

# THE EXCESSES OF INDIVIDUALISM

*For Meaningful Healthcare Reform, the United States  
Needs a Renewed Sense of Community*

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**H**ealthcare reform must begin with a critique of the values that currently shape health and healthcare in the United States. One of the critical value choices faced by all societies concerns the importance of individuals relative to the importance of community. Too much emphasis on community to the detriment of the individual person leads to a dehumanizing collectivism. Individuality, freedom, and tolerance are lost as persons are absorbed into the whole. Too much emphasis on the individual to the detriment of community leads to a dehumanizing alienation. Solidarity, cooperation, and shared meanings are lost as persons become absorbed with themselves. Either extreme distorts human relationships and impoverishes life. The ethical challenge is to use the tension between these extremes to set a creative balance

in values that acknowledges the legitimate claims of both.

In the United States at the end of the twentieth century, the balance tilts too far toward the individual. The correction needed is not a collectivism that destroys the individual—the other extreme—but a renewed sense of community that enhances the lives of individuals as it serves the common good.

## **DISTORTED TRUTHS**

The first step toward creating a new balance is a critique of the present imbalance and of the excessive forms of individualism that affect every aspect of our health and healthcare delivery system. Even as the excesses of individualism are criticized, however, important truths about individuals must be acknowledged. The individual person is sacred, created in God's image. Each

**Summary** In the United States at the end of the twentieth century, the balance of values tilts too far toward the individual and away from the community. What is needed is a renewed sense of community that enhances the lives of individuals as it serves the common good. The first step toward creating a new balance is a critique of the present imbalance, which is shaped by excessive forms of individualism that affect every aspect of our healthcare delivery system.

Technological individualism occurs when the value of technology is measured only by its service to the individual. The results are a technological imperative, unreasonable expectations on the part of the community, distorted judgment on the statistical likelihoods of individual outcomes, fragmentation of care, and a reliance on rescue medicine.

A psychosocial individualism has misshapen our attitudes about ourselves and our communities,

bringing with it a deepening sense of alienation. The results in U.S. healthcare include commercialization, exclusion of the poor, a litigious provider-patient relationship, declining respect for life, and a sense of community that excludes other generations and nations.

Libertarian individualism has created political isolation and prevents the evolution of democratic decision making and real partnerships in healthcare. The results are an unpooling of insurance risk, an interpretation of freedom that is inimical to family and community ties, hostility to government, a view of healthcare as a commodity, and deprofessionalization of the medical professions.

Healthcare reform must seek to change what medical technology does for us, repair the psychosocial harms healthcare individualism has produced, and promote citizen participation in the healthcare system in new and important ways.

individual partakes in the mysteries of life—of birth, growth and development, joy and suffering, and death. Each has a unique spiritual destiny. These profound truths form the basis of our cultural respect for persons and commitment to individual human rights.

But these truths are distorted when they are removed from their natural context in community. If each person is sacred, so are the communities that make persons possible. If persons are made in the image of God, then God must contain the social relationships that are reflected in each person's existence. Birth, growth and development, joy and suffering, and death are social as well as private events. Our spiritual destinies are plainly tied to one another's. These equally profound truths about community values are too often overwhelmed by an exaggerated emphasis on individuals abstracted from their real relationships.

This pattern of extreme individualism affects all dimensions of life in the United States, including healthcare. A meaningful critique of the values in healthcare is necessarily a critique of this exaggerated individualism. Such a critique can be organized around three questions: How does individualism shape what healthcare does *for* us? How does individualism affect what the healthcare delivery system does *to* us? How does individualism influence the way we *participate* in health and healthcare?

### WHAT HEALTHCARE DOES FOR US: TECHNOLOGICAL INDIVIDUALISM

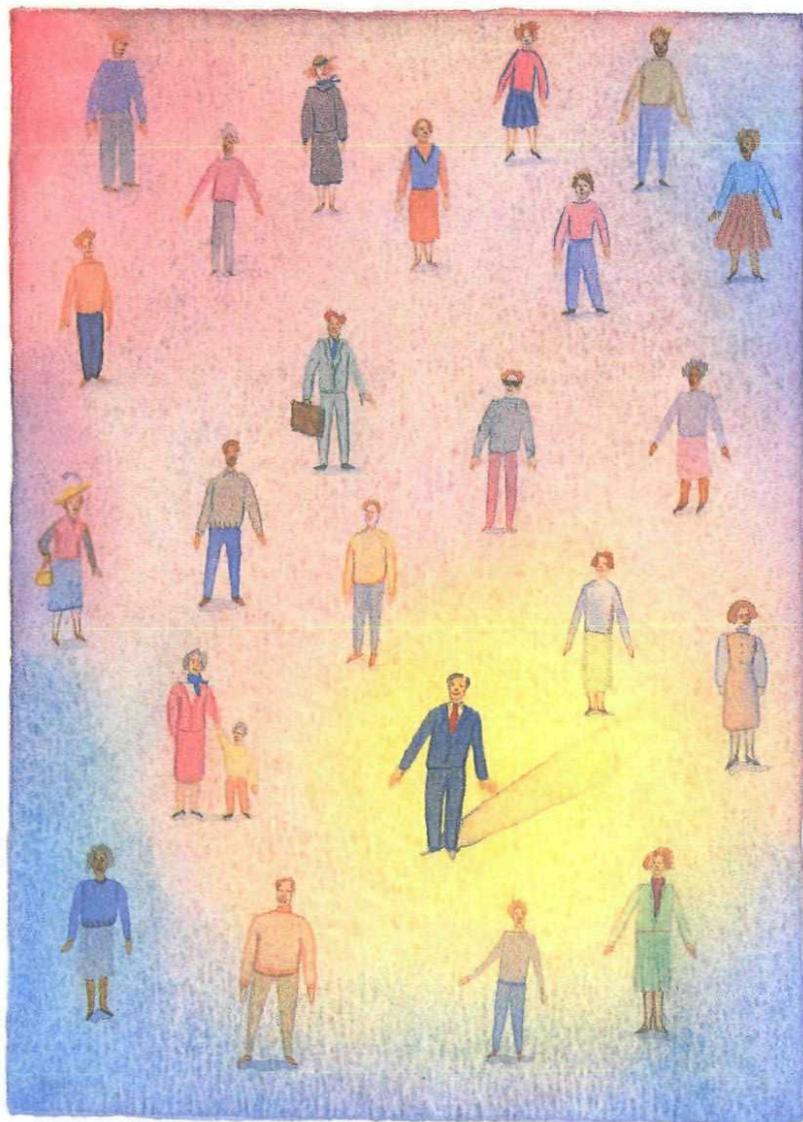
Every healthcare delivery system is at root an organization of people helping other people. What distinguishes U.S. healthcare delivery is an extraordinary reliance on technology as the instrument for helping people. Modern medical technology often works miracles, saving persons from premature deaths and preserving or restoring quality to innumerable lives. But emphasis on technology in healthcare has negative implications too. Technological individualism occurs when the value of technology is measured only by its service to the individual.

**Technological Imperative** When a technology is even marginally useful for some individuals, an insistent technological imperative brings it into general use. Technologies that can be developed are developed; technologies that are developed are used. We have no standards for assessing the medical effectiveness of new technologies and for evaluating their cost-effectiveness for the population as a whole. As a result, technologies that are useful for some individuals become burdens for many others.

In many cases, clinical judgment is strongly

influenced by technological presumptions. Many healthcare providers believe that technologies at hand are part of the ordinary standard of care, even when their use for particular patients may be futile or may create more burdens than benefits. For example, physicians often find it hard not to use dialysis machines, ventilators, and feeding tubes even when they serve largely to prolong dying. Patients and families find it hard to refuse them. Thus the availability of machinery often overwhelms human judgment. Because some individuals can benefit from these and other medical technologies, all individuals become subject to their use.

Moreover, the entire community bears the economic burden of the technological imperative. The dimensions of this economic burden make it



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increasingly difficult to provide the most basic primary care to all citizens, even as the technology of tertiary care spreads throughout the delivery system.

**Unreasonable Expectations**

Media attention to individual cases of successful technological innovation often generates unreasonable expectations on the part of the community. These expectations in turn spur the technological imperative, creating a vicious cycle.

Consumers expect every hospital, doctor's office, and site of care to be fully equipped with the most modern medical technology. This demand of everything for everybody has led to wasteful duplication of technologies in many communities and an uncontrolled cost escalation throughout the healthcare sector.

Insatiable public demands blind us to the need for limits, personally and socially. They also obscure the natural realities of illness, disability, and death. Even the reality of a natural life span has been blurred by the effort to extend individual lives indefinitely by any technical means possible. Medical technology and the public demand related to it thus foster denial—of limits, of illness, of death itself.

**Distorted Judgment** Expectations of a technological solution for every individual malady have affected our ability to deal with probability in individual cases. Patients, family members, and providers too often ignore the overwhelming evidence of statistical likelihoods and use heroic technology in the hope of a miracle. Medical miracles do occur, but fixation on these individual cases leads to untold suffering for others whose interests would be better served by less technology and more acceptance.

Medical technology has affected reasoning at the social level as well. Increasingly, policy decisions to expand expensive technological services and to make capital improvements rely on private technical solutions in place of public political choices. In the past decade regional health planning councils and state certificate-of-need reviews have been weakened or disbanded. Although both these processes had flaws, they held out the promise of community involvement in health planning. Now individual healthcare institutions and private providers make their own choices,

**T**his litigious  
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relying on general business techniques and professional marketing analyses. Throughout the healthcare arena, it is easier to plan with the techniques of experts than with the common sense of fellow citizens.

**Fragmentation of Care**

Ironically, increased dependence on medical technology has fragmented healthcare even as it has forced more emphasis on team medicine. Focus on tech-

nology has fostered specialization and a division of labor in contemporary healthcare. As physicians and nurses have developed expertise in specific treatment techniques, their responsiveness to the whole person in need has diminished. In many cases the continuity and comprehensiveness of care have been affected. Patients often feel overwhelmed by the sheer number of specialists and administrative procedures. Time for listening and for providing emotional support for those who are ill and dying is not highly valued in the system, as evidenced by the fact that these activities are not reimbursed. Too often, medical technologies *for* individuals overwhelm relationships *with* individuals.

**Rescue Medicine** Fascination with technology has heightened our emphasis on rescuing people who are ill without bringing proportional attention to prevention.

The healthcare system provides unprecedented amounts of money to support high-technology care for individuals after their health has been compromised, but proportionately little for public health programs, social services, and economic development that can prevent illness and keep communities healthy. Hundreds of thousands can be spent saving a two-pound newborn in a neonatal intensive care unit, while little is spent educating mothers on measures to prevent premature births. Prevention has little of the prestige and economic reward associated with high-technology rescue medicine, but it does save lives and maintain their quality. Technology serves individuals; prevention serves the community.

**WHAT HEALTHCARE DOES TO US:  
PSYCHOSOCIAL INDIVIDUALISM**

Individualism also affects the way people think and feel about healthcare. A psychosocial individ-

ualism in healthcare has misshapen our attitudes about ourselves and our communities. Psychosocial individualism is a spontaneous mode of thinking and feeling about oneself and others that consistently stresses the value of the individual and underrates the value of the community. Although this attitude has fostered some important accomplishments, most notably the establishment of the right to informed consent, it has brought with it a deepening sense of alienation.

**Commercialization** U.S. healthcare places less emphasis on mission and more on margin; less emphasis on the needs of others, more on self-interest. Large parts of the delivery system have become commercialized. Many hospitals whose founding intentions were based on compassion for the sick, especially for the sick poor, are now operated like businesses and are expected to generate sizeable margins. In the 1980s, as investor-owned, for-profit hospitals spread throughout the United States, the traditional moral notions that profit should not be made on the illnesses of others and that commercial competition in healthcare is inappropriate began to break down. Some institutional providers that are technically not-for-profit are as margin driven and competitive as their for-profit peers. Pharmaceutical houses and manufacturers of medical technology and supplies make exceptionally high profits. Healthcare is a major focus of investment in the stock and bond market, and philanthropy to hospitals has all but disappeared.

Individual providers have been affected, too. Physicians, nurses, and other healthcare professionals provide significantly less charity care than they did a generation ago. Doctors' investments in preferred provider organizations, imaging centers, and other new sites for testing and treatment have provoked government scrutiny. Clinical research has been probed for conflicts of interest. Pharmaceutical companies' gifts to doctors and to continuing medical education programs have elicited new restrictive guidelines.

The public has become more suspicious of the motives of healthcare providers as their behavior has appeared increasingly selfish, an inversion of the traditional motive for healthcare. Individualism promotes cynicism about altruism and increasingly frank admissions of self-interest. More and more healthcare providers regard their work as little different from that in other careers. The traditional ethos of medicine, *primum non nocere* (first do no harm), is being replaced by the ethos of the marketplace, *caveat emptor* (let the buyer beware).

**Exclusion of the Poor** Lack of a vital concept of community has resulted in extremes of medical

poverty in the midst of a general affluence. Alone among industrialized democracies, the United States has failed to provide a basic level of care for all its citizens. More than 35 million Americans are completely uninsured; millions more are temporarily uninsured or substantially underinsured.

The medical "safety net" of Medicaid covers a declining percentage of those living below the federal poverty line, dropping from 65 percent of the below-poverty population in 1975 to less than 40 percent in 1990. While white Americans in affluent suburbs receive some of the best medical care in the world, many poor black and Hispanic Americans in the inner cities have no primary healthcare providers and must rely on hospital emergency rooms as their only source of care. The healthcare system for rural Americans continues to decay with few signs of renewal. Our psychosocial individualism makes it difficult or impossible for healthcare "haves" to identify with the plight of healthcare "have-nots."

**Other as Threat** A hallmark of contemporary healthcare is the medical malpractice suit and the defensive medicine practiced to protect against it. Patients enter relationships with providers with a consumer's product-liability mentality. Providers are increasingly wary of their patients as potential litigants. Tests and procedures whose only justification is protection against potential lawsuits add millions to our healthcare costs annually. Lawyers on contingent-fee arrangements bring suits that healthcare providers frequently find wholly without merit, but insurers settle to avoid the costs of trials.

This litigious environment distorts clinical judgments and policy choices. Before asking what is best for a patient and right for a community, many providers ask what the law requires and whether they can be sued in the event of a bad outcome. Moral and political judgment is preempted by legal fears. The mission of healing and helping those in need is undermined by the perception of patients as threats.

**Throwaway Lives** The staggering annual rate of elective abortion is evidence of a declining respect for life in the United States. Fetuses that are not "wanted" are considered valueless by growing numbers of Americans. Moreover, the cycles of poverty and other social problems that foster unplanned pregnancies and frequently lead to abortion have not been addressed effectively. There are too few social networks that can support a woman's decision to carry a difficult pregnancy to term and raise her child in a secure household. It is small surprise, then, that many Americans choose abortion.

The other end of life raises concerns as well.

Because the successes of modern medicine have also made dying more difficult for many Americans, public scrutiny of care for the terminally ill has been growing. Many patients and their families are exercising their right to refuse futile or burdensome treatments. Many people are executing advance directives to control their care when dying. And political demands are increasing for estab-

lishment of a long-term care system that will provide dignified care to all those with diminished capacities.

These are appropriate responses to the expansion of medical technologies for managing disability, decline, and death. But some are demanding more. They are calling for legalized medical killing and establishment of a right to suicide when life has become a burden or has fallen below some notion of acceptable quality. They look to healthcare to kill in a "safe and humane" way when life is no longer valued.

But neither abortion nor euthanasia is an ethically acceptable alternative in difficult situations. Both are direct acts of killing. Both uproot healthcare from its Judeo-Christian and Hippocratic traditions. And in both cases the rhetoric of personal choice voices an extreme individualism that arbitrarily limits our conception of community.

**Fixation on the Here and Now** Psychosocial individualism in healthcare has limited our sense of community in two other important ways. Unlimited demand that healthcare address all our desires has contributed to a national indebtedness so substantial that it compromises the ability to address legitimate needs of future generations, in healthcare as well as in other important areas. In spite of recent cost-containing measures, bankruptcy of Medicare's Hospital Trust Fund is projected for the first decade of the twenty-first century. There are some indications that increased healthcare spending for the elderly is being paid for by cuts in programs that primarily serve children, especially poor children. The children of today's children may fare even worse. Their interests have little apparent effect on our national healthcare planning. Intergenerational conflict of this sort is unfair to all parties; it pits vulnerable groups

## Libertarian individualism makes healthcare into a commodity.

against one another.

At the same time that our temporal sense of community has become attenuated, we seem less committed to addressing the healthcare needs of our contemporaries in other nations. While U.S. spending on healthcare has spiraled, we have substantially reduced nonmilitary foreign aid. Dramatic improvements in the health of millions living in Third World poverty could

easily be accomplished by small U.S. investments in better nutrition, clean water, closed sewers, and other public health measures. But our individualism makes us unable or unwilling to conceive of a world community of healthcare needs.

### HOW HEALTHCARE LIMITS PARTICIPATION: LIBERTARIAN INDIVIDUALISM

Even though the healthcare industry is one of the largest sectors of the economy, excessive individualism limits participation in the system. Libertarian individualism—the belief that individual liberty is the highest political value and that government is the main threat to that value—creates political isolation and prevents the evolution of democratic decision making and real partnerships in healthcare.

**Unpooling Risk** The clearest example of the triumph of libertarian individualism and consequent distortion of a sense of community in healthcare is contemporary health insurance. The social function of insurance is to pool risk, to spread the financial burden of sickness. At its inception, most health insurance was based on community rating, that is, on a single premium and benefit package for all. But most insurance is now sold on the basis of experience rating, that is, with premiums and benefit structures tied to group or individual experience with illness and health risk. Thus those who have been ill and those who are likely to be ill pay more for less coverage, if they can afford it at all.

This marketing strategy creates the uninsurable, the untouchables of healthcare financing. Excluding those with significant experience with illness and those at high risk of becoming ill is not only a conscious industry strategy, but also a response to a growing public demand. Americans appear to want risk-adjusted health insurance pre-

miums. Our individualistic sense of fairness entails that those who may cost more should pay more.

But experience rating undermines the social justification for health insurance by marginalizing those most in need of coverage. In essence, increasing risk segmentation in health insurance is a refusal by the wealthy and the well to share the financial burden of caring for the sick and the poor.

**Freedom From** The dominant understanding of freedom in the United States is freedom to be left alone, an individual right to noninterference by others. This interpretation of freedom is inimical to family and community ties. It promotes loneliness and alienation. It blinds us to social dimensions of health, leading us to regard disease as primarily an individual event. The system reacts accordingly, focusing on chemotherapy for an individual's cancer, not on the environmental pollution that may have triggered it. There is investment in angioplasty for heart attack victims but not in social measures to reduce the stresses of daily life.

Americans' disposition to be left alone also promotes the isolation of the handicapped, the sick, and the dying in institutions. We prefer not to see those who are in crisis or who are simply different. Ironically, our individualism promotes conformity and is challenged by differences.

**Hostility to Government** Libertarian individualism takes a special expression in political terms. Americans are deeply suspicious of government, resenting its role as a regulator, perceiving it as incompetent, and regarding it as a threat to freedom and innovation. Most comparable nations view the financing or provision of healthcare as a fundamental responsibility of government and a right of all citizens. With few exceptions—most notably the Medicare program—we have chosen the marketplace over government as a means of financing and providing healthcare. Government represents a single voice for the community, whereas the marketplace is a field of individual freedom to compete.

Preference for the market has accelerated in the past two decades so that now the competitive atmosphere of business pervades healthcare. Institutional marketing and professional advertising—scorned as wasteful and denigrating just 20 years ago—are now widespread. The ethos in much of the healthcare system is becoming indistinguishable from that of business in general. At the same time, public mechanisms for financing healthcare face restrictions and tax revolts.

Americans do not participate in the healthcare system as citizens but as consumers. Whereas equality is assumed among citizens, inequality is

the presumption among consumers. Whereas citizens have rights, consumers make demands. Those who can pay receive all the healthcare they want, often more than they need. Those who cannot pay face substantial barriers to care. People have no right of access to healthcare in the medical marketplace.

**Healthcare as Commodity** As libertarian individualism makes patients into consumers, so it makes healthcare into a commodity. Healthcare services are developed, added, or dropped more because of their ability to generate revenue, and less because of community needs. Healthcare is produced for sale, not for service.

As medical specialization has become a guaranteed path to the highest socioeconomic status in the nation, students increasingly regard their education in the health professions as an investment in future earnings, not as preparation for a life of service to others. And consumers increasingly regard health as something that can be bought.

**Deprofessionalization** The isolation promoted by libertarianism has affected the health professions. The educational preparation of many healthcare professionals has become purely technical, disengaged from notions of professional obligation and fiduciary responsibility. The traditional notion of medicine as a professional guild that regulates itself in light of its commitment to public service has eroded. In its place has come competition among individual physicians, widespread advertising and other marketing techniques, and decreasing public prestige. Accelerating costs and malpractice suits have led to unprecedented regulation of physicians' behavior and to a sea of red tape. The medical profession is becoming increasingly unsatisfying to practicing physicians and unappealing to talented students who might otherwise consider medicine as a career. The long-term effects of this process do not bode well for physicians or for the public they serve.

### HOW TO ENRICH OUR SENSE OF COMMUNITY

A critique of our system's technological, psychosocial, and libertarian individualism constitutes a major indictment of our healthcare system. But the impact of exaggerated individualism is tempered by the genuine dedication of millions of healthcare professionals, by a persisting focus on mission within many healthcare institutions, and by a growing awareness of the need for moderated expectations on the part of the general public. Systemic reform must draw on these resources. It must seek to change what our medical technology does for us, repair the psychosocial harms healthcare individualism has brought to us, and promote citizen participation in the

healthcare system in new and important ways.

**Technology for the Common Good** Americans are not about to disassemble the technological armamentaria of modern healthcare, nor should we. But the development, distribution, and use of medical technology must be regulated by a more robust sense of the common good. New technologies should be held to high standards of medical outcomes and cost-effectiveness before they are brought into general use. Doctors should have the clinical freedom to determine whether a technology that is ordinarily used has become extraordinary for a particular patient. Spending on research and development in medical technology should be subjected to greater scrutiny. More research attention should be paid to chronic illnesses (e.g., arthritis, osteoporosis, Alzheimer's disease). The U.S. public must be educated on the economic and social limits of medical technology. Doctors and hospitals must contain the desire for individual miracles and help patients and families reason more clearly about statistical likelihoods.

Local healthcare planning efforts should be renewed. Hospitals and other sites of diagnosis and treatment should be permitted and encouraged to share expensive medical technology. A primary healthcare network for all Americans must be developed in which everyone can identify an individual provider or social worker who integrates care and ensures continuity and comprehensiveness. Emphasis on high technologies of rescue medicine should be balanced with more emphasis on the low technologies of prevention. Generally, we must stress more what technology does for communities and less what it can do for individuals. We must impose human and community values on machines to prevent machines from imposing their logic on us.

**Thinking and Feeling Inclusively** Measures are needed to reinvigorate the original goals of healthcare throughout the system. Leaders should defend altruism and reject both cynicism and behavior based on self-interest. Excessive profits and incomes should be reduced. The poor and the uninsured must be brought into the system as valued groups of Americans. The differential health outcomes associated with racial and ethnic status should be attacked and erased. The tort system should be reformed to blunt the most negative dimensions of medical malpractice and defensive medicine.

Healthcare institutions and professionals should take the lead in creating the social networks needed to reduce the number of elective abortions. Dignified long-term care arrangements must be available to keep the elderly and disabled

as independent as possible as long as possible and to help family members help each other. A greater effort should be made to distinguish legitimate healthcare needs from healthcare desires. The former should be addressed universally, the latter ignored or left to individuals' private devices. Our sense of healthcare community should expand to avoid intergenerational conflict and to include the needs of human beings worldwide.

**Political Integration** Risk segmentation in health insurance must be ended and the pooling of risks restored as the main ethical value of healthcare financing. No American should be uninsured. A community of shared risk between the wealthy and well and the poor and sick must be established.

Americans need a more complete conception of freedom, one that sees opportunities in relationships with others and not simply limitations. The handicapped, the sick, and the dying should be brought into the mainstream of life. We must reexamine the role of government, searching for ways to use it as a partner to help create a system that is both equitable to all and capable of containing costs. The experiment in the 1980s with the commercialization of healthcare has reached its ethical limit and should be reversed. A right to healthcare must be established and guaranteed in a system that retains its plural vitality, yet provides a basic level of care sufficiently comprehensive to address healthcare needs across the United States.

Health should be regarded as something to be actively engaged in, not something to be bought as a commodity. Physicians should be freed to make clinical judgments in the best interests of the patients they serve, with a minimum of third-party interference. Administration must be simplified so that professionals can maintain their fiduciary relationships with their patients.

### MANY CHALLENGES

These goals are complex and will be difficult to achieve. But they can be achieved by drawing on existing strengths in our institutional, professional, and cultural resources. Many challenges confront those who work for systemic healthcare reform in the United States. But renewal of our sense of community, while we preserve the important achievements of respect for individual persons, is the most important challenge at hand. It is a matter of striking a new sense of balance in our most fundamental values. □

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