consumer would be a better agent of choice, but rather that simplifying assumptions, which may be defensible in some contexts, have been mistaken for reality. Are interests, desires, and preferences, and the choices that follow from them, predetermined and fixed, or are they rather open to influence and development?

Take, for example, the issue of choice of a health plan. In the standard analysis that focuses on the patient or consumer in isolation, the first and perhaps the last question is whether deMeurers's choice of the Health Net plan was a free and informed one. The choice seems voluntary. After all, no one held a gun to deMeurers's head. Further, deMeurers's employer offered alternative plans, and the family's circumstances were apparently comfortable enough that choice of a higher cost plan would not have been a simple financial impossibility. True, deMeurers's role seems a rather passive and contained one—her "choice" was the work of a moment—but that is not out of line with common understanding and practice.\(^\text{15}\) Traditional medical ethics has been very concerned with decision making authority, but largely indifferent to more subtle issues of power. Only a more controversial interpretation of "voluntary," linked to an argument for some special incapacity in connection with health care decision making, or a break with the

\(^{15}\) Of course, ethicists may still be dissatisfied by the intrusion of the employer. For example, Wendy Mariner, a professor of health law, lists three practical problems with assuming that choice of plan satisfies the "requirements of choice": (1) employers choose plans; (2) patients rarely know what benefits their plans offer when they choose; and (3) many patients do not want to be bound by their contracts. The last is a little unusual. Mariner's point seems to be that, when someone is dying, contracts and such seem rather trivial, and that patients do not find claims that their care must be limited due to scarcity credible when
focus on the individual in isolation, would support belaboring this aspect of the question.

On the other hand, one can make a strong argument that the information deMeurers and her family received about Health Net was inadequate to permit informed choice. (Whether the availability of more adequate information would actually affect decision making is a different question.) The deMeurerses did not receive the Health Net contract until after they had enrolled in the plan. Further, there is no evidence that they received comparative information on the quality of the various plans among which they could choose. The source of this problem with choice is typically identified as industry reluctance to disclose information, and a lack of standardization that impairs comparative judgments when information is made available. The standard solution is for the government or a private organization such as the managed care industry's own National Committee for Quality Assurance to develop a "report card" for managed care plans that will include information on coverage and quality.

But what if a report card of any degree of sophistication defies the understanding of the ordinary consumer? Can an incorrigibly uninformed choice ever be a truly voluntary choice? Perhaps it is a sense that she will be defeated by the difficult subject matter that explains deMeurers's failure to demand copies of contracts and information on quality prior to enrollment. The problem identified here is the daunting complexity of advanced technological medicine. Although this problem is usually alluded to in arguing that there is an inescapable asymmetry between physician and patient, it may be extended to the asymmetry between plan and member in light of the baroque arrangements for health care delivery characteristic of our fragmented system. One

executives are raking in millions. Wendy K. Mariner, "Business vs. Medical Ethics: Conflicting
solution would be to expand the mandate of the governmental or private health care
monitor to include evaluation of plans. The monitor, as agent for consumers, might even
be given the responsibility of weeding out low-quality plans.

There are, however, further perplexities along these lines. For example, how does
one evaluate quality? Are aggregations of measures of the quality of performance of
individual physicians within the network sufficient? If differences in quality tend to
average out across groups, this approach may offer little basis for comparative judgments.
And what is "quality" and how does one measure it? Does quality have to do with
technical competence, suggesting criteria such as board certification, or data on morbidity
and mortality, or is it broader and more amorphous? Could one incorporate a measure for
level of trust? Perhaps patient satisfaction measures are the best indicators of quality of
relationship. But how informed are patient opinions? Can patients measure
trustworthiness, if they are in the dark concerning the financial incentives and other
pressures that may influence the conduct (judgment) of their physicians?

It may be that the focus of quality assessment should be the plan itself. One
could generate numbers that provide insight into its policies-in-practice, such as average
length of hospitalization. But is a "short" stay in the hospital bad, or good? Is it good to
return patients as quickly as possible to the bosom of their families, or is that patient
dumping? What about data on administrative expenses as a percentage of total
expenditures, or executive compensation? Is "high" compensation bad, or good? Is a
multi-million dollar salary evidence of greed achieving and exploiting monopoly power, or
is a robust compensation package a well-deserved reward for efficiency and innovation?

And how do these various aspects of a plan fit together? Inevitably, difficult value judgments seem to be called for. Criteria are moral as well as technical, but this, in turn, gives rise to more questions. Does the observation about the necessity of value judgments mean that "experts" on values should be included on the evaluation team? Or is the inextricability of technical and moral questions a reason to return the task of judgment to individuals?

Further, one might want to know how organizational structures are related to the conduct and concerns of individuals, including the choices they make. The concepts we require would focus attention on the moral aspects of this relation. Also, the term "structures" seems too static to provide insight into the rapid development of an organization such as Health Net. Is there a concept that captures the dynamism of these structures? Then, too, we need to understand how an organization is affected by and affects its own environment, a question parallel to the one posed concerning individuals and their immediate organizational environments. The idea that individuals or organizations come equipped with predetermined motives and interests is open to challenge, as is any simple faith in incentives.

Having reviewed some of the difficulties that attend an attempt to respond to the problem of limited knowledge on the part of consumers, it is well to note an even stronger and more controversial statement of the problem. Simply put, not only are consumers incapable of judging health care plans on relatively objective terms, e.g., arriving at an adequate understanding of the terms of contracts and making comparative judgments about plans based on quality criteria, but they are also incapable of judging their own subjective preference for health care prior to the occurrence of an event that puts them at
the mercy of a plan. The deMeurerses did not attempt to understand the terms of the contract with Health Net until Christine deMeurers was diagnosed with breast cancer. The problem, some would argue, is that health care is a special good not only in its complexity, but also in its "existential" significance. Many of us would prefer not to reflect on the possibility that we may become seriously ill, and we may tend to undervalue health care relative to other goods. On the other hand, we, or our physicians, may expend large amounts of our own or society's resources on health care that offers little or no prospect of benefit (and subjects us to prolonged pain and suffering), while other pressing needs such as education are neglected.

Yet what to do? If I choose not to think about my mortality, is that not a personal choice? If I cannot seem to forego the purchase of a new television, or ten packs of cigarettes a day, even if it means that I am left with insufficient funds to purchase good health insurance, what is that but a reflection (and revelation) of my personal ordering of preferences? If neither I nor my physicians have a sense of the proper limits of medicine, or a context or forum in which to weigh the claims of health care—or particular types of health care—against other goods, what is that but a consequence, regrettable but unavoidable, of our nature as separated beings and the subjectivity and relativity of all things moral? But are mortality, the losses of aging and illness, and anxieties about the future purely private troubles? Are consumption patterns impervious to social influence? Perhaps matters are not so black and white. It may be that our problems, and the means of addressing them, are social as well as individual. It may be that in the health care context we can aid one another with gifts of understanding as well as money. One of the most pressing questions may be how to locate or create settings for mutual aid.
Similar problems arise with the other standard categories of analysis. The conflict of interest concept is a blunt instrument. Where the physician has a direct financial incentive to overtreat or undertreat patients, conflict of interest analysis helps us to see this and to understand that the arrangement is not ideal. But the model has a limited scope; it cannot be applied indiscriminately without confusion, or harm to relationships, or both. Consider the transplant specialist's need to believe in her procedure, or the general discomfort with delivering bad news and the general resistance to hearing it. Certainly these are factors to be considered, but are they best understood as interests in conflict with other interests?

Things are even more complicated if some interests arise intersubjectively or in relationship and may not be strictly assignable to one person. Such interests would have to be artificially sundered and reconstructed so that they could "conflict" according to the terms of the model. Analysis on these terms effectively dissolves the relationship. Normally, patients and physicians do not watch one another with a suspicious eye. It is a sign of something gone wrong when the relationship must be dissected and every aspect picked over for interests and oppositions. Or consider marriage, which lies further along the continuum of intimate relationships. Can we speculate that Alan deMeurers encouraged his wife to continue her suit past the point where it was in her interest because he had an interest in collecting $1.2 million? It seems inappropriate even to raise the question. We need to think critically about family relationships, but if this kind of speculation were to become customary, marriage as we know it would have come to an end. The individual case is bound up with the institution.

As for resource allocation, a category that fits under the general heading of
distributive justice, it should be clear by now that there is nothing simple about this activity. We need to sort out social meanings. We need to decide which considerations to admit and which to exclude and how the various considerations admitted will be weighted. We need to decide who should decide. The patient? Is this a matter for the patient to resolve in the privacy of her own conscience based on her conception of the good and the right, or according to whatever preferences she just happens to have? The physician? A panel of physicians? A panel of physicians and patients and medical ethicists? If a panel, would they decide for the whole of society? Or would each institution have its own panel? How firm would the rationing policies be? Would exceptions be made for "squeaky wheels" and particularly affecting cases? The questions, it seems, are virtually endless.

A careful analysis would provide a much more exhaustive treatment of each of the categories selected for consideration, and attempt to tie up the loose ends and render a general verdict. But proceeding in this way simply fails to capture much of what I find striking in the deMeurers story: the spread of fear and suspicion through the network of relationships; the problem of how we give meaning to our experience and especially our suffering; the active-passive character of the involvement of all of the actors, against, for example, the view of the patient as either victim or sovereign chooser; the disconnection between the wheeling and dealing of the top corporate executives and the distress of the patient and her family; and, finally, the "characters" of the institutional actors. In the category-by-category analysis of choice, conflicts of interest, and rationing principles, the large organizations that figure so prominently in the story—Health Net, the UCLA Medical Center, HSI—recede into the background. A myopic ethics cannot make sense
of the interactions among institutions and individuals that constitute the narrative. The tools and concepts do not quite fit, or they create a fragmentary analysis, when what we seem to require is a moral vision that can encompass the larger wholes.

To summarize and reflect on some of the issues raised thus far, the role of the administrator or manager in managed care emerges as particularly problematic. Managers might be responsible for putting in place systems to aid practitioners and contribute to the control of costs and performance in the interests of fairness and to assure that standards of quality are consistently met, and yet take professionalism and human relationships seriously. Managers cannot let themselves be dominated by force of desire in particular cases without risk of unfairness, but brutality and a total lack of vulnerability to the plight of those affected by policies and decisions is not the only other option. Managers might open up the process of standard setting and communicate with rather than dictate to providers and plan members. They might provide leadership and vision, exercising power responsibly and with a degree of humility. On the other hand, some skepticism concerning technique, and what good management can do, seems warranted. Good management cannot eliminate organizational problems or personal tragedy. Good managers might, however, respond intelligently to problems and do their best to anticipate and prevent them, and they might do their very best to ensure that the manner in which they perform their role serves to lessen rather than to intensify suffering. The deMeurers case may be more useful in showing the dangers than the potential contributions of the managerial role, and this is true despite the fact that the managers we
encounter are physicians, and hence cannot be dismissed as mere clerks or number
 crunchers.

The response of the physicians (and other practitioners) to managers and to the
new order in medicine is a separate but related issue. There is a sense that the
appropriate response will include "seeing both sides." Physicians must acknowledge the
weight of concerns about justice and the legitimacy of administrative demands for
consistency and accountability. They must also insist that their own patients have
special claims on them and legitimately demand responsiveness to their particular needs
and desires. Yet one cannot simply veer erratically between the two poles of moral
obligation. The solution to this problem will be bound up with making moral sense of the
managerial role; that is, the ability of physicians to honor, appropriately, the first set of
concerns is linked to the ability of managers to honor the second. Open and honest
communication will be essential to the process of creating the conditions for mutual
respect.

The third member of the triad is the patient. How might justice become a concern
of plan member-patients as well as managers and physicians? Ideally, this
"consciousness-raising" would not occur when persons are most truly patients, in the
midst of a health crisis. Ideally, it would occur through involving members in policy
making for the plan and enabling patients to participate more fully in their own care. We
are all aware of the scarcity of resources, but because we are not involved in determining
how those scarce resources are allocated, restrictions that affect us personally are likely to
seem arbitrary and unfair. We know that we are in some sense responsible for our own
health, but we tend to think of health care as something to be done to us or for us.
Involving plan members in policy making and nurturing their sense of responsibility and self-efficacy in relation to health is not simple. A major concern in the remainder of this dissertation will be finding a way to talk about participation that marks its importance and yet does not strain credulity. Michael Shadid's cooperative and the dream of health care as a truly collaborative enterprise seem to have little to do with contemporary practice, yet these ideals remind us of what we may strive for in a world of changing health care organization and medical practice.

The prospects for participation are linked to some large existential questions. Sooner or later, we must come to terms with the tensions in our relationships to others, and our vulnerability to various kinds of loss, physical and mental illness, aging, and death. Are these basic forms of insecurity individual or social problems? If others have something to say about the kind of health care I receive, am I being used as a mere means to their ends? If I draw on the resources of others, am I using them as a mere means to my ends? In short, what is the best way to understand our corporate projects in this and other areas? Allow, for the moment, that social influences are important and that members of a society have responsibilities to one another, and the range of possible answers is still very broad. We need a social ethic, but a social ethic can take many forms, and draw on a number of social values.

A social ethic can also be more or less attuned to the full range of considerations affecting conduct, the usual focus of moral theory. I have spoken of roles. Persons inhabit roles, and so it is valuable to have some general notion of what people are like. It is a matter of psychology. But it is also a matter of sociology. The role of manager or physician or patient, like any other, cannot be removed from its social and organizational
context. The role of manager, for example, cannot be understood apart from the phenomenon of bureaucracy, and the role of a particular manager cannot be understood apart from the structures of the particular organization. I have stressed the need to take account of organizational settings. This is an area in which medical ethics has been relatively weak, in theory if not in (clinical) practice. The standard approaches to managed care neglect the importance and complexity of the relationships that form the background for specific conflicts or dilemmas. So we end asking how to begin.
Chapter Three: Toward a More Social Ethic

I have argued that in order to understand managed care we need to get beyond the ideologies of medicine and business. Both are myopic. In particular, both neglect the organizational and social dimensions of existence. If we do not proceed under the banner of "the Hippocratic tradition" or "the business creed," traditional medical ethics or traditional business ethics, where are we to look for guidance? I have also argued that merely looking at this or that fragment, choice, or conflict of interest, or rationing principles, will not enable us to grasp the interconnections among phenomena. A more systematic approach may be in order. But what kind of system? There are several fine sociological accounts that address inter- and intra-organizational dynamics in the context of health care, but I wish to raise moral questions that are not addressed directly in these accounts. When one surveys the landscape of contemporary medical ethics, or contemporary ethics for that matter, the tools for such an analysis appear few and far between. If a theorist ventures beyond the physician-patient dyad, she is likely to go directly to questions of national or global scale. Two schools of moral and social philosophy have been particularly influential in medical ethics, utilitarianism and social contract theory. In addition, "communitarian" approaches have become increasingly prominent in recent years. In this chapter, I will undertake a brief review of the work of representative thinkers for each of these three schools and evaluate their capacities to address the issues and questions I have identified.

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1 As Haavi Morreim has pointed out, the emphasis on individuals, and the doctor-patient relationship, is a product of a specific history. Medical ethics as a discipline arose largely as a response to revelations about the abuse of subjects in medical research and to routine medical paternalism. E. Haavi Morreim, "Moral Justice and Legal Justice in Managed Care: The Ascent of Contributive Justice," *Journal of Law, Medicine & Ethics* 23, no. 3 (1995): 247-65 at 248. Still, had not the initial predisposition been to view such moral failures as problems of individual judgment and action, medical ethics would not have taken the
1. Utilitarianism

The classic statement of the basic principles of utilitarian moral theory comes from Jeremy Bentham. The classical theory is anchored in a view of human nature commonly known as "psychological hedonism." In the words that open the first chapter of Bentham's *Introduction to the Principles of Morals and Legislation*, "Nature has placed mankind under the governance of two sovereign masters, pain and pleasure. It is for them alone to point out what we ought to do, as well as to determine what we shall do."

The lessening of pain, or the increase of pleasure, are then both natural (desired) and moral (desirable) objects. Psychological hedonism is translated into the principle of utility, "which approves or disapproves of every action whatsoever, according to the tendency which it appears to have to augment or diminish the happiness of the party whose interest is in question." "Utility" is simply "that property in any object, whereby it tends to produce benefit, advantage, pleasure, good, or happiness...or...to prevent the happening of mischief, pain, evil, or unhappiness to the party [individual or community] whose interest is considered." The "greatest happiness principle" extends the principle of utility to cover all sentient beings; what ought to be done is that which produces the greatest good or happiness for the greatest number. In the classical view, judgments of utility are based on observation of the tendencies of the action or actions to be assessed.

Although Bentham presents utilitarianism as a general theory, and his followers

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and disciples have done the same, he was trained as a lawyer and his great project was the reform of the legal system. This orientation obviously shaped the theory. For example, it is the perspective of the legislator that dominates. Also, Bentham's reforming zeal was prompted in part by his disgust at the way lawyers had succeeded in exploiting their status as professionals to their benefit and the public's detriment. His experience with the legal profession explains the skeptical thrust of his views. John Stuart Mill wrote of Bentham that "[t]he greatest service rendered by him to the philosophy of universal human nature, is, perhaps, his illustration of what he terms 'interest-begotten prejudice' - the common tendency of man to make a duty and a virtue of following his self-interest."5 Bentham was, then, an early critic of ideology.6

In general, Bentham had a low tolerance for ambiguity. According to Mill, "Words, he thought, were perverted from their proper office when they were employed in uttering anything but precise logical truth."7 Bentham was certainly an uncompromising nominalist, as reflected in his definition of community: "The community is a fictitious body, composed of the individual persons who are considered as constituting as it were its members. The interest of the community then is, what? - the sum of the interests of the several members who compose it."8 Mill believed that "Bentham's idea of the world is that of a collection of persons pursuing each his separate interest or pleasure... He committed the mistake of supposing that the business part of human affairs was the

8Bentham, Introduction, 66.
whole of them." The interests of a community or society are simply the aggregated interests of its members, and the interests of the members are given through a precise calculation of possible pleasures and pains for each one, separately considered. These sorts of considerations have supported the charge that utilitarianism is not only reductionistic but individualistic, which might at first seem an odd label for a theory that has also been accused of subordinating the individual to the community.

Bentham is important not only as a moral theorist, but also as a social reformer whose ideas have coalesced with important structures in modern society, such as bureaucracy. As to utilitarian moral theory proper, there have, of course, been further developments. For example, much debate has raged over act- versus rule-utilitarianism, a debate I will pass over here. Given the importance of expectation in the work of Bentham and Mill (discussed in more detail below), neither would favor judgment de novo for every act, and this diminishes the significance of the distinction. There is also a divergence between abstract ideal observer theories and desire or preference theories fashioned to the needs of economists and policy analysts. The latter have had much more of an influence in the health care field, and hence I will make them my focus.

As noted, the legislator rendering judgment based on the observed tendencies of acts to produce pleasures or pains is the paradigm for Bentham's utilitarianism. Preference utilitarians such as John Harsanyi reject this paradigm. Harsanyi contends that people are motivated by forces other than pleasures and pains. Once the basic psychology begins to lose its coherence, it becomes increasingly difficult to see how any objective judgment is possible. Mill thought that one could allow for complex

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motivations such as the desire for virtue and yet retain an element of objectivity. The complexity of motivation simply meant that a special kind of judge was required, one of broad experience, not that objective judgment was impossible. The preference utilitarian's solution to the problem of judgment is to define a utility function for each person "in terms of his own preferences as manifested in his choice behavior."¹⁰ (Harsanyi notes that choice behavior may include verbal choices made in response to hypothetical situations.) Of course, this approach introduces its own complications. If the subjectivity of individual motivation is the reason for abandoning the possibility of objective, third party judgments of value, how are utility functions derived from a collection of individuals with diverse motivations and preferences to be compared? Some utilitarians have stipulated universalizability of preferences and impartiality as methodological conditions, while others have assumed that individuals are identical.

Observer judgments or evaluations may also be introduced into preference theory in another way. Questions such as the following bedevil the preference utilitarian: What weight ought I to give your preference if it is based on a mistake, which I, with superior information, am able to identify? Harsanyi favors "idealized" or "corrected" preferentialism, rather than pure preferentialism. This requires him to make several distinctions. First, a person's manifest or actual preferences must be disregarded in favor of his or her true preferences, that is, actual preferences corrected by sufficient factual information for a decision, careful reasoning, and the capacity for rational choice. Harsanyi would also exclude misinformed preferences, i.e., preferences based on false assumptions, and spurious preferences based on self-deception, from consideration.

¹⁰John C. Harsanyi, "Individual Utilities and Utilitarian Ethics," in Paradoxical Effects of Social
Further, Harsanyi distinguishes between first-order and second-order preferences. This distinction is best captured with an example: I may have a first-order preference for a cigarette and a second-order preference to quit smoking. Harsanyi argues that we should always give precedence to second-order preferences.

The person who derives pleasure from vicious activity, such as torturing others, has always been considered a hard case for utilitarianism. The usual response is that the pain to the victims would surely outweigh the pleasure to the sadist. Harsanyi excludes such "antisocial" preferences altogether. First, he argues that such preferences are inconsistent with the basic premise of utilitarian theory, which is benevolence to other people. In other words, the appeal to benevolence overrides the appeal to individual preference. Second, he argues that antisocial preferences should be excluded because they are external preferences. Personal preferences tell us how a person wants to be treated, external preferences, how a person wants others to be treated. Utilitarianism respects only the first. The consequence of this logic is that benevolent or social preferences, as well as antisocial preferences, must be excluded from consideration: "For if we included external preferences of either kind in our social-utility function, we would violate the principle that the interests of all individuals must be given equal weight." What matters for analysis is the individual's "self-interest-limited" utility function. This is somewhat ironic, since a major objection to psychological hedonism was that it did not allow for altruistic motivation. Economists, in particular, have been accused of further narrowing the interests that count to monetary interests. While the concept of an "externality" or third-party effect seems to open up economic analysis to considerations which are social

rather than individual, and consequences that extend beyond the financial, Steven Rhoads has demonstrated that in practice economists seldom look at effects on others that are not financial in nature.\textsuperscript{12}

**Application to health care**

All of these technical distinctions may seem very arcane, but they are of great practical importance to health care because they shape the methodologies currently in use in technology assessment and in the making of rationing decisions. I believe an account of managed care that addresses only the question of resource allocation is deficient, but there is no doubt that these decisions are an important component in the total mix. Common methodologies include cost-benefit, cost-effectiveness, and risk-benefit analysis. Cost-benefit analysis is especially controversial because it involves the monetarization of both costs and benefits. (In cost-effectiveness analysis, two or more paths to the same benefit are compared. The comparison takes place in monetary terms, but the benefit itself does not need to be assigned a monetary value.) Cost-benefit analysis is difficult in health care, where many things that people may either suffer or gain are not typically priced, such as life. So, for example, economists and other policy makers may employ a "willingness to pay" strategy for valuing life and other "nonmarket" goods. Willingness to pay is a form of preference utilitarianism. As the label suggests, consumers are asked how much they would be willing to pay to avoid some risk (cost) or attain some benefit, or how much they would have to receive to assume some risk (cost) or give up some benefit.

The questions are usually hypothetical, which introduces some difficulties. In

\textsuperscript{11}Harsanyi, "Individual Utilities," 9. For example, people with many friends and relatives "wishing them well" would fare better than others.

particular, "hypothetical bias" must be weighed against "strategic bias." Hypothetical bias refers to the weakness of the incentives respondents have to give accurate information if they believe that questions have no relevance to their lives. Strategic bias refers to the incentive respondents have to strategically misrepresent their values if they believe that their responses will influence policy making that may affect them. The quality-adjusted life year (QALY) approach—technically a form of cost effectiveness analysis in that benefits are not monetarized—is an alternative to the willingness to pay approach to valuation. Like the willingness to pay approach, the QALY approach relies on individual preferences elicited through hypothetical questions. Respondents are presented with a series of impairment descriptions and asked to rank them on a 0-1 scale, with death equivalent to zero. Values can be negative, if a particular impairment is considered worse than death. Unlike the willingness to pay approach, the QALY approach is intended to minimize the effects of economic factors such as income and price on valuations. Although the valuation of health states is highly controversial and subject to some technical difficulties, economists point out that reliably estimating the changes in health that will result from adoption of a policy may be even more difficult.

**Criticism and reconstruction**

A number of criticisms have been directed at cost-benefit analysis. Cost-benefit analysis can be criticized for its failure to give sufficient weight to expectations, or, in the language of justice, rights. Steven Kelman suggests that the methodology may obscure the

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14 See George Tolley, Donald Kenkel, Robert Fabian, and David Webster, "The Use of Health Values in Policy," in *Valuing Health for Policy*, 345-91.
significance people accord to having a right. It assumes "there is no difference between
the price a person would require for giving up something to which he has a preexisting
right and the price he would pay to gain something to which he enjoys no right."\textsuperscript{15}
Kelman also criticizes another assumption that he considers unwarranted, the assumption
that there is no difference between how people value certain things in private individual
transactions and how they would wish those same things to be valued in public collective
decisions.

These comments on cost-benefit analysis are related to more general criticisms of
utilitarianism as a moral theory. One of the most frequently repeated criticisms is that
utilitarianism neglects distributional issues. John Rawls has charged that utilitarianism, at
least classical utilitarianism, treats the whole of society as a single individual. All desires
are conflated into a single system of desire and this mass then becomes the raw material to
which one applies the greatest happiness principle, the principle of choice for a single
person writ large. In a famous passage in \textit{A Theory of Justice}, Rawls states that
"Utilitarianism does not take seriously the distinction between persons."\textsuperscript{16} Now we have
seen that certain aspects of utilitarian theory tend to preserve "the distinction between
persons." Most obviously, there is the dictum that in the calculations required by the
greatest happiness principle "each one is to count for one." Harsanyi goes so far as to
rule out all external preferences on the grounds that their inclusion may give the interests
of some more weight than those of others. At the same time, it is readily apparent that
this dictum alone does not give the preservation of personality itself any weight in the

ensuing calculations. The criticism concerning distributional issues has been made in a more pointed way concerning cost-benefit analysis, which in some applications may actually reinforce existing patterns of discrimination among social groups, e.g., the discounted future earnings approach to the valuation of life. Under the discounted future earnings approach, if one is poorly paid, one's life is worth less; if one is without employment prospects, one's life is worthless. 17

Other critics have rejected what they see as the "totalizing" tendency of utilitarianism. Charles Taylor has questioned the impulse to fashion a single principle or set of principles to govern the whole of morality (his criticism applies equally to various species of formalism). Taylor writes that "[t]he unity of the moral is a question which is conceptually decided from the first on the grounds that moral reasoning just is equivalent to calculating consequences for human happiness, or determining the universal applicability of maxims, or something of the sort." 18 Taylor says that the "really important question" may be "how we combine in our lives two or three or four different goals, or virtues, or standards, which we feel we cannot repudiate but which seem to demand incompatible things of us." 19 Other, related, criticisms link utilitarianism with the growing tyranny of the market over other spheres of life. According to Jeffrey Stout, utilitarianism entices us into speaking the language of the marketplace "all the time."

17 Another example would be the way attitudes about disability in the population at large—which are not shared by most people actually affected by disabilities—may influence valuations of health states. In one study, researchers found that nearly one-half of a sample of about 1,000 individuals felt that being confined to a wheelchair was as bad or worse than death. George Tolley, Donald Kenkel, and Robert Fabian, "State-of-the-Art Health Values," in Valuing Health for Policy, 323-44 at 341. As I understand QALY analysis, this valuation would not eventuate in a policy that people in wheelchairs should be denied care because they are "better off dead," but it could mean that treatments that could achieve no better outcome than wheelchair dependence might be ranked very low. See, e.g., Alexander Morgan Capron, "Oregon's Disability: Principles or Politics?" Hastings Center Report 22, no. 6 (1992): 18-20 at 20.

Complex goods such as the goods of various kinds of social relationships are either
ignored altogether or "flattened out into units of pleasure and pain, satisfaction and
dissatisfaction, so that they can be absorbed into the calculus of utility." ²⁰

A different portrait of Bentham, and therefore a different view of the utilitarian
project, emerges from the work of Nancy Rosenblum. In Rosenblum's revisionist
account, awareness of suffering rather than calculation predominates, and justice is not
neglected. She writes that Bentham's "psychology is not the system of a dry calculator,
but of a sensibility horrified by pain, for whom the distinction between essential and
inessential feelings was clear." ²¹ Given his early acquaintance with the abuses of power
institutionalized in the legal system, Bentham was particularly concerned about the plight
of the weak at the hands of the powerful. If Bentham is read as a man possessed by the
idea of eliminating unnecessary pain, there is a shift in emphasis in the theory as a whole.
"Bentham's psychology undermines the view of utilitarianism as a teleological theory
aimed at maximizing aggregate happiness regardless of its effect on individuals. Instead, it
supports a view of utilitarianism as a moral theory in which the equality of persons—
certainly with respect to their interest in avoiding physical pain and fear—operates as
both an ontological assumption and a limitation on justifiable social choices." ²²

Rosenblum also challenges the view that Bentham ignored social feelings.
Utilitarian theory assumes that people will understand the imperative nature of
minimizing the arbitrary infliction of suffering. As Mill explicitly recognized,
utilitarianism rests on no firmer foundation than the conviction that one is a social being,

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²⁰Taylor, "Diversity," 35.
that one's well-being is linked with that of others. Rosenblum concludes that Bentham accepted contemporary views concerning sympathy and the natural harmony of interests, but he did not think sympathy and nature sufficiently reliable and predictable in their effects. Hence, he looked to legislation to effect an artificial identification of interests through carefully targeted rewards and punishments. (Corporations were thought to disrupt the natural harmony of interests and complicate the artificial harmonization of personal and general interests.23 These considerations may explain why classical utilitarianism lacks a developed theory of civil society.) Elie Halévy's study of the early utilitarians puts the accent in another place. Halévy describes how Bentham's drive to establish morals as an exact science led him to look with special favor on the motive of pecuniary interest, which seemed to lend itself to calculation.24 Bentham was, however, forced to admit that both pleasures and pains are heterogeneous, and his "science" of legislation developed as a system of classification rather than strict calculation.25

However imperfect his method judged by his aspirations, Bentham focused his attention on the detailed modifications to social institutions that he believed were required to bring about that artificial harmony of interests and, ultimately, the greatest happiness for the greatest number. Justice in the guise of secured expectations figures prominently in this project, and mediates between the greatest happiness principle and concrete judgments in particular cases. The utilitarian "theory of justice" is built around the concept of expectation. According to Rosenblum:

24Halévy, Philosophic Radicalism, 14-15. Bentham in any event believed it to be the strongest motive.
We know that in Bentham's theory of legislation fear and insecurity are reasons for government, and the object of utilitarian legislation can be refined from instituting "positive good" to securing expectations.... Expectation is the alternative to dumb habit and blind routine on one side, and to everything spontaneous and purely visionary on the other. Securing expectations is the alternative to both rigid custom and revolutionary fanaticism.... Bentham's radicalism consists in acknowledging expectations not previously afforded legal recognition.26

Mill was at pains to stress the importance of "secondary ends" and "secondary principles" that reflect social wisdom and shape social expectations, and are of much more immediate concern than the greatest happiness principle. According to Mill, the ultimate standard is invoked only when it becomes necessary to choose between two incompatible obligations. He believed that the malign effects of breaches of friendship and promise and other disappointments of expectation are obvious and compelling: "Few hurts which human beings can sustain are greater, and none wound more, than when that on which they habitually and with full assurance relied, fails them in the hour of need; and few wrongs are greater than this mere withholding of good; none excite more resentment, either in the person suffering, or in a sympathizing spectator."27

What are some of the implications of this account of justice? Rosenblum cites Bentham's treatment of public office as an example. Office was at one time defined by its association with the creed of noblesse oblige, virtuous self-sacrifice, and contempt for money. By the late 18th century, these associations were fading. Bentham observed that office was increasingly exploited as a business for private gain, a system which he described as a "solid peace...between pride and cupidity." According to Rosenblum, Bentham's response to this corruption was not "a reassertion of the ideology of

aristocratic honor," but rather "an emerging conception of public administration as a form of professional service and responsibility."28 In other words, while Bentham was hostile in the extreme toward professional privilege without accountability, he favored a professional ethic that emphasized service and responsibility. Bentham also considered the expectations of those nourished under the dying system and puzzled over how to ease the transition consistent with his "disappointment prevention principle."

The infamous "Panopticon" prison design can serve as an example of how Bentham proposed to make use of financial incentives to ensure performance of social duties. Much comment has been addressed to the architecture of the prison, intended to permit total surveillance. Less has been written about Bentham's proposal for administration of the prison by contract. According to Halévy, the idea was that an administrator-entrepreneur would take charge of the inmates with payment on a capitation basis (plus the right to receive the returns from any convict labor). Under this scheme, the administrator would not be inclined to coddle the inmates or waste money in running the prison. Indeed, the administrator might be inclined to neglect the health and safety of his charges. Bentham recognized this, and proposed certain measures to ensure that the administrator's duties toward the inmates were, in his words, "so bound up with his interest that he would be forced to do for his own advantage anything that he was not inclined to do for theirs."29 Halévy mentions the imposition of penalties for each death (a fixed dollar amount per life per year) and the offering of rewards for each life preserved, or for any reduction in expected mortality. In the current vocabulary, we would say that

29Bentham quoted by Halévy in Philosopich Radicalism at 84-85.
Bentham was a proponent of an "incentivizing" strategy. Mill continued this stress on the educational functions of social institutions, but he shifted the emphasis to character. He saw native sympathy, education of character, and external reward and punishment as mutually reinforcing, writing that the "smallest germs" of the social feeling "are laid hold of and nourished by the contagion of sympathy and the influences of education; and a complete web of corroborative association is woven round it, by the powerful agency of external sanctions."\(^{30}\)

Still, returning to the criticisms, even where utilitarian theory might allow for more comprehensive and nuanced valuations, the model of the "exact science" leads to repeated acts of reduction in practice. In cost-benefit analysis, what cannot be priced is not considered, or the assumption is made that everything has a price, which may be just as destructive. Harsanyi's generous impulse to construct a form of utilitarianism that will allow for diverse motivations or desires, including, prominently, altruistic ones, is no barrier at all to the exclusion of all "external" or other-directed preferences. Social bonds are sundered because the theory is understood to require monads.

We might say, too, that utilitarianism in its contemporary forms is inadequate as a social ethic because it focuses exclusively on outcomes and does not consider process. My utility "may not only depend on what I (or others) get but on the manner in which I get it,"\(^{31}\) in a number of ways. Christy deMeurers eventually got her bone marrow transplant, but the process she went through to obtain it was hardly a pleasant one. Given the scarcity of resources, it may be that there are good reasons for HMOs to refuse

\(^{30}\)Mill, "Utilitarianism," 305.

\(^{31}\)Frank Hahn, "On Some Difficulties of the Utilitarian Economist," in *Utilitarianism and Beyond*, 187-98 at 188.
to pay for certain treatments absent clinical research establishing effectiveness, but we may feel differently about such a policy depending upon whether we participate in shaping it or how it is implemented. It is surely true, as well, that policies shape preferences. If the great majority of insurers exclude bone marrow transplants for advanced breast cancer from coverage, we may be more likely to credit the evidence that the procedure is not beneficial to women with this level of disease. A bone marrow transplant may not even register as an option. A corrected preferentialism might try to neutralize certain effects of previously adopted policies, but that leads to the paradox of disregarding people's actual preferences in order to secure some ideal of autonomy as independence from social influence.

Finally, the utility of utilitarianism for an analysis of managed care is limited by the very high level of generality of the standard. The question, "does managed care, or some alternative, secure the greatest good for the greatest number," is simply unmanageable. Mill and Bentham seem to agree that even very good utilitarians will rarely start so broadly, and that expectations are of great importance. Mill in particular allows for a thick middle range of considerations that may lead us far from a straightforward application of the greatest happiness principle.

These criticisms are weighty, and may well prevent us from wholeheartedly embracing utilitarianism. At the same time, some insights gleaned from this cursory review of utilitarian thought are highly relevant to managed care. Five are particularly striking. First, we need to be attuned to consequences, and to the production of pain. From Bentham's sensitivity to pain we learn to give proper weight to the forms of pain and suffering that health care and other social institutions can create, and to resist
becoming so remote in our designing or administering that we cease to feel a sympathetic twinge. Certainly, we should never inflict pain or suffering on another without careful deliberation. We might also go beyond this predominantly negative response and use our concern and creativity to find ways to actively lessen pain and suffering. Even if some people must be denied some things that they very much want, there are better and worse ways of handling the situation. Even if limits on the resources available for health care necessitate rationing decisions, there are better and worse ways of making and implementing those decisions.

Second, deliberation may consist, in part, in the judicious use of techniques such as cost-benefit analysis. In such deliberations, we must consider distributional issues. We must remember the great importance of expectations, and strive for social institutions in which we nurture only the expectations we can satisfy, and satisfy all the expectations we create: "Few hurts which human beings can sustain are greater, and none wound more, than when that on which they habitually and with full assurance relied, fails them in the hour of need..."32 Third, it is time fully to acknowledge the power of incentives to motivate all sorts of people to engage in previously unappealing behavior, or to reinforce certain patterns of behavior. We need to understand incentives and use them as intelligently as we can, but with Mill, we also need to be alert to the perils of "incentivizing," of relying upon external sanctions alone. Fourth, we might extend Bentham's two-pronged approach to the professional ideal to health care. Bentham combined diligence in criticism of unwarranted professional privilege with diligence in the cultivation of a professional ethic of service and responsibility. Fifth and finally, we

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might strive to recapture some of the early utilitarians' reformist zeal. Philosophy and advocacy are not necessarily incompatible.

2. Social Contract Theory

The moral theory we label utilitarianism has a host of distinguished practitioners, and fresh interpretations of the founding figures add to the diversity of the field. Social contract theory has one great contemporary exponent, John Rawls, and his innovations are so significant that he may be said to have founded his own school. In any event, I do not perceive a need here to "go behind" Rawls to the earlier social contract thinkers who influence his work—Hobbes, Locke, Rousseau, and, especially, Kant. Sufficient complexity is introduced by the shifts in Rawls's own thought between *A Theory of Justice* and *Political Liberalism*. The first point to make is the rather obvious one that Rawls is offering a theory of *justice*. In presenting his version of social contract theory, Rawls disclaims any intention of offering a general or comprehensive theory of morality. Rawls notes that justice becomes the subject of debate when two conditions are met: resources are scarce, and there is no agreed upon view of the good life to guide laws and policies. According to Rawls, the primary subject of justice is the basic structure of society, that is, its principal economic and social arrangements.

Rawls begins with the basic idea, which he calls "intuitive," that "since everyone's well-being depends upon a scheme of cooperation without which no one could have a satisfactory life, the division of advantages should be such as to draw forth the willing cooperation of everyone taking part in it, including those less well situated."33 To this he adds the idea that people regard themselves and their fellows as "free and equal rational

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beings." Rawls's famous heuristic of the "original position" is intended to frame the discussion of justice so that we gratify our desire to realize our nature as free and equal rational beings through a scheme of cooperation. In the original position (hypothetical) the parties (imagined) are given the task of deciding "which principles when consciously followed and acted upon in everyday life will best manifest this freedom in their community, most fully reveal their independence from natural contingencies and social accident."\textsuperscript{34}

The device of the "veil of ignorance" contributes to the goal by denying the parties knowledge of their natural or social circumstances, although they are endowed with knowledge of "general facts" about human nature and society. Among the things the parties do not know is their conception of the good. This follows from Rawls's subordination of the good to the right. According to Rawls, "a conception of right is a set of principles, general in form and universal in application, that is to be publicly recognized as a final court of appeal for ordering the conflicting claims of moral persons."\textsuperscript{35} A conception of the good, on the other hand, must be essentially private, since the term is introduced as equivalent to each individual's "plan of life," meaning the ends and purposes each individual pursues.\textsuperscript{36} A condition of "mutual disinterest" ensures that while the parties are not aware of their specific differences, they know that they are different from one another and have interests they wish to pursue that may conflict with those of others. Among other things, they know that they may have conflicting conceptions of the good. The essential features of the original position are completed by

\textsuperscript{34}Rawls, \textit{Theory of Justice}, 255.
\textsuperscript{35}Rawls, \textit{Theory of Justice}, 135
\textsuperscript{36}Rawls, \textit{Theory of Justice}, 127. Also, "it is, in general, a good thing that individuals' conceptions of \textit{their} good should differ in significant ways, whereas this is not so for conceptions of right." Rawls,
the "thin theory of the good," which gives the parties something to deliberate about. The parties in the original position know that whatever interests they have, these will be advanced by certain rights and liberties and opportunities and powers, income and wealth, and the social bases of self-respect or self-esteem.

With these constraints in place, the parties in the original position are presented with a short list of alternative principles of justice for their consideration. The "deliberations" within the original position are governed by the terms of rational choice theory, meaning that the parties are motivated by self-interest. Rawls writes that within the original position the concept of rationality must be interpreted in the narrow means-ends sense of economic theory "to avoid introducing…any controversial ethical elements." With an eye to their own advantage, in light of their lack of knowledge of where their advantage might lie, the parties adopt a "maximin" strategy. Considering that they may occupy the very worst position when the veil of ignorance is lifted, they choose principles of justice that maximize the welfare of the least advantaged persons in the society (the minimum)—consistent with the preservation of liberties suitable to their nature as free and equal rational beings. The result is two basic principles of justice that constitute justice as fairness:

First Principle
Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all.

Second Principle
Social and economic inequalities are to be arranged so that they are both: (a) to the greatest benefit of the least advantaged, consistent with the just savings principle, and

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Theory of Justice, 447 (emphasis added).

(b) attached to offices and positions open to all under conditions of fair equality of opportunity.\textsuperscript{38}

Priority rules establish, one, that the first principle has priority over the second (and that liberty can only be restricted for the sake of liberty), and two, that the second principle, the "difference principle," has priority over principles of efficiency and total welfare maximization. The "just savings principle" referenced in the second principle ensures fairness across generations. The principles accepted in the original position are to be compared to our considered convictions. The dialectic between the two poles constitutes Rawls's method of "reflective equilibrium": "By going back and forth, sometimes altering the conditions of the contractual circumstances, at others withdrawing our judgments and conforming them to principle, I assume that eventually we shall find a description of the initial situation that both expresses reasonable conditions and yields principles that match our considered judgments duly pruned and adjusted."\textsuperscript{39}

Bentham begins his most famous work with a claim about moral psychology. Rawls takes up that subject in the concluding section of his book, as he considers the stability of justice as fairness as the basis for the social order. It is interesting to note some of the differences between the two treatments of moral psychology, but the more pressing reason for returning to the subject is our search for answers to the questions about human nature raised by managed care. One piece of the psychological puzzle is what Rawls calls the "Aristotelian Principle." All other things being equal, he says, "human beings enjoy the exercise of their realized capacities (their innate or trained

\textsuperscript{38}Rawls, \textit{Theory of Justice}, 302-3.
\textsuperscript{39}Rawls, \textit{Theory of Justice}, 20. It is not clear whether Rawls actually followed this method in evolving his principles of justice, whether he worked through a process in which the conditions in the original position were adjusted because the principles generated initially did not match his considered judgments,
abilities), and this enjoyment increases the more the capacity is realized, or the greater its complexity." 40 The Aristotelian Principle is meant to offer insight into the nature of a satisfactory life plan, but it is also a point to be considered in the design of social institutions. It is closely related to the primary good of self-respect, defined as a sense of one's own value based on confirmation of one's self and life plan by esteemed others, and a sense of self-efficacy.

Rawls identifies two main traditions of moral psychology, one running from Hume and most utilitarians to social learning theory, the other from Rousseau and Kant to Piaget. For the first, the goal of moral training is to supply missing motives through administration of rewards and punishments. For the second, the full complement of moral motives is already present, and the goal is simply to support their natural development. The second tradition also ties moral development much more closely to cognitive development—the apex for both lines of development is the grasp of (impersonal) principles. Rawls believes that it is best to try to combine the two perspectives in some "natural" way. He identifies three stages of moral development, each with its appropriate morality: the morality of authority, the morality of association, and the morality of principles. It seems that, for Rawls, the most natural combination is a progression in which any original deficiencies in motivation are quickly remedied so that the second tradition can occupy the field. In the highest stage, our moral sentiments come to display "an independence from the accidental circumstances of our world," a pure transcendence. 41 That said, Rawls's treatment of the dawning of affection and then
respect through encounters with a widening circle of others is very sensitive, and has won him the admiration of feminists such as Susan Moller Okin. At each level, the idea of reciprocity, of response in kind, is central.

Application to health care

Rawls’s theory has been appropriated by a number of philosophers more directly interested in health care. Norman Daniels is probably the best known. Daniels situates health care under the guarantee of fair equality of opportunity. (An alternative would be to treat health care as a primary good subject to the difference principle.) This placement gives Daniels’s treatment a functional orientation. Health care becomes identified with enabling persons to pursue careers on equal terms with their fellows, rather than with other possible goals, such as the relief of suffering. Daniels defines basic medical services as those services needed to maintain, restore, or compensate for the loss of normal species-typical functioning. These services—preventive services, personal medical and rehabilitative services, chronic medical services, and nursing and social services—are to be provided equally to all according to objectively defined need.

Fair equality of opportunity becomes a rationing principle, although its directives are far from precise. Cosmetic surgery and luxuries that simply make hospital patients more comfortable during their stay are among the few exclusions specified. In general, Daniels suggests that preventive measures and social support services will receive more support than they have in the past, while acute measures and medical services will receive less. Some caveats may, however, undermine the force of fair equality of opportunity.

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even as a weak rationing principle. For example, Daniels states that his account is not
exhaustive of distributive issues in health care. Contraception may not be a means to
restoration of normal species-typical functioning (pregnancy is normal), but there may be
other considerations that support public funding of this service.

**Criticism and reconstruction**

Recall that Charles Taylor criticized formalism as well as utilitarianism as
totalizing. We may protest the preeminence that Rawls claims for justice within social
morality, and for rules and rule-following within a conception of justice. Consider the
prominence of general rules in Rawls's definition of society in *A Theory of Justice.*
According to Rawls, a society "is a more or less self-sufficient association of persons who
in their relations to one another recognize certain rules of conduct as binding and who for
the most part act in accordance with them."\(^4\) In a similar vein, an institution is "a public
system of rules which defines offices and positions with their rights and duties, powers
and immunities, and the like."\(^5\) Rawls favors mathematical metaphors and machine
images. He writes that his argument "aims eventually to be strictly deductive" and that in
a theory of justice we "should strive for a kind of moral geometry."\(^6\) He describes
politics as a kind of computer that, it seems, aggregates preferences: "We may think of the
political process as a machine which makes social decisions when the views of
representatives and their constituents are fed into it."\(^7\) A theory with these assumptions
and aspirations will likely be hostile to suggestions that rules and rule-following only
make sense in a world already constituted by relationships. In the deMeurers case, we

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\(^6\)Rawls, *Theory of Justice,* 121.
\(^7\)Rawls, *Theory of Justice,* 196.
observe that when relationships become unsettled and distrust creeps in, rules become weapons rather than sources of moral order.

Yet Rawls is not wholly committed to the view of society and social institutions as systems of rules. While Kantian austerity and rational choice theory dominate the first part of *A Theory of Justice*, the liberal humanism of John Stuart Mill and Alexander von Humboldt is more in evidence in the third and final section of the book. In particular, Rawls is very much taken with the idea of a "social union of social unions." Rawls says that "we may say following Humboldt that it is through social union founded upon the needs and potentialities of its members that each person can participate in the total sum of the realized natural assets of the others."48 Unfortunately, this vision of society is never fully developed, and it does not seem very relevant to what goes on in the original position. This may be so because of Rawls’s concern to maintain a strict subordination of the good to the right. Jeffrey Stout has asked why we cannot be allowed a "self-limiting" conception of the good that leaves room for private bonds and the pursuit of individual life plans, while at the same time offering members of a society the opportunity to find a part of their identity through participation in public life and the pursuit of the good in common.49

In any event, in contractualism as in utilitarianism, theoretical openness to complexity, or a hint at a more nuanced view of the moral world, gives way before the drive for rigor and consistency. Rawls, like Bentham, can be charged with reductionism. Consider the assumption of mutual disinterestedness in the original position. This assumption means that the parties in the original position are conceived of as not taking

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an interest in one another's interests; they are not willing to have their interests, of
whatever nature, "sacrificed" to others. This condition is imposed so that the parties
will not simply collapse into one another, as with perfect altruists. According to Rawls,
the assumption of mutual disinterestedness is not intended to imply that the parties in
the original position, or the actual persons they represent, are egoists. But surely the
effect of the assumption is to suppress the question of how social feelings figure in a
conception of justice. The motivation behind the assumption, theoretical purity, is
similar to the motive behind Harsanyi's exclusion of external preferences from his
utilitarian calculus. (Rawls also assumes that the parties in the original position are free
of at least one anti-social feeling: envy.) To cite another example, Rawls includes the
social bases of self-respect among the primary social goods, but when it comes to
identifying the "least advantaged," the focus is exclusively on income, wealth and social
status. The social bases of self-respect simply vanish from the equation.

If we do not regard the simplifications of the original position as a virtue, we may
be led to ask why the original position is necessary at all. What does the original position
contribute to Rawls's theory? The use of principles of rational choice within the original
position may obscure the nature and depth of the moral commitments required to adopt
this view of justice—a very demanding form of respect, if not benevolence. People might
be persuaded that adopting the two principles of justice "in reality" is equivalent to
adopting a maximin strategy out of enlightened self-interest within the original position.

Or perhaps the original position gratifies a Platonic impulse to claim the philosopher's

49 Stout, Ethics After Babel, 235.
50 Rawls, Theory of Justice, 127, 129.
51 Rawls, Theory of Justice, 98.
ideal as the truly real. Robert Veatch, a follower of Rawls, writes of social contract theorists (and somewhat less plausibly, the ancient Israelites and modern day Protestants) that they "all concede that...the real moral order would be the one acknowledged by a hypothetical group of contractors who are capable of perfect knowledge and of perfectly taking the moral point of view."\(^{52}\) Or perhaps it is simply the charm of the device. Are we not fascinated by technology and numbers? The original position may appear to be an especially sophisticated machine or algorithm for making social decisions.\(^{53}\)

In \textit{Political Liberalism}, Rawls defends the original position against its critics. He writes that the idea of the original position was introduced "because there seems no better way to elaborate a political conception of justice for the basic structure from the fundamental idea of society as an ongoing and fair system of cooperation between citizens regarded as free and equal."\(^{54}\) So we accept the original position for want of something better. Rawls admits that abstractness may invite "misunderstanding." For example, one might suppose that there is some connection between the way persons are depicted in the original position and the way persons essentially are. No, says Rawls, "When, in this way, we simulate being in the original position, our reasoning no more commits us to a particular metaphysical doctrine about the nature of the self than our acting a part in a play, say of Macbeth or Lady Macbeth, commits us to thinking that we are really a king


\(^{53}\)Stout, for one, is unimpressed: "Rawls gave us a valuable trope for saying what liberal justice is all about but, with the help of his many followers, immediately pressed it too hard in hope of finding something sophisticated and technical for liberal moral philosophers to do. The resulting rigor was almost entirely misplaced." Stout, \textit{Ethics After Babel}, 228.

or a queen engaged in a desperate struggle for political power." Imagining what goes on in the original position is merely another form of role-playing. Yet this argument seems misleading. When I play Macbeth, I do not become convinced that I am a king, but I likely play the role more or less well depending on my understanding of the dynamics of power, and my knowledge of power and its corruptions will likely deepen as I more fully inhabit the role. Further, if there were no connection between role and reality and no insights into human nature to be gained, Macbeth would be a far inferior play, and I would be disinclined to take up the role. If this is true in the case of an entertainment, how much more is it true in the case of a political philosophy!

Rawls also argues that the "work of abstraction" allows for continuation of public discussion "when shared understandings of lesser generality have broken down." He states that "[w]e should be prepared to find that the deeper the conflict, the higher the level of abstraction to which we must ascend to get a clear and uncluttered view of its roots." He offers no further argument. Even if agreement is more likely at a higher level of abstraction, it may be merely verbal. If so, shared understandings are unlikely to hold once content is reintroduced. The metaphor also points up certain difficulties. Roots

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55 Rawls, Political Liberalism, 27.
56 Rawls, Political Liberalism, 46.
57 David Brink puts forward an argument for the limited value of agreement on abstractions that I do credit. First, he points out, as many others have, that without shared concepts, our differences would be mere differences, not disagreements. He next claims that agreement on abstract concepts or values may be more important psychologically than our concrete disagreements. By this he means that if one is the recipient of information that must unsettle the abstract agreement or the concrete disagreement, one will more readily give up the concrete disagreement. Here is Brink's illustration, with some minor modifications: A and B agree that cruel and unusual punishment should be prohibited. A and B disagree about the death penalty; A favors the death penalty and B opposes it. B presents A with evidence that the death penalty is not being administered humanely or fairly—executions are routinely bungled and only persons in certain racial categories are actually executed. Does A (a) come to oppose the death penalty, as currently administered, as cruel and unusual punishment, or (b) continue to favor the death penalty and give up her opposition to cruel and unusual punishment? The first alternative seems more likely; the shared commitment to the abstract value means that the continuing conversation between A and B may have real consequences for their more concrete judgments. (Note that A and B do not reach agreement by ascending; rather, their
are commonly buried underground. If we want to see them, we may have to dig rather than "ascend." In a later section of the book, Rawls argues that we must require the parties to reason as if they know very little about themselves because "to proceed otherwise" is to allow "diverse and deep contingent effects to influence the principles that are to regulate their social relations" as free and rational persons.\(^8\) Again, there seem to be flaws in this reasoning. If a person (John Rawls, for example) can eliminate these diverse and deep contingent effects when he simulates being in the original position, without truly eliminating knowledge, why can't the parties within the original position do the same? The absurdity of the question suggests the absurdity of the idea that through a "device" we can gain some control over ourselves which cannot be obtained simply by thinking seriously about what we value in and for ourselves and others, and why.

The idea of the original position is not without value, but I believe it can make its modest contribution only if it is reconceived. I would argue that the original position is not a way of arriving at the single best method of organizing a society or single best set of principles of justice, nor is it a path to agreement on social organization or justice, based on considerations introduced by Rawls himself in Political Liberalism. There Rawls takes up the subject of the "burdens" of judgment, that is, barriers to agreement. He says he is cataloguing only the most obvious sources of reasonable disagreement, but the list is quite impressive. First, the scientific or empirical evidence bearing on a case may be conflicting and complex, and hence difficult to evaluate. Second, even where we agree about the kinds of considerations that count, we may disagree about their relative weight.
Third, concepts are by their nature more or less vague and "subject to hard cases," and this indeterminacy means that we must rely on judgments and interpretations—and judgments about interpretations—within some range that cannot be sharply specified in advance. Fourth, "the way we assess evidence and weigh moral and political values is shaped by our total experience, our whole course of life up to now; and our total experience must always differ." Fifth, there may be normative considerations on both sides of an issue, making an overall assessment difficult. Sixth, "any system of social institutions is limited in the values it can admit so that some selection must be made from the full range of moral and political values that might be realized."59 Prejudice and bias, self- and group interest, blindness and willfulness are additional sources of disagreement, although they are unreasonable and therefore have a different status.

Rawls uses this list to argue for the importance of tolerance, but it also seems to undermine any expectation of agreement on the two principles of justice, or their interpretation and implementation. Taking this into consideration, we may wish to recast the "design device" of the original position as a "filter device." According to Robert Nozick, a design device is used to construct a single object. For a society, "the result of the design process is a description of one society, obtained by people (or a person) sitting down and thinking about what the best society is." Nozick offers his opinion that given the enormous complexity of human beings and human relationships, it is unlikely that, even were there one ideal pattern for society, it could be found in this fashion. Nozick has a more favorable view of filter devices: "Filter devices involve a process which

58Rawls, Political Liberalism, 272.
59Rawls, Political Liberalism, 56-57.
eliminates (filters out) many from a large set of alternatives.\textsuperscript{60} What would \textit{A Theory of Justice} look like with the original position functioning as a filter device?

Seyla Benhabib has created a "conversational" model of social life that combines the work of Rawls (and Jürgen Habermas) with feminist theory. A review of the Lawrence Kohlberg-Carol Gilligan debate in moral psychology leads Benhabib to conclude that we need both universalistic and particularistic discourses. According to Benhabib, Rawls's theory assumes that the socially privileged can reach agreement for society through a purely hypothetical, purely analytical venture of thought. Such a procedure reproduces, rather than brings into question, "the ideal of autonomy conceived in the image of a disembedded and disembodied male ego."\textsuperscript{61} It is a symptom of the problem that the privileged will likely fail to understand the basis for any objection to this procedure.

If we grant that there may be grounds for objection, we may begin to recast the theory. Benhabib begins with two "strong" assumptions, straightforwardly acknowledged as such. These are the principle of universal moral respect, and the principle of egalitarian reciprocity.\textsuperscript{62} Universal moral respect means that all beings capable of speech and action have a right to participate in the moral conversation, and egalitarian reciprocity means that each has the same right to speak, to introduce a new topic, and so on. There are at least three major changes from Rawls's way of modeling

deliberation in the original position. First, justice is no longer the exclusive subject matter. Second, the ideal role-taking is not a hypothetical thought process, but rather an actual conversation is which actual moral agents deliberate with one another. Third, the veil of ignorance is unnecessary, "for the more knowledge is available to moral agents about each other, their history, the particulars of their society, its structure and future, the more rational will be the outcome of their deliberations." The object of the deliberations is not to reach agreement or consensus, but to sustain the conversation. Still, the process may make agreement more likely. Recall that Rawls identified divergent experiences as a barrier to shared judgments. In Benhabib's model, the deliberative situation is itself a shared experience that may bring the participants closer to mutual understanding, if not agreement. As a related matter, reaching agreement is not equated with enacting legislation. The legal is a limited space within the broader social conversation.

With this recasting of the original position, the fear may be that matters are too loose. Benhabib introduces a helpful distinction between "ethical cognitivism" and "ethical rationality." Ethical cognitivism is "the view that ethical judgments and principles have a cognitively articulable kernel, that they are neither mere statements of preference nor mere statements of taste but that they imply validity claims." Ethical rationalism is "a theoretical position...which neglects that the moral self is not a moral geometer but an embodied, finite, suffering, and emotive being." Ethical cognitivists state reasons and care about truth, truthfulness and rightness, but for them these are not the whole of morality, nor can they be considered apart from specific contexts. Ethical rationalists cannot or will not take account of the variety and richness and significance of

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63 Benhabib, "Generalized and Concrete Other," 169.
emotional and moral development, and this leads to a distorted vision of human relationships and their moral texture. In particular, Benhabib argues that under the influence of such theories we lose touch with our ordinary moral experience: "[T]he less we view such discourses along the model of public fora or courts of appeal, and the more we understand them as the continuation of ordinary moral conversations in which we seek to come to terms with and appreciate the other's point of view, the less do we submit to the distorting lens of procedural universalism."65

It is always possible that the interpretive abilities and skills that allow us to appreciate the other's point of view, and to view ourselves from the perspective of the other, may be abused. If we understand others well, we are equipped to manipulate them as well as to engage them in sensitive moral conversations. It is for this reason that we need to retain principles of universal moral respect and egalitarian reciprocity. These principles filter out certain forms of social organization and social relationship, such as the purely manipulative. Benhabib has yet to develop a positive model of functioning institutions. What the conversational model provides is an assumption "that institutions can function as channels of illegitimate exclusion and silencing" and a presumption "in favor of the radical democratization of such processes."66 The concern is not only who gets what, but who gets heard. Such an approach corrects for a problem that Rawls's theory shares with utilitarian theory—the neglect of process.

The principles of justice, however interpreted, underdetermine the result in particular cases. This is less a criticism than a call for an acknowledgment of limits. And,

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64 Benhabib, "Afterword," 355-56.
65 Benhabib, "Afterword," 358.
indeed, the Rawls of *Political Liberalism* is freer in acknowledging limits. Collective provision of certain basic services is a constitutional essential, but levels of social support will vary across societies. The political conception of justice must be supplemented in order to address the many economic and social issues that legislative bodies must regularly consider. Rawls also allows space for civil society, for forms of social life that are not under the direct purview of the state. The political conception is defined by the kinds of values it speaks to (rights, liberties, and procedures) and by the kinds of limits it incorporates. Other values may apply to the personal, the familial, and the associational. This leads us back to the question of the basic structure, the “principal economic and social arrangements” that are the subject of justice. If these terms are not interpreted with care, the distinction between a political conception and a more comprehensive conception will collapse—political values will serve as the test of “other values,” and families and associations will be treated in the same manner as state agencies. Especially if we accept the more sociological understanding of institutions in *Political Liberalism*, this prospect should lead us to consider the kind of people we want to become. There Rawls states that “the institutions of the basic structure have deep and long-term social effects and in fundamental ways shape citizens’ character and aims, the kinds of persons they are and aspire to be.” Respect and reciprocity may be valuable ideals in any sphere of human life, but is this true of the matrix of bureaucratic rights, liberties, and procedures? These seem like more qualified social goods, and beyond some

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68What Rawls calls a “freestanding” political conception simply picks up fundamental ideas implicit in the public political culture, without inquiring into their origins. (Note that whatever the benefits of this approach, it precludes ideology critique.) A comprehensive as opposed to political conception includes ideals about “what is of value in human life, and ideals of personal character, as well as ideals of friendship and of familial and associational relationships,” and so on. Rawls, *Political Liberalism*, 10, 13.
point, as Michael Sandel and others have argued, they are surely social evils.

What, then, can Rawlsian social contract theory contribute to an ethic for managed care? First, we can see the value of using certain moral principles or moral commitments, such as respect for persons and concern for the most vulnerable, or universal moral respect and egalitarian reciprocity, as "filters." Health care and other social institutions that do not reflect these principles and commitments are not morally acceptable. At the same time, many different ways of organizing health care at many levels may be consistent with these criteria. The search for the single best way may be a red herring. We may become caught up in our own abstractions, and relegate essential questions to a morally suspect category of "strategy." What does respect look like in health care administration and practice? How are health care professionals to balance the claims of their own patients against the claims of others? How might concern for the most vulnerable figure in an assessment of managed care? Second, the dialectical notion of reflective equilibrium can help us to understand the process through which we develop and test our ideas, but it must be broadened to allow for the development and testing of one's skills of interpretation. Cost-benefit analysis and guideline development are ventures in understanding as well as tasks requiring mastery of a certain body of technical knowledge. Third and finally, Rawls increases our awareness of the limits of politics. The good that we seek through the political process will be a limited good, because our idea of the common good includes peaceable cooperation among those who hold different and even conflicting views on the nature of the good life. This will be truer still of the good we secure through punitive legislation. The rich territory of voluntary association

69 Rawls, Political Liberalism, 67-68.
remains open to fuller exploration.

3. Communitarianism

Many feel that something is missing from the utilitarian and social contract theories. In contrast to such "liberal" theories, some theorists have made the good life and our pursuit of it in common a central preoccupation. In other words, communitarians focus their attention on the very areas that utilitarians and Rawlsians typically regard as beyond or beneath their concern. Communitarians speak languages of qualitative contrast rather than universalistic languages of utility or rights. They attempt to think "holistically" rather than "atomistically" about the nature of society. For many communitarians, society is more like an organism than a mechanism, a kind of intersubjective existence rather than a system of rules. As the label "communitarian" suggests, society is viewed as a collection of more intimate communities, rather than as an aggregation of individuals. And, in some communitarian accounts, the individual is clearly the secondary phenomenon. The qualifier "some" is important, because the group of thinkers subsumed within the category of communitarianism is extremely broad and eclectic. Neo-Aristotelians such as Alasdair MacIntyre rub shoulders with civic republicans such as Michael Sandel and social democrats such as Michael Walzer.

Even if one is not interested in simply inverting the priorities of liberal moral theories, one may feel the need for a greater appreciation of the "texture" of social life. Virginia Held, speaking from a specifically feminist perspective, writes that "[e]ven if we hesitate to compare shared, collective progress with individual self-development, or reject a comparison ascribing greater value to either, we should at least be able to ask of a social theory that it ascribe appropriate values to social relationships between persons in ways
distinct from its valuation of gain and losses to individuals in isolation from one another." As Alasdair MacIntyre is one of the most prominent moral philosophers gifted or cursed with the communitarian label and a pioneering thinker in this area—despite or because of his deep concern with tradition. For our purposes, MacIntyre's moral theory may be understood as having two aspects. First, there is MacIntyre's criticism and rejection of liberal moral theories. Second, there is MacIntyre's constructive project, what MacIntyre calls his "partial account of a core conception of the virtues."

The criticism is expressed through a story of decline and fall. That story, presented first through a hypothetical scenario and then through a whirlwind tour of the history of moral philosophy, is intended to support MacIntyre's "catastrophe hypothesis." As Jeffrey Stout, a critic of some of MacIntyre's views and champion of others, states the hypothesis: "Where once there was coherent discourse on the virtues and the common good, we now have the assertion of arbitrary wills, masked by moral fictions, managed by bureaucrats." In the well-known opening lines from the second chapter of *After Virtue*, MacIntyre asserts: "The most striking feature of contemporary moral utterance is that so much of it is used to express disagreements; and the most striking feature of the debates in which these disagreements are expressed is their interminable character.... There seems to be no rational way of securing moral agreement in our culture." In the case of justice, for example, the debate between welfare liberals and libertarians scarcely advances. Welfare liberals adopt a principle of equality with respect to needs; libertarians adopt a principle of equality with respect to entitlement.

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According to MacIntyre, the two forms of discourse are incompatible and incommensurable. The philosophical champions of the opposed views are agreed only on the irrelevance of *desert*. Desert is a judgment of worthiness, and hence entitlement to reward, based on contribution to the common tasks of a community in pursuing shared goods.

MacIntyre believes that desert is a concept that makes sense only within a moral framework with a threefold structure. There is "untutored human-nature-as-it-happens-to-be, human-nature-as-it-could-be-if-it-realized-its-telos and the precepts of rational ethics as the means for the transition from one to the other." MacIntyre attributes the loss of this structure and the coherence it brings to a number of historical developments. When the middle term, an agreed upon *telos*, disappears during the Enlightenment, the relationship between the two remaining elements, human nature and ethical standards, becomes unclear. According to MacIntyre, that lack of clarity leads to the muddle of contemporary moral theory and practice. It also fashions the emblematic social types of modernity, the aesthete, the therapist, and the manager.

MacIntyre links all three to the moral theory of "emotivism." The central idea of emotivism is that our views on moral issues are simply expressions of our subjective preferences. So-called rational justification is merely ex post facto window-dressing. Hence, emotivism represents the obliteration of the distinction between manipulative and nonmanipulative social relations. Once upon a time, we understood what it meant to treat someone as an end rather than a means: "To treat someone else as an end is to offer them what I take to be good reasons for acting in one way rather than another, but to leave it to
them to evaluate those reasons.... By contrast, to treat someone else as a means is to seek
to make him or her an instrument of my purposes by adducing whatever influences or
considerations will in fact be effective on this or that occasion." 74 Now we think that if
we manage (or incentivize) properly we can eliminate the need for trust and for moral
suasion. Managerial effectiveness is part of a masquerade of social control. For, as it
turns out, we are oppressed by impotence rather than true mastery of the circumstances
of human existence. Too much escapes our grasp. The impossible demand for ever
greater mastery gives rise to simulation and dissimulation, creating space for arbitrariness
and the operation of fear and greed. It is a grim picture.

Faced with this moral disorder, which goes by the name of "pluralism," the best
we can do is retreat into enclaves of resistance to modernity. "What matters at this stage
is the construction of local forms of community within which civility and the intellectual
and moral life can be sustained through the new dark ages which are already upon us." 75
What, then, does MacIntyre offer as a constructive alternative? What will go on in such
communities? MacIntyre argues for a retrieval of the earlier framework, but he does much
more than offer a gloss on Aristotle or Aquinas. MacIntyre's "partial account of a core
conception of the virtues" is a sociologically sophisticated approach to understanding
morality. The account consists in a number of interlocking concepts: practice, internal
and external goods, virtue, institution, tradition, and narrative rationality. The concept of
practice is near the core of the core conception. MacIntyre defines a practice as "any
coherent and complex form of socially established cooperative human activity through

73MacIntyre, After Virtue, 53.
74MacIntyre, After Virtue, 23-24.
75MacIntyre, After Virtue, 263.
which goods internal to that form of activity are realized in the course of trying to achieve
those standards of excellence which are appropriate to, and partially definitive of, that
form of activity, with the result that human powers to achieve excellence, and human
conceptions of the ends and goods involved, are systematically extended."76 A practice
realizes certain goods, but the achievement of goods is not the sole principle or purpose
of a practice. A practice "involves standards of excellence and obedience to rules as well
as the achievement of goods."77

MacIntyre's concept of virtue assumes a social world structured by practices. A
virtue, on his account, is an "acquired" quality the possession and exercise of which
enables us to achieve goods internal to practices.78 Although virtues may vary with the
practice, any practice will require the virtues of justice, courage and honesty. One must
be able to recognize what is due to whom, take self-endangering risks, and receive and
respond to criticism with careful attention to the facts of the matter. Without all three of
these virtues in some form, moral relationships cannot be formed and internal goods
cannot be realized. Note that a collective activity oriented only to the achievement of
external goods is not a practice. External goods are things such as money, fame or social
status, and certain forms of power, that bear no necessary connection to any particular
practice. Such goods typically have a "zero sum" structure and create definite winners
and losers. For all that, external goods are genuine goods: "Not only are they
characteristic objects of human desire, whose allocation is what gives point to the virtues
of justice and generosity, but no one can despise them altogether without a certain

76MacIntyre, After Virtue, 187.
77MacIntyre, After Virtue, 190.
78MacIntyre, After Virtue, 191.
hypocrisy." Yet the achievement of external goods will often be in competition with internal goods—"notoriously the cultivation of truthfulness, justice and courage will often, the world being what it contingently is, bar us from being rich or famous or powerful."\textsuperscript{79}

The competing allegiances that individuals may experience in relation to internal and external goods is reproduced at another level in social institutions. MacIntyre says of institutions that they are "characteristically and necessarily" concerned with external goods. Institutions "are involved in acquiring money and other material goods; they are structured in terms of power and status, and they distribute money, power and status as rewards." This is not a perversion, a fall from some purer state of institutional being, but rather part of what it means to say that external goods are genuine goods. Institutions cannot be otherwise than concerned with external goods "if they are to sustain not only themselves, but also the practices of which they are the bearers."\textsuperscript{80} Of course, practices must also "sustain" or give meaning and moral weight to institutions. Virtues of justice, courage, and truthfulness anchor resistance to the corrupting power of institutions, that is, they anchor resistance to the corrupting power of external goods within institutions, and the power of corrupt institutions within the social order.

Yet if institutions do have corrupting power, the making and sustaining of forms of human community—and therefore of institutions—itself has all the characteristics of a practice, and moreover of a practice which stands in a peculiarly close relationship to the exercise of the virtues in two important ways. The exercise of the virtues is itself apt to require a highly determinate attitude to social and political issues; and it is always within

\textsuperscript{79}MacIntyre, \textit{After Virtue}, 196
\textsuperscript{80}MacIntyre, \textit{After Virtue}, 194.
some particular community with its own specific institutional forms that we learn or fail to learn to exercise the virtues.\textsuperscript{81}

An adequate "moral sociology," then, will take account of the operation of virtues and vices in determinate social and institutional contexts. An adequate moral theory will note that virtues (and vices) are fostered by certain types of social institutions and endangered by others, and will put the classification of social institutions on its agenda.

Whether we are concerned with persons, practices, institutions, or societies, MacIntyre argues that a meaningful moral account will incorporate elements of narrative. MacIntyre asserts that there is "no such thing as 'behavior,' to be identified prior to and independently of intentions, beliefs and settings," and a causal and temporal order.\textsuperscript{82}

According to MacIntyre, a coherent narrative is only possible if there is a telos, a more or less definite end which exerts a unifying force. He connects a concern with unity and wholeness to the highly important virtue of integrity or constancy. But how determinate must this telos be? How much complexity and heterogeneity does it allow? When MacIntyre compares the unity of a human life to the unity of a quest, and provisionally concludes that "the good life for man is the life spent in seeking for the good life for man," he implies an open-ended and revisable end-in-view.\textsuperscript{83} It is highly suggestive that when MacIntyre comes at last to the most encompassing concept, tradition, he chooses to define it in terms of argument. He writes that a living tradition is "an historically extended, socially embodied argument, and an argument precisely in part about the goods which constitute that tradition."\textsuperscript{84} On one reading, then, MacIntyre is very close to a

\textsuperscript{81}MacIntyre, \textit{After Virtue}, 194-95.
\textsuperscript{82}MacIntyre, \textit{After Virtue}, 208.
\textsuperscript{83}MacIntyre, \textit{After Virtue}, 219.
\textsuperscript{84}MacIntyre, \textit{After Virtue}, 222.
conversational model. A tradition requires difference and disagreement to save it from stagnation and death.

**Application to health care**

In addition to issuing broad calls for construction of local forms of community that recover the tradition of the virtues, MacIntyre has written occasional pieces on ethics in various spheres of life and practice. Among the latter are pieces on medicine and business. In each case, MacIntyre asks what can be done in the field, given the imperfections of the present. He approaches medical ethics in characteristic style, with a decline and fall narrative. The medical profession historically spoke with recognized authority on all matters concerning or affecting medical practice. With the loss of moral consensus in the larger society, the "practice" of medicine has lost its coherence.

According to MacIntyre, we cannot reach social consensus on controversial issues because we have lost a shared frame of reference. At the very least, we have lost a shared commitment to the ideal of social consensus and stable authority. Echoing the language of *After Virtue*, he writes that "what makes the problems of medical ethics *unresolvable* in our culture is the lack of any shared background of beliefs which could provide a context for moral reasoning by providing a view of human nature and society."\(^85\)

In the absence of social consensus, power of decision would seem to fall to the individual physician or health care provider. However, the disappearance of a shared moral framework has also affected the nature of relationships within health care. For MacIntyre, authority has vanished. Where the physician-patient relationship once rested on the trust that patients reposed in physicians, and the greatest wrong was abuse of that

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\(^{85}\) Alasdair MacIntyre, "Patients as Agents," in *Philosophical Medical Ethics*, ed. S.F. Spicker and H.T.
trust, bureaucratic medicine aspires to offer rules so little subject to interpretation that uniformity of expectations and predictive reliability will be achieved. Trust is placed in the rules, not persons. Further, if the rules are to do their work there must be sanctions for violations. Rules and sanctions are matters of contract, and in theory they operate according to the will of parties. Error, rather than abuse of trust, becomes the basis for sanctions (and forgiveness is not a concept that makes much sense within the moral economy of bureaucracy). The consequence of this shift is, by default, an increase in each patient's responsibility for his or her care, including those aspects of care which may be morally problematic. What Veatch describes as a sort of patient and social awakening to the tyranny of the profession is rather our flailing about in a vacuum. Autonomy is a last resort rather than a central moral good. The best that can be hoped for is the establishment of some enclaves of virtuous practice.

MacIntyre does not specifically address issues of justice in the context of health care. As noted above, in his general treatment of the subject he wishes to reestablish the principle of desert. It is not clear that MacIntyre would regard desert as the appropriate distributional principle for medical services. In other words, I doubt he would applaud one managed care organization's strategy of promising plan members "ALL THE HEALTHCARE YOU DESERVE." Desert makes more sense in the context of the distribution of professional rewards; the principle suggests that physicians and other providers of health care should be rewarded for excellent performance, recognized as such by their peers.

In his piece on business ethics, MacIntyre again takes up the theme of pluralism. He writes that pluralism is not simply a term for the "inherited confusion" chronicled in *After Virtue*, a matter of conflict among groups. Individuals in our culture are *internally* divided. He also identifies the persistence of scarcity as a reason why we may expect that conflict and disagreement will continue to be at the center of our social and moral lives. Even if certain moral claims or values are universally recognized, where these conflict there will be disagreement over their relative weight. These considerations could support a more positive, distinctively communitarian account of pluralism. Might not people of diverse experience come together to work out their common problems, and, in the process, create communities that sustain them against the darkness of modernity and the darkness of existence? Both MacIntyre and Rawls consider failure to reach agreement on a social *telos* or set of basic principles a moral disaster. At the same time, each recognizes that such agreement is unlikely to be achieved even among reasonable people committed to the good and the right. Perhaps the kind of agreement demanded is not the only basis for social union. Rather than provide a communitarian account of pluralism, MacIntyre returns to the theme of how best to weather the current dark ages. He comments that, after all, "to inhabit such a radically imperfect form of social life is itself a moral task which can be performed well or badly."\(^86\)

How is one to assess whether the moral task is being performed well or badly? MacIntyre writes that we must direct our attention to the level of social and cultural structure, rather than individual moral agency. He suggests that three problems of contemporary corporate life must be addressed if the limited but real moral possibilities

\(^86\) Alasdair MacIntyre, "Why Are the Problems of Business Ethics Insoluble?" in *Moral Responsibility and...*
of the present are to be realized. The first problem has to do with the time scale of
organizations, that is, the frequently lamented "short-term" orientation of U.S. business.
The limits of our powers of prediction, and our reliance on predictions in planning, tend
to narrow our focus. Our focus is also narrowed by our habit of living in perpetual crisis.
Second, MacIntyre focuses on the way organizations may fragment the self, partitioning
the person into a series of roles. Third and finally, there is the problem of opacity.
MacIntyre writes that when those who interact within or through organizations lose a
sense of the whole, "a great deal that individuals do and effect in corporations becomes
invisible to them and to others." Each problem is structural, and its intensity will vary
across forms of organization. An adequate response must draw on a variety of resources.
Precisely because "fixes" for all three problems require changes in organizational and
broader cultural forms, MacIntyre believes that legislation at the federal or state levels or
action by business or professional associations is unlikely to have much of an effect.
Purely formal measures, such as the adoption of codes of ethics, will also fail to
contribute significantly to the solution, although adoption of a code "may be admirable
and useful for other reasons." 87 In conclusion, MacIntyre calls for more sociological
research into the connections between forms of organization and moral perspectives.

Criticism and reconstruction

MacIntyre's work is open to a number of criticisms. Richard Bernstein takes
issue with MacIntyre from a philosophical perspective. Bernstein points out a number
of weaknesses in MacIntyre's argument that we need not take up here. For our purposes,

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the Professions, ed. Bernard Baumrin and Benjamin Freedman (New York: Haven Publications, 1982),
350-59 at 356.
87MacIntyre, "Business Ethics," 358.
it is relevant that Bernstein charges MacIntyre with engaging in a totalizing critique. MacIntyre's attack on the Enlightenment is too complete—MacIntyre fails to do justice to the moral motivation behind the broader social movement and to specific thinkers, and he ignores his own debt to the Enlightenment. For example, if slavery and the subordination of women could not be excised from the tradition of the virtues, MacIntyre would not present that tradition as a guide for the present. Historians and philosophers may also quarrel with MacIntyre's portrayal of the past. To take a simple example from heath care, the period during which the medical profession enjoyed virtually unchallenged authority was very limited. MacIntyre protects himself by arguing that he is really describing a shared social ideal rather than a reality, but consensus even on the ideal may have been less secure than MacIntyre would like to admit. The issue cannot be settled here, but we should always be wary of accounts that posit some prior golden age.

MacIntyre's use of equivocal or vague terms such as "pluralism" does not help matters. No doubt contemporary Western culture is more "pluralistic" than the Christendom of the Middle Ages. No doubt a general practice of excluding women, the nonpropertied masses, and others from public fora tended to lessen disagreement. At the same time, disagreement has always been much in evidence, and if in the past such disagreements by and large reached a terminus, it is not clear that this was accomplished by rational argument within a unified moral discourse such as MacIntyre seems to require. If the difference is the surrender of even an aspiration to unity, this movement may be an appropriate response to changed historical conditions and the development of practices.

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89See, e.g., Starr, Social Transformation, 2.
MacIntyre sometimes equates pluralism with moral arbitrariness and unintelligibility. He does not seem to allow that pluralism might make sense within a certain narrative. Further, disagreement does not necessarily result from a lack of rationality in moral discourse, or an absence of any shared beliefs that might allow for fruitful, if sometimes acrimonious moral conversations.

If we refuse the all or nothing propositions with which we are faced, we can begin to appreciate how pluralism, suitably qualified, might make sense. Liberal institutions make do in the absence of perfect agreement on "man-as-he-would-be-if-he-realized-his-telos," and, in a sense, they exclude such agreement. But Stout believes MacIntyre cannot rule out the possibility that our society is held together by a limited but still significant agreement on the good. "Where MacIntyre sees the social embodiment of emotivism," he says, "I see implicit commitment to a provisional, self-limiting conception of the good." 90 Stout also offers an alternative account of the fragmented character of contemporary moral discourse. Stout notes that MacIntyre tends to treat the various fragments of contemporary moral language as static systems that can only make sense when restored to their original settings. He "seems not to consider the possibility that the coherent moral languages of earlier generations were themselves products of eclectic bricolage, on the one hand, and conceptual adaptation to new circumstances, on the other." 91 Like Molière’s prose-speaking bourgeois gentilhomme, we may find that we have been pragmatists all along, merely awaiting the label. Indeed, Stout shows how MacIntyre’s own work might be reconstructed along pragmatist lines.

90 Stout, Ethics After Babel, 237-38.
91 Stout, Ethics After Babel, 218. Indeed, Aristotle was arguably one of the most brilliant of our bricoleurs. In the Politics, he allows that something is due to freedom (need), wealth (entitlement), and virtue (desert). Such a balance secures social and political stability, which is in the interests of all.
Stout believes that MacIntyre's concepts can be used to construct a kind of social
criticism that integrates the various levels of social life, what Stout calls "stereoscopic"
social criticism. Stout contrasts stereoscopic social criticism with what he takes to be the
standard approaches, reductionist sociology and a species of cultural anthropology. He
writes:

We know how to describe a clinic or an academic profession in the idiom
of reductionist sociology, but somehow we make everything look like a
system of external goods in which people are moved only by the desire for
status, money, and power. The standard way to compensate for this
deficiency is to concentrate attention narrowly on the pursuit of internal
goods, trying to get descriptions that are "thicker," "warmer," or "less
dry" than the other approach can provide. This is done by showing
"empathy" for participants in the practice, aiming to "understand" their
mentalité or their "social world" rather than trying to "explain" what they
are doing as a "function" or "reflection" of institutional structure.

Reductionist sociology bites too hard, while thick description lacks teeth. The choice of
method is not, however, entirely arbitrary. Each approach has affinities with certain areas
of human endeavor. A reductionist sociology fits best with the marketplace and the
bureaucracy—areas "where people are for the most part pursuing external goods or
merely procedural justice and are not surprised to be told so." We should not be shocked
that there is gambling in the casino. At the same time, all institutions pursue external
goods and employ certain procedures which aim at fairness. Further, most institutions of
any durability, for-profit firms and government agencies included, involve internal goods
and relationships that are not strictly rule-defined. If we have had experience of such
institutions, we may be dissatisfied with sociological accounts in which these aspects of
institutional life are too readily dismissed.\textsuperscript{92}

The second approach may commend itself as a way of remedying these deficiencies, but it also screens certain things from view. The mirror image of reductionist sociology, it simplifies matters by ignoring external goods and other sources of conflict. "It takes a more generous view of human motivation and thus grants to others the kind of charity we normally show to ourselves. It allows us to stave off a merely cynical view of people and thus to affirm our own interpretive practices. Too often, however, it seems simply to be wishing away the realities of power and the power of self-deception."\textsuperscript{93} The two approaches are in some sense complementary, but merely setting the results side-by-side is not sufficient. An overly simplistic cynicism plus an overly simplistic romanticism does not a thorough, balanced appraisal of social life make.

Stout believes that concepts such as practice and institution, and internal and external goods, are necessary to make sense of the whole, concerned, as they are, with the relatedness of things. These concepts also structure the interests and research agenda of the stereoscopic social critic. "A stereoscopic social critic would be inclined to concentrate on factors like these: the tendency of the capitalist marketplace and large-scale bureaucracies to provide the material conditions that permit social practices to flourish, while at the same time they undermine the moral conditions needed to achieve goods internal to such practices; the tendency of professionalization and bureaucratic enforcement of rights, in some instances, to mitigate the bad effects of the marketplace on specific social practices and the people participating in them; the tendency of particular social practices, especially within the professions, to become all-consuming, thus making

\textsuperscript{92}Stout, \textit{Ethics After Babel}, 279.
it increasingly difficult to be both a full-fledged participant in the practice and a good anything else."94

It is interesting that MacIntyre does not make use of his own conceptual framework in his pieces on medicine and business. Stout, on the other hand, uses health care as a preliminary test of the usefulness of MacIntyre's conceptual scheme. Stout suggests that the increasing importance of external goods in medicine is threatening to make physicians lose sight of its internal goods. He writes that "medical care in our society tends increasingly to be dominated by the modes of interaction and patterns of thought characteristic of the market and the bureaucracies, where goods external to medical care reign." Yet, consistent with MacIntyre's analysis, Stout says the solution is not to rid the practice of the institutions with which it has become entangled: "Without the marketplace and the bureaucracies, the practice would undoubtedly suffer terribly." The task is to prevent medicine from being "overwhelmed" by goods and roles divorced from its telos.95

What of the telos of medicine? MacIntyre suggests that unless we agree on a robust conception of the good, we cannot specify the telos of a social practice such as medicine or health care. Stout counters that we do have widespread agreement on a limited conception of the good and that we "mostly" agree on the ends of medical practice:

We want our doctors and nurses to care for us when we are sick, to ease our suffering and cure us when they can, to inform us about how to prevent illness, to learn whatever they need to learn to do all of these

things, and to receive just monetary compensation and prestige (no more, no less) in return. We are prepared, if at times reluctantly, to submit to their authority, to put our lives in their hands, even when they are strangers to us. Despite our concerns about their fallibility, the corruptions of prestige and wealth, and the facelessness of modern medical bureaucracies, we still pay tribute to the virtues and worth of medical practitioners. Few of them are saints, but most are more than technicians.96

Stout also touches on distributional issues, although he does not make justice the highest concern in social life. He draws on the work of Michael Walzer.97 Walzer argues that distributional principles will vary according to the social meaning of the good to be distributed. There are “spheres of justice.” In the case of health care, he argues that distribution should be egalitarian on the basis of need, because health care is a highly valued good and because absent collective provision for all, the existing, limited forms of public spending for health care unfairly benefit those citizens with ready access to the system. According to Walzer, certain entailments must be respected. If a society chooses to subsidize health care with public funds, it is thereby committed to an egalitarian distribution of the benefits produced by the public investment. It is unjust for the comfortable majority to support tax deductions for employers, the exclusion of health care benefits from income, and the use of public funds for medical education and research and hospital construction, without giving the remainder of their fellow citizens access to the institutions through which the benefits of such public programs are distributed. It is unjust to require a sales clerk whose corporate employer does not offer health insurance to the majority of its employees to subsidize the health care of the company's chief

96Stout, Ethics After Babel, 281-82.
executive officer through the taxes she pays.

It becomes clear that MacIntyre’s work, like that of Bentham and Mill and Rawls, has something to contribute to an ethical analysis of managed care. First, MacIntyre’s account suggests the importance of the virtues (and character) and practices in sustaining meaningful forms of public and private life. Health care can be understood as a practice, or as a constellation of practices. Managed care can then be evaluated in terms of its effects on these practices. Second, MacIntyre draws attention to the problem of manipulation in social relations and nicely captures the distinction between treating others as ends and treating them as means. These sorts of considerations may figure in the evaluation of incentive schemes and other structures associated with managed care. Third, MacIntyre presents us with a set of concepts that help to counteract myopia, concepts of internal and external goods, institution, and tradition, as well as virtue and practice. These concepts taken together can contribute to the construction of a complex, variegated social ethic as a basis for a stereoscopic social criticism.

In concluding this chapter, I want to set out a loose set of requirements for an adequate social ethic—aadequate, that is, to the range of concerns raised by managed care. I am going to organize those requirements in terms of four fields of moral discourse. They are method, social values, moral psychology, and moral sociology. The fields are, of course, interrelated, and a problem encountered in one field will likely have reverberations in each of the others.

1. **Method.** We need to begin with some understanding of how one ought to approach a question about what to do, or about what kinds of social arrangements are
morally desirable. "Method" is simply a general term to describe such an understanding. Method is less demanding than theory or system. A method is a way of modeling moral reflection. The model may be one in which a theory is constructed and then applied, but it need not be. Some methods, which is to say, some models of moral reflection, might dispense with theory altogether.

Utilitarians and contractualists by and large believe that reflective morality begins with the construction of theory. Bentham looked for a single principle that could serve as a standard for the whole of morality, and he thought he found it in the greatest happiness principle. In utilitarianism, answers to specific questions become, in theory, a matter of deduction from that principle. Empirical investigation is required—one must identify consequences. But the process of inquiry is not open. If one accepts that investigation or reflection may cast doubt on the sufficiency of the greatest happiness principle, one is not a utilitarian.

Contractualists such as Rawls look for a set of principles or rules that all rational (or reasonable) agents will agree to. The aim is a fully deductive system. Contractualists typically resort to elaborate hypotheticals like the original position, as the kind of agreement that would satisfy them is notably lacking in real life. The point of the hypothetical must be to suppress the factors which are productive of actual disagreements. Again, empirical investigation is not absent. Having arrived at a set of principles, one must determine whether they are viable, and specification of what the principles demand in any particular context will require attention to the facts. But the objection that our ideas about justice are variable in ways not captured by the
theory—with the implication that modeling moral reasoning in this fashion is mistaken—will not be seriously entertained.

Communitarians such as MacIntyre suggest that we proceed not through the construction and application of theory, but through identification with a coherent moral tradition. If we find aspects of different traditions appealing, and are tempted to mix and match, so much the worse for us. To avoid a vacuous emotivism, we must prune our moral commitments to achieve coherence. On the other hand, of all the moral philosophers examined in this chapter, MacIntyre is the most open to the social sciences and to empirical investigation. He calls for others to complete his project through inquiry into particular spheres of human activity, and he ventures in that direction himself.

Given the powerful criticisms that have been leveled at utilitarianism, contract theory, and communitarianism, we would be well-advised to look elsewhere for a method to guide ethical reflection on managed care. In particular, if we feel the pull of diverse and sometimes conflicting considerations when we read a story such as Christine deMeuriers’s, we will want a method that does justice to diversity and conflict. Such stories, and our responses to them, are an important but insufficient basis for judging a phenomenon as complex as managed care. What seems called for, then, is a method that will prompt wider investigation and guide reflection, but refrain from prejudging the issue by removing whole areas of experience from consideration. Finally, we will want a method that marks how engagements with others shape our thought—here, engagements with Bentham, Rawls, and MacIntyre, and Relman, Reinhardt, Macklin, and Waymack, and deMeuriers and the other actors in the Health Net saga, and the audience of critical readers.
2. **Social values.** We need to find some way of assessing managed care, of understanding what is to be approved and what is to be disapproved. This assessment will require consideration of how managed care stands in relation to important social values. No doubt there are many ways of placing managed care in the context of a broader social vision. Values must be interpreted, and the interpretation will reflect the interpreter's sensibility. In the exchange between Reinhardt and Relman, we are exposed to two rather different readings of contemporary social values affecting health care in the United States. (As Reinhardt points out, it is pointless to speak of social values in general.)

In contemporary utilitarian reflections on social policy and health care, there is a cleavage between the primary values, general benevolence and the elimination of suffering, and the secondary values of preference-satisfaction and rationalization. None of these values seems a very fitting guide for an assessment of managed care. General benevolence is of little help because it is so abstract. Further, it cannot aid us in assessing the claims of special relationships, or rather, it sees no such claims. This is the kind of prejudgment to be avoided. The importance of cultivating a lively awareness of suffering has been remarked, but where suffering or the elimination of suffering is the overriding consideration, the tendency is to force those defined as sufferers into passivity, as in traditional medical paternalism. Finally, preference-satisfaction and rationalization are not very rich moral notions. They may figure in assessment, but they need values of greater emotional potency and complexity to give them meaning.

The contract tradition naturally gravitates toward justice as the defining value or constellation of values for social life. Further, there is a tendency to treat justice as a
matter of rules and procedures. This rather austere vision has great power for philosophers, lawyers, and civil libertarians, but its broader appeal may be doubted. The rhetoric of rights has a life of its own, but it is not a great aid to reflection. A "right to health care" does not tell us what services are to be covered. Fairness does seem to require that there be rules and procedures that govern what goes on in organizations and that people follow them. On the other hand, justice, especially justice in Rawls's terms, cannot give us much insight into the erosion of the quality of relationships brought about by bureaucracy as impersonal adherence to rules and procedures. Benhabib's work opens the path to a more inclusive vision, but leaves much work to be done. Justice is an important, but not sufficient, way of thematizing moral concern about managed care.

MacIntyre and the communitarians direct our attention to the particular community to which we belong. As members of a community, we join our fellows in discovering or constructing the values that define us. The "problem" here is that most of us are members of diverse communities, and many of those communities are themselves diverse internally. We do not wish for the complete annulment of these boundaries and divisions, and most of the time we accept the tensions this kind of fragmentation introduces into our lives. Indeed, most of us are fairly adept at working across the boundaries and divisions.

We may be led to ask whether there is a way to speak of this diversity as having value in moral terms. Rawls's comments on a social union of social unions have the right tone, but they are too vague to supply the need. We might draw on an overlapping allegiance to democracy, look at some of the possible permutations of the democratic ideal, and allow democracy to exert some pull on justice. This is what Benhabib and
many contemporary political theorists are about, but (predictably) they are preoccupied
with the political realm. We are searching for something broader, something that captures
the qualities of common life that matter to persons who are more than citizens.

3. Moral psychology. Moral psychology is clearly of great importance to moral
understanding and to ethics. The great moral philosophers of the past consistently
addressed the subject, and we have seen how implicit moral psychologies figure in the
exchange between Relman and Reinhardt. An ethical analysis of managed care, with its
heavy reliance on incentives and its assumptions about human responses to them, clearly
demands an exploration of the nexus between character and conduct. We also need to
investigate the other psychological categories in use in the managed care debate: choice,
self, interest, motive.

Bentham begins with a relatively simple moral psychology, and whatever nuance
Rosenblum may introduce, his successors have resorted to all sorts of simplifying
assumptions to further their calculations. In particular, preference utilitarians employ a
model of the self that is static and self-enclosed, and they do not show much interest in
character and the like. Utilitarian moral psychology gives us reason to believe that
persons will be responsive to incentives, but it gives us few clues to the complexity of the
processes involved.

Rawls offers a much more sophisticated treatment of moral psychology, but in his
case as well the object is to see if the self can be made to conform to the demands of
theory. And theory construction rests on an extremely primitive moral psychology, that
of the representatives in the original position. As for character, just institutions form
character in their own image: character becomes a matter of knowing and conscientiously
applying the rules. Finally, Rawls does not tell us how to handle socially corrosive sentiments such as envy, or fear and greed.

MacIntyre presents us with two moral psychologies. On the one hand, there is the chameleon-like emotivist self shaped by modernity, and on the other, there is the stable, virtuous character formed within a community with a coherent moral vision. There seems to be little middle ground. Still, by linking virtues to practices and institutions, MacIntyre does provide insight into a common type of moral conflict, the conflict between internal and external goods. Indeed, one might say that this is the central conflict for providers of health care in a managed care environment. But the ideas need to be developed within the context of a moral sociology, as MacIntyre himself recognizes.

4. **Moral sociology.** Moral sociology, unlike moral psychology, is not a term in use, but it is a marker for a discipline we need. Faced with a phenomenon like managed care, we must begin, however inadequately, to make use of the work of sociologists. At the very least, we must consider the relation between the individual and the social, and we must try to anchor our moral judgments in the appropriate social, historical, and institutional contexts. In particular, I wish to contribute to the correction of a deficiency in much scholarship in the field of medical ethics: the failure to think seriously about the role of organizations.

Ideology is a good bridge between moral psychology and moral sociology. Bentham hints at the influence our interests may exert on our ideas. It may also be the case that our ideas, developed in specific institutional and social contexts, influence our (conception of our) interests. The ideologies of medicine and business may be rather crude, but they are not mere rationalizations for what people would be inclined to do
anyway. Contract theory is quite insensitive in this area, and when communitarians invoke the concept, it is usually to undermine somebody else's pretensions to neutrality or objectivity. So we are still in search of a satisfactory account of ideology.

As for a moral sociology of organizations, we have nothing approaching a full account in the three alternatives reviewed. Bentham gives us institutions as instrumentalities for adjusting incentives. Organizations are largely transparent (or just plain invisible) in the kinds of cost-benefit analyses applied to health care. Rawls gives us two views of institutions. First, institutions are systems of rules. This scarcely seems adequate to experience, whatever it may contribute to the coherence of the theory. Second, institutions are agencies of character formation. This is significant, but the idea is in need of fuller development. MacIntyre's account of institutions comes closest to meeting our needs, but his concepts must be carried into particular contexts to prove their worth. Stout begins to do this with health care.

While the beginning is important, we need to sharpen and extend Stout's analysis and bring in developments associated with managed care. We need to create general criteria for assessing organizations. This process will involve looking at the qualities of character cultivated by organizations. We will also need to consider how to approach the organization as a something with its own character. In assessing organizational character, we may specify what justice demands of organizations, in particular, health care organizations. We will also want to identify some additional organizational virtues. Finally, in the case of organizations established to provide goods and services, we must ask about efficiency and other "economic" concerns.

Along the way, we should address MacIntyre's concerns about time scale and role
fragmentation and organizational opacity, and we should reflect on the significance of the market, bureaucracy, and professionalism. Bentham gives us reason to consider the practical advantages of the market, while Rawls submits the market and all other basic structures to judgment according to the two principles of justice and MacIntyre tells cautionary tales about the market's effects. In different ways, Bentham and Rawls embrace bureaucracy, while MacIntyre gives us reason to be more critical. Bentham teaches us skepticism concerning the claims of professionals, while MacIntyre suggests a way of reconceiving professionalism through the concept of practice. (Rawls simply tells us that in a just world people will fulfill their duties and obligations and uphold the ideals of their "station.") Some of the tensions may be ineradicable, but in certain cases synthesis may be possible.

I earlier used the word "pragmatist" to describe Stout's *bricoleur*. The work of philosophers and scholars such as Richard Bernstein, Richard Rorty, Cornel West, and Jeffrey Stout has lead to a resurgence of interest in pragmatism. Pragmatism, at its best, is not unprincipled yielding to expediency, but the creative melding of insights from various sources to address social problems. It is the firm refusal of dualisms and simplistic either/or's, although it does not deny the necessity of discrimination and choice. It combines normative commitments with some degree of psychological and sociological sophistication. It is systematic but not totalizing—part framework, part patchwork.

Managed care has finally succeeded in putting institutional concerns on the medical ethicist's agenda, but the initial forays into this area are still quite limited.98 In

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this area, the work of John Dewey and others within the pragmatic tradition is extremely suggestive, and the beauty of the fit seems to have inspired Susan Wolf's heralding of a pragmatic reformation of medical ethics. When the "corporatization" of America is finally experienced as a significant development even in the medical enclave, there may be good reason to re-examine the work of a philosopher who viewed the arrival of "corporate civilization" as momentous for ethics, and to consider the work of his intellectual heirs in political theory and sociology. Indeed, we are in the midst of something of a Dewey renaissance. Three major biographies and a burgeoning literature in the fields of literary criticism and philosophy, as well as political theory and sociology, suggest a broad awakening to the relevance of Dewey and Deweyan pragmatism to a broad range of current issues and social developments.


Chapter Four: A Deweyan Ethic for an Age of Organizations

One can only see from a certain standpoint, but this fact does not make all standpoints of equal value. A standpoint which is nowhere in particular and from which things are not seen at a special angle is an absurdity. But one may have affection for a standpoint which gives a rich and ordered landscape rather than for one from which things are seen confusedly and meagerly.

—John Dewey, "Context and Thought"

[Deliberation takes its point of departure not from non-sense, but rather from insufficient sense; and it culminates not in Archimedean vision of a determinate terminus, but rather in conduct's emergence on a path whose sense can be fully ascertained only by following it into the situations toward which it points.]

—Timothy Kaufman-Osborn, Politics/Sense/Experience

When we are faced with a problem, John Dewey tells us, "deliberate inquiry is the only alternative to inconsiderate, undirected, and hence probably violent changes:—changes involving undue relaxation of moral ties on the one side and arbitrary reactions on the other." (EI, 322) Those frustrated by the medicine-business polemic will welcome this view, because it opens up a third option. One need no longer choose either to accept the weakening of established moral ties, an embrace of the ideology of business, or to endorse claims about the essential rightness of the traditional way of doing things, an embrace of the ideology of medicine. Reinhardt and Hasan are at least allies in this, that

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1Quotations from John Dewey's works are cited in the text with the abbreviations listed below. MW refers to the Middle Works and LW refers to the Later Works. If a reprint is listed, page citations are to the reprint.

QC: The Quest for Certainty (New York: Minton, Balch, 1929; reprint, LW 4).
they are ready to get rid of the old and embrace the new, with some reservations, to be sure, in Reinhardt's case. Of course, one may question the novelty of the new. While the changes currently underway in health care include the emergence of new organizational forms for health care delivery and the disruption of the customary morality of the medical profession and not-for-profit hospitals, many of the organizational forms that are new to health care merely imitate standard business models, and the transformation in morality is defended by Hasan and others in terms set by the business ideology. In other words, there is little movement toward a conscious, creative refashioning of health care at the level of organization or symbolic expression.

As for Relman, he does not "arbitrarily react" to change, although many of his colleagues come close to meeting this description. Still, one senses that, for Relman, the traditional values under threat are simply too close and too dear to be submitted to scrutiny. Thus, despite his immense professional stature and moral authority, the tone of his letters is almost wistful, and unsympathetic readers are likely to label his defense of his profession an exercise in nostalgia. Noting the speed with which many physicians have embraced the entrepreneurial style of Hasan's new health care, Reinhardt in effect asks Relman, Have you an enemy, or a betrayer? Dewey's remarks in Human Nature and Conduct seem to fit the case: "Curiously enough, the chief practical effect of refusing to recognize the connection of custom with moral standards is to deify some special custom and treat it as eternal, immutable, outside of criticism and revision. The consequence is especially harmful in times of rapid social flux. For it leads to disparity between nominal standards, which become ineffectual and hypocritical in exact ratio to their theoretical

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exaltation, and actual habits which have to take note of existing conditions." (HNC, 58)

Can the work of Dewey and others in the pragmatic tradition aid in the task of making sense of managed care? I believe the answer is yes for a number of reasons. First, Dewey's work helps us to better understand the situation in which we begin. Change is continual, and it is not surprising that old certainties have been put in question and easy answers are not forthcoming (or, if advanced by some, fail to satisfy). At the same time, we have the capacity to be more than driftwood, caught up and carried along by impersonal forces. We cannot take up a standpoint altogether outside the circumstances that confront us, but through inquiry we can hope to find a standpoint that gives a richer and more ordered landscape. I use the term "making sense" to label this project, in preference to terms like "explaining," in order to emphasize that the task is a creative, not merely didactic or analytic one. The visual metaphor of the standpoint should not be allowed to obscure the fact that we are participants rather than spectators. Dewey was one of the most relentless critics of spectator theories of knowledge, and he thought philosophy should contribute to the solution of social problems.

At the end of the last chapter, I laid out some requirements for an adequate social ethic. How does Deweyan pragmatism fare in meeting those requirements? My first set of requirements concerned method. Dewey lays out a method intended to assist individuals and social groups in their sense-making activity, a method he labels "democratic." It is broad and inclusive and it honors the collaborative nature of the endeavor. My chief responsibility in this area will be to bring Dewey up-to-date by showing how his views on method relate to some recent developments in moral philosophy. As for social values, Dewey presents an inspiring vision of democracy as
the preeminent American social value. Dewey takes democracy in an interesting direction that straddles the divide between liberals and communitarians. The viability of the political order is linked to the flourishing of diverse associations in the sphere of civil society. This gives us something like the communitarian account, but without the animosity toward pluralism. That is, the Deweyan account also resembles the liberal account.

Deweyan democracy focuses attention on the quality of the relationships nurtured by particular social arrangements. The fracturing of relationships is surely one of the most troubling aspects of the deMeurers case. Against some communitarians, a Deweyan pragmatist would assert that our being troubled does not depend on identification with the communities of identity of the central actors. Many of the problems we face are common problems. Deweyan democracy plays on themes of commonality, community, and communication, but there is an effort to show how these presume and benefit from difference. Dewey does not have much to say about how democracy and justice are related, and this omission must be remedied. I will draw out some of the implications of bringing the two together by borrowing a concept, subsidiarity, from Roman Catholic social thought.

Finally, Dewey offers an array of concepts that may be helpful in resolving or getting beyond some of the argumentative dead ends in the Relman-Reinhardt debate. Indeed, I think of Dewey's philosophy as a sort of tool-box from which we may select whatever is useful for the problem at hand, and this is perfectly consistent with Dewey's intentions for his work. The weaknesses of the accounts of moral psychology considered in the last chapter had to do with what was omitted, as much as any obvious errors. My
efforts will be directed toward clarifying the relationship between character and conduct, and scrutinizing beliefs about choice and freedom, the self, interests, and motives. I will also have occasion to touch on greed and fear, as well as one of the emotions Rawls exiled from the original position: envy.

Of course, I cannot treat these topics exhaustively here. The discussion will have to be tailored to the problem. In the Relman-Reinhardt debate, the plasticity of human nature emerged as a significant question. Dewey's concept of character allows for the formation of relatively stable patterns of conduct. Human beings are not entirely malleable. At the same time, character is pried loose from the grip of consciousness and intention. Human beings do not have the degree of self-control the ideology of medicine requires of physicians or the ideology of business requires of consumers. Dewey's analysis of the self casts additional light on the concept of interest. Self-interest is unreliable as a guide and questionable as an object of opposition if selves and interests vary with social forms. It is desirable to nurture sympathy and the social affections as these have the power to enlarge the self, but these sentiments cannot eliminate the insecurity created by freedom and finitude, and this insecurity is a powerful barrier to intelligent social reform. Still, insecurity is itself social as well as individual and may be lessened or intensified through social action, a truth expressed in Reinhold Niebuhr's notion of "common grace."

Dewey also has something to say about ideology, a concept I have identified as a link between moral psychology and moral sociology. He makes some sharp observations about ideology and our understanding of the market and other social institutions. Dewey's account of institutions, which is an important part of his social ethic,
emphasizes the role institutions play in shaping character. The kinds of characters and
relationships institutions form and nurture are as important as the goods and services
they produce, and this is true of economic institutions as well as schools and universities.
Dewey's work prepares the way for a more thorough investigation of the moral
significance of institutions and the development of criteria for their evaluation.

My object in this chapter is not to lay the groundwork for a new philosophy or
social theory, but rather to lay out some of the tools for a stereoscopic social criticism. I
will be making two kinds of claims. First, I will be arguing that unless certain features of
the moral and social landscape are considered, our actions will be misdirected. If we
adopt a method that does not attend to the full range of considerations, we virtually
ensure that the consequences that follow our actions will be unexpected and will find us
unprepared. Even if one is not a consequentialist, one has reason to seek the fullest
possible account of the situation before rendering judgment and taking action. For
example, whether or not one agrees with Mark Waymack's approach of concentrating the
whole of morality in relation to managed care in the consumer's choice of a health plan,
one must agree that it is significant for such a conception that nearly half of all employers
offer their employees a single option for health care coverage, and that the information
available to consumers is sparse and difficult to interpret. Or, to anticipate the discussion
of specific managed care structures and policy recommendations from Chapter 6, those
who suggest that conversation between patient and physician will substitute for
technology need to consider that the forces limiting the use of technology also limit the
opportunities for physician-patient interaction.
Similar claims can be advanced in other areas. We cannot simply dispense with values, or ignore the role of some subset of values in orienting moral discourse. More strongly, values, or our interpretations of them, shape our definition of what is at stake in any situation. Reinhardt argues that the current reconsideration of health care financing and delivery reflects a moral crisis, a crisis of social values, not a crisis of costs. Cost has become the focus of attention because we do not value health care, or health care for certain populations, all that highly. In the area of moral psychology, we must recognize that character is malleable, and that it also offers some resistance to manipulation. The image of the physician as impervious to influence is untenable, but so is the instrumentalist view of the person as a set of predictable responses to particular stimuli. The intersubjective constitution of the self is another basic fact. The image of persons as atoms cannot be taken seriously as an approximation of reality. The image of persons as atoms is employed because it reflects and confirms a certain constellation of social arrangements and beliefs about the proper organization of social life. Finally, we must acknowledge that institutions shape character and conduct and provide us with part of our interpretive matrix.

Second, I will be suggesting that certain ways of framing or developing these basic facts are appealing, at least to those with a certain sensibility or range of experience. This strand will emerge most strongly in the section on social values. Deweyan democracy and pragmatic justice are not self-evident truths, nor can they be defended with “superpower” arguments. Although they can be supported with reasons, they are more in the realm of

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2See note 23 to Chapter 1 and accompanying text.
3Jeffrey Stout concludes *Ethics After Babel* with a lexicon in which he defines the “superpower view of defense” as “Bernard Williams’s name for the view that you have adequately defended a position ‘only if you can annihilate the other side’ (*Ethics and the Limits of Philosophy*, p. 84)”. Stout invites the reader to
*pathos* than *logos*. In the area of moral psychology, claims for breadth of vision and
sympathy and for normative intersubjectivity—the assignment of moral value to human
relationships—are of a similar nature. So, too, is my discussion of the qualities of
character and relationship that institutions ought to cultivate. Within a pragmatic
framework, the audience is invited to ask of an interpretation or analysis not only “Does
this comport with our beliefs, or with ‘reality’?” but “Does it make sense? Does it help
us to negotiate our way through this particular problematic situation?” I hope to
demonstrate that in each of these areas Dewey’s work yields insights that prove fruitful
in practice.

1. "Experimentalism" as a Method for Moral Reflection

   Ethics as relation-mapping and problem-solving

   Initially, I think it is important to note that Dewey’s view of ethics is broad and
inclusive enough to capture the concerns of Relman and Reinhardt. Reinhardt may
invoke social science research, but he does not simply oppose "economic logic" to "ethical
conscience." He argues, among other things, that Relman fails to consider how far actual
conduct falls short of the philanthropic ideal and the consequences of this divergence.
Surely this belongs within the field of ethics.4 It would scarcely be helpful to define
ethics in a manner that swallows the universe. At the same time, restrictive definitions
are often tied to attempts to exclude from consideration concerns that the author of the
definition does not share. That is, the author uses the definition polemically to dignify

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4I follow Dewey in using "ethics" or "ethical" and "moral" interchangeably, although use of the term
"ethics" may more strongly emphasize the element of conscious reflection or formal study.

"compare Robert Nozick (Philosophical Explanations, pp. 4-5) on the philosopher’s hope for ‘arguments
so powerful they set up reverberations in the brain: if the person refuses to accept the conclusion, he dies.’"
Jeffrey Stout, Ethics After Babel: The Languages of Morals and Their Discontents (Boston: Beacon
his own preoccupations and denigrate those of others—as non-moral. Hence, there is
good reason to favor a broad and inclusive definition. Initially, the conditions for
admission of claims and concerns should be weak.

In their text on ethics, Dewey and his co-author, James H. Tufts, define ethics as
the study of the relation between "inner" processes and purposes and "outer" conditions,
both natural and social, and the rendering of judgments of good or bad, right or wrong, or
approval or disapproval according to some standard. (EI, 3; EII, 10) I put the adjectives
"inner" and "outer" within quotation marks to signal the need to guard against reifying and
opposing the inner life (desires, purposes, choices, and dispositions) to outer conditions
(the occasions for inner phenomena, the material for their development and expression,
and their consequences). These designations make analysis possible, but they hinder
understanding if the distinctions are taken to be ontological rather than functional. The
emphasis is on relations among phenomena. Indeed, we might refer to ethics as a kind of
"relation-mapping," a following out of connections. An illustration may be helpful.

Dewey and Tufts state that ethics has no particular subject matter, but rather has to do
with the kind of concern that guides inquiry. If we study the activities of a corporation
"as resulting from the purposes of persons or as affecting the welfare of persons," with
the object of judging "its acts as good or bad," that is ethics. (EI, 10) If we interrogate an
organization as to the purposes of the persons who exercise power through the
organization, the ways in which it constrains or shapes the purposes of persons, and its
effects upon the welfare of persons, and render a judgment of good or bad, that is ethics.

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5The book is jointly authored by Dewey and James Tufts, with Tufts bearing primary responsibility for
Part I and Part III and Dewey bearing primary responsibility for Part II, "The Theory of the Moral Life," which includes the sections on moral theory and the nature of the self.
In Dewey's view, ethics or moral reflection is associated with a particular kind of conflict. I may be absolutely certain that I should not steal a pear from my neighbor's tree, and yet long to do so anyway. This sort of conflict requires a gathering of moral forces, but it does not generally issue in reflection or deliberation—although an understanding of character and habit may give me insight into my predicament. But let us change the facts. I am absolutely certain that revealing my supervisor's fraud is the right thing to do, and yet blanch at the prospect of being labeled a "whistle-blower" and the likely consequences for my career. Here the conflict is generated by the power structure and culture of the organization and industry, as much as by personal weakness, and it may well give rise to reflection concerning relations among persons and the moral significance of the economic order. Dewey tends to focus on another paradigm, the case in which "the right thing to do" is itself unclear, but his account of ethics scarcely excludes consideration of this kind of conflict. The situation of apparent powerlessness to act for the right within an organizational or cultural context is, to say the very least, problematic. Although problems are not at the center of morality for the Deweyan pragmatist, they are at the center of moral reflection.

In general, it is reasonable to assert that the occasion for moral reflection is a problem, either a conflict of values or duties or an unsettling of received views due to the emergence of new phenomena. Only then does a portion of "customary morality," the stock of inherited ideals, beliefs, concepts, maxims, rules, virtues, values, and so on, that we unreflectively rely on in our day-to-day living, become an object of inquiry. Two concerns might be raised about this view of ethics. First, must we simply accept whatever ideals or values people (we) happen to hold as given, incorrigible? Yes and no.
Although we can reflect on our ideals and values, we can never get behind or beyond them altogether. Rather, in the process of reflection we criticize and preserve or creatively reconstruct some aspects of customary morality while, perhaps, leaving others behind. There may be significant leaps, but there is always continuity, and we never succeed in putting all our beliefs in question simultaneously.\footnote{E.g., "An empirical philosophy is in any case a kind of intellectual disrobing. We cannot permanently divest ourselves of the intellectual habits we take on and wear when we assimilate the culture of our own time and place. But intelligent furthering of culture demands that we take some of them off, that we inspect them critically to see what they are made of and what wearing them does to us. We cannot achieve recovery of primitive naïveté. But there is attainable a cultivated naïveté of eye, ear and thought, one that can be acquired only through the discipline of severe thought." (EN, 40).}

Second, is this simply a species of "quandary ethics"? Again, the answer is yes and no. Certainly, there is a strong emphasis in Dewey's work on problems as the key to reflective morality. Deweyan pragmatism will have the greatest appeal for those who find contemporary social arrangements problematic and cherish the hope that they can make some small contribution to social betterment through reflection and criticism. At the same time, the focus on reflective morality should not cause us to lose sight of the importance of customary morality. The greater part of our transactions with one another are guided, unproblematically, by this great store of social wisdom. Also, problems should be distinguished from puzzles. The reflection occasioned by a problem will often lead to a changed understanding or redefinition of the problem. Then, too, problems may be resolved in the sense of being lived through, or experienced as meaningful, rather than being solved like an equation or dissolved through elimination of the underlying conflict. Above all, the future is open, inviting creativity. In other words, a Deweyan problem is a world away from the kind of set piece some professors of ethics delight in fashioning for their students.
Even so, Dewey's approach may not be adequate to the whole range of moral experience. It is, however, well suited to the subject at hand. Managed care is a problem because we value care and efficiency, and because we value health, and health care very highly, but not to the exclusion of other personal and social goods. And so we seem to be faced with a choice between incompatible values or sets of values. The message of the medicine-business polemic is "choose!" The message here is "reflect!" What reflection, or moral deliberation, entails must now be explored in greater depth.

**Intuition**

Dewey's ideas concerning moral deliberation take shape over against the theory of moral sense intuitionism. In *Ethics and the Limits of Philosophy*, Bernard Williams describes the decline of the kind of intuitionism Dewey battled. Intuition was regarded as an intellectual power or faculty for arriving at abstract truths. The thrust of Dewey's comments is that the truths yielded by intuition bear more than a family resemblance to established social customs. Customs that have been internalized rise to the surface of consciousness as "intuitions" when they are contested. These intuitions are defended with a force roughly proportionate to the threat revision would pose to prerogatives. Even a generally serviceable custom may become inappropriate or wrong if adhered to under dramatically changed circumstances. In other words, Dewey's critique is historicist and psychological. As Williams reports, old school intuitionism was ultimately "demolished" by more strictly philosophical criticisms: Intuitionism "failed to explain how eternal truths could provide a practical consideration,...it was wrong in assimilating ethical truths to necessities,... [and a]bove all, the appeal to intuition as a faculty
explained nothing." 7 On either account, the idea of intuition as a mysterious pipeline to
Ultimate Moral Truth cannot survive.

Nevertheless, certain kinds of intuitionism are still philosophically respectable.
These variants have no use for a special faculty. The contemporary proponents of
intuitionism have turned their attention to intuitions, now understood as "spontaneous
convictions, moderately reflective but not yet theorized, about the answer to some ethical
question, usually hypothetical and couched in general terms." 8 In other words, intuitions
are understood within a framework of discursive reason, as insights awaiting theoretical
elaboration. Dewey also allows for a partial rehabilitation of intuition. Custom and the
whole of one's prior moral experience are not to be deified, but neither are they to be
disdained. Further, old school intuitionism is correct "in its implicit emphasis upon the
importance of direct responsiveness to the qualities of situations and acts." (ElI, 268)
That is, it is important to acknowledge that morality is not wholly a matter of discursive
reason or logic. Still, even as agent for this broader complex, intuition is not allowed to
occupy the whole field of ethics. According to Dewey, intuition and discursive reason
work together. What seems to be lost in the contemporary species of intuitionism
described by Williams is the sense of intuition as direct responsiveness to qualities in the
world. Did Dewey simply take a wrong turn in his own effort at reconstruction?

Although I cannot resolve the issue here, I am struck by some of the
correspondences between Dewey's admittedly sketchy account of how intuition works,
and Ronald de Sousa's analysis of the contribution of the emotions to moral reasoning. 9 I

8Williams, Ethics, 94.
believe that intuitions are best understood as emotional responses with cognitive content, not un- or under-developed arguments. This need not entail that intuitions are irrational. To the contrary, discursive reason and emotion are usually allies. In our interactions with the environment, emotions help us to select what is important and requires attention. In other words, emotions control the salience of features of perception and reasoning. How do they do this? De Sousa contends that emotions are structured in terms of "paradigm scenarios." Paradigm scenarios bring together a situation type and a set of normal responses to the situation. The situation type defines the range of objects that evoke a specific emotion. For example, in our culture, the formal object of indignation would be some kind of injustice. Normal responses are biological and cultural. We learn paradigm scenarios through everyday interpersonal interactions and through stories, art, and culture. Emotional readings of a situation have a dramatic structure: I am indignant that

Donna took the credit for Angela's work or that managed care executives make money by denying care to patients.

Emotions play a crucial role in moral deliberation and judgment. In de Sousa's words, they "set the agenda" for beliefs and desires. Also, in a sense, emotions are moral judgments. The qualification warns against assimilating emotions too fully to ratiocination, losing the sense of a stamp of approval or disapproval based on a non-analytical, holistic appraisal. De Sousa describes the stamp as the conclusion of a process of "matching" paradigms and situations. This is not emotivism. Emotions may

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10 One might substitute "holographic" for "holistic": "The capacity of experts to store in memory tens of thousands of typical situations and rapidly and effortlessly to see the present situation as similar to one of these, suggests that the brain does not work like a heuristically programmed digital computer applying rules to bits of information. Rather it suggests, as some neuropsychologists already believe, that the brain—at times, at least—works holographically, superimposing the records of whole situations and measuring their similarity." Hubert L. Dreyfus and Stuart E. Dreyfus, "From Socrates to Expert Systems:.
be projective, but in principle they respond to something that is really out there.

Emotions apprehend the axiological or value dimension of reality. Emotions are
dependent on a complex that includes states of the organism and states of the world. So
the standard of success for fear is that its target, the actual particular to which it relates,
be fearsome (for an organism with such and such characteristics). Paradigms, and hence
emotions, are subject to critical evaluation by a number of routes. A paradigm may be
challenged on the grounds that it ignores relevant features of the situation, or that
competing paradigms seem more fitting. In many situations the qualities emergent in
experience will be multiple; de Sousa argues that in some cases ambivalence has an
objective basis. While emotions settle conflicts between competing analytical constructs
and motivational structures, emotions themselves may conflict. In such cases, other tools
must be brought in to referee. The structure of moral deliberation is heterarchical rather
than hierarchical.¹¹

The main point of this compressed rendering of de Sousa's central ideas is that our
direct apprehensions of value are worthy of some respect. Our immediate responses to
narratives concerning managed care are not an adequate basis for moral judgment, but they
are sources of valuable information. Dewey knew that this was true, and tried to express
the idea through the vocabulary of intuitionism. De Sousa's account suggests to me that
framing "intuitions" in terms of the emotions may be more fruitful. It also fits quite
nicely with Dewey's views on experience, to be addressed shortly.

¹¹Heterarchy "suggests many partial systems working in parallel, with any one capable of taking over
control according to need." De Sousa, Emotion, 74.
Moral deliberation

"Deliberation" is the name Dewey and Tufts give to the process in which the various operations involved in moral reflection are fitted together. The method models deliberation as a series of stages. The division into distinct stages is, of course, somewhat artificial, more for the convenience of the expositor than anything else. In the beginning is the problem, a state of affairs that gives rise to doubt about what should be done. The first stage in resolving the problematic situation is an investigation of the facts with an eye toward more clearly defining the nature of the problem. The word "facts" should be broadly construed. The facts of the situation will include the full complement of social resources that may contribute to a better understanding of the problem and its solution. Social resources include moral codes and customs, legislation and judicial decisions, the histories of institutions and values, moral theory, social science research, and journalistic reports. This fact-gathering or assembling of tools and resources, a sort of bricolage, is followed by an active rehearsal of the various alternatives, an imaginative, dramatic performance of the probable consequences of pursuing each of the possible paths. In keeping with the account of intuition, this dramatic rehearsal comes complete with Greek chorus: "There is developed a running commentary which stamps values at once as good or evil" and it "is this direct sense of value, not the consciousness of general rules or ultimate goals, which finally determines the worth of the act to the agent." (EII, 274-75)

Finally, it is highly significant that the context for inquiry is the community of interested

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12Dewey and Tufts state that they are not advocating "an eclectic combination" of the shards of different moral theories and so on, but that is only to say that bricolage is an intelligent activity. (EII, 180) As noted in the previous chapter, Stout links Claude Lévi-Strauss's term and pragmatism. For a more in depth exploration of the fruitfulness of bringing Dewey and Lévi-Strauss into conversation, and a discussion of the senses in which Dewey's method is and is not bricolage according to Lévi-Strauss's definition of the term, see Edith Wyschogrod, "The Logic of Artifactual Existents: John Dewey and Claude Lévi-Strauss,"
and engaged persons. Fre and open discussion, and publication of the findings and conclusions of the members of the community, are essential to deliberation.

In the passage quoted above, Dewey and Tufts deny that rules are central to moral deliberation, but rules do play a number of roles. General rules or principles serve as a kind of checklist of points to be considered. Principles "economize" on thinking by supplying the main headings which give us our bearings in assessing our desires and purposes. As Martha Nussbaum remarks in a more extensive and nuanced treatment of the subject, they are more like rules of thumb than commands that tell us precisely what to do in any given situation. They also "guide" thinking by keeping us alert to certain important considerations as we survey the scene. (EI, 333) Take, for example, principles such as "tell the truth" (truthfulness) and "keep your promises" (fidelity). At the very least, these principles alert us to the severity of the problem posed by managed care; in the deMeurers case, there are allegations that several of the actors economized on the truth and failed to keep faith. Other principles relevant to the problem might include variations on Kantian and biblical injunctions such as "treat persons as ends and never as means only" or "protect the vulnerable." In contrast to Rawls, Dewey repeatedly stresses the importance of creativity in moral reflection. The objective is not merely to achieve equilibrium or consistency between procedures for generating principles, or the principles themselves, and our considered judgments in particular cases. Although such internal consistency of belief is by no means to be disdained, there are always new things to be learned and created through our engagements with the world and with one another.  


14Dewey obviously has little sympathy with what are often referred to as "command moralities," and
Once they are generated and tested by reason and emotion, and conversation with others, our moral judgments undergo a second test when we act on them. It is central to Deweyan pragmatism that "theory and practice are 'reciprocally,' not 'dialectically,' related": "The 'test' of theory by practice is designed to modify theory, not merely to exhibit it."\(^{15}\) Judgments are always open to revision. The test of the experimental method itself must be its fruitfulness in practice. Some care is required in this area, since Deweyan pragmatism has been (mis)characterized as a kind of success philosophy. Let us say that I am committed to equality of opportunity. I believe that socialism is the economic system most consistent with its realization. I become a vigorous advocate for the party and its platform, but socialist candidates invariably suffer humiliating defeats. What kinds of revisions are called for? It is certainly not the case that I abandon my most basic moral commitments, but I may explore ways of making my advocacy more effective, e.g., are the concepts I use foreign to my audience, am I condescending in manner, do I ignore inconvenient questions. Here the criteria of effectiveness are internal to the good sought. Now imagine that I revise my approach, a socialist candidate is elected, the platform is enacted as law, and from all I can discern equality of opportunity is decreasing. Is it possible that some factor besides the institutionalization of the socialist program is responsible for the decline? If it appears that the problem is with the program itself, is it a matter of implementation? Or is the design itself flawed in some

respect? I may be able to create a scenario that forces the question of the reasonableness of a belief in equality of opportunity, but that is a world away from yielding principle in the interests of expediency.16

According to Dewey biographer Alan Ryan, Dewey preferred the label of "experimentalism" to "pragmatism" or "instrumentalism." Ryan writes that what Dewey meant "was that the truth, or more broadly the value, of any belief or statement about the world is to be measured in experience."17 This suggests an exacting project of continually testing ideals and proposals for social reform. Of course, experimentalism is itself an ideal, an embrace of certain possibilities suggested by the practice of the scientific community.

**Dewey's concept of "experience" and the rejection of familiar dualisms**

In his short history of pragmatism, John Murphy suggests that the impetus for Dewey's reconstruction of the concept of experience is his dissatisfaction with the way experience is portrayed in the Hegelian and Cartesian traditions.18 Dewey must navigate between the organicism and idealization of the Hegelians and the atomism and detachment of the Cartesianians, and avoid the error he believes they share, what Dewey in *Experience*

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16 Along these lines, Alasdair MacIntyre has linked pragmatism with the view that "all problems are piecemeal and detailed" and the failure to criticize social wholes. (MacIntyre is referring to what he calls the "middle aged pragmatism" of proponents of the "end-of-ideology" thesis such as Edward Shils, Seymour Martin Lipset, and Daniel Bell.) Does the patient study of variables and contexts necessarily correlate with a certain narrowness or complacency? Dewey certainly did not share this belief: "The process of producing the changes will be, in any case, a gradual one. But 'reforms' that deal now with this abuse and now with that without having a social goal based upon an inclusive plan, differ entirely from effort at re-forming, in its literal sense, the institutional scheme of things." (LS4, 45) It may nevertheless be significant that later "pragmatists" were unable to sustain—or lost interest in—this broader vision and purpose. The lesson for those engaged in the process of retrieval is to beware of a tendency to become too cramped in outlook and forgetful of large ambitions. See Alasdair MacIntyre, "The End of Ideology and the End of the End of Ideology," in *Against the Self-Images of the Age: Essays on Ideology and Philosophy* (New York: Schocken Books, 1971), 3-11, especially 10-11.

and Nature calls "arbitrary intellectualism." Dewey's first move is to return thought to experience. He draws a distinction between primary and secondary experience. In primary experience there is no dualism of subject and object. Any rigid dualism between activity and passivity is also out of place. In primary experience we are always agent and patient: "The nature of experience can be understood only by noting that it includes an active and a passive element peculiarly combined. On the active hand, experience is trying—a meaning which is made explicit in the connected term experiment. On the passive, it is undergoing. When we experience something we act upon it, we do something with it; then we suffer or undergo the consequences." (DE, 146)

Primary experience is primarily non-discursive. Among the qualities of experience which are immediately perceived are those apprehended by the five senses, such as taste and touch, and by way of emotions or feelings, what we might call the tone of the experience. Experience is always richly textured and highly complex. Further, Dewey, like de Sousa, asserts that the qualities that make things "lovable and contemptible, beautiful and ugly, adorable and awful" are themselves emergent in experience—they are not merely

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18John P. Murphy, Pragmatism: From Peirce to Davidson (Boulder: Westview Press, 1990), 64.
19To modify one of Dewey's examples, when I am hungry I may ravenously devour a cheeseburger. In the first instance, there is no "me" and "it"; there is only the total complex of eating-in-order-to-satisfy-hunger. This is not to deny that things are. Dewey holds (1) that there is no dualism of subject and object in primary experience and (2) that individuality is a basic trait of existence—along with connection or relationship. In response to George Santayana, Dewey writes: "Since I find in human life, from its biological roots to its ideal flowers and fruits, things both individual and associational—each word being adjectival—I hold that nature has both an irreducible brute unique 'itselfness' in everything which exists and also a connection of each thing (which is just what it is) with other things such that without them it 'can neither be nor be conceived.'" John Dewey, "Half-Hearted Naturalism," in LW 3:80-81, quoted in Steven C. Rockefeller, John Dewey: Religious Faith and Democratic Humanism (New York: Columbia University Press, 1991), 422.
20Although Dewey tends to stress the active element in experience, elaborated as effort, control, or mastery, he never suggests that we might inhabit a world without passivity and suffering in the sense of the endurance of death, pain, or distress. He participates in Bentham's great campaign against the acceptance and frequent valorization of preventable suffering, but he has a post-Christian sense of the potential meaningfulness of suffering within the context of relationships. Human solidarity means sharing in the sufferings of others, and shared suffering has a different moral and aesthetic coloration. The relief of suffering is an unqualified good; its avoidance or elimination is not.
projections of a subject onto an object. (EN, 28)

Discursive reason, and the active element in experience, become more pronounced in secondary experience. Primary experience is continuous and flowing, but the flow can be interrupted. Our actions and purposes may be frustrated or come into conflict, and these difficulties give rise to thought. Under these circumstances, distinct "objects" crystallize against a background of matter to which we are, for the moment, indifferent.

The relation of the passive and active elements of experience becomes the key to knowledge: "Mere activity does not constitute experience. It is dispersive, centrifugal, dissipating. Experience as trying involves change, but change is meaningless transition unless it is consciously connected with the return wave of consequences which flow from it. When an activity is continued into the undergoing of consequences, when the change made by action is reflected back into a change made in us, the mere flux is loaded with significance." (DE, 146) This is a loaded passage. Of greatest significance for our purposes is the reinforcement of the notion that experience is not total absorption in some other nor the impress of external forces on an essentially separated being, but rather a flow of trans-actions. Experience can be put to use because we can affect the environment that affects us. If either change or regularity were lacking in experience, and if experience did not take shape through transactions, we would not be the kind of thinking, tool-fashioning, sense-making creatures we are.

One might take the distinction between primary and secondary experience in two contradictory directions. One might characterize secondary experience as the realm of the technique, to be contrasted unfavorably with the Edenic fullness and immediacy of primary experience. Dewey's work does not support a denigration of secondary
experience, or a sentimental view of primary experience. Distance is necessary to problem-solving; without it we are likely to be overwhelmed, immobilized by fear or anxiety. A problem in its immediacy is confusion, disorientation, frustration, insufficient sense. To define some set of circumstances as a problem is already to take charge, to begin to recover a sense of efficacy. Then, too, Dewey's recovery of experience must be distinguished from a phenomenological exploration of "lived experience"—Dewey draws attention to influences not readily apparent in experience, to social and cultural formations that help shape consciousness. His aims are critical, rather than purely descriptive. Finally, to perceive relations intelligently and to relate intelligently to other creatures and things is no mean accomplishment. And in Dewey's account, the finding or creation of "significance" out of experience is not reserved for a special kind of activity, such as contemplation, or a special class of persons, such as philosophers. Sense-making is democratic.

On the other hand, one might come to regard primary experience as something primitive to be overcome or superseded. Dewey also argues against the denigration of primary experience relative to thought or reflection. The neglect of primary experience leads to arbitrary intellectualism. Where a subject is explored in unempirical fashion, the results of philosophical reflection are bound to be deficient: "Not tested by being employed to see what it leads to in ordinary experience and what new meanings it contributes, this subject-matter becomes arbitrary, aloof—what is called 'abstract' when that word is used in a bad sense to designate something which exclusively occupies a realm of its own without contact with the things of ordinary experience." (EN, 17) Science as well as philosophy can be unempirical in unduly restricting the range of
experience it takes to be relevant. Dewey's account of experience belongs in the category of secondary experience, but it gives primary experience its due by gesturing at what it cannot fully capture. According to Dewey, all experience has a dimension that is unknown and unknowable, "ineffable," and possessed of "a certain ultimacy and finality." Such qualities and such consummations are to be respected, without being removed to a special realm, art, or limited to a special class of persons, artists.

As suggested by Dewey's resistance to the idea that reflection, or ethics or aesthetics, must be the province of a privileged class of actors, Dewey and those who find his account of experience persuasive will be unsympathetic to many traditional hierarchies. Dewey uses the term "experience" to refer to practical learning, the development of certain aptitudes and skills over a lifetime, as well as the process by which immediacy yields reflection. The common element is the attempt to redeem the "common," the widely-shared, ordinary and familiar, from neglect, and to fight the disdain reflected in the term's other connotations of inferiority and coarseness. Dewey wishes to return experience to its ordinary, idiomatic usage, as in "experienced traveler" or "experienced teacher." "To have experience, in this sense," says Murphy, "one has to have had experiences—events or sequences of events that one has participated in or at least lived through.... Dewey's claim is that not only the craftsman's skill and the practical man's wisdom, but the scientist's knowledge are based on experience in this quite

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21Rockefeller, John Dewey, 392.
22Timothy Kaufman-Osborn believes that ancient medicine offers a paradigm for resistance to the "subjugation" of experience. He writes that "within this domain there could be no supreme specialists whose assertion of expert wisdom so transcended the limitations of ordinary intelligence that it justified disregard for the claims of common sense or obviated the need for personal acquaintance with the matter at hand." Timothy V. Kaufman-Osborn, Politics/Sense/Experience: A Pragmatic Inquiry into the Promise of Democracy (Ithaca, N.Y.: Cornell University Press, 1991), 57. It is ironic that medicine evolved into a field of specialists and expertise over against "ordinary intelligence."
ordinary sense of the term.“\(^2\)

In this usage, we may speak of an experienced physician or nurse, but also, I think, of an experienced patient. The experiences of patient and physician are not interchangeable, but both may lay claim to valid and valuable knowledge concerning health and health care. Stanley Reiser chronicles how the patient's experience of illness was progressively devalued as physicians increasingly understood their work in terms set by the natural sciences. More and more, patients became objects of study and sites for the application of technique. The trend began to change when the appropriate use of new technologies became a pressing question, calling not for a better disease classification scheme or more technique, but for explicit judgments of value. Along with developments in the culture at large such as the civil rights movement, this awareness that science itself could not provide all the answers set the stage for the "reemergence" of the patient. Reiser makes a number of innovative proposals. For example, he puts forward the idea of a corps of patient consultants who, drawing on their experience as patients, would provide advice to other patients and physicians. This idea rests on the belief that patients have valuable knowledge to share.\(^3\)

To the extent that experience is shaped by one's position within a particular institutional matrix, we may speak of "socialization." As we saw with Reinhardt the economist and Relman the physician, professional socialization shapes one's perspective. In Dewey's scheme there is no necessary convergence on a single object, such as "health" or "health care," that simply is what it is apart from our experience of it. Dewey does,

\(^{23}\) Murphy, Pragmatism, 64.

however, hold out the possibility of the achievement of more comprehensive knowledge through inquiry. Further, because we are not essentially separated beings, mutual transformation may occur through communication. Physicians can learn from patients’ experience, and vice versa. The receptivity to influence that leads us to the concept of socialization must qualify our understanding of the term.

**Anticipation of some objections to pragmatic ethics**

It remains to respond to some possible objections to experimentalism and to pragmatic ethics in general. Detractors might castigate Deweyan pragmatism as a kind of success philosophy or as a form of "scientism." I have already addressed the first charge. As to the second, I believe Dewey can scarcely be cited as a forefather of scientism, naive faith in science. He opposes the estrangement of thought from experience; the reservations he expresses concerning an abstract and hegemonic philosophy will also count against an abstract and hegemonic science. Dewey clearly states that the methods of the natural sciences should not be taken as a model for the social sciences, and he does not believe science to be beyond criticism. In *Freedom and Culture*, he warns against the confusion of experimentalism and "thoughtless empiricism." Observation must be directed by general ideas, otherwise it falls prey to covert manipulation. *(FC, 95)*

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25 According to Edith Wyschogrod, Dewey holds that science must be anchored in experience or applied in two senses. First, science depends on the experiential context for its very intelligibility: "It may be necessary to formulate theories as free from particular existential reference but such theories are meaningless unless they become operational." Second, Dewey believes that "human nature is as much part of the referential field of science as any other natural object," and hence, "a science which fails to become applied in a secondary sense, that is, to take human ends into account, has failed to fulfill its objective: It is science alienated from itself." Wyschogrod, "The Logic of Artifactual Existents," 161-62. Further, as Richard Bernstein observes, what Dewey admires in science and the scientific method is not the promise of certainty. "[I]t is crucial to look and see what he [Dewey] meant by 'scientific method'... He did not mean a set of formal decision procedures or rules for advancing and justifying scientific hypotheses and theories... It is the openness of scientific inquiry, the imagination required for its successful practice, the willingness to submit hypotheses to public test and criticism, the intrinsic communal and cooperative character of scientific inquiry that Dewey highlighted when he spoke of 'scientific method.'" Richard J. Bernstein, "John Dewey on Democracy: The Task Before Us," in *Philosophical Profiles: Essays in a*
Regarding the social sciences, he says:

A more adequate science of human nature might conceivably only multiply the agencies by which some human beings manipulate other human beings for their own advantage. Failure to take account of the moral phase of the problem, the question of values and ends, marks, although from the opposite pole, a relapse into the fallacy of the theorists of a century ago who assumed that "free"—that is to say, politically unrestrained—manifestation of human wants and impulses would tend to bring about social prosperity, progress, and harmony. (FC, 171)

Too much can be made of the fact that Dewey and others unselfconsciously discuss the relative merits of various approaches to "social control." Robert Westbrook points out that for those of Dewey's generation the term signified opposition to laissez-faire market controls. Still, given evidence that the social sciences have played a part in the proliferation of agencies of manipulation, and the meaning that social control has for us now, we may be slightly more sensitive than Dewey to the costs of mastery.

Related to the charge of scientism, Dewey and the pragmatists have been accused of propagating a purely calculative rationality. Utilitarian reasoning is so widespread in our culture that a more subtle consequentialism such as that espoused by Dewey is vulnerable to misunderstanding. Passages such as the following may help to reduce misunderstanding, at least concerning Dewey's intentions: "The choice at stake in a moral deliberation or valuation is the worth of this and that kind of character and disposition.

26 Robert B. Westbrook, John Dewey and American Democracy (Ithaca, N.Y.: Cornell University Press, 1991), 189, n. 44. Hans Joas makes a similar point: "Dewey's program... is explicitly opposed to a 'naturalization' of the market and to a conception of it as a self-regulating, problem-solving mechanism. It is precisely the consequences of the interconnection of actions having economic ends that require a collective interpretation and assessment. In the specific way that the notion of 'social control' was used by this group of thinkers, this notion did not refer to a guarantee of social conformity but, rather, to conscious self-regulation, to the idea of self-government effected through the medium of communication and understood as the solving of collective problems. Thus this concept of 'social control' was, in the theory of social order, the equivalent of the concept of 'self-control' in the theory of action." Hans Joas,
Deliberation is not then to be identified with calculation, or a quasi-mathematical reckoning of profit and loss. Such calculation assumes that the nature of the self does not enter into question, but only how much the self is going to get of this and that. Moral deliberation deals not with quantity of value but with quality." (EII, 274) A Deweyan pragmatist will, I think, allow that calculation, the quantification and comparison of benefits and harms, may be helpful—but only where this process can be accomplished without doing violence to distinctions of quality. It is a good idea, then, to arm oneself in advance against the dangers. For example, no consideration of means should take place apart from a consideration of ends. This formulation is, however, misleading, if it implies that means can be separated from ends. Means constitute (truly become) ends, and one had better be sure that they are consistent with one's considered ends or intentions.

Further, modifying the usual assertion that the ends justify the means, one might say that the means "justify" the end, in the sense of showing the end to be right, just and reasonable. The operation of an organization dedicated to the spread of democracy on democratic principles, and the realization of the promised goods of democracy among its members, is the best evidence of the practicability and desirability of democracy.

Once we have set our course, we enter a different phase of the problem. Given the complexity of the environment, we are bound to narrow the field of considerations in effectively carrying out our various responsibilities. The correction demanded is not an effort to keep all considerations in view at all times, but rather a periodic check to ensure that activities are consistent with and in the service of broader goals. Consider an example from contemporary health care administration. What are the consequences of using the

term "medical-loss ratio" to refer to the proportion of premium dollars actually spent on the delivery of health care? The prevention of illness (and attendant upon that, a reduction in the need for medical services) is highly desirable. Likewise, we should always strive to reduce unnecessary expenditures—waste—through the elimination of redundancies, useless medical work, useless paperwork, and so on. At the same time, it is perverse to equate the desirability of these kinds of goals with the desirability of a goal of minimizing medical services, absolutely. The term medical-loss ratio suggests that the provision of health care is itself loss, waste.\textsuperscript{27} Taken together with other terms currently in vogue, such as the term "covered life" for persons who have entrusted their health care to a plan or provider, the term medical-loss ratio establishes the greatest possible distance between the goals and activities of administrators and the broader mission of providing appropriate care.

To parse out matters in this way is not to do away with the tensions among various ways of thinking, as in the classical Weberian distinction between formal and substantive rationality.\textsuperscript{28} (At the same time, one must take care to avoid reifying functional distinctions.) Complex philosophical treatments of the problem are available, and further consideration of that nature is beyond the scope of this dissertation. That contemporary corporate and regulatory culture tends to foster models of rationality according to which ends are given and unproblematic, and their realization is a matter of

\textsuperscript{27}As George Anders points out, the term functioned differently in its original context, the traditional indemnity insurance industry. There accountants used the term to describe the percentage of premium dollars paid out on medical claims. George Anders, \textit{Health Against Wealth: HMOs and the Breakdown of Medical Trust} (New York: Houghton Mifflin, 1996), 62. Insurance companies had no role in providing care, and they had little or no power to limit the quantity or quality of the health care services received by the people they insured. Their only control over losses was the prospective adjustment of premiums to bring revenues more in line with expenses.

\textsuperscript{28}Later students of organization have also distinguished between "practical" or functional rationality, which correlates with increased efficiency, and formal rationality as an orientation of action to formal rules and
selection and refinement of techniques, would not, I think, be controverted by many.

Hence the stress here will be on unsettling calculative rationality, on problematizing goals and broadening responsibility. In the health care field, that means thinking critically about the penetration of practice by accounting terminology, the increasing reliance on cost-benefit analysis, and the turn to incentive schemes to control behavior. In general, the method of experimentalism lends itself to this task. It pushes the inquirer toward a stereoscopic social criticism. By initially casting the net very wide—by learning as much as possible about what managed care has meant and will mean in practice, by analyzing breakdowns in communication and understanding in discussions of managed care, by garnering insights from a variety of moral theories and thinkers, by identifying standard failures of thought, and by marking the "blind spots" in our culture—we do what we can to ensure that our inquiry is a fruitful one for practice.

2. Social Values: Deweyan Democracy and Pragmatic Justice

Democracy

Democracy is the great unifying theme in Dewey's work on ethics and culture. Dewey and Tufts describe the experimental approach to solving problems as the method of democracy. This is so because it involves "a positive toleration which amounts to sympathetic regard for the intelligence and personality of others, even if they hold views opposed to ours, and of scientific inquiry into facts and testing of ideas." (EII, 329)

Wedding the notion of "sympathetic regard" and Seyla Benhabib's conversational model we realize that in carrying out the task of inquiry, we are not only searching for solutions to the problems of social life, we are in fact living, socially. The adoption and

laws. Some have found an awareness of this tension in the work of Weber himself.
implementation of principles of universal moral respect and egalitarian reciprocity, and
the cultivation of the ability to take the standpoint of the other, are the instrumentalities
through which democracy is realized. Democracy in its political aspect may include
procedural protections such as universal suffrage, majority rule subject to constitutional
constraints, and the panoply of rules and regulations designed to assure the impartiality
of governmental administrators, but these are less than the whole, even of political
democracy.

The viability of political democracy is, in any event, linked to the flourishing of
"social democracy," a concept that is much broader in scope. This is what makes
Deweyan democracy especially relevant to managed care and the health care sector
generally. Most managed care organizations, for-profit or not-for-profit, are part of civil
society. As the incubator of social democracy, civil society has special importance in the
work of Dewey and his heirs. Deweyan pragmatism seeks above all to understand and
cultivate the goods of voluntary association. If democracy as method establishes the
ground rules for participation in the solving of social problems and the fashioning of social
arrangements, what we might call democracy as liberation becomes a standard for judging
social arrangements generally.29 *Human Nature and Conduct* contains the fullest
expression of the idea of democracy as liberation:

To "make others happy" except through liberating their powers and
engaging them in activities that enlarge the meaning of life is to harm them
and to indulge ourselves under the cover of exercising a special virtue. Our
moral measure for estimating any existing arrangement or any proposed
reform is its effect upon impulse and habits. Does it liberate or suppress,
ossify or render flexible, divide or unify interest? Is perception quickened

29It is important to note that the aim of an arrangement need not be identical with the standard in order for
the arrangement to merit approval according to the standard. Our actions and their consequences may
escape our intentions, not only in a negative way, but also by bringing goods we did not foresee.
or dulled? Is memory made apt and extensive or narrow and diffusely irrelevant? Is imagination diverted to fantasy and compensatory dreams, or does it add fertility to life? Is thought creative or pushed one side into pedantic specialisms?... To foster conditions that widen the horizon of others and give them command of their own powers, so that they can find their own happiness in their own fashion, is the way of "social" action. *(HNC, 202-3)*

This view of democracy, taken as a moral standard, may be too flexible, too open-ended, to please many moralists. A simple utilitarian calculus, is, for example, precluded. It is not our business to dole out happiness, or health, as if it were a commodity. And it would be presumptuous, anti-experimental and undemocratic, to lay down the moral law for all persons, times, and places with too much specificity. But we can exhibit moral concern in contributing to the formation of social institutions that nurture capacities for happiness, and health.

Others might object that the proposed standard is too subjective, in either of two ways. First, it might be argued that social benefit remains a matter of individual judgment. Dewey’s model of moral deliberation as cooperative inquiry renders his position less purely subjective than this particular formulation might imply. Second, Dewey’s stress on what is one’s own, as in "own" happiness and "own" fashion might be taken to suggest that happiness is a purely individual matter. Can happiness be distinguished from a subjective standard of self-realization? Yes, if a distinctively moral happiness includes regard for the happiness of others, and that includes the wish that they (we) in concert develop an ever richer and finer appreciation for what is valuable: "Regard for the happiness of others means *regard for those conditions and objects which permit others freely to exercise their own powers from their own initiative, reflection, and choice.* Regard for their final happiness... demands that these others shall find the
controlling objects of preference, resolution, and endeavor in the things that are worthwhile." (EI, 302-3) As Dewey notes in The Quest for Certainty, "The fact that something is desired only raises the question of its desirability; it does not settle it. Only a child in the degree of his immaturity thinks to settle the question of desirability by reiterated proclamation: 'I want it, I want it.'" (QC, 208) Judgments of value have to do with exploration of the consequences attendant upon satisfaction of spontaneous desire, that is, they require moral deliberation. Respect for others is not necessarily expressed in treating their spontaneous desires as final. Further, in many cases, the question of desirability cannot be settled in the privacy of individual appetite or conscience.30

Even this argument may be misleading. In the course of his career, Dewey became increasingly concerned with eliminating the residue of a philosophical conception of the individual and society as separate and opposed entities from his thought and prose. In the revised edition of the Ethics, Dewey and Tufts catalogue the evidence of human interdependence, from the absolute dependence of the infant, to the dependence of individuality itself on social nurture, to the omnipresence of language. These "facts of life" are so familiar that we miss their import, "namely, that the human being is an individual because of and in relations with others." Imagined apart from these relations, "he [or she] is an individual only as a stick of wood is, namely, as spatially and numerically separate." (EII, 227) Specific forms of relationship may be the subject of critical attention and demands for reformation. Relation itself is put into question only through an act of supreme abstraction from experience, a maneuver which is highly questionable from a Deweyan perspective. For example, the arbitrariness of particular

30 "Communication, sharing, joint participation are the only actual ways of universalizing the moral law"
rights and duties does not extend to the concept of right itself and what it expresses of experience, that is, "the way in which the good of a number of persons, held together by intrinsic ties, become efficacious in the regulation of the members of a community." (EII, 228)

Human relatedness is not merely an unexpungeable aspect of experience with certain implications in the area of right and duty. It also figures prominently in Dewey's account of the good and his aesthetic and religious vision. Dewey claims that "[s]hared experience is the greatest of human goods." (EN, 157) Dewey also uses the term "conjoint communicated experience" to describe the kind of consummation of which social life is capable. For Dewey, "community" is the apex of the development of associated life. In Dewey's trajectory, the association or interaction that is a basic feature of existence becomes elaborated as shared activity, which makes possible the emergence of shared values. It is this final stage that defines true community: "Wherever there is conjoint activity whose consequences are appreciated as good by all singular persons who take part in it, and where the realization of the good is such as to effect an energetic desire and effort to sustain it in being just because it is a good shared by all, there is in so far a community." (PP, 149) As this definition suggests, community will often be a matter of degree, a partial or temporary achievement. Further, the degree of homogeneity, or unity on matters of belief, is not necessarily a good index of community. Although for Dewey "the community cannot be a community without some degree of shared experience and shared meanings," "this communality implies also a richness, a complexity of possible

and end." (RP, 197).

perspectives to enter into, not the simplicity of identity."32 Finally, it is consistent with Dewey’s view to allow for limited communities constituted by persons who might otherwise be moral strangers to address a common problem—if working together is experienced as a good and so on—and to recognize community even where there are deep divisions.

For Dewey, community is bound up with communication, the sharing of meanings, in its instrumental and consummatory aspects. He writes, "Democracy will come into its own, for democracy is a name for a life of free and enriching communion. It has its seer in Walt Whitman. It will have its consummation when free social inquiry is indissolubly wedded to the art of full and moving communication." (PP, 184)33 Dewey’s paradigm of full and moving communication can be contrasted with a paradigm of disclosure, frequently employed in the health care context. In the disclosure paradigm, the focus is on the transfer of identified pieces of information. A subject is required to receive the information, but the origination point and vehicle of disclosure are largely a matter of indifference. The paradigm of communication shifts the focus to what happens between two or more subjects: "To be a recipient of a communication is to have an enlarged and changed experience. One shares in what another has thought and felt and in so far, meagerly or amply, has his own attitude modified. Nor is the one who communicates left unaffected.... The experience has to be formulated in order to be communicated. To formulate requires getting outside of it, seeing it as another would see

33The difference between this view of community and Bentham’s is striking. In siding with Dewey or Bentham, one must consider one’s own experience of common life. But perhaps there is no choice. I am persuaded by Dewey that Bentham is simply wrong in denying intrinsic ties, and the idea of communion fires the imagination. On the other hand, Bentham, and Dewey in his reflections on right, remind us of the
it, considering what points of contact it has with the life of another so that it may be got into such form that he can appreciate its meaning." (DE, 8-9) Both recipient and communicator are changed by the encounter, and in a genuine conversation the positions are reversible.34

Democracy and Justice

A good portion of the last chapter was devoted to the subject of justice. What must be accomplished here is the integration of various perspectives on justice into a pragmatic framework. We might begin by defining justice as the expression of the Deweyan concept of right, that is, "the way in which the good of a group of persons, held together by intrinsic ties, become efficacious in the regulation of the members of a community."35 Justice is a term that captures the forms of regulation that develop to sustain a community or society also "held together by intrinsic ties." In its broadest sense, it expresses obligation, and doing justice consists in the fulfillment of obligation. In a narrower sense, it defines the area of legally enforceable right. Certain formulas historically associated with justice, such as giving each person his or her due, or treating like cases alike, may have greater or lesser relevance depending on whether one is using justice to indicate obligation or a more restricted sphere of right. For example, the notion of treating like cases alike fits better with justice in public administration than justice in the family. Justice is often symbolized by a blindfolded figure with a scale, suggesting impartiality, a careful weighing of all relevant considerations, and an achievement of sober work that needs to be done if we are to manage the conflicts of social existence.

34 For all its dialogical properties, this way of way of describing things may still be criticized as overly individualistic in light of contemporary theories of communication. Thought itself is dialogical and social rather than monological. Although Dewey stresses the connection between thought and problems encountered in the natural environment, thought also bears the impress of the social-cultural environment.
balance in one's final appraisal.

Philosophers and jurists have constructed classificatory schemes to aid in the analysis of justice. Traditionally, a distinction is made between distributive justice and commutative justice. According to one classical account, that of Thomas Aquinas, distributive justice refers to the proportionate distribution of common goods, or "what the whole owes the parts." The rule of distributive justice is often presented as some variation of the ancient formulas, such as persons should be treated similarly, receive equal shares and so on, unless there are good reasons, relevant to the particular instance of distribution, for treating them differently. Walzer argues that all goods are social, but only some are common in the sense that they are to be distributed by the whole, the community. Certain goods are provided by the community to all because they are recognized as especially significant by members of the community. Walzer holds that in areas of communal provision the appropriate principle of distribution is need, meaning that difference in need is the only proper basis for differential treatment. He allows for other goods to be distributed according to principles of mutual agreement (free exchange) or desert. MacIntyre stresses the importance of desert as a principle of distribution within the best type of community, the community dedicated to virtue and excellence and agreed on standards for judging achievement.

Rawls treats all goods as common goods to be distributed according to the two principles of justice. At the same time, he suggests that justice as fairness is founded upon a basic intuition concerning mutual advantage, a recognition of the importance of willing cooperation, and an appreciation of the importance of reciprocity in social life.

35One can contrast Rawls's definition of right as "a set of principles, general in form and universal in
These are terms associated with what Aquinas, following Aristotle, calls commutative justice. Commutative justice is an aspect of the dealings between "private" persons. The sphere of private transactions is contrasted with the sphere of public administration, although private transactions are facilitated by laws and by the availability of the courts for the settlement of private disputes. As suggested by Haavi Morreim, this kind of justice might be termed "contractual justice," as it concerns the standards that govern the making and carrying out and breaking of voluntary agreements or contracts. The utilitarian perspective on justice, with its focus on the protection of justified expectations, seems most relevant in this area.

On this conception of justice as the development of forms of regulation, moral and legal, to aid in the maintenance of community, justice is both natural and artificial. Although we may end up with a set of very general principles in a highly cosmopolitan and legalistic society, even those general principles need some emotional nourishment. Robert Solomon argues that the emotions are the raw material of justice, and that justice is corrupted whenever its emotional connections are denied or obscured: "Justice begins not with Socratic insights but with the promptings of some basic emotions, among them envy, jealousy, and resentment, a sense of being personally cheated or neglected, and the desire to get even—but also, of course, those basic feelings of sharing, compassion, sympathy, and generosity... Whatever one's principles of justice, they are utterly meaningless without that fundamental human sense of caring and the ability to understand

application, that is to be publicly recognized as a final court of appeal for ordering the conflicting claims of moral persons." Rawls, *Theory of Justice*, 135.

and personally care about the well-being of other human beings..." No one emotion need predominate. Allowing for this multiplicity, we can understand why justice might be accounted for in terms of fear or insecurity (Bentham), mutual advantage (the Rawls of the original position), an appreciation of excellence or merit (MacIntyre), and sympathy (Rawls's moral psychology and the idea of social union).

As for the universality of justice, it is obviously important to a democratic notion of justice that legal rules in particular apply to all members of the community. Further, there are needs, and related to them, obligations, that are recognized with such regularity that we have every reason to call them universal or basic. On the other hand, we have every reason to believe that what justice requires will vary across cultures and communities. What follows from this is not a relativizing of the demands of justice. There are claims so powerful that they must be addressed. As Solomon puts it: "It is true that basic needs are relative and not absolute in the sense of a single, universal measure of misery. But it is also true that they are absolute in the sense that they are concerns that no amount of argument should lead us to ignore..." At the same time, without giving up the insistence that we have obligations to others, there may be good reason for marking off some region of personal inviolability from coercion, a certain "deontological space." Doing so will set limits on who or what can be conscripted to achieve social goals. There may be some worthy ends that we cannot realize because the required consents cannot be secured. This point is powerfully argued by Robert Nozick and H. Tristram Engelhardt, Jr. We may disagree about what is encompassed in

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deontological space, but the basic principle is one that we have reason to respect if we respect anything at all.\(^{39}\)

The difficulty is in weighing all of these considerations in a particular case, in determining what interests or concerns are to be weighed and where to strike the balance, especially in the area of distributive justice. That is what leads us back to Michael Walzer's spheres of justice and to democracy as a method for addressing the problematic. Walzer and Reinhardt and Relman agree that we cannot neglect the health care needs of our fellows altogether, and they are likewise agreed that an interpretation of social meanings will guide distribution. Further, I think Walzer is correct in arguing that in areas of social provision it is unjust to require people to contribute to goods from which they are excluded \((\textit{de facto} \text{ if not } \textit{de jure})\), especially if the result is a transfer of wealth from the poor to the affluent. Beyond this, what is just is a matter for communal inquiry and decision. That, at least, is where political democracy leaves the issue. Social democracy introduces an additional consideration. The idea is not simply that people are to be given their fair share of commodities, at least enough to meet their basic needs. People are to be enabled to develop their capacities, including the capacity to supply their own needs to

\(^{39}\)See Robert Nozick, \textit{Anarchy, State, and Utopia} (New York: Basic Books, 1974), and H. Tristram Engelhardt, Jr., \textit{The Foundations of Bioethics}, 2nd ed. (New York: Oxford University Press, 1996). In the work of both philosophers, there is an interesting compound of libertarianism and communitarianism. (What is interesting is not really odd, given that these two lines intersect in anarchism.) In a more recent book, Nozick emerges as more strongly communitarian. Robert Nozick, \textit{The Examined Life: Philosophical Meditations} (New York: Simon and Schuster, 1989). As for disagreement over the shape of deontological space, one might regard a person's mind and body as inviolable in the sense that torture would never be permissible, without allowing that a person has a right to commit suicide and to enlist others in the effort. Those who argue in terms of respect for life will see a clear difference between the two cases, while those who argue in terms of property rights or rights of control will see a distinction without a difference. Likewise, one might regard certain forms of property as so closely bound up with personal identity that they share in the inviolability of mind-body, without allowing that there is an absolute private right of ownership extending to the means of production. Those who argue that the self is embedded in webs of relationships with other persons and things, with gradations of significance, will see a difference, while those who argue that the self is mixed with or extended into its products—of whatever nature—will not (unless their thought takes a Marxist turn).
the greatest extent possible.40 These sorts of concerns have figured prominently in recent
Roman Catholic social thought, and are captured in what has become known as the
principle of subsidiarity. The principle was first articulated by Pope Pius XI, in
response to the kind of corporatism associated with Italian fascism. In Quadragesimo
Anno, the Pope stated that "one should not withdraw from individuals and commit to the
community what they can accomplish by their own enterprise and industry." "Inasmuch
as every social activity should, by its very nature, prove a help to members of the social
body, it should never destroy or absorb them."41

The principle of subsidiarity has guided the thinking of the U.S. Catholic bishops
on health and health care and the economy.42 In an introduction to church teachings
concerning health care, Kevin O'Rourke and Philip Boyle state the developed principle
clearly and concisely: "(1) Decision making rests first with the person, then with the
lower social levels, and horizontally with functional social units; and (2) The higher social
units intervene only to supply the lower units with the goods they cannot achieve by
themselves, while at the same time working to make it easier in the future for lower units
and individuals to satisfy these needs by their own efforts."43 I note the consonance of
this view with Dewey's injunction to show regard for "those conditions and objects

40Relative to cultural context, in that what is appropriate will depend on cultural conditions. In an agrarian
society, each family might be enabled to grow its own food. In New York City, one might promote rooftop
gardens, but it would probably be a good idea to focus on ensuring that each neighborhood has a clean,
safe grocery store with a good selection of reasonably priced goods.
41Quadragesimo Anno (1931), quoted in Dennis P. McCann, "Toward a Theology of the Corporation: A
Second Chance for Catholic Social Teaching," in Catholic Social Thought and the New World Order, ed.
Oliver F. Williams and John W. Houch (Notre Dame: University of Notre Dame Press, 1993), 329-50 at
342.
42In the pastoral letter on health and health care, the bishops affirm the value of pluralism, and they call for
the creation of a comprehensive health system drawing on the resources of the public and private sectors.
43Kevin D. O'Rourke and Philip Boyle, Medical Ethics: Sources of Catholic Teaching, 2nd ed.
which permit others freely to exercise their own powers from their own initiative, reflection, and choice.” On this view, self-help and social support are complementary rather than antagonistic concepts.

In the next chapter, I will consider how justice should figure in an assessment of health care organizations. At this point, I wish only to remark how the principle of subsidiarity might influence our thinking about justice in more general ways. First, the bases of self-respect and self-esteem are not allowed to simply disappear from the picture. Robert Solomon argues that relationships—fellowship and fellow feeling, belonging to a community (with whatever degree of identification), and being recognized and respected by others—are the "primary currency" of justice.⁴⁴ Self-respect and self-esteem, and the social relationships that undergird them, can only be properly formed if the capacities of individuals, families, and voluntary associations are nurtured and respected. An account of basic needs and primary goods must include satisfying human relationships, for which the social bases of self-respect may serve as a proxy in the political order. At the same time, these goods cannot be separated from other goods. Stable and fulfilling human relationships are fostered when other basic needs are met. Homelessness, joblessness, and poor health and health care, or anxiety about any of these conditions, are corrosive forces on human relationships.

Second, as a related matter, we are urged to recognize the connection between process and outcome. Consider two elderly women recovering from strokes of comparable severity. One receives extensive physical therapy and so is able to do her own grocery shopping and so on. The other receives minimal physical therapy but is

⁴⁴Solomon, Justice, 90.
supplied with a home health aide who sees that her needs for food and the like are met. Justice requires that basic needs be provided for, and so it might seem that neither woman has cause for complaint. But justice informed by the principle of subsidiarity seems to require that restorative measures be favored over maintenance measures. Given that restorative measures are clearly feasible, the woman who is managed as a "head in a bed" can claim that she is being treated unjustly. Third, while the principle of subsidiarity alone will not support an absolute priority for the "least advantaged," the effort to enable all to participate fully in associated life will require greater attention to those who lack the social and material supports for effective freedom and moral equality. Fourth and finally, the kind of universalism associated with the principle of subsidiarity is not opposed in principle to special relationships. It does not require that I abandon a healthy self-regard or special concern for family members, friends, my own patients or clients, or the associations to which I belong. I am, however, required to work for social conditions that will support the flourishing of other persons, families, professional relationships, and associations on their own terms.

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45It would be even better to prevent strokes, but preventive measures cannot substitute for maintenance measures in the same way that restorative measures can.
46Deweyan democracy and pragmatic justice do not require a leveling down. Dewey and Tufts have this to say on the subject of equality in the revised edition of the Ethics: "It does not mean sameness; it is not to be understood quantitatively, an interpretation which always ends in ideas of external and mechanical equality.... One person is morally equal to others when he has the same opportunity for developing his capacities and playing his part that others have, although his capacities are quite unlike theirs. When there is an equation in his own life and experience between what he contributes to the group activity and experience and what he receives in return in the way of stimulus and of enrichment of experience, he is morally equal." (EII, 346) The central idea is similar to Michael Walzer’s notion of “complex” equality: “The aim of political egalitarianism is a society free from domination. This is the lively hope named by the word equality: no more bowing and scrapping, fawning and toady-ing; no more fearful trembling; no more high-and-mightiness; no more masters, no more slaves. It is not a hope for the elimination of differences; we don’t all have to be the same or have the same amounts of the same things. Men and women are one another’s equals... when no one possesses or controls the means of domination.” Michael Walzer, Spheres of Justice: A Defense of Pluralism and Equality (New York: Basic Books, 1983), xiii.
To conclude, Deweyan democracy and pragmatic justice form part of a "provisional, self-limiting conception of the good," and the right, that commands widespread allegiance. The themes of democracy and justice resonate with many persons and many traditions. There is a good fit with contemporary Roman Catholic social thought. There is some overlap with Rawls, and the utilitarians and the communitarians. Still, I am not arguing that this scheme, were it possible to deduce a set of directives from it, could be imposed on grounds that we all agree with it, or would if we were adequately informed and really thought about it. My primary aim is to articulate a general orientation that can be adapted to the needs of the individuals and associations that make up civil society. Although some activities are carried on exclusively within and for the benefit of particular communities and can be guided entirely by the appropriate content-full moralities, many individuals and associations will desire an ethic that speaks to their transactions with the culture-at-large. Deweyan democracy and pragmatic justice are social values to guide individuals and associations that want to contribute to goods that are common.

3. Moral Psychology: Character and the Self

Conduct and character

For Dewey, the occasion for moral reflection is a question as to the proper course of conduct, a question of how to act in the face of uncertainty or conflict. At the same time, Dewey and Tufts argue that the ultimate question in any moral situation is "what shall the agent be?" "[A]ctions not only lead up to other actions which follow as their effects but they also leave an enduring impress on the one who performs them, strengthening and weakening permanent tendencies to act." (EII, 170) These tendencies
are "habits," in a usage that builds on—but is not identical to—the common understanding of the term, and habits build character.

An act, then, is not an isolated phenomenon. First, each act takes place within a flow of experience and activity. Second, acts, including acts of choice, have reverberations—often beyond what we intend or foresee. Each act is a transaction with the natural and social environment bringing a return wave of consequences back on the agent. What I choose now, indeed, the nature of the choices I am faced with now, is partially determined by what I have done or chosen before. The choices I will face in the future, and the nature of those choices, are partially determined by all my past and present choices. When John Glaspy agreed to serve as a consultant for Health Net, he no doubt failed to foresee (or wished not to dwell upon the likelihood of) a serious conflict of obligations down the road. Choices of affiliation are particularly weighty acts, since they open and close whole fields of action. They condition the moral problems that we will face, even what we will see as a moral problem, since in choosing we reinforce commitments to certain values and neglect others or allow them to fade away altogether.

What would at one time have been a problem, becomes merely a part of the routine. Certain pressures and influences become part of my world, shaping my judgments, molding my conduct, forming my character, with or without my conscious awareness of what is going on.

One can view character in terms of how it is built up, as the total complex of habits. Dewey and Tufts define character as "that body of active tendencies and interests

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in the individual which make him open, ready, warm to certain aims, and callous, cold, blind to others, and which accordingly habitually tend to make him acutely aware of and favorable to certain sorts of consequences, and ignorant of or hostile to other consequences." (EI, 255) Character is a matter of one's particular sensitivities and overall breadth of vision—selfishness is portrayed as a sort of nearsightedness. Judgments about character follow observation. Such judgments are bound to be complex, because the relationships among tendencies and interests, and between each of these and the environment, are complex. Character traits interpenetrate, but Owen Flanagan rightly associates Dewey with the "multiple-competence" rather than unitary view of character.48

I may be conscientious and insensitive, or kind at the office and not at home. Further, on this view important aspects of character are beyond my control. Character includes aspects of the self which are below consciousness and beyond intention. The observer may detect a pattern to which the naive self, and possibly even the reflexive self, is oblivious. And character is vulnerable—even good character is not proof against misfortune.49 This vulnerability also has a positive side. First, sometimes the things that just happen prove immensely significant and valuable. I feign sleep to avoid conversation with the man sitting next to me on the airplane, but when he spills a drink in my lap we have occasion to speak, and before you know it we are married. Second, although the old saying that suffering builds character is open to challenge, it does contain a grain of truth. Conflict and tension and disappointment are part of the normal process of character

49For a much more nuanced treatment of character and contingency, see Nussbaum, Fragility of Goodness, especially 318-72 and 397-421.
formation, and contending with these difficulties can lead to the development of strengths or virtues. Finally, character is a thoroughly historical phenomenon. If you ask me about the character of x, you are inviting a biography—but an open one.\footnote{To sketch in some of the features of Dewey’s psychology, action itself on Dewey’s account requires no originating motive. Activity is the normal “state” of the human organism. Activity does, however, display a certain selectivity of response, and activity may be channeled toward certain objects. These “spontaneous” preferences are the remote bases for our choices, that is, there is a certain development-with-continuity between unexamined preference and choice. Choice as knowing decision results when deliberation occasioned by incompatible preferences intervenes between preference and action. There is another kind of progression between the concepts of act, conduct, habit, and character. In each case, the next term in the sequence takes in a larger field of ramifications and reciprocal influences. Again, Dewey stresses the continuities in the aspects of experience he is attempting to formulate in philosophical terms. (Hence, even though a habit is a more complex phenomenon than an act, by repeatedly acting differently one may change a habit and, ultimately, one’s character.) A similar view of character as closely linked to behavior and subject to change—over against Thomas Nagel’s treatment of character as something substantial and unchangeable—is defended in Michele Moody-Adams, “On the Old Saw That Character Is Destiny,” in \textit{Identity, Character, and Morality: Essays in Moral Psychology}, ed. Owen Flanagan and Amélie Oksenberg Rorty (Cambridge, Mass.: MIT Press, 1990), 111-31.}

This discussion of character leaves open a number of significant questions. For example, are men and women born egoists, and then socialized out of selfishness? Or is the “natural” tendency to consider what is closest to us first morally neutral, with development into egoism or selfishness merely one possible outcome? Dewey is committed to the proposition that all natural impulses or tendencies are morally neutral, or pre-moral. At the same time, some tendencies are less neutral than others: “[T]here is in every one a tendency to fix in his mind only a part of the probable consequences of his deed; the part which is most innocent, upon which a favorable construction may most easily be put, or which is temporarily most agreeable to contemplate. Thus the person concentrates his thought, his forecast of consequences upon external and indifferent matters, upon distribution of commodities, increase of money or material resources, and upon positively valuable results, at the expense of other changes—changes for the worse.

in his disposition and in the well-being and freedom of others." (EI, 257) The suggestion is that consequences affecting our own characters or the well-being (material and non-material) of others deserve greater weight than we are usually inclined to give them.

One way to read Dewey here is in keeping with the long line of philosophers (including Aristotle and John Rawls) who regard excessive concern with material goods as a kind of moral failure, and large possessions as a moral hindrance, without denying the value of material comforts or the necessity of a certain level of material welfare for a moral life. As an alternative to the path through philosophy, consider the legacy of the Christian "Social Gospel" movement (roughly 1870-1920). The religious reformers associated with the movement were all critical of aspects of capitalism, with significant variations to be sure. Alongside concern about the plight of the poor, there was concern about the plight of the rich. The main line of argument, according to Max Stackhouse, was that "if people are so rich that they are no longer subject to the vicissitudes of life that daily affect their neighbors, if they are isolated from the needs of humanity, and if they can utilize their wealth to distort the structures of the common life for private ends, something is wrong either with them or with the structure of the social system that allows such uncontrolled special privilege."53

52 So far as I can tell, this section disappears in the revised edition of the Ethics. A passage in the later work suggests that although Dewey's terminology can be confusing, he does not regard material reproduction as inherently inferior to other projects. He writes that the distinction between "ideal values" and "material values" is "one between goods which, when they present themselves to imagination, are approved by reflection after wide examination of their relations, and the goods which are such only because their wider connections are not looked into." "There are occasions when attention to the material environment constitutes the ideal good because that is the act which thoroughgoing inquiry would approve." (EI, 212) I do not think that this resolution renders the earlier argument moot, although I think it likely that the mature Dewey would develop the point more contextually.

Indeed, this sort of spirit seems to animate Dewey and Tufts. They state that "all special privilege narrows the outlook of those who possess it, as well as limits the possibilities of those not having it." They add, "The intellectual blindness caused by privileged and monopolistic possession is made evident in 'rationalization' of the misery and cultural degradation of others which attend its existence." (EII, 347-48) There is some evidence of a correlation between privilege and insensitivity to the misery of others in the deMeurers case. Roger Greaves and Malik Hasan inhabit a different world from the middle-class deMeurseres—let alone the poor. No sudden illness will put their families in danger of financial ruin. And yet, no amount of money will make these men invulnerable to personal tragedy, sickness, and death.

Vulnerability to loss is the true root of problem, according to Reinhold Niebuhr. Niebuhr certainly has much to say about the immorality of society and social structures, but he frames the problem of greed in terms of humankind's existential anxiety. The problem is a perennial one, as evidenced by the denunciations of biblical writers: "The warnings in the scripture against covetousness are frequent and explicit; and they are justified by the observation that 'a man's life consisteth not in the abundance of the things he possesseth' (Luke 12: 15). In Christ's parable of the rich fool, the effort to protect the future against all contingencies by heaping up wealth is rebuked by a reminder of the brevity of life of all men."54 We seek salvation in things which will ultimately fail to secure us against loss and death, in the process abandoning much that is of value and genuinely lies within our grasp.

113.
R.H. Tawney, in his manifesto against acquisitiveness, makes a similar argument.

He also makes the scandal of disproportion as concrete as possible by describing the bloated income of the executive in terms of the number of families that might be supported by such an amount: "It is true that special talent is worth any price, and that a payment of £10,000 a year to the head of a business with a turnover of millions is economically a bagatelle. But economic considerations are not the only considerations. There is also 'the point of honor.' And the truth is that these hundred-family salaries are ungentlemanly." 55 Even allowing for inflation, and translation between currencies, Roger Greaves's $8.9 million salary must qualify as ungentlemanly. The terminology may be quaint, but there is something attractive about this holdover from a morality of personal honor and social seemliness. There is something unseemly in the contrast between the stinginess managed care executives display in relation to patient care or payments to providers, and their lavish compensation packages. Journalist George Anders very cleverly labels these executives the "barons of austerity." Anders recounts how one baron, Dan Crowley of Foundation Health, led the industry in 1994 with a compensation package valued at $19 million. The deal provoked outrage, and the next year Crowley accepted a more modest package. In a speech to a physician group, Crowley conceded, "In this environment, it's doggone piggy to put your face that far in the trough when other people are hurting." 56

In concluding this section, a few qualifications are in order. First, there is a tendency in some quarters to romanticize pre-capitalist economic actors. This is foolish.

56Anders, Health Against Wealth, 64-65. (This reminds me of a good piece of prudential advice: Little pigs get fat, big pigs get eaten.)
Peasants could be grasping, and feudal chieftains could be rapacious. Likewise, in societies that have adopted state capitalism, party bosses have proved very adept in separating themselves from the common lot. This does not amount to proof that the level of greed is stable across cultures, but I believe it does support Niebuhr's point, that what we are describing is a perennial problem. Second, we need to beware of envy and resentment. If Solomon is right, these two emotions may play a role in motivating us to respond to injustice, but it is another thing altogether if we are striving to bring people down simply because they are happy or prosperous.

**Reconstructing the inherited categories**

The passages quoted above in the discussion of character are in many ways Dewey's final word on any deep flaw in human nature. In general, any talk of a fixed "nature" is uncongenial to Dewey. In any event, Dewey and Tufts reject the usual construction of the moral problem in terms of "self-denial" (or self-sacrifice) and "self-assertion" (or the will-to-power), and their critical analysis extends to the very notions of "self" and "interest." The theory that morality consists in denying the claims of the self arises because we tend to identify the self with one of its components, or get stuck in a rut. "In general, to point out the truth which this theory perverts, to emphasize the demand for constant reconstruction and rearrangement of the habitual powers of the self—is sufficient criticism of it." But, given the pervasive influence of the belief that the self is the problem, it is important to consider the evils to which the theory gives rise. First, the whole of morality acquires a negative cast. "While asceticism is in no danger of becoming a popular doctrine, there is a common tendency...to fail to see that the important thing is some positive good for which a desire is controlled." (EI, 366)
Second, feminist social critics alert us to the fact that women are the usual casualties of the doctrine of self-denial and the resultant deformations of the self. Finally, the self denied frequently displays a kind of deviousness in demanding recognition and reward: "The one who is conscious of continually denying himself cannot rid himself of the idea that it ought to be 'made up' to him; that a compensating happiness is due him for what he has sacrificed, somewhat increased, if anything, on account of the unnatural virtue he has displayed." (EI, 368) To cite a specific example, many physicians no doubt believe they are entitled to whatever they can get after enduring the multiple deprivations of residency.

The doctrine of self-assertion takes the enemy constructed by the self-denial school—the affirming, acquisitive, power-seeking self—and makes it the ideal. The survival of the fittest is not only accepted as a law of nature; it is fashioned into a moral law. This is in some ways a healthy reaction to the negativity of self-denial. "Goodness has been too much identified with practical feebleness and ineptitude; strength and solidarity of accomplishment, with unscrupulousness." (EI, 373) But to pursue power for the sake of power is to fall under the sway of an abstraction. And, although it is in some ways the mirror image of self-denial, self-assertion also demands the sacrifice of certain dispositions or capacities of the self. Friendship and family ties, play and recreation, community involvement, and the like, may be slighted in the drive to get or hold on to power. At bottom, the prophets and disciples of self-assertion, like the prophets and disciples of self-denial, fail to grasp the true nature of the self.

That brings us to the concept of self-interest. It is not uncommon to come across the argument that something called "self-interest" is the universal motivator. Adherents of both the self-denial and self-assertion schools may advance this position, although they
do not agree on its further implications. One school argues that the self must be
dispossessed of certain interests and objects, the other that the self's primary interest is in
possession of as many objects as possible. In either case, the self exists apart from its
objects, which are mere means to pleasure and profit, or perdition. But in a transactional
universe, we should not be surprised to find that the self cannot be easily disentangled
from its objects. On the face of it, say Dewey and Tufts, the notion of self-interest is
both true and false. It is true in the sense that "the self is constituted and developed
through instincts and interests which are directed upon their own objects." It is false
when it "implies that the self exists by itself apart from these objective ends." (EI, 378)
One of the examples given is becoming aware of another's distress and acting to relieve her
pain. In the example, the welfare of the other is my object and interest, a part of my self.
There is nothing indirect about it, no reference to some other interest that is more truly
my own, e.g., some service the other can render me upon restoration to health, or the
psychic reward that accompanies the doing of a good deed.

The adherents of the self-assertion school in particular tend to regard interests as
fixed drives to possess certain objects, and as fundamentally asocial, or even anti-social.57
When we unfix the self by attending to the processes through which it is continually being
formed and reformed, we cannot continue to think of interests in this manner. I have
suggested that it is truer to experience to picture a self that takes shape through a series of
transactions with the natural and social environment. This picture of the self is fully

57Or as Owen Flanagan puts it, "both countermoral and socially unindexed." Flanagan, Moral
Personality, 259. I sidestep a definition of interests. Dewey and Tufts use the term in the simple sense of
whatever someone happens to be interested in. Interests are subjective in the sense that they are not fixed,
but not in the sense of being arbitrary or "socially unindexed."
consistent with the findings of recent research into infant and child development. We are primed at birth to relate to our environment. From the beginning, we differentiate between persons, to whom we relate on terms of mutuality (not, primarily, drive- or need-satisfaction), and other objects with which other kinds of relations are appropriate. Throughout our lives we are continually interacting with other persons and the culture at large, both through our personal contacts and through various media.

If selves vary with their objects, and interests vary with social forms, then in matters of "self-interest" or "self-preservation," the crucial questions will concern the nature (or character) of the self served or preserved, and the nature (or character) of the relevant social institutions. I will defer consideration of institutions for the time being, and concentrate on the evaluation of the self. In general, there is a natural division of labor that makes it both natural and right that our chief responsibilities flow to the appropriate maintenance of ourselves and those with whom we are most intimately involved (consistent with the principle of subsidiarity). Remarkably on an instinct of self-preservation, Dewey and Tufts argue that it is good for society, as well as the individual, "that each of us should instinctively have his powers most actively and intensely called out by the things that distinctively affect him and his own welfare." (EI, 380-81)

At the same time, morality requires the cultivation of the widest possible sphere of attention, concern and responsiveness. I have mentioned that Dewey and Tufts treat

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59 Helen Haste suggests that we think in terms of a triangle consisting of "the individual (who has some agency in 'making sense'), the interpersonal network (within which meaning is constructed, negotiated, or merely transmitted through discourse and performance of shared tasks), and the culture (the sociohistorical context that constitutes the repertoire of available frameworks and schemata within which both interpersonal discourse and individual cognition are constrained and constructed)." Helen Haste, "Morality, Self, and Sociohistorical Context: The Role of Lay Social Theory," in *The Moral Self*, 175-208 at 183 (emphasis
all instincts or impulses as morally neutral. An instinct of sympathy, or acquisitiveness, is open to variable development; its expression may be socially valuable, or damaging. One can, for example, do positive harm to others by seeking to do things to them or for them. Yet sympathy is less neutral than the other instincts. To paraphrase St. Paul, the greatest of the instincts are the social affections, because these have the power to transform all the others:

It still remains true that the instinctive affectionate reactions in their various forms (parental, filial, sexual, compassionate, sympathetic) are the sole portions of the psychological structure or mechanism of a man which can be relied upon to work the identification of other’s ends with one’s own interests. What is required is a blending, a fusing of the sympathetic tendencies with all the other impulsive and habitual traits of the self. When an interest in power is permeated with an affectionate impulse, it is protected from being a tendency to dominate and tyrannize; it becomes an interest in effectiveness of regard for common ends. When an interest in artistic or scientific objects is similarly fused, it loses the indifferent and coldly impersonal character which marks the specialist as such, and becomes an interest in the adequate aesthetic and intellectual development of the conditions of a common life.... This same fusion protects sympathy from sentimentality and narrowness.... In short, the fusion of affectionate reactions with the other dispositions of the self illumines, gives perspective and body to the former, while it gives social quality and direction to the latter. (EI, 299)

The moral life calls for a kind of "disinterested interest." This is not apathy or lack of interest, but rather interest affected by concern for others. It is the habit of considering the consequences of one’s actions for others as part of what matters to oneself in any deliberation.

In keeping with the comments on self-denial, this view should be distinguished from a requirement that one engage in a constant evaluation of one’s conduct to determine
whether others are being maximally benefited. "The scholar, artist, physician, engineer, carries on the great part of his work without consciously asking himself whether his work is going to benefit himself or someone else. He is interested in the work itself; such objective interest is a condition of mental and moral health." (EI, 297) In other words, under ordinary conditions absorption in one's work—if it is good work—requires no apology. In the case of health care, the philanthropic ethic (if truly adhered to) and the incentivizing strategy both upset this condition of moral health by forcing the question of who benefits in everyday clinical encounters. The phrase "good, cost-effective medicine" expresses the hope that legitimate concerns about the use of resources can enter into the practice of medicine on terms other than the repeated weighing of "my benefit versus yours." This cannot happen where there are direct financial conflicts of interest between a physician or other clinician and a patient. With the removal of obvious conflicts, it becomes possible to imagine forms of health care organization that are adapted to changed conditions and yet permit practitioners to do good work.

In following out the implications of the transactional model of the self for social life, we need to consider human freedom. For Dewey, freedom is an interstitial phenomenon within nature and culture. This view may be undramatic, but precisely because nature and culture are not fixed, intelligent social reform becomes a genuine possibility. For Reinhold Niebuhr a specifically human freedom is freedom over nature and culture. The creature gains an awareness of its creatureliness and its transcendence simultaneously—and becomes hostage to its insecurity. The combination of finitude and freedom, and the insecurity to which it gives rise, confer on human wants and desires a certain inordinateness. Human nature includes this radical freedom over nature that brings
with it potential for great evil, and we are not free to change this nature. The
inordinateness of human wants and desires continually confounds the rationalists and
upsets the plans of social reformers. Freedom and our ambivalence towards it, as much as
our creatureliness, set limits to what is possible in the way of social progress.

I believe history has proved Niebuhr more right than Dewey on the recalcitrance
of human beings to moral improvement, and Niebuhr's attribution of this recalcitrance to
the insecurity created by the awakening to one's finitude is highly credible. How many of
our moral failures can be traced to either fear or greed? And what underlies these two, but
insecurity? Still, our freedom may be more modest and more bound up with nature and
culture, for good or ill, than Niebuhr allows in his more Luciferean moments. Insecurity is
a social as well as an individual or purely personal phenomenon: "Fear of loss of work,
dread of the oncoming of old age, create anxiety and eat into self-respect." (ION, 68)
Social isolation and loneliness intensify fear. If the tendency to limit my "self" to "my
self" (over against or in competition with other selves) is a stronger part of our
constitution than Dewey allows, Dewey seems more right than Niebuhr in asserting that
direct concern for others is also a genuine possibility arising in and through the
development of human relationships, and that development is itself a vitally important
feature of the moral life. In a late work, Man's Nature and His Communities, in an essay
entitled "Man's Selfhood in its Self-Seeking and Self-Giving," Niebuhr develops a notion
of "common grace" which ventures in that direction.\(^60\) Common grace is "the power of
responsibilities and affections to draw the self beyond itself, and thus create the condition

\(^60\)In Reformed theology, common grace—contrasted with the special or saving grace which accompanies a
certain type of religious experience—reflects God's favorable attitude toward creation in general. It provides
a basis for human responsibility and for a recognition and appreciation of what is good and beautiful in the
world. Picking up this theme, Niebuhr suggests that we think of common grace as the gift of security.
for self-fulfillment which a consistent drive for self-realization can not accomplish and which always leads to self defeat."61 It is grace mediated through parental affection, help from others in a crisis, and the demands of a situation in which we find the strength to give help to others.

Common grace is a theological concept, but Niebuhr’s interpretation of it emerges out of a conversation with psychoanalysis. (In Erik Erikson’s work, the idea is expressed by the term "basic trust.") Does it make sense to speak of common grace outside a theological or religious framework? Yes and no. In a sense, to detach the concept from its theological moorings is simply to complete the circle. Procreation and parental love and nurture provide one way of understanding who God is—the creator and caretaker of creation, the divine parent. God is understood through the prism of ordinary (common) human experience, and the caretaking activity of parents and others becomes an expression of divine care. A naturalized notion of common grace simply leaves out the middleman. Ordinary experience—which, upon reflection, is quite extraordinary—is returned to its original place. We have grace without God. On the other hand, there may be something about appreciating parental love, and the other forms of care we receive or find ourselves capable of giving, as extraordinary that makes us receptive to the idea of love and care at work in the universe. In this sense, the notion of common grace reflects and fosters a religious attitude.

Does accepting some notion of common grace make any difference in the way we live our lives? I believe that thinking in this way shapes our response to contingency, to all the things, especially the bad ones, that just happen to us or lie beyond our control.

which frees the self of its self-preoccupation and enables one to reach out to others.
Rawlsian justice assumes the moral order is constructed over against an alien contingency. To be sure, Rawls pictures the world in a way that sometimes suggests the operation of a principle like grace. Parental affection, and the help of others received through associations and through the institutions of society at large, inspire reciprocal attitudes of affection and readiness to contribute. But the object, in the end, is to remove contingency from the picture insofar as this is possible. As I understand the economy of grace, one accepts the forms of social security in full recognition of their contingency, and one is able to acknowledge (and in a qualified sense accept) the contingency of human existence because one has been the beneficiary of these real but limited social supports. The proper response is gratitude, which is best expressed in becoming a medium of grace for others. Grace is more basic than entitlements of any sort (to one's fair share of basic goods, to one's property), although there are good reasons for working for a world in which people can count on certain things.

The notion of common grace brings Niebuhr closer to Dewey. At the same time, Niebuhr retains his distinctive voice. Provoked by Niebuhr's attacks, Dewey inquired why he had "to believe that every man is born a sonofabitch even before he acts like one, and regardless of why and how he becomes one?" Niebuhr might have responded that the more interesting question was why so many for so long have acted like sonofabitches (including oneself, on more than a few occasions), and what might be done to prevent the sonofabitches from annihilating one another. Either Dewey or Niebuhr may seem to have more insight into the human condition, according to the nature of the problem at hand. As Westbrook observes with great insight, Dewey and Niebuhr differed most in what they

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61Reinhold Niebuhr, "Man's Selfhood In Its Self-Seeking and Self-Giving," in Man's Nature and His
worried about: "Dewey worried more about despair than arrogance and Niebuhr worried more about arrogance than despair." Neibuhr may tell us more about the behavior of those who hold power, while Dewey may speak more to the situation of those who feel themselves at the mercy of forces beyond their control.

The pragmatic moral psychology presented here cannot offer assurance that the person of good character will be impervious to economic or social pressures. On the other hand, neither does it offer much comfort to those who would create a system of economic and social pressures so precisely calibrated that conduct is brought into perfect conformity with the intentions of the designers and character is rendered superfluous. We cannot afford to ignore incentives, but neither can we afford to rely on incentives alone to achieve our ends. Further, we have reason to guard against the transformations in our relations with others that occur when we fall into the habit of regarding them solely as instruments to our ends. The analysis of character and external goods has the same equivocal character. External goods are genuine goods, but we can attack a preoccupation with money both in terms of its costliness to those under its sway, who are deprived of other goods they might enjoy, and in terms of an erosion of social solidarity. Again, with freedom, I take the position that we are not wholly free nor are we wholly determined, and that freedom can be put to good or bad use. Niebuhr's notion of common grace is one way of understanding how freedom and community might develop together, in complementary fashion.


62Westbrook, John Dewey, 530.
4. Ideology and the "Profit-Motive"

Ideaology

How do we get the notion that the self has certain fixed properties? What are we to make, for example, of the asserted existence of a "profit motive"? Initially, Dewey deconstructs the general concept of motive, understood as some basic drive of the self, fixed prior to or apart from its formation in interaction with the environment. He then reconstructs the concept on terms more congenial to his moral psychology—and sociology:

It is absurd to ask what induces a man to activity generally speaking. He is an active being and that is all there is to be said on that score. But when we want to get him to act in this specific way rather than in that, when we want to direct his activity that is to say in a specified channel, then the question of motive is pertinent. A motive is then that element in the total complex of a man's activity which, if it can be sufficiently stimulated, will result in an act having specified consequences. (HNC, 84)

According to Dewey, motives originate, not in the depths of the psyche, but in the social world of persuasion, manipulation, and domination. When we investigate theories of human nature which reify the self and identify it with certain motives, we are entering the realm of ideology.

In Freedom and Culture, Dewey explicitly labels competing schools of social philosophy as ideologies. Surveying the history of philosophy and noting the shifts in what is identified as the ruling motive in human nature, we are lead to believe that philosophers have "taken the cart to be the horse." A particular social practice becomes its own explanation, the faculty or motive to engage in that sort of practice. But, says Dewey, "It is at least as true that the state of culture determines the order and
arrangement of native tendencies as that human nature produces any particular set or system of social phenomena so as to obtain satisfaction for itself." (FC, 18) Dewey, measured as ever, adds that he does not mean to deny the importance of biological heredity and native individual differences. But he does assert that these "natural" factors operate, gather shape, and take effect within given social forms. Even the idea of the individual, and individualism, are thoroughly social phenomena: "The idea that human nature is inherently and exclusively individual is itself a product of a cultural individualistic movement. The idea that mind and consciousness are intrinsically individual did not even occur to any one for much the greater part of human history."

(FC, 21)

Although he uses the term, Dewey does not provide a full account of ideology. A brief excursus may be helpful in clarifying the concept. Initially "ideology" named the study of ideas, but the term rapidly acquired other associations. Now we may study ideologies, systems of expressed belief, as in the case of medicine or business, or we may say that all systems of belief have an ideological dimension. In a series of lectures on the subject of ideology, polymath philosopher Paul Ricoeur provides an admirably clear review. Ricoeur examines, in roughly the order of their arrival on the intellectual scene, three levels or functions of ideology. First, ideology is understood as distortion. A hermeneutics of suspicion attends to impersonal forces and structures that underlie distortions in the symbolic "superstructure." These distortions mask the reality of domination. This approach to ideology derives from Karl Marx. There are actually two strands in the Marxian approach which ought to be distinguished. One centers around the opposition between ideology and science, as the undeceived vision of reality. The other
focuses on the correlation between ideology and sectional interests. Here, ideology refers to the processes by which the interests of particular sub-groups or classes come to appear as universal ones. This transformation occurs chiefly through the manipulation of symbols (although none of the processes referred to need be fully conscious). In this sense, ideology as distortion flows into ideology as legitimation. The distribution of power in a society is not determined by the existing mode of production or anything else. First, the relationship between structure and superstructure is more dialectical than vertical; there is, to use Max Weber's term, an "elective affinity" of material and ideal forces. Second, the creation and maintenance of power over others depends upon the cultivation of belief in the necessity and appropriateness of such power.

At a third level, ideology is understood as integration. Champions of this point of view, such as Clifford Geertz and Erik Erikson, argue that ideology is simply inescapable for a social being. Ideology is the social bond expressed symbolically. Ricoeur's approach to ideology is synthetic, and he suggests dialectical movement among the three levels. Still, the third level tends to enfold the other two, as the background condition for their meaningfulness. Ricoeur says that "[w]e must integrate the concept of ideology as distortion into a framework that recognizes the symbolic structure of social life." For, "[u]nless social life has a symbolic structure, there is no way to understand how we live, do things, and project these activities in ideas, no way to understand how reality can become an idea or how real life can produce illusions."63 In popular usage, however, ideology usually means distortion—what the other fellow (erroneously) believes without

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question and continues to believe only because he refuses to question.\textsuperscript{64} 

The market ideology

As a pragmatist, Dewey is chiefly concerned with a particular instance of the general phenomenon. His target is the "old" individualism (Dewey was proposing a "new," thoroughly social, individualism) and classical laissez-faire liberalism. It is the ideology of the market, what I have called the ideology of business. In \textit{Liberalism and Social Action}, Dewey writes: "The underlying philosophy [atomism] and psychology [the self as register of discrete sensations] of earlier liberalism led to a conception of individuality as something ready-made, already possessed, and needing only the removal of certain legal restrictions to come into full play. It was not conceived as a moving thing, something that is attained only by continuous growth. Because of this failure, the dependence in fact of individuals upon social conditions was made little of." (\textit{LSA}, 30) What is significant is that the idea of the individual, and all that it obscures, has now become available for use by groups seeking to hold on to or consolidate social power. In the commercial sphere it is allied with a theory of motivation, which takes general human selfishness in a purely pecuniary direction, and essentializes and then valorizes it as that engine of progress, the profit motive.

Even putting aside the ambiguities in the notion of profit, we can scarcely hold that the indubitable fact that, in our experience, financial incentives influence behavior, is

\textsuperscript{64}There is also the "end of ideology" school, which is vulnerable to challenge on so many grounds that I do not take it very seriously. MacIntyre's little essay alone is fairly devastating. See MacIntyre, "The End of Ideology." Of course, Richard Rorty is a force to be reckoned with, but I am not yet persuaded that his social philosophy will have much influence. It lends itself too readily to misunderstanding as a justification of upper middle-class privilege. For evidence that this is far from Rorty's intent, see Rorty's exchange of views with Richard Bernstein in \textit{Political Theory}, Richard J. Bernstein, "One Step Forward, Two Steps Backward: Richard Rorty on Liberal Democracy and Philosophy," \textit{Political Theory} 15, no. 4 (1987): 538-63, and Richard Rorty, "Thugs and Theorists: A Reply to Bernstein," \textit{Political Theory} 15, no. 4 (1987): 564-80.
satisfactorily accounted for by the existence of a profit motive, which is just this responsiveness to financial incentives. Dewey allows for an instinct or impulse of appropriation. This is not a concession, as Dewey's general view of phenomena in relational terms, his transactional view of the self, and his active/passive conception of experience all fit with a biological instinct that establishes the meaning of objects in the environment in relation to the self:

No unprejudiced observer will lightly deny the existence of an original tendency to assimilate objects and events to the self, to make them part of the "me." We may even admit that the "me" cannot exist without the "mine." The self gets solidity and form through an appropriation of things which identifies them with whatever we call myself. But these same considerations evince the versatility of possessive activity. My worldly goods, my good name, my friends, my honor and shame all depend upon a possessive tendency. It expends itself in predatory aggression, in forming friendships, in seeking fame, in literary creation, in scientific production. In the face of this elasticity, it requires an arrogant ignorance to take the existing complex system of stocks and bonds, of wills and inheritance, a system supported at every point by manifold legal and political arrangements, and treat it as the sole legitimate and baptized child of an instinct of appropriation. (HNC, 82-83)

It is not acquisitiveness per se, but the ways in which it is channeled and fueled that are properly subject to moral judgment.

It is important to stress that the business ideology obscures the social context in which acquisitiveness takes shape in multiple ways. The web of legal, political, and social structures that undergird actual markets become nearly invisible. The social shaping of the self and conduct is also neglected, as are the social resources on which the individual draws in his or her activity. And a careful assessment of the full range of social consequences following from each form of economic activity is declared unnecessary. The ideology is forever losing sight of the fact that business depends on the willingness of
people not to exploit the trust that others place in them. The ideology does not counsel managers to work against the interests of shareholders whenever it suits their own interests. Why should shareholders and managers be told that they have no reason to refrain from exploiting the trust that the public places in them, for example, in giving corporations benefits such as limited liability? Or consider the social complexity obscured by the notion of profit-maximization. As Christopher Stone points out, choices that maximize long-term profit are not the same as those that maximize short-term profit. The interests of long-term investors and speculators diverge. So, too, what benefits the holders of common stock may not benefit the holders of preferred stock, or bonds. Managers necessarily make difficult judgments that balance the interests of various groups. Why not acknowledge this, and straightforwardly bring in the interests of the corporation's other constituencies? (I will return to the subject of corporate social responsibility in the next chapter.)

Dewey is not content with the approach that establishes classes of heroes and villains, with scientists and social reformers in the first class and business leaders in the second. We must ask how social conditions have contributed to a certain one-sidedness in the development of creativity in some spheres of activity. "A study of the educative effect, the influence upon habit, of each definite form of human intercourse, is prerequisite to effective reform." (HNC, 103) Dewey does not present us with a series of case studies. Still, some general comments about social conditions and particular spheres are possible. If health care professionals have demonstrated "unselfish" devotion to their patients' welfare, if they have found themselves capable of acting on "higher" motives,

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65Christopher D. Stone, "Corporate Accountability in Law and Morals," in The Judeo-Christian Vision
they have been aided by the cultural matrix and the organizational contexts of medical practice. For physicians, the structures of practice have been such that social status, the approbation of peers, and monetary reward converged in establishing the interest of the patient among the interests of the physician-self. And physicians have energetically fought to erect and maintain these structures, disregarding other important interests.

Likewise, participants in "the market," as we quaintly term the system of industry and commerce "supported at every point by manifold legal and political arrangements," define and pursue their interests in accordance with these structures, even as they seek to manipulate them to further advance those interests. Commentators have noted the co-incidence of the rise of large, for-profit corporations delivering health care, government programs such as Medicare, and tax policies favoring acquisitions, e.g., rapid depreciation allowances and full deductibility of interest on debt. The same sort of analysis applies to evolving consumer preferences. All of these phenomena have social dimensions, are social, and all of them are linked to organizations. Increasingly, these organizations are large corporations.

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Marx makes the case very well. He notes that "down to 1815, the emigration of mechanics employed in machine making was, in England, forbidden, under grievous pains and penalties." When, as a consequence of civil war in the United States, a majority of the workers in the Lancashire cotton industry lost their jobs, proposals were made for government or voluntary contributions to enable the workers to emigrate. But the capitalists were not ready to let go their hold on "free" labor. One Edmund Potter, a former president of the Manchester Chamber of Commerce, wrote a letter, published in the London Times, in which he opposed any such policy. I quote from Marx's edited version of the letter: "I allow that the workers are not a property, not the property of Lancashire and the masters; but they are the strength of both; they are the mental and trained power which cannot be replaced for a generation; the mere machinery which they work might much of it be beneficially replaced, nay improved, in a twelvemonth. Encourage or allow (I) the working-power to emigrate, and what of the capitalist?" Karl Marx, Capital, vol. II, ch. 23 (London: Swan, Sonnenschein, Lowrey & Co., 1887), 586-87, 588.

Consider the role of the media in exciting and channeling consumer demand. If we credit the limited rationality of corporate managers, we must assume there is a return for all those dollars expended on advertising. In the health care arena, the influence of advertising in medical journals on physician attitudes and behavior has been documented. See Chapter 6, note 23. Direct advertising to consumers is the newest trend.
We may pause to ask why self-interest and the profit motive have struck so many
as appealing explanations of human conduct. How do we account for the persistence of
the doctrine? For, on the face of it, this is not a particularly engaging view of human
nature. Yet the attractions include the promise of a containment of forces, calculability,
and even harmony. Unfortunately, the basic premises of laissez-faire liberalism were
incorrect in several respects:

The basic doctrine of early economic liberals was that the régime of
economic liberty as they conceived it, would almost automatically direct
production through competition into channels that would provide, as
effectively as possible, socially needed commodities and services. Desire
for personal gain early learned that it could better further the satisfaction
of that desire by stifling competition and substituting great combinations
of non-competing capital. The liberals supposed the motive of individual
self-interest would so release productive energies as to produce ever-
increasing abundance. They overlooked the fact that in many cases
personal profit can be better served by maintaining artificial scarcity and
by what Veblen called systematic sabotage of production. (LSA, 27-28)

To take one of Dewey's simpler points, the significance of monopoly power cannot be
overlooked. In its acquisition of Health Net, QualMed eliminated a major competitor. A
company called National Medical Care has a near monopoly on "competitive" kidney
dialysis services. Its unsavory, if not illegal, efforts to stifle competition cannot be
altogether unprecedented. (Some of the details of the National Medical Care saga will be
recounted in the final chapter of this dissertation.) This is not Adam Smith's world of
independent buyers and sellers.

In general, Dewey takes wide assent to the proposition that productive activity
must be stimulated by external goods, such as money, as an indicator of social distress,
since human beings are by nature active creatures. "If productive activity has become so
inherently unsatisfactory that men have to be artificially induced to engage in it, this fact is ample proof that the conditions under which work is carried on balk the complex of activities instead of promoting them, irritate and frustrate natural tendencies instead of carrying them forward to fruition." (HNC, 87) Dewey may be overcompensating in a bid to do away with the view that work is a punishment, and that human beings are naturally slothful. One can allow that humans are by nature active creatures, without concluding that they "naturally" work for the sheer joy of it. Even assuming that all normal productive activity offers some intrinsic rewards, the prospect of gain may serve as a prod and a reinforcement when work seems merely tedious. We properly exert ourselves to obtain the necessities, and some of the conveniences, of life.

Niebuhr, for one, combines skepticism concerning *homo economicus* with skepticism toward attempts to dispense with economic man altogether. He writes that the assurance of a "'pre-established harmony of nature' which transmuted all competitive strivings into an ultimate harmony, was obviously a more dubious doctrine than the basic assurance that men must be engaged primarily through their self-interest to participate in the vast web of mutual services which has always characterized man's economic life and which increasing specialization of labor has made ever more intricate." 68 Niebuhr does not credit the unswerving pursuit of individual material advantage as a comprehensive explanation of human conduct, and hence he sees no reason to expect the automatic harmonization of economic and social interests. He does credit certain claims made for markets, namely, that the alternatives involve increasing concentration of power in the hands of politicians and government bureaucrats, and that markets display some self-

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68Niebuhr, "Economic Life," 140.
regulating tendencies, and serve to foster initiative.

Other benefits of markets include flexibility and responsiveness to consumers' desires. Not all markets display these tendencies and realize these benefits to the same degree. The market for health care services is a notorious example of an imperfect market, combining barriers to entry (licensing), differentiated products and services which are difficult for consumers and patients (and experts on quality) to assess,\(^6^9\) induced demand, and insensitivity to price owing to third-party payments. Further, it is misleading to refer to "the market" for health care services, given the variations by region. Then, too, there are forces at work in any market that call for wider social direction and control. Competition can become predation. Corporate influence can corrupt the political sphere. Smith relied on government rather than the market to provide a range of public goods, and economists of whatever ideological bent recognize the problems created by externalities.

We must become more discriminating in our judgments about markets, and more discerning in our analysis of the relations between markets and other features of the social topography. Not all markets are the same. Markets for health care services have distinctive features. And some ways of understanding markets and their social effects are more adequate than others. In a perceptive piece on corporate governance, James Boyd White argues that moderate critics of corporations have been misguided in focusing on the distinction between short-term and long-term profit. We do not advance very far by

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\(^6^9\)This is not simply because health care is a complex good. It is because health care is more like a can of tuna than a dress. I can look at a dress and even try it on before I buy it. I can only learn how good the tuna is by consuming it. So a seller of tuna could conceivably put a low quality product in an attractive package and do quite well—for a time. To the extent that the seller desired repeat business, however, there would be an incentive not to pull this kind of trick. The problem in the health care case is that a failure on one occasion may be sufficient to end the life of the consumer. More generally, the losses that may be experienced while the system works itself out may be intolerable. Such losses would include not only the physical and emotional toll on specific patients and their families, but also a potentially irremediable loss of social trust. On the distinction between "search" qualities and "experience" qualities, see Edward R.
convincing corporate leaders that their task is to maximize the long-term profitability of
the enterprise. According to White, the "real evil" is "the economic model of wealth,
which takes in only exchanges." The model assumes that the social background is stable,
whereas it must be perpetually remade. An ideology that allows the business corporation
only one goal, the maximization of profits, defines the corporation "as a kind of shark that
lives off the community rather than as an important agency in the construction,
maintenance, and transformation of our shared lives."70

5. Moral Sociology: Institutions

The pedagogical role of institutions

At the end of the last chapter, I fastened on Rawls's description of institutions as
agencies of character formation and suggested that the idea was in need of fuller
development. Who better to speak to the pedagogical role of institutions than John
Dewey? The idea has a long philosophical ancestry, but Dewey is most indebted to the
work of John Stuart Mill. In Chapter 3, I touched on Mill's idea of an innate sociality
that could be awakened and developed by social institutions. On this view, the limits of
Bentham's reward/punishment paradigm are clear. "Hope of reward and fear of penalty
are real enough motives in human life; but acts performed mainly or solely on their
account do not, in the unprejudiced judgment of mankind, rank very high morally."
Moreover, "[h]abitually to appeal to such motives is rather to weaken than to strengthen
the tendencies in the individual which make for right action." (EI, 355) External sanctions
should serve as reinforcements for right conduct, and in this role they are extremely
valuable, but a Deweyan pragmatist will resist the separation of means and ends.

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Conduct is "ethical" not merely because it conforms to certain norms, but also because it expresses and reinforces good, that is, open, generous, creative, reflective, character. Institutions are valuable and valued not merely for what they produce but for the kinds of conduct and character they form and the kinds of social relationships they foster.71

Although this view of sociality would seem to rule out a crude behaviorism that disregards the meanings that institutions have for individuals, it still leaves room for more subtle manipulations. The great task for Mill, and for the Deweyan pragmatist, is to show how human beings can be socialized, awakened to their social nature and shaped in such a way that social considerations are a part of the individual's own self-definition, without being reduced to mere instrumentalities of some abstract social interest. Dewey does not identify society with the territorial government, or any other organization, or with a kind of general will. Society "is many associations" and "means association," the "coming together in joint intercourse and action for the better realization of any form of experience which is augmented and confirmed by being shared." (RP, 197) Such terms as "social" or "common," it is asserted, "do not mean a sacrifice of individuality"—the "submergence" of what is distinctive in different human beings would impoverish rather than serve the social whole. (EII, 345) It was very clear, to Dewey at least, that the idea of a social interest, and sociality itself, could easily become hostage to the project of domination of one group or another. The truly pedagogical view aims to enhance the individual's awareness of sociality as a part of the development of critical intelligence.

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71The idea of institutions as agencies of character formation has shown up in some recent writing on health care, e.g., Roger J. Bulger, "Covenant, Leadership, and Value Formation in Academic Health Center," in Integrity in Health Care Institutions, ed. Ruth Ellen Bulger and Stanley Joel Reiser (Iowa City: University of Iowa Press, 1990), 3-17 at 6, and the other essays in that collection, and Leon R. Kass,
Another way of stating the issue is to note that sociality and social institutions are always subject to judgment in terms of some standard or set of criteria. In the revised edition of the *Ethics*, Dewey and Tufts write that the "final test" of law and institutions "is what they do to awaken curiosity and inquiry in worthy directions; what they do to render men and women more sensitive to beauty and truth; more disposed to act in creative ways; more skilled in voluntary cooperation." (*EII*, 364) Societies which are democratic, in political terms, have tended to overlook the educative effect of legal and economic institutions. Many political and moral philosophers view institutions entirely within the context of distribution and hence repeat that neglect. In Rawls's primary account of justice, social institutions are systems of rules or mechanisms for parceling out discrete rights and goods. For Dewey and Tufts, institutions are more continuous with the "social union" strand in Rawls's work. The sharing of the necessities of life can be thematized as mutual aid rather than distribution:

The positive import of "common good" is suggested by the idea of sharing, participating—an idea involved in the very idea of *community*. Sharing a good or value in a way which makes it social in quality is not identical with dividing up a material thing into physical parts. To partake is to *take* part, to *play* a role. It is something active, something which engages the desires and aims of each contributing member.... Each contributes something distinctive from his own store of knowledge, ability, taste, while receiving at the same time elements of value contributed by others. What is contributed to each is, first, a support, a reinforcement, of his own action; thereby each receives from others the factors which give his own position greater *security*—a fact illustrated by the mutual aid given to one another by the partners... In the second place what is contributed is enjoyment of new meanings, new values. (*EII*, 345)

Openness to the possibility of mutual transformation is set over against the advancement

of pre-established interests. Dewey and Tufts use an analogy to lend concreteness to the
distinction: "In a debate each debater on the same 'side' tries to strengthen or reinforce the
position of every other one on that side. But in a genuine conversation the ideas of one
are corrected and changed by what others say; what is confirmed is not his previous
notions, which may have been narrow and ill-informed, but his capacity to judge wisely."
(Ell, 345-46)

I have noted the importance of communication in the overview of Deweyan
democracy. Here I would stress that the process of mutual correction Dewey describes
presupposes difference and does not necessarily conclude with its annihilation: "To
cooperate by giving differences a chance to show themselves because of the belief that the
expression of difference is not only a right of the other persons but is a means of enriching
one's own life-experience, is inherent in the democratic way of life." 72 Some convergence
of belief is likely, but reaching agreement on matters of belief need be neither the aim of,
nor the justification for, conversation.

We are once again ringing changes on the theme of democracy. I have quoted some
lovely sentiments about openness and beauty and truth and creativity and cooperation
and the like, but one might be excused for asking whether these are realistic criteria for
evaluating health care organizations. In speaking of institutions as agencies of character
formation, there is no way to avoid talk of values. At the same time, to borrow a bit of
social science jargon, these criteria need to be "operationalized." Let us begin with
openness. In the Deweyan conception of character, openness as sensitivity to the other
is a highly valued trait. It is important that managers and practitioners not become

72 John Dewey, "Creative Democracy—The Task Before Us," in The Philosophy of the Common Man:
hardened to patient needs and to the promptings of their own moral sense owing to organizational pressures. Consider the case of Dr. Linda Peeno. Peeno was hired by a large managed care organization as a medical reviewer. In that role, she was presented with a request for authorization of a heart transplant. According to her own account:

I sat at my desk, contemplating the paper given to me by the nurse, who had reminded me, in her dutiful way, that this was a "very expensive" case. I knew well by now what this euphemism meant: You better find a way to deny this. Medically this case was clear, with no grounds upon which I could issue a denial based on necessity.... I was left only with finding a loophole that would justify the denial of payment based on coverage limitations. A few quick calls to the benefit department about contracts in Nevada, and a review of the language in this man's own "certificate of coverage" gave me what I needed.... That this man, who I would never know, would fail to get his heart was of less importance to me at that moment than the accolades I would get when word spread that I saved the company several hundred thousand dollars.73

We have every reason to believe that Peeno was and is a person of basically sound character, but within a certain kind of organization she became desensitized. Openness as sensitivity is nourished when managers are invited and even forced to consider the human dimensions of what they do.

Fields other than health care seem to have more of a mission in the area of beauty, but health care institutions can at least avoid stunting the growth of aesthetic sensitivity through an aggressive ugliness.74 And certain health care settings should make beauty a priority—a hospice, for example, or a pediatric ward. The very young and the dying are

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73This account is taken from Anders, Health Against Wealth, 53-54. The extended quotation is from a personal essay by Peeno, "Going Beyond the Requirements," written in the spring of 1994.
74The ramifications may be broader. James Haughton describes the corrosive effects of poor maintenance at Chicago's Cook County Hospital. Filth and disrepair expressed disrespect for patients and staff, and they got the message and carried it into their dealings with one another. A thorough cleaning and a good paint job raised morale by affirming that the hospital's staff and clientele were worthy of a decent environment. James G. Haughton, "Determinants of the Culture and Personality of Institutions," in Integrity in Health
in particular need of aesthetic and spiritual nourishment. To the extent that managed care reinforces the baldly utilitarian strain in health care by stripping away "inessentials" such as beauty, it deforms character. (Of course, not only the extravagant or baroque is beautiful; the spare, practical objects created by the Shakers have great beauty.)

Institutions cultivate truthfulness as a character trait by modeling it. At a minimum, health care institutions must communicate honestly when information is requested or disclosure is required. But merely honoring requests for information and meeting legal requirements is not enough. Health care institutions should substitute the communication paradigm for the disclosure paradigm whenever possible. Beyond this, institutions should make it a rule to favor openness, especially when questions arise about how to handle a problem. The deMeurerses thought that they were up against a network of institutions "managing" Christy deMeurers's case through channels that were not visible to them. They responded by hiding information from health care providers. It is easier to adopt and honor a rule of openness if openness is already standard practice—if important decisions are not shielded from the public eye, and important policies are published so that dissenters and critics can have their say.

Institutions cultivate creativity by creating space for it and rewarding it. Health care institutions can foster creativity among staff members and plan members. They can support research, and regularly solicit the ideas of staff and plan members or patients receiving particular kinds of care. They can give out bonuses or awards for staff members who engage in research or contribute ideas that lead to improved patient care or reduce waste. They can expand the usual patient satisfaction questionnaire to solicit the ideas of

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*Care Institutions*, 141-47 at 146
member-patients, and offer recognition payments or praise in a newsletter to those who make a contribution. They can conduct focus groups in connection with important policies and decisions, or develop more creative ways of involving members and staff in decision making. It is of the essence of creativity that the forms it will take cannot be specified in advance. Openness as receptivity to new ideas must join openness as publicity and sensitivity.

Finally, in a society for which social democracy serves as an ideal, voluntary cooperation will be of the highest importance. Institutions cultivate the cooperative virtues primarily through support for collaboration among staff members and member-patients, and between these two groups. They promote mutual concern and understanding across the usual boundaries of discipline, gender, socioeconomic status, and so on. The possible variations are virtually endless. The major concerns in this area are inauthentic efforts, and unrealistic hopes. The category of "inauthentic efforts" would include the cheerful "we're all in this together" meant to compensate for imbalances of power, or make differences in experience and degrees of suffering disappear. It would include the imposition of a team model by executive fiat, and the team in name only—the basic structures, such as the reward system, are not altered to support the collaboration that will make care a truly cooperative enterprise.

As for unrealistic hopes, I have emphasized the importance of relationships. In analyzing the correspondence between Relman and Reinhardt, I suggested that Relman moved to firmer ground when he shifted his focus from the virtue of physicians to the doctor-patient relationship. Here I would add that the long-term, intimate relationship cannot serve as the model for all relationships in health care. An anesthesiologist-patient
relationship is different from a family doctor-patient relationship. Work relationships are different from family relationships. Patients will do a better job of accepting this diversity if physicians, and ethicists, resist the temptation to romanticize. As Stephen Toulmin observes, patients “cannot be blamed for measuring the realities of personal interaction within a present-day hospital clinic against the romantic image, which the profession still likes to project, of the doctor-patient relationship at its closest and warmest best. As a result, patients often enough become suspicious of the physicians with whom they have to deal, and read their institutional caution as a lapse from the moral commitments which patients have been taught to expect.”75 William F. May counsels physicians and administrators to “accept without false dismay the incompleteness of their contacts with those over whom they exercise control. In doing their limited jobs, they often serve persons well whose fellowship, in personal terms, they will never enjoy.”76

Markets, which some may feel have taken a beating here, have long been praised for cultivating certain desirable character traits. As Niebuhr notes, competitive markets foster initiative. Adam Smith and Pope John Paul II agree that markets may nurture the virtue of industriousness. Commerce has also been credited with bringing people of diverse backgrounds together and hence fostering tolerance and combating prejudice.77 From the perspective of social democracy, there is every reason to value these kinds of traits.

75Stephen Toulmin, "Medical Institutions and Their Moral Constraints," in Integrity in Health Care Institutions, 21-32 at 24-25.
Of course, some institutions do more than form character—they provide us with goods and services. Managed care organizations serve an insurance function and provide (or provide for) health care services. While I would insist, with Dewey, that institutions in the economic sphere must be judged on the basis of the kind of character they form, additional criteria are appropriate. In the case of a productive enterprise, we ask whether it serves the community as a whole, satisfying the needs of community members "effectively and fairly," while simultaneously "providing the means of livelihood and personal development to the individuals who carry it on." (EII, 299) The pragmatic tradition provides many of the tools for this kind of assessment. I will return to this subject in the next chapter, where organizations will be the exclusive focus.

In concluding this section, I introduce the same caveat that accompanied the discussion of persons. The Deweyan pragmatist does not hold that those associated with particular institutions should be continually scrutinizing their practices to determine whether these are in every instance of the greatest possible benefit to the community. In a just social order, "the very relations which persons bear to one another" demand of those carrying out a line of business the kind of conduct which meets the needs of others, while they also enable each business person to express and develop his or her own capacities. (EII, 299) The prominence of the question "who benefits" in health care is a sign of social disorder; it is not a purely personal or individual problem.

**Institutions as sources of moral corruption**

Niebuhr charges that Dewey and his fellow liberals fail to appreciate the "brutal" character of the behavior of all human groups, what Niebuhr calls the "power of collective egoism" in intergroup relations. This aspect of Niebuhr's thought has been particularly
influential, hence it is important to understand his reservations.\textsuperscript{78} At the very beginning of \textit{Moral Man and Immoral Society}, Niebuhr asserts that social life compounds human vices.\textsuperscript{79} Implicitly, he adopts the view that the characters of concrete human beings are radically separate from society, and that the character of collectivities is somehow fixed by the very nature of group dynamics. Others have stressed the similarities or parallels between individual and group selfishness.\textsuperscript{80} I take the position that persons and groups are both like and unlike. While many of the moral concepts we apply to persons apply with equal force to groups, groups have qualities which persons do not have (and vice versa). We must address what is distinctive, as well as what is common. Rejecting Niebuhr's notion of radical freedom, one can still identify problematic features of groups, but these will have to be specified with care. Take, for example, "relentlessness," which Richard Scott has identified as the chief pathology of organizations. He uses the term to capture a number of features of organizations, but his main point is that corporate interests differ from those of natural persons in being more "narrow, intense, refined, and single-minded." Organizations are by no means monolithic, but compared with natural persons they are relatively specialized in their purposes and they are (typically) intended

\textsuperscript{78}It is ironic that in a sociology that favors technical language, and has little to do with theologians and moral philosophers, Niebuhr's judgments concerning corporate life are held in high esteem. The following quotation is taken from a footnote to Murray Milner's excellent case study of interorganizational relations in health care: "In dealing with individuals, the assumption of a clear preference for autonomy over interdependence is admittedly a problematic oversimplification, though probably more accurate than the opposite assumption. When, however, we are dealing with collectivities, such as organizations, the assumption is a much more tolerable one. While individuals may have some innate need for interdependence and a significant capacity to identify with the needs of others, these characteristics seem to be considerably weaker at the collective level. Probably the best discussion of this difference in individual and collective attributes is still Reinhold Niebuhr's \textit{Moral Man and Immoral Society}." Murray Milner, Jr., \textit{Unequal Care} (New York: Columbia University Press, 1980), 182, n. 12.

\textsuperscript{79}"For all the centuries of experience, men have not yet learned how to live together without compounding their vices and covering each other 'with mud and with blood.'" Reinhold Niebuhr, \textit{Moral Man and Immoral Society} (New York: Charles Scribner's Sons, 1960), 1 (emphasis added).

\textsuperscript{80}E.g., Tawney, \textit{Acquisitive Society}; 48.
and designed, in a word, "organized," to pursue these purposes "unreservedly."\textsuperscript{81} And yet, even here, the focus may change over time, escaping the intentions of the organization's founders. This is an issue to be examined in greater detail in the next chapter.

Scott also adopts the view that in the world of organizations, power is a non-zero sum game. Following James Coleman, he asserts that "in a social structure containing both natural persons and corporate actors, it is possible for one natural person to lose power without a corresponding gain on the part of another natural person." (The same can be said of responsibility—diffusion leads to a net loss.) But then, is it not possible for organizations to benefit natural persons by increasing their power, without loss on the part of any natural person? Further, are not Herman Daly and John Cobb correct in distinguishing among various types of power, with contrast pairs such as persuasive and coercive, emancipatory and manipulative, receptive and active, and shared and individual?\textsuperscript{82} Alasdair MacIntyre argues that practices cannot survive without institutions, and this gives institutions a certain dignity. It also seems that organizations may play a constructive role in providing support for fluctuating or flagging individual


\textsuperscript{82}Herman E. Daly and John B. Cobb, Jr., \textit{For the Common Good} (Boston: Beacon Press, 1989), 184-85. With reference to the contrast pair "emancipatory and manipulative," consider this distinction, applied to care rather than power, in Fred Dallmayr's interpretation of Heidegger: "\textit{Emancipatory} solicitude—also called anticipative-emancipatory solicitude—is introduced in the section delineating different types of care, especially as a counterpoint to \textit{managerial} solicitude. In contradistinction to the latter's manipulative thrust, Heidegger writes, 'there is the possibility of a kind of solicitude which does not so much displace the other as anticipate him in his essential potentiality for Being—not in order to take 'care' away from him but in order to restore it to him in a genuine fashion.'" Richard J. Bernstein, "Heidegger on Humanism," in \textit{Philosophical Profiles}, 197-220 at 212 (emphasis added). As I am not a scholar of Heidegger, I am not sure quite what is meant by "essential potentiality for Being," but otherwise this exquisite passage is perfectly compatible with a Deweyan ethic. The distinction between emancipatory and managerial solicitude or care is particularly relevant to the treatment of bureaucracy. I also find the description of emancipatory care beautifully appropriate to the work of healing, which should aim not so much at "taking care away," as "restoring it in a genuine fashion."
commitments. Finally, organizations may provide structures through which persons mediate common grace to one another.

Even with caveats about the necessity of judging institutions according to some standard, one may still be inclined to regard the prospect of pedagogical institutions and conscious socialization apprehensively, as somehow totalitarian. Some resistance is justified. It is important to a Deweyan pragmatist that social life is, and continue to be, pluralistic. Dewey tends to stress cooperation over competition, and he sees no ultimate or inevitable conflict between the individual and society. Still, he paints social life as a scene of conflict as well as harmony. Change is inevitable, and change brings conflict. In a dynamic universe, the options available for human consideration, judgment and choice are present in the "conflict of patterns involved in institutions." (HNC, 90) "The problem is to extract the desirable traits of forms of community life which actually exist, and employ them to criticize undesirable features and suggest improvement." (DE, 88-89) Especially in modern, complex societies, a survey of institutions will offer up multiple patterns for organizing social relations. The hope, at least, is that the differences revealed can be made to serve the cause of social transformation in morally desirable directions. The kernel of truth in the medicine-business dichotomy lies here.

Institutions do not confront us as an undifferentiated mass. There are significant

83 [D]ifficulties that the large-scale organization of professionals faces in maintaining its drive for excellence argue for critical reflection and experiment with alternative modes of organization, but they do not persuade one to join the nostalgic who yearn for the days of the free-lance entrepreneur, the private practitioner. The nineteenth-century liberal myth saw people as better in isolation than in society. Even the realistic Reinhold Niebuhr fell prey to liberal innocence when he titled his work Moral Man and Immoral Society. Men and women need community not merely for the instrumental purpose of producing greater things than they can achieve by themselves, but for the moral reason of helping them to be better than they can be by themselves. " May. Physician's Covenant, 180-81 (emphasis added).

differences in structure and purpose among them, and these are related to different kinds of character, relationship, and practice.

I have argued for a broad and inclusive understanding of ethics as a kind of relation-mapping. In the case of a corporation, our attention is directed to relations among the purposes of persons, particular corporate activities, and the consequences of these activities for human welfare. I have described moral reflection as a kind of problem-solving. Conditions change, or values come into conflict, and we experience uncertainty about how to proceed. Reflection is the alternative to reaction, uncritical rejection or defense of the status quo. The experimental method combines factual investigation with an imaginative projection of alternatives and situates reflection within a community of inquiry committed to the open exchange of ideas. It is "stereoscopic," that is, it is appreciative of the broad range of social phenomena that may bear on a particular problem.

Experimentalism returns reflection to experience. Dewey's broad notion of experience subverts many traditional oppositions: reason/emotion, subject/object, agent/patient. The flow of primary experience is interrupted when purposes are frustrated or conflict. Secondary experience includes our efforts to make sense by relating activities and consequences, by taking account of the transactional nature of experience. We can also use the term experience to describe practical learning. If we concede that craftspeople and scientists and patients and physicians may all lay claim to valid knowledge based on experience, we will be less inclined to uncritically accept traditional

Walter W. Powell and Paul J. DiMaggio (Chicago: University of Chicago Press, 1991), 232-63 at 248,
hierarchies of activity and knowledge. Dewey's concept of democracy links experimentalism to the realization of diverse goods in community. Democracy as Dewey conceives it is a way of life. More than a set of political procedures, it is the liberation of the powers of individuals in community. As a standard for evaluating social arrangements, it directs our attention to the kinds of relationships fostered by specific social arrangements and their effects on individual growth and happiness. The individual and the social are not, in principle, opposed. Human beings are individuals only in and through relations with others. Communities are regulated through some notion of right or justice. Pragmatic justice is multivalent; its directives vary across spheres of practice and levels of organization in a pluralistic social order.

In keeping with the emphasis on relations in ethics and transactions in experience, I have argued that conduct and character cannot be separated, and that these inclusive concepts are important because they work against atomism and other forms of myopia in the area of moral psychology. Our practice, as well as our theorizing, may be myopic. Our moral vision is frequently truncated and distorted. The prospect of immediate gain overshadows consequences for character and for the well-being and freedom of others. Great wealth may insulate its possessors from the common problems of humankind, and may hasten the eclipse of the other. Greed may be rooted in existential anxiety; we detect its presence in a lack of due proportion.

To round out the picture, I have argued that we need a transactional model of the self. The doctrines of self-denial, self-assertion, and self-interest share a basic flaw. They imagine the self apart from its objects, and interests as fixed and asocial. If selves vary
with their objects, and interests vary with social forms, then in matters of "self-interest" the crucial questions will concern the character of the self served and the character of the relevant social institutions. Human beings have instincts, but these cannot be evaluated apart from their variable expressions. Nevertheless, sympathy has a special status because it has the power to transform and direct other instincts. How great is the possible transformation? Are we free? Is radical social change possible? Finitude and freedom, and the insecurity to which these give rise, are barriers to social reform. At the same time, insecurity is social as well as individual and may be lessened or intensified through social action. The notion of "common grace" is one way of describing the forms of social security human beings may create for one another.

We can also talk about barriers to social reform in terms of ideology. Certain groups benefit when social arrangements are made to appear fixed. The illusion of fixity is created and maintained through the manipulation of symbols. Ideology can be understood as the distortion of reality—the passing off of sectional interests as universal ones, as the legitimation of authority to those called upon to submit to it, or as a means of social integration. The ideology of business portrays the individual as ready-made, complete with a motive to pursue profit. It hides the degree to which the intense pursuit of external goods is the consequence of specific legal, political, and social structures. The same is true of the ideology of medicine. The social supports for professional altruism are seldom examined. One aspect of the ideology of business, the notion of a profit-motive, is appealing because it promises to bring harmony—universal prosperity—out of the "free" interaction of individuals. Critics point to phenomena that are inconsistent with laissez-faire assumptions. In particular, the assumption that the social background
is stable, and will not be affected by corporate activities that erode social relationships, seems unwarranted.

By focusing on the pedagogical role of institutions, we gain the freedom to think about the effects of corporations and corporate activities on character and on the quality of relationships. I have argued that we cannot afford indifference to the means by which a desirable outcome is generated, or a desired action brought about. I have begun to construct criteria for assessing institutions, using Deweyan themes such as participation, creativity, communication, and voluntary cooperation. In the case of a productive enterprise, we look as well at the satisfaction of a range of needs. In a just social order, institutional structures will support relationships that meet the needs of all concerned. Institutions can be sources of moral corruption, but they can also be agencies of moral renewal. Finally, I have argued that we must pay attention to the differences among institutions. We are confronted with a range of institutional models, and we have the opportunity to turn the conflicts among them to good use through critical evaluation.

Partly by way of compensation for past neglect, the focus of the remaining chapters of this dissertation will be on institutions. The intent is not to deny the importance of the individual. Dewey himself expended considerable effort in developing a manifesto for a new, socially aware individualism. Neither recognition of the fact of social dependence, nor the embrace of a social ethic, necessarily leads to a rejection of individualism as a belief in the unique capacities and potentialities of each human being. The responsibility of individual actors for their own conduct need not disappear. Dewey and Tufts speak of a change from personal to social morality, but they wish to be very clear about what this change entails:
It does not signify that morality becomes impersonal and collective; it remains and must remain personal in that social problems have to be faced by individuals, and decisions reached in the forum of individual minds have to be carried into effect by individual agents, who are in turn personally responsible for the consequences of their acts. Morals are personal because they spring from personal insight, judgment, and choice. Such facts as these, however, are wholly consistent with the fact that what men think and believe is affected by common factors, and that the thought and choice of one individual spreads to others. They do not mitigate against the fact that men have to act together, and that their conjoint action is embodied in institutions and laws.... In other words, it is a fact that a vast network of relations surrounds the individual: indeed, "surrounds" is too external a term, since every individual lives in the network as a part of it. The material of personal reflection and of choice comes to each of us from the customs, traditions, institutions, policies, and plans of these large collective wholes. They are the influences which form his character, evoke and confirm his attitudes, and affect at every turn the quality of his happiness and his aspirations. (EII, 317-18)

I mean to make the case that concentrated social forces are extremely powerful—under certain conditions irresistible. At the same time, such conditions rarely obtain. If anything, I wish to stress that individuals are inclined to underestimate the power they have personally, or in alliance with like-minded others, either because exerting power and organizing involves considerable effort, or because they are unwilling to risk some degree of hardship for themselves or their dependents, however limited. Hence, the degree of effort required or the possible hardship are exaggerated to the point where it seems foolhardy to resist or work for change. Less cynically, it is also true that some people simply cannot imagine alternatives. One goal in exploring an array of ideologies and organizations is to show something of the range and texture of the alternatives, and to increase the visibility of certain neglected options.
Chapter Five: The Character of Institutions

We need to think less about doctrine and principles and the rules to govern behavior, more about education and institutions...

—Leon Kass, "Practicing Ethics: Where's the Action?"

In this chapter, I shift the focus from institutions as agencies of character formation to the character of institutions. My account of institutions will build on the material presented in the last chapter, but I will also draw heavily on recent work in the social sciences. I will delve into the sociological literature, especially the work of institutional theorist Philip Selznick and medical sociologist Eliot Freidson, and I will appropriate some insights from Charles Anderson’s pragmatic version of political economy. I begin by clarifying certain key concepts: institution, organization, institutionalization, and community. Next, I ask whether the concepts of moral agency, moral responsibility, and character make sense in the case of organizations. I will argue that they do, subject to certain qualifications. In particular, the concept of character applied to an organization refers to the commitments the organization supports, the opportunities it creates or forecloses, the priorities it sets, and its characteristic failings. Organizations can only act through persons, but persons act differently depending upon the kind of organization they inhabit.

I argue, by way of demonstration, that the concept of organizational character can fruitfully be developed through an examination of the virtues of justice, integrity and responsiveness. The account of justice looks at matters of distribution and contract, and explores some of the contours of the principle of subsidiarity. The account of integrity
internal and external goods. The account of responsiveness surveys some of the factors that tend to narrow the range of interests and values to which an organization is responsive, as well as some of the possible correctives. I conclude this section by arguing for the relevance of standards of economy and efficiency, but in pragmatic terms. That is, I argue that economy and efficiency are not meaningful standards apart from some specification of ends and some understanding of practices.

Finally, picking up on a comment made by Jeffrey Stout, I consider whether bureaucracy can mitigate some of the negative effects of markets, and professionalism without accountability. I argue that we need to begin by framing our questions with care. In the case of bureaucracy, the real question is how to go about reconciling a range of legitimate claims in practice while maintaining meaningful human relationships. Using Freidson's work, I argue against the substitution of bureaucratic methods of control, and external sanctions or incentivizing strategies, for collegial ones. Especially where social trust is weak, bureaucratic controls may be perceived as manipulative and invite manipulation in turn. At the same time, bureaucracy has its virtues, and bureaucratic controls may support collegial ones.

Professionalism also has its virtues, but it has often been allied to unwarranted group privilege. I argue that the professional ideal can be democratized. Difference is possible without hierarchy, and to show how this might be so, I link profession and MacIntyre's concept of practice. As to the virtues of professionalism, the professional model aims at a qualitative product, an appealing quality in a field that touches us as intimately as health care. Further, one can argue that the professional model is the most democratic, in the sense that people control their own work by cooperative, collective
means. At the same time, the professional model has its characteristic pathologies. Cost, distribution, and quality vary widely. I conclude, with Freidson, that market and bureaucratic methods can and should be used to control cost and performance, but with care that the specific methods chosen do not seriously undermine what is desirable in professionalism. I make a plea for preserving a place for moral language and moral ideals in health care, and I close with a comment on the practice of medical ethics and power.

1. Clarification of Concepts

The term "institution" is used very loosely by Dewey and others. Some distinctions may lead to greater precision, and avoid certain confusions. Sociologists will often distinguish between organizations, meaning groups or associations that have reached a certain stage of formalization, and institutions as broad social phenomena. Examples of the latter would include the family, the school, the church, and so on. Philip Selznick uses the term institution in a different way, within a developmental scheme. Three concepts—organization, institution, and community—allow one to discriminate among corporate enterprises according to qualities that are significant from a Deweyan perspective. This is not surprising, as Selznick is a "professing pragmatist" heavily influenced by Dewey.

According to Selznick, a pure organization is "a special-purpose tool, a rational instrument engineered to do a job." An institution is "a product of social adaptation" reflecting an array of interests and values. It is a more organic phenomenon. In Selznick's formulation, we can use the term "organization" generically to signify both pure organizations and institutions, because pure organization and institution are points on a

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1Dewey, and Dewey and Tufts, usually speak generically of "institutions." The concrete organizations that
continuum defined by the process of institutionalization, "the emergence of orderly, stable, socially integrating patterns out of unstable, loosely organized, or narrowly technical activities." This process constrains conduct in at least two ways, "by bringing it within a normative order, and by making it hostage to its own history." As a process, institutionalization is not without change or regularity. Institutionalization is a move toward relative fixity and permanence, and hence always carries with it the problem of the appropriate balance between integrity and responsiveness, preservation of tradition and openness to change, sensitivity to the claims of particular persons and universality, and internal and external goods.

This description of institutionalization suggests a natural movement from pure organization to institution to community. Selznick finds the ideal of community to be implicit in both institution-building and openness to the social environment.

"Internally,... culture is sustained by a sense of community, that is, in the context of organization, by person-centered sharing in a common enterprise.... Attention must be paid to fragile incentives, multiple interests, and the dynamics of cooperation and conflict." "Externally, the institutionalized organization is a locus of value and a center of power. The surrounding community has a stake in its existence and in the proper conduct of its affairs. More than either organization or institution, the notion of community is heavily normative. It also has a somewhat checkered history. Its use as a term of art can be traced back to the German sociologist Ferdinand Tönnies. Tönnies distinguished between Gemeinschaft (usually translated "community") and Gesellschaft (usually

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interested Dewey most were schools, and he devoted a great deal of attention to how a school should be organized.

translated "society") as ideal types. Tönnies' own account was rather neutral, but the concepts were subsequently picked up by those who expressed disgust with the deracinated character of modern existence and yearned for the "recovery" of some deep, organic (and quasi-mystical) communion. Community became an ideal in the more robust sense. On this side of the Atlantic, community is often associated with Alexis de Tocqueville's America, a society built up of strong local associations. The term was central to the philosophy of Josiah Royce, who spoke of the "Beloved Community" and the "Great Community," and as we have seen it figures prominently in Dewey's work.4

The movement along the continuum from organization to institution to community is natural in the sense that having a sense of history is a function of having a history, of the number of years an organization has been in existence. On the other hand, because the applicability of the concept of community in particular is determined in part by the consciousness of the participants—their sense of being part of a community upholding certain moral values—the developmental process is scarcely automatic. A company may exist for many years with the slogan, "WE CARE ABOUT PROFITS, NOT PEOPLE OR VALUES." The company's policies, e.g., its manner of dealing with external regulators and its system of internal rewards, will reflect its absolute commitment to profit-maximization. Presumably it will attract employees who share this commitment. Of course, this absolute profit-orientation is itself a value, a statement and a reflection of what the organization values. But this value presupposes the inapplicability of all other

values and moral considerations to the affairs of the company, and the organizational environment is hostile to the cultivation of values and practices which are not instrumental to profit-generation. There is no community.

2. Moral Agency and Moral Responsibility

There is an ongoing debate in legal and philosophical circles about whether it is appropriate to ascribe moral agency and responsibility to organizations. The pragmatist approach is to ask "What difference does it make?" Why might one resist this ascription? In the first place, some might argue that applied to organizations rather than to persons these concepts simply do not make sense. Analogies between persons and social groupings go back at least as far as Plato. I have argued that in some ways organizations are like persons, and in other ways they are not. There are no easy answers. We have to look more closely at the particular concepts and what they entail.

What does moral agency suggest in the case of persons? Very generally, it suggests some level of competence or ability to effect consequences in accordance with purposes, and some level of accountability. Accountability means that other agents may (rationally) demand an account. An organization clearly has the ability to bring about consequences, in accordance with collective purposes. The organization can only act through persons, but the actions of those persons are shaped by the fact that they act with others, and by tangible and intangible aspects of the organization such as plant and equipment and rules and policies. People act differently when they act in coordinated fashion: "the attributes, successes, and failures of organizations are phenomena that

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Hague: Martinus Nijhoff, 1972), 149-60 (on the idea of community in Royce's philosophy).

5My analysis takes a slightly different path than Christopher Stone's, but I follow Stone in proceeding pragmatically and putting the question of intelligibility first. See Christopher D. Stone, "Corporate Accountability in Law and Morals," in The Judeo-Christian Vision and the Modern Corporation, ed.
emerge from the coordination of persons' attributes and that explanations of such phenomena require categories of analysis and description beyond the level of the individual." As for accountability, it would be irrational to demand an account from a tree that happened to shed a branch on your head. The tree isn't going to respond. It would be nonsensical to ascribe moral agency to a tree—there are limits to intelligibility. It would not be irrational to demand an account from a corporation that polluted your town's well. The corporation can respond, in two senses. It can issue a press release or write you a letter, acting through persons who would not do what they do absent the role they occupy in relation to the corporation. And it can change how it operates to avoid further pollution and compensate the town for the harm, or refuse to change or provide compensation. So the description of organizations as moral agents is not senseless.

If moral agency makes sense, then moral responsibility likely will too. Moral responsibility is usually associated with terms like rationality and respect. In a widely-cited article, Kenneth Goodpaster and John Matthews argue that rationality and respect, in organizational terms, would include things like assessments of social costs and benefits, justice in the distribution of goods and services, recognition of basic rights and duties, and fidelity to contracts. Of course, there may be other reasons to oppose the extension of these concepts. Some may fear that if organizations are granted moral agency and responsibility they will also be credited with possessing moral rights (which will be in

Oliver F. Williams and John W. Houck (Notre Dame: University of Notre Dame Press, 1982), 264-91.


competition with individual rights). I believe this fear is misplaced. People acting collectively or in association should have moral rights, claims to be free of state interference absent illegal conduct and so on. To be effective, these rights have to attach to the association. If the community is more than an aggregate of individuals, if the whole is greater than the sum of its parts, then the goods of community can only be protected by protecting the community itself. That said, treating an association—at least one that has reached a certain level of organization—as a moral agent bearing moral responsibility does not add to its moral rights. The rules and policies and plant and equipment do not somehow become endowed with moral claims that float free of the people whose cooperative project the organization is.

Another objection might be that if moral responsibility is ascribed to organizations, individual moral responsibility will be eroded. People will come to believe that they are less responsible, or people may actually become less responsible in the sense that, given the scope of their agency within an organization, we cannot properly blame them for harms or wrongs. If the town well is polluted due to a series of oversights, minor mistakes, and design failures all down the line, there may be no one individual or group of individuals who can be blamed for the incident. If there is an erosion of individual moral responsibility in this sense, it is occurring regardless of our terminology. So the focus must be on the first sense, and the fear that using moral language in relation to organizations will deaden the sense of individual responsibility. Here I can only stress that this need not happen.

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8This kind of concern seems to lie behind George Annas's statement that "[h]ospitals are corporations that have no natural personhood, and hence are incapable of having moral or ethical objections to actions." George Annas, "Transferring the Ethical Hot Potato," Hastings Center Report 17, no. 1 (1987): 20-21.
As Dewey and Tufts argue, there is no reason why we cannot recognize social forces and preserve individual responsibility. There is no reason why we cannot hold individuals and organizations responsible under appropriate circumstances. For example, let us say that one of the engineers employed by the corporation that polluted the well told a vice president that some toxin was likely to leak into the ground water if a relatively inexpensive device was not installed. The vice president decided to do nothing because the president had just made a speech about belt-tightening. Perhaps the engineer should have warned the townspeople directly. Perhaps the president should have been aware of how her speech would be perceived by her subordinates. We can argue about how responsible these individuals were, morally, for the harm. There is no question that the vice president can be held morally responsible. He had the information and the power to act to prevent the harm. That said, we may also want to hold the organization morally responsible. Should systems have been in place to prevent the harm? For example, would it have been reasonable for the corporation to conduct periodic safety reviews, with results routed to at least two corporate officers? In short, individual moral responsibility does not disappear, but the question of how to reform the organization to lessen the risk of malpractice or malfeasance is given greater weight. The same kinds of issues arise repeatedly in the context of managed care, where organizational policies may render practitioners more likely to make certain kinds of mistakes or engage in certain kinds of wrong-doing.

If all of this is true, what affirmative reasons might be offered for using the language of moral agency and moral responsibility in relation to organizations? We might want to use this language precisely to draw attention to features of organizations that are
connected with wrongful or immoral conduct, and to bring about changes. If I say that an 
HMO such as Health Net is morally responsible for administrative practices that 
contribute to the suffering of member-patients such as Christine deMeurers, I am saying 
no more than that the consequences of actions taken in the name of the organization 
should be better assessed, that there should be more attention to justice, a Fuller 
recognition of rights and duties, and a greater conscientiousness in contractual matters—
and that any failures should be remedied by the organization. Managers should (and 
should be urged to) consider consequences beyond the company's short-term financial 
performance. Like cases should be treated alike. The rights and duties attaching to the 
doctor-patient relationship should be recognized and respected. Contractual provisions 
that appear to promise some benefit should be honored promptly. These corrections will 
require changes in policies, procedures, hiring practices, reward systems, and the like. In 
other words, organizational structures, and not merely minds and hearts, will have to be 
changed.

In order to better understand the moral agency of organizations, we need to pay 
more attention to structures, and in focusing on structures, we need to beware of an 
overly static conception of organization. An organization is really an "organizing," an 
going process of change characterized by certain regularities. And, to use the standard 
terminology, organizations always consist of both "formal" and "informal" structures.9

9Another way of working through these issues would be to borrow from Anthony Giddens's theory of 
"structuration." One of Giddens's key concepts is the duality of structure. Giddens explains that "structure 
is both medium and outcome of the reproduction of practices" through action. Anthony Giddens, Central 
Problems in Social Theory (Berkeley: University of California Press, 1979), 5. It is both a property of 
social activity and its artifact. Structure is instantiated in the form of rules and resources. (Giddens is a 
social rather than organizational theorist, and he does not distinguish between formal and informal 
structures.) A major concern of Giddens is to prevent human subjects from disappearing altogether in 
social theory. As pictured in his work, persons are knowledgeable, with in-built capacities that are 
developed through learning, and they reflexively monitor their own conduct. Knowledgeable action both
Organizational theorist Richard Scott defines formal structures as those norms and behavior patterns that exist regardless of the characteristics of the individual actors. (Of course, formal structures usually reflect the purposes of a particular set of individual actors, the organization’s founders and leaders.) Formal structures include such items as the hierarchy reflected on organizational charts, the organization’s decision making structure, its system of coordinated roles, its system of financial incentives and rewards, its mission statement and code of ethics, and its history of policy and practice. Scott defines informal structures as those structures which are based on the personal characteristics or resources of the specific participants, as contrasted with characteristics or resources attached to certain roles or positions. Informal structures include such things as the regular gripe sessions in the break room, or the enormous power exercised by the administrative assistant who has made himself the gatekeeper for the CEO. Theorists may view the informal structure as an impediment to implementation of the formal design, or as a corrective for its inadequacies. For example, informal structures can be credited with easing communication and facilitating trust, or sabotaging critical policies.\textsuperscript{10} Many students of organization argue that the informal structures are the most important part of any organization.

Formal and informal structures may be more or less integrated with one another. According to Selznick, "The formal system is effective to the extent work is done to maintain it and insofar as it is supported by an adequate array of incentives, including

motives that drive the informal structure. Rules and purposes must be effectively part of and made good by a social matrix." In an interesting article relevant to the issue of structural integration, sociologist David Mechanic and his colleagues assert that caring can be defined in cognitive, affective, and behavioral terms, that people can learn how to express it, and that "medical practice can be organized, administered, and financed in ways that will cultivate and sustain it." They argue that caring is undermined by some common formal and informal structures, including quantitative approaches to cost-containment, specialization, the assignment of nurses to wards rather than to patient panels, and the antagonism and poor communication between doctors and nurses. They make two major recommendations. First, they suggest better training and supervision of staff using models developed in the service industries. They find deficiencies in this area across the medical hierarchy, but they are especially struck by the tendency to ignore the training needs of personnel who have patient contact but little power or education. Second, they suggest better reimbursement for "cognitive services" (talking with patients). Especially in these cost-conscious times, they believe it is essential to stress that caring is the task of the entire organization, meaning each person who has contact with a patient. This will become a reality only if staff develop a different understanding of the nature of their work; socialization processes, specific policies, and the organization of work must change.

Medical ethicists, to the extent that they have been organizationally aware, have tended to focus on mechanisms associated with the formal structure, that is, codes of

Prentice-Hall, 1992), 54.
ethics, and written policies and procedures. Policies to address such organizational issues as conflicts of interest, marketing, admission, transfer, discharge, billing practices, and relationships with other institutions are only now being crafted in response to the inclusion of "organizational ethics" in standards for accreditation. The accreditation manual published by the Joint Commission for the Accreditation of Healthcare Organizations suggests that most of these issues can be satisfactorily addressed by adding to the organization's existing code of ethics. Yet there is evidence that codes of ethics, especially codes of ethics that are poorly institutionalized, are mostly irrelevant to practice. Indeed, it is hard to see how they could have much effect, when members of an organization may not know that they exist, likely did not participate in their development, and have little notion of their implications for day-to-day activity. The evidence suggests that much greater sensitivity to the complexity of organizations is required on the part of ethicists.

3. Organizational Character and Its Assessment

The concept of character, like the concept of moral agency, can be used in relation to organizations as well as persons. Character "refers to the commitments that help to determine the kinds of tasks an organization takes on, the opportunities it creates or closes off, the priorities it sets, and the abuses to which it is prone." Some of these

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14 This is the conclusion of a comparative study of the experience with codes of ethics among health care and energy companies: "Despite relatively recent media attention focused on codes of ethics, our study indicates that the adoption of such codes is rarely accompanied by either a thorough development process or a system for assuring that the codes are known and used. As is indicated by existing literature, the absence of clear evaluation standards reflects a situation within which neither management nor employees know what to expect from a code of ethics. This situation holds from widely different sectors of the economy: contrary to what might be expected, our health care facilities were less likely to develop or effectively implement codes than were our energy companies." Isaac D. Montoia and Alan J. Richard, "A Comparative Study of Codes of Ethics in Health Care Facilities and Energy Companies," *Journal of*
aspects of organizational character are planned, while others are "contingent and unintended." In sum, the Deweyan concept of character for an organization is very similar to the Deweyan concept of character for a person. Both are transactional and historical in nature. Both link being and doing, combine controlled (planned) and uncontrolled (unplanned) elements, and allow for some interpenetration of elements without demanding unity. And both are highly variable. Every individual has a character, but character differs dramatically across individuals, along dimensions of coherence and goodness. The same is true of organizations. Goodpaster and Matthews observe that "when we look about us, we can readily see differences in moral responsibility among corporations in much the same way that we see differences among persons. Some corporations have built features into their management incentive systems, board structures, internal control systems, and research agendas that in a person we would call self-control, integrity, and conscientiousness. Some have institutionalized awareness and concern for consumers, employees, and the rest of the public in ways that others clearly have not."

I have suggested that in assessing organizational character, we need to begin with justice, but we also need to identify other virtues of organizations. The remarks of Goodpaster and Matthews suggest a number of these. I believe integrity and what they

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16 Goodpaster and Matthews, "Conscience," 148. It is a little confusing to say that there are "differences in moral responsibility," since it suggests that corporations that have not institutionalized moral concern may be held to a lower moral standard. There is a bit of truth here. It makes more sense to hold an institution (in Selznick's sense) morally responsible, than it does to hold a pure organization, a rational tool, morally responsible. In the latter case, the connection with the individuals who use the organization as a tool is so clear and so tight that one might as well heap the whole of blame or praise on them. But one can imagine a corporation that is very much an institution, and yet has taken no steps to institutionalize moral concern. We have as much reason to hold this corporation morally responsible as we do the exemplary corporation described by Goodpaster and Matthews. It is less moral and less responsible,
refer to as "awareness and concern" for the public, what I will call responsiveness, are among the most important. And I will conclude this section by addressing economy and efficiency. Since this is a problem-guided, practical inquiry, I will develop these criteria for the assessment of organizational character with reference to health care and managed care in particular.

**Justice**

Justice may or may not be the first virtue of institutions, or a virtue primarily of institutions, but I put it first because it is certainly important. My object here is to work out some of the practical implications of the insights collected in Chapter 3, the account of pragmatic justice presented in Chapter 4, and the account of moral responsibility presented earlier in this chapter. We can begin with an interpretation of social meanings in the health care sphere. There does seem to be fairly broad social agreement that the primary principle for distribution of health care services should be medical need, and that every citizen should be supplied with at least a basic minimum of health care services.

Still, the principle of distribution according to need will underdetermine the result in many cases; it does not, for example, tell us which needs are most pressing. Further, other considerations may limit the scope of operation of the principle. The advantages of a uniform package of health care benefits must be weighed against our desire for choice and our recognition that people have different needs and wants. A quest for uniformity may also bump up against deontological space, where coercive measures are proposed. The public ambivalence captured in the exchange between Relman and Reinhardt is not unreasonable. We are fearful of government involvement, but the standard alternative, the

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but not less morally responsible.
market, is also a source of fear.\textsuperscript{17} We want to help others (and ourselves) by creating a system in which there is greater security, but we are also guarded because we foresee escalating demand, and we want to protect what we have now. If we are to understand justice in terms of social meanings, this ambivalence cannot simply be dismissed.

Mapping alternative approaches to system-wide health care reform in terms of pragmatic justice is a project for another day. I will focus on what justice demands of lower social units, specifically, the organizations that manage and provide health care, with two caveats. First, given evidence of the incapacity of lower units to ensure decent health care for all, the higher units must act to better equip lower units for the task. Second, the activity of private actors is facilitated when the state establishes the ground rules for private transactions and protects legitimate expectations. Higher and lower units are interdependent, and failures at one level have reverberations at the other levels. I will examine some specific proposals for state oversight and regulation of managed care in the next chapter.

1. \textbf{Organizations and distributive justice}. A just health care organization will undertake an independent assessment of what it can provide in the way of uncompensated or undercompensated care, in recognition of the benefits it derives from the maintenance of social order (consistent with Rawlsian reciprocity). A thorough assessment will consider community needs and organizational resources. This matter is especially pressing in the absence of some form of universal coverage, but the concern about fairness would not disappear even if Medicare-type benefits were extended to the

\textsuperscript{17}Of course, some of the fear of government is unreasonable, to the point of being comical. Uwe Reinhardt quotes a report (in the \textit{Economist} magazine) of a woman so alarmed by the efforts of the anti-health care reform forces that she pleaded with a legislator, "Please stop that Clinton plan, Senator. I don't want the government in my Medicare." Uwe E. Reinhardt, "A Social Contract for 21st Century Health Care:
entire population. Even under such a scenario, it would be important that organizations resist the temptation to "cherry-pick," to recruit patients or enrollees selectively according to health status. Each organization should bear its fair share of expensive cases. Government payments are premised on an even distribution of hard cases, and cost-shifting across organizations invites, indeed demands, the kind of heavy-handed government regulation that may not be in anybody's best interest. Peer pressure and the prospect of negative publicity may help to keep potential "free riders" in line. Each organization should also conduct an independent assessment of contributions the organization can make toward public goods such as medical education and research, in light of the benefits received by the organization from these activities. It should be perfectly acceptable to tailor efforts in this area to the particular commitments and capacities of the organization.

Justice has little to say about the for-profit/not-for-profit distinction, so long as provision is made for support of public goods. (Note that this is the place to critically evaluate the claim of for-profit corporations that they contribute as much to the common good as not-for-profits, chiefly through tax payments. This claim cannot be dismissed out of hand, but neither should it be believed without evidence.) Third party payers and patients do commonly expect that the lion's share of premium payments will go toward health care. An organization that does not plan to honor this expectation should prominently display its medical-loss ratio on marketing materials.

Those who make organizational policy, like those who make public policy, need to consider distributional effects when they employ cost-benefit analysis. Results of
these analyses should be checked to ensure that they do not reproduce or reinforce existing patterns of discrimination. Results favoring policies that will, in effect, transfer funds away from care for the elderly, the disabled, women, African-Americans, and other classes of persons that have long suffered from discrimination should be scrutinized with particular care. The organization acting through its utilization managers and providers should also avoid bringing factors like age into treatment decisions, absent extraordinary efforts to clarify for potential enrollees that benefits will be adjusted on this basis, since the expectation would otherwise be that care will be distributed on the basis of medical need. The organization should avoid structuring rules in a way that invites providers and patients to game the system (with the result that similar cases are treated dissimilarly). On the other hand, the organization cannot eliminate potential for abuse of discretion without eliminating all discretion. This would be counterproductive in terms of overall goals, and suppress rather than nurture individual capacities. It would be much better to put "sensors" in place to detect gross deviations and recurrent inequities.

There may seem to be less cause for attention to distributive justice in the treatment of employees. Of course, organizations must abide by anti-discrimination laws, but is there anything more to be said? When sacrifices have to be made, there should be some rough justice between administrators and other employees. Also, there should be a readiness to consider the discriminatory effects of practices which are adopted with no discriminatory intent. For example, many managed care organizations use board certification as a proxy for physician competence. Board certification is an expensive as well as demanding process. What if it turns out that few practitioners from disadvantaged backgrounds are board certified? In practice, the board certification policy will have a
strongly discriminatory effect. A just organization might allow practitioners a certain period of time to obtain board certification, subsidize the further training of physicians who meet certain criteria, or develop a more complex procedure for assessing competence.

2. Organizations and contractual justice. A just health care organization will treat third-party payers and potential and actual member-patients fairly. 18 It will adopt marketing practices and disclosure policies that make consumer and patient choice meaningful. It will honor rather than attempt to weasel out of the terms of its contracts, especially as these concern responsibilities to members. (Some of the ways of the managed care weasel will be discussed in the next chapter.) In general, justice should be generous rather than grudging. 19 A just health care organization will avoid erecting barriers of inconvenience to the receipt of covered benefits. It will recognize that fear itself is a cost unjustly imposed on members, and the public at large, when administration is not reliable. It will avoid adopting unreasonable productivity requirements for providers. A requirement is unreasonable when it prevents providers from giving patients adequate medical care or destroys the relationship between patient and provider.

A just health care organization will do what it can to ensure that practitioners treat patients fairly. For example, practitioners cannot help liking some patients more than others, and contracts seldom command equal liking. But somewhere between treating

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18 In many cases, member-patients will have no direct contractual relationship with an HMO or other managed care organization. Rather, they will be beneficiaries under a contract between the managed care organization and their employer. While this fact is significant for the individuals involved, in that they lack the power to negotiate terms and may have trouble gaining access to the contract, it is still the case that the basic relationship is structured by contract.

19 Consider this example of pettiness. Many patients arrive at Bellevue Hospital in such severe distress that their identities cannot be immediately determined. Some are victims of accidents or violent crime. In nearly 100 such cases during a six-month span in 1995, managed care organizations refused to pay for treatment—on the grounds that Bellevue failed to notify them of the patients' status within 48 hours of admission. George Anders, *Health Against Wealth: HMOs and the Breakdown of Medical Trust* (New York: Houghton Mifflin, 1996), 146.
patients differently (e.g., joking more with Sally than with Jane) and treating patients differently (e.g., offering therapeutic options to Sally that are not offered to Jane) there lies a kind of favoritism that easily becomes injustice in the context of managed care. Again, the organization cannot eliminate these kinds of problems altogether without creating larger ones, but it can put sensors in place. An organization might go further and do what it can to enable practitioners to better perform their jobs and improve services. Finally, a just health care organization will attempt to increase member-patient participation, as well as choice. (Some of the ways in which this can be done will be discussed in the next chapter.)

A just health care organization will also treat employees fairly. It will pay a decent wage. It will institute some due process protections in the case of terminations. It is patently unjust to suggest that employees who were laid off because the organization is in financial trouble were fired for incompetence, in order to avoid publicizing the organization’s difficulties. It will attempt to involve practitioners, and the entire range of employees, in at least some aspects of policy creation and governance. Justice may not require any particular level of pay, process, or participation, but the principle of subsidiarity seems to pull in the direction of more participation than we have at present. Finally, guided by a Benthamite sensitivity to pain and Deweyan ideals of community and communication, and a sense of justice in the broadest sense, a health care organization will nurture in managers, practitioners, and patients an awareness of their personal responsibility to each of the “others” with whom they interact as a person. The role of managed care utilization reviewer may render those who inhabit it particularly prone to an impersonality that goes beyond what the task demands. Fellowship with each and every
plan member, or affiliated practitioner, may be precluded. This fact of life does not excuse callousness or brutality. Significant decisions should be given a human face, by power of sympathetic imagination and by periodic visits to sites where services are delivered.

**Integrity and Responsiveness**

Like justice, integrity and responsiveness are key organizational virtues. The significance of these two virtues is related to the Deweyan concept of character. The concept of character attempts to capture what develops over time through transactions that cross boundaries between inner and outer. Integrity is an inward-looking virtue. It requires the appropriate maintenance of boundaries, so that what is individual in a person or organization is not lost in dispersion, so that what is self does not simply collapse into what is other. It also looks at the articulation of inwardness, that is, at how various internal structures fit and work together, or fail to do so. Responsiveness is an outward-looking virtue. It requires the appropriate disruption of boundaries, in consideration of the associated or social nature of persons and organizations. It also directs attention to structures—structures that keep organizations open to those it affects within and without, and structures that allow adaptation to a changed environment.

Selznick calls fidelity to self-defined principles the chief virtue of the virtue of integrity. To use integrity as a test of organizational character, one must identify the organization's mission and principles, and then evaluate the organization's structures and practices against that standard. Integrity implies wholeness and soundness and coherence, but not, as Selznick says, "coherence of every sort." The coherence sought is moral coherence. Selznick sharply distinguishes integrity from simple consistency.
Consistency "asks too little if it does not require judgment based on the integration of purpose, policy, and implementation; it asks too much because integrity is not sacrificed merely because decisions are highly circumstantial, selective, or for other reasons do not follow a definite pattern."

These distinctions ensure that judging integrity will be no simple matter. It is no accident that proponents of the institutional school favor detailed case studies, or that Selznick himself wrote a well-known case study of the Tennessee Valley Authority. Selznick chronicled how the TVA's official doctrine or ideology of favoring "grass roots" democracy took shape in practice in the ceding of certain areas of its mandate to local agencies. Representatives of local agencies were appointed to key administrative posts within the TVA, assuring that there would be no internal checks to the turn-over of authority and responsibility to their former associates. The local agencies, as might have been expected, tended to favor established interests. In particular, the aid channeled through the TVA actually reinforced existing patterns of racial segregation and economic inequality. As Selznick makes clear, all of this occurred without any real villains.

Further, the doctrine of grass roots involvement had and has substantial moral and tactical appeal. Then, too, not all compromise is anathema to the pragmatist. Selznick pinpoints a breach in organizational integrity as the key factor that set the course from compromise.

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Selznick, Moral Commonwealth, 322-23. Integrity is a coherence notion, but to hold this virtue in high esteem one need not endorse a purely formal notion of morality. Quite the contrary. In various fields of human endeavor, accounts of virtues and goods intrinsic to specific practices must be developed. For example, Stanley Reiser argues that health care institutions should be guided by the values of humaneness, reciprocal benefit, trust, fairness, dignity, gratitude, service, and stewardship, with each term having a particular meaning in the context of health care. Integrity would then entail fidelity to these values. Stanley Joel Reiser, "The Ethical Life of Health Care Organizations," Hastings Center Report 24, no. 6 (1994): 28-35. Also, integrity is not necessarily a solipsistic notion. Of integrity as a personal virtue, William May says, "While referring to the self in its wholeness, integrity also points beyond the self toward the person, the ideal, the transcendent which gives shape to the person's life." William F. May, "The Virtues in a Professional Setting," Soundings 67, no. 3 (1984): 245-66 at 259.
to capitulation: "This was not a case of simple compromise made by an organization capable of retaining its internal unity. Rather, a split in the character of the agency was created. As a result, the TVA was unable to retain control over the course of the basic compromise. Concessions were demanded and won which may not have been essential if there had been fundamental unity within the organization." *"If there is a practical lesson for leadership here, it is this: if you have to compromise, guard against organizational surrender."*²¹ This warning is not without weight at a time when many not-for-profit agencies are tempted to make deals with profit-oriented companies. Some of these deals seem too good to be true—ready access to capital, and assurances that the values of the not-for-profit will be respected. The deal may be that good, but common sense skepticism is often justified.

Still, any organization that entirely neglects capital needs is not long for this world.²² Although Selznick invites organizations to consider the substantial costs of a surrender of integrity, integrity is not compromised merely by recognizing the value of a dollar in furthering good work. Recall Alasdair MacIntyre's handling of the distinction between internal and external goods. Internal goods are intrinsically related to social practices, and they cannot be had apart from the specific activities which constitute a practice. To use an example from medical practice, the exhilaration of arriving at the correct diagnosis following the careful detective work involved in taking a history, ordering appropriate tests, and then interpreting the results in light of the history, belongs


²²The emphasis should be on the phrase "entirely neglects." I would challenge the notion that not-for-profit organizations must literally "sell-out" to survive. An article describing the achievements of the Laurel Health System, one of the first integrated health networks in a rural area of the United States, notes
to just this sequence of activities. It is not available for purchase or barter. External goods such as money lack intrinsic connection to any particular activity. Yet they are genuine goods; without some level of external goods, social practices could not be maintained. Physicians could not practice medicine apart from social institutions—not just medical schools and hospitals, but all the organizations linked to the financing and material support of medical work—although a physician may on occasion work with little immediate assistance. A tension arises because the quest for external goods, initially sought to support practices, are constantly threatening to distort or undermine those very practices and damage their internal goods. A vicious cycle can result, in which the loss of internal goods stimulates the quest for external goods, which leads to the further erosion of internal goods, which is compensated for with yet more external goods, and so on.

Many fear that this cycle is currently in motion in health care. Salaried physicians meet with demands for greater productivity. More and more "patient encounters" must be squeezed into a workday. Genuine conversations with others—patients or colleagues—become out of the question. External monitoring and criticism, even when justified, may be resented. For those compensated through capitation, rather than salary, every patient becomes an object of suspicion. The patient is either a potential loss, someone with a serious health problem that will eat into the physician's income, or a potential waste of time, someone with a trivial complaint determined to get the attention she (or her employer or the government) has paid for. As the satisfactions derived from good work and meaningful personal relationships diminish, bonuses and other financial incentives become increasingly significant. But if one is to receive greater financial

that the system "reached its goals without much money." Claudia Coates, "Tucked Away in Rural
rewards, one must learn how to manipulate patients and others with greater finesse. One must become adept at "churnum," "cherry-picking" or "cream-skimming," and "buffing" and "turfing." Churning involves increasing the revisit rate of existing patients more than is medically necessary, and tends to occur where the reward system emphasizes productivity. Here, cherry-picking and cream-skimming are labels for the practice of culling sick patients out of one's practice in order to make one's utilization profile look better. Buffing is a term for making this practice appear justifiable, and turfing is transferring the sickest patients to other providers participating in the plan.

The same kinds of processes may operate at the level of the organization. As competition becomes fiercer, the object of winning more "covered lives" (taking in more premium dollars) while reducing the "medical-loss ratio" (spending as little as possible on health care) begins to predominate. Everywhere one seems to find confirmation of the Darwinism of Herbert Spencer. Large employers must be assiduously courted. A quality assurance program is put in place, since this is a major selling point. But because the concern is appearance rather than substance, the plan administrators "teach to the test." They work hard to improve quality, but only in the areas specifically covered by the standardized report card. Marketing and administrative costs increase. Since premiums cannot be increased, additional pressure is applied to providers to hold down costs and absorb more risk. A provider may agree to live with more "downside" risk, but only on condition that she receive a greater share in the "upside," profit, if she succeeds in further increasing productivity or shrinking utilization. Here profit sharing is not a path to greater solidarity or a way of rewarding good work, but rather the instrument for the

destruction of a sense of collegiality and other practice values. And so the two cycles feed one another. The only possible way out is to step back and reconsider personal and organizational commitments.

Organizations, like persons, have characteristic failings, and the chief flaw of organizational character is opportunism. Opportunism is "the pursuit of short-run advantage without effective restraint by principle and ultimate consequence." Moreover, opportunism as a general phenomenon is linked to or exacerbated by a particular structural defect, overgeneralized purpose. "When purposes are abstract, yet decisions must be made, more realistic but uncontrolled criteria will govern."23 The goal "to deliver quality health care" is abstract; a health care organization might stand a better chance with a goal of improving patient care. Fragile goods can only be secured against displacement if protections are institutionalized. Institutionalization entails thinking hard about what a high sounding ideal means in practice, in this organization's practices. A mission statement should be tied to more concrete goals and objectives. Major policies should undergo an ethics review to ensure that they are consistent with mission, goals, and objectives. Finally, attention should be given to monitoring informal structures: Do they support or subvert the mission, goals, and objectives? What are the failures of implementation, and how can these failures be remedied?

In a Deweyan ethic, organizational virtues will be understood in light of democratic values: the business of the organization should be carried out in a democratic manner. This means, among other things, that decision making processes will be open, both in the sense of being public and in the sense of facilitating the participation of all

who have an interest in the work of the organization. Further, to the greatest extent possible, consultation, negotiation, cooperation, and persuasion will replace coercion, intimidation, domination, and manipulation. These kinds of themes will be discussed in connection with the virtue of responsiveness, but participation becomes a matter of integrity when one of the organization’s central commitments is to democracy. Robert Michels is known for his account of the demise of democracy in organizations and the so-called "iron law of oligarchy."24 Even organizations with strong commitments to high ideals readily drift toward structures incompatible with their founding principles.

Selznick notes that despite the "iron law" rhetoric, Michels identifies two regulative principles which check or restrain the drift toward oligarchy and mitigate its effects. "First, democracy tends to 'stimulate and strengthen in the individual the intellectual aptitudes for criticism and control.'" Second, "oligarchy can be limited when power is available to check power, a process which, to be sustained, depends on the energy and activity of elites."25 One may see a tension between the first and second principles. After all, is not the gathering of power in the hands of elites the first step toward oligarchy? Even if the power of elites is not transformed into domination, because elites are multiple and serve to check one another, is not the very notion of an elite antithetical to democracy? Deweyan democracy is the fullest possible development of individual capacities and powers, including the social dimensions of these. If a person has an interest in and talent for the exercise of social power, this can be used for social purposes. The term “elite” may refer to the beneficiaries of class privilege, or a special

24"It is organization which gives birth to the domination of the elected over the electors, of the mandatories over the mandators, of the delegates over the delegators. Who says organization says oligarchy." Robert Michels, Political Parties (Glencoe, Ill.: Free Press, 1949), 401.
class of experts, but it may also take in those from whatever walk of life who are gifted with "political" intelligence and leadership ability.

We need leaders, and there is nothing particularly scandalous in the fact that some are leaders in some areas, so long as power is as fully dispersed as possible, authority is structurally limited and open to contestation, and leadership in one area does not translate into dominance in other spheres of activity. It seems foolish to rely on the spontaneous organization of patients or consumers to counter the power of insurance companies and managed care organizations, or to assign to these groups the task of overseeing daily operations. Further, the model of democracy as universal participation in governance scarcely works in the political arena. Its extension to the management and practices of health care organizations is, at present, unrealistic. The means by which such a revolution is to be accomplished have yet to be fully articulated. I cannot imagine middle-class Americans, let alone those worrying whether there will be enough money to buy food and pay the monthly utility bill, becoming health care activists en masse in response to the call of civic duty. Some of us may want health care organizations to be "managed in our interests, but also in our absence."26

26What I am raising here is what Ryan labels the "central puzzle" of participatory democracy—what does it look like? "Dewey did not suppose that the American public was longing for a world in which the average worker would come home from work at six in the evening, grab a sandwich, and rush off to a town meeting to decide whether his block should purchase its electricity from Con Ed or brew its own. Oscar Wilde had complained that socialism was all very well but would eat rather painfully into one's evenings, and Dewey was not so attached to head-in-the-air abstraction that he could not see the point. But what is it to be like? Every clear answer is a negative answer." Alan Ryan, John Dewey and the High Tide of American Liberalism (New York: W.W. Norton & Company, 1995), 311. Although I admire Ezekiel Emanuel's work, I think Emanuel, like his mentor, Michael Sandel, envisions a world in which working men and women attend a lot of evening meetings.

In a short piece on civil society, Michael Walzer looks at four common answers to the question of the good life. The first, the "left" political, holds that the preferred setting for the good life is the political community. "If politics is our highest calling, then we are called away from every other activity (or, every other activity is redefined in political terms)..." But, says Walzer, the political ideology is not "real," as the rule of the demos is in significant ways illusory, and because "despite the singlemindedness of republican ideology, politics rarely engages the full attention of the citizens who are supposed to be its chief protagonists." Ordinary folk must worry about making a living. Further, although republican theorists
On the other hand, people do need to become more active and responsible in the matter of their own health and health care, and this sort of democracy, in the broad, Deweyan sense of democracy, is a realistic goal. These forms of local involvement may also serve to "stimulate and strengthen in the individual the intellectual aptitudes for criticism and control," and may even furnish the basis for more properly political activity—without being merely instrumental to this purpose. In terms of monitoring and checking the political activity of health care organizations, and attending to and participating in their internal politics, policy formation and decision making, the activity of elites will likely remain a significant factor. And yet, we should always be striving for something more fully participatory. Improvement of the existing situation is certainly feasible. Health care touches us more closely than many an issue debated in Washington or the state capitol, and understanding the ways in which organizations condition what goes on in the doctor's office and the surgical suite should be part of health education in schools and beyond. No one should be satisfied with the conveyance of this sort of information through sound bites, infomercials, and billboards with beaming moms and babies and the promise that your managed care organization will provide "ALL THE

tend to disdain non-political activity, a more generous—and less aristocratic—view will allow that work, family, etc. have their own value. The other three answers to the question of the good life are the Marxist, capitalist, and nationalist. Walzer favors a fifth option, "civil society," which is "part alternative, part incorporation" of the others. Civil society is less...political than the political conception of the good life seems to allow. "A democratic civil society is one controlled by its members not through a single process of self-determination but through a large number of different and uncoordinated processes." Such a society is not relentlessly democratic (in the political sense), "for we are likely to be members of many associations and we will want some of them to be managed in our interests, but also in our absence." Michael Walzer, "The Idea of Civil Society," Dissent 38 (1991): 293-304 at 294-95.

27 For example, as noted by Laurie Zoloth-Dorfman and Susan Rubin, the care which has been exercised in reforming Medicare, and the protections which have been established for Medicare recipients, contrast sharply with the haste in turning Medicaid beneficiaries over to managed care organizations— with any problems to be worked out later. They point to the existence of an effective lobbying organization for the elderly, the American Association of Retired Persons, as the crucial distinguishing factor. See Laurie Zoloth-Dorfman and Susan Rubin, "The Patient as Commodity: Managed Care and the Question of Ethics," Journal of Clinical Ethics 6, no. 4 (1995): 339-57.
HEALTH CARE YOU DESERVE."

The virtue of responsiveness is a potential counter to integrity. Some other factors that may work against integrity lack moral weight. The mad scramble for external goods, and the "successful" operation of the organization on terms inconsistent with its mission and principles, have little moral dignity. The appropriate response is to institutionalize, to the extent possible, a process of recollection and restraint that restores the proper balance. But concerns about integrity do not absolve an organization of any responsibility to address new problems, to take account of the effects of new forces in the environment, and to consider new claims and expectations. Responsiveness is an aspect of moral responsibility, of thinking of a person or organization as responsible to and for others. Responsiveness requires that an organization avoid insularity without embracing opportunism, here in the form of "uncontrolled adaptation" or capitulation to pressure. There is an element of integrity in responsiveness, and vice versa. Being responsible means being reliable. An organization that yields to every pressure or follows every fad cannot be relied on by those inside or outside the organization. On the other hand, integrity is a hollow virtue if it exists "for itself."

A great obstacle to the appropriate regulation of organizations and organizational behavior has been the assumption that organizations must be either persons or (moral) nullities. I have argued that some responsibilities are organizational rather than individual. The identification of the corporation with the stockholders has had an especially pernicious effect on corporate rationality, as what is rational for stockholders, or certain groups of stockholders, may not be rational for the organization or the larger community,

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e.g., takeover and looting. These sorts of concerns have fueled a debate over the meaning of "corporate social responsibility." In what relation does the corporation stand to the needs and interests of the larger community? Opinion ranges from Milton Friedman's pronouncement that the responsibility of business is to increase its profits, to a kind of casual volunteerism, to traditional arts-oriented philanthropy, to proposals for active corporate involvement in bettering life in all segments of the community, including projects such as single-handedly taking responsibility for rehabilitating the hard-core unemployed in a particular region.

I am largely in agreement with Selznick: "The moral responsibility of the enterprise, like that of the natural person, runs primarily to the control of its own conduct (1) in the light of how its activities affect the community, especially the persons, institutions, and values in which it is directly implicated, and (2) in the light of its internal morality, that is, of the ends and means to which it is committed." 29 Large health care organizations may reap public relations benefits from sponsoring public art exhibits, and on the whole art is a very good thing, but the chief corporate responsibility is to improve health and offer excellent health care. Now, this may very well include heightened attention to the aesthetic dimensions of health and healing through, for example, the development of an art therapy program, or the creation of an environment that is tranquil and conducive to well-being. But the primary mission still sets the standard. The art therapy program ought not to become such a point of pride that only patients judged excellent artists are allowed to participate. The interior decorating budget ought not to rival the budget for indigent care.

To frame the issue in this way, in terms of values, is to reject the carry-over of interest group democracy from the political to the private sphere. Like integrity, responsiveness must be institutionalized if it is to be meaningful in an organizational context. Frequently, the institutionalization of responsiveness begins, and ends, with appointing representatives of major constituencies to the board of directors. This sort of group representation may seem to follow from the shift in focus from stockholders to stakeholders, but it can have unfortunate consequences. At its worst, it becomes a kind of tokenism that makes values totally irrelevant, so long as each of the most vocal groups in the community is represented in the decision making body and hence "has its say."

The issue is obviously a tricky one, since the label of "tokenism" may be used to challenge every attempt to extend the range of values which are brought to bear on the operations of an organization, or to close the organization to those who criticize its practices according to the standard of its announced principles and values.

What is required is a sense of balance. Persons who do not share the central commitments of the organization ought not to become a part of it. Their efforts are better directed to founding an alternative organization that reflects their own commitments, or working for the regulation of the existing organization, if they think its operations are sufficiently harmful. Within the circle of those who largely share the organization's commitments, every effort should be made to gather persons with different life experiences for committees and boards. This will require conscious effort on the part of corporate leaders and some overcoming of resistance, as we tend to surround ourselves with people who are like us. There need be no intention to discriminate, only a normal desire for comfort that has injurious consequences in organizational contexts. Such a
diversity of experience insures that discussions of policy will be full and rich, while agreement on basic values and principles will ensure that policy debates do not degenerate into unwieldy free-for-alls. If discussion is nothing more than a contest of wills, decisions are likely to be arbitrary or absent, as in the case of decision by failure to take action. Where stalemates are common, the bodies credited with guiding or governing the organization are in effect neutralized.30

Even if a board is composed of persons who combine commitment to values and principles with awareness of the needs and interests of the community, the organization can go badly wrong if other steps are not taken to institutionalize responsiveness. Many factors narrow the field of concern for managers and their subordinates. Selznick is sympathetic to the claim that American management participates in a "culture of shortsightedness." A number of developments, including a relative decline in spending on research and development, choice of imitative over innovative product designs, recruitment of leaders from finance and law rather than on the basis of specific knowledge of, and commitment to, production and technology, and a preoccupation with mergers and acquisitions, have tended to reinforce one another.31 One might note as well mobility within and across organizations. Executives and managers often make decisions that are economically and socially costly in the long-run because they expect to be elsewhere when the costs are incurred.32 The time horizon problem created by these developments can only be ameliorated by changes in structures, such as adjustments to the internal

32 I know this from personal experience, but it is also documented in Robert Jackall, Moral Mazes: The
reward system, modification of employee recruitment and retention policies, and retraining of managers.

Yet it is difficult to see how a single organization, or even a number of organizations acting separately, can hold out against a culture that dominates the "resource system" and is enshrined in significant practices. These practices may or may not have been intended to orient businesses toward short-term financial results. Some critics point to the influence of modern accounting. Developed primarily for external financial reporting, these practices emphasize direct labor costs and short-term returns, structuring thinking in terms of fiscal quarters rather than years or decades. The critics argue, in effect, that a socially destructive restriction of time (and space) has been the unintended by-product of attempts to increase accountability and the flow of information. What was, initially, unintended has been taken up with enthusiasm.

If such practices are becoming more widespread in health care, does this constitute evidence of a link between short-term thinking and economic efficiency, if not more strictly moral desiderata? Arguably, no. Paul DiMaggio and Walter Powell observe that "bureaucratization and other forms of organizational change occur as the result of

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World of Corporate Managers (New York: Oxford University Press, 1988)

33Wall Street, in the case of for-profit firms. Not-for-profits face their own version of the culture of short-sightedness. Donors increasingly demand demonstrations of effectiveness, "outcomes," within time frames which many administrators (in private) label unrealistic.

34See Friedland and Alford, "Bringing Society Back In." 245. In a cruel parody of Adam Smith's notion of a hidden hand, it is possible for social ills to be attributable to no one's intentional action. Albert Hirschman describes one such instance. So long as they had a monopoly, the Nigerian railways and their customers fared well. When the railways were subjected to competition from road transport, the situation deteriorated. Why? As a monopoly, the railways had not been disciplined by desertion, but they were still affected by protest. Competition did not deprive the railways of a random fraction of users; rather, it took away their most demanding customers. This example is discussed in Raymond Boudon, The Unintended Consequences of Social Action (New York: St. Martin's Press, 1982), 36-38.

35Accounting rules may have effects other than the truncation of the time horizon. Accounting may have had a great deal to do with the acceleration of the trend toward managed care, if not the origination of the trend. The reduction of health care expenditures became a priority for many large corporations at the turn of the last decade because a change in the rules concerning accounting for retiree health benefits forced them to
processes that make organizations more similar without necessarily making them more efficient." They argue, quite cogently, that "[t]he ubiquity of certain kinds of structural arrangements can more likely be credited to the universality of mimetic processes than to any concrete evidence that the adopted models enhance efficiency" and that "[t]o the extent that organizational effectiveness is enhanced, the reason will often be that organizations are rewarded for being similar to other organizations in their fields." 36

Among the factors predictive of "isomorphic" change are the centralization of the supply of vital resources, uncertain technology, ambiguous goals, and a scarcity of visible alternative organizational models.37

Two points are especially important for our purposes. First, the increasing adoption of a focus on short-term results is good evidence that such practices are rewarded by "resource suppliers," i.e., Wall Street and government, and not much else.

Consider what happened to managed care giant U.S. Healthcare when it announced plans to increase physician compensation in an effort to improve the quality of its networks.

The company had managed a medical-loss ratio of just sixty-eight percent in the fourth quarter of 1994; the announcement came in April of 1995. Within a two-day period following the announcement, U.S. Healthcare's stock price "tumbled," wiping out more

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37Isomorphism is defined as "a constraining process that forces one unit in a population to resemble other units that face the same set of environmental conditions." DiMaggio and Powell, "Iron Cage Revisited," 149. DiMaggio and Powell conclude that "[a]n understanding of the manner in which fields become more homogeneous would prevent policy makers and analysts from confusing the disappearance of an organizational form with its substantive failure." DiMaggio and Powell, "Iron Cage Revisited," 158. If the not-for-profit form of health care delivery is on the decline, this is not necessarily due to the greater "efficiency" of for-profit firms. See Jeff C. Goldsmith, "The Illusive Logic of Integration," in 1996 *Health Network & Alliance Sourcebook*, C52-56 (citing the work of Stephen Shortell).
than $1 billion in shareholder value. This was a powerful sanction against deviation from the short-term perspective. Although investors merit consideration, even they are not necessarily well-served by companies that bow to this kind of pressure. Second, even if the focus on the short-term has unfortunate consequences, moral or economic, and likely both, it will be difficult to alter it absent changes in the attitudes and behavior of investors and administrators of government agencies. What, then, can organizations and individuals do? They might define their own goals with greater care, and work to increase the visibility of alternative organizational models, while working to change attitudes and behavior.

Efficiency and economy

In commenting on standards for judging productive enterprise, Dewey and Tufts suggest that we ask whether community needs are satisfied effectively and fairly, and whether those who actually do the work are provided with the means to live and opportunities for personal development. I have already touched on what fairness might entail under the heading of justice. Here I focus on effectiveness, and the meaning of work for practitioners. Charles Anderson draws a distinction between efficiency and economy, and he uses both terms in a way shaped by the pragmatic tradition. The basic idea is that these two standards develop out of the "logic" of productive activity, that activity be productive, and what efficiency or economy may require can only be specified in terms of the goals of a particular practice. According to Anderson, "efficiency" is "fittedness to purpose—that technique and organization are as appropriate as possible to the end in

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view."[^39] In Chapter 1, I alluded to the emptiness of efficiency as a slogan in the medicine-business polemic. Efficiency can only be assessed if the end is specified, and then the end itself becomes open to assessment. In health care, the end in view must be something like Jeffrey Stout's description of the telos of medicine: care for those who are sick, easing of suffering, cure when possible, and education in prevention. If a form of organization compromises care for the sick and so on, then even if it saves money, it cannot be judged more efficient than forms better adapted to these ends. Efficiency also implies reliability, some degree of standardization and quality control.

The moral significance of efficiency, defined in this manner, is bound up with the values and virtues productive activity can exemplify, and with the concept of a practice. In the pragmatic version of political economy, production is opposed to an abstract commercialism. This strand of pragmatism is particularly visible in Thorstein Veblen's analysis of the moral psychology of business. According to Anderson, Veblen argued that "the 'pecuniary' and 'predatory' skills, which he associated with the more avaricious kinds of business leadership, with business perceived only as financial calculation, were parasitical on a productive system which was itself the product of 'idle curiousity,' or scientific inquiry and invention, a 'parental instinct' which connotes management as good stewardship, and a 'pride in workmanship' which was the foundation of rational, consistent performance, or efficiency." This understanding of the relation between business as institutionalized avarice and business as a productive system affects how the role of profit is understood: "The public function of the firm is to make a useful product. Profitability is a test of its performance, but not the definition of its purpose. The aim is

to make a given product as economically as possible, not to make those products that will yield the highest rate of return.\textsuperscript{40}

This way of thinking about economics makes sense if one views social life in terms of practices. Practice is a commitment term. It indicates staying power, time for the development of standards of good practice, technical and moral excellence, and so on. If one is going to argue for the practical and normative significance of practices, one must also argue that there should be some resistance to the transfer of energies from one field to another. Obviously there can be too much resistance to change. Productive activity has the satisfaction of human needs as an end-in-view, and for a variety of reasons a practice may become divorced from this end. Profitability is an important, if not all-sufficient, test of performance and basic social usefulness. It is not the end of productive activity. Linking efficiency to practices also draws attention to the satisfaction to be found by producers, or providers of services, in doing good work.

"Economy" is the performance of a function at the lowest possible cost consistent with purpose—what we think we are about in doing cost-effectiveness analyses or seeking to reduce waste of all sorts. It is a standard that is most relevant to assessing alternative techniques within practices, within the bounds set by efficiency. The moral significance of economy is linked to concepts like stewardship and sustainability. Once again, we are called to recognize that expenditure of resources can only be judged waste in relation to a careful analysis of means and ends. The term medical-loss ratio, detached from the sphere where it made sense in relation to the ends of a practice (insurance), tends to suggest that all medical care is waste. A low medical-loss

\textsuperscript{40}Anderson, \textit{Pragmatic Liberalism}, 27.
ratio by itself tells us nothing about efficiency or economy in the provision of health care.

4. Bureaucracy

Bureaucracy is the many-headed monster of contemporary life. Is anyone in favor of it? One obvious fallacy traded in the debate over health care is that bureaucracy is a feature of "the government," rather than large organizations as such. The first thing worth stressing about bureaucracy is that it has its virtues. Remember Jeffrey Stout's call for investigation of the potential of "bureaucratic enforcement of rights" to mitigate the bad effects of the marketplace on social practices and the participants in them. Professionalism without accountability may also have effects which stand in some need of mitigation. The virtues of bureaucracy become clearer when one attempts to enumerate the features of bureaucracy in its ideal-typical form, rather than focusing immediately on its concrete failures. According to Selznick, they include: "(1) fidelity to assigned responsibilities; (2) accountability to the institution and its sponsors; (3) consultation as a corollary of the diffusion of authority; and (4) mitigation of arbitrariness through self-restrained, rule-governed decision." While these are "process values," "they protect and enhance substantive interests." The last feature, mitigation of arbitrariness, may be the most significant: "From the point of view of moral theory, the most striking feature of bureaucracy is this stress on objectivity and impersonality. Ideally, bureaucratic administration is the antithesis of arbitrary rule."41 The virtues are associated with specific principles of organization such as a fixed division of labor with clear lines of authority, general rules to govern performance, and selection of personnel on the basis of technical qualifications.

41Selznick, Moral Commonwealth, 280, 277.
The major criticisms of bureaucracy fall into two categories, the technocratic and the moral. The technocratic criticisms are a sophisticated form of the common complaint about bureaucratic "red tape." Although Weber thought that one of the features of bureaucracy (or rational-legal authority) that made it attractive to private industry was its facilitation of rapid response to change, decades of experience with bureaucracy suggest that this form of organization may rather hamper innovation. Appointment to positions based on technical competence and the establishment of clear lines of authority would seem to support effective, prompt decision making. In practice, however, a civil service-type system may protect the jobs of incompetent officials or managers, and clear lines of authority may be honored by the slow movement of a proposal through multiple layers within and across divisions. Rules may be rigid and inflexible, not allowing for sufficient discretion. Further, the history of bureaucracy does not show organizations becoming ever purer and more rational. Feudal elements such as the exchange of fealty for protection have shown a remarkable resilience, flourishing amidst corporate charts, long-range strategic plans, and volumes of company policies and procedures. The rational bureaucratic-traditional hybrid is a creature sui generis. Finally, as a more general point, formal, rule-following rationality tends to overstress means and neglect ends, and exhibit the other failings of calculative rationality.

42Reinhardt is something of a contrarian on this point, since he credits bureaucrats, and government bureaucrats no less, with introducing several innovations that have been imitated in the private sector. Reinhardt, "Social Contract," 496.
43In what may be the ultimate technocratic verdict on the utility of bureaucratic hierarchy, Scott and a colleague conclude that "formal hierarchies aid the performance of tasks requiring the efficient coordination of information and routine decision making, but they interfere with tasks presenting very complex or ambiguous problems." Scott, Organizations, 161.
44On "patrimonial bureaucracy," see Jackall, Moral Mazes, 11-12.
The technocratic criticisms cannot be separated altogether from distinctively moral concerns, but the latter stress the dark side of bureaucratic impersonality. Selznick uses the term "domination" to describe the experience of bureaucracy by supplicants and lower-level functionaries. Domination is a "parcelling-out of the soul," to use Weber's colorful phrase. Initially, it may seem that domination is the necessary price to be paid for the significant moral virtues of bureaucracies, as well as its other advantages as a form of organization: "The irony is that bureaucratic domination stems in large part from some of the very features that encourage self-restraint. The ethos of system, and of governance by rules, professionalizes administration and limits corruption. At the same time, it produces a people-processing culture in which persons are treated as administrative objects and their special needs and circumstances are ignored. Among ordinary clients and subjects, this is mainly what domination is about."\(^45\) In Weber's original conception of bureaucracy, discretion and flexibility in the application of rules and standards, within limits, are essential features, not threats to be minimized. Although impersonality is also prized, discretion restores something of humanity to bureaucracy. Even when discretion is abused, it is this person, and not "the system" alone, that commits the wrong. But our experience with bureaucracy reveals that maintaining discretion and limit at the same time is difficult.

It is significant, then, that many close observers of the world of organizations have announced the arrival on the scene of the "post-bureaucratic" organization. There is, not surprisingly, some disagreement over the nature of the emerging phenomenon. Disputes have arisen over whether changes detected in organizations are merely reformist

\(^{45}\text{Selznick, Moral Commonwealth, 285-86.}\)
bureaucracy or a true break with the bureaucratic type. In any event, in many organizations, structures are becoming more fluid and rules are becoming more flexible, with authority and discretion pushed down to lower levels in the organization. Some business authors have even linked the new styles of organization to the principle of subsidiarity. 46 The corporate hierarchy is being flattened out, as whole levels of management disappear. Cooperation and team work are also receiving greater emphasis, although these themes date back to the work of Chester Barnard and Mary Parker Follett. Post-bureaucratic organization holds significant promise for health care. 47 For the time being, however, we will have to address the influence of the old-fashioned kind of bureaucracy on health care, since it is far from moribund.

For many physicians and medical ethicists, the question of the fit between bureaucracy and health care reduces to: What are we to do about the physician’s new role as a functionary in the health care system, an agent of social or fiscal policy? The contrast is with the role of physician as agent for the present patient. I wish to quarrel with this way of framing the issue, while acknowledging that some physicians now see themselves as agents of social fiscal policy, and that this is a very undesirable

47 Mitchell Rabkin, a hospital administrator, describes a “participative management” model that goes a long way toward addressing Alasdair MacIntyre’s concerns about opacity as it affects those within the organization. An organization that operates according to the model will keep staff informed of how the organization is doing and how the particular areas they work in are related to the success of the organization as a whole. It will create structures through which staff can communicate ideas and concerns, and structures through which those ideas and concerns can be acted upon. Finally, it will reward performance. Mitchell T. Rabkin, “The Hospital-Academic Health Center Interface: The Community of Practice and the Community of Learning,” in Integrity in Health Care Institutions, ed. Ruth Ellen Bulger and Stanley Joel Reiser (Iowa City: University of Iowa Press, 1990), 130-40 at 137-38. In a post-bureaucratic managed care organization, much discretion would be restored to physicians, but some reform of the hierarchical structures which have long been a part of medicine would also be required. By the term “hierarchical structures,” I mean physician dominance over nurses, specialist dominance over primary care physicians, the strict observance of chain of command to the detriment of patient care, and, in some settings, a concern
development. (The worst constitute themselves judges of the social worth of others—the physician still alone with his or her conscience, but with a change in the intended beneficiary from the present patient to an abstraction.) To return to the quarrel, the role of the physician may be affected with a social interest in two ways. First, physicians function as social gatekeepers in a number of contexts, determining access to social resources and making judgments about fitness for social responsibilities. They served in such roles long before the term "gatekeeper" came into vogue. These roles are problematic, but there may be good reasons for them. I do not wish to argue the merits of involving physicians as experts in commitment proceedings and so on here. The point is that physicians have long been functionaries. Second, in their ordinary activity, caring for patients, physicians have understood their role as one of agency for their particular patients—but only within socially established limits and subject to certain social considerations. The agents of society are dangerous, but so are physicians who serve only their patients' interests. The arena of medical research may serve as an example. Research has always had a certain moral dignity, even though it has led to some of the most egregious abuses of individual rights and social trust. Are we to applaud the physician who subverts a randomized clinical trial by "sneaking" her sickest patients into the treatment group?48 Not every recognition of the claims of society, or other patients, is illegitimate. One may yield to such claims without "giving in"—or abandoning the patient.

To rephrase the question, then: How do we assess, morally, the various means open to us for translating the legitimate claims of plan members as a group, present

with pecking order that may strike other professionals as absurd.
patients as a group, future patients as a group, the various communities to which we belong, and so on, into ordinary medical practice, consistent with the preservation of the kinds of relationships in which persons develop and flourish? Eliot Freidson, one of the most prominent sociologists in the field of medicine and of the professions generally, has devoted a lifetime to the study of the organization of medical work. His work is an invaluable source of information on the effects of bureaucratic and other structures on medical practice. Although hospitals and other health care organizations have long conformed in certain respects to the bureaucratic model, the arrival of Medicare, Medicaid, and claims processing for private insurers was associated with a new emphasis on administration and the control of physician performance. This regime is the context for Freidson’s analysis.

Freidson employs various distinctions, but his primary distinction in analyzing methods of control is between the bureaucratic and the collegial. The bureaucratic mode "relies on secondhand reports rather than on the direct observation of performance." This method does not allow for much subtlety, hence it "is best fitted to deal with what is measurable and quantifiable." The collegial method relies as much as possible on direct observation of performance, and as suggested by the term, performance is evaluated by colleagues. Since the primary concern in health care administration for decades has been cost, a matter seemingly in the realm of the quantifiable, the emphasis has been on bureaucratic methods of control. Review of claims, and the many forms of utilization review, are bureaucratic controls. Beyond the obvious point that the administrative

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structure required is itself costly in economic terms, there are other sorts of costs to be considered. According to Freidson, "we may assume that those who head and staff it will develop an ideological as well as a personal vested interest in expanding it well past its true usefulness" and "that its very logic of operation will reward conformity to statistical standards even when what is being dealt with actually falls outside the norm."50 These are points worth dwelling on, given the readiness of governments and private companies to embrace these methods, seemingly unaware of the lessons of past experience with more limited measures. Also, insofar as bureaucratic controls are perceived as manipulative, and foster manipulation as a mode of resistance, they invite particular scrutiny within an ethical framework that focuses on the quality of social relations.

Freidson believes that bureaucratic methods of control are most questionable when financial incentives are the primary means of ensuring compliance with rules and the ruling ideology. Primary reliance on impersonal incentives directed to individual physicians is likely to stimulate those physicians to maximize their economic benefits. Recall Dewey's reflections on the pedagogical role of institutions. What is the "lesson" of heavy reliance on financial incentives? It seems to be something like this: "People are greedy, out to get as much as they can for themselves. We are realists, we recognize this, and bright as you are, we think you do too. So get as much for yourself as you can—and help us in the bargain (we're greedy too, and we wouldn't put the proposition to you unless we thought we'd get something out of it)." But why should the convert to the gospel of greed care much for the interests of the proselytizers? We, doubting the truth of this particular gospel, may believe that many will "stay honest." They will either

50Freidson, Medical Work, 73 (emphasis added).
work within the system while doing their best to ignore it, or they will leave it altogether. But the converts, what reason have they to refrain from manipulating the system, or subverting it, in order to maximize their own earnings potential? As for the others, the virtuous remnant, they may find it impossible to escape altogether the pressures toward conformity—the pressures to play the system's game or to "game the system." And they will no doubt be demoralized. According to Freidson, "the profound weakness of neoclassical economic assumptions" is that "financial incentives tend to subvert policy goals by stimulating the efforts of those most inclined to put gain before any other end and discouraging the others." Freidson uses diagnosis-related groups (DRGs) as an illustration of the process of manipulation and subversion of bureaucratic controls. "DRG creep" names a host of questionable practices, from the selection of patients with diagnoses that have favorable reimbursement rates (others can go elsewhere) to the selection of diagnoses with favorable reimbursement rates for the patients one has. Freidson writes that DRG creep "suggests how vulnerable the system is to those who create its records," since "service is not exactly and irrevocably specifiable independently of the discretionary judgment of the 'worker.'" The manipulation may extend well beyond patient-selection and creative record-keeping. A patient's course of treatment may be altered, or her wishes disregarded, in order to ensure that her care is reimbursable. Freidson adds that such a system would

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54Steven Miles describes a particularly egregious example: "Recently surgeons told a colleague of mine that they never withdrew futile or unwanted life-support within thirty days of cardiac transplantation in order to defer deaths beyond the peri-operative period so as to not adversely affect their eligibility for Medicare reimbursement." Steven H. Miles, "New Business for Ethics Committees," *H.E.C. Forum* 4, no. 2 (1992): 97-102, 98.
not have been adopted had administrators not believed that responses to financial incentives would be counter-balanced by professional and moral considerations. The policy presupposes a kind of character at variance with the lesson it teaches. The lesson might be different were the policy embedded in a larger network of practices that nourish social trust. But the relationship between practitioners and administrators has long been adversarial. Freidson himself seems to identify this variable of social trust as significant when he remarks that "[a]n enormous variety of empirical studies carried out over the past half-century has shown that, when they feel no loyalty to it, people do not passively obey, but instead actively seek ways of 'getting around the system' wherever they can." In general, we might expect greater respect for limits where these are perceived as legitimate. And it is not merely a matter of perception; limits are more or less legitimate according to the processes that give rise to them, their compatibility with an institution's particular values and principles, and the consistency with which they are adhered to.

The DRG example points up the connection between financial incentives and subversion. Other examples suggest that the lack of subtlety in many quantification strategies, in combination with ordinary desires to do well or avoid criticism, may be sufficient to produce similar dysfunctions. This illustration is taken from the work of Daly and Cobb:

The director of a public tuberculosis hospital was instructed to improve efficiency by following a plan of management by quantitative objectives. The director was instructed to define the hospital's objective, develop a measurable index of success in attaining that objective, and to evaluate all activities and personnel in terms of their measured contribution to that

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55 Administrators tended to ignore the fact that "[m]any factors, even the inclination to rationally calculate economic self-interest, are variables rather than constants, so that if they change so will the aggregate results." Freidson, *Medical Work*, 6.

56 Freidson, *Medical Work*, 196 (emphasis added).
goal.... Stating the goal was easy: restoring TB patients to health. A measurable index of success was more difficult, but not impossible. TB victims cough a lot. As they get better they cough less. Little microphones were placed by each pillow to record the coughs of each patient. Soon the staff and even the patients realized the significance of those tiny microphones. The frequency of coughing fell dramatically as prescriptions of valium and codeine increased. Relaxed patients cough less. Patients who cough less must be getting healthier, right? Wrong. They were getting worse, precisely because they were not coughing and spitting out the congestion. The cough index was abandoned.57

No one sympathetic to Dewey's views would argue that consequences or outcomes should be ignored. Massive funding of social programs with little notion of what works and what doesn't, and little apparent interest in finding out, is a recipe for disaster. At the same time, the judgments called for are difficult, not obvious or "technical," and in general attempts made to evaluate outcomes neglect qualitative factors. It is a problem for an organization to firmly moor such limited tools as outcomes evaluation to substantive purposes and principles, and to credit the intelligence of its staff and clientele.

It is worth noting that Freidson, like Selznick, allows bureaucracy its share of virtues. Even if we shift attention from the ideal type to the forms bureaucracy may take in practice, limited bureaucracy may have much to recommend it: "There is no logical reason why it cannot be efficient, reliable, high quality, and protective of the rights of its clients: logically, it is designed to be so. In order for it to actually be so, one of course needs first of all a well-designed framework, with adequate resources; one also needs workers who are adequately trained and motivated, a social milieu for work that operates as a continuous, positive reinforcement to conscientious performance in the spirit of the

plan, and effective methods to correct inadequate performance."

In sum, bureaucracy is less a hydra to be slain than a complex of organizational features that can be beneficial or destructive depending on details of implementation and the spirit which animates the process. This dual nature can be seen in the story of Christine deMeurders and Health Net. As the narrative unfolds, it seems that we have both too much and too little bureaucracy. Or perhaps Health Net has many of the vices of bureaucracy without its virtues. Too much bureaucracy, when corporate decision makers display so little sensitivity to the experience of the average person that they seem shocked when their rulings are received as death sentences and vigorously contested. The vices of bureaucracy, when recalcitrant physicians are brought into line by calls from headquarters. Too little bureaucracy, when physicians seem poorly integrated into the philosophy of care of the organization. Lacking in the virtues of bureaucracy, when the decisions rendered seem totally arbitrary from the point of view of the plan member-patient. The task is to retain at least some of the virtues, while limiting the vices.

5. Professionalism

Professionalization was Stout's second potential corrective to the corrosive forces of the market. I believe the view of professionalism most consistent with a Deweyan moral framework would evolve along lines suggested by R.H. Tawney. In Chapter 3, I commended Jeremy Bentham for blending diligence in criticism of unwarranted professional privilege with diligence in the cultivation of a professional ethic of service and responsibility. Like Bentham, Tawney has little sympathy for claims to exclusivity of expertise or virtue which are mere ornaments for the monopolistic drive. On the other

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58 Freidson, Medical Work, 245-46.
hand, Tawney values the association of profession with high standards, even if these standards are not always attained. He writes that "[t]here is all the difference between maintaining a standard which is occasionally abandoned, and affirming as the central truth of existence that there is no standard to maintain." 59 (Of course, if a standard is so remote from practice that is it is only occasionally attained, it has the bad odor of hypocrisy and ideology as distortion.) Tawney sees the professional attitude as an antidote to the "acquisitive society," and he proposes the extension of professionalism to all areas of productive life. 60

Tawney holds out the hope of difference without hierarchy. Because all fields of human endeavor will be professionalized, there will be no moral hierarchy of occupations. At the same time, different standards will be appropriate to different kinds of work; in MacIntyre's terms, each practice will have its own distinctive complex of internal goods and rules. The goods of health care and automobile repair will not be identical, although there may well be areas of overlap. 61 The code for physicians will not be identical to the

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59 Tawney, Acquisitive Society, 95. Compare this line from the introduction to the Institute of Medicine Report on for-profit health care: "Ideals, even if imperfectly realized, may affect where the balance is struck, as may the way care is organized and paid for." Institute of Medicine, introduction to For-Profit Enterprise in Health Care, ed. Bradford H. Gray (Washington, D.C.: National Academy Press, 1986), 14.

60 Tawney believes that industry, as well as the traditional professions, can be good work. He sees no sharp line between industries such as footwear manufacturing or construction and professions such as teaching and medicine: "The work of making boots or building a house is in itself no more degrading than that of curing the sick or teaching the ignorant. It should be at least equally bound by rules which have as their object to maintain the standards of professional service. It should be at least equally free from the vulgar subordination of moral standards to financial interests." Tawney, Acquisitive Society, 96. Some object that one cannot have a professional without a client. I favor a more general definition of profession, in keeping with the concept of practice. For example, a professional can be defined as one who displays four attributes: "(1) training in a systematic body of knowledge (professed) social knowledge; (2) dedication to values that will enhance the common good; (3) voluntary adherence to norms of practice established and enforced by colleagues; and (4) participation in a system of rewards, monetary and honorary, which acknowledge excellence in performance." Williams and Houtz, Judeo-Christian Vision, 260. (Somewhat ironically, the more business takes Friedman's view of the manager as an agent for the stockholder as its ideal, the more nearly it satisfies the client-centered definition of profession.)

61 Some of the parallels are striking: "In 1992, Sears, Roebuck & Company was inundated with complaints about its automotive service business. Consumers and attorneys general in more than 40 states had accused the company of misleading customers and selling them unnecessary parts and services.... In
code for auto mechanics. Other spheres of business will have their own distinctive goods, codes, and models of excellence. Health care administration would itself constitute a practice. Tawney has a sense of the dangers of the annihilation of difference. Health care, and the fields of human endeavor comprehended by the term business, lose their distinctive shapes as practices when they are treated as meaningless means to the sole or primary end of generating income and profit. Tawney fears the industrialization of the professions, and he uses medicine as an example. Precisely because he sees no unexpungeable divisions, no ontological necessities, Tawney writes, "It is conceivable, at least, that some branches of medicine might have developed on the lines of industrial capitalism, with hospitals as factories, doctors hired at competitive wages as their 'hands,' large dividends paid to shareholders by catering for the rich, and the poor, who do not offer a profitable market, supplied with an inferior service or with no service at all.""
Freidson carries Tawney's thought forward. He is suspicious of professional privilege, but he has a great deal of respect for specialized knowledge or expertise, within limits, and he prefers to keep a large measure of discretion in the hands of physicians. In particular, he believes that the fit between the bureaucratic model and health care is rather poor (the same is true of a Friedmanesque market model), with negative consequences for all concerned. It is fundamentally a question of guiding purpose. If the free market model is oriented toward a gainful product, and the bureaucratic model is oriented toward a standardized, predictable product, the professional model is oriented toward a qualitative product. Of course, like each of the other models, the professional model has its characteristic "pathologies." These are expertly described by Freidson:

[T]he collegium becomes more concerned with its own welfare than that of its customers; it expands the scope of its monopoly well past its capacity to serve public needs; it actually resists efforts at rationalization that would reduce the cost of its work and the range of its jurisdiction and control, and practices featherbedding with impunity; it becomes preoccupied with refining its knowledge and skill for their own sake, irrespective of public need; stratification develops internally, dividing its members. Cost, distribution, and quality are virtually uncontrolled by the regulatory processes that the collegium claims it exercises. Quality varies widely—from extraordinary virtuosity to perfunctory routine and even negligent incompetence.64

It is no wonder that Freidson's work has been cited by such radical critics of medicine as Ivan Illich. Still, Freidson will conclude that the professional model is the "least bad" alternative.

The accent may be a little too negative, however. If we are conducting our analysis within a Deweyan framework, we will find it significant that Freidson links

64Freidson, *Medical Work*, 237.
profession and democracy. With no explicit reference to Dewey, but echoing him all the same, Freidson writes:

The professional model is based on the democratic notion that people are capable of controlling themselves by cooperative, collective means and that, in the case of complex work, those who perform it are in the best position to make sure that it gets done well. It contains within it the assumption that when people can control their own work, and when their work, while specialized, is complex and challenging, they will be committed to it rather than alienated from it. According to the terms of the model, people find intrinsic value and interest in the work itself, which leads them to want to do it well. Furthermore, they constitute a kind of community in that they interact on grounds of strongly held common interests both in maintaining their professional position and in performing the work they do.65

One need only add that the democratic organization of work must be reconciled with the democratic development of the capacities and powers of the recipients of services, not merely in isolation, but in their relations with providers of services and with one another. Relations among kinds of practitioners need to be democratized as well.

Freidson concludes that "[b]oth market and bureaucratic methods should be used to reduce cost and control performance, but only those that do not destroy or seriously weaken what is desirable in professionalism."66 What Freidson desires is a chastened medical profession and professionalism. Freidson's specific recommendations for reform include an emphasis on "professional" rather than bureaucratic or economic incentives, things like pride in the quality of one's work and the respect of colleagues and patients (although concern for colleagues can make practitioners indifferent to patient concerns67). Fee-for-service payment, as well as capitation with various withholds and bonuses, tends

65Freidson, Professionalism Reborn, 176.
66Freidson, Professionalism Reborn, 194.
to sharpen awareness of the physician's economic interest in performing or not performing this or that service, and in favoring certain recommendations over others. Freidson, like most other academics who have studied the issues, favors a salaried profession. To those who regard this as an oxymoron, he notes that engineers, priests, and scientists have traditionally been employees with modest salaries, without loss of intellectual or moral excellence. (Ironically, many managed care organizations go to great lengths to avoid having physicians as employees, in an effort to limit the organization's malpractice exposure.) Freidson has a hard time seeing anything good in the autonomy reflex of physicians. Not only do physicians react defensively to scrutiny by administrators and patients, they also resist "intrusions" by colleagues in the form of peer review. Physicians are notoriously reluctant to criticize one another. Freidson writes that "[i]f professionalism is to flourish it is essential that practice be infused with a spirit of openness, infused by the conviction that one's decisions must be routinely open to inspection and evaluation."68

Although Freidson is clearly engaged in social criticism, he strives for a certain measured neutrality. If he does not yield to outrage over the discrepancy between the announced ideals of the medical profession and the actual conduct of physicians, he also tends to discount the significance of moral standards and values in general.69 Freidson, unlike Tawney, cannot recognize moral ideals as potential elements of ideology, in the bad sense, and yet allow for their beneficial operation as standards for guiding and judging practice. Certainly we should not expect virtue or conscientiousness to prevail too long

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67See Chapter 1, footnote 21 and accompanying text.
69E.g., Freidson, *Professionalism Reborn*, 124. Freidson favors the "analytical" model of professionalism, which is cool not only toward medicine's traditional claims to moral superiority, but toward moral
or among too many in the absence of encouragement; the limits of virtue should not be tested too frequently, and it is always best to have incentives and conscience working in the same direction. This is not, however, equivalent to an argument for discounting the effects of an ideal altogether. It may be that Freidson is simply wiser than Tawney. But restrained cynicism, like anything else, may have its origins in ideology—more or less taken-for-granted patterns of thought. It protects one against disappointment (recall Reinhardt's tale of youthful disillusionment). It also supports a certain flattening out or homogenization of experience. As Dewey says of his own generation, "we use the word ideal reluctantly, and have difficulty in giving the word moral much force beyond, say, a limited field of mutually kindly relations among individuals." (FC, 163-54) What is being lost, or left out?

At the very least, many people still act as if values matter. Differences over moral values seem to be extremely significant in the intramural conflicts among the various groups of professionals in health care. I do not wish to slight the importance of power in battles between nurses and physicians, and physicians and administrators, and nurses and administrators, but in the nature of things, even battles over power are partly battles over what power shall be used for.70 Physicians want power, resources and freedom in part to preserve life, which they often conceive of as holding off death to the last possible

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70I do not think the following observation by Freidson, which strikes me as very shrewd, undermines my argument: "[The ideology of professionalism] may also be used to motivate workers in the absence of occupational control over work.... Indeed, those working under the direction of professionals may very well manifest greater devotion to serving others than do professionals themselves." Freidson, Professionalism Reborn, 124. My impression is that nurses have a better claim than physicians to moral heroism. No doubt there are certain psychological compensations for the nurse-heroes, given that they lack the satisfactions associated with controlling their work, and no doubt it has long suited physicians and others to have nurses dedicating themselves to an ideal of service and demanding little in the way of pay or power. The dynamics would be consistent with Dewey's analysis of the doctrine of self-denial and its pathologies. What I mean to deny is that power games and psychological mechanisms explain (away) the use of moral
moment, and to advance medical knowledge through research. Nurses want power, resources and freedom in part to demonstrate care and to resist physician demands which are counter to a patient's interests, as they conceive those interests based on their more intimate association with the patient and family. Administrators want power, resources and freedom in part to conserve resources for future generations, and to resist demands by physicians and nurses which they regard as improvident or as displaying an insensitivity to the interests of the organization as a whole.

Each group of professionals has legitimate claims, and I do not believe it would be an advance if they were to put aside questions of value and focus on the "real issue," whatever that might be. One of the most attractive things about the health care field is that people within it still do, on occasion, speak frankly about ideals and moral concerns. In the business world generally, talk about morality must often be disguised in the language of cost-benefit analysis or efficiency and effectiveness.\textsuperscript{71} So, the answer is not to train people to care less about what they care deeply about. Rather, the solution to the dilemma, inevitably partial, seems to be the creation of structures that cross professional boundaries. For example, if nurses serve on planning committees, they will better understand the sources and the \textit{moral} weight of administrators' concerns about costs and budgets and the efficient implementation of initially cumbersome new management information systems. If administrators spend one week a year "on the floor," they will better understand nurses' concerns about understaffing and the lack of effective processes for ensuring that patients' wishes are known and honored.

\textsuperscript{71}See, e.g., Jackall, \textit{Moral Mazes}. 

\textsuperscript{71}See, e.g., Jackall, \textit{Moral Mazes}. 

language, and contests over values, without remainder.
Retaining the focus on moral and ethical issues, I am sympathetic to Daniel Chambliss's recent indictment of traditional medical ethics as inattentive to power. This criticism can be made in a blanket way, but Chambliss, who looks at the moral world of nurses, has a quite specific concern. Medical ethics has been concerned with the resolution of difficult moral questions or quandaries. The task of ethics basically ends with the identification of the preferred solution. That sort of approach works (used to work) for physicians, who usually have (had) the discretion to act based on their understanding of what is right. But what of the health care worker faced with a situation that is problematic, not because the preferred solution is unclear, but because the worker seemingly lacks the power to act? Short of a revolution in which the morally right are automatically gifted with power, the solution to this dilemma requires attention to features of organizations, the establishment of structures to address this sort of situation. The task is to interest persons who do have social power in the issue of powerlessness, and to establish channels for the less powerful to communicate their concerns outside the "chain of command." Whistle-blower protection policies might also be implemented, but it remains true that taking action will always be attended by risk.

I have argued that the concepts of moral agency, moral responsibility and character can sensibly be applied to organizations. Strictly speaking, an organization cannot act, but it can have definite effects. Organizations exercise influence through structures, formal and informal. Medical ethicists with an interest in organizations have tended to focus on formal structures, and the neglect of informal structures and

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72Daniel F. Chambliss, *Beyond Caring: Hospitals, Nurses, and the Social Organization of Ethics*
organizational complexity must be remedied. Organizations can be judged on the basis of their own qualities of character, as well as their influence on the characters of persons. I have tried to draw out the sense of the virtues of justice, integrity and responsiveness in the organizational context. In judging organizations, we look for justice. We also look for internal moral coherence, and for openness to the environment and to change. Integrity and responsiveness are in some tension, but they can also support one another. In addition, we can judge the performance of a productive enterprise using standards of efficiency and economy.

Finally, I have considered bureaucracy and professionalism. Using Freidson’s work, I have argued against the substitution of bureaucratic methods of control for collegial ones. Bureaucracy has its virtues, but where trust is absent bureaucratic interventions breed manipulation. At the same time, collegial or professional methods of control alone are unsatisfactory. Professionalism can become an ideological cover for unwarranted group privilege. Bureaucratic and market methods can be used to control cost and performance in health care, but the particular methods chosen should preserve what is valuable in professionalism. Professionalism at its best is attentive to quality, including qualities of relationship, and it democratically nurtures the capacities of people to control their own work through collaborative means.

Chapter Six: The Rise of Corporate Civilization

In this chapter, I begin by looking at the anxieties created by the spread of large-scale organizations. Once again, the question is how to make sense of new developments, how to render these kinds of organizations amenable to moral judgment and guidance. Part of this task can be accomplished through law, but legal regulation has its limits. Further, the state is one of the large-scale organizations to be brought under control. A second mode of approach is required. Dewey suggests the development of face-to-face associations, local agencies of communication and cooperation that foster stable, loyal relationships. Governments can create conditions that are hostile or hospitable to associations, but the idea is fundamentally non-statist. Face-to-face associations are communities of resistance to the "centrifugal forces" of modernity. They provide avenues for penetrating the opaque surface of large organizations, restore elements of personality to impersonal structures, and increase responsiveness to local needs. I argue that the theme of community still has many powerful associations in the health care field. It is also open to manipulation.

Within this broad context, I look at the consequences of corporatization for health care. I argue that blanket indictments will not do—we need to identify specific structures and ask what effects they have on human welfare. Drawing on the bioethics literature, I examine possible internal policies and governance structures for managed care organizations, and proposals for external regulation and oversight. I also consider research findings, especially as these shed light on the consequences of managed care for the most vulnerable. I conclude that consideration of structures and outcomes is valuable, but this kind of analysis needs to be completed by an analysis of organizational character. We
need to examine how standards and ideals are "incarnated in the flesh" in particular organizations. Although this inquiry is not determined in all particulars by the version of pragmatism developed in Chapters 4 and 5, the method guiding inquiry is the one explicated in Chapter 4, and, pragmatically, material derived from a broad range of sources—moral theorists and researchers and practitioners of various disciplines—will be brought to bear on the issues.

1. Statement of the Problem

How are we to make sense of the spread of large-scale organizations in health care in moral terms? Let us quickly dispense with the naive view that, merely by bringing human beings into relationships of greater interdependence, corporate civilization will usher in a new age of deepened social awareness and increased cooperation. Dewey follows Rousseau in pointing out that “interdependence provides just the situation which makes it possible and worthwhile for the stronger and abler to exploit others for their own ends.” (PP, 155) Dewey is nevertheless inclined to regard corporate civilization as a fait accompli. The question is chiefly how to respond to this development. In Freedom and Culture, Dewey notes that the new corporate phenomena dramatically alter our experience of time and space and threaten us with their seeming impersonality. The connections between activity and consequence become difficult to trace. “Even when they can be anticipated, the results are produced by factors over which the average person has hardly any more control than he has over those which produce earthquakes.” (FC, 58) This is highly significant because these connections are the basis for sense-making activity; when they are lost, we experience a loss of sense, and we lose our sense of efficacy.
Elsewhere, Dewey speculates that organizations are both necessary and dangerous to the process of fuller human development. Commenting on the clash between captains of industry and commerce and government regulators seeking to contain the new forces, Dewey argues that the point is not to establish who is right and who is wrong, but rather to think through the relation of organization and democracy as liberation. There are convincing arguments on both sides of the question of the value of large organizations, and the issue cannot be decided in the abstract. It is clear to Dewey that certain kinds of organizations are detrimental to the cause of democracy:

Individuals can find the security and protection that are prerequisites for freedom only in association with others—and then the organization these associations take on, as a measure of securing their efficiency, limits the freedom of those who have entered into them.... The predicament is that individuality demands association to develop and sustain it and association requires arrangement and coordination of its elements, or organization—since otherwise it is formless and void of power. But we have now a kind of molluscan organization, soft individuals within and a hard constrictive shell without. Individuals voluntarily enter associations which have become practically nothing but organizations; and then conditions under which they act take control of what they do whether they want it or not. (FC, 166-67)

Dewey believes that the regulatory power of the government is a partial response to the problems created by “molluscan” organizations. He stresses a fact that many critics of government intervention neglect, that the corporation is a child begot by the state. He also sees very clearly that the danger that large corporations will dominate the government and the political process is as great as the danger that the government will dominate its citizens through expansionary policies intended to control corporations.

In the Ethics, Dewey and Tufts list publicity and law as the two major methods for addressing the threats to individual freedom and responsibility posed by large
corporations. They argue that law is less significant as a system of punishments than as a standard and a help to those who wish to do the right thing. The law "defines a standard" and "helps the morally disposed to maintain this standard by freeing him from unscrupulous competition." (EI, 521) Dewey and Tufts do not suggest that we work through government to bring about the demise of the large corporation; they regard increased production as a genuine if limited contribution to human well-being, and hence a moral good. They also have some reservations about administrative rule. The fear of government is, to be sure, exaggerated, but agencies of government are included among the organizations that threaten freedom and individuality. Therefore, the state cannot be the sole means for addressing the problems arising from the activities of corporations.

Dewey's discussion of the problems accompanying corporate civilization in Freedom and Culture does not, then, conclude with state action. Dewey thinks the problem of impersonality, in particular, can only be effectively addressed by the cultivation of "face-to-face" associations:

The situation calls emphatic attention to the need for face-to-face associations, whose interactions with one another may offset if not control the dread impersonality of the sweep of present forces.... It involves even more than apprenticeship in the practical processes of self-government, important as that is, which Jefferson had in mind. It involves development of local agencies of communication and cooperation, creating stable loyal attachments, to militate against the centrifugal forces of present culture, while at the same time they are of a kind to respond flexibly to the demands of the larger unseen and indefinite public. (FC, 159, 160-61)

Here we encounter again the meshing of Dewey's democratic ideal and community. By incorporating the notion of community into his developmental trajectory for the organization, Selznick nourishes the hope that the entities that simultaneously sustain and
oppress us might themselves take on a more democratic character. Yet alongside the rise of the corporation, we may observe the transformation of the notion of community itself by a calculating rationality. Robert Merton coined the term "pseudo-Gemeinschaft" to name the manipulation and exploitation of sentiment. The rich, positive associations of "community" are mere fodder to men "for whom a tree is not a tree, but timber ", (Karl Mannheim). And Christopher Lasch used the term "Gemeinschaftschmerz" to label the kind of pious twaddle that has always been the great temptation for the communitarian tradition.

The rhetoric and ideal of community are deeply woven into the fabric and history of health care in the United States. Community hospitals have often opened with much public fanfare, and many have been a continuing source of local pride. Along with the school and the church, the hospital has been one of the pillars of small rural communities and embattled urban neighborhoods. Often, when these institutions shut their doors, the community dies. And Roman Catholic medical ethics, in particular, has long displayed a particular affinity for the language of community. The religiously-informed vision of community and service is linked to a sense that Roman Catholic health care institutions and providers have a distinctive mission or calling, but it tends to lead away from a narrow parochialism. There is also the concept of "community-oriented primary care." In the dry, technical vocabulary of public health, a community may be simply a "defined population." Nevertheless, the community-oriented primary care model incorporates principles that reflect a more robust conception of community, and under favorable conditions it has developed along lines consistent with such a conception, and the

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1See, e.g., Benedict M. Ashley and Kevin D. O'Rourke, *Health Care Ethics: A Theological Analysis*, 2d
Deweyan democratic ideal. But what of the present? For-profit hospital chains continue to benefit from the services of volunteers, an incongruity that demonstrates the resilience of the old spirit of community service and volunteerism. Some for-profit corporations do what they can to foster this sort of confusion—note the frequent use of the word "community" in the names of for-profit hospitals and managed care plans. (Some hospital chains have even retained or invented religious sounding names.) One hospital made its post-partum discharge policy sound like a community service—and the ultimate in family values—in a flyer for patients entitled "Positive Thoughts Regarding the Eight-Hour Discharge." These uses and abuses of the language of community alert us to the need for a critical and discerning eye when we explore the possible ways in which the cultivation of community may answer the challenges posed by the increasing prominence of large organizations in health care.

2. The Consequences of "Corporate Civilization" for Health Care

Given uncertainty about how to proceed, and a vague notion of some of the dangers of large corporations and possible ways of addressing them, the experimental method directs us to the concrete consequences of corporate activity in the health care field. What are the consequences of the spread of large corporations for health care?

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ed. (St. Louis: Catholic Hospital Association, 1982), a text that combines a strong emphasis on community with a powerful universalism.

2As in a number of the case studies published in Institute of Medicine, Community Oriented Primary Care: New Directions for Health Services Delivery, ed. Eileen Connor and Fitzhugh Mullan (Washington, D.C.: National Academy Press, 1983).


4An instance of manipulative pseudo-Gemeinschaft if ever there was one. Among the listed benefits: (1) "Childbirth is a natural event and an early homecoming is a celebration of such"; (2) "Bonding with an infant is an intimate pleasure which can best be pursued in the privacy of one's own home"; and (3) "Unlimited visitors at home." Still, the list also included such seldom-discussed truths as "Hospital food is not tasty" and "Less risk of nosocomial [hospital-acquired] infections when hospital stay is brief." Cited in Laurie Zoloth-Dorfman and Susan Rubin, "The Patient as Commodity: Managed Care and the Question of Ethics," Journal of Clinical Ethics 6, no. 4 (1995): 339-57 at 346.
Insurance companies, pharmaceutical companies, and academic health centers of considerable size are not new. What is unprecedented is the consolidation among corporations which are already quite large and the extension of the corporate domain to include practitioners. Also, while early forms of managed care were certainly corporate in nature, such efforts were largely local and not-for-profit. The increasing dominance of large corporations, and within that category large for-profit corporations, by itself, is not evidence of their superior efficiency, or desirability according to more strictly moral criteria. (The work of Paul DiMaggio and Walter Powell suggests that pressures to conformity may be as powerful among organizations as they are among teenagers.) We cannot escape the task of independent and considered judgment of current trends. I have cited Eliot Freidson's work at length. Freidson, in contrast to Paul Starr, does not see "corporatization" per se as a threat to health care. Rather, he identifies the "industrialization" of health care as the development to be strenuously resisted. He argues that fee-for-service payment does not assure independence when reimbursement rates are low; contrariwise, "the mere fact of employment by large, corporate institutions owned and ultimately directed by non-professionals need not be hostile to professionalism."  

If broad-brush judgments will not do, there are nevertheless distinctions to be made. Freidson directs attention to "concrete internal policies," which may vary considerably among health care organizations. We need to explore the conditions that sustain or destroy professionalism, and, more broadly, worthwhile human relationships. I have already spent considerable time elaborating on the significance of certain

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organizational virtues. Another place to begin is with the bioethics literature that is slowly developing to address issues of policy and organizational structure in the context of managed care. I will take up internal policies on significant issues, governance structures, and proposals for external regulation and oversight, in roughly that order, although regulatory issues intrude on internal policies. I will then briefly examine what outcomes research has thus far revealed concerning the consequences of various forms of health care organization.

Internal policies

1. Reward System/Financial Incentives. The use of incentives is so central to managed care that the expenditure of some time in understanding and evaluating specific incentive structures is warranted. The first thing to note is that incentives are pervasive. Where physicians are paid a fee for a service, there is an incentive to perform more of that service. Where there are treatment alternatives, and physicians are paid a higher fee for one alternative relative to the others, there is an incentive to recommend the most highly compensated treatment. Under traditional indemnity insurance policies with payment to providers on a fee-for-service basis, the costs involved in performing surgery were typically reimbursed, while patient education and other “cognitive services” were not. Predictably, the tendency was to neglect the latter. Inpatient services brought more generous payments than outpatient services, if outpatient services were covered at all. Accordingly, the tendency was to admit patients to the hospital for procedures and tests that might otherwise have been performed on an outpatient basis. These incentives could be particularly perverse in system terms. The result in many cases was higher cost and greater risk to patients of iatrogenic harm (harm caused by medical care) without any
corresponding benefit.

Managed care has multiplied the range of reward systems employed in health care. The focus has been on the physician. There are now three major ways of structuring physicians’ basic income: fee-for-service, salary, and capitation. As noted, physicians have traditionally been paid on a fee-for-service or “piecework” basis. This mode of payment is sometimes considered exploitative of workers, as in the garment industry. It has been favored by physicians because the immediate payers, mostly insurance companies, let physicians set their own rates and control the manner and pace of their work. In other words, physicians were able to maximize their incomes and their discretion. Although managed care and fee-for-service payment can coexist, the rules for fee-for-service have changed. Managed care organizations negotiate discounted fee schedules with selected physicians or groups of physicians, and they employ measures such as preauthorization procedures for hospitalizations to control utilization. Both income and discretion are limited. There may also be attempts to control utilization through adjustments to fees. An HMO might pay an obstetrician $1025 for a delivery with a one day hospital stay, and a much lower fee of $600 if the patient stays in the hospital for three days. Finally, there may be embellishments such as bonuses and withholds, features to which I will turn momentarily.

Payment by salary is fairly uncomplicated. Utilization is a concern for the physician only as it affects the economic viability of the enterprise that employs her.

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6 An HMO in San Antonio, Texas, allegedly adopted this payment scheme to reduce length-of-stay. See E. Haavi Morreim, Balancing Act: The New Medical Ethics of Medicine’s New Economics (Dordrecht: Kluwer Academic Publishers, 1991), 38. Another example Morreim cites is an HMO that (allegedly) raised its fee of $1200 per delivery, with a 30 percent withhold, to $1700 per delivery—but with the costs of any sonograms, fetal monitoring, or stress tests deducted directly from the fee. The idea, clearly, was to discourage use of these tests.
physician may recognize that her continued employment depends on the wise use of resources, on her part and that of her colleagues, but her base income is not affected by the number of services she performs. In theory, then, there is no incentive to either overtreat or undertreat. For this reason many in academic circles favor this mode of payment. Of course, the salaried physician also has no incentive to increase her productivity—apart from the prospect of a salary increase in future years, internal pressures to perform, or a sense that her contribution is important to the enterprise. For this reason many HMOs have erected other incentive schemes atop the basic structure of salary, introducing the complications salary seemed to escape.

Capitation in relation to physicians involves the payment of a fixed amount per month or other time period to the participating physician designated as the primary care physician or PCP for a plan member. The physician is then responsible for providing all the services specified in the contract for the member over the period. (Specialists may also be capitated, although this is less common.) There are two primary sources of complexity. First, capitation more than any other mode of payment stimulates development of various mechanisms for segmenting and adjusting risk, including bonuses and withholds and stop-loss protection. Second, there may be tiers of compensation, especially in the case of independent practice association or network HMOs. In a network HMO, for example, members select or are assigned to an individual physician who belongs to a particular IPA or physician group. A managed care plan and physician group might be capitated, paid a certain amount per member per month or year, and yet physicians treating patients might be paid on a fee-for-service or salaried basis.
Any of the basic modes of payments may be combined with additional features intended to alter or enhance its incentive effects. I referred to bonuses and withholds as embellishments, but these may be far from ornamental. Bonuses are straightforward in conception, and highly variable in practice. The basic idea is to reward certain desirable practices with a payment over and above base income. A bonus is supposed to be a carrot, a reward promised for good behavior. Also, a bonus is usually small relative to total income. If base income is very low, a bonus begins to resemble a stick, and a big one at that. The formula for determining bonuses may be very complex, including factors such as productivity and patient satisfaction as well as utilization. The time frame for which bonuses are calculated may also vary considerably.

Withholds are usually combined with capitation or fee-for-service arrangements. A percentage of the per member per month payment to the physician, or the fee paid to the physician according to the managed care organization’s fee schedule, is held back and placed in a special account or “risk pool.” In capitated plans, the funds in a risk pool may be used to pay for referrals to specialists, laboratory tests, hospitalizations, or extraordinarily costly treatments, or separate pools may be established for each category. The nature of the items covered will depend on the extent of the risk assumed by the physician. The exact nature and structure of the risk pool or pools will be a matter for negotiation. In fee-for-service plans, a risk pool may be used to fund payments to physicians that exceed the managed care organization’s forecasts of utilization. At the end of some period, usually a year, any funds remaining in a pool may be distributed to physicians, or physicians who meet certain criteria. For example, physicians who have

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7For a catalogue of some possible variations, for bonuses and for other features of managed care incentive
drawn heavily on a pool may be excluded from participation in the distribution. If a pool has a “negative balance,” that is, if funds prove inadequate to cover expenses incurred in the period, physicians may be required to make up the difference. In capitated plans, risk pooling for extraordinarily expensive treatments is only one of the options for addressing the problem of patients who are cost “outliers,” to use an ugly but serviceable term. Capitation payments may be adjusted for risk. At present, however, risk-adjustment is a very inexact science. Plans may also purchase stop-loss insurance, or cap the amount of a physician’s liability for the care of a single patient in a particular period.

The use of these types of incentives is widespread and increasing. On the other hand, certain factors have tended to blunt their force. First, many of these schemes are complicated, and we can expect to see a “learning curve” in physician understanding of and responsiveness to incentives. Second, many physicians and physician groups participate in multiple managed care plans, each with its own distinctive incentive structure. This may flatten out the learning curve. More importantly, the evolution of managed care toward non-exclusive relationships—IPA HMOs are growing much faster than arrangements in which an HMO and its providers deal exclusively with one another—means that responses to incentives will be highly variable, depending on the constellation of plans and incentives involved in a particular practice.

Stephen Latham employs the concept of “intensity” to describe the variables that affect the force incentives may be expected to have in practice, that is, effects on actual

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8See, e.g., Bodenheimer and Grumbach, “Capitation or Decapitation,” 1028.
clinical encounters and on the decisions made concerning the care of particular patients. The simplest case is one in which the receipt of some amount of money is tied to a specific decision. The first principle of intensity is that “an incentive plan that ties a large amount of money to a particular decision will have greater intensity than one that ties a small amount of money to that same decision.” The second principle is that “incentive intensity decreases as the number of clinical decisions over which risk is spread increases, even when the ratio of total dollars at risk to number of decisions is the same.” The significant variables are the length of the period and the size of the group for which the incentive payment is calculated. Related to intensity, we can look for the operation of the “end-of-the-year effect,” the “large numbers effect,” and the “tipping phenomenon.”

The end-of-the-year effect is the tendency to err on the side of spending—ordering tests, making referrals to specialists, and so on—at the beginning of the fiscal year and to err on the side of not spending at the end of the fiscal year. Latham identifies two reasons for the effect, the “psychological tendency for people to weigh immediate concerns more heavily than those that are distant,” and the “impact of the physician’s uncertainty, at the beginning of any given year, as to whether she will experience a high- or low-cost year.” As to the second factor, he comments that “[a]ny sophisticated physician (and especially one who is paid according to an incentive scheme) will keep track of her costs, and as the end of the fiscal year approaches, she will have much better information about what kind of cost-year she has been having.” She may find “her entire annual bonus amount riding on her ability to save substantial costs in the relatively few

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cases left for her to manage.”¹¹ The large numbers effect is the tendency of extremes to average out over a large number of cases. Over a number of years, or over a number of physician practices, costs will average out. Hence, an incentive scheme that applies to a group of physicians will reduce the end-of-the-year effect, because costs are easier to predict and hence uncertainty decreases.

The tipping phenomenon shifts attention to the difference made by case mix, the proportion of a practice that consists of patients in managed care plans and how the practice is perceived by physicians. In many regions of the country, only a small percentage of a practice may be composed of patients in managed care plans, although this is changing. Even where a majority of patients belong to managed care plans, the number in any particular plan may be quite small. The portion of the practice subject to managed care incentives may be perceived in two ways: “If the physician or group regards that small group of patients as a ‘line of business,’ separable from the rest of the practice, then the intensity of incentives associated with treating members of that group has potential to be large…. If, on the other hand, those patients are simply regarded as part of the total practice, then incentive intensity is apt to be very small, because they account for so small a proportion of the practice’s potential earnings.” While limited data suggest that the second response is more common, there is anecdotal evidence that when forty percent of income is derived from plans with incentive schemes, physicians begin to take incentives much more seriously.¹²

At present, there is a paucity of data concerning the effects of particular financial incentives on practice, which is to say, on physicians and on patient care. What little

data there is shows that some types of incentives affect utilization, but do not appear to affect outcomes.\textsuperscript{13} Effects on quality of care are largely unknown. Also, most of the research (limited as it is) dates from early in the experience with managed care, and the findings may not be generalizable to the present or future. If there is a learning curve and a tipping point, we would expect to find greater changes in behavior among today’s more knowledgeable and more thoroughly incentivized physicians. Further, it is difficult to extricate the effects of financial incentives from the influence of other factors. An incentive which is not intense in one situation may be very intense in another. As one expert says of capitation, the mode of payment “is never an isolated factor in determining the patterns of care”; its effects “depend on many other factors in the organization of care, such as the form of the delivery system, the risk relation, the cultural norms, and the specific methods used to try to mold physicians’ behavior.”\textsuperscript{14} For example, nonfinancial incentives such as peer pressure may be extremely significant. In one setting, a strong sense of professionalism may counteract financial incentives to limit care, while in another, shared fear or greed may give added weight to an “identical” incentive scheme. In

\textsuperscript{12}Latham, “Regulation,” 411.


\textsuperscript{14}Donald M. Berwick, “Payment By Capitation and the Quality of Care,” \textit{New England Journal of Medicine} 335 (1996): 1227-31 at 1227-28. Berwick concludes that the research literature confounds these variables. The study of utilization by Alan Hillman and colleagues supports the conclusion that factors besides direct financial incentives are at work. Although the investigators found that capitation was associated with lower rates of hospitalization than fee-for-service payment, salary was associated with even lower rates, a statistic that leads to speculation about the effects of peer review. Also, a finding of no direct association between placing physicians at financial risk as individuals and hospitalization rates might be explained by bias in patient selection, another complicating factor. Alan L. Hillman, Mark V. Pauly, and Joseph J. Kerstein, “How Do Financial Incentives Affect Physicians’ Clinical Decisions and the Financial Performance of Health Maintenance Organizations?” \textit{New England Journal of Medicine} 321 (1989): 86-92. Hillman has commented on “the important role of the context or organizational culture in which financial incentives are used.” Alan L. Hillman, “Health Maintenance Organizations, Financial Incentives, and
other words, the problems researchers have had in isolating incentive effects from other variables are not easily solved. Behavior cannot be neatly separated from character, nor can individual character be neatly separated from organizational character.

Incentives are pervasive. The cause for moral concern cannot be that now we have incentives, or financial incentives, where formerly there were none. What is new in health care is the conscious manipulation of incentives to effect certain goals. Although these goals are usually articulated as cost containment and quality improvement, one of the problems in this area is the tendency to reserve the second consideration for ceremonial occasions. Efficiency and economy are important. One need not apologize for considering the economic effects of various policies and practices, but efficiency in the pragmatic sense demands that cost and quality be held together. Where financial incentives are designed and implemented solely to reduce utilization of services on the part of individual health care providers, payment is functioning as a non-specific rationing technique. Defenders of incentives to limit services (or undertreat) argue that these incentives are merely compensations for the excesses which resulted from fee-for-service incentives to overtreat. Somehow "appropriate utilization" of services is supposed to emerge from the mix. Robert Berenson, and others, have pointed to the flaw in this logic. Using capitated payment as an example, Berenson writes, "In essence, an HMO takes the same physicians who it thinks abuse fee-for-service incentives and trusts them not to underserve their capitated patients while giving them direct incentives to do just that."15 Further, the very "diffuseness" of incentives employed in this manner may be a barrier to

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research to monitor the effects of the incentives on practice. In any event, the object of this strategy is a reversal of incentives, not systematic reform of the manner in which care is delivered.

Drawing on the discussion in the previous chapters, I would put forward four general ethical considerations, before we proceed to an analysis of the particulars. First, as the previous discussion suggests, we need to beware of incentive schemes that are too crude. An incentive is crude if it is unintelligent, put into effect with no very clear idea of what it will do, or short-sighted. By “short-sighted,” I mean that the predicted effects meet short-term goals of the persons or entities that design and implement the incentive structure, while significant negative externalities or long-term harms are disregarded. For example, an HMO may discourage referrals to specialists through use of a referral risk pool, and cumbersome referral procedures. There is an immediate windfall to the HMO, because specialist care is expensive. At the same time, specialist care may resolve certain medical problems in a more efficient manner. The managers of the HMO may be indifferent if the costs of inefficiency are borne by the PCP (who has to provide more care over a longer period of time) or the patient, although one would hope for more inclusive sympathies. Still, even in strictly financial terms, there may be long-term gains to the HMO from practicing more efficiently and not simply more cheaply, e.g., reduced hospitalizations for conditions that recur if inadequately treated. Also, the consequences for the PCP and the patient may eventually return on the HMO. The PCP that takes on too much to avoid a costly referral may make a mistake that eventuates in a malpractice

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16 "Research has shown that financial incentives change clinical behavior in the aggregate. However,... their impact in specific clinical circumstances is much more difficult to measure than is the impact of rules." Alan L. Hillman, “Managing the Physician: Rules Versus Incentives,” Health Affairs 10, no. 4 (1991): 138-46 at 141.
suit against practitioner and organization. The patient may disenroll from the HMO, rather than suffering patiently or switching PCPs. The patient’s employer may look at a report on medical absences for employees enrolled in the HMO and conclude that it should take its business elsewhere.

Second, we need to beware of incentive schemes that are too refined. Recall Alasdair MacIntyre’s comment on the obliteration of the distinction between manipulative and nonmanipulative social relations. The designer of an incentive scheme that is precisely calibrated in every particular treats others as instruments of her purposes. They become mere sites for the application of technique. Consider a concrete example offered by Latham. A plan offers obstetricians a fixed end-of-year bonus if their average inpatient length-of-stay (LOS) for deliveries is below a certain target figure. How is the target set?

An unrealistically low target... would be out of the question for every conscientious physician and would amount to no incentive at all.... On the other hand, the requirement must not be too simple to obtain or the incentive will fail to squeeze out all the savings... In short, an incentive planner should set the average LOS that triggers the bonus at the most difficult possible level which a conscientious physician would be willing to attempt to obtain. If a planner sets the perfect target level, the entire bonus amount would effectively be at stake in each individual clinical decision.¹⁷

Latham’s planner, if only as a matter of realism, allows that there is a standard of “conscientiousness” which limits the responsiveness of physicians. Were she to ask how far physicians might be pushed to compromise their standards through the application of incentives alone, and not through any effort to persuade physicians that standards ought

¹⁷Latham, “Regulation,” 423.
to be changed for such-and-such reasons, any sense of what it means to treats others as ends and not as means only would have been lost.

The project of the precisely calibrated incentive structure may also be self-defeating. Behavior may fail to conform to expectations, if only because people fail to understand the structures that confront them. Active subversion is also a possibility. Further, the designer is not omniscient. The meaning of the data concerning past experience with incentives is scarcely clear, and the future and what it holds is even more of a mystery: “Of course, plans’ ability to set those numbers is not so perfect. We still have very little knowledge about the limits of cost-saving and very little agreement about where cost-saving may become dangerous. Moreover, even where plans can predict cost levels reasonably well for the population of their insureds, the populations that go to any given physician may vary considerably from the norm.”18 Latham’s measured observations confirm MacIntyre’s jeremiad against faith in administration. Some appreciation of limits is in order.

Third, where decreased utilization produces a direct financial benefit to the practitioner, the risk that the question of who benefits, or whose benefit matters more, will enter into the decision making of the practitioner is very great. This sort of incessant questioning can only erode the quality of the work for patient and provider alike. For this reason, where rationing is necessary, and reliance on practice guidelines or other methods of guiding resource use are possible, these other methods should be introduced in preference to reliance on incentives. Of course, guidelines are not possible for every conceivable kind of decision that must be made, and even good, research-based guidelines

cannot eliminate uncertainty or the need for discretionary judgment on the part of practitioners. Also, guidelines may have limited motivational force. So we still have reason for a cautious assessment of particular financial incentives.

Fourth and finally, a question to ask of any particular financial incentive is whether it supports and reinforces other types of incentives that influence practitioners, or rather tends to dominate or undermine them. By "other types of incentives" I mean chiefly the professional incentives outlined by Freidson, such as the approval of peers and patients. I would, for the most part, follow Freidson in suggesting that salary is the best method for paying health care professionals because it is relatively neutral and creates space for the operation of professional incentives. At the same time, very few outside the sociological and medical ethics communities, and medicine's academic elite, seem to favor this form of payment. The first task, then, is to identify the kinds of financial incentives to practitioners that are clearly bad, condemn them, and advise all persons and institutions of good character to avoid them.

I will begin with the American Medical Association's pronouncements on these matters. In 1995, the AMA's Council on Ethical and Judicial Affairs released a report entitled "Ethical Issues in Managed Care" (AMA Report). The AMA Report avoids

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19See, e.g., Eric B. Beresford, "Uncertainty and the Shaping of Medical Decisions," Hastings Center Report 21, no. 4 (1991): 6-11. It is alarming that some have seized upon guidelines as a panacea. Guidelines, critical pathways, computerized medical information systems, and the like, are all for sale in the marketplace, and their promoters make extravagant claims for them. Their purchasers often seem to pin their hopes on these technologies or techniques alone, in lieu of intelligent incorporation of selected items in the reorganization of practice to better meet the needs of individual patients and the population served. See David Blumenthal and Arnold M. Epstein, "The Role of Physicians in the Future of Quality Management," New England Journal of Medicine 335 (1996): 1328-31 at 1330.

20In a fairly recent survey, only 8 percent of managed care plans responding (n=108) reported paying primary care physicians by salary with no withholding or bonus. A total of 60 percent (84 percent, in the case of independent practice association-type HMOs) reported some sharing of risk with primary care physicians, and 37 percent (36 percent of IPA HMOs) reported using capitation as the predominant method of payment. Capitation numbers for specialists were slightly lower. Gold et al., "National Survey," 1681.

21Council on Ethical and Judicial Affairs, American Medical Association, "Ethical Issues in Managed
setting forth any hard and fast rules concerning financial incentives; it simply counsels attention to such factors as the percentage of income placed at risk, the frequency with which incentive payments are calculated, and the size of the group whose performance is the basis for judgment. (The AMA Report also states that incentives to undertreat are more problematic than incentives to overtreat because incentives to undertreat actually "exploit" the never- quite-absent physician financial motive, are less likely to coincide with patients' interests, and are less likely to be noticed. This statement, and the assumptions behind it, have been vigorously contested.\textsuperscript{22}) The intent is obviously to blunt the force of incentives, the assumption being that weak incentives will operate only at the margins or in the "gray areas" of medical uncertainty. The ideology of medicine, which portrays the physician as invulnerable to social and organizational pressures, lies in the background. In fact, even very weak incentives—and influences that can scarcely be labeled incentives at all—may be significant.\textsuperscript{23} Incentives are all the more dangerous where susceptibility to incentives is denied.

In the AMA Report, little attention is paid to the logic of particular incentives. For the most part, incentives are treated as non-specific rationing techniques. The AMA Report does add that the most effective way to eliminate inappropriate conflicts is to


\textsuperscript{23}In a study to test the influence of advertising, physicians were asked to state the properties of certain drugs and their appropriate uses: "The answers revealed many beliefs that did not correspond to published medical reports but did reflect the claims producers had made in advertisements. Yet the physicians studied contended that they based their assessment of medical products only on scientific evaluations, literature, and experience." Two studies found that pharmaceutical companies' sponsorship of continuing medical education influenced the attitudes of instructors and participants in the courses. Instructors assessed the drug made by their sponsoring firm more favorably, and participating physicians increased their use of the sponsor's drug the most. These biases emerged even though the host institution, Georgetown University School of Medicine, followed guidelines that required disclosure of the sponsorship and affiliation of speakers, and even though drugs were only referred to by their generic names. These studies are cited in Marc A. Rodwin, \textit{Medicine, Money, and Morals: Physicians' Conflicts of Interest...}
base payment on the quality rather than quantity of services provided. Quality criteria would include objective outcomes data corrected for caseload, the degree of adherence to practice guidelines and other standards of care, patient satisfaction, and peer review. (Some of the difficulties in evaluating physician performance are noted below under "Quality Assurance.") Haavi Morreim also avoids prescribing definite limits, but she observes, as many have, that incentives should influence physician judgment, not distort it. This common distinction, typically presented as if the difference between influence and distortion were self-evident, is not helpful. Morreim does not leave matters there, however. She writes that a “well-designed incentive should prompt the physician to consider more carefully what he does with clinical uncertainties and borderline options; it should not induce him to forego what he believes is clearly in the patient's interest.”  

The first part of this statement is interesting. It suggests that incentives are most effective in influencing—but not distorting—when they occasion thoughtfulness about one’s general mode of practice. Incentives may be more likely to initiate this kind of thoughtful consideration when they affect a group of physicians practicing together. In the context of a group practice, questions about how we ought to practice medicine may predominate over questions about whether I can get by without doing this test or making this referral, given that the end of the year is approaching and I may have been too liberal in my test-ordering and referring in previous fiscal quarters.

Other commentators have been more willing to offer numbers. Ezekiel Emanuel has stated that a salary withhold or bonus in excess of twenty percent of an individual

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(24Morreim, Balancing, ibid., 124.)
practitioner's salary is too large and should be prohibited. Katherine Swartz and Troyen Brennan would empower state insurance commissioners to define limits on the dollars of care per patient for which a group of providers or care unit is potentially liable. They foresee a sliding scale according to the types of care for which the unit is at risk, the number of primary care physicians in the unit, and the number of patients who have selected the unit. The probable mechanism for limiting liability would be stop-loss insurance or reinsurance. The current rules for managed care plans that participate in Medicare and Medicaid prohibit payments to physicians or physician groups as an incentive to limit medically necessary services to a specific individual. They also require plans to limit potential financial losses for physicians at "substantial" financial risk for any referrals they make. Physicians are at substantial risk if the group to which they belong may be called upon to give up more than twenty-five percent of its potential payments to cover the costs of referrals. (Other provisions require plans to conduct an annual survey of beneficiaries and those who disenroll, and to disclose general features of physician incentive arrangements to enrollees who ask.)

Latham has been among the first to offer detailed criticisms of these rules, promulgated by the federal Health Care Financing Administration. The first rule is aimed at a practice that has not been popular among managed care organizations—implementing

incentive schemes aimed at single-patient transactions. The prohibition does not extend to incentive payments based on aggregate utilization, no matter how intense. The second rule focuses on protecting physicians from financial risk rather than protecting patients from the potential harms of intense incentives. The trigger for the regulation is overall annual financial risk, not financial risk in connection with referral services for a particular patient, and plans have the option of offering aggregate rather than per-patient stop-loss coverage. Latham states that "there is simply no nexus between the total amount for which a physician is at risk under an incentive plan and the amount at stake when the physician makes a decision about the consumer's care." This may be too strong. There may not be a nexus between the amounts, but physicians and physician groups that are desperate at the prospect of losing income may be readier to take risks with patient care; anxiety may compromise judgment.

On the other hand, Latham is surely correct to point out the gaping holes in the regulatory scheme. He proposes that regulators focus on the substance rather than the form of incentive structures. For example, the intensity of incentives may vary in proportion to the percentage of a practice's patients in plans with incentives. Latham believes that the kind of scrutiny required may make it wise to delegate regulatory power over incentives to state authorities with greater knowledge of the markets in their regions. In this he echoes Swartz and Brennan. He also supports an outright ban on incentive schemes that apply to individual physician's services and referrals. These schemes are

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29Latham, "Regulation." 428.
simply too intense. Failing that, he would require massive quality-assurance and stop-loss protection. Where a physician or physician group accepts substantial risk, in the twenty-five percent range, the stop-loss coverage required should be on a per-patient basis. As a general matter, regulators should require that both cost goals and quality goals be included in the criteria for award of incentive payments. Finally, Latham argues that regulators should “favor” incentive structures in which bonuses and withhold amounts are earned “retail rather than wholesale,” i.e., in a graduated way rather than by attainment of a single goal.30

None of the numbers proposed have any magic to them. The research on incentives is too meager to aid much in line drawing, and we cannot suppose that a percentage point or two will make a great difference. At the same time, it seems sensible to conclude that the dangers posed by incentives increase with intensity, and hence to endorse Latham’s recommendations concerning the regulation of intense incentives. Further, if one fears the effects of general financial insecurity as well as incentives that bear on particular clinical decisions, one will want limits on the percentage of physician income and group revenue at risk, allowing for some adjustment in the case of a group to account for factors such as size. While the specific numbers selected are bound to be somewhat arbitrary, the range in which they will lie is not. Fifty percent seems too high, five percent too low. One can then leave it to the policy makers to specify the outside limit, and administrators and physicians to find the danger points in their own organizations or practices.

30Latham, “Regulation,” 430.
Two questions might be asked here. First, how can the use of any financial incentives be justified, given that even weak incentives may have significant effects? It is partly a practical matter. The prospects for restraining the use of financial incentives are better than the prospects for eliminating them. Also, while Freidson and others make strong arguments for preferring professional incentives to financial ones, Freidson himself documents how some professional incentives can render practitioners insensitive to patient needs. Incentives tied to patient satisfaction can counter these effects. It is simply impossible to eliminate all incentives, or all financial incentives, just as it is impossible to eliminate all conflicts of interest. One can only eliminate the worst and hope for the best. (And I will argue that appropriately tailored financial incentives can serve as a prod to beneficial innovation.)

Second, why should we accept a "somewhat arbitrary" limit, based on a common sense belief that in general the magnitude of the effects on behavior will vary with the proportion of income at stake and certain other factors? Part of the caution has to do with the non-specific nature of most incentive systems in use. In most cases, rewards depend on reductions in overall utilization. How these reductions are achieved will depend in part on the character of the practitioner, the sophistication and persistence of the patient, and the extent of the managed care organization's quality assurance monitoring. That is, in a good number of cases, the practitioner will not succumb to the temptation to skimp on patient care to enhance her own income. In a number of cases where the practitioner attempts to cut corners, a vigilant patient or a peer review program will keep the practitioner in line. We may expect that there will be real problems only in a relatively small number of cases. Yet the risk in finding out more about the nature of the
risk may be unacceptably high. Further, we need to consider the effects of incentives on trust. Common sense says that there is a difference between standing to lose five percent of your income if utilization targets are not met and standing to lose fifty percent. If people know the fifty percenters are out there, the damage is already done in an increase in general suspiciousness. Should studies show that fifty percenters are not hazardous to our health, the findings may not have much of an effect. Also, in this area the results of experiments in the classical sense—controlled clinical trials—may not be generalizable. If monitoring itself is a deterrent to undertreatment, then the monitoring that is a necessary part of a research study will necessarily bias the results. The danger with adopting the approach I recommend is that people will be lulled into a false sense of security. They may assume that because weak rules against some strong incentives are in place, they have no need for concern.

All of this leaves open the question of how incentives which are not morally or at least prudentially out-of-bounds are to be evaluated. To a certain extent, the concerns here are purely procedural. Within the realm of arguably appropriate financial incentives, how are decisions to be made concerning the design and implementation of specific incentive structures, and by whom? (Some possible variations for the "by whom" are examined below under the rubric of governance structures.) The "how" dimension will, however, have a substantive aspect, if we think general criteria of desirability are possible. In determining what kinds of incentives should be prohibited, the focus is usually on the effects of payment on the choices made by individual physicians. The idea is to make physicians cost-aware, without creating risks of gain or loss so great that income effects dominate all other considerations in clinical encounters. But as an astute observer has
recently pointed out, a form of payment such as capitation may affect quality of care in two ways, by influencing individual decisions, but also "by encouraging systemic integration and innovation in the design and delivery of services"\textsuperscript{31}

Attention to the systemic dimension can become the basis for developing general criteria of desirability. When one asks whether particular payment structures promote integration and innovation, one is no longer using an incentive scheme as a non-specific rationing technique. Rather, one is using incentives intelligently to effect certain results. At the same time, one is not simply acting as puppeteer—one is fostering creativity in others. For example, a capitation contract must specify the services that the physician or group is expected to provide in exchange for the fixed monthly payment. Certain services may be explicitly carved out and reimbursed separately on a fee-for-service basis. In determining whether a service should be included in a contract or carved out, one might ask whether the entity that will become the bearer of risk has the capacity to redesign the pattern of care to improve quality, while simultaneously reducing costs. If the entity lacks the capacity to redesign in a particular area, that service should be excluded. If too many services must be excluded, then this is not an entity that should be entering into a capitation contract. The ideal is to aggregate payment for the total care of a defined population, reducing the stake fragmented providers have in preserving inefficient, uneconomical patterns of care. For example, where payment is aggregated, the costs associated with a cost-effective innovation like home outreach for patients with asthma can be "paid for" with the cost-savings from reduced office visits and hospitalizations. "Properly designed, capitation can broaden time horizons, clarify areas of

\textsuperscript{31} Berwick, "Payment By Capitation." 1228 (emphasis added).
interdependence, and encourage cooperation, all of which can improve the quality of care."32 These kinds of incentive effects are all highly desirable from the perspective of a Deweyan pragmatist. The discussion of financial incentives will resume under the heading of disclosure.

2. **Gatekeeping/Case Management.** For many managed care organizations, "gatekeeping" simply means giving an individual physician control over the full range of health services, including specialist referrals and hospitalization. Berenson comments that "[a] different form of gatekeeper program would be one in which the managed care organization assumed responsibility for the competence of gatekeepers to act as providers of primary care and coordinators of specialized care."33 This would involve more than credentialing. Managed care organizations might offer remedial education for providers new to the case management role, and continuing education for all providers on new approaches to case management. Further, they might develop information management systems to support case management. The designation of a particular health care provider as gatekeeper or case manager, like certain forms of capitation, *may* serve the cause of integration and innovation, continuity of care, and coordination across the whole spectrum of care from health promotion and preventative care to acute care to home health care.

Indeed, one may use a qualitatively different term, such as "caretaker" or "mentor," to indicate a qualitatively different practice of taking care or providing guidance, whether or not one is delivering services. James E. Sabin and Carlos Neu, two psychiatrists affiliated with Harvard Pilgrim Health Care, look at the difference between

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32Berwick, "Payment by Capitation." 1229.
gatekeeping and caretaking in the case of a defensible exclusion of certain services from coverage: "If a patient's suffering or dysfunction will not receive insurance coverage because it does not arise from a mental disorder, an ethical or just managed care program would ask the clinician to advise the patient on alternative directions to take (that is, identifying other gates through which the patient can pass) not simply to send the patient away (i.e., closing the gate)." Caretaking involves organizational as well as individual commitments. Principally, it involves an organizational commitment to commitment, in the sense of fidelity, in practitioner-patient relationships. Drawing on their experience, Sabin and Neu write: "In our practices we have found that patients are generally prepared to work on limited goals via efficient techniques if the clinician is able to create a strong caretaking bond between them. This can only be accomplished if the clinician is able to make reliable commitments." They add that "while ethical managed care systems are appropriately concerned with limiting expenditures, they will express this concern by establishing a culture that understands, accepts, and uses cost-effective modes of treatment, not through micro-management techniques like only approving treatment in small dollops."34 In other words, administrators of ethical managed care organizations will repose some trust in the judgment of practitioners, having devoted thought and effort to creating an environment in which such trust is justified.

3. Quality Assurance. There are a number of levels, and forms, of quality assurance. At the level of the plan, there are efforts to develop standardized outcome-

33Berenson, "A Physician's View of Managed Care," 115.
34James E. Sabin and Carlos Neu, "Real World Resource Allocation: The Concept of 'Good-Enough' Psychotherapy," Bioethics Forum 12, no. 1 (1996): 3-9 at 4, 6-7. The article title refers to Sabin and Neu's adaptation of D.W. Winnicott's concept of "good-enough mothering" to the practice of psychotherapy in the managed care context. I think their effort to develop an ethic adapted to the managed care environment out of the resources of their own discipline is to be highly commended.
based performance measures that can be used to make comparative judgments across plans. Plans may use these measures in their own quality improvement efforts. The best known is the series of measures developed under the heading "Health Plan Employer Data and Information Set" (HEDIS) by the National Committee for Quality Assurance. Although these efforts are valuable, the experience with HEDIS reveals some of the limitations of performance measures. HEDIS-based report cards for 1995 showed significant disparities among providers, even though the twenty-one HMOs that took part in the project were among the most established in the field. Commentators note that it is difficult to assess the findings because it is not clear what the norm should be in many areas. A low number of hospital days per enrollee may mean that the plan is denying hospital care to patients who need it, while a high number may mean that the plan is wasting resources by hospitalizing patients who do not require this level of care or by keeping patients in the hospital too long. Then, too, similar outcomes may reflect vastly different realities. A low readmission rate for persons treated for chemical dependency may signal an effective program that ensures recovery before discharge, or rigid adherence to a benefits schedule that caps annual treatment days. A low utilization rate for provider services may be a sign of restrictive guidelines or lack of access, or an excellent health education and illness prevention program. Part of the variation is likely attributable to simple misunderstandings about data collection and reporting and differences in populations served. The hope is that experience will resolve some of these difficulties.

Others note that the first generation HEDIS measures are not true outcome measures. In general, HEDIS looks at the frequency of certain procedures, not the effects
of the care offered by the plan on the health of the population served. Some have even suggested that the managed care industry has fooled the media and the public into accepting the kind of simple primary care measures that make HMOs look good as the standard for quality in health care.35 Nothing is revealed about skill in caring for sick people. Several of the measures included in the revised HEDIS consider how well a patient feels he or she is functioning. One journalist writes, "The rationale for such an approach is not merely that there are problems in using medical outcomes measures, but that a patient's description of functional status may well be the best tool to get at the original goal when HEDIS was developed: aiding in selecting the managed care plan that best fits buyers'—and enrollees'—needs."36 As suggested by the title for which HEDIS serves as acronym, large employers are the most significant force shaping quality assessment efforts at the plan level. Yet the possibility that the patient's experience may become the standard of value is cause for rejoicing among those who would like to see health care become more democratic.

Finally, critics of report cards argue that they give health care organizations an incentive to focus their quality improvement efforts on the specific areas covered on the

35“HMO report cards...are starting to peel back the ignorance of who cures best," declared Fortune in 1994. But in developing the HEDIS measures, HMOs such as Harvard Community Health Plan were thinking of what would make them look best. According to a representative of the Plan, "We said, 'Look, we can develop some measures that will show our value. If we can do that to purchasers' satisfaction, it will give us an advantage in the marketplace.'" HEDIS 3.0 includes measures for ongoing care of people with AIDS, diabetes, and other chronic illnesses. The Foundation for Accountability (FAC), established by Paul Ellwood, plans to develop similar outcome measures. It will be interesting to see whether FAC will generate different measures. NCQA officials have taken some steps to achieve independence from the HMO industry, but George Anders reports that as of mid-1996, it was still receiving 40 percent of its funding from HMOs, and HMOs controlled at least one third of the board of directors. There is another kind of industry influence: it is not much good to come up with standards if nobody will use them. One HMO surveyor says, "Our primary business is to sell to the Kaisers and Aetnas and Cignas of the world. We don't want anything in print that would get them irritated." George Anders, Health Against Wealth: HMOs and the Breakdown of Medical Trust (New York: Houghton Mifflin, 1996), 41-42, 258.

report card and neglect the remainder of their operations. They argue that even assuming
agreement is reached on standards, any report large enough to be broadly representative of
quality would be too voluminous and involved to be of much use, and in any event the
information would be stale given the time necessary for data collection, validation, and
publication. Analysts of outcomes data frequently voice the concern that their findings
do not speak to current practices. The managed care of 1992 may not have resulted in
significantly different outcomes from fee-for-service practice, but what of managed care
circa 1996 or 1997? The response to the critics can only be that some information, the
best available information, is better than no information at all—so long as it is delivered in
a context that stresses its imperfections.

Questions also arise about the quality of the services offered by facilities with
which a plan may contract. Journalist George Anders documents how even major
differences in quality among providers of specific services may be overlooked if the price
is right. Further, even where quality control measures are in place to govern the work of
subcontractors, these measures may be ineffective in practice. There is no substitute for
independent evaluation of the performance of subcontractors. Those seeking to evaluate

\[\text{Health Network & Alliance Sourcebook, N3-N6 at N6. Originally published in Medicine & Health}
\text{Perspectives, May 8, 1995.} \]
\[\text{37Lois Wingerson, "Big Future for Report Cards—But Which Kind? For Whom?" in 1996 Health}
\text{Network & Alliance Sourcebook, N7-N10. Originally published in Medical Outcomes & Guidelines}
\text{Alert, September 28, 1995.} \]
\[\text{38Anders looks at subcontracting for cardiac care in great detail in Health Against Wealth, 92-111.}
\text{Laboratory services are also a frequent item for subcontracting. Consider, then, these comments from the}
\text{chief actuary of a major California HMO in 1994: "I marvel at the kinds of deals we're able to get from}
\text{medical labs. It's literally impossible for labs to make money at the rates we're getting." If the labs are}
\text{making money, is there any question that corners are being cut? The case of Karin Smith, a young woman}
\text{who died of cervical cancer which repeated pap smears and biopsies failed to disclose, illustrates the}
\text{potential weaknesses of quality control measures. Smith's test results had been analyzed at a lab affiliated}
\text{with her HMO. A reporter, Edward Dolnick, pinpointed the system failure. The lab followed industry}
\text{practice in reinspecting one in every ten slides for quality control. But a technician testified in a sworn}
\text{deposition that the lab reinspected only those slides whose code number ended with a two and this system}
\text{was known among the technicians. As Dolnick observed, "A technician could race along to her heart's}
the performance of individual practitioners may also face difficulties. Criteria will vary, depending on the closeness of the connection between the provider and the plan. Where physicians are employed by or work exclusively with a single plan, the criteria will be more subjective. A textbook on managed care lists the following categories for assessment: productivity, medical charting, dependability, after-hours call duty, medical knowledge, management of patient care, management of outside resources, patient relations, staff relations, attitude and leadership, and participation, as, for example, participation in quality assurance activities. All of these affect quality of care. And, with the possible exceptions of productivity and management of outside resources, the physician or other provider who scores high in these areas likely contributes to the quality of care for her own patients and the population served by the organization. Where ties are looser, criteria are more objective. The categories listed for open panels (i.e., plans that contract with physicians who contract with multiple plans) are productivity, referral utilization, hospital utilization, ancillary utilization, cooperation with precertification and authorization requirements, compliance with use of plan network, cooperation with plan policies and procedures, participation with quality assurance, and patient relations. Here the relationship between the evaluation criteria and quality is much more ambiguous; the author notes that the best performance in some of these categories may be performance around the norm, rather than the lowest utilization.³⁹

As described in Chapter 5, objective criteria are open to manipulation. Two of the favorite "games" are churning and buffing and turfing. On the other hand, subjective criteria create space for the play of favoritism and bias. Even patient satisfaction measures of performance are not fool-proof. Regular patient satisfaction surveys may be an important way of nourishing responsiveness to the needs of plan members. Patients are likely smarter than many experts have given them credit for, and they are certainly the best source of data on the interpersonal aspects of care. Their contributions to quality assurance and improvement can be enhanced if they are allowed to comment on their experience, rather than simply expressing their general level of satisfaction. And, since most people are interested in the experiences of others who are "like them," this information is also valuable to prospective plan members or patients.\textsuperscript{40} Making good use of surveys means giving the survey instrument a great deal of thought, and using the results not only to adjust compensation, but also to modify the operations of the organization. Even so, surveys are not a substitute for other structures that cultivate and reinforce good practice. Patient perceptions of quality are simply too easily manipulated to allow them to serve as the lone test of quality, or to counterbalance structures that tend to erode quality. Various strategies for evaluating performance must be combined.

Finally, the development of clinical guidelines may be integrated with quality assurance activities, rather than simply constituting another method of cost control or rationing. For example, HealthSystem Minnesota and the Institute for Clinical Studies Integration have developed and implemented more than twenty clinical guidelines, covering common illnesses and procedures such as breast cancer detection, childhood

\textsuperscript{40}See Allyson Ross Davies and John E. Ware, Jr., "Involving Consumers in Quality of Care Assessment,"
asthma, hypertension diagnosis, lower back pain, and stable coronary artery disease. The breast cancer detection guidelines are one of the success stories. Prior to development of the guidelines, a positive diagnosis could take up to three weeks. With a team of primary care physicians, radiologists, surgeons and others working together, the time from mammography to ultrasound to needle biopsy was reduced to three hours. This would not have been possible if an organizational commitment to quality, practitioners skilled in the cooperative virtues, and the reward system had not been working together. For example, one significant change was to have radiologists use stereotactic methods for most biopsies. This innovation might not have received the support of the surgeons had they not been working within a capitated system. Under the right conditions, guidelines can improve quality and reduce suffering.\(^\text{41}\)

On the other hand, guidelines must be flexible and subject to periodic evaluation. Guidelines may suffer from an assortment of deficiencies: they may be founded on inadequate research, neglect qualitative variables, gloss over uncertainties and contingencies, fail to make provision for “outliers” or extraordinary cases, or rule out consideration of patient-specific systems of value.\(^\text{42}\) The designers may even be blind to the uncertainties affecting their project. For example, it is not always easy to identify what tests or treatments are of only “marginal” benefit, and there are always value judgments involved. Finally, attention must be paid to implementation. If guidelines

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\(\text{Health Affairs} \, 7, \, \text{no. } 1 \, (1988): \, 33-48\), and Susan Edgman-Levitan and Paul D. Cleary, “What Information Do Consumers Want And Need?” \(\text{Health Affairs} \, 15, \, \text{no. } 4 \, (1996): \, 42-36\).

\(^{41}\) The breast cancer guidelines are described in Dean C. Coddington, Keith D. Moore, and Elizabeth A. Fischer, \textit{Making Integrated Health Care Work} (Englewood, Colo.: Center for Research in Ambulatory Health Care Administration, 1996), 89-90.

\(^{42}\) These matters are discussed in greater detail in Moreim, \textit{Balancing Act}, 53-58. The need for openness to adjustment may be even greater where guidelines are adopted exclusively as a cost control measure. For example, guidelines may require a certain drug regimen because alternatives are more costly. With the lapse of time, the more expensive drugs may decline in price to the point where they are actually the least
represent best practice, patients are harmed (or denied a benefit) if implementation is less than thorough. If guidelines deny a marginal benefit in the interests of cost-containment, incomplete or careless implementation is a positive injustice. Like cases are treated differently. The assessment and improvement of quality is a problem in the Deweyan sense that it is an area of some conflict that demands further inquiry. It is important that the inquirers be cognizant of the values at stake and pay attention to qualitative factors in carrying out their research.

4. Disclosure Rules and Informed Consent Procedures. Ethicists and moral philosophers who are proponents of the free market (old liberals) join their (new) liberal colleagues in advocating full disclosure to persons in whatever capacity they may appear: as citizens and taxpayers, representatives of third party payers, consumers, plan members, and patients. Indeed, disclosure takes on added importance when more substantive protections are disallowed. Morreim argues that disclosure has three primary justifications. First, certain information is a kind of property, to which the member or patient has a right. Second, the member or patient is likely the weaker party in the transaction with plan or practitioner, and therefore in need of protection. Disclosure makes the relationship between the parties more nearly equal, because the knowledge base of the member or patient is increased. Third and finally, disclosure enhances autonomy, understood as the capacity to make one's own decisions in light of one's own personal values and goals, and then to take responsibility for those decisions. This last consideration will have special force in a Deweyan pragmatism informed by the principle of subsidiarity, if it is not taken to imply an atomistic understanding of the individual.

costly, in which case the guidelines make no sense.
Disclosure rules, whether adopted voluntarily or imposed, must provide for the appropriate communication of various kinds of information. The AMA proposes a division of labor and responsibility between managed care organizations and physicians. The managed care organization is to be responsible for ensuring disclosure of restrictions on benefits and any incentives the organization offers providers to limit care (recall the AMA's relative lack of concern about incentives to provide too much care). It is important to note here that a single managed care organization may offer multiple managed care plans. Physicians are responsible for disclosing treatment alternatives, financial incentives affecting their own practice, and any contractual agreements restricting referrals. There are a number of considerations to keep in mind. If financial incentives are of sufficient magnitude, and the connection between the incentive and services delivered is clear, disclosure will clearly undermine patient trust and the healing alliance between patient and practitioner. This is not an argument against disclosure; it is an argument against employing the incentive.

Another issue that arises in the managed care context is the specificity of disclosure. Morreim suggests that the form of the disclosure for incentives be patterned after the form of the incentive: "Where an incentive operates on a global level, as year-long spending patterns yield year-end salary adjustments, a global disclosure is usually appropriate.... Where incentives are decision-specific, as where the physician will receive a specific cash bonus for discharging a particular patient a day early, then so must the

44The AMA itself has been accused of less than adequate disclosure in its report on ethics and managed care. In the late 1970s, the Federal Trade Commission investigated charges that the AMA was conspiring to inhibit the growth of HMOs, in part through its pronouncements on ethics. In 1979, the federal agency imposed a "cease and desist" order on anticompetitive use of ethics standards. The AMA Report is nearly silent on these events (and the constraints that resulted) and its own conflicts of interest. See Miles and
disclosure be specific to the individual decision.” The concern here goes back to Latham’s analysis of the way in which a global incentive can come to have very specific effects. Disclosure rules that would capture all the possible nuances would likely prove unworkable in practice—a good reason for attempting to address this concern at the level of regulation rather than disclosure, by putting safeguards in place that spread or limit risk.

Another area may be even more troublesome. Should the physician disclose every potentially beneficial test or treatment option, including those not covered by the plan? In this area, some standard of materiality, of what a reasonably prudent patient would wish to know, is probably in order, for two reasons. First, maximal disclosure is not necessarily in the interests of patients. Disclosure may raise needless anxieties or hinder judgments of significance. This is a common complaint about current informed consent forms, on which every risk, however remote, is displayed in a vast list of potential calamities. Second, people may respond differently to information, but a judgment of how any particular person will be affected by any particular piece of information is difficult. Telling a patient about treatments the plan does not cover may be cruel; some may wish that they had never been told. But others will appreciate the honesty even if they choose not to act, or vow to go down fighting the coverage limitations, or set about raising the funds to pay for treatment on their own. The most difficult case may be presented by all the relatively trivial “marginal benefits” selected against by guidelines or formularies. Some disclosure is obviously required, but is a general statement that the plan saves money where it can sufficient? One resolution would be for the plan and

physician to present the member or patient with a kind of global disclosure, and then offer opportunities for more specific disclosure. The plan's global disclosure should include instructions on how to access more specific information. The physician should offer to answer any questions the patient might have, and to provide the level of detail the patient requests (within reason) in their future transactions with one another.

As critics of the informed consent process in practice continually point out, the "how" of disclosure is as important as the "what," the information conveyed. Some sensitivity is called for—considering the viewpoint of the plan member or patient, trying to make the information meaningful by relating it to the other's experience, responding to questions and concerns. In place of an extended discussion of the difference between sensitivity and a cowardly reticence concerning an unpalatable reality, consider this example excerpted from a case presented by Sabin. A psychiatrist named Jones proposed sessions every four-to-six weeks for a depressive patient who had demanded long-term therapy with frequent visits; the patient expressed his belief that the HMO was only interested in saving money. So "Jones explained that while the public generally thinks of psychotherapy as weekly or even more frequent, and while much of the professional community locally agreed with that view, outcome research does not answer the question and that his own experience suggested that they could achieve their objectives in the plan he was proposing. He acknowledged that the HMO did indeed try to save money where possible, which was then available for other aspects of care."46 Note that Jones is not a communications virtuoso. Note, too, that the final statement is only truthful within an organization that retains its earnings and channels those funds into improved patient care.

For other observers, a concern with disclosure suggests that more ethical scrutiny of the area of marketing is in order. Some ethicists focus on the informational content of promotional materials. Advertising may be mere puffery (ALL THE HEALTH CARE YOU DESERVE), or it may be misleading or outright false. Loosely monitored sales personnel interested in rapidly increasing enrollment may employ tactics that are highly questionable from an ethical standpoint.47 Sadly, patients are often surprised to discover that their plan will not pay for care from their long-time physician or their neighborhood health center. The Midwest Bioethics Center report on managed care states that plan members (and, presumably, potential plan members) should receive education and information in the appropriate language on matters such as: names and qualifications of practitioners; benefits and services included and excluded; out-of-plan coverage; procedures for choosing and changing practitioners; deductibles, caps, co-payments and the like; termination of membership, denial of claims, and grievance procedures; conflicts of interest, including financial incentive arrangements that may affect access to care; outcome and quality data; and the corporate nature of the plan (e.g., for-profit or not-for-profit). Although it may be difficult to make this information available in a form that makes sense to the average person, the effort is absolutely essential from an ethical perspective. Alternative modes of presentation adapted to different learning styles are

47In 1996, Humana, not atypically, paid sales people $9,400 a month for enrolling seven or eight elderly people a week; Foundation Health offered up to $190,000 a year in perquisites and bonuses to those who could bring in fifty new recruits in a month. Managed care plans participating in TennCare, Tennessee's Medicaid managed care program, offered free turkeys, credit cards, life insurance deals, and other inducements to attract members. TennCare officials originally regarded such gimmicks as benign, but changed their views when critics pointed out that giveaways were diverting funds from health care. HMOs were also allowed to pay "per-head" commissions to door-to-door sales workers. One enterprising salesman signed up prison inmates, who were already receiving free care. Door-to-door salespeople were sometimes given explicit instructions on whom to avoid—such as pregnant women. Anders, Health Against Wealth, 66, 198-99.
desirable, and interactive computer programs that allow people to access information selectively show considerable promise.

In one of the most extensive ethical commentaries now available on managed care, Laurie Zoloth-Dorfman and Susan Rubin conclude their analysis by offering six recommendations. Among other things, they call for individual moral agency, by which they appear to mean structures or policies (public and organizational) that support individual moral agency. For Zoloth-Dorfman and Rubin, this category of response includes firm opposition to all gag rules and the alleviation of the climate of fearfulness created by layoffs, in addition to disclosure and informed consent. The demise of written policies or contractual provisions silencing physicians is nearly complete, owing in large part to negative publicity. This does not mean that a climate of openness has been established, however. Zoloth-Dorfman and Rubin rightly point to fear as a major hindrance to individual moral agency. They do not suggest how the problem might be addressed.\(^48\) The issues are thorny. Job security for employees is purchased at the cost of organizational flexibility. Health care organizations might take a step toward altering the climate of fearfulness by adopting a policy of offering employees in overstaffed areas the option of reassignment to any suitable open position within the organization, with support for retraining within some limits of reasonableness. They might also sacrifice some flexibility in order to share information about reorganizations or other contemplated transactions with staff.

5. **Distribution of Savings/Member Incentives.** Zoloth-Dorfman and Rubin urge organizations to give serious consideration to distributive justice. The example they give

\(^{48}\)Zoloth-Dorfman and Rubin, "The Patient as Commodity," 351.
is a rebate to patients of a portion of the savings from a managed care provider's cost reduction efforts: "If a postpartum mother is sent home in eight hours, which saves the insurer $2,000 per day, then the patient ought to share in the savings and be offered a rebate." I have some reservations about this proposal. If early release from the hospital creates a significant health risk for the mother or child, then a share in the savings is scarcely an adequate response. Zoloth-Dorfman and Rubin chain the rebate scheme to full disclosure and informed consent, but it is doubtful that any insurance company or HMO will seek consent to "releasing you earlier, with significantly increased risk to you and your baby." (Should they do so, financially strapped families will be faced with a kind of "Sophie's Choice": whether to trade off the well-being of mother and/or child for the cash payment.) If early release creates no significant risk, or brings significant benefits, then it is hard to see why this particular patient is entitled to a share in the savings. Perhaps, as with some mutual insurance companies, plan members as a group should share in the rewards of good financial performance, but that is another matter. Others have suggested that any profit or surplus from operations be reinvested in patient care activities. They give the greater flexibility of the not-for-profit corporation in disposing of revenues as a reason for favoring that form of organization. Rather than simply allowing members or patients to share in cost-savings, some have proposed making them partners in cost-containment efforts by offering them incentives related to

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49 Zoloth-Dorfman and Rubin, "The Patient as Commodity," 352.
50 E.g., an earlier homecoming celebration, better bonding, unlimited visitors, better food, and lower risk of infection, if one managed care organization is to be believed.
51 E.g., Carolyn M. Clancy and Howard Brody, "Managed Care: Jekyll or Hyde?" JAMA 273 (1995): 338-339. For example, Mercy Health Plan, a not-for-profit IPA HMO, gave $1.3 million to a city health department to aid immunization efforts. The money supports development of a city-wide computerized immunization tracking system, and also goes toward longer hours of operation and more staff at public health clinics. The HMO invested additional funds in a project to increase immunization rates for its own members. See Kathleen M. Kennedy and Kevin Brown goehl, "A 'High-Tech, 'Soft-Touch' Immunization
utilization. There is obviously room for experimentation in this area.

6. Regulation of Caseload. Caseload is not emphasized in the recent literature on ethics and managed care, but Freidson considers it an extremely important factor affecting the quality of professionals' work: "Whether they work in private organizations devoted to maximizing profits or growth by minimizing production costs, or publicly supported organizations required to maximize production with minimal resources in order to keep taxes and political pressure low, an overwhelming caseload combined with a poverty of resources by which to handle it will at least discourage if not destroy both the inclination and the capacity to do good work." Many of the proposals for ameliorating some of the potential ill-effects of managed care assume that practitioners will be able to devote time to explaining the new structures to patients. Morreim gives physicians the task of helping patients to live with uncertainty. She writes, "Conversation, rather than

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52 For example, Morreim suggests that each plan member be given a certain number of points. Points would be deducted for most services, but additional points would be awarded for desired behavior such as keeping immunizations up-to-date and keeping follow-up appointments to manage chronic illnesses. Points could be used to obtain care that falls outside the plan's guidelines and policies, or could be redeemed at year-end for cash or in-kind rewards. As Morreim points out, incentives associated with current practices, such as copayments, have at least as much potential to discourage people from seeking necessary care. On the other hand, she assumes that "healthier" patients seeking unnecessary services are a significant category, without offering any data to support this. These healthier patients are the real target of Morreim's incentive scheme; if a change in their behavior does not result in the realization of substantial savings, over and above the funds involved in implementing the scheme, then few managed care organizations will be inclined to adopt it. The moral justification for the scheme includes the assurance that all members will continue to enjoy complete access to care, so savings cannot be realized by cutting back on basic services. E. Haavi Morreim, "The Ethics of Incentives in Managed Care," Trends In Health Care, Law & Ethics 10, no. 1/2 (1995): 56-62 at 59-60.

53 Freidson, Professionalism Reborn, 210-11. An amusing study showing the link between busy-ness and lack of moral concern may by relevant here: "In a truly mischievous experiment, ... seminarians at Princeton Theological Seminary... were randomly assigned to prepare a short talk on either the parable of the Good Samaritan or the issue of job opportunities for seminary graduates. Subsequent to preparing the notes for their talks, each seminarian was sent from the preparation site ('Jerusalem') to the site where they were to give their talk ('Jericho'). Half the students in each group were told that they were running late and should hurry to the delivery site. A student confederate was slumped over in some distress along the route, and the dependent variable was simply whether the student stopped to help or not. Did the seminarians stop with any frequency? No. Was their stopping in any way related to the content of the talk they were about to give? No, not at all. The only variable of any significance was whether the seminarian was in a rush! The less the subjects were rushed, the more likely they were to help." Owen Flanagan, Varieties of Moral Personality (Cambridge: Harvard University Press, 1991), 301-2.
technology, must become the greater tool for marginal reassurance." Conversation is
time-consuming. If caseload or productivity requirements limit patient encounters to ten
minutes, there can be no realistic expectation that conversation will fill the void left by
technology. Freidson point outs that the solo practitioner can encounter the same
difficulties under certain market conditions, e.g., when reimbursement rates are low. This
is not purely a "managed care problem."

It is in areas such as this that character is crucial. A physician or an organization
that values high-quality patient care, including meaningful personal relationships, and has
made a commitment to caring for a group of patients so large that it threatens to
overwhelm available resources, is confronted with a problem. In the Deweyan scheme of
things, this is a place to begin to imagine alternative paths of response, not the point of
resignation. The physician alone, the solo practitioner may have more "freedom." She
answers to nobody but herself. But the physician-as-employee, and the organization,
may have more alternatives. In the concluding chapter, I will describe how one physician
and his organization solved this particular problem, and did it in a way that, intentionally
or not, advanced the cause of face-to-face association and community.

Internal governing and advisory bodies

1. Governing Board/Medical Board. The AMA Report proposes that managed
care organizations replicate the medical staff structure of hospitals. The report specifies
that the managed care organization should have a governing board with at least three
physician members and a medical board composed entirely of physicians. The desire is
clearly that physicians remain firmly in control of all "medical" matters and have a

\[^{54}\]Morreim also expects a finer honing of skills in history taking, physical exams, and problem-solving
significant voice in the direction of the organization (it is odd that the authors of the report specified the number of physician board members, rather than a percentage). Guidelines might be under the purview of the medical board; the report states only that they are to be established at a "higher policy making level." The AMA Report also recommends the creation of mechanisms for taking member-patient preferences and values into account. Town meetings are listed as a possible avenue for solicitation of preferences and values, along with disclosure rules and a well-structured appeals process.

Inclusion of plan members, or other health professionals, in the governance of the organization is not suggested. For this reason, the report's recommendations may not appeal to those who are dissatisfied with the traditional medical hierarchy. While physicians clearly have an important role to play in general governance, and should, for the most part, control standards for medical practice, it is not clear that they should entirely dominate in either area. I have argued that unproductive inter-professional rivalry might be reduced through greater communication across traditional boundaries. When physicians and nurses and administrators, and plan members or patients, serve together on boards and committees, respect for the experience of the other may become more of a reality. As for the solicitation of preferences and values, the approaches to member-patient involvement which are recommended are rather passive and diffuse. Member-patient involvement is more likely to be meaningful if it is both active and focused. Member-patients need to be given actual responsibilities to carry out, for example, rotating on and off the boards and committees that manage the managed care organization.

following adoption of a new ethic of "diagnostic elegance and clinical parsimony." Morreim, Balancing Act, 100, 99.
2. Internal Oversight Board. Ezekiel Emanuel and Nancy Dubler suggest that a board of patients and physicians be granted authority to approve policies on such significant minutiae as the length of office visits and the availability of practitioners for patient telephone calls. Swartz and Brennan propose that oversight committees composed of providers, administrators and patients review incentives, guidelines and the like. Experiments in this area would certainly be desirable, and should precede any broad legislative mandate to establish a board and grant it certain powers.

3. Other Forms of Member Participation. Zoloth-Dorfman and Rubin call for "collective civic discourse," an "a priori" debate about the necessity of rational rationing and civic justice." The denouement of the Clinton health care reform effort suggests that fostering collective civic discourse may be very difficult. Zoloth-Dorfman and Rubin cite the inclusion of members in decision making by the Group Health Cooperative of Puget Sound, and Kaiser Permanente's dissemination of some practice guidelines to members, as instances of what they are seeking. The Group Health Cooperative of Puget Sound is governed by a lay board elected by members, holds annual meetings which stand in an advisory relation to the board, and sponsors town meetings on especially significant or controversial decisions. Such efforts are to be applauded, but one must frankly

56Lisa Disch describes the depoliticization of the health care reform debate. With reference to the pro-reform forces, she observes that policy deliberations and choices were reserved for "experts" and carried out in private. Public events were staged spectacles that failed to equip citizens to critically evaluate alternative proposals. Lisa Disch, "Publicity-Stunt Participation and Sound Bite Polemics: The Health Care Debate 1993-94," Journal of Health Politics, Policy and Law 27, no. 1 (1996): 3-33. Analyzing the efforts of opponents of reform, Darrell West and colleagues conclude: "The health care experience shows that outside strategies can work not just by targeting the public but also by altering the impressions of news reporters and Washington elites.... If elites can be persuaded that the public does not approve of a particular proposal, that campaign is successful even if elite views are based on misperceptions." Darrell M. West, Diane Heath, and Chris Goodwin, "Harry and Louise Go to Washington: Political Advertising and Health Care Reform," Journal of Health Politics, Policy and Law 27, no. 1 (1996): 35-68 at 64. This is all very discouraging, but we can learn from experience.
acknowledge the largely formal nature of this "discourse." The efforts of Kaiser, in particular, do not seem to go much beyond the disclosure paradigm. Still, given the pressures to eliminate even these limited efforts, perhaps an additional round of applause is in order.

As for the hope that public debate can somehow be cultivated "a priori," "long before the drama reaches a clinic or hospital," I have two responses. First, we are too late to be a priori about very much. Rationing has already reached the clinic and the hospital, and not just in the obvious but neglected sense that we have always rationed by ability to pay. We already have hospital discharge planners dispatching patients with similar diagnoses to different fates depending on whether they have traditional employer-provided or self-pay indemnity insurance, are covered under Medicare, or are members of an HMO. Second, how can we even know what the debate is about before we have a sense of the problem? Too a priori, and whatever debate occurs will be hopelessly abstract. Also, people will, not unreasonably, be uninterested in an issue if drama is altogether lacking. No doubt the point is that we should begin the debate before the problem becomes a catastrophe that forecloses deliberation by inviting the kind of fragmentary, ill-thought out "crisis response" that has been the curse of the health care field for the last several decades.

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58 Indemnity insurers reimburse providers for each service. Patients with indemnity insurance can stay as long as they want—longer, if possible, and preferably in any empty beds in the intensive care unit. Under Medicare's DRG system, the hospital receives a fixed payment for total care based on diagnosis. Medicare patients are, therefore, to be discharged at the earliest possible opportunity. Unless they own their own hospitals, most HMOs pay hospitals in their network a fixed rate per diem. The HMO patients, like the patients with indemnity insurance, can stay as long as they want—but not in the ICU. This is perhaps an exaggeration, but not too much of one.
4. **Ethicists and Ethics Committees.** Zoloth-Dorfman and Rubin urge "a recognition of the role of ethics," really, clinical ethicists, "in the process of the debate about health care reform." On the one hand, they argue that ethicists do not stand outside the system of health care. Ethicists are participants, not spectators. On the other hand, they argue that the conflict of interest at the clinical level "in this new form of managed care is so direct, that the social stance of the clinical ethicist as outsider assumes even greater importance." 59 Their point is that ethicists need to take a greater interest in addressing the management decisions that shape policies and ultimately affect the direction of health care. Ethicists seem especially well suited for this task because they straddle the boundary between "inside" and "outside." Yet this posture makes them as vulnerable as any boundary-spanner, and Zoloth-Dorfman and Rubin do not mention the ethicists' own conflict of interest. Obviously, ethicists, like others, wish to please their employers and colleagues. For years, medical ethics as a discipline has been criticized for adopting the agenda of medical professionals, physicians in particular. The interests of ethicists have been shaped by the institutional world they inhabit. Without denying the many contributions of medical ethics, the development of the role of clinical ethicist is no panacea. It does, however, represent a limited institutionalization of ethical concern, as does the development of ethics committees.

Proposals for extension of the ethics committee concept to HMOs and other managed care organizations stress both the departures from and continuities with traditional hospital-based structures. 60 Although commentators stress that ethics

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59 Zoloth-Dorfman and Rubin, "The Patient as Commodity," 353 (emphasis added).
committees should not be given, or attempt to take on, resource allocation, utilization
review or cost containment functions, committees will operate within an environment
constrained and sometimes defined by these functions. Hence, ethics committees are
charged by some with arriving at a sharpened understanding of terms such as "futile" and
"marginal" and "experimental." Such conceptual work cannot be too sharply separated
from the concrete practices of the organization overseen by other committees, and this
suggests that cross-representation between committees may be desirable. No doubt some
would argue that this sort of arrangement compromises the ethics committee and its task.
Certainly there are dangers associated with this approach, e.g., that the ethics committee
deliberations will become a sort of Good Housekeeping seal of approval on policies
established outside the purview of the committee. A lively awareness of the dangers is
the best defense against them. The alternative is to ensure purity by building in
irrelevance. Furthermore, it is to accept a highly questionable model of the ethics
committee's function, one in which the committee becomes the conscience or moral center
for the morally-suspect "body" of the organization. The weight of Deweyan pragmatism
is against this kind of dualism and the hierarchy it implies. In addition to the
development or refinement of the conceptual frame for resource allocation decisions,
topics of great urgency in the managed care context include proprietary practices, that is,
the growing tendency to view innovations that improve patient care as trade secrets to be
kept from competitors rather than as knowledge to be freely communicated for the benefit
of all, ethical aspects of long-term health care in non-hospital settings including the home,

for Managed Care Organizations," *Trends in Health Care, Law & Ethics* 10, no. 1/2 (1995): 87-90; and
Joan D. Biblo, Myra J. Christopher, Linda Johnson, Robert Lyman Potter, *Ethical Issues in Managed
Care: Guidelines for Clinicians and Recommendations to Accrediting Organizations* (Kansas City, Mo.:
and the protection of confidentiality and privacy in light of increased collection and wider diffusion of data.\footnote{On confidentiality and privacy issues, see Ida Critelli Schick, "Personal Privacy and Confidentiality in an Electronic Environment," Bioethics Forum 12, no. 1 (1996): 25-30. The abuses mentioned include the careless failure of some clinics to delete patient identifiers from data sold to drug companies (through an intermediary), the sale of patient information (names, addresses, medical records, and income figures) to HMO recruiters by Medicaid clerks, and entry of data into electronic systems without proper safeguards against unauthorized use. In general, one may question the propriety of sharing patient data beyond the group of persons directly responsible for patient care absent consent (except as required by law), let alone selling it.}

Robert Potter suggests that the most significant task for the ethics committee in a managed care organization is the policy review and development function. The grievance process, rather than the ethics committee, is given the task of individual or discrete case review. Potter calls for an active, integrated model for ethics committees operating within managed care organizations. By this he means that the work of the committee is integrated with quality improvement efforts and includes tasks such as encouraging honest, effective and open communication, adopting and honoring statements of rights and responsibilities, educating employees, providers, and members about ethical issues and the institutional mechanisms available for addressing them, involving providers and members in developing policies and procedures to offer guidance on ethical issues, integrating ethical considerations into decision making at all levels, and ensuring that contracts are with organizations that have compatible policies, procedures and practices.\footnote{These elements are taken from the Midwest Bioethics Center report, Ethical Issues in Managed Care.}

Although this is but an outline, the model gives the ethics committee a comprehensive mission, suitable to organizations that aim to provide comprehensive care. Stanley Reiser, speaking to health care organizations in general and not just to managed care organizations, proposes "administrative ethics rounds" as a way of drawing attention to
the ethical dimensions of the managerial role.63

Proposals to extend structures such as ethics committees and the position of clinical ethicist to managed care organizations are not to be sneered at. Neither are proposals to extend the scope of responsibility of clinical ethicists and ethics committees to include management and policy to be disdained, particularly when the approach recommended is a holistic one. On the other hand, one must remain sensitive to the limits of these structures. A managed care organization in which the decision makers in the first or last instance, the executive officers of the corporation, are not already sensitive to ethical considerations will not support an ethics committee that makes the integration of ethical considerations into decision making at all levels and the monitoring of contractors for ethical compatibility a part of its mission. The ethicist or ethics committee can only be effective within an organization that has some ethical commitments.

**External Regulation and Oversight**

1. **Media scrutiny.** The first item on the list of recommendations presented by Zoloth-Dorfman and Rubin is a "vigorous public press." Dewey and Tufts also suggest that publicity may shame corporate leaders into more ethical conduct. Further, publicity provides the impetus for the lawmaking that they believe is necessary to free the morally disposed from unscrupulous competition. The power of the media is demonstrated in the awakening of public outrage over "gag rules" (restrictions on communication in physician contracts), "drive-through deliveries" (early postpartum discharge), and so on. Yet a vigorous public press may be met by a wall of silence. Journalist Dave Lindorff found physicians affiliated with for-profit corporations were sometimes unwilling to venture a

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critical comment about their business partners. Further, the press may compress material
to fit within its own space-time matrix, the available space on the page or time on the air,
or to fit with its perception of "what the public wants" in the way of drama or simple
truths—note the catchphrases in use for the abuses thus far brought to light.
Complexities and ambiguities will often be neglected.

2. **Threat of litigation.** The courts are another external mechanism for disciplining
individual practitioners and managed care organizations, and the same is true of arbitration
panels. Many managed care organizations include an arbitration clause in their contracts.
They apparently believe that the arbitration process is less expensive or that they will
receive more favorable treatment. The $1.02 million award in the deMeurers case came
from an arbitration panel, which found that Health Net was contractually obligated to pay
for deMeurers's bone marrow transplant and that Health Net wrongly interfered with the
doctor-patient relationship. The panel declared that interference within the legal
definition of "extreme and outrageous behavior exceeding all bounds usually tolerated in a
civilized society."\(^{64}\) Arbitrators do not always favor HMOs.

Defenders of financial incentives to limit services may point to the fear of
malpractice liability as a deterrent to deficient—as opposed to conservative—practice on
the part of physicians. We know that the threat of liability has some influence on the
behavior of some physicians, but malpractice liability is scarcely a predictable outcome of
deficient practice, and hence one would not wish to rely on it exclusively. Such reliance
would be especially foolhardy in light of proposals to sharply limit the amount and/or
availability of relief. In a number of malpractice suits, the managed care plan has itself

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been named as a defendant. The view of corporate moral responsibility presented in Chapter 5 supports this practice. It is extremely edifying to observe how some managed care organizations try to shield themselves from liability for the conduct they engender. Either they avail themselves of the protection of a federal law, or they go through contractual contortions to deny on paper the influence they exert in practice. (Courts have held that the federal Employee Retirement Income Security Act of 1974 or ERISA preempts state tort actions against health plans for harms that allegedly result from plan design in cases involving self-insured employers.) Similar efforts are undertaken to dodge liability for wrongs committed directly by the organization, e.g., breach of contract, bad faith, or intentional infliction of emotional distress.

3. **Government regulation and oversight.** Nearly every ethicist who has examined the ethics of managed care has called for increased regulation of managed care organizations. Swartz and Brennan propose that existing state regulations, which may be limited to certain classes of managed care organizations, be extended to cover all such organizations. The ERISA barrier to the progress of state tort actions would be removed. They also advocate legislation that would impose limits on capitation, mandate the oversight committees described above, and require public disclosure of incentive structures and health care outcome data (after adjustment for clinical severity).66

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66The record in states that have mandated collection and reporting of outcome data (risk-adjusted mortality after coronary-artery bypass surgery) is mixed. There is evidence of some improvement in quality, but little evidence that patients have paid attention to the data. Also, some physicians and hospitals have
Latham's recommendations for regulation of incentives to physicians have already been discussed in some detail. Emanuel and Dubler want an independent review board to assess quality indicators. The simple availability of a managed care ombudsman in the state agency that regulates insurance might make a significant difference. Plan members experiencing problems would benefit from the opportunity to discuss their complaints with a person sympathetic to their interests and knowledgeable concerning the organization of plans and the legal requirements affecting them. It is significant that federal and state governments also regulate managed care by setting standards for participation in the Medicare and Medicaid programs and benefit programs for government employees such as the Federal Health Benefits Program.

Physicians' organizations have lobbied vigorously for legislation that would require a managed care organization to contract with any physician willing to accept its payment rate and basic terms. These bills are often termed "Patient Protection Acts." The label is rather disingenuous, since this type of legislation seems intended to protect physicians as much as patients. Few seem concerned to distinguish between physician selection criteria that have to do with quality and those that have to do with a history of low utilization, for example. Also, a managed care organization's ability to offer lower premiums may be contingent upon its ability to negotiate lower rates with physicians and other providers, which may be contingent upon its ability to promise a certain volume of patients to those providers. Managed care organizations cannot make such commitments absent some control over the make-up of their provider panels. Ethicists have not been engaged in strategic behavior in order to improve their statistics, e.g., changing their coding practices so that more patients are listed as having coexisting conditions going into surgery, and refusing to operate on severely ill patients. See Blumenthal and Epstein, "The Role of Physicians in the Future of Quality Management," 1329.
terribly enthusiastic about these acts, favoring instead legislation that gives patients direct access to certain specialists and mandates minimum stays for certain procedures.⁶⁷

Many of the proposals for increased regulation seem sensible, as far as they go, although a superstructure of review boards may prove excessively cumbersome or inflexible in practice. The more general problem is that they do not go all that far, being mainly formal or procedural, and it may be very difficult to enact even such limited forms of regulation and oversight in the current environment. Zoloth-Dorfman and Rubin point with approval to a California law that requires certain plans and insurers to provide subscribers suffering from terminal illnesses with a statement of reasons for a denial of coverage for a treatment or service on the grounds that it is experimental. Legislation that renders the organization and its processes less opaque to members and grants them a right to be heard and to receive a response is certainly to be approved. Zoloth-Dorfman and Rubin see a connection between this type of legislation and collective civic discourse that extends beyond the boundaries of any particular organization. They state that "[s]uch a regulation opens the door for the formation of an ethical and moral community in much the way that early discussions about the Quinlan case suggested the emergence of ethics committees."⁶⁸

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⁶⁷See Judith Haverman, "HMOs, Doctors Battle in State Legislatures Over Managed Care Limits," in 1996 Health Network & Alliance Sourcebook, C141-C42 at C141. Seven states have enacted any-willing provider laws that cover most providers, and 31 states have passed any-willing provider or freedom-of-choice laws restricting managed care plans from selective contracting with pharmacies. But the trend is to focus directly on preserving or enhancing the quality of care. In 1994, legislatures passed the first laws that provide enrollees in managed care plans with direct access to certain types of specialists, and in 1995, the first laws that require minimum lengths of stay for deliveries. Whereas most any-willing provider and freedom-of-choice laws have been enacted in states with low levels of managed care penetration, the reverse is true of direct-access and mandated minimum stay laws. Fred J. Helling, "The Expanding Scope of State Legislation," J.A.M.A. 276 (1996): 1065-70.

⁶⁸Zoloth-Dorfman and Rubin, "The Patient as Commodity," 352. Subscribers are also to receive a description of alternative treatments covered by the plan and a copy of the plan's grievance procedures. The plan has to provide a "conference" to determine the disposition of any complaint within thirty days (five days if the illness warrants).
Managed care has provoked public discussion, much of it unfocused, but it is difficult to see how the procedure mandated by the California law creates a moral community. It seems an essentially private response to the problems made visible, if not created, by managed care. Zoloth-Dorfman and Rubin propose that a similar process would allow for "community-based reflection" on the issues of tort reform, disclosure of incentives and coverage limitations, and post-partum care. Legislation is necessary to establish minimum standards and to give aid and comfort to the morally disposed. Still, legislation has its limits; by its nature it tends to generate procedure rather than goodness. Further, it bears repeating that the political sphere is also the playground of large corporations and other interest groups. A review of some of the recent legislative and administrative battles over managed care at the national and state levels scarcely inspires confidence. Legislative and regulative processes should not be relied on as the ultimate guarantors of ethics and quality in health care. These processes are but pieces of the whole, as Zoloth-Dorfman and Rubin recognize.

4. Purchasing Cooperatives/Large Employers. In the same way that the government may exert influence as the administrator of programs that managed care organizations want to participate in, purchasing cooperatives or employers that control large numbers of "covered lives" can set the agenda for plans in their regions. Some benefits managers have used this power to force managed care organizations to offer standard benefit structures. This standardization prevents risk selection—the design of coverage options to appeal to certain desirable classes of potential plan members—as well as permitting employees to better understand coverage and make comparisons. It also allows benefits managers to begin to evaluate the relative efficiency of managed care
organizations. One may bemoan this intervention as an instance of paternalism. Indeed, it might be preferable to sever the tie between health care and employment, a tie that is largely an accident of history (the exclusion of health benefits from government wage and price controls in wartime). At the same time, some benefit managers are knowledgeable and effective intermediaries between employees and managed care organizations. They keep the managed care organizations honest. Given the system we have, their efforts are, for the most part, to be welcomed.

Outcomes research and the plight of the "least advantaged"

Proceeding in an empirical mode, we are accustomed to turn to the data. It is difficult to argue that generic "fee-for-service" practice produces health outcomes which are superior to generic "managed care" practice. A number of research studies, some involving vulnerable populations, seem to demonstrate that managed care results in improved health outcomes. For example, a recent study of patients with rheumatoid arthritis found similar utilization and outcomes for persons with rheumatoid arthritis in fee-for-service and prepaid group practice settings. On the other hand, the troubling findings of the Medical Outcomes Study (MOS) cannot be ignored. The MOS was a four-year observational study of 2235 patients (aged 18 to 97) with hypertension, non-insulin-dependent diabetes mellitus, recent acute myocardial infarction, congestive heart failure, and depressive disorder. Data was collected in 1986, with follow-up in 1990.

The data for patients over 65 covered by Medicare and low-income patients (200 percent

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70 See Miles and Koepp, "Comments on the AMA Report," 308, 311, n.11, for a staggering number of citations.

71 Edward H. Yelin, Lindsey A. Criswell, and Paul G. Feigenbaum, "Health Care Utilization and Outcomes Among Persons With Rheumatoid Arthritis in Fee-for-Service and Prepaid Group Practice"
of poverty) were analyzed separately. The study compared practice styles and outcomes for patients treated in staff-model or independent practice association-model HMOs with similarly circumstanced patients treated in large multispecialty groups, small, single-specialty groups, and solo practices compensated on a fee-for-service basis. The investigators found that physical and mental health outcomes did not differ for the average patient; however, they did differ for sub-groups of the population differing in age and poverty status. Outcomes favored fee-for-service over HMOs for the poverty and elderly groups and favored HMOs over fee-for-service for the nonpoverty and nonelderly groups. Elderly and poor patients were more than twice as likely to decline in health in an HMO versus a fee-for-service plan (68 percent declined in physical health in an HMO versus 27 percent in fee-for-service). (However, in one of the three study sites mental health outcomes were better for elderly patients in HMOs relative to elderly patients treated on a fee-for-service basis.)

Likewise, the RAND Health Insurance Experiment found that while the average patient did very well in an HMO, people who were both poor and sick were likely to suffer in a system that required co-payments or used other incentives to patients to decrease inappropriate utilization of health care services. And given the demand of pragmatic justice that people be enabled to meet their own needs, the findings of a study commissioned by the Health Care Financing Administration command special attention. Researchers found that HMOs handled their home-care patients faster, cheaper and less effectively than providers compensated on a fee-for-service basis under traditional

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72 John E. Ware, Jr. et al., "Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems," JAMA 276 (1996): 1039-1047.
73 See Joseph P. Newhouse, Free for All? Lessons from the RAND Health Insurance Experiment
Medicare. The HMOs spent an average of $877 per case and approved an average of 12.7 post-hospitalization home-care visits, compared to $1305 per case and 18.8 visits for traditional Medicare. The patients with traditional Medicare had significantly more favorable outcomes. They were more likely to be able to feed themselves, use the toilet on their own, manage their medications, and shop for themselves. The lead researcher concluded, "HMOs tend to approach some aspects of home health care with more of a maintenance philosophy rather than a rehabilitative/restorative philosophy."\(^{74}\)

Further, managed care is likely to worsen the situation of all of lack insurance. The cost-shifting that supported some care for the uninsured in mainstream health care institutions is no longer possible in a world where costs for insured patients are relentlessly driven down. Public hospitals and community health centers, which have taken as their primary mission provision of health care to those who are unattractive to other providers, have used Medicaid and Medicare funds to cross-subsidize care for the uninsured. Some managed care organizations now believe that there is money to be had in care for the insured poor—especially if they can pick off the healthiest by legal or illegal means.\(^{75}\) That leaves public hospitals and community health centers to care for the sickest insured at a loss and to provide totally uncompensated care to the uninsured.\(^{76}\)

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\(^{74}\)Anders, *Health Against Wealth*, 185.

\(^{75}\)In at least one instance, HMO recruiters purchased patient names, addresses, medical records, and income figures from Medicaid clerks. See Schick, "Personal Privacy and Confidentiality."

\(^{76}\)For a discussion of the effects of managed care on community health centers, see Helen Halpin Schaufler and Jessica Wolin, "Community Health Clinics under Managed Competition: Navigating Uncharted Waters," *Journal of Health Politics, Policy and Law* 21, no. 3 (1996): 461-88. Managed care plans receive 95 percent of the average cost of a beneficiary in the traditional Medicare program in a particular county. A study conducted by Mathematica Policy Research found that private plans actually save 10 percent on each beneficiary owing to economies generated by managed care strategies and their ability to pick off the healthiest Medicare patients. Average cost figures include components for care for the uninsured and medical education, hence these are passed along in the 95 percent rate—this despite the fact that many managed care plans provide no care for the uninsured and do not support medical education. Martin Gottlieb, "Health Lobbyists Win Adjustments to Medicare Plan," *New York Times*, 10 December 1995, 1.
There may be a silver lining to this, a gathering of will to address a newly visible problem. In the meantime, the suffering occasioned by the disruption of settled patterns for coping is increasing.

If we take Rawls's difference principle seriously as a kind of filter, directing our attention to the plight of the least advantaged, then we will be unable to simply shrug off these findings. Yet we may express reservations about broad-brush comparisons. In the MOS study, HMOs located in one study site seemed to have organized mental health services in a manner that produced superior outcomes for the elderly. Some forms of managed care might provide more comprehensive services and result in better outcomes for those with chronic conditions. And, in general, we can argue about whether it makes sense to posit a tight causal connection between payment structures abstractly considered and particular outcomes, good or bad.\textsuperscript{77} One has to look at how concepts work out in practice in particular contexts, something statistics may hide.

Finally, much of what we care about morally is particular rather than general. We care that a statistically significant number of patients does better (or worse) under managed care. On the other hand, we also care that this particular patient was denied a potentially beneficial treatment, or given inadequate pain medication, or treated with rudeness, or lied to, and that this particular physician was reprimanded for spending too much time with a distraught patient, or recommending a potentially beneficial treatment not covered by the HMO. We care that the health status of this group of patients

\textsuperscript{77}For example, William Glaser, author of the basic texts on incentives in health care, writes: "At the start of a research project, it is easy to predict that some payment systems control costs, inspire efficiency, and foster good care better than others. Such predictions actually are based on theoretical incentives rather than reality. After studying each payment system's history and after comparing countries, one has to conclude that all these hypotheses fail. Overriding the potentials of all payment systems is how they are administered by governments, payers, hospital managers, and doctors." William A. Glaser, \textit{Paying the
improved because the HMO put a great deal of thought, time, effort and money into designing an effective health education and disease prevention program. We care that this particular patient felt better, even if he had no hope of getting better, because someone took the time to respond to his concerns and helped his family come to terms with the situation. We may want something more from persons, and institutions, than simple conformity to certain general requirements.

3. The Return to Character

Then, too, consideration of this or that structure in isolation is no substitute for the total complex that Dewey and Selznick label character. For example, a written policy may provide for and even encourage practitioners to be open with patients. I have already touched upon the movement, through publicity and legislation, to eliminate provisions in contracts that restrict communication with patients. A written policy favoring open discussion with patients should prevent a plan from "dropping" a physician for the stated reason that she discussed the plan's coverage limits with a patient. But it will not give the physician the kind of freedom associated with membership in an organization that truly values openness. It will not allow the physician to speak critically about the plan to the media without fear of reprisal. It will not prevent the kind of situation described by Zoloth-Dorfman and Rubin in their piece on managed care. A surgeon believed that an inexpensive histopathological confirmation was necessary to rule out an admittedly remote chance of malignancy following surgical removal of some tumors. Informed by the patient that his HMO would not pay for the test, the surgeon explained his reasoning to the HMO, citing the literature. The HMO

Hospital: The Organization, Dynamics, and Effects of Differing Financial Arrangements (San Francisco:
would not yield. The surgeon felt so strongly that the exam was indicated that he sent the specimen to the lab at his own expense. On the advice of his liability carrier, he documented his communications with the HMO and sent copies to his local medical society. Thereafter, he received his first ever negative rating on quality from the HMO, and he was punished with the loss of sixty-five percent of the HMO's withhold of ten percent of total reimbursement for the year. A letter from the HMO stated: "The forwarding of a copy of your letter to the patient and to [the local medical society] suggests strongly that you are not acting in a collegial mode with us in this matter." 78 The implicit message, one the surgeon got very clearly, was that further action in a "non-collegial mode" would result in removal from the HMO's panel and the loss of a substantial number of patients.

78Zoloth-Dorfman and Rubin, "The Patient as Commodity," 343.
Interlude: The Virtues of Pessimism

While Dewey appreciates the goods of community, and thinks it important to nourish local forms of association, he is too critical of the past and too open to the future to fall prey to nostalgia. He is ready to relinquish groups based on "physical contiguity," the small New England town and the close urban neighborhood, in favor of groups with a "functional" basis, i.e., groups established on the basis of common needs and interests. (FC, 161) The continuity between the two forms of association is in the resistance they offer to the "centrifugal forces" of the modern world, the large corporation and central government. Also, Dewey usually avoids a simple-minded optimism or faith in progress. He has faith in human beings, and in the survival of moral concern under the banner of humanism, but he has a view of the world and of history that contains sufficient complexity and unpredictability to thwart the most intelligent efforts at social engineering. Further, he is too closely involved in social life to retain many illusions about the enormity of the problems to be overcome in approximating the ideal. On the virtue of moral courage, Dewey writes:

The individual whose pursuit of the good is colored by honest recognition of existing and threatening evils is almost always charged with being a pessimist; with cynical delight in dwelling upon what is morbid, base, or sordid; and he is urged to be an "optimist," meaning in effect to conceal from himself and others evils that obtain.... Hope and aspiration, belief in the supremacy of the good in spite of all evil, belief in the realizability of good in spite of all obstacles, are necessary inspirations in the life of virtue. The good can never be demonstrated to the senses, nor be proved by calculations of personal profit. It involves a radical venture of the will in the interest of what is unseen and prudentially incalculable. But such optimism of will, such determination of the man that, so far as his choice is concerned, only the good shall be recognized as real, is very different from a sentimental refusal to look at the realities of the situation just as they are. In fact a certain intellectual pessimism, in the sense of a steadfast willingness to uncover sore points, to acknowledge and search for abuses,
to note how presumed good often serves as a cloak for actual bad, is a necessary part of the moral optimism which actively devotes itself to making the right prevail. (EI, 413)

This creed has governed much of Selznick's work, and explains both its "exposé" character and its hopefulness. The guiding hope is that through criticism comes learning and, ultimately, improvement.

Still, the claims that Dewey and other liberals are overly optimistic about human capacities, to their own detriment and the detriment of societies captive to their ideas, are not totally without evidentiary support. Dewey calls attention to the significance of unintended consequences and the limits of rationality, but he cannot give up the idea that reason must prevail. Commenting on the currency of the doctrine of self-assertion in his day, he writes: "Humanity has long lived a precarious and a stunted life because of its partial and easily shaken hold on natural resources. Starved by centuries of abstinence...it is not surprising that it should be intoxicated when scientific discovery bears its fruit of power in utilization of natural forces, or that, temporarily unbalanced, it should take the external conditions of happiness for happiness itself. But when the values of material acquisition and achievement become familiar they will lose the contrast value they now possess; and human endeavor will concern itself mainly with the problem of rendering its conquests in power and efficiency tributary to the life of intelligence and art and social communication. (emphasis added)" (EI, 374) Niebuhr,¹ and C. Wright Mills, no doubt with reference to this sort of thing, charge Dewey with promoting a naive "cultural lag" theory.

Niebuhr, in particular, argues that the "constitutional weakness" of the liberal approach is a failure to perceive the inevitable subordination of reason to interest. The cultural lag theory does not grasp the nature of resistance to change; it suggests that the social customs and beliefs which it labels ideology were once functional for the society as a whole, and have only become instrumental to certain limited interests in being retained past the point of social utility (in light of changed conditions). Niebuhr argues that social customs and beliefs always serve to create and maintain the prerogatives of certain groups. This does not mean that violence is inevitable in order for change to occur, but it does mean that the avoidance of violence depends on considerations other than the spread of freed intelligence. Niebuhr stresses, for example, the formation of political alliances among "disenfranchised" groups. For Dewey, a recognition that, by its nature, the social sphere sometimes requires that problems be solved through a conflictual process is sufficient evidence of his sensitivity to the limits of intelligence. Looking back, and forward, I am inclined to judge both correct. In certain areas of social life, if conditions are right, we are capable of doing better than Niebuhr's vision suggests. On the other hand, in far more circumstances than Dewey might be willing to concede, Niebuhr's power politics may be the best we can do. We should cultivate fora in which democratic practice can flourish, but we are hopelessly naive if we believe that we can oppose the democratic ideal alone to the financial and political muscle of giant corporations.

Further, I believe Niebuhr is the clear winner in the crystal-ball gazing competition with Dewey. In Niebuhr's view, the conquest of nature has exacerbated rather than eased the problem of justice. Human desires and ambitions are without natural limit. That said, the open frontier and the vast supply of natural resources long available for exploitation
have allowed us to defer certain conflicts. Niebuhr saw the clock running down, and his hope, as venturesome as Dewey's, is that such conflicts might be defused or ameliorated by attending to the root: "It would, of course, be foolish to deny the moral and spiritual significance of the 'conquest' of nature in our civilization or to yearn after the poverty-stricken conditions of nontechnical societies.... But it is also true that this dominion cannot annul nature's final triumph over man.... The only possible triumph over death for man is a triumph of faith, which is to say a conception of the meaning of life from the standpoint of which death is not the annulment of all meaning."² How to choose between a pessimistic optimism, and an optimistic pessimism? Pragmatism exists in that tension. Dewey's pragmatism reminds us, more forcefully than Niebuhr's, that meanings are shared. Niebuhr stresses the need to come to terms with our fears and insecurities. Wherever one chooses to place the accent, one cannot be a pragmatist without cultivating the virtue of humility as well as hope. On this point, Dewey and Niebuhr are in agreement.

Chapter Seven: Can Care Survive Managed Care? A Character Study and a Look to the Future

To my mind, the proper perspective of the social critic is that of the moral pragmatist. The latter does not shrink from symbolism nor does he reject the rhetoric of hope and aspiration. He knows that a steady diet of cynicism and self-doubt can be spiritually corrosive and politically enervating. Therefore he cannot forego ideology. Yet as a pragmatist he seeks never to lose his critical sensibility, never to stop asking whether the end he has in view or the means he uses are governed by truly operative criteria of moral worth. Therefore he strives to think concretely, to look at real choices and trace their actual consequences. And the consequences he has most in mind are those that redound back on the character of the actor.

—Philip Selznick, Preface, TVA and the Grass Roots

If you’ve seen one HMO, you’ve seen one HMO.

—popular adage (among health care analysts)

Heeding Dewey’s call to survey the field to “extract the desirable traits of forms of community life which actually exist,” I present a study of the character of one the oldest managed care organizations in the United States, Kaiser Permanente. The Kaiser example shows some of the ways in which managed care might improve health and health care and contribute to the “development of local agencies of communication and cooperation.” It also illustrates some of the perennial problems of organizations, the force of ethical concerns about features of managed care such as the reliance on cost-benefit analysis, and the challenges faced by health care organizations with a sense of mission in a time of rapid change and great uncertainty. I close with a look at the future of managed care.

1. Kaiser Permanente

The Kaiser Permanente Medical Care Program is one of the oldest and largest health maintenance organizations in the United States. Henry J. Kaiser, a prominent
industrialist, founded the program in the 1930s to provide health care to workers in remote locations. In the 1940s, the program was opened to the public at large. It consists of the Kaiser Foundation Health Plan, a not-for-profit health plan corporation that enrolls members, manages finances, and maintains membership records; Kaiser Foundation Hospitals, a not-for-profit hospital corporation that owns and operates a number of hospitals and medical offices; and the Permanente Medical Groups, independent professional corporations organized by region to provide medical care to plan members. The corporate family also includes the Kaiser Permanente Center for Health Research, which was founded in the 1960s to conduct health services research at Kaiser facilities. Kaiser currently has approximately 6.6 million members. (Facing increasingly aggressive competition, the program experienced its first decline in total membership in 1993.) Its net income for 1993 was $848 million, on revenues of $12 billion.\(^1\)

The leadership of the medical groups is determined by the physicians in the particular region, in periodic elections. David M. Lawrence is currently chairman and chief executive officer of the Plan and Kaiser Foundation Hospitals. Before joining Kaiser, Lawrence served as a county health officer, an academic physician, and a Peace Corps doctor. Lawrence failed to join Greaves and Hasan on the list of managed care’s ten highest paid executives for 1993; in 1994, he earned a relatively modest $600,000.\(^2\) In 1994, Lawrence gave an extensive interview to John Iglehart, in which he shared his philosophy—and the philosophy of his organization. Referring, perhaps, to the organization of medical groups by region, Lawrence remarks that, "While we have a


national presence, our health plans and physicians are community based, and they respond to local members and community needs." Integration is central to the organization's identity, but this is distinguished from centralized ownership and control. A prepaid, capitated payment covers a full range of services, "whether provided in a hospital, a doctor's office, or the patient's home," but these services are coordinated at the regional level. Lawrence contrasts this approach with that of the more common IPA HMOs, in which the planning of physicians, hospitals, and home health agencies is not directly tied to the HMO. Concerning Kaiser's not-for-profit status, he says, "The net income we generate is used solely for the benefit of members—to provide facilities, purchase medical technology, and fund health care research and innovations. This amount is planned, based on capital needs, and we make no attempt to maximize earnings." (On the other hand, under pressure from purchasers, Kaiser does attempt to minimize costs. Kaiser reportedly has plans to cut costs at least five percent per enrollee for each of the next five years.)

Lawrence is an articulate spokesman for Kaiser, and for its style of managed care. He also has a coherent vision. This becomes ever more apparent in the course of the interview, as Lawrence and Iglehart tackle increasingly knotty issues. Asked about the use of financial incentives in a managed care system, and the associated risks of undertreatment, Lawrence says there are risks, "particularly in organizations in which the profit motive is dominant and understanding of health care delivery is minimal." On the other hand, "the opportunities in prepayment are great, not only in rational organization

3 Unless otherwise indicated, all of the quotations that follow are taken from Iglehart, "Changing Course in Turbulent Times," 66-77. The text follows the flow of the interview, hence particular page citations are omitted.
4 Louise Kertesz, "Kaiser Physicians Unhappy with Changes, Memo Says," Modern Healthcare, 19
of health care delivery, but also in the incentives to provide preventive services and early
intervention in the disease process.” Lawrence then takes issue with the question, for
implying that the incentive effects of fee-for-service payment are benign. Lawrence adds
that we need to rely upon the character of health care professionals, “but we also need
government regulation to assure that the more egregious abuses are detected and their
practitioners barred from practice.”

Perhaps following up on Lawrence’s reference to the profit-motive, Iglehart asks if
Kaiser is "really any different than a for-profit managed care plan that is driven by its
bottom-line considerations." Lawrence responds:

Absolutely. We are different in several ways. We operate on the social
insurance, not the commercial insurance, side of the spectrum. We do not
underwrite groups and have no preexisting condition exclusions for groups.
We have always offered to convert to an individual membership, without
medical review, members who have lost their group coverage. We were
forced by the market to abandon community rating and adopt adjusted
community rating, which charges groups based on their past use and
demographics. Even so, we placed an upper cap on the amount we charge
small groups and individuals under adjusted community rating, and we
established a dues subsidy program to subsidize the coverage of low-
income persons.

Kaiser has clearly been unwilling to "go it alone" against increasingly severe economic
pressures, to the point of institutional suicide. It is no martyr among organizations. At
the same time, its distinctive commitments have shaped its response to the forces of the
market, and the environment generally. It has tried to mitigate the negative consequences
of its adaptation to market conditions. And it is interesting that Lawrence’s response
stresses the ways in which Kaiser is structured to serve interests other than the

February 1996, 12.
generation of profit. Yes, Lawrence argues that Kaiser's dedication to social service
distinguishes it from its for-profit competitors, and one may rightly be skeptical of such
self-serving rhetoric. However, the argument is anchored in the various ways Kaiser has
institutionalized its social commitment through specific policies and practices.

Iglehart also asks about the conflicts between "medicine" and "management." He
has in mind battles between medical directors and plan managers over resource allocation.
Lawrence replies that viewing the relationship exclusively in these conflictual terms, one
can never do justice to Kaiser's approach to allocation decisions. Kaiser's approach—by
which Lawrence appears to mean a species of global budgeting and supply side
controls\(^5\)—does not eliminate all conflict, but it does create agreement on broad principles
that prevent conflict from escalating into warfare or a mere contest of forces:

Our approach—so greatly misunderstood by critics—involves changing
the economics and delivery of health care so that it is possible to provide
the right care at the right time and place. Management and medicine work
together to achieve this kind of efficient, high-quality care with the
appropriate consumption of resources. What happens when the quality of
medical care is high? Costs go down. So managers and physicians have a
common vision. While at times there may be dynamic negotiations
between the medical directors and regional managers, this shared vision
takes a lot of the unhealthy tension out of the relationship.

From the member's point of view, being in a group-practice HMO
means that physicians can truly be patient advocates, because individual
clinical decisions do not directly affect physicians' income. Knowing that
patients will not be financially burdened also frees physicians to base
clinical decisions on what is medically appropriate and to provide care in
the setting that best meets the patient's needs.

This presentation is no doubt simplistic. For example, it is hard to see any

straightforward connection between high quality and low costs. But the basic point

\(^5\)See, e.g., the exchange between Dr. Les Zendle of Kaiser and Drs. Grumbach and Bodenheimer published
seems to be that Kaiser has been at least partially successful in creating a system in which administrators and physicians, and physicians and patients, have reason to trust one another. There may still be conflict, but conflicts emerge against a background of agreement on certain shared principles and priorities.

Asked about the prospects for "professionalism" in health care, Lawrence provides information on how Kaiser compensates physicians. Base salary is determined by the leadership of each medical group. It may be supplemented by limited-incentive compensation related to regional financial performance, member satisfaction, and improvements in population health; there are no incentives related to frequency of specialty referrals. The medical group that serves Southern California recently extended incentives to nurses, nurse practitioners, and physician assistants, drawing the ire of the California Nurses Association. Annual payments on the order of $500 to $800 per employee will be awarded if the Southern California operations meet goals set for reductions in operating costs, and increases in enrollment and member satisfaction. Leaders of the CNA object to the contamination of nursing by the sorts of conflicts of interest now common for physicians. Others might find this extension a welcome move toward greater egalitarianism among professionals in the health care field.6 Perhaps suggesting a counter-trend, some Kaiser physicians have discontinued their incentive payments for shortening hospital stays and prescribing less costly drugs.7 Clearly, members of the Kaiser organization share in the professional ambivalence concerning

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financial incentives exhibited by the AMA. There is a sense that weak incentives, especially incentives tied to "quality," have generally positive effects, as prods to cost-awareness and the adoption of a true customer-service orientation. At the same time, there is fear that an increasing reliance on external incentives will erode internalized commitments to competence and compassion, and that patient trust in practitioners will be undermined.

Earlier in this dissertation, I suggested some difficulties with definitions of quality. A reasonably clear specification of what quality entails seems essential if we are to make meaningful comparative judgments. Yet agreement has proved elusive. Lawrence's views on the topic may therefore be of interest. In his opinion, there are three critical elements of quality. The first element of quality is the relationship between patient and provider. The second element is the impact of care on populations and the application of knowledge concerning prevention, health education, and early intervention. Effectiveness in this area is measured in mortality and morbidity rates by gender, age, and ethnicity. The third element is cost. The third element is related to the second: "Whether we are misusing those resources has a great deal to do with whether we will be able to meet the needs of various populations."

Finally, I am struck by what Lawrence says about standards for judging the performance of managed care organizations. He calls for a combination of government regulation and monitoring by what he calls "leading-edge employers," no doubt the kind of corporations sophisticated enough to appreciate Kaiser's approach to health care. He concludes his comments on standard-setting by remarking that he would like to see the National Committee for Quality Assurance and other organizations "expand their reviews
to include the ethics of decision making related to benefits and care decisions—who makes the decisions, and by what process and ethical standards." Although some of Lawrence's statements seem rationalistic, this sort of comment is bound to endear him to ethicists, and those who are persuaded that fact and value are intertwined. If "technical" or "scientific" judgments are also judgments of value, then it is important to acknowledge this and openly discuss the values at stake. Explicitly incorporating ethical concerns into standards forces organizations to confront these issues, even if they only do so in a cursory or superficial way.

As I have said, Lawrence is an articulate spokesman for his organization. This is certainly a valuable quality in a leader, but are his words borne out in Kaiser's practices? To a certain extent, yes. Take the issue of financial incentives. There is evidence that Kaiser's integration of care and its mode of paying physicians—as aspects of Kaiser's distinctive corporate character—do make a difference. In December of 1995, the New York Times ran a series of three articles on kidney dialysis. The second article in the series focused on the practices of National Medical Care, at the time the largest provider in the competitive dialysis business in the United States. According to the Times, National Medical ensured the loyalty of kidney specialists by offering them profit sharing and extravagant perquisites. The supervisor of one clinic, a Dr. Roland, owned a Rolls Royce. National Medical reportedly paid for the insurance on this vehicle, and covered some of Roland's personal credit card bills as well. His partners were not pleased when they uncovered this arrangement. "Worse," they discovered that National Medical "was also secretly splitting the clinic's profits with Dr. Roland: he was pocketing more than
$250,000 a year, and in some years far more, for a few hours of work a week." Why was National Medical willing to be so generous? Dialysis can be a very lucrative business. Payment is steady—the federal government covers eighty percent of the total price tag for dialysis as a special item under Medicare. And according to the *Times*, National Medical used old dialysis machines and reused disposable equipment, thus keeping costs low. Dialysis providers in the United States have also been criticized for shifting duties from doctors and nurses to poorly trained, lower paid employees. Through profit sharing and more creative arrangements such as the one worked out with Roland, companies such as National Medical acquire access to the flow of patients controlled by kidney specialists, and an "edge" on contracts to provide dialysis services to hospitals.

The *Times* reports that Roland's disgruntled partners eventually decided to do business with a new company started by defectors from National Medical. The new company, West Coast Medical Specialties, offered state of the art dialysis machines, refused to reuse equipment, and offered better pay and benefits for nurses, along with profit sharing for physicians comparable to National Medical's. West Coast quickly attracted several hospital contracts, including three lured away from National Medical. Displeased, National Medical decided to sever its ties with Roland, and offered his old partners Roland's share of the spoils. The fickle partners promptly switched their allegiances back to National Medical. West Coast was informed that the partners, and their new patron, National Medical, would allow West Coast to keep the contracts it had already won, but only on condition that it not pursue any more contracts in the region. West Coast was awarded another contract, and was given an ultimatum: return the

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contract, or be driven out of business. West Coast refused to yield, and National Medical sued, accusing the company of stealing "trade secrets." With the litigation in progress, West Coast's sources of funding dried up. There is also evidence that National Medical used its size and financial muscle to dictate terms to area hospitals which virtually ensured that it would be awarded all future contracts. Although the allegations summarized in this account must be treated cautiously, the article on National Medical Care at least points to some of the abuses that might arise in connection with fee-for-service payment.

According to the third article in the Times series, the annual mortality rate for dialysis patients in the United States is twice that of Japan and some European countries. But the picture is far from uniform. Government statistics reveal that Kaiser patients are hospitalized for less than a third as many days annually as the average dialysis patient, and are nearly twice as likely to work or attend school full-time. Further, "even though Kaiser treats a larger-than-average number of diabetics—a group with a higher death rate among dialysis patients—its annual mortality rate is sixteen percent, almost a third below the national average for all patients." Kaiser dialysis clinics do not reuse blood lines, and Kaiser offers patients a choice between cleaned and reused dialyzers and new devices (first use of new devices has been associated with adverse reactions) and replaces its dialysis machines approximately every five years. Because Kaiser is an integrated system, it has a financial incentive to keep patients out of the hospital—it knows it will end up paying the hospital bills. (Of course, in theory an HMO could erect barriers to hospitalization, speeding its sickest and costliest dialysis patients to the grave. Its

mortality statistics would suffer, but these are not routinely disclosed.) And Kaiser's 
* salaried* kidney specialists have no financial incentive to scrimp on care. Dr. Hock Yeoh, 
the medical director for Kaiser's Los Angeles unit, tells the reporter for the *Times*, "Here, 
you're not driven by how much money you can get from the patient. You just do what is 
best for them."9 One would hardly expect him to say otherwise. Still, a specialist looking 
to get rich would never join Kaiser; the average salary of around $150,000 is far less than 
one might earn elsewhere. Kaiser's integrated approach is also reflected in its staffing 
patterns. The dialysis unit in Los Angeles is staffed by at least two of its six kidney 
specialists, as well as registered nurses, dietitians, and social workers.

Kaiser, like other managed care organizations, has made rationing decisions. 
Lawrence alludes to these decisions in a general way in his interview. We have special 
insight into the process at Kaiser thanks to Dr. David M. Eddy, a regular columnist for 
*JAMA* who also happens to be a consultant to Kaiser Permanente Southern California 
Region (KPSC). In one of his columns, Eddy describes how KPSC developed a practice 
guideline for the intravenous use of iodinated contrast agents for radiographic procedures. 
Eddy states that nearly ten million of these procedures are performed in the United States 
each year. For decades, use of agents with a relatively high osmolality—"high osmolar 
contrast agents" or HOCAs—was standard. According to Eddy, HOCAs have "excellent 
diagnostic properties," but can cause discomfort and adverse reactions. In the 1980s, a 
new set of agents were developed that lowered the risk of discomfort and adverse 
reactions. Known as "low osmolar contrast agents" or LOCAs, these agents cost ten to 
twenty times as much as HOCAs. The guideline adopted by KPSC recommends the use

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of HOCAs unless a patient has risk factors indicating a higher than average chance of an adverse reaction. The guideline was developed using a methodical approach consisting of four basic steps: "(1) analyze the evidence about the occurrence of reactions with HOCAs vs. LOCAs; (2) estimate the actual rates of different types of reactions in low-risk patients who receive the agents intravenously; (3) estimate the costs of the agents; and (4) determine if the differences in reaction rates are worth the difference in cost." As Eddy first tells the story, a painstaking review of the literature was the basis for conservative estimates which yielded obvious conclusions. Then Eddy gives the reader what he calls the "inside story."

In 1989, the American College of Radiologists (ACR) endorsed a large Japanese study establishing the benefits of LOCAs. The ACR also took the position that it is reasonable to use HOCAs with low-risk patients. Initially, KPSC's associate medical director/physician manager of operations told the radiology chiefs to use LOCAs if they were believed to be medically indicated. He asked only for an estimate of expected use for budgetary purposes. Thereafter, the radiology chiefs directed that intravenous pyelograms and computed tomography (CT) scans be switched to LOCAs exclusively. (Compliance with this directive was uneven across centers, radiologists and procedures.) Then the financial climate changed dramatically. Corporate customers wanted to be shown that they were getting "value" for money. Also, the amount actually spent on contrast agents greatly exceeded estimates. A work group appointed by the radiology chiefs recommended that HOCAs be used for low-risk patients. Still, the group as a
whole was reluctant to reverse the directive. According to Eddy, the major problems were concern for patients who, at a minimum, would experience increased discomfort, the radiologists' immediate responsibility for treating reactions, a sense of exhaustion at the prospect of revisiting a popular decision, and a vague fear that savings, if realized, would not be reallocated to increase value. A desire to break the deadlock in a principled way set the stage for the adoption of the method described above.

When Eddy and his colleagues came to the cost-benefit analysis phase, Eddy remarks that they felt the issues were "too complex to solve in their heads." They looked for some "beacon" to guide their deliberations. The "obvious beacon" was "the preferences of the people who would actually receive the agents, suffer the risks, and pay the costs—the members of our Health Plan."11 The group favored a member questionnaire or poll. Before conducting a large-scale member survey, they decided to test the feasibility and accuracy of this approach with member focus groups. The focus groups were presented with descriptions of the risks associated with HOCAs, then asked about their willingness-to-pay to lower the risks. Eddy writes that, unfortunately, the strategy of putting cost-benefit questions directly to members did not work.12 Thwarted

12"Although the focus groups provided good information about how our members thought about the risks and costs of contrast agents, they did not yield a clear answer to the questions of whether the lower reaction rates of LOCAs were worth the amount specified. For example, they overwhelmingly indicated that they would not be willing to pay the higher costs of LOCAs in order to receive the lower risks.... However, when members were asked to imagine themselves as healthy people who might some day need an IVP or CT scan and were asked whether they were willing to pay a slight increase in their monthly premium to receive LOCAs and their lower reaction rates (a mathematically equivalent but psychologically different question), they overwhelmingly said they would be willing to pay for LOCAs. There are theoretical reasons to discount the answers to the second question because it involves numbers that are so small as to be nearly incomprehensible.... Nonetheless, the inconsistency was disconcerting. More troublesome was the fact that when we examined some questions that were built into the process to determine whether the participants truly understood the issues, we discovered that many of them did not. For example, after they had read an information sheet saying that LOCAs cost about $82 more than HOCAs, they were asked which agent cost more money. Several participants answered 'HOCAs.'" Eddy, "Cost-effectiveness Analysis," 2579.
in their attempt to find a beacon, Eddy's group began to look for a "sign": "We needed some sign from above that our budget had truly hit the point at which additional increases could not be tolerated and priorities had to be set." They got their sign when a major customer asked KPSC to lower its rates; they ended consideration of using LOCAs for all, and they proceeded to analyze the cost-effectiveness of LOCAs in low-risk patients. They determined that using HOCAs in low-risk patients would "free up" approximately $3.5 million each year, and that expenditure of a comparable amount on screening for breast and cervical cancer, or a cholesterol treatment program, would produce much greater health benefits. The availability of the funds saved for other uses seems somewhat at odds with the nature of the sign—surely the adoption of the guideline was intended to reduce the budget. It is true that some reallocation of funds within a tightened budget would still be possible.\textsuperscript{13}

The final step was to consider "nonscientific and nonfinancial" issues. Eddy writes that these boiled down to three questions: would they be sued, would they lose a suit, and would the costs of litigation and bad publicity wipe out any gains from adoption of the guideline. The group believed that they should win any lawsuit. They had done everything right. The prospect of bad publicity continued to trouble them, but they felt such costs were outweighed by the principle at stake: "If we thought the guideline truly served the interests of our members, we believed we should stand up for it. To fail to make what we think are medically correct choices because of a fear of lawsuits would be to abrogate our overriding responsibility to our members."\textsuperscript{14}

\textsuperscript{13}In his conclusion, Eddy writes that KPSC "has already initiated plans to reallocate resources to beef up our preventive activities such as cancer screening." Eddy, "Cost-effectiveness Analysis," 2580, 2582.
\textsuperscript{14}Eddy, "Cost-effectiveness Analysis," 2581.
Outlining the factors that make this case a relatively easy one, Eddy concludes:

"Finally, the value judgments, although they appeared so difficult when they were presented in qualitative terms, were really quite obvious once they were described with numbers. Who could fail to choose to prevent 35 to 100 cancer deaths over 40 severe but nonfatal reactions?"\textsuperscript{15} This way of putting the matter entirely ignores distributional questions. What if the winners, or losers, all belonged to a particular racial group or gender? And the issue of when to yield to pressures from customers to control costs, and how to address member concerns, has entirely faded from view. On the latter point, without identifying the organization involved, ethicists Laurie Zoloth-Dorfman and Susan Rubin describe how they were approached by nurses distressed over their employer's policy of using HOCAs for low-risk patients. The nurses asked, "Shouldn't someone inform them [patients] that a more expensive option exists that probably would have no side effects? And what about the small number of patients who do somehow learn of LOCM [LOCAs]; is it fair to give it to them when they ask for it by name, which we do, if others are not given the same choice?"\textsuperscript{16} Eddy does not mention how the KPSC guideline deals with patients who specifically request LOCAs. We are not told whether the (non)availability of HOCAs is routinely disclosed by KPSC physicians. The nurses who sought advice from Zoloth-Dorfman and Rubin were also concerned that the policy at their institution did not take into account their actual patients' experiences with the less expensive contrast agent. Although Eddy reports a thorough literature review, and an attempt to solicit member preferences, there is no mention of any systematic research

\textsuperscript{15} Eddy, "Cost-effectiveness Analysis," 2581 (emphasis added).
into the effects of post-LOCA use of HOCAs. Obviously, the experience of the radiologists was given some weight in the deliberations, but so far as we know, no provision was made for monitoring the consequences of the new guideline following its implementation.

Kaiser has also had difficulties controlling the utilization of bone marrow transplants. In the case of Comer v. Kaiser Foundation Health Plan,\textsuperscript{17} the United States Supreme Court declined to hear a case in which a mother initially sued Kaiser in state court for the wrongful death of her son. Kaiser had declined to pay for a bone marrow transplant it deemed "experimental." The Supreme Court's action let stand a Ninth Circuit Court of Appeals decision holding that ERISA preempts state tort remedies related to benefits provided by a self-insured employer.\textsuperscript{18} In other words, the claim against Kaiser was not tested in court; there will never be a ruling on the propriety of Kaiser's actions.

Other "resource allocation" problems facing Kaiser and its practitioners and members are of a different nature. To gather further evidence on Kaiser's character, we leave Southern California for the Rocky Mountains. Competition in the Denver area is not quite as fierce as in Los Angeles. Nevertheless, a Kaiser clinic in the Denver suburbs faced a major problem, and the problem arose from pressures similar to those described in connection with the HOCA/LOCA guideline. The focus shifts, though, from the development of region-wide policies to the effects of such competitive pressures at the clinical level. A writer for the trade journal \textit{Hospitals & Health Networks} begins the story of the problem this way:

\textsuperscript{17}45 F.3d 435 (9th Cir. 1995), \textit{cert. denied}, 115 S.Ct. 1963 (1995).
Each time John Scott hurried from one patient to the next that July morning four years ago, he sank a little lower. No matter how hard he pushed himself..., he left exam room after exam room feeling that he somehow hadn't met his patients needs. At the front desk, Scott stopped to study the list of 10 people lined up to see him that morning. All were over 80 years old and suffering variations on the themes of aging and chronic illness. A glance at his afternoon schedule promised more of the same. The feeling of not doing enough suddenly became too much. "Comforting, teaching, explaining treatment options, discussing the emotions of aging and end of life—all of this is being dumped by the wayside in the name of efficiency," he says. "The way the world is going, we're being asked to do more and more with less and less. We end up compromising our beliefs about what our role as physicians should be."19

Scott's harried day in July of 1991 contrasts with the (relatively) leisurely pace of practice characteristic of Kaiser when he joined the plan in 1977. At that time, Kaiser was the only managed care plan in Denver, and Scott saw fourteen to fifteen patients a day. On "that July morning" Scott finally aired his frustrations, and found that they were shared by other doctors, nurses, and clinic and central office administrators. Together, they developed a "simple" solution that nobody else had apparently thought of—what they call "cooperative care clinics."20 A managed care analyst comments that HMOs share with the health care field in general an emphasis on "diagnosing and curing" rather than "managing and maintaining." He adds, "Chronic care is the biggest ticking time bomb facing HMO's."21 We should not be surprised to learn that most HMOs participate in the culture of short-sightedness, that is, they concentrate on squeezing hospitals and

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20 Actually, as one might expect, there are precedents. In England, chronic care clinics or "miniclinics" of a similar nature were developed in the 1970s. See Edward H. Wagner, Brian T. Austin, and Michael Von Korff, "Organizing Care for Patients with Chronic Illness," *Milbank Quarterly* 74, no. 4 (1996): 522-44 at 522.
21 Peter Boland, quoted in Lumsdon, "Working Smarter, Not Harder," 28.
other providers. If, by way of contrast, the cooperative care clinic concept takes the long view, the driving force behind it was nevertheless the immediate problem of providing quality care to a particular group of elderly patients.

A cooperative clinic consists in monthly meetings of twenty to twenty-five patients, overseen by the patients' doctor and a nurse. The Kaiser program targets patients over sixty-three with one or more chronic conditions. At the meetings, the groups get routine check-ups, and they hear from Kaiser's in-house experts on exercise, diet, living wills, managing medications and other topics of their choice. Family members and friends who act as caregivers are invited to join in. Patients are given time to browse through their charts and ask questions of any of the medical staff. They receive preventive care such as flu shots. Time is also allotted for people who need private exams or special attention. "But what makes the biggest difference," according to the writer, is that "patients help one another over the rough spots of aging and illness, such as coping with the death of a spouse or a revoked driver's license. The groups become a forum for discussing events big and small that can chip away at independence and dignity, potentially sending patients into a spiral of depression and worsening health." Sharon Strammel, a registered nurse who helps run the clinics says, "Above all, these groups elevate patients to equal partners in their care—and hallelujah for that. We are not the experts on living with a chronic illness; they are. They deal with this much more openly and gracefully than clinical people do. And we learn from them."22

Note that Kaiser as an organization was able to do what no solo practitioner could easily accomplish, in terms of dedicating staff time to the task of organizing and

evaluating the cooperative care clinics, and marshaling an impressive array of experts.

Kaiser also has computer systems in place capable of tracking immunizations and flu shots and identifying people at special risk. As numbers matter so much to some—and I think most of us would agree that outcomes matter—it is significant that over a one year period cooperative care patients made thirty-nine percent fewer emergency department visits than a control group receiving traditional care, and had twenty-four percent fewer hospital admissions. Among patients hospitalized, length of stay was nearly twenty percent lower for the experimental group. The Robert Wood Johnson Foundation is funding a full scale study of fifteen cooperative care groups. The Foundation plans to disseminate its findings widely, in the hope that other managed care organizations will emulate Kaiser. Scott, who is already making presentations to other HMOs, thinks that is just fine. He says, "I'd hate to see this concept used as one more tool in the vicious war between health plans."23

Current patients "rave" about the "luxury" of spending more time with their own doctors, who can give extended explanations and still economize on time. The same is true for other health care providers, such as pharmacists and therapists. One patient with a spouse suffering from chronic lung disease comments, "We know a lot more people in the Kaiser system than we once did… When you get older and need health care more often, you also need that sense of belonging." Patients have also developed a deep bond with Strammel, the nurse involved with many of the clinics. No longer an anonymous voice on the phone when the doctor is not immediately available, she now receives many of the calls. The article in Hospitals & Health Networks concludes with two themes, the

"common grace" patients mediate to one another, and money:

Naysayers at Kaiser predicted that patients would refuse to talk openly about sensitive topics or voice their fears to each other. But patients like Anne Temple proved them wrong. Scott was leading a session on arthritis when a woman in Temple’s group spoke up from the back of the room, her voice breaking: "You mean I’m going to live with this for the rest of my life? How am I ever going to do that?” Temple, a 76-year-old widow with two artificial knees, a reconstructed shoulder and gnarled fingers, thanks to rheumatoid arthritis, waved a hand in the air. "Honey, look at this. I’ve been living this way for years. During our break, I’ll tell you exactly how I do it."

"I couldn’t do that," says Scott. "I’ve never had arthritis. Not even a rheumatology specialist could tell her what Anne could. The amount of support people get from one another, not from some overburdened medical system, is astounding. And it doesn’t cost anything, either."24

I do not mean to suggest that everything is wonderful at Kaiser. Quality may vary significantly across regions. Rationalization and standardization of practice may enable Kaiser to deliver reliable, cost-effective care to the majority of patients, but they have their limits. As George Anders says, even the best HMOs have one great vulnerability: the unexpected case. A baby with a fever is rarely suffering from a meningococcemia, a bacterial infection that only strikes about eight hundred infants a year. A 35-year-old man who experiences chest pain is rarely dying of a heart attack.25 It is the accumulation of such rare cases that opens HMOs—in these cases, Kaiser Foundation Health Plan of Georgia—to criticism. Is it possible, as a matter of standard practice, to be responsive to the exceptional? And what about the dollars at stake?

Research suggests that emergency room care is two and half times as expensive as similar

care in an office or clinic setting. In the nonemergency case, the extra expenditures are clearly waste. Or are they? How easy is it for patients and their families to determine that they have a "true" medical emergency warranting a departure from the standard procedures? How much should the possibility of getting stuck with the bill weigh on their minds as they try to decide what to do?

Consider the case of the feverish baby. There were three critical points in Kaiser Georgia's handling of such a case. First, there was the initial screen. Lamona Adams, the mother of the baby, asked for and received a same day appointment with a pediatrician. The exam failed to disclose the infection. There were no allegations of malpractice in connection with the exam, and experts testified that it would be unusual for any physician to have diagnosed the problem based on the baby's symptoms at the time of the exam. But the unusual becomes yet more improbable in light of the time constraints. Kaiser had just reduced its routine pediatric exam to ten minutes, from fifteen. Second, there was the procedure for follow-up. When the baby's condition worsened, Adams followed Kaiser's instructions and called the after-hours nurse advice line. Here the system clearly failed. Despite some alarming symptoms (communicated to the operator, who passed a "summary sheet" to the nurse), the nurse did not direct Adams to call 911. Indeed, she directed Adams to a hospital forty-two miles from the Adamses' home. The hospital had agreed to give Kaiser a volume discount. Third, there was the system's internal check.

The nurse called a pediatrician at home to confirm her handling of the case; based on the

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27According to Anders, a Kaiser Permanente plan in California defines a covered emergency as "medically necessary health services for unforeseen illnesses or injuries that require immediate medical attention as determined by Health Plan." Anders, Health Against Wealth, 137.

28The case is now a lawsuit, Lamona Adams v. Kaiser Foundation Health Plan of Georgia Inc. (filed in
information given (which is disputed), the physician confirmed the treatment plan. The Adamses got lost on the way to the hospital, the baby's heart stopped, and they followed signs to a hospital just off the freeway. The baby survived, but his feet and hands had to be amputated.

In response to this case, Kaiser added the question, "Is there anything that makes you think that you should go to an emergency room right away," to its script for repeat callers to the nurse hotline. But Kaiser administrators refused to admit that there were any basic flaws in its manner of handling possible emergencies. A Kaiser spokesman denied that the issues had anything to do with managed care. In a sense he is correct. Miscommunication is possible outside of a managed care system. But in managed care "the system" makes miscommunication more likely by putting more links in the chain. Anyone who has ever played the game of "telephone" knows that messages become increasing garbled as they move away from the source. Further, the system makes communication less likely. Lamona Adams reported feeling rushed in the pediatrician's office, and a system of rules constrained her ability to seek reassurance by talking directly to a physician or by proceeding directly to the closest emergency room.

Then there are the signs of increasing discontent in some Kaiser regions. Someone leaked a critical memo from a group of Kaiser physicians in Northern California to the San Francisco Chronicle. The memo, which Kaiser later released to other members of the media, charges that "drastic cuts" are harming the "caregiver-patient relationship." The memo alleges that Kaiser has doubled the number of administrative personnel while cutting "front line personnel" such as nurses. Clearly trying to put the best face on

Fulton County state court). The story is discussed in Anders, Health Against Wealth, 1-15.
things, a Kaiser spokesman described the memo as part of Kaiser's "democratic system."
The memo was distributed internally in connection with an upcoming election battle over
the position of executive director for the region. 29 Finally, at least one regional plan has
been enmeshed in the scandal over gag rules. A directive from the Ohio Kaiser
Permanente HMO to physicians prohibited them from discussing proposed treatments
with patients prior to authorization, or even describing the authorization procedure to
patients. 30

Yet Kaiser is still remarkable for the way it blends bureaucracy and
professionalism with considerable sensitivity to the democratic principle of developing
the capacities of plan member-patients. We can evaluate Kaiser's "character" using the
tools of character assessment presented in previous chapters. We can begin by asking
what qualities of character Kaiser nourishes in leaders, and what qualities the organization
and its leaders nourish in physicians, other practitioners, and member-patients. Consider
Kaiser's leader, David Lawrence. Lawrence's own history suggests a strong commitment
to social service. He articulates a vision in which the values of management and care exist
in tension. The tension may not always be fruitful; some principles, such as pure
community rating, are abandoned. But the value is not abandoned—various measures are
instituted to promote wider access to Kaiser services among the poor. In Robert Nozick's
terms, the principle not followed leaves "moral traces." The message is that Kaiser will
compromise with the forces of the market, but not surrender. Lawrence is also politically
astute. He realizes that Kaiser needs the support of intelligent regulation to maintain its

29Louise Kertesz, "Kaiser Physicians Unhappy with Changes, Memo Shows," Modern Healthcare, 19
February 1996, 12.
30David Mechanic and Mark Schlesinger, "The Impact of Managed Care on Patients' Trust in Medical Care
distinctive character.

As for the practitioners, clearly, Kaiser physicians and nurses are frustrated by the demands they face. Yet, when those frustrations are voiced, they may be understood by others within the organization, administrators included. Medical staff and administrators at the Denver clinic were able to mount a collective, effective response to one of the problems they confronted. And they did it in a way that built on their collegial relationships, cutting across physician/nurse and other professional and disciplinary boundaries, and ultimately enhanced their relationships with patients. They displayed the cooperative (and parental) virtues in hatching the cooperative care clinics. Further, the cooperative clinics have developed the capacities of plan members to aid one another. They come to see what they have in common, and they help each other make sense of the losses of aging and the terrors of illness. The voluntary cooperation nourished in these informal communities extends beyond staff to members, and to family and other caregivers.

What of the intellectual virtues prized by experimentalism? Does Kaiser foster free, experimental cooperative inquiry? Is there open discussion and publication of ideas and research findings? Is there support for creativity and innovation? With its resources, and a commitment to experimentation, Kaiser supports some truly creative and value-enhancing innovations. It also attracts funding from other organizations interested in sponsoring research and disseminating research findings, such as the Robert Wood Johnson Foundation. And, for the most part, Kaiser displays a commendable commitment to openness. The silencing of physicians in Ohio is a lamentable episode in Kaiser's biography, but that biography also reveals many accomplishments in this area.
For example, the HOCA/LOCA guideline could hardly be kept a secret, but Kaiser displayed a commitment to openness in allowing an "insider's" account of its deliberations into print. The refusal to treat the concept of cooperative clinics as some sort of trade secret is to be commended. There is some indication that these qualities are communicated to members and patients. According to Zoloth-Dorfman and Rubin, Kaiser circulates some guidelines and policies to members for their review. Finally, Kaiser has taken its distinctive character to is customers in its advertising. Current print advertisements stress that Kaiser plans are not-for-profit and that its physicians are paid by salary, rather than capitation. Of course, this is self-serving, but as Dewey says, everything depends on the nature of the self served.

What of justice? In the area of distributive justice, I note that Kaiser has taken steps to subsidize the premiums of those who would otherwise be unable to afford its services. I have already commented on Kaiser's activities in the area of research and education. Does Kaiser meet the public expectation that premium payments will be spent on patient care? Kaiser spends only three percent of its budget on administration, with the remainder going toward patient care. As for the nature of that care, Kaiser seems to adopt restorative rather than maintenance strategies in caring for many of its members. We see this demonstrated in the areas of kidney dialysis and care for the chronically ill elderly. On the other side of the ledger, Eddy's account gives us no sign of awareness of the distributional concerns raised by the use of cost-benefit analysis.

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In the area of contractual justice, Kaiser has a mixed record. It can be grudging, sometimes favoring contractual language that gives members very little idea of what they can count on. It has availed itself of the ERISA defense in order to avoid a hearing on the merits where it has been accused of wrongdoing. It has imposed productivity requirements on practitioners that at least border on the unreasonable. On the other hand, Kaiser gives its members a fair amount of choice within the system. Patients in cooperative care clinics appear very satisfied, although we may assume that interviews were not arranged with disgruntled patients, if they exist. Still, some Kaiser patients are not getting potentially beneficial treatments they want, such as bone marrow transplants. These treatments are clearly desired, but justice will often prompt an inquiry into their desirability, given resource constraints. On the other hand, justice never requires arrogance or brutality. Decision makers can be humble about the limits of their knowledge, and decisions can be communicated with respect and compassion. What of justice in relation to providers? Although some physicians are discontented, relative to physicians in other managed care organizations Kaiser physicians have a great deal of control over their conditions of work. Even if Kaiser salaries are generally below the income averages for the various specialties, physicians have found their salaries acceptable. On the other hand, many of Kaiser’s nurses are profoundly unhappy with current working conditions.33

What of organizational integrity and responsiveness? Recall that, in simplified terms, integrity suggests integration and moral coherence, and that one test of integrity is the degree of fidelity to self-defined principles. Responsiveness requires openness and

33 J. Duncan Moore, Jr., “CNA Nurses to Strike at 45 Kaiser Hospitals,” Modern Healthcare, 17 March
flexibility. Lawrence and Eddy stress integration and moral coherence in the accounts that they give of their organization. The very fact that these accounts of Kaiser's philosophy and practice have been published gives them significant weight. It is through the making of such records that Kaiser becomes "hostage to its history" as a public-spirited, innovative enterprise. And through its integrated approach to health care and its system of rewards, and the kinds of administrators and physicians and nurses that these structures attract, Kaiser institutionalizes its commitments and does what it can to ensure that its distinctive character will be preserved through the changes that a changing environment will bring.

Lawrence expounds on institutional identity, and his responses to a broad range of questions display consistency. His broad themes are responsiveness to members and local community needs and commitment to comprehensive services integrated across the spectrum of care. Lawrence's discussion of quality suggests three concerns and related commitments: a concern for individuals and a commitment to the enhancement of interpersonal relationships, a concern for populations and a commitment to general improvements in health, and a concern about costs and a commitment to the elimination of waste—as a means to the extension of health services to a larger share of the population. These concerns exist in some tension, but integrity does not consist in narrowing concern or the single-minded pursuit of a single goal. The question is whether Kaiser attempts to honor each of these concerns at multiple levels of the organization, through its organizational structure, reward system, research and educational activities, and significant policies. Regional variations are a challenge to the integrity, and

1997, 17.
reputation, of the organization as a whole. The very same decentralization that promotes responsiveness to local community concerns permits the Ohio Kaiser Permanente HMO to issue a directive silencing physicians.

Eddy describes an attempt to involve Kaiser members in policy making, which he concedes to have been a failure. It remains to be seen whether Kaiser is sufficiently committed to responsiveness to refine its strategy for involving members in the development of guidelines, or to experiment with other strategies. The difficulties the member-off-the-street may have in understanding the issues suggests that Kaiser might do well to cultivate a group of member-experts, a group defined by a shared interest in health care issues and a willingness to devote time to further study. As to the involvement of members generally, I am inclined to think that Eddy and his colleagues asked the wrong kinds of questions. Despite, or perhaps because of their extreme rationalism, they looked for signs and portents and unambiguous numbers, and failed at the work of nuanced interpretation and meaningful conversation outside the medical-scientific circle. Participants in the member focus groups were presented with calculations of no immediate significance to them; one may well believe that they were not given a sufficient experiential "handle" on the problem. Some ingenuity might be exercised in this area, perhaps drafting member-experts to participate in developing more meaningful modes of involvement for the membership-at-large.

More generally, rationalism may inhibit responsiveness to the full range of member concerns. Ultimately, this has to do with a tension between two perspectives, what we might call statistical rationalism and encounter personalism. Anders charges that the managed-care industry as a whole "is dominated by people who see many statistics
and few patients,” who “want to be judged by how they treat healthy populations overall.” He argues that in fact the crucial test of a health plan is “how it performs when anxious families are fighting medical disaster.” This follows from his belief that the primary reason people seek health care coverage of any kind is to have some security in a medical crisis. The focus on populations and statistics rather than persons and encounters leads to a devaluing of the experience of practitioners, as well as a slighting of the concerns of people in crisis. Many share Eddy’s belief in the number. 34 I would suggest that we need to consider experience gained in practice and statistics, persons and populations, and preventative and acute care, as well as care for those suffering from chronic illnesses. Kaiser does not always strike the proper balance, but at least leaders like Lawrence and practitioners like Scott and Strammel are aware of the personal side.

The value of rationalization is linked to considerations of efficiency and economy. Recall that efficiency requires that technique and organization be as appropriate as possible to the end in view, and entails some degree of standardization and quality control. It is bound up with the notion of good practice, and it involves good stewardship and pride in workmanship. Economy requires that a function be performed at the lowest possible cost consistent with purpose. Waste of resources is not to be tolerated, but an expenditure of resources can only judged "waste" in relation to an analysis of means and ends. In the notion of the “false economy,” common sense recognizes that savings in one area may produce losses in another, and that short-term savings may bring greater long-term costs. In terms of efficiency, cost and quality, Kaiser does quite well, but there appear to be significant variations across regions. The indications are that in general

34Anders, Health Against Wealth, 15, 37. Per Leonard Abramson, the founder of U.S. Healthcare (now
Kaiser offers a high quality "product." The statistics on kidney dialysis and the cooperative care clinics show that at least some Kaiser patients are functioning better than their counterparts in other arrangements, and this may be more significant than any current report card score. Historically, Kaiser has offered a competitively priced product, although its efforts to remain competitive may be becoming increasingly desperate. As for the practice virtues, these are clearly turbulent times at Kaiser, and it is not clear which forces will prevail. At least some Kaiser physicians fear that under competitive pressures the organization is in peril of losing its distinctive character. They fear that patient care is being compromised, and no doubt they are experiencing a loss of the internal goods of practice.

As for democracy, Kaiser members do not vote. On the other hand, the professional leadership is elected—by physicians. And Kaiser is democratic in Eliot Freidson's sense: its operations are for the most part "based on the democratic notion that people are capable of controlling themselves by cooperative, collective means and that, in the case of complex work, those who perform it are in the best position to make sure that it gets done well." One could only wish that this principle extended to practitioners other than physicians. Further, Kaiser, either by intention or accident, is contributing to the "development of local agencies of communication and cooperation, creating stable loyal attachments" through innovations such as its cooperative care clinics. Within these fora, people are becoming more active and responsible in the matters of their own health and health care. And they are learning what it means to live out one's individuality in community.

part of Aetna), "It doesn't count if you can't count it." Anders, Health Against Wealth, 38.
Community, for Dewey, is a voluntary ideal. The conditions for community can be put in place, but community itself is an "unforced flower." There may be those for whom even the finest achievements of communal health care are unappealing, who shudder at the prospect of attending a cooperative care clinic. The views espoused here do not support the elimination of alternatives. Indeed, in keeping with a positive account of pluralism, we will hope for the flourishing of many different models for the provision of care. We have our filters and our criteria to assist in the making of value judgments, but these allow for a broad range of ideals to be realized in practice. Further, institutions can be expected to develop and change. What worked once may not work in the future. Change is not the enemy, although there are changes that should be resisted. Even as this dissertation was being written, there were signs of transformation.

2. The Future of Managed Care

In reflecting on organizations and health care in 1983, William F. May wrote, "We may be moving toward a period of duplex social organization in which we require both large-scale institutions, with the resources they can mobilize, and smaller, more informal communities, delivering services that supplement and experiment in ways unavailable to huge, more cumbersome institutions."36 We have already seen how Kaiser's cooperative care clinics create small communities drawing on the resources of the larger organization. There are some indications that managed care organizations, the new masters in health care, may soon be consigned to a servant role. They will provide support services to the actual providers of health care services: physicians (and perhaps other practitioners) and

hospitals and their affiliated enterprises. This would not be the end of organizations in health care, but rather a reshaping of organization to a more human scale. The devolution of power would also bring health care more in line with the professional model of organization, subject to certain bureaucratic and market controls.

What is arguably the next revolution in health care is beginning in Minnesota. By 1995, approximately eighty percent of the insured individuals in the Minneapolis-St. Paul area were in managed care plans; three large plans alone accounted for about seventy-eight percent of the managed care market. (By state law, all plans must be not-for-profit.) An active group of business leaders contributed to the early dominance of managed care, but they began to feel, in the words of a spokesman for the group, that "networks have grown so large that data about quality of care is averaged across a broad spectrum that is almost meaningless to consumers" and "premiums reflect the average value of services provided by both efficient and inefficient providers." Many providers participated in multiple plans, and this overlap of providers in the major networks meant that real costs did not vary significantly between plans. The networks were mere aggregates put together to command market share, rather than integrated systems. Under the new regime, the Buyer's Health Care Action Group is contracting directly with competing subgroups of providers within the large plans. Providers will be assessed using standardized criteria of cost, quality, and service. Yet another catch-phrase has been coined for this purpose: the program is known as "Choice Plus." Employees of participating corporations are able to choose how much choice they want; they are given three options offering three different levels of cost and coverage. In the past, plans purchased the

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37For some tales of the beginnings of managed care in Minnesota, see Emily Friedman, "Capitation,
services of providers. Now provider groups will purchase services such as information systems from plans.\textsuperscript{38}

Is managed care destined to be yet another fad that leaves no trace? I think not. We will never return to the free-spending days of yore. Two basic social facts, the commitment to the development and diffusion of new medical technologies, and the aging of the population, virtually guarantee that cost control will be a pressing concern for the next several decades. Gazing into my crystal ball, I predict that primary care physicians will continue to advance relative to their specialist and sub-specialist colleagues. At the very least, the latter will never return to their unchallenged dominance. The services of physicians will continue to be complemented by those of a range of other health care professionals. Acute care hospitals will continue to evolve into points in a network of connected services—still central to health care, but no longer the center.\textsuperscript{39} Experiments will continue with incentives, case management, means of evaluating and improving the quality of care, and innovative structures for delivering care. The market will continue to play a role, although we will probably have fewer “barons of austerity” with multi-million dollar compensation packages. Health plans will fail, as the cushion, the concessions that can be extracted from providers, disappears. The tensions between bureaucratic and professional controls, and bureaucrats (many of them physicians) and practitioners, will not disappear. There will be more litigation, and more regulation.

\textsuperscript{38}Robert Cunningham, “Minnesota Business Group Fosters New Wave of Competition,” in 1996 Health Network & Alliance Sourcebook, B52-B55 at B52 (reprinted from Medicine & Health Perspectives, April 3, 1995).

We will have many more pages of ethical reflection. More will be said about
denials of specific treatments in hard cases, choice, conflicts of interest, and resource
allocation. A variety of models or methods will be employed. Analysis will be shaped
by different implicit, and sometimes explicit, moral psychologies and moral sociologies.
Different sensibilities will select different social values for emphasis. Deweyan
democracy, with its subsidiary themes of creativity, communication, and community, and
what I have called pragmatic justice, may be among the values chosen for further
consideration. Those with whom this vision of democracy and justice resonates will not
be satisfied with their own reflections. They will seek to engage others in conversation.
Like Willard Gaylin, they may find expert policy making an inadequate substitute for a
“wide-open far-ranging public debate about the deeper issues of health care—our
attitudes toward life and death, the goals of medicine, the meaning of health, suffering
versus survival, who shall live and who shall die (and who shall decide).” Gaylin
presents an ambitious agenda. Perhaps too ambitious. We might wish to retain the
breadth and depth of concern, but shift the debate to smaller units. This is Ezekiel
Emanuel’s proposal, discussed in the introduction. In Emanuel’s federated system,
community health plans of no more than 20,000-25,000 citizen-members become the fora
for debate of these issues. Alternatively, we might adopt a less comprehensive agenda,
and proceed piecemeal. This is the approach the politicians seem to favor.

In keeping with Deweyan pragmatism as I have articulated it, I would propose a
slightly different accommodation. Keep the large issues before the public. Work for the
democratization of health plans, and their evolution as sites for discussion and debate.

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40Gaylin, Willard, “Faulty Diagnosis: Why Clinton’s Health Care Plan Won’t Cure What Ails Us,”
The devolution of power in Minnesota is a hopeful sign. But allow for some issues to be addressed at some levels and not at others. Our powers of vision, concern, and attention, and deliberation, judgment, and action, are scarce resources. They, too, must be allocated, and in a manner that can only be worked out in real life. Further, allow that some issues may be addressed, not through debate, but through the giving and receiving of help in communities constituted by those with common identities or common problems.

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Appendix

A Managed Care Bestiary

The emergence of managed care as a studied phenomenon has led to a proliferation of acronyms, a veritable "alphabet soup" of labels for the various types of managed care organizations (MCOs). The best exemplification of managed care principles is the health maintenance organization or HMO. An HMO will accept responsibility and financial risk for providing specified medical services to a defined population during a defined period of time for a defined (fixed) dollar amount. Whereas traditional indemnity insurance plans reimburse covered individuals for the cost of health care, HMOs provide health care services to covered members through affiliated providers. HMOs were the first to offer coverage for preventive health services and pioneered the primary care physician (PCP) concept. A PCP is responsible for coordinating care for an assigned group of patients. Typically, the PCP provides all primary care and controls access to specialists and ancillary services. The five common models are staff, group practice, network, individual practice association (IPA), and direct contract. The first two are the most distinctive.

In the staff model, physicians are typically employees of the HMO on a full-time salaried basis (they may also receive bonus or incentive payments based on performance and productivity). Provided with a fully capitated budget, physicians are not at personal financial risk for the services they provide. In the group model, 

\[1\]The descriptions that follow derive from a number of sources, but the primary source is Eric R. Wagner,
physicians are employed by a group practice, not the HMO. The HMO is usually responsible for marketing, enrollment, collections, etc. In the captive group model, the group practice exists solely to provide services to the HMO's members e.g., the Permanente Medical Groups provide physician services exclusively to the Kaiser Foundation Health Plan. In the independent group model, the HMO contracts with an existing, independent, multi-specialty physician group, which may continue to provide services to non-HMO patients. The staff and group models are also known as "closed panel" HMOs because the HMO is "closed" to physicians who are not on staff or part of a participating group.

In the network model, the HMO contracts with multiple group practices to provide services to members. Plans may be either open or closed panel. In the IPA model, as the term suggests, the HMO contracts with an IPA. An IPA is an association of independent physicians or small groups of physicians formed for the purpose of contracting with one or more MCOs. Many IPAs accept capitation payments from HMOs and "convert" these payments into (discounted) fee-for-service payments to individual participating physicians. IPAs provide a mechanism for HMOs to recruit large panels of physicians. In the direct contract model, the HMO contracts directly with individual physicians.

The physician-hospital organization (PHO) is a relatively recent innovation. PHOs are entities formed by hospitals and panels of providers to provide

comprehensive services for a capitated fee, or under a discounted fee-for-service arrangement. They may contract with multiple insurers and HMOs, or they may contract directly with employers (in competition with insurers and HMOs).

A *preferred provider organizations* (PPO) sits on the boundary between managed care and traditional fee-for-service medicine. Employer health benefit plans and insurance companies contract with or create a PPO to purchase health care services for covered beneficiaries from a selected group of providers. Participating providers typically agree to abide by utilization management and other procedures and agree to accept the PPO's reimbursement structure and payment levels. In return, PPOs often limit the size of provider panels and provide incentives for their covered beneficiaries to use participating providers. In contrast to the typical HMO, individuals with PPO coverage are permitted to use non-PPO providers, but usually with higher copayments or deductibles.