

MEDICINE, PUBLIC HEALTH, AND THE ETHICS OF RATIONING

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ABSTRACT Physicians, like all citizens, have communal and private identities, each attending various associated roles and fulfilling diverse obligations. In light of these dual personae, we seek a moral philosophy which encompasses the responsibility for providing care to the patient and at the same time acknowledges the physician's role of arbiter of distributed care. In the traditional doctor/patient relationship, rationing, the admission that health resources are limited and must be distributed equitably by universally accepted criteria, is essentially ignored. When the physician assumes a population-based system of ethics to optimize care for all patients within a group, rationing is embraced as the realistic admission that any social action resides within boundaries—in this case health care resources—and that such restraints have economic consequences that present ethical choices. A common ground to accommodate these dual allegiances is offered by communitarian philosophy, whose outline and applicability is presented here as an alternative to the apparent moral opposition of optimized individual care and the requirement of community-wide distribution of limited health resources.

WE ARE NOW ACUTELY AWARE that physician choices are influenced by economic forces that intervene between the health care provider and the patient. This highly complex social and economic structure is intimately linked

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to the public policy of health care, which in turn is grounded in both social philosophy and the ethics of medicine. Although these deeper philosophies (each of which are subject to contentious debate) both inform and direct our general attitudes about specific policy decisions, considerations of such abstract ideas are generally “silent,” left to the realm of the esoteric. Precisely because these philosophical matters are left outside most discussions, I wish to raise them here, for I do not believe that we will effectively and fairly extract ourselves from the health care conundrum—accelerating health care costs, the growing numbers of uninsured, the discontent with the corporate mentality of providers—unless an *ethical* commitment is made towards establishing a national consensus about health care.

Presented here is the outline of what I believe comprises an ethical approach to reforming the American health care system, one based on an equitable distribution of medical resources. If we affirm universal coverage as an ethical position, then a certain set of economic and political parameters follow; if we continue the present unequal system, then our current fragmented policy suffices, if not economically at least as an expression of certain moral choices. Indeed, the very character of our current heterogenous system clearly reflects a particular attitude about providing health care, one that has been borrowed from our consumer society: medical care is purchased like any other commodity, and we witness the same kind of stratification of services reflected in other economic realms of American culture. This is a political and, ultimately, moral decision, one deliberated and confirmed by legislatures.

Presently, Americans enjoy or suffer, depending on their wealth, individualized solutions for illness interventions. Absent a global policy of how to order, prioritize, and integrate medical services into the broader social agenda, we are now left, in too many instances, with ad hoc solutions, ones based not on deep political commitments, but rather on stop-gap measures that address immediate stresses and strains. Health care in this setting is not an expression of some national mandate to distribute medical care equitably, but has become a patchwork of various kinds of economic packages—some bought (insurance, HMOs), some given to particular groups (the elderly, veterans, Native Americans, etc.), and, one hopes, some safety nets for the approximately 42 million people without insurance (Schroeder 2001). And providing health care through such a patchwork constitutes a moral decision, as the recent comments of the former editor of the *New England Journal of Medicine*, Jerome Kassirer (1998) make clear:

The fundamental flaw in any universal ethic of medical care in this country is the structure of our health care system. Some patients are still in fee-for-service plans with virtually no limit on coverage, some are in plans with limited coverage or large deductibles, and many, of course, have no coverage at all. A system in which there is no equity is, in fact, already unethical. We gave up the idea of having an equitable system when we decided several years ago to give up on a proposed national health system with consistent coverage for the entire population.

Rarely has discussion deliberately considered the moral ends we wish to achieve, yet defining our national health care policy is to decide on its purpose, which is debated at a different level than discussions about cost, allocations, and access. The “structure” that frames these concrete matters is the ends we wish to secure, and that concern is fundamentally a moral question, not one of economics or organization. To be sure, the financing is crucial, but the budget only reflects an overall philosophy that guides the total dollar amounts and allocations. From this perspective, the health care debate ought to be recast in a manner that effectively integrates all levels of discussions, most centrally the moral, to the end of redefining *what* we want.

Basically, contention over the character of our health care system is communal decision-making about the moral currency of medicine, one that demands that we come to terms with public health (writ large) as social policy. So if health care reforms are addressed morally, and not just economically, we become engaged in determining common civic purpose (Churchill 1994). When couched in these civic terms, we begin to understand that the crisis is not simply over balancing a ledger, but involves pivotal issues about citizenship that mark our national debate about other matters concerning general welfare and cultural values. Various critics along the political spectrum are pointing out that without communal cohesion—civic allegiance and shared values—our pluralistic society has opted both politically and judicially for a rights-based government, for better and for worse (Sandel 1996). This means, simply, that Americans are increasingly moving from an interventionist government model of social reform to a more neutral agency, a government advocating no specific social ideal, but instead facilitating, indeed, celebrating individual choice. The clear benefit is tolerance for all members of an increasingly pluralistic, multicultural society. The challenge is to maintain collective values that allow for concerted national efforts towards solving social problems that honor individual rights. Health care is a matrix in which these contending forces are dramatically played.

In the discussion that follows, I have regarded the health care crisis from this broader vantage of the debate about communal consensus-building versus a rights-based individualism. Specifically, I have placed the physician at the fulcrum of the debate, because he or she both represents the individual patient—the embodiment of individual rights—and at the same time serves as the agent of a social system that imposes constraints on individual agency. The focus of action in the medical setting, the meeting point of these unresolved liberal tensions in the clinic, is resource allocation. To what extent is the physician the *dispenser* of the social health allowance, as opposed to being the *protector* of the patient, seeking the maximum resources and options for the individual? The issue, in the contemporary setting of the clinic and hospital, is a particular expression of the tremulous political balance between the interests of the collective and the individual—the claims for individual health care versus the economics of a mammoth industry ultimately subsidized by society at large. As long

as the issue is perceived as an irreconcilable conflict of state versus individual, little progress will be made. Yet a common ground must be found. In offering an outline of the ethical structure of this current conflict, I hope to expose the moral dilemma more clearly, and thereby to offer some insight into how we might better understand, and so successfully address, this quandary.

THE PREDICAMENT

Putting aside the moral “right” for health care for all Americans, there are apparent, as well as hidden, social and economic costs that are driving the health care debate towards more overt forms of restricting access to medical resources. As health care costs rise, expected to consume over 16 percent of the gross domestic product by 2008 at current growth, the number of uninsured will swell and the scope of coverage of the insured will become more obviously stratified, as medical insurance will become more burdensome for a significant proportion of Americans (Blumenthal 2001). Managed care is not achieving the cost containment expected, and consequently health care policy makers must study more restrictive policies, ones that will have wide-ranging economic and social ramifications. In short, the “R-word,” *rationing*, is a steadfast member of the health care policy lexicon, albeit always undergoing redefinition. As our use of rationing evolves, we should be acutely aware of the moral choices involved, and those decisions preferably should be made with the intent of equitable reform.

The discussion about rationing revolves around access to services—the impact of new technologies and therapies, the allocation of personnel and hospital resources, and the establishment of local and global goals of the health care budget. We already have constraints in place: the disenfranchised have difficulty obtaining medical care; those insured by the government face local discrepancies in resources and coverage; even for the privately insured, access to medical services is heterogenous. As already noted, these “solutions” are default positions resulting from uncoordinated policy, and rather than regarding them as frustrated forms of rationing, I would prefer to call them simply, embarrassments. Let us reserve *rationing* for the equitable sharing of scarce goods and services according to a central plan, one which orders the rationing process (Churchill 1994, p. 6). No plan is in place, and, consequently, we have neither organized control over costs, nor equity. Indeed, no such policy is in sight.

The rationing lesson is difficult to learn, and even more difficult to institute. It appears that the major impediments to rational health care allocations rests on at least two major obstacles: an increasingly educated public that demands the perceived best (and the most expensive) of our technology and pharmacies, and the complementary sense of moral responsibility to the patient that guides the physician to prescribe such diagnostics and therapeutics. This alliance of the doctor and patient pitted against the demands of the corporation or state has resulted in a pitched battle, and I will focus my comments from this perspective.

With the shift to managed care, half of the doctors in the United States are employed by health plans, a setting in which the doctor is increasingly an employee of an administrative unit that ultimately mediates—or interposes itself in—the doctor-patient relationship. Although a large segment of the population is not in this setting, it still offers a stark illustration of our moral predicament. Increasingly, physicians confront a complex calculus of weighing benefits for the individual patient against the aims and performance of amorphous managed care organizations. In such an institutionalized setting, physicians have divided loyalties. They act as gatekeepers, rationing medical resources for the benefit of the providers, insurers, the government, or society at large. In this context, beyond following certain prescribed protocols of patient care, their tasks include limiting specialty referrals, certifying eligibility for diagnostic or therapeutic procedures, and determining disability benefits. As Marc Rodwin (1995) observes, patients are but “one of the many parties that have a claim on physicians’ loyalty, but not one that overrides the claims of other parties” (p. 254). None of the issues swirling in this discussion is more charged than those directed at reducing physician options for the care of their patients, although this seems to be more exaggerated than an issue of real merit (Weinstein 1999).

The first response to restricting health care resources has been to deny the legitimacy of such restrictions, so that we have increasingly witnessed an advocacy model being adopted by physicians to “protect” their patients from seemingly draconian administrative measures, and ethicists have debated the merits of physicians remaining fundamentally committed to the care of their individual patients, as a principled moral position (Council of Ethical and Judicial Affairs 1995). This hardly appears at first glance as a radical attitude. The ethical commitment to the patient’s well being may seem a crucial precept of being a physician, but in the American context, the doctor’s fiduciary responsibilities are quite limited. The law defines a *fiduciary* as a person entrusted with power or property to be used for the benefit of another and who, in that role, is legally held to highest standard of conduct. As Rodwin (1995) notes, although doctors perform fiduciary-like roles and hold themselves out as fiduciaries in their ethical codes, at present American law regards such fiduciary function only in limited situations: physicians cannot abandon their patients, they must keep clinical information confidential, and they must disclose to patients any financial interests in clinical research. So while the doctor-patient relationship presupposes entrusting physicians to act on their patient’s behalf, fiduciary principles, indeed, have limited application.

The other major judicial directive driving physician responsibility, standards of malpractice, focuses on technical competence. So, by and large, at least in the United States, a patient’s legal recourse is almost always channeled through charges of negligence, not through dereliction of fiduciary responsibility. When applied as a guiding ethos for the doctor-patient relationship, doctors generally are not held accountable, other than as technicians who must perform up to

community standards. In sum, since fear of malpractice is only a defensive posture, and “fiduciary” is a metaphor without much legal application to the doctor-patient relationship, we are better off seeking to understand the basis of physician responsibility in an older religious or metaphysical calling (Tauber 1999), one so fundamental to physician identity, I believe, that only in recasting the idea of “care” can we begin to wrestle with the health care crisis.

The split identity of the physician is most clearly illustrated in the setting of corporate or government medical care, and increasingly under capitated contracts between insurers and physicians. Identification with government or insurer versus affiliation with the patient’s interests, often perceived as countervailing, creates a complex tension. Because of medicine’s ancient and abiding commitment to the individual patient, some see the current balance between these competing interests as in need of correction, arguing that physicians must now function as patient advocates to offset what is perceived as an infringement on that primary relationship of caring. For the policy maker attempting to fairly adjudicate limited resources, the interests of the group must dominate. I maintain a middle position: the physician remains an advocate of the patient within a system ordered by equity of access. Once those parameters are established as public policy, then as a citizen the doctor may comfortably adhere to the communal decision of resource allocation. The moral imbroglio is that in today’s setting, the choices are open-ended and everyone competes for seemingly unlimited resources. But once access standards are established, *and* each has equal access, the dilemma of individual choice is resolved in the name of community. But alas, we are very far from what might appear as a utopian solution.

PUBLIC HEALTH VERSUS THE PHYSICIAN

The struggle of the individual versus the state takes myriad forms. In medicine, we have developed special disciplines to represent each sector. The bifurcation of medicine and public health in the United States may be dated to 1916, when the Rockefeller Foundation decided to create schools of public health independent of schools of medicine (White 1991). “The result was an abandonment of the social impulse within American medical education” and the establishment of two histories of Western medicine that hitherto had been indivisible (Horton 2000). The net result: public health (society’s concerns for the public-at-large) and clinical medicine (patient-based) have become professionally and politically distinct disciplines. Recently, however, a reconsideration of this primary organizational divide of institutions dedicated to health has begun (Lasker 1997).

Largely because of the economic challenge of rising health costs, a concerted effort has been made over the past 25 years to establish more deliberate public policy to marshal cost effectiveness in the health sector, and in those deliberations, the artificiality of thinking of medical care as separate from public health has become an issue of discussion. Critics increasingly note that part of the cri-

sis of contemporary medicine is the uncoordinated allocation of resources to health care for individuals without more attention paid to the implications of such distributions for the comprehensive health of the public. This lack of coordination reflects the enormous divide between patient-oriented health care providers and public health workers who necessarily deal with populations and health care policy on a global scale. Different professional faculties teach these respective disciplines; disparate professional organizations and literatures offer distinct discourses; and different health care concerns reflect a deep professional separation. Besides different goals (diagnosis and treatment versus prevention and eradication), professional identities (doctors and nurses versus multidisciplinary specialists ranging from engineers, policy makers, epidemiologists, etc.), tools (medications, surgery, diagnostics versus policies, education, quarantine), and place of action (clinic versus the field), they differ most basically in their focus: medicine on the individual patient, public health on the care of the population-at-large. This last difference informs and determines all the others.

Most simply, because of its commitment to the individual, medicine is morally governed by principles of autonomy, beneficence, non-maleficence, justice, and relational (sometimes fiduciary) responsibility (Beauchamp and Childress 1994). Public health shares with medicine the principles of justice and respect of individual autonomy, but utilitarianism and public responsibility dominate public health's moral universe. Despite their shared concerns, the divergence of public health's and medicine's ethical mandates at first glance looms large. Individual rights are generally regarded as mercilessly pitted against the public's. But are the ethical mandates of medicine and public health truly divergent, if not competitive? If we leave the answer to that question open for the moment, we have an interesting opportunity to rethink both the significance of their obvious differences and the implications of their potential integration. I will argue how medicine and public health may be regarded as merged, forming one piece on a continuum from the individual to the collective. In adopting this perspective, we have a ready moral and political handle to approach the rationing problem with a fresh perspective. By establishing a moral structure that will forge some unity between these differing perspectives, we can redefine the ethical mandates of medicine and public health, so they become, if not fully integrated, then at least coordinated. And once the individual versus the state relationship is recast, we will have a conceptual apparatus by which to redirect public debate about rationing. Let us begin by unpacking the apparent disparate moral positions held by medicine and public health.

MEDICINE'S ETHICS

The foundations of medical ethics are a synthesis of two distinct, albeit overlapping positions. The first resides in positing and respecting the autonomous agent. From this consideration justice and non-maleficence may be subordinated. But

patient autonomy does not suffice as a foundation for medical ethics, and we must add to our philosophical underpinnings the health care provider's basic moral responsibility for the patient (Tauber 1999). Physicians and nurses are in principle committed to the care of the patient, and this commitment is distinct from so-called patient rights. Although "responsibility" in large measure defines professional identity, the legal issues of autonomy appear today to dominate more nebulous relational morality in discussions of medical ethics. Indeed, contemporary medical ethics appear as the reiteration and formal adoption of the same principles by which our judicial and political culture celebrates the autonomous individual and the protection of his or her rights. Medical ethics in its current guise in the United States was born largely to fit this latter political model. So, in its simplest format, medical ethics is structured by relational responsibility expressed in a system of justice based on the autonomous rights of the individual.

The relational component of medical ethics is perhaps less well defined, and in a sense more subtle, than ethics based on autonomy, for it rests on an older ethos of ministering to the ill. There are various forms by which such an ethic may be understood, but for simplicity let me offer its most basic formulation: the physician's or nurse's commitment is simply to serve the patient as an act of responsibility. This *unconditional* relationship alone sufficiently accounts for medicine's call. It is, to be sure, open to criticism as being too simple. How does one account—even in this most fundamental encounter—for potential conflict regarding medical ideals, or the competing economic or social interests at play, not to mention the potential for differing moral values? We might well consider introducing some caveats, but for our discussion, I believe it suffices to acknowledge these potential problems and yet remain focused on the fundamental ethics governing the primary doctor/patient encounter, namely the physician's responsibility for the patient, a responsibility that begins with an unconditional commitment to serve the best interests of the sufferer. But there is another dimension to the physician's responsibility, one dictated by his or her participation in a community. In this dimension, the ethics of caring takes on additional complexity, one in which the doctor assumes a social-based ethics which seeks to optimize care for all patients within a group (Hall and Berenson 1998).

THE MIXED MORAL AGENDA OF PUBLIC HEALTH

Clearly, public health's ethical mandate addresses the general well-being of the community in adherence to an idea of justice within a utilitarian ethos. While respecting individual rights, traditional public health policy is grounded in communal concerns. Hence the interesting tension: within a political culture organized around legal autonomy, public health operates by a communitarian ethic. Communitarianism is currently a highly charged term in both philosophical and political discussions. In the latter context, communitarians attempt to move beyond the right-left divide and focus their program against what they regard as

a pervasive and insidious culture of rights, where (radical) political and judicial protection of the individual is seen as eroding those social values that must operate for communities to effectively cohere (Etzioni 1996; Tam 1998). They seek a more balanced emphasis on an ethos of shared values that emphasize the needs of the community-at-large. Interestingly, health care has not held a prominent position in these discussions, but it seems to me that it is precisely in this arena that the issues raised by communitarians become especially cogent.

Communitarian philosophy as championed by the philosophers Alasdair MacIntyre (1984), Michael Sandel (1982), Charles Taylor (1985), and Michael Walzer (1983) may be broadly understood as a sustained argument with John Rawls. Rawls, in *A Theory of Justice* (1971), follows traditional liberal individualism, which celebrates themes of individuality, autonomy, and disengaged rationality, so that the self is understood as ideally rational and capable of free choice as a self-aware and assertive individual. To express these capacities, the individual must be allowed to act as independently as possible, both within his or her local social group, as well as within the larger state. Hence protective rights are enacted and enforced to limit the power of the state, and it is at this point that the political debate has ensued.

Philosophical critiques begin as to how important communitarian themes are represented in liberal philosophy, and more specifically, how clear a distinction must be drawn between liberalism and individualism (Frazer 1999, p. 19). Rawls himself, in later writings, denies any bias to individualism, and emphasizes the values of reciprocity and associational life, stressing the importance of communal values to liberal politics (Rawls 1993, p. 190, n. 221). Putting aside the specific debate between Rawls and his critics, the argument in fact goes back to Kantian notions of autonomy (as well as his ideas of free choice and the role of rationality). Kant's ideas have been disputed by a variety of 19th- and 20th-century theorists, who, rather than emphasizing the autonomous person, build upon the social relations of individuals, who play multiple social roles, enact diverse social responsibilities, and engage in various social discourses. The contexts in which citizens develop and live are conceptualized as "non-natural" (i.e., culturally constructed), and thus individual choices, reasons, and actions are conceptualized as contingent, but sociologically or historically explicable (Frazer 1999, pp. 15–23). In short, autonomy is "encumbered" with social identities and commitments to class, gender, race, education, religion, and local community. This conception of the person as essentially social is associated with values that sustain social order—trust, reciprocity, mutuality, substantive equality, and community (Frazer 1999). (In this regard, communitarianism is an application of the basic sociological tenet concerning the primary social identity of persons [Mead 1934].)

Contemporary communitarianism is philosophically based on three theses:

1. Communities are not reducible to individuals and their rights.

2. It follows then that community values are not simply the extrapolated values of the autonomous individual, but must encompass the values of the social individual, which are derived from community-sustaining values. These include the values of reciprocity, trust, solidarity, and tradition.
3. Derived from the above two tenets, the concluding position is that the individual does not, indeed cannot, stand in a direct unmediated relationship with the state and society. There are, to be sure, degrees of choice and independence, but the notion of strict social, political, or ethical autonomy is regarded by communitarians as not only a conceit, but also as a distorting of the social reality. Most importantly, the moral relation of the individual and the state demands a reciprocity of responsibility that places those values sustaining the community as paramount.

In short, the debate swirling around communitarianism has focused on the political strain between an autonomy-based ethics and the view of the individual as assuming his or her identity as a result of identification or membership in a group or community. Issues such as the responsibility of the group to the individual and the reciprocal question of the individual's relation to the group assume quite a different character when approached from these disparate points of view. Perhaps the best known aspect of communitarianism concerns a critical governing precept, utilitarianism—the greatest good of the greatest number. But the principles of communitarianism are broader than simple utilitarianism. In a communitarian ethic, the communal structure determines not only how choices are made, but more particularly what those choices might be as driven by concern for the community at large. These may be utilitarian, but they may also be driven by other goals or ideals. Whatever the communal ethic, the position of the individual is balanced within and against social needs.

Just as a relational responsibility guides medicine's most basic moral mandate, communitarian principles—those relations governing the collective's responsibilities to the individual—orient the mission of public health. These principles have also been advocated by some ethicists as appropriate for clinical medicine (Engelhardt 1996), but the ethos of the medical community seems to reside more squarely with an individual-based approach (Annas 1997; Levinsky 1984). Nonetheless, from the communal point of view, the “structure” of the ethics of public health expresses a shift away from the protection of individual rights as fundamental, to the collective interests of the community. Autonomy, then, must be balanced with communal interests, specifically when determining how to spend limited resources to protect and promote the public's health and society's overall welfare.

This is the ethical orientation that guides such traditional public health activities as environmental protection, food and drug safety, or quarantine and immunization. But this mission diversifies because of the various ways in which the

public has extended its arm towards the individual. In the United States, public health, by historical precedent, is not restricted only to protecting the health of the citizenry, but extends also to the delivery of health care to various groups—the elderly, the poor, Native Americans, the veterans of the armed forces—and thus establishes public policy that impacts directly on individual care. Simply put, no neat division separates public health and individual medical care. The precedent for such individualized care as a public responsibility rests on a communitarian ethic, which has extended its moral object beyond the community as a whole to the individual. This is a potentially far-reaching broadening of the ethical mandate of public health, and I believe it offers us a means by which to formulate a comprehensive policy that consolidates the ethical concerns of both medicine and public health and allows us to develop a coherent approach towards rationing care.

A MERGED ETHIC

We have strong political, religious, and moral mandates to care for our fellow citizens as a public responsibility, so that the community's resources are marshaled not only to protect the group, but also to care for those who require individual assistance. Aside from fulfilling the ethical responsibility towards individuals, such public policy strengthens group solidarity and cohesiveness, values that build communal strength. When viewed in this fashion, interesting resemblances emerge between the guiding ethic of medicine and that of public health, so that their apparent differences are less compelling than their shared concerns. Thus, if we regard communitarianism as including responsibility for the individual, as well as for the group, and if we see this double focus as fundamental to, and supervening, other ethical options, we find an interesting result: medicine and public health share the same moral foundation, namely, the responsibility for the other. This principle is based on an ethic of relational responsibility, reflecting the same deep ethical structure described for medicine's focus on the individual. In the case of medicine, the doctor-patient setting, the relationship is one-on-one; in the case of public health, the relational ethic is the community's responsibility for the individual citizen. The difference is only in the agency: the doctor/nurse, clinic/hospital or the public health institution, government office or policy.

Although utilitarian constraints may dictate restrictions based on economic and political choices, these remain secondary to the dominant ethic of relation and response. In this formulation, the respective ethical foundations of medicine and public health appear to merge. Responsibility need no longer be parsed into two different domains. In other words, from the perspective I propose here, the division of medicine and public health is *not* dictated by different moral agendas.

The community is responsible to and for all its citizens, each of whom should have the same opportunity for care, at least as dictated by the moral structure of relational responsibility. We would all choose to be healthy rather than ill; any of

us may require the community's help; we should all be assured of the opportunity to pursue optimal health as members of the community. So, of the various consequences resulting from placing clinical medicine and public health on the same ethical continuum, the most compelling are political. If we adopt a moral public philosophy that encompasses the individual and the community under the same ethical mandate outlined here, a major impetus for providing universal health care emerges: *health care becomes a human right in a communal setting where a relational ethic dictates moral choices.* If the community has a responsibility for its individual citizens, where the collective is morally compelled to assure equitable access for its individuals, then the current American system is arbitrary and artificial. We may be autonomous in choosing our political affiliations, in deciding whether we send our children to public or private schools, or in choosing whether we buy a fur coat or watch pornography, but the community's health is the collective health of all of its citizens. This affirmation is the product of a relational morality.

Public health policy optimizes health by assuring water purity, sanitation of environment and food, the safety of drugs, immunization against infectious diseases, and safety in the work place, home, and highway. Numerous other public health functions maximize health and longevity, activities based on the attempt to assure the well-being of the citizen. These measures are equitably distributed. Why is medicine, the individual delivery of health care, split off into its own sphere of interest and not part of community-based public health?

The immediate political question posed by my argument is, why do we not have universal health care coverage? There are *historical* reasons, but no *moral* ones. If one further blurs, if not erases, the line between public health and medicine, the commonality of their ethical structure dictates a reassessment of the health care principles that sustains them. Individually focused health care and community-based public health are responses of responsibility dictated by a relational ethic in which each of us has the same moral standing. From this philosophical position, the following conclusion seems appropriate: just as citizens enjoy equal political and legal rights irrespective of their individual social, religious, or economic status, so too should the community enjoy the just and equitable distribution of opportunities for health. These moral dictates indeed have political consequences—the institution of universal health care.

THE APPARENT IMBROGLIO OF RATIONING

The ethical structure I have been arguing for allows rationing a full philosophical hearing. Indeed, to institute universal coverage that endeavors to be equitable, rationing becomes an economic necessity. Social policy must then become explicit about rationing, and various proposals have already been made. Some, like Daniel Callahan (1998), have advocated a utilitarian approach, whereby we should ration the health care budget toward preventive medicine and public

health, and adopt a more critical attitude concerning the cost effectiveness of technology. If we advocate relief of symptoms and treatment of disability as opposed to curative efforts, defining appropriate care for the greatest number will mean making difficult choices in withholding end-of-life support and resources directed toward the older population, where cost/benefit ratios are deemed too high relative to the rest of the younger population. But the problem is far deeper than what to do about the growing elderly population, for even in considering the young and middle aged, difficult decisions must be made as to what is the best allocation of limited resources.

The most famous example of this kind of prioritization was the Oregon Plan, a graded listing of conditions that would be treated for the indigent enrolled in government-sponsored Medicaid (Bodenheimer 1997). The scheme was ultimately rejected, not only because of contention regarding its priority strategy, but because it singled out the poor for such limits. Despite its failure, the Oregon Plan became a pioneering effort to set such ranking in a systematic fashion and brought the issue squarely before the American public: unless deliberate choices are made, health care remains a commodity most accessible to the rich and least available to the vulnerable. By embracing rational rationing, a moral commitment to the individual is assured, and the calculus of caring is switched from one of competition to one of communal responsibility.

While there is much talk of how we might attempt to limit access for marginal and unnecessary care, the institution of such policy is rigorously resisted, both in the private sector and when government tentatively suggests it. Part of the reason is due to the paucity of bona fide knowledge concerning the cost effectiveness of various diagnostic and therapeutic strategies. We simply do not have the data in too many cases to make informed decisions. That state of ignorance could be altered with a greater commitment to obtaining such evidence (a movement of sorts is underway). But the major obstacle, and the one I have addressed here, is finding a meeting ground between the rights of the individual and the claims of the body politic. The compelling rationale notwithstanding, institution of rationing seems distant. Some readily admit that they see no immediate political resolution to the rationing question and are simply leaving its settlement to the marketplace coupled with medical progress (Schwartz 1998). Putting faith in some nebulous notion of future medical advance, which entails cost savings success, strikes me as Pollyannaish. Simply put, the R-word will not go away. We are faced with a crisis now, and under the aegis of rationing, we require a forthright policy, at once both economically rational and politically ethical—one that upholds the precept that all citizens should have equal access to medical care. Communitarian principles offer the philosophical foundation for finding a consensus, embracing a moral commitment that must serve as the essential basis of reform. To be sure, our health care system is in economic crisis, but more importantly the impasse over rationing is testament to the erosion of the American community—sustaining cohesive social values and the political

will to translate those values into policy. For all of America's clinical successes, our communal health is in dire straits.

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Free Creations

The place beyond our stars is crowded thought,
Filled with m-c squares and quiet visions,
With fusions, formulas, and mental fissions.

Incredible spiral nebulae, space-dust,
Red giants and white dwarfs play
Across uncharted thoughts in minds
Exploding with uncharted universes—
Free creations,
Quite at odds with the straightjackets
Of each earth-tied day.

HARRY P. KROITOR