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BEYOND *JUST HEALTH CARE*

By

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ABSTRACT

BEYOND *JUST HEALTH CARE*

By

Allison Brooke Wolf

What constitutes a just health care system? Since the publication of his book, *Just Health Care*, in 1985, many bioethicists have agreed with Norman Daniels' claim that a just health care system is one that meets distributes its scarce resources in a way that protects citizens' fair equality of opportunity. Despite the popularity of Daniels' view, however, I maintain that his framework has serious limitations, many of which originate in Daniels' unjustifiable restriction of the scope of health care justice to distributive questions. This restriction is problematic for three reasons. First, it misidentifies the U.S. health care crisis solely as a distributive justice problem when health care justice involves both distributive and non-distributive matters. Second, the restriction leads Daniels' theory to ignore an entire area of health care injustice, non-distributive issues. Third, this restriction leads Daniels' framework to misidentify the aim of justice. All of these limitations suggest that Daniels view is, at best, an incomplete account of health care justice and, at worst, an account that allows or perpetuates health care injustice (an absolute problem for a theory purporting to outline a system free of such injustice).

Since I argue that Daniels' view is incomplete, I then offer an alternative framework that will not fall victim to Daniels' problems. Specifically, I suggest that we employ a framework based on social justice, which I define as the active process of creating a world without oppression. Based on this definition of social justice, in contrast to Daniels, I argue that a just health care system is one that aims to eliminate institutionalized oppression, especially in the health care system. A just health care policy, system, or practice is one that does not create, reflect, or perpetuate institutionalized oppression. Given all of the above, I argue that we must move beyond *Just Health Care*.

For Grammy

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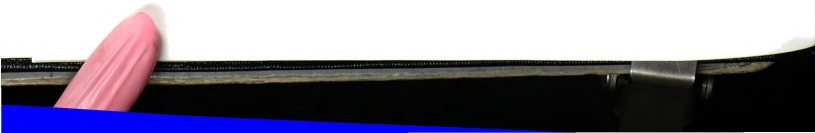

Introduction: Why We Must Move Beyond *Just Health Care*

Karen Thompson and Sharon Kowalski had been together for four years when Sharon was hit by a drunk driver and sustained severe head injuries that left her in a coma. When Karen found out, she rushed to the hospital but was not able to see Sharon or receive information about her condition because she was not "immediate family."[1]

Fran came out as a lesbian to her doctor when he was asking her about birth control. During the exam, when he was placing the speculum in her vagina, he was extremely rough and he used a size that was uncomfortable for her. When Fran complained, he said, "I'm just trying to change your mind."[2]

Well it's like this. There's white folks. And there's black and brown and red and yellow folks. Now white folks done treated all us different kinds of colored folks bad. Them doctors did not care enough about me to listen and get it right. We all Niggers to the white folks. So it don't matter to them doctors whether I'm Indian or a black man. We all into drugs and alcohol. And because my skin color is a little bit yellow-red and my hair is straight like a Indian's, they just decided I must be a alcoholic Indian. I ain't neither. I am a sick black man whose job made his health bad.[3]

After the birth I felt just miserable, agonizingly miserable. ... And ashamed. I felt so ashamed of myself for screaming, and for not being able to do it. And you know, I had a friend who gave birth a few days later, and her labor was longer than mine, and she ended up with a perfectly normal labor. And I spent months and months comparing our experiences – going over the times and what happened to each of us step by step. And it just didn't make any sense to me. The doctor said it was "CPD" [cephalo-pelvic disproportion, a condition in which the baby is too large to fit through the mother's pelvis and "failure to progress." But her baby was bigger than mine, and I'm bigger than she is, and she was in labor longer than me. And then I had so many questions that I started to read some more. More and more. And I started to admit to myself that I felt humiliated by my birth. And then when I realized that I probably hadn't even needed a Cesarean, I started to realize that I felt raped, and violated somehow, in some really fundamental way. And then I got angry.[4]

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[1] Michele J. Eliason, *Who Cares? Institutional Barriers to Health Care for Gay, Lesbian, & Bisexual Persons* (NY: NLN Press, 1996) 7.
[2] R. Denenberg, "Invisible Women: Lesbians and Health Care," *Health Policy Advisory Center Bulletin* 1982, 14.
[3] "Uncle Boy" in *It Just Ain't Fair: the Ethics of Health Care for African Americans*, eds. Annette Dula and Sara Goering (Westport, CT: Praeger, 1994) 2.
[4] "Elise" in Robbie Davis-Floyd, *Birth as an American Rite of Passage*, (Berkeley, Los Angeles, and London: University of California Press, 1992) 233-234.

The Context for This Project

While these cases appear to be clear examples of health care injustices, the health care justice literature has ignored them.[5] Bioethicists traditionally conceptualize these occurrences as unfortunate examples of morally objectionable behavior by some health care practitioners, not injustices in the health care system. Since health care justice focuses on how to construct a fair health care system, random occurrences of morally objectionable behavior by random practitioners need not be identified (or addressed) by a theory of health care justice.

I strongly disagree with this characterization and maintain that we must have a theory of health care justice that will identify Karen's, Fran's, Uncle Boy's, and Elise's cases as the health care injustices that they are. When I raised these concerns to bioethicists and those working in health care justice, however, I faced deep skepticism and consistently encountered three questions. First, why are these cases examples of health care injustice? Second, if I am right that they are health care injustices, why have they not been so identified by the bioethics literature? Third, what would a theory of health care justice look like that could identify Karen, Fran, Uncle Boy, and Elise's experiences as health care injustices? I answer these three questions in my dissertation in the hopes of improving health care justice theories and, importantly, in the hopes of

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[5] For sources of other examples of institutionalized oppression in health care see: *It Just Ain't Fair: The Ethics of Health Care for African Americans*, eds. Annette Dula and Sara Goering, (Westport, CT: Praeger, 1994); *The Black Women's Health Book*, ed. Evelyn C. White, (Seal, 1994); Michele J. Eliason, *Who Cares? Institutional Barriers to Health Care for Gay, Lesbian, & Bisexual Persons*, (NY: NLN Press, 1996); *Health Care for Lesbians and Gay Men: Confronting Homophobia and Heterosexism*, ed. K. Jean Peterson, (NY: The Haworth Press, 1996); Shirlee Passau-Buck, *Male-Ordered Health Care: The Inequities of Women*, (NY: Power Publications, 1994); Leslie Laurence and Beth Weinhouse, *Outrageous Practices: How Gender Bias Threatens Women's Health*, (NJ: Rutgers University Press, 1994); Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, (NY: Pantheon Books, 1997); John M. Smith, *Women and Doctors*, (NY: The Atlantic Monthly Press, 1992); *Man-Made Medicine: Women's Health, Public Policy, and Reform*; Kary L. Moss, ed. (NC: Duke University Press, 1996)

hearing the voices of marginalized groups by identifying and beginning to eliminate the institutionalized oppression that they face in the health care system.

In response to the first query, all of the above instances are examples of institutionalized oppression in health care. Feminist political philosophy has long identified institutionalized oppression as an injustice that must be remedied.[6] So, what makes these cases examples of health care injustice is that they are all examples of oppression and such oppression is unjust. Still, institutionalized oppression in health care is not currently recognized as a health care injustice by our current frameworks. Why?

In short, the reason that our current theories of health care justice, including the most widely accepted framework offered by Norman Daniels, do not recognize institutionalized oppression as a health care injustice is because they cannot do so. As a result, Daniels' theory will not recognize the cases that begin this work as health care injustices. But, is this lack of recognition an inherent part of Daniels' view? In other words, could Daniels' model be modified to recognize such injustices as such? I argue that the answer to this question is "no" because the reason Daniels' framework does not recognize these instances as injustices is that it is rooted in Rawls' political philosophy and the distributive paradigm of justice, in particular. Consequently, modifying Daniels' theory in the needed ways would require creating a totally new framework.

Given that Daniels' theory cannot be modified to recognize Karen's, Fran's, Uncle Boy's, and Elise's cases – and, for that matter, any case of institutionalized oppression in health care - and given that we need a theory that will acknowledge such

[6] In fact, while there is wide variety in feminism, common threads through all of these branches are the claims that (1) Women are oppressed; (2) That oppression is wrong; and (3) This oppression in not natural and thus can and should be changed. So, the entirety of feminist theory is predicated an the assumption that oppression is unjust and must be eliminated.

cases as injustices, I suggest that we need a different model of health care justice to accomplish this task. I think that such a theory is one based on social justice, which I will propose in this work. Based on this model, I will suggest that when the health care system perpetuates, reflects, or supports oppression, health care injustice exists. Conversely, a just health care policy, system, or practice is one that does not create, reflect, or perpetuate institutionalized oppression.

In this Introduction, I will outline some background of the health care justice discussion that has brought us to this place. In the process, I will outline my major contentions and my proposed model of health care justice that will not fall victim to the problems Daniels' model of health care justice encounters. Finally, I will outline the way the project will proceed.

BACKGROUND: WHAT IS THE PROBLEM?

For the last three decades, the United States has been in a health care crisis often characterized by two problems: (1) the rising number of uninsured and underinsured persons (now at an estimated 43.9 million people)[7] and (2) the rising costs of health care.[8] Medical ethicists traditionally classify this health care crisis as a special kind of scarce resource problem. The problem, in other words, is: How do we fairly allocate the country's finite health care resources while providing people access to the health care services they require? Given this understanding of the health care crisis, most medical ethicists utilize the philosophical approach designed specifically for dealing with scarce resource allocation, the distributive paradigm of justice, to seek remedies for current

[7] Institute of Medicine Report, January 2004
[8] U.S. Census Bureau Report, 2001

health care woes. Primarily, they utilize Norman Daniels' theory of health care justice as presented in his book *Just Health Care*.

NORMAN DANIELS' SOLUTION

Before 1985, debates about our health care crisis focused on determining whether a right to health care exists. All sides assumed that if a right to health care exists, then the state must provide health care resources for all of its citizens as a matter of protecting its citizens' basic human rights. If a right to health care exists, distributive justice requires providing health care services and if it does not, justice does not mandate such an allocation.

The health care debate changed, however, when Norman Daniels published his book *Just Health Care* in 1985.[9] Daniels argued that concentrating on the existence (or lack thereof) of a right to health care does not help us resolve our health care crisis because even if a right does exist in the United States, that fact alone neither suggests a solution to the problem of the uninsured and underinsured (it simply shows why this state of affairs is wrong) nor offers a way to address the problem of rising costs. In addition, Daniels stated that this wrongheaded focus of the debate reflected a misunderstanding of the problem of unequal access to health care resources. Inequalities in access to health care are not problematic because fundamental rights are violated (as was claimed), but rather because allowing some of these inequalities infringes upon people's fair equality of opportunity to live their lives according to their conception of the good. Inhibiting fair equality of opportunity, however, is unjust as John Rawls argues in his *Theory of Justice.*

[9] Norman Daniels, *Just Health Care*, (NY: Cambridge University Press, 1985)

Since, says Daniels, not receiving certain health care therapies or interventions impedes fair equality of opportunity, and since a society that does not provide this level of services is unjust, we must provide the level of health care needed to protect fair equality of opportunity as part of the larger project of creating a just society.

Daniels, then, shows why it is unjust for the United States to fail to provide universal health care to its citizens. In addition, unlike his predecessors, Daniels presents a possible remedy to the crisis by stating the level of resources that a just society must provide, namely whatever level is required to protect fair equality of opportunity. