Chinese University of Hong Kong Second Lecture 2017
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Medical Science, Social Welfare, and Individual Lives: **Integrating Competing Claims**

In my first presentation I indicated that both in medicine and in philosophy our understanding requires us to grasp connections between conceptual, empirical, and normative considerations. In this second presentation I want to highlight another group of considerations related to each other in important ways, namely, **medical science**, **social welfare**, and the life of **the individual**. To better understand the significance of medical practice and health we have to come to grips with each of those categories. Each is a source of important values. As citizens of political communities we unavoidably encounter questions concerning social aspects of maintaining health and the practice of medicine. And our views of what is most important in individuals' lives are never far from the center of reasoning about what to do.

Considering how these issues are related is a way to come to grips with the challenge of a **plurality of values**, something that is unavoidable in the context of ethics and healthcare.

By "plurality of values" or "value pluralism " I mean that there is more than one source or ground of value—both in regard to general ***kinds of value*** such as ethical value, aesthetic value, epistemic value, possibly other types—and in regard to there being ***multiple sources*** or grounds **of *ethical value***. There is not just one source or ground of ethical value. That point, and some of its implications will be the primary concerns in the present discussion.

Value monism—the view that there is one source or ground of moral value—is the position held by John Stuart Mill. He thought that ethical reasoning and judgment concern just one value—what he called "utility." And he held that the moral rightness of an action was always a matter of whether, of the actions available to an agent, the action performed was the one most likely to produce the greatest amount of utility in the situation. By "utility" he meant pleasure or happiness, what we might call "well-being."

Even if there are numerous significant philosophical objections to utilitarianism it is fair to say that many people—and in particular, many legislators and developers of policy—often evaluate situations and policies mainly in terms of their impact on overall human welfare—on the basis of their alleged benefits. That is an understandable way to think

about policies and practices even if, on reflection and inspection we find it to be seriously problematic.

When we are considering the wisdom of a possible policy or rule it makes good sense to think in terms of **(i)** who will be impacted and **(ii)** in what ways—thought of mainly in terms of its likely costs and its likely benefits. That is, we want to make as educated a judgment as possible of **what difference it will make** to implement the rule of policy. And the difference that seems to matter most is how it will impact **human welfare**.

However, it does not take long to see that the issues are almost certainly more complex than that.

Mill was anxious to show that his concern with welfare or happiness was neither egoistic nor hedonistic in a vulgar sense. He held that the utility in question is the utility of all persons affected and not just the utility of the agent performing the action or that agent and the people about whom that person cares. In addition, by pleasure or happiness Mill did not mean only sensual or physical pleasures or whatever pleasures might be most easily attainable in the situation. He included physical pleasures but he also included pleasures of the mind, of learning and understanding, of aesthetic appreciation, of the imagination, and of achievement and striving, and so forth. He endorsed a hedonist theory of value but it was not vulgar hedonism, and he argued that there are qualitative distinctions between pleasures, not just quantitative ones.

That was a problematic aspect of his view, and it was problematic in a way that has to do with the monism of his theory. On the one hand, he wanted to show that ethical judgments are empirical, objective, based on facts about what is most productive of pleasure, while on the other hand he insisted that pleasures differ **qualitatively** and not just **quantitatively**. How could he maintain both claims without violating his commitment to ethical judgment being based on empirical, factual grounds? What empirical basis is there for saying that some pleasures are qualitatively superior to others? His solution was to find an empirical, factual basis for making qualitative distinctions. He argued that the only factually supportable way to do that is to regard as authoritative the preferences of persons with the greatest breadth of experience of different pleasures.

Suppose someone has had the experience of being pleasantly intoxicated and has enjoyed many different physical pleasures but has also acquired an informed interest in certain styles of painting and is a skilled and enthusiastic chess player. If we were to ask that person, “around which sorts of pleasures do you believe it would best to fashion a central, guiding conception of how to live?” most of us probably expect the person to answer in terms of the pleasures of the mind, of human interaction, and those involving the exercise of ‘higher’ rather than just ‘lower’ faculties. (Mill had distinguished between the higher faculties of a human being and the lower faculties but he was careful not to define superior pleasures as pleasures of the higher faculties. That needed

to be an empirical matter ascertained by empirical inquiry.) Mill was not trying to minimize the importance of sensual pleasures, nor did he think that someone is an ethically bad person if that individual is not motivated primarily to pursue superior pleasures. But he did argue for an empirical measure of which pleasures are superior and which are inferior…people who have experienced both kinds tend to prefer the pleasures of the higher faculties.

