Philosophy & Public Policy Quarterly

The Institute for Philosophy and Public Policy
School of Public Policy • University of Maryland

About Altruism

Judith Lichtenberg

There are two main things we want to know about altruistic behavior. First, does it exist? Second, if so, how can we produce more of it?

The second question is practical. Although altruism does not guarantee desirable results—suicide bombers may be as selfless as anyone you can find—what we might call constructive altruism could alleviate a lot of suffering. If we knew how to get people to care less about Number One and more about others, the world might become a less nasty place.

The first question, by contrast, is abstract and theoretical. It usually gets asked by philosophers, scientists, undergraduates, and others pondering the essential nature of human action. They want to know whether people *ever* act in a way that is genuinely selfless, or whether instead human motives are always egoistic—aimed at the agent's own good. This is the question on which I shall focus in this essay, since unless we can answer it, we never get to the second question.

Who would doubt the existence of altruism? Two recent news stories seem to prove it. Just after the new year, Wesley Autrey, a man standing with his two young daughters on a New York City subway platform, jumped down onto the tracks as a train was approaching to save another man who had suffered a seizure and fallen. (Autrey succeeded, and neither man was hurt.) In April, an engineering professor, Liviu Librescu, blocked the door to his classroom so his students could escape the bullets of Seung-Hui Cho, the Virginia Tech student who killed thirty-two of his classmates. The students were able to jump to safety from the classroom window. Professor Librescu was less fortunate, and died from Cho's gunshots.

It may seem that when people act to aid others they get something in return—at the very least, the satisfaction of having their desire to help fulfilled. From there some conclude that achieving their own satisfaction is always people's dominant motive.

If these acts aren't altruistic, you may say, then what in the world could altruism be? What could people possibly mean when they doubt that altruism exists?

Anyone who has considered these questions knows that doubting altruism is easy. Yes, it's undeniable that people sometimes act in a way that benefits others, and that they may do so at what appears to be significant cost to themselves. Yet it may seem that when people act to aid others they get something in return—at the very least, the satisfaction of having their desire to help fulfilled. From there some conclude that achieving their own satisfaction is always people's dominant motive. Genuine altruism, it seems to follow, is an illusion. To those caught in its web the logic of these steps may seem inexorable.

Biological Altruism

Philosophers and undergraduates are not the only ones to ask how altruism is possible. Evolutionary theory also makes the question compelling. At first glance it appears that evolution has no place for altruism, since organisms who put others' interests above their own would not survive to reproduce their kind. This is the crude but popular picture of evolution as "survival of the fittest." Yet we seem to observe examples of altruism in nature, and evolutionary theory must explain how they are possible.

Three accounts of altruism have been proposed. One is *reciprocal altruism*, first described by William Trivers in 1971. Reciprocal altruism elevates "I scratch your back, you scratch mine" to a theory. Organisms sometimes sacrifice their good to the good of others, but they do so, according to this view, in the expectation that the favor will be returned. Reciprocal altruism requires that organisms interact more than once and that they are capable of recognizing each other, otherwise returning the favor would be impossible. Examples of reciprocal altruism include vampire bats who donate blood, by regurgitation, to others of their group who fail to feed on a given night (since vampire

bats die if they go without food for more than a few days).

A second theory of biological altruism is *kin selection*, also known as inclusive fitness. Where reciprocal altruism focuses on the individual organism as the unit of selection, kin selection centers on the gene. This is the famous "selfish gene" theory made popular by Richard Dawkins, although the idea was developed originally by William Hamilton in 1964. On this view, an individual who behaves altruistically to others sharing its genes will tend to reproduce those genes; the likelihood that the genes will be passed on depends on how closely related the individuals are. Parents share half their genes with offspring; likewise among siblings; first cousins share an eighth. The theory is supported by the observation that individuals tend to behave altruistically toward close kin.

The third evolutionary approach departs both from reciprocal altruism's focus on the individual organism and kin selection's focus on the gene. *Group selection* takes groups of organisms as the evolutionary unit. The idea is that groups containing altruists possess survival advantages against groups that do not. A clan in which members work for the good of all rather than their individual good will prosper against enemies. The weakness in this view is that groups of altruists seem to be subject to "subversion from within," as Dawkins calls it. "Free riders" who behave selfishly will possess advantages within the group, and altruists, it appears, will eventually die out. Although Darwin himself first proposed group selection, it eventually fell out of favor among evolutionary theorists. Elliot Sober and David Sloan Wilson have recently revived it, but it remains controversial.

What Does Biological Altruism Have to Do with Altruism?

Although contemporary discussions of altruism quickly turn to evolutionary explanations, the connection between the latter and the commonsense meaning of altruism as we apply it to humans is questionable. A look at reciprocal altruism reveals one reason why. If a person acts to benefit another in the expectation that the favor will be returned, the natural response is: "That's not altruism!" Genuine altruism, we think, requires a person to sacrifice her own interests for another without consideration of personal gain. Calculating what's in it for me is the very opposite of what we have in mind. Reciprocal altruism seems at best to amount to enlightened self-interest.

But there is a further reason why evolutionary altruism does not amount to altruism in the ordinary meaning of the term. When we ask whether people have acted altruistically, we are interested in their *motives* or *intentions*: we want to know whether they intended to benefit another person (recognizing the cost to themselves) or whether their motive was to benefit another (without regard to gain for themselves). Whether people act altruistically, then, depends on their psychological state, on what is going on or not going on in their mind when they act.

Biological altruism, on the other hand, is defined in terms of "reproductive fitness": an organism behaves altruistically when it tends to increase another organism's ability to survive and reproduce while decreasing its own. Biological altruism implies nothing about mental states; birds and bats and even bees are capable of it. As Sober and Wilson put it, "An organism need not have a mind for it to be an evolutionary altruist."

So in a certain sense evolutionary and psychological altruism have nothing to do with each other, since the everyday, psychological variety has everything to do with motives and the evolutionary variety has nothing to do with them. Indeed, as Samir Okasha notes, thinking of most biological organisms as selfish is just as wrong-headed as thinking of them as altruistic: selfishness, like altruism, is about motives and intentions.

Of course, biological and psychological altruism can go together: a person who intentionally sacrifices her interests for another will, other things being equal, decrease her reproductive fitness. If she sacrifices her life, her genes will not be carried on (unless she sacrifices her life for a close relative, as kin selection observes). Still, the existence of evolutionary altruism is not *sufficient* for psychological altruism, our commonsense understanding of the concept, which has to do with motives and intentions. Nor is evolutionary altruism *necessary* for psychological altruism. Behavior is not determined solely by genes and evolution; environment, culture, and choice also play a role. Even if we found no examples of evolutionary altruism, psychological altruism would still be possible.

If a person acts to benefit another in the expectation that the favor will be returned, the natural response is: "That's not altruism!"

It's worth noting an ironic twist in the relationship between biological and psychological altruism. Kin selection and group selection, two of the evolutionary accounts of biological altruism, have a dark side in terms of our usual understanding of unselfish behavior. Individuals who favor their genetic relatives, members of their own group, or others similar to them lack these inclinations toward those who are not so connected. Altruism, from this point of view, is relative, and correlates with the division between in-groups

and out-groups. If our hope is that altruism can enlarge empathy for other human beings and lessen hostility or indifference, the biological account may be disappointing, because it implies an "us" and a "them." Still, biology is only part of the story.

Understanding Psychological Altruism

Our question is whether people ever act altruistically, in the ordinary, psychological sense of that term. According to egoism, people never intentionally act to benefit others except to obtain some good for themselves. Altruism is the denial of egoism, so if ever in the history of the world one person acted intentionally to benefit another, but not as a means to his own well-being, egoism would be refuted. In this sense altruism is a very weak doctrine: by itself it says nothing about the *extent* of selfless behavior; it asserts only that there is at least a little bit of it in the world.

Egoism possesses a powerful lure over our thinking, which has, I believe, two sources. One is logical: it derives from philosophical puzzles and difficulties encountered in thinking about these questions. The other is psychological: it rests on thinking about our own motives and intentions.

Consider first the psychological. One reason people feel pushed to deny that altruism exists is that, looking inward, they doubt the purity of their own motives. We know that even when we appear to act altruistically, other reasons for our behavior can sometimes be unearthed: the prospect of a future favor, the boost to our reputation, or simply the good feeling that comes from appearing to act unselfishly. As Kant and Freud observed, people's true motives may be hidden, even (or perhaps especially) from themselves: even if we think we are acting solely to further another person's good, that might not be the real reason. Perhaps there is no single "real reason"—actions can have multiple motives. To decide whether an altruistic motive is dominant or decisive requires a counterfactual test: would you still have performed the action had you not benefited in some way? But even if the question is theoretically answerable, we are rarely if ever in a position to answer it.

We know that we are not as selfless as we would like to be or even as we might appear.

So the lure of egoism as a theory of human action is partly explained, I believe, by a certain wisdom, humility, or skepticism people have about their own or others' motives. We know that we are not as selfless as we would like to be or even as we might appear. But there is also a less flattering reason for our attraction to egoism: it provides a convenient excuse for selfish behavior. If "everybody is like that"—if everybody *must* be like that—we need not feel guilty about our own self-interested behavior or try to change it.

But although these observations give us reason to be cautious in attributing altruistic motives to ourselves or others, they do not license the conclusion that no one ever acts altruistically. Generally that inference is aided and abetted by consideration of some logical puzzles surrounding altruism and egoism.

A central enticement of egoism is that it seems impossible to disprove. No matter how altruistic a person appears to be—take Mr. Autrey or Professor Librescu or your favorite do-gooder as an example—it is possible to conceive of their motive in egoistic terms. If Mr. Autrey had ignored the man on the tracks, he would have suffered such guilt or remorse that risking his life was worth avoiding that pain. The person who gives up a comfortable life to care for AIDS patients in a remote and hard place does what she wants to do, and therefore gets satisfaction from what appears to be self-sacrifice. So, it appears, altruism is simply self-interest of a subtle kind.

Although these observations give us reason to be cautious in attributing altruistic motives to ourselves or others, they do not license the conclusion that no one ever acts altruistically.

The impossibility of disproving egoism may sound like a virtue, but, as students of the philosophy of science know, it's really a fatal drawback. An empirical theory that purports to tell us something about the world—such as egoism, which claims to describe the nature of human motivation—should be falsifiable. Not false, of course, but capable of being tested and thus proved false. If no state of affairs is incompatible with egoism, then it does not really tell us anything distinctive about how things are.

Is egoism unfalsifiable? It's not clear. Daniel Batson and his colleagues attempted to test egoism through a number of complex experiments. One experiment considered a common version of egoism, what Batson calls the "aversive-arousal reduction hypothesis." This is the idea that observing someone in need of help is unpleasant and causes people to attempt to reduce the unpleasantness, for example by helping. The alternative explanation Batson calls the "empathy-altruism hypothesis," which says that a person's motive in helping is ultimately to relieve the *other's* distress, not one's own. In the experiment, subjects viewed a video-

tape of a woman ("Elaine") who they believed was receiving painful electric shocks. After witnessing two shocks, the subjects were told they could substitute for Elaine—receiving the shocks themselves. Subjects in the "easy-escape" treatment had been told at the outset that they could quit the experiment after witnessing two shocks; those in the "difficult-escape" treatment were told they would have to watch Elaine endure ten shocks. Subjects also varied in how much empathy they felt for Elaine; on the assumption that empathy increases when we identify with another person, the experimenters manipulated the amount of empathy by leading subjects to believe they had a lot, or not very much, in common with her.

The altruistic hypothesis predicts that high-empathy subjects—the people who at least *appear* to be altruistic—will be more likely to agree to take the shocks for Elaine than low-empathy subjects when escape is easy; egoism predicts that when escape is easy even high-empathy subjects will choose to exit, thereby avoiding the aversive feelings produced by seeing Elaine receive shocks. The results of the experiment confirmed the altruistic hypothesis, but they do not disprove egoism. Perhaps high-empathy subjects realized they would experience guilt or unpleasant memories of the shock victim afterwards and chose not to escape for that reason. Batson and his colleagues devised an experiment to test *this* version of egoism as well. Its results also disconfirmed egoism, but again further egoistic accounts can be given to explain the results. Batson and his colleagues tested several versions and all were found wanting.

As Sober and Wilson note, this does not prove that other versions of egoism will also fail. Because sophisticated forms of egoism appeal to the internal rewards of helping others—rather that simply money, say—it's always possible that a more subtle psychological reward lurks that the experiments have not detected. This possibility will strike many as far-fetched and confirm suspicions that egoism is unfalsifiable; nevertheless it permits those attracted to egoism to hang on to their convictions.

The Objects of Our Desires

Another reason the debate between altruism and egoism is hard to resolve has to do with ambiguity in the concepts of desire and the satisfaction of desire. If people possess altruistic motives, then they sometimes act to benefit others without the prospect of benefit to themselves. Another way to put the point is that they desire the good of others ultimately or intrinsically or for its own sake—not simply as a means to their own satisfaction. Suppose I desire that another person in danger not die, and act accordingly to save his life. If my action is successful, my desire will be satisfied. It does not follow, however, that *I* will be satisfied—since my desire would be satisfied even if I myself died in the attempt to save the other person's life. As Sober and Wilson argue, the fact that a person's desire is satisfied tells us nothing about any effect on her mental state or personal well-being.

On the other hand, when one of my desires is satisfied I normally experience a certain degree of satisfaction. (Not always: a person may be perverse in the sense that the satisfaction of a desire brings no satisfaction to him.) In that case, the satisfaction of even an apparently altruistic desire will bring the agent some sense of well-being. We normally feel good when we do good. But it does not follow that we do good *only in order* to feel good. Indeed, it seems plausible that if we did not desire the good of others for its own sake then attaining it would not in fact make us feel good.

Interestingly, Sober and Wilson argue that having altruistic desires or motives could in fact be advantageous from an evolutionary perspective. (Charles Darwin himself suggested such a view in *The Descent of Man*.) Evolutionary theory would predict that people have desires and motives that enhance their reproductive fitness. The desire to take care of one's children fits this description. If human beings are egoists, then they are wired to feel good when they take care of their children, and ultimately that's why they do it. If, on the other hand, parents have altruistic desires for their children's welfare, then when they see that their children need help they will be directly motivated to act, without consideration of their own well-being. Altruism is a more reliable and efficient mechanism for getting parents to take care of their children, because egoism requires a further step: the belief that helping one's children will produce pleasure or avoid pain for oneself.

Altruistic and self-interested motives might coexist—so tightly as to be difficult to pry apart. . . .

If humans possessed both altruistic and egoistic motives to help their children, that would further increase their reproductive fitness. We shall see that the idea that altruistic and self-interested motives might coexist—so tightly as to be difficult to pry apart—is plausible for other reasons as well.

Altruism and Self-interest Intertwined

Common sense tells us that some people are more altruistic than others. The point is not limited to the

realm of saints and heroes. In everyday life people vary in their propensities to benefit others; we judge them accordingly. Egoism's claim that these differences are illusory—that deep down, everybody acts only to further their own interests—contradicts our observations and deep-seated human practices of moral evaluation.

At the same time, we may notice that many people whose habits lie at the more altruistic end of the spectrum seem not to suffer more or flourish less than those who are more self-interested. Often they may be more content or fulfilled. Some will find this judgment surprising. Don't nice guys finish last? Don't we all know people who routinely sacrifice their own interests to others—typically a significant other or perhaps a workplace superior—and suffer for their self-effacement? The experiences of such people seem to refute the view that altruists get satisfaction from choosing to do good.

But this objection confuses two different kinds of people. We admire Wesley Autrey and Liviu Librescu; Paul Rusesabagina, the hotel manager who saved over 1,000 Tutsis and moderate Hutus during the 1994 Rwandan genocide; the (much-studied) rescuers of Jews from the Nazis; health workers who give up comfortable lives to treat sick people in poor countries. But we don't admire "doormats"; we feel sorry for them. As Jean Hampton argues, their "selflessness" amounts to a lack of self-respect. By contrast, admirable altruists are fully self-respecting. Unlike the behavior of the suspiciously selfless, their actions do not depend on believing that other people's interests always trump their own.

We should not go to the other, naively rosy extreme and conclude that it always pays to be good. Nice guys don't always finish first. The point is rather that the kind of altruism we ought to encourage, and probably the only kind with staying power, tends to be satisfying to those who practice it. Studies of rescuers show that they tend not to believe their behavior is extraordinary; they feel that they have to do what they do, because it's just part of who they are. Neera Badhwar argues convincingly that such people would suffer had they not performed these heroic acts; they would feel they were betraying their moral selves. In carrying out their actions, "they actualized their values, the values they endorsed and with which they were most deeply identified. ...They satisfied a fundamental human interest, the interest in shaping the world in light of one's values and affirming one's identity." The same holds, I believe, for more common, less newsworthy acts—working in soup kitchens, taking pets to people in nursing homes, helping strangers find their way, being neighborly. People who do such things believe that they ought to, but they also want to do them, because these acts affirm the kind of people they are and want to be and the kind of world they want to exist. This idea accords with the view discussed earlier: people typically get satisfaction from doing what they desire, and this is quite independent of the content of those desires—specifically, whether they are oriented toward self or others.

So the answer to the first question posed at the beginning of this essay is that there is some altruism in the world, although in healthy people it intertwines subtly with the well-being of the agent who does good. And this is crucial for answering the second, practical question: how to increase the sum of altruism. Aristotle in the *Nicomachean Ethics* (II.3) had it right: we have to raise people from their "very youth" and educate them "so as both to delight in and to be pained by the things that we ought." Excellent advice, although putting it into practice is easier said than done. Still, once we recognize that the pursuit of self-interest is not our inevitable fate, we can get to work on figuring out how to wean people from what is nonetheless the path of least resistance.

Judith Lichtenberg
Professor
Department of Philosophy
Georgetown University
jl537@georgetown.edu

Sources: Elliot Sober and David Sloan Wilson, *Unto Others: The Evolution and Psychology of Unselfish Behavior* (Cambridge: Harvard, 1998); Samir Okasha, "Biological Altruism," *Stanford Encyclopedia of Philosophy (Summer 2005 Edition)*, Edward N. Zalta, ed., http://plato.stanford.edu/archives/sum2005/entries/altruism-biological/; W.D. Hamilton, 1964, "The Genetical Evolution of Social Behaviour I and II," *Journal of Theoretical Biology* 7 (1964); R.L. Trivers, "The Evolution of Reciprocal Altruism," *Quarterly Review of Biology* 46 (1971); Richard Dawkins, *The Selfish Gene* (New York: Oxford, 1976); Daniel Batson, *The Altruism Question: Toward a Social-Psychological Answer* (Hillsdale, N.J.: Lawrence Erlbaum Associates, 1991); Jean Hampton, "Selflessness and the Loss of Self," in *Altruism*, ed. by E.F. Paul, F.D. Miller, Jr., and J. Paul (Cambridge: Cambridge, 1993); Neera Kapur Badhwar, "Altruism Versus Self-Interest: Sometimes a False Dichotomy," in Paul et al., *Altruism*.

Pushing Drugs or Pushing the Envelope: The Prosecution of Doctors in Connection with Over-Prescribing of Opium-Based Drugs

Deborah Hellman

Introduction

On July 13, 2007, Dr. William Hurwitz was sentenced to 57 months in federal prison for drug-trafficking. This result was portrayed by the press as a victory for the defendant as this conviction and sentence resulted from a retrial (his original conviction was overturned by the 4th Circuit) of counts that had originally landed Hurwitz with a 25-year sentence. But while 57 months is surely better for the doctor than 25 years, it is still a troubling sentence for a doctor whom the judge acknowledged was not motivated by financial gain and who arguably did much to help both his individual patients and the cause of pain patients generally.

Dr. Hurwitz is one of a growing number of doctors being prosecuted in federal and state courts for prescribing controlled substances (usually opium-based drugs) in a manner not authorized by their professional licenses or federal law. The doctors are usually charged with drug trafficking, but also sometimes with conspiracy to distribute drugs or even with homicide in cases where patients have died. The statute under which most of these prosecutions occur—the Controlled Substances Act (CSA)—allows physicians to prescribe controlled substances (if the physicians are registered to do so) in the course of medical practice but prohibits them from distributing drugs outside of such medical practice. While physician actions that are deemed to be outside the bounds of reasonable medical care are typically the basis for civil liability for malpractice only, the Supreme Court has held (as long ago as 1975) that a medical professional is not immune from normal criminal liability for drug trafficking. Just because a person holds a medical degree does not mean that he can simply sell drugs or sell prescriptions for controlled substances. Such action constitutes drug trafficking. But when the doctor writes prescriptions in his office, following consultation with a patient, and receives no compensation other than the normal fee for service, can this still be drug trafficking? Recent cases have emphatically held "yes." This result makes a kind of sense as well. After all, an unscrupulous doctor *could* simply be writing any and all prescriptions asked for, while wearing the white coat and doing business in a room that looks like a doctor's office. While the doctor is only getting a routine fee for an office consultation, if the doctor offers no real medical consultation and merely sees so-called patients one after the other, dispensing scripts to all-comers, then the fee-for-service becomes the method of payment for prescriptions (which enable the "patient" to get access to controlled drugs). Is this not drug-trafficking merely dressed up in medical guise?

When the doctor writes prescriptions in his office, following consultation with a patient, and receives no compensation other than the normal fee for service, can this still be drug trafficking?

After all, what makes actions (here writing prescriptions) *medical practice*? It isn't just *who* is doing it. The white coat and the office setting don't ensure that actions constitute medical practice. Perhaps it is whether the person is being paid money (or something else) *for* prescriptions. If so, the actions don't constitute medical practice. But once we recognize that this payment can be indirect, like in the scenario described above, it is unclear whether this test works or instead devolves into one that focuses on the intentions of the physician him or herself. If she intends to practice medicine (and makes money by way of doing so) then it is medical practice. If she intends to make money by selling drugs, then it isn't. But this is a tricky path to

walk down. Its very structure is reminiscent of debates about the doctrine of double effect which itself has proved quite controversial.

Before proceeding down this route, let's take a closer look at the legal standard being adopted by courts to delineate permissible (though potentially negligent) actions from criminal behavior by physicians. A violation of the Controlled Substances Act requires that the physician (1) knowingly distribute a controlled substance (2) with knowledge that it is controlled and (3) that he or she do so "outside the usual course of medical practice." It is easy to anticipate the problem this formulation of the legal standard presents. Elements (1) and (2) require knowledge *but* that knowledge is uncontroversial in cases of physician prescribing. The physician knows that she is writing a prescription (distributing) for a controlled substance and she knows that the substance is controlled. The controversy surrounds whether the knowledge requirement also modifies element (3). Must the physician know that her actions are outside the bounds of medical practice? While a straightforward reading of these elements would suggest not, this reading seems untenable as it would criminalize behavior that is merely negligent. It surely cannot be the case that knowingly prescribing controlled substances in a manner that a court later determines is outside the bounds of medical practice turns one into a drug dealer, can it?

Predictably, most of the challenges to convictions of physicians under the CSA have focused on whether the physician is in fact being held criminally responsible for actions that are merely negligent. (Hurwitz himself had his first conviction overruled by the 4th Circuit on the grounds that the trial court erroneously disallowed the jury to consider whether the doctor had acted in good faith.) But the result of these challenges has left a patchwork of standards without adequate analysis of the issues involved and the theories of criminal responsibility that would animate each of the various formulations of the legal standard. In what follows, I will argue that the standards (as different courts are interpreting the requirements of the CSA differently) for criminal liability currently being applied in courts are problematic for four reasons:

- First, there is an unresolved ambiguity about whether in fact doctors are responsible only when they *knowingly* prescribe in a manner that lies outside the bounds of medical practice or if something less than knowledge will suffice. This lowering of the standard (from knowledge to something less) is in part brought about by courts' allowing so-called "willful blindness" to substitute for knowledge.
- But, as I will argue, the use of the willful blindness doctrine in this context is inapt in two ways; these are the second and third problems with the standard for criminal liability applied in these cases. Willful blindness requires that an actor take some action to avoid knowledge. But in most of the physician prescribing cases, no such action is present. Moreover (third problem), often the reason the doctor doesn't know his patients are abusing or diverting the drugs is because he trusts his patients. Because the good physician-patient relationship is built on trust, the doctor has a good reason to trust his patient and that distinguishes this situation from culpable willful blindness.
- Finally, the doctor also has an ethical obligation to put his patient's needs above those of society. This asymmetry in the way the doctor ought to evaluate the harms and benefits of different courses of action may change the assessment of whether some actions are reckless. Because some courts treat willful blindness as a form of extreme recklessness, the fact that actions which would be reckless if done by others are not reckless when done by a physician matters to how courts ought evaluate whether the physician acts culpably in these cases.

Willful blindness requires that an actor take some action to avoid knowledge.

Ambiguity about the Standard for Criminal Responsibility

While courts seem to concede that knowledge is the appropriate *mens rea*—the legal term for the mental state of the actor accused of the crime—for the third element (acting outside the bounds of medical practice), they back-peddle in interpreting this requirement in two ways. First, some courts approach this element by asking whether the doctor acted in "good faith." What exactly good faith is and how it should be assessed is notoriously under-analyzed in law generally and therefore especially problematic when used to interpret whether someone has violated criminal law. Some of the courts that see "good faith" as relevant to whether a physician has violated the CSA understand good faith as, at least in part, objectively defined. Indeed, the opinion that reversed Dr. Hurwitz's original conviction held that "good faith" should be viewed objectively. If good faith is understood objectively, the physician can be prosecuted for prescribing in a manner that he should have known exceeds the bounds of medical practice. Requiring what these courts term

"objective good faith" abandons the requirement of knowledge for element (3) and therefore lowers the standard for a finding of criminal conduct.

Other courts do adopt a subjective test of good faith—asking whether the physician believed in good faith that his or her actions exceeded the bounds of medical practice—but back-peddle as well in a different way. Instead, they allow *willful blindness* to indicate that the doctor was prescribing to drug users and dealers to fulfill the knowledge element of the offense.

There is thus an unresolved ambiguity about whether the physician is criminally responsible only for knowingly prescribing in a way that lies outside medical practice or instead whether something less will satisfy the elements of the offense.

Willful Blindness Requires Avoiding Information

Willful blindness is seen as the moral or legal equivalent of knowledge in those instances where one deliberately avoids knowing facts that if known would require (morally or legally) that one desist from ones actions. The drug courier who never looks in the pouch he is paid a large sum of money to carry into the country is willfully blind to the fact that he carries drugs. Here his willful blindness seems culpable because he has reason to believe that the pouch may carry drugs (why else is he offered such a large sum to transport it?) and he refrains from investigating in order to reap some gain. Courts see a parallel in the doctor cases. The physician who continues to prescribe drugs to the patient despite numerous "red flags" indicating that the patient may be abusing or selling these drugs is held to be willfully blind to the fact that he is dispensing drugs outside the bounds of medical practice. But this parallel may be inapt.

There is . . . an unresolved ambiguity about whether the physician is criminally responsible only for knowingly prescribing in a way that lies outside medical practice or instead whether something less will satisfy the elements of the offense.

The drug courier avoids gathering information—his *willful* blindness results from a choice to avoid taking some action which would provide the relevant information. In contrast, Dr. Hurwitz didn't avoid gathering information, rather he failed to make the inferential leap from this information to the conclusion that his patients were dealing or using drugs. He didn't know, not because he didn't have the facts that might suggest such a conclusion. Rather, he didn't know because he—perhaps naively—didn't see the facts he did know as clearly indicating that his patients were doing these things. Interestingly the court rejected, mistakenly in my view, the argument made by Hurwitz's lawyers against the inclusion of a willful blindness instruction to the jury on the grounds that *willful* blindness requires that the person take some action to shield himself from knowledge—which, they argued, Hurwitz had not done. The failure to draw the reasonable inference from a known set of facts is not the same as shielding oneself from learning facts one suspects may be troubling.

Willful Blindness and Trust

Hurwitz argued that he didn't draw the (perhaps reasonable) inferences from the facts he had because he was disposed to trust his patients. Compare this to the drug courier case. In the drug courier case, willful blindness is culpable because the courier deliberately decides to remain ignorant for reasons that are at best morally ambivalent and at worse devious and wrong. At best, the courier refrains from looking inside the pouch so that he won't be faced with the decision about what to do—knowingly carry the drugs or forgo the money he's been paid for transport. At worst, the courier refrains from looking so that he can carry what he suspects are drugs but can do so in a manner that allows him to escape legal liability for doing so *knowingly*. Hurwitz, by contrast, offers a good reason in support of his actions. He trusted his patients.

Trust is indisputably a cornerstone of the physician-patient relationship. There are both instrumental and non-instrumental justifications for the importance of trust to this relationship. Trust is instrumentally important because it encourages the free flow of information by the patient to the doctor, information that may be critical in accurately diagnosing and treating the patient. The doctor's trust in the patient is also important because this display of trust helps the patient to feel valued and respected. These feelings are especially important in the case of chronic pain patients (who made up Dr. Hurwitz's practice) as such patients are often shunned by other doctors (who don't know how to treat them) or doubted and disbelieved by these other doctors or by co-workers, family and friends because they often have no visible or clearly verifiable injury or disease to point to that accounts for the pain they suffer. Patients often experience significant mental suffering from this skepticism and while not as bad as the physical pain they endure, piles on in a cruel and difficult way.

Perhaps more controversially, trust is important to the doctor-patient relationship for non-instrumental reasons as well. A good doctor trusts his patients. While this account cannot be fully developed here, the

good doctor does not merely perform a service for the patient, rather she or he enters into a special sort of relationship with the patient. It is an imbalanced relationship in which the patient is vulnerable. The good doctor respects that vulnerability by treating the patient as much as possible as an equal—by respecting her autonomy to make decisions (when adequately informed by the doctor) and by treating her as a person whose word and reports of symptoms are to be trusted. If the doctor's blindness results from his disposition to trust his patients, it is not culpably willfully blind and therefore ought not to subject the doctor to criminal sanction.

Putting the Patient First

Some accounts of willful blindness see it as a form of extreme recklessness. An actor acts recklessly when he takes a substantial and unjustifiable risk of which she is aware. The problem with seeing the doctor's actions as criminal recklessness is that courts fail to pay attention to the fact that the same action that may be reckless if done by an ordinary person may not be reckless when done by a physician.

Courts see these pain doctors as acting recklessly when they prescribe drugs to patients whom the doctor suspects are likely to be abusing or reselling the drugs. This account may be too simplistic however. It isn't reckless to risk a harmful action, even if it is very

likely to occur, if the harm is significantly smaller than the harm that inaction may cause. Suppose the likelihood of X occurring if you do Y is 90%. The likelihood of not-X is thus 10%. If the harm of X is much, much smaller than the harm of not-X, it may well make sense to do Y, notwithstanding the likelihood of X occurring and the harm that X will cause. The definition of recklessness as taking a substantial and *unjustifiable* risk is meant to capture this point. The drug courier recklessly brings drugs into the country when he carries the pouch knowing that is very likely that the pouch contains drugs because if it *does* contain drugs, these will cause significant harm (we assume). But if the pouch *does not* contain drugs (unlikely but possible), failing to bring in the pouch is unlikely to cause significant harm. Without some reason to believe or suspect that there is some great harm his failure to transport a legitimate package will cause, the drug courier's action is reckless.

Now compare this to Hurwitz's action. Suppose that he suspects with a high degree of certainly (90%) that his patient is using or dealing drugs. If he continues to write prescriptions for this patient, he yet may not be reckless. To see why, suppose he is wrong and his patient is not using or dealing but legitimately needs the drugs to curb her crushing pain. If so, then failing to prescribe to her will cause terrible harm. Because this harm may be significantly greater (failing to relieve awful suffering) than the harm caused by facilitating access to drugs to users or dealers, the doctor's action may not be reckless. And this is so even when the likelihood that the patient is using or dealing is significantly greater than the likelihood that she is legitimately in need.

The physician must care more for his patient's suffering than for the harm to society and this obligation puts an extra thumb on the scale in favor of prescribing despite the risk that the patient is selling the drugs.

Further, the doctor does not approach these harms neutrally. Rather, he is obligated to care more about alleviating the suffering of his patient than he cares about avoiding harm to society. The physician's obligation of loyalty to his patient requires him to help his patient, to care especially about alleviating her suffering, when possible. Special relationships, like parent/child, doctor/patient, friend/friend, allow or even require the participants to value the interests of the related person more than the interests of others. So the physician confronted with the possibility—even a probability—that he may be writing a prescription for a patient who will abuse or sell the drugs prescribed does not simply reason that it would be reckless to continue because there is a significant likelihood of harm. He must also ask himself what would be the harm of failing to prescribe if his patient is legitimately in need. If that is great, it might outweigh the likelier harm of prescribing to the user even for the neutral observer. For the physician, however, the considerations are not to be weighed neutrally. The physician must care more for his patient's suffering than for the harm to society and this obligation puts an extra thumb on the scale in favor of prescribing despite the risk that the patient is selling the drugs.

Finally, the above discussion overly simplifies the analysis by avoiding the most difficult and troubling sort of case: the patient whom the doctor both believes is in pain and suspects is selling some of his medication (perhaps even in order to make money to afford the pain medication for herself). In one of the tape recordings secretly made of Dr. Hurwitz during the time that he was under investigation, he says "that it was 'not inconceivable' to him that some patients were 'selling part of their medicines so they could buy the rest." Whether continuing to prescribe drugs to such a person is "unjustified"—in the way that the Model Penal Code envisions in its definition of recklessness—is far from clear. While the Drug Enforcement Agency appears to take the position that doing so is not permissible, the doctor's professional obligations push in the other direction.

What Is "Medical Practice"?

If we reject the appropriateness of using willful blindness to substitute for the *mens rea* of knowledge in the context of prosecuting doctors for their prescribing practices, where does this leave us? The prosecution must show, in such cases, that the doctor *knowingly* prescribed in a manner "outside the usual course of medical practice." But this formulation raises as many questions as it answers. What *is* it that the doctor must know? That he is prescribing to drug dealers or addicts? That he is prescribing in a way that he believes lies outside the bounds of medical practice? That he is balancing the harms of prescribing to drug users and dealers versus the harms of failing to prescribe to legitimate patients in a vastly different way than how other doctors would balance such harms? Ambiguity abounds. Let me focus on just one of the possible objects of the physician's knowledge and explore its complexities.

When we say that the doctor must knowingly act in a manner that is "outside the usual course of medical practice," do we mean that he knowingly acts in a way that the medical profession considers to be outside the bounds of medical practice (medical practice defined *objectively*), or do we mean that he knowingly acts in a way that he believes is outside the bounds of medical practice rightly conceived (medical practice defined

subjectively)? This question returns us to the inquiry that lies at the heart of this issue and that I flagged at the beginning of this piece: *what is medical practice*? Is medical practice to be defined by what the community of practicing physicians believe is medical practice? Medical malpractice law is built on such an idea. But this doesn't resolve the issue for our purposes here. The focus of medical malpractice is incompetence—which practices of medicine (whatever that is) fall below the standard for how such practices are to be carried out? Our focus is more basic—we are asking what defines or delineates the practice of medicine, rather than what instances of the practice of medicine do it so poorly as to be considered incompetent (though no one disputes they are still the practice of medicine).

In particular, we are asking whether medical practice encompasses practices that push the envelope. Research science is innovative—innovation is an integral part of what it is to be a researcher. But what of medicine? Is innovation a part of the practice of medicine? While it is surely not as central as it is to the research enterprise, it would be odd for the law to define the practice of medicine in such a way that it forbids innovative practice. This conclusion suggests that the practice of medicine cannot simply be defined by what the community of doctors currently think constitutes medical practice. But does such an account allow a rogue physician to do whatever he wants (sell prescriptions for money and call that "medical practice")? Clearly not. However, it is unlikely such a physician honestly believes *that* constitutes medical practice. Moreover, a jury would still be entitled to assess whether it believes the doctor's claim that he was doing what he honestly believes constitutes practicing medicine. Moreover, medical malpractice (and the civil sanctions it carries) will continue to provide limits to physician action. When patients believe they have been treated in a manner that falls below professional competence, patients can choose to sue. But while failed innovative procedures could constitute medical malpractice, they would not subject the physician to criminal liability for practicing outside the bounds of medicine.

Ironically, US District Judge Leonie M. Brinkema, who presided over the retrial of William Hurwitz, explained before hearing arguments related to his sentencing, that in the years between the first trial and the re-sentencing in the summer of 2007, the level of expertise about the proper way to treat chronic pain patients had advanced considerably. In particular she emphasized that experts now agree that there is no upper limit on the amount of opioids that can safely and appropriately be prescribed to such patients. Dr. Hurwitz's practice was on the vanguard of these changes. And yet, the judge did not find that these facts provided a reason to grant the defendant's motion for an acquittal. In denying that motion, Brinkema stated that the physician seems to have a "God-complex" rather than to be motivated by financial gain. But as she saw it, this was no reason to find the case not one of drug-trafficking. But having a God-complex is not criminal, one would think. Moreover, one is left wondering what true innovators are free from the kind of arrogance she attributes to Hurwitz. Innovative practice should be viewed as part of the practice of medicine. When done unreasonably, it may constitute medical malpractice but no more. Pushing the envelope is not morally or legally equivalent to pushing drugs.

Deborah Hellman
Visiting Professor of Law
University of Pennsylvania Law School
dhellman@law.upenn.edu

Sources: The Supreme Court held that a medical professional is not immune from normal criminal liability for drug trafficking in *United States v. Moore*, 423 US 122 (1975); the requirements for violation of the Controlled Substances Act occurs in *US v. McIver*, 470 F.3d 550, 556; for a case that adopted a subjective test of good faith, see: *US v. Tran Trong Cuong*, 18 F. 3d. 1132, 1138 (1994), and the court that heard the retrial of Hurwitz's case allowed the jury to convict on the basis of willful blindness. The term "red flags" is used both in legal cases and by the Drug Enforcement Agency. David Luban, "Contrived Ignorance," 87 *Georgetown Law Journal* 957 (1999). According to the Model Penal Code, willful blindness acts as a substitute for knowledge precisely because the actor knows, at the least, that there is a high probability that his actions are illegal: "When knowledge of the existence of a particular fact is an element of an offense, such knowledge is established if a person is aware of a high probability of its existence, unless he actually believes that it does not exist." *Model Penal Code § 2.02 (7)* (Proposed Official Draft 1962). Commentary to the Code suggests that this expansion of the concept of knowledge is meant to accommodate cases of willful blindness. *Model Penal Code § 2.02 (2)* cmt. 9. The discussion of the tape made of Dr. Hurwitz discussing the possibility that some patients were "selling part of their medicines so they could buy the rest" occurs at *US v. Hurwitz*, 459 F. 3d. 463, 467 (2006).

Public Policy and Residential Segregation: A Critique of Iris Young's Strategy of Differentiated Solidarity

Chris M. Herbst

Introduction

The recently suspended Democratic presidential campaign of US Senator John Edwards of North Carolina has refocused the public's attention on the issue of poverty and public policies to aid urban communities. Indeed, not since President Lyndon Johnson's War on Poverty has a major political figure emphasized the plight of low-income citizens to such a degree. In many ways, Edwards's policy platform was more ambitious than that of President Johnson. With a goal of eradicating poverty altogether by 2036, the cornerstone of his plan included universal health care, a tripling of the Earned Income Tax Credit, the creation of "work bonds" to promote private savings, and providing housing vouchers to families so that they can afford apartments outside blighted neighborhoods.

Perhaps the defining principle of Edwards's proposal was that it viewed disadvantage holistically, and not just as a byproduct of economic depravity. Edwards's decision to promote housing mobility was an interesting case in point because such policy proposals are frequently omitted from the debate on how to ameliorate urban poverty. Academic researchers have provided substantial evidence that residing in neighborhoods that are economically, socially, and physically detached from more advantaged urban areas—referred to as residential segregation—is associated with a number of deleterious outcomes, including the geographic concentration of poverty, high unemployment and crime rates, and low levels of civic and political participation. However, housing mobility proposals are rarely part of a broader anti-poverty agenda.

That residential segregation brushes up against so many other social ills leads many observers to view it as the linchpin of urban disadvantage. Herein lies the promise of public policies that aim to increase residential mobility and economic freedom in the housing market. If low-income families are given incentives to leave neighborhoods with deep pockets of poverty and social decay, the thinking goes, they will choose areas with greater employment opportunities and mainstream values. You can take the family out of poverty, and you can take the poverty out of the family.

Given that the causes and consequences of residential segregation share a constellation of complex economic, social, and political roots, it is surprising that academic research on the topic has been dominated by those using empirical methods. Such studies are not able to advance an understanding of how residential segregation impacts outcomes associated with political empowerment and inclusion, equality in the distribution of political resources, and the ability to participate in the policymaking process.

A noteworthy exception to previous research appears in philosopher Iris Young's *Inclusion and Democracy*, in which she describes the processes through which residential location causes or exacerbates forms of economic and political exclusion. Her writing focuses on the implications of racially-based residential segregation in US cities, and she cites an influential book, *American Apartheid* by Douglas Massey and Nancy Denton, as evidence of its pervasiveness throughout the twentieth century. Repudiating the notion that racial clustering itself is wrong, Young instead argues that it is the "processes of segregation from [economic and political] privileges and benefits" which are problematic. The author cites a

Researchers have provided substantial evidence that residing in neighborhoods that are economically, socially, and physically detached from more advantaged urban areas—referred to as residential segregation—is associated with a number of deleterious outcomes. . . .

number of "wrongs" associated with racially-based residential segregation and proposes an idea called "differentiated solidarity" to deal with them.

In this article, I provide a critique of Young's normative analysis of residential segregation, and I evaluate her policy recommendations against the empirical evidence. I argue that although Young assesses correctly the *consequences* of residential segregation, her evaluation of its *causes* is incomplete. In particular, Young states "there is a large body of evidence that residential segregation in the United States has been produced and is maintained by legal and illegal discrimination by landlords, home owners, real estate agents, banks, and other individuals and institutions." Young later concludes: "Thus in the United States residential racial segregation is the product largely of the discriminatory actions of private market actors, who self-consciously discriminate by race, or who manipulate a racist market for the sake of making profits." While the historical record clearly shows evidence of racial discrimination in the housing market, I present evidence that several other factors played an equal, if not greater, role in driving residential segregation. Young's omission of alternative explanations, furthermore, leads to a policy prescription—differentiated solidarity—that is similarly incomplete. Therefore, one of the primary goals of this article is to review public policies that reflect a fuller understanding of the causes of residential segregation.

Although Young assesses correctly the consequences *of residential segregation, her evaluation of its* causes *is incomplete.*

Young's "Wrongs" of Residential Segregation and the Notion of Differentiated Solidarity

According to Young, the implications of racially-based housing segregation are fourfold. First, there are structural components of segregation that preclude individuals from choosing to live where they wish. Second, racial clustering in space is associated with the simultaneous concentration of other negative social and economic conditions, including unemployment, poverty, crime, and housing decay. Residential segregation also hides the sense of privilege, and therefore the injustice inherent in segregation, from those who are economically and politically advantaged. Finally, the processes of segregation lead to political marginalization and decrease the influence of segregated groups in the policy process.

Given the broad set of public and private actors who, in Young's view, have promoted discrimination toward segregation's end, it is perhaps surprising that her normative prescriptions are minimally authoritative. Instead of calling on the federal government to use a big-stick approach to achieve residential integration, she advocates an idea called differentiated solidarity. This ideal "affirms a freedom to cluster, both in urban space and in religious, cultural, and affinity group associations…but should be balanced with a commitment to non-discrimination." In other words, given the economic, social, and political interrelatedness of individuals with diverse loyalties and interests within a metropolitan area, there should be an obligation to "promote justice among the strangers who dwell together in a region." But, at the same time, there can be a certain degree of spatial separation among individuals who actively look for each other in order to celebrate commonalities.

When it is time to translate the notion of differentiated solidarity into public policy, however, Young returns to more imposing methods. She argues that "while the preferences of housing consumers should be respected as much as possible, the same is not true for the institutions and owners whose actions contribute to housing opportunities or the conditions of neighborhoods. Most existing patterns…of residential racial segregation cannot be reversed…without monitoring and regulating the activities of landlords, financial institutions, developers, and other private agents whose actions most affect the social meaning of urban space."

When it is time to translate the notion of differentiated solidarity into public policy. . . . Young returns to more imposing methods.

There are two fundamental flaws with this policy prescription. The first deals with the way markets operate. Young advocates using the big-stick policy approach on the supply-side of the market, while allowing the demand-side to act according to rational, utility-maximizing principles. As the last several decades have borne out, white families maximize utility in the housing market by fleeing the central city and establishing largely homogenous suburban and exurban communities. As long as this demand persists, banks, contractors, and developers will respond by making suburban housing available. In addition, jobs and services will continue to follow the suburban dwellers. Therefore, a policy based on differentiated solidarity, which provides individuals freedom of

movement in space, will likely and paradoxically exacerbate Young's "wrongs" of segregation.

The second flaw stems from Young's idiosyncratic translation of the causes of residential segregation into practical methods for ameliorating it. Even if we accept Young's argument that the primary driver behind segregation is the "discriminatory actions of private market actors," it seems reasonable that public policy should take authoritative steps on both sides of the market to reverse this discriminatory behavior. However, her notion of differentiated solidarity affords an opportunity for citizens—and not institutions—to recognize their interconnectedness in space by supporting an informal commitment to social justice. In other words, Young draws a stark line between housing consumers, who in her view should be able to pursue housing according to preferences, and the institutions that control the means of obtaining housing. It is on the latter group, according to Young, that policy should focus, through a system of monitoring and regulation.

Causes of Racially-based Residential Segregation

Additional explanations exist regarding the causes of residential segregation, informed by both empirical and ethnographic scholarly research. This should elucidate the important drivers behind racial clustering, and as a result, should focus policy proposals more squarely on the problem.

It is worth noting that racial segregation increases the susceptibility of neighborhoods to other deleterious social and economic conditions. Scholars have noted a rise in racial residential segregation over the past few decades, linking it to a simultaneous increase in the concentration of poverty, the odds of dropping out of high school and bearing children out of wedlock, male unemployment, single motherhood, lower IQ scores, and lower lifetime earnings. The geographic concentration of disadvantage through residential segregation also has implications for political and civic participation. For example, one study found that as neighborhoods become poorer and racially homogenous, individuals are less likely to have a connection to political and neighborhood institutions, less likely to feel politically efficacious, and more distrustful of politicians.

The first line of research on the causes of poverty-based residential segregation is advanced by Harvard professor of public policy and urban policy William J. Wilson, in the book *The Truly Disadvantaged*. Drawing on data from Chicago, Wilson argues that the intense clustering of racial disadvantage is due to structural transformations underway in central cities, specifically a movement from manufacturing to low-wage services economies and the migration of high-earning blacks to suburban areas. As the economic and demographic mix of central cities change, there is concomitant increase in the spatial clustering of poor minorities who do not have access to jobs or other institutions conducive to integration in mainstream society. The main problem, according to Wilson, is that when non-poor black families leave inner city neighborhoods for the suburbs, they take with them the services and jobs that competed for their attention.

The second explanation for residential segregation, advanced by Harvard professor of urban economics John Kain, is the spatial mismatch hypothesis (SMH). This theory recognizes not only the spatial clustering and simultaneous growth of disadvantage among inner city minorities, but also the rapid suburbanization of new employment opportunities. Indeed, there is consistent evidence that employment opportunities, especially low-wage service sector jobs, are following the 'white flight' to the suburbs. The growing spatial division between the location of low-skilled employment opportunities and the labor supply who might qualify for those jobs has led scholars to argue that spatial location itself has an independent effect on individuals' social and economic outcomes. Therefore, according to the SMH, blacks' employment problems are due in part to the intersection of job suburbanization (where the supply of low-wage jobs are located) and racial segregation in inner cities (where low-wage labor supply is located). These spatial patterns of employment and residence result in an oversupply of low-skilled workers relative to the number of jobs for which they are qualified in the inner city.

Racial segregation increases the susceptibility of neighborhoods to other deleterious social and economic conditions.

Conservative policy intellectuals countered the liberal structural arguments by focusing on another possible cause of concentrated ghetto poverty and segregation: the US welfare system. According to an influential book, *Losing Ground* by Charles Murray, the creation of dense pockets of urban underclass communities owes to a liberal welfare state that creates work and marriage disincentives and rewards bearing children out-of-wedlock. Specifically, Murray's "law of unintended consequences" states that antipoverty programs giving either cash or in-kind benefits inexorably strengthen the incentive to maintain the condition that the program sought to ameliorate in the first place. Moreover, conservative scholar Lawrence Mead

argued in his book, *Beyond Entitlement*, that it is not the generosity but the permissiveness of the welfare system that creates segregated neighborhoods of underclass minorities. By not requiring anything from the welfare dependent, cash assistance weakens the sense of independence and commitment to mainstream values, thereby perpetuating a culture of disadvantage. Mead argues that the federal government should make welfare receipt and other benefits contingent on acts of "good citizenship" by requiring work and placing time limits on benefit receipt.

Policy Implications

The preceding discussion suggests there are several mechanisms that produce residential segregation. Support for these competing hypotheses does not equate to a repudiation of Iris Young's thesis that segregation is the product of housing discrimination by private individuals. Instead, one can view these alternative arguments as deriving from structural changes in the economy and demography of urban areas that were gaining momentum during a period when discrimination by private actors was at its height. There were innumerable private actions taken in order to maintain the color line, and Young is right to point this out. For example, a common neighborhood-level solution to the threat of black residential expansion was the formation of "improvement associations." These groups used a number of tools to restrict blacks' residential choices, including lobbying for zoning restrictions, boycotting real estate firms and stores that sold homes and goods to blacks, and offering cash bonuses to black residents who agreed to leave the neighborhood. For-profit realtors also contributed to the spatial concentration of minorities through the practice of "blockbusting." Agents would identify an urban area that looked promising for racial turnover—neighborhoods adjacent to already segregated areas with older housing units, poorer families, and near undesirable railroad tracks or major thoroughfares. White fear of black families would be stirred by the realtors, who promised white residents a generous sum of money to sell their homes. Meanwhile, the same agents advertised in predominately black neighborhoods, pointing out the availability of good housing in a newly opened neighborhood. Given the intensity of white fear and prejudice (as well as the intense demand for black housing), the entry of a small number of black residents would quickly set off another round of neighborhood turnover, thereby increasing the size of segregated black areas.

There are several mechanisms that produce residential segregation.

The first major policy response to eradicate residential segregation and housing discrimination was the 1968 Fair Housing Act (FHA). This legislation prohibited the refusal to rent or sell a home to any person because of race; it prohibited discrimination in conditions of any rental or sale; it outlawed discrimination in real estate advertising; it banned agents from making false statements about a home's availability in order to deny it to a black family; and it contained specific language against blockbusting and red-lining. The primary criticism of the FHA was not its coverage, but rather its limited enforcement powers. Title VII of the law, for example, authorized the Department of Housing and Urban Development (HUD) to investigate complaints made only by "aggrieved persons," and it had just 30 days to pursue or dismiss such allegations. If HUD did in fact find evidence of discrimination, it was compelled to engage only in "conference, conciliation, and persuasion" to resolve the problem.

Legislative attempts to desegregate urban areas did not end with the 1968 FHA. Throughout the 1970s, the federal government incrementally chipped away at the institutional barriers to fully accessible housing for minority families. In 1974, for example, Congress passed the Equal Credit Opportunity Act which explicitly barred discrimination in home lending and required banks to compile data on the racial composition of clients it accepted and rejected for mortgage loans. The Home Mortgage Disclosure Act of 1975 required banks to report which neighborhoods received mortgage and home improvement loans. The law also intensified the pace of prosecuting red-lining cases under the FHA. Finally, Congress in 1977 passed the Community Reinvestment Act, which required banks to demonstrate that they were in fact providing credit to low-income areas that had been previously denied capital projects.

These policy prescriptions, which involve the authority of the federal government to dismantle residential segregation sponsored by private institutions, accords with Young's diagnosis of the problem. But these policies have done little to ameliorate the other causes of racially-based residential segregation—the structural changes in urban economies, suburbanization of service-sector jobs, and the spatial mismatch between the location of low-wage labor supply and low-wage employment. A different set of policies is needed to address these constraints on residential choice.

One such policy has been the shift away from high-rise public housing developments, which many argue

foster segregation, toward providing low-income families with vouchers to purchase housing in the private market. Between 1977 and 1997, the number of families receiving housing vouchers increased from 162,000 to 1.4 million. In 1996, Congress passed Section 202 of the Omnibus Consolidated Rescissions and Appropriations Act, requiring housing authorities to conduct a quality assessment of their public housing stock. If the cost of rehabilitation for a particular unit exceeded the cost of providing that family with a rent subsidy over a 20-year period, then the housing authority must remove the unit from its stock.

In practice, policies that increase residential choice and mobility influence families in several ways. First, voucher programs provide families economic freedom of movement. Relocation to more affluent neighborhoods has the ancillary effect of increasing the average quality of schools children can attend. Third, regardless of where a family might relocate, vouchers allow families to move out of public housing, which alone effects employment, earnings, or educational outcomes. On the other hand, it is conceivable that moving to a new neighborhood would fuel familial disruption. A new neighborhood environment, coupled with the loss of social capital established in public housing and the transition to a new job or school, may lead to negative short-run outcomes.

Despite these dramatic policy changes, relatively little is known about the impact of increasing residential choice through housing vouchers. Some of the earliest evidence on housing vouchers comes from the Experimental Housing Allowance Program (EHAP) from the 1970s. A review of studies on this experiment reveals that housing vouchers neither increased mobility nor affected racial/economic segregation. This conclusion appears to be supported by other evidence, which finds that minority voucher recipients tend to relocate close to their original neighborhood. Another researcher, P. Fischer, found that nearly 80 percent of relocated families in Chicago moved to census tracts that were over 90 percent black, while 90 percent moved to tracts with median incomes under $15,000.

A recent attempt by the federal government to influence and analyze the effects of housing mobility is through the Moving to Opportunity (MTO) program. Unlike previous designs, the MTO program was a randomized experiment that assigned program participants to one of three groups: (1) an experimental group that received housing subsidies and search assistance for private-market housing in affluent neighborhoods, (2) a comparison group that received Section 8 housing vouchers and no search help, and (3) a control group that received no special assistance. Results from the MTO experiment indicate substantial benefits of housing mobility, especially for children. Participation in the experimental group lead to greater relocation in non-poor neighborhoods, improved mental and physical health, increased satisfaction with the neighborhood and schools, decreased behavioral problems among children (including juvenile arrests), and increased math and reading test scores.

A final policy approach to decrease residential segregation involves increasing access to public transportation. For inner-city residents who use public transportation to work in suburban areas, accessibility represents real costs in terms of travel time and other expenditures. Therefore, residents in segregated communities with less spatial accessibility to jobs and transportation face higher work-related costs and thus greater constraints on employment. Furthermore, commuting times by public modes are considerably longer than by private modes, suggesting that wages net of travel time are significantly reduced if workers in segregated urban areas must travel to jobs in suburbs. Such costs have been quantified by transportation experts, who define as "accessible" those distances less than a quarter mile from a public transit stop. Using this definition, a study of four metropolitan areas found that 65 to 70 percent of all low-skilled jobs are located in white suburbs, and that nearly half of these jobs are inaccessible. On the other hand, just one-quarter of low-skilled jobs are located in the central city, with 86 percent accessible by public transportation.

These findings suggest that policy interventions aimed at making low-skilled jobs physically accessible to central city residents are likely to have a positive effect on employment and earnings. Two general approaches have been cited to increase job accessibility in segregated neighborhoods. The first is to increase access to suburban housing. However, housing mobility programs, such as MTO, are costly and limited in scale. The second approach involves subsidizing commutes by providing van pools to suburbs or improving public transportation's connectivity between the central city and suburbs. A major drawback of this approach is that it does not attempt induce relocation. An example of this policy is HUD's Bridges to Work initiative, which conducts job placements and transportation assistance to suburban jobs. While these programs are less costly per participant and less politically controversial than voucher programs, they do not address fully the deleterious effects of living in segregated areas with concentrated poverty.

Policies that increase residential choice and mobility influence families in several ways.

Conclusion

I began this article by broadening the scope of the causes of residential segregation beyond Young's "private actors" argument. While Young correctly points out that private citizens are actively engaged in maintaining segregation, I argue that the relative importance of these actors declined in the past several decades, in part due to the big-stick policy approach implemented by the federal government. After the flurry of legislative activity in the 1960s and 1970s, the nature of racially-based residential segregation changed to more subtle mechanisms, specifically the out-migration to homogenous suburbs and the attending suburbanization of low-skilled service jobs.

To counter these changing causes of residential segregation, the federal government refocused its policy approach. One such policy is marked by a shift away from high-rise public housing developments and toward providing low-income families with vouchers to purchase housing in the private market. By increasing choice and purchasing power, vouchers allow families to relocate to more affluent neighborhoods, closer to employment centers or nearby public transportation hubs. Another set of policies attempts to increase suburban job accessibility by either adding to the existing public transportation infrastructure or creating new methods for transporting low-income workers to jobs.

A serious policy response to residential segregation must focus on the full constellation of factors perpetuating segregation, and must account for the interrelatedness among the causes. Young's notion of differentiated solidarity advocates neither: it commits only supply-side actors to a rigorous system of regulation and punishment, while leaving demand-side actors to act according to utility-maximizing principles. Moreover, Young's policy recommendation does not create incentives for low-income families to leave segregated neighborhoods for affluent areas with greater employment opportunities. Differentiated solidarity can only succeed if the same freedom of movement typically taken for granted by high-income families is extended to low-income families. Housing vouchers and other mobility programs of the sort that Senator Edwards proposed is a good start toward that ideal.

Chris M. Herbst
Assistant Professor
School of Public Affairs
Arizona State University
Chris.Herbst@asu.edu

Sources I. Young, *Inclusion and Democracy* (New York: Oxford University Press, 2000); D. Massey and N. Denton, *American Apartheid: Segregation and the Making of the Underclass* (Cambridge, MA: Harvard University Pres, 1993); for one of many studies recounting the effects of growing up in a poor neighborhood, see C. Jencks and S. Mayer, "The Social Consequences of Growing Up in a Poor Neighborhood," in *Inner City Poverty in the United States*, edited by L. E. Lynn and M. McGeary (Washington, DC: National Academy of Sciences, 1990); for one of many discussions noting that as neighborhoods become poorer and racially homogenous, individuals are less likely to have a connection to political and neighborhood institutions, see: C. Cohen and M. Dawson, "Neighborhood Poverty and African American Politics," *American Political Science Review*, 87 (1993); W.J. Wilson, *The Truly Disadvantaged: The Inner City and the Underclass*, (Chicago, IL: University of Chicago Press, 1987); C. Murray, *Losing Ground: American Social Policy, 1950* (New York: Basic Books, 1984); J. Kain, "The Spatial Mismatch Hypothesis: Three Decades Later, *Housing Policy Debate*, 3 (1992); L. Mead, *Beyond Entitlement: The Social Obligations of Citizenship*, (New York: Free Press, 1986); the review of studies into EHAP occurs in R. Struyk and J. Bendick, *Housing Vouchers for the Poor: Lessons from a National Experiment* (Washington, DC: The Urban Institute Press, 1981); P. Fischer, "Section 8 and the Public Housing Revolution; Where Will the Families Go?", (unpublished manuscript, Lake Forest College); the study of the four metropolitan areas (Atlanta, Boston, Detroit, and Los Angeles) was conducted by M. Stoll, H. Holzer, and K. Ihlanfeldt, K., "Within Cities and Suburbs: Racial Residential Concentration and the Spatial Distribution of Employment Across Sub-metropolitan Areas," *Journal of Policy Analysis and Management*, 19, 2000.

Enlightenment Thinking Could Bring Health Care for All Americans

Stephen F. Gambescia

Introduction

Many health care groups are giddy about the prospect of real national health care reform, following the Democratic takeover of both Congressional chambers in January 2007. Taking this cue, the several presidential campaigns give priority to health care reform and are, therefore, slowly divulging their plans. Recalling President and Mrs. Clinton's efforts of fifteen years ago, presidential hopefuls of today perceive this as an opportunity to advance a Democratic "core value": *universal health care.*

President Bush and some Republican Congressional members understandably have their own ideas regarding how to slow the increase in costs of health care, to insure more people, and (generally) to assist the system to "heal thyself."

Getting health care reform onto a "national agenda" is a vital first step to improving the health care of all Americans, but keeping it there and making significant change is of far greater import. Thus, if the latest national health care reform movement follows the perfunctory *political stream*, the result will be yet another set of incremental policy changes that add more complexity, but these changes will provide little improvement to a system very much in distress. We must get serious about true health care reform.

Keeping History in Mind

Those health care policy pundits who critique the notion of health care for all Americans, have failed to integrate the *history* of how health care developed in America. Prior to the Clinton Administration's 1993 effort to grant all Americans an opportunity for health care, proposals and initiatives—both incremental and sweeping—never became central. The failure to adopt legislation had little to do with which political party controlled the White House or Congress. Theodore Roosevelt had national health insurance on his platform in 1912 while running for the Progressive Party. In 1934, Franklin D. Roosevelt created a Committee on Economic Security that seriously considered "social insurance," but he stopped short of endorsing wide-scale health insurance in fear that it would jeopardize his Social Security Act. Senator Robert F. Wagner, Sr. of New York crafted major legislation for a national health insurance plan in 1935 and again in 1943. In 1949, President Harry S. Truman called for compulsory national health insurance, even with Democratic majorities in both Houses, but to no avail. In the early 1970's President Nixon made a thoughtful attempt at getting the nation some type of national health insurance but settled for what became a major federal boost for managed health care. Congress was also active with bills during this time, but none prevailed.

Getting health care reform onto a "national agenda" is a vital first step to improving the health care of all Americans, but keeping it there and making significant change is of far greater import.

Thus, it would be a mistake for groups to validate either major political party's motivation or ability to accomplish anything substantive in health care reform. Looking to the *founding precepts* of our nation, inspired by *Enlightenment thinking*, will do more to guide us in finding a way to finally provide basic health care services for all, than trying to predict the vagaries of our political parties and their leaders.

The Enlightenment Tradition

Those critics who eschew government interference into the health care enterprise correctly emphasize that no one has an *explicit Constitutional right* to health care. It is, however, fair to quote the Preamble to the US Constitution that our government has the duty to "promote the general welfare." I contend that in com-

mon sense terms the general welfare encompasses the opportunity for health care. What is more, the healthier we are, the more likely we are able (both as individuals and as groups) to "form a more perfect union, establish justice, and provide for the common defense…." In short, keeping people healthy carries a big communal payoff.

The American philosophy of governance, laws, and order stem from the Enlightenment tradition, which views the entrance of citizens into a social contract, is motivated by the gain of protection of their person and property. The prominent Enlightenment thinker John Locke (who lived from 1632 to 1704) noted that labor is also considered to be property. His influential *Second Treatise of Government* (which was published in 1690) clearly set out his natural right theories. In this work, Locke argued that everyone has property in his own person, that the labor of each person can rightfully be considered his property, and this deserves all the rights and privileges in our society which holds property in high regard.

Naturally, people—especially those in free-market societies—will enter in agreements and *barter their labor* in exchange for rewards that provide various forms of sustenance. This exchange is primarily in the form of wages, but in highly developed societies compensation to employees who work for companies includes a number of "fringe" benefits well beyond wages, such as vacation time, pensions, and reimbursement for education. However, the second largest benefit has been coverage for employee (and sometimes their families) health insurance.

Indeed, some employers have been deeply involved in worker health care since the late nineteenth century. Labor-intensive industries especially, such as mining,

The American philosophy of governance, laws, and order stem from the Enlightenment tradition, which views the entrance of citizens into a social contract as motivated by the gain of protection of their person and property.

lumber, and railroad construction recognized the need to keep people on the job, and that ill health interrupted business. This view even encompassed teachers, whose absence was arguably the most disruptive to the community. Companies in remote areas knew that it made good business sense to provide some type of health care onsite, since workers were considered a company's greatest asset. Given the expansive job growth in the early 1900s, in order to gain a competitive advantage, some companies began to add health insurance coverage to their compensation packages, even offering such insurance to white collar workers.

During the World War II period, although the American government saw it as a economic necessity to slow and freeze wages, fringe benefits were exempted from this government oversight of workers' compensation. More and more companies began to offer such non-wage benefits as health insurance. Furthermore, the federal government began to exempt group health insurance premiums from income tax (although it must be pointed out that this system actually favored the high wage earner.) Providing health benefits became a smart and cost-effective compensation strategy that attracted and retained workers. Over time, a large *employer-based* health insurance system developed in the US,—one that covered nearly two-thirds of the country's population. (However, 20 percent of working adults are not offered insurance through an employer.)

During the World War II period, although the American government saw it as a economic necessity to slow and freeze wages, fringe benefits were exempted from this government oversight of workers' compensation.

Employers became central to the US health care economy, paying the majority of premiums. Understandably, because of the great financial investment and increasing cost of premiums, employers took more control in the deciding *who gets covered* (worker and family), the *nature of health coverage* (the menu of services covered), and the *extent of coverage* (the amount of dollars allocated). Initially, employers were a passive funder of their employees' health plan package, but over time employers became much more circumspect about the above considerations, while employees saw less and less choice.

Yet, I would contend, once our property (labor) has been linked, even tacitly, to our person (that is, the health of our person), when we abdicate control to another entity, we *misuse an inalienable right*. With care of our person inextricably linked to our station in life, our right to our welfare is no longer unconditional. Abdication of control of our health is philosophically and morally untenable; unfortunately, it is a well-entrenched part of the American health care system.

Initially the employer and employee had a reasonable *quid pro quo*, which satisfied the marketplace and improved the lot of the worker. This arrangement also fit nicely with American ideology, an ideology that generally wants to avoid high level of control from the welfare state, as was the path taken for most developed

countries addressing their health care needs. As a practical matter, we really have not escaped Big Brother minding our health care; he may not be the government, but many people consider Big Brother to be the corporation. Health care information held by the corporation is a constant risk to an individual's privacy, regardless of the rule put into place.

Furthermore, the lack of portability of employer-based health insurance often indentures an employee to a job or company that otherwise the employee would rather move away from, using his or her talents in new ways or at another company.

Therefore, we must *relieve* employers of such control as well as any vestige of that control. It may have been prudent more than a half-century ago to create this type of financing of health care services, but it makes no sense in a free and autonomous society for employers to be involved in our health care decision making—at any level. We need to emancipate ourselves from employer-based control of our ability to flourish.

The Escape from Health Care?

Employers of all sizes are beginning to recognize they can no longer sustain a large portion of the financing of our system. They act as if they wish to escape from the health insurance business when they (1) cost-shift to employees, (2) reduce benefits, or (3) join cooperatives that can promote cost-sharing. The signs are here that they will be getting out of the health insurance business for their employees.

A salient reason for this escape is that the average monthly dollar contribution for health insurance has nearly doubled for company-sponsored workers from 1999–2006. Companies are poised to shift a larger percentage of the payments to workers, if they have not done so already. The question for senior benefits managers today in selecting what plans to offer in a company is this: Since we can no longer simply afford to give our employees the "cadillac" plan or the "chevy" plan, what are the *minimalist plans* that we *can* offer? Large employers, such as Wal-Mart, AT&T, Kelly Services, and Intel Corp., have publicly called for "quality, affordable health care for all Americans," which begins to shift the thinking that employer-sponsored health care has to be the bulk of any national health care reform.

Employer-sponsored health care has to be the bulk of any national health care reform.

Furthermore, businesses at some point realize that managing health care benefits is not part of their *core business*. What had started as an advantageous employee compensation incentive, relatively simple to administer, has turned into a staff intensive, time-consuming, and now costly internal enterprise. As businesses and whole industries poise to compete in the twenty-first century's global economy, they have come to realize that they need to focus on the business of their business. Managing the health care of employees cannot be a part of their business. For example, we have heard often executives of US car manufacturers lament that health-care costs are their biggest competitive disadvantage. Managing health benefits for companies and organizations is an occupation in itself, commanding many professionals and support staff. Car manufacturers who have shifted the management of some health care benefits (especially those of retired workers) to unions believe that leaving the health care arena carries greater benefits for autoworkers and carmakers. For instance, companies can devote more of their energies to improving workplace safety, developing employee wellness programs and work environment improvement programs.

Furthermore, the growth of an economy today has much more to do with small businesses, sole proprietors, consultants, and independent workers, than with established companies. Higher education levels, improved technology for individual use, and overall prosperity support an *enlightened creative class* that wants to use its talents in many different ways, but not within "the firm." Those who own small companies or those who are independent workers constantly struggle over the health insurance coverage issue. Often times they carry little or no health insurance, thus either placing themselves or their families at risk. Such persons risk their health if care is needed, but they also risk becoming a free rider into a health care system that they have not even paid marginally into.

Letting Go of the Market-based Model

Although America's capitalist economy has been its backbone for centuries, the earliest health care delivery system was actually built on two other founding American precepts: *charity and fraternity*. Many early successes of healthcare in America are a tribute to the philanthropic and volunteer spirit of Americans. As the US population expanded and the health care system grew, and medicine and treatments advanced, the US began to switch support to a market-based system, boosted by government support when needed. The history of the development of the health care *systems* (that is plural) in America is an interesting, but long, one. Suffice it to say that we have enough evidence now to show that health care should not be working first and foremost from a market-based model. If for no other reason than for the nearly 47 million individuals

uninsured, we need to let go of the notion that more market forces will bring more people into the system and slow increases in cost. Further, changing the label of the strategy to "managed care," "consumer-driven health care," or "value-based health care" is not the solution. And no finds no evidence that a resurgence of more charity and fraternity can meet the demands of health care for our growing and aging population. However, it is worth considering more of a Communitarian perspective. Where the two values of community and marketplace efficiency clash—and they need not—the Communitarian gives priority to considerations of the community.

Ostensibly American public opinion does not favor more government control over its health care. However, the percentage of people insured through some type of government program is creeping upward. Publicly-funded insurance now accounts for 38 percent of those with health insurance in our population, which includes Medicare, Medicaid, active-duty military personnel and their families, veterans, and those who work in the public sector. Adding other public health monies or uncompensated care expectations for hospitals reveals that the US government has even a larger role in funding health care. For a country that on the surface may abhor government-sponsored health insurance, we are approaching half way.

Americans should take pride in their health care providers and the many support services and products that comprise health care. Health care providers are driven by a willingness to use talents, to experiment, invent, and innovate and work hard to improve the human condition. Americans should do all that they can to develop a health care system that supports those who work in these most important professions and businesses. The challenge is to create a system where those who excel and are committed to the healing arts can *reach everyone* and be properly rewarded. The philosophical basis for change is neither a notion of health provider paternalism nor the abject dependency of patients on providers. Instead, the philosophical basis for change rests on the the Enlightenment, which stressed the exercise of one's talents and placed great confidence in human progress. Although advances in medical technology and the development of new medications receive much publicity at present, a cognitively-based clinical care approach will be much more important for the future. This approach values health promotion advice, basic preventive medical services, and the appropriate management of chronic diseases for populations.

American public opinion does not favor more government control over its health care. However, the percentage of people insured through some type of government program is creeping upward.

Conclusion

The healing arts professions each have a unique and interesting history and professional association organization. One can find cynical interpretations today that the healing arts professions are part of the problem in the lack of health care for all. Are these autonomous, noble professionals looking only to their own self interest, or are they genuine advocates for their patients? One hopes that they stay true to their calling as the father of medicine, Hippocrates, wrote in his *Precepts*: "Where there is love of humankind, there is also love of the art of medicine."

I contend that we are now seeing clear signs that our *general will* (a concept of Enlightenment thinker, Jean-Jacques Rousseau, who lived from 1712–1778) is moving to fix our hodgepodge national health care system. Rousseau had proposed that ones self interest can best be achieved by considering the well being of others, and I see the general will at work in the health care debates. Governors and legislatures in a half-dozen states are making major proposals to ensure health care coverage for all residents of their states. Coalitions of companies, unions, and senior citizen groups are consulting with one another, hoping to create a better health care system. The CEO of pharmaceutical company Glaxo-SmithKline has publicly called for national health insurance. Organized medicine is poised to work toward a plan that gives basic health services to all Americans. After three years and six studies, the Institute of Medicine (a part of the National Academy of Sciences) concluded that our health care system is unsustainable, and that the US must move toward universal health care. In short, the factions against providing health care to all are in decline.

Americans need to create a health care system that allows everyone an opportunity to receive care. I suspect that, deep down, most Americans believe that quality health care should be provided for all. While we may have many differences, the gulf in quality of care among groups, in the end, will come to be viewed as unacceptable, and un-American. If we exercise the Enlightened "general will" over the political opportunities or liabilities, we will be exercising our true political authority that can bring about progress in this area. To stimulate resolution, I am not suggesting that we don't need to invest time in the public policy process. I am suggesting that attention given to the political parties' agenda as a primary strategy is doomed to fail, as it has in the past.

Consider for a moment that, if we are "one nation under God," and if we agree to respect each others' inalienable rights, doesn't it make sense that we all *join in the same health risk pool* and work from there?

The issue of health care for all is not about "the political will" to change that we have heard for decades. The answer lies fundamentally in "we the people" communicating the Enlightenment concept of the *general will* that we need a system where all Americans receive basic health care services. The time to act should not be tied to the political party or an individual candidate's calendar. If ever there were a case and time to exercise our true sovereignty, it is for this issue, and it is becoming clear that the time is now!

Stephen F. Gambescia
Associate Professor
Health Services Administration
College of Nursing and Health Professions
Drexel University
1505 Race Street, second floor
Philadelphia, PA 19102
sfg23@drexel.edu

Sources: Robin Toner, "A Critical Condition Rises for 2008," *Philadelphia Inquirer*; Chris Mondies, "Bush to Hospitals: Heal Thyselves," *Philadelphia Inquirer* (February 12, 2007); Theodoor J. Litman and Leonard Robins, *Health, Politics, and Policy* (Albany, NY: Delmar Publishers, 1997); Steven Jonas, *An Introduction to the US Health Care System* (NY: Springer Publishing Co., 2003); John Locke, *Second Treatise of Government* (Indianapolis, IN: Hackett Publishing Co , 1980); John R. Boatright, *Ethics and the Conduct of Business* (Upper Saddle River, NJ: Prentice Hall, 2003); Uwe E. Reinhardt, "Employer-Based Health Insurance: A Balance Sheet," *Health Affairs,* vol. 18, no. 6 (November/December 1999); Amitai Etzioni, *The Limits of Privacy* (New York: Basic Books, 1999); Jonathan Cohn, "What's the One Thing Big Business and the Left Have in Common?" *New York Times Magazine*, (April 1, 2007); Jim Jaffe, "The Great Benefits Shift," *Philadelphia Inquirer* (September 18, 2005); Tom Krisher, "GM Says Health-care Costs Are Its Biggest Competitive Disadvantage," *Philadelphia Inquirer* (March 16, 2007); Dan Caterinicchia, "Employers Cooperate for Health-care Initiative," *Philadelphia Inquirer* (February 12, 2007); Rosemary Stevens, *In Sickness and in Wealth*: *American Hospitals in the 21st Century* (New York: Basic Books, 1989); Daniel Gross, "National Health Care? We're Halfway There," *New York Times* (December 3, 2006); Amitai Etzioni, et al. *Core Values in Health Care Reform: A Communitarian Approach*. (Washington, DC : The Communitarian Network, 1993); Paul Starr. *The Social Transformation of American Medicine*, (New York: Basic Books, 1984); *Hippocrates*. vol I, translated by W.H.S. Jones (Cambridge, MA: Loeb Classical Library, 1923); Jean-Jacques Rousseau, *The Social Contract and Discourse on the Origin of Inequality,* translated by Donald A. Cress (Indianapolis, IN: Hackett Publishing Co., 1987); Chris Mondies, "Glaxo's CEO: Insure Everyone," *Philadelphia Inquirer* (April 18, 2006).

Established in 1976 at the University of Maryland and now part of the School of Public Policy, the Institute for Philosophy and Public Policy was founded to conduct research into the conceptual and normative questions underlying public policy formation. This research is conducted cooperatively by philosophers, policy makers and analysts, and other experts both within and outside of government.

To make its research readily available to a broad audience, the Institute for Philosophy and Public Policy publishes this quarterly journal. Articles are intended to advance philosophically-informed debate on current policy choices; the views presented are not necessarily those of the Institute or its sponsors.

Editorial Policy: While the principal mission of *Philosophy & Public Policy Quarterly* (ISSN 1067-2478) is to present the work of Institute members, the work of individuals who are not members of the Institute also appears in the *Quarterly* from time to time. Interested individuals should direct submissions to the editor. Articles that appear in the *Quarterly* may be made available in whole or in part to third-party indexing sources.

Correspondence with Contributors: Readers may direct their correspondence to authors, whose mailing addresses and e-mail addresses follow their articles, or in care of the editor.

Subscriptions: A subscription to *Philosophy & Public Policy Quarterly* is free of charge to anyone making a request. Please let us know of changes in address, or whether you are receiving multiple copies of the *Quarterly*.

Electronic Access: The Institute for Philosophy and Public Policy directs interested individuals to its Web site: **http://www.puaf.umd.edu/IPPP.** Current and past issues of the *Quarterly* are available on the site. Copies of articles may be downloaded for personal use free of charge. Downloading for classroom or other use requires permission.

Non-Profit Organization
U.S. Postage
PAID
Permit No. 10
College Park, MD

Institute for Philosophy and Public Policy
School of Public Policy
University of Maryland
College Park, MD 20742

Address Service Requested