If more people were given the opportunity to experience pleasures of the mind, of aesthetic experience, of exercising complex skills, and so forth ***their desires would change***. They would come to desire those pleasures rather than building their lives around pursuit of sensual pleasures. He argued that the reason so many poor and uneducated persons indulge in drunkenness, fighting, petty gambling, and so on is that they have no opportunity and lack the resources for experiencing other pleasures. If you live in squalor, work twelve hours per day for little pay, have little if any education, and have almost no prospect of improving your lot in life it is not surprising if, on your one day off per week, all you want to do is get drunk. Just telling someone that the pleasures of the mind are superior to the pleasures of intoxication is not likely to be persuasive. Actually experiencing both kinds of pleasure would, Mill thought, generally motivate desire for the superior pleasures.

The main reason for lingering over Mill's view is that it is a clear example of a ***monistic*** theory of value; the claim that there is one value, and it is pleasure. Mill even understood virtue in terms of a reliable disposition to act in ways that impartially maximize utility. In his view that is what makes honesty, courage, and compassion virtues. They are valuable because of the kinds of states of affairs they bring about, not valuable intrinsically. There is a second reason for Mill's thought to be a way into our issues. As I mentioned, it is plausible, or at least, many people *believe* it is plausible to consider ethical issues of health care in utilitarian terms. Health is something it is rational for all persons to desire. Why not regard policies that promote and preserve health as among the ethical obligations of—well, of whom? Should they be ethical obligations of the state? Should we regard a certain minimum level of health care as a human *right*? We will say more about such questions shortly. At this point I just want to note that health care certainly *seems* to be something it makes sense to regard in broadly utilitarian terms. We will need to see if that holds up upon reflection.

We should also ask if value-monism is a plausible view. What might be other values besides pleasure or wellbeing? We do not need to look far. In fact, looking at Mill's *Utilitarianism* points in a helpful direction. That little book has five chapters and chapters four and five are each motivated by the need Mill felt to show that **virtue** and **justice** are values that can be understood in utilitarian terms. That is, he wanted to show that they are not independent sources of ethical value, though, to a great many people they certainly seem to be just that. In some of the most influential conceptions of virtue it is held that virtues have intrinsic value as well as being conducive to human flourishing or happiness (which is not interpreted as pleasure). The notion that justice has value in

its own right, that its value is not dependent on its contribution to utility is certainly widely held. In fact, not only is justice thought to have value independent of utility it is also often thought to be *in tension* with utility. For example, it is not difficult to imagine situations in which what justice requires is at odds with what would bring about the greatest utility. We might say, of a situation, "it is a shame that doing what was fair resulted in disappointment for some of the people involved, but doing justice and doing what pleases people the most are two different things." Or, "respecting people's legitimate rights-claims and making people are two different things."

It is easy to imagine a situation in which we are thinking, "Several people will be disappointed by this decision but it is the fair thing to do." Or, in another situation we might say, "It seems that people are very happy with the outcome of that decision but it is clear that what was decided was unfair."

If we think about the kinds of considerations that seem to be morally relevant there is a good chance that the list might include justice, rights, happiness, autonomy, equality, and possibly other things, as well. When considering the ethical aspects of situations or actions it is likely that it will seem that there are multiple grounds of value. We may find that a situation involves multiple, diverse values. It is common for the discussion of government policies to involve disputes about fairness and about welfare or utility. The fairness issue may depend primarily on whether anyone's rights would be violated by the proposed policy or whether the proposed policy would remedy a current violation of rights. But the question of fairness is just one of numerous morally relevant aspects of the issue and there isn't a fixed formula telling us which values take priority over others.

It is easy to see that debates about healthcare, medicine, and government policy could involve multiple values. A politician may be telling the truth when he says that he wants to respect the rights of individuals *and* promote their welfare. The politician may have a simplistic notion of how to achieve that goal but the statement reflects awareness of a plurality of values. At the level of state policy there is an understandable emphasis on costs and benefits but that does not mean that only utility matters. The estimate of costs and benefits might be made in a context that takes certain rights for granted or presupposes that certain promises to specific groups will be kept. That is often the case in regard to social welfare.

When we think about health, medicine, and health policy at the social level we quickly encounter issues concerning whether or not the distribution of health care is just. It is a finite resource, and the resources of any society overall are finite. How are we to decide what resources to devote to healthcare and in what ways? This is a question about more than one value—e.g., fairness. It concerns fairness, various rights-claims, the issue of promoting the general welfare, and the good of individuals.

It is not as though there is a known quantity of healthcare that is given as a starting point. Depending on how healthcare is provided in a society there may be very different

amounts of it and the quantity might change for various reasons. For example, in the U.S., where many people seem to regard healthcare and medical attention as a consumption-good very large amounts of healthcare are made available and for those who can afford it, the supply seems almost endless. At the same time, there are many people who find the cost of healthcare prohibitive or struggle to find affordable health insurance. In the U.K. the question of how much to fund the NHS is a perennial public policy question; most of the healthcare provided there is provided by the state and it is regarded as an entitlement. That does not mean that a sufficient quantity of healthcare is provided (whatever that would mean) or that specific forms of healthcare are supplied in sufficient amounts. Also, there is no such thing as 'free' healthcare. The goods and services involved in healthcare are costly and they have to be paid for; one of the main debates is over how the burden of that cost should be borne.

Even if the debate about whether healthcare should have the status of a right is decided in favor of it being a right there remains the question of how much healthcare the society is to provide, what kinds of care, how it is to be provided, and how to pay for it. The rights issue is not fully detachable from the cost issue; the cost issue is not fully detachable from views about the worth or value of various types of health care.

Determining that it is a right does not guarantee that there are sufficient resources of the relevant kinds. The issue of whether healthcare is a right is connected with debates over the significance and role of health as a human good, debates concerning what justice requires, and debates about equality. It is clear that *health* is a human good but that does not settle the matter of where it ranks in regard to other goods, how it figures in human good overall, and what level of healthcare is supposed to be a matter of a right. What should guide decisions about what sorts of healthcare should be researched and provided-for?

There are also important concerns in regard to the allocation of healthcare across different generations. What should be the distribution of healthcare to the young, those in the prime of life, and the elderly? On what basis should such decisions be made, especially if healthcare is, in large measure, provided publicly rather than privately? Given scarce resources, should we prioritize medical research and the search for cures or should we strive to be as effective as possible in treating people today?

Suppose a society is quite prosperous and also that its healthcare-needs are satisfactorily met by the market, or that they are met with few serious deficiencies. Should we still say there is a right to a certain minimum level of healthcare in that society—or is it a right only if the market does not meet everyone's needs? (If a society is prosperous and people are prudent; they look after their health, they purchase medical insurance, and so forth—is there a right to healthcare in that society?)

This may be a way that healthcare differs from freedom of expression or freedom of association or other basic political liberties. It makes sense for the latter to be a matter

of rights even in political communities in which they are protected and exercised without interference. Is healthcare a right in the same way? [Many fundamental rights are mainly a matter of non-interference; they do not involve the positive provision of some costly good. Other rights do involve the provision of costly goods. If there is a right to healthcare it is a right of the latter kind. That also means that its cost needs to be considered in relation to whatever other costs are borne by the public treasury.]

The pluralism of values involved in the context of medicine and healthcare makes it clear that there isn't some single, master-criterion or principle to which we can appeal for the resolution of all the difficult questions. Thus, in addition to the scarcity (finiteness) of healthcare there are the challenges of integrating the various values involved at the three issues mentioned in the title of this talk we find at least the following sources of moral debate.

The following are among the most basic questions motivated by the issues in the title of this talk:

1. How should the science of medicine be pursued and what should be its priorities? If a nation has a nationalized healthcare system it still needs to address the question of what are the research priorities, how should **severity of a disease** be weighed in contrast to **the numbers of people** possibly affected by it? How should we balance the search for large-scale, long-term progress (say, in genetic engineering) against addressing current health issues? How should the support for research be weighed as a social priority in relation to other social aims?

2. Nearly all of those questions are also directly relevant to the issue of how to promote social welfare. In many contemporary nations—including many liberal democracies—there are more or less extensive social welfare entitlements. Even in the U.S., which does not have a nationalized health service, entitlement programs such as Medicaid and Medicare address issues of healthcare for very large numbers of people. Politically, it is very difficult to shrink such programs even if there is a strong rationale for doing so. Also, there are conflicts between liberty and social welfare, as is the case with anti-smoking ordinances and advertising the dangers of tobacco use. Less tobacco use might mean that fewer people die of tobacco-related disease but it might also mean that, in living longer, they actually increase the overall cost of healthcare. Another possible source of conflict has to do with whether there should be prohibition of, or surcharges on such food items as super-large sodas, very high-calorie, high-sodium and high-fat menu-items. Mayor Bloomfield of New York City wanted to institute a ban on super-large sugary drinks and the highest court of New York State rejected the ban as exceeding the regulatory authority of the city's Board of Health. Are such issues appropriately addressed by the democratic political process or by some other means?

Concern about diet and lifestyle (for example, exercise, sleep, substance use, and so forth) are found in wealthy societies but not only there. In many countries where per

capita income is rising (often from a very low starting point) and people's daily lives are changing the consumption of fast-food, processed food—basically, foods with high sugar and sodium content—has increased dramatically, with very troubling increases in the incidence of diabetes and obesity. Millions of people lifted out of poverty are encountering serious health issues consequent on how they spend their increased income. In a number of respects prosperity can multiple healthcare issues, not just in terms of increases in longevity and decreases in infant mortality but in terms of *declines* in health due to diet and lack of exercise.

It might seem that such developments should be regarded as public health issues and accordingly, should be addressed at the level of social policy. But there are genuine issues of individual liberty involved and there is no guarantee that civil servants, regulators, and lawmakers will be guided in a disinterested, well-informed manner with social welfare as the clear aim of policy.

Last time I argued that if we are to be responsive to the complexity of moral reality, we need to acknowledge that almost any situation or action may have several ethically relevant aspects. Also, we also need to acknowledge that there is not a fundamental principle or criterion that addresses all of the ethically relevant aspects of an action, policy or situation. That is because of the pluralism of values. In addition there is an unavoidable role for *judgment* in responding to the various values figuring in the situation. We cannot replace responsibility for judgment with the mechanical application of a master-rule or principle. It is quite implausible to think that morality can be codified.

Of course, policy is needed and being able to rely on a code is a way of relying on careful informed thought in a huge number of cases where one's own judgment may be unsettled, incomplete or inexpert. Plus, a code saves a great deal of time and energy. My point is not that no ethical situation can be addressed by a code; it is that ethics overall cannot be codified—mainly because of the multiplicity of values and the inevitable need for judgment. Also, judgment will not be developed if people rely on a code as if it is a body of ready-made judgments. It will seem that way to people who do not reflectively consider the reasons for the elements of the code; and that is where ethical thought can be stunted in a very unhelpful way.

Here I want to make a point about the difference between **derivation** and **determination**. If an ethical rule is derived from a principle that is to say it is a logical implication of that principle. Thus, if taking another's rightful possessions without permission and without voluntary agreement is wrong, then withdrawing money from another person's bank account with counterfeit identification is wrong.

Determination is when the specific, determinate form of application of a general rule or principle has to be formulated by reason. Thus, if a house is a durable, enclosed shelter for human beings and their possessions, then if you are asked to design a house for

someone you need to arrive at a determinate design, within constraints of cost, building materials, amount of time, etc. The architect does not derive the blueprint from the definition of a house. Rather, the architect formulates a specific determination of the general features of a house. And, let's suppose that, if intentional acts causing damage to another person's property are unjust and are to be punished—then the sanction for destroying jewelry and stock certificates, together valued at more than $10,000 HKD but less than 100,000 HKD from a person's home is to be imprisonment of no less than 6 months and no more than 3 years. [The sanction is nit a straightforward implication of the prohibition on stealing.]

This does not mean that moral judgments are subjective or that they cannot be supported by reasons. In fact, it makes *the giving of reasons* even more important. It means that explicating the weights and interrelations of the various relevant values is vitally important. However, ultimately, the basis of any codification of morality involves judgment and there will inevitably be cases that are not addressed by the code. Thus, there is a role for determination or specification of the kind that is made possible by practical wisdom. Often, determination of what is ethically justified (even if more than one course of action is justifiable) is not a matter of derivation, of inferring a requirement from a principle. It is a matter of specifying how the relevant values figure in the situation. It is a matter of seeing how, for example, honesty, fairness, compassion, and fortitude figure in the circumstances. The decision needs to respond to the values involved in the circumstances and how they are integrated. That is what the practically wise person understands.

One of the most important tasks in thinking through the ethics of healthcare issues is being alert to the several different ethical aspects of almost any issue. There are aspects of different kinds.

Thus,

1. There are different values such as welfare (and minimizing suffering) justice, rights, autonomy, public good.

2. Reflecting on those we realize there are different contexts of value—the individual, the community, inter-generational considerations, the distinctive claim on us of the present

3. There are very difficult questions concerning whether certain drugs should be put on a do-not-prescribe list of a national health service as a cost-savings measure. Is this a violation of clinical freedom? [The autonomy and the rights of physicians.]

In the U.S. and U.K. there are very different acceptance rates for patients for the treatment of End Stage Renal Failure. Also, proportionately more U.S. patients are on unit dialysis rather than home dialysis, and have more dialysis than transplantation as a

definitive treatment. Also, non-profit teaching hospitals had more than twice as many patients on less lucrative home dialysis than profit-making hospitals.

Also, there is a much higher rate of Caesarean deliveries in U.S. and it is higher among private patients than non-private patients. In general, in the U.S. doctors will tend to continue treatment until there is no further chance of success or benefit; in the U.K. treatment will not be offered or will be withdrawn when benefits are thought to be marginal or improbable, especially if serious side-effects are anticipated. British doctors have implicitly accepted rationing f services—and so has the public. In a society in which healthcare is considered a right, how should decisions be made about the extent of the relevant rights-claims?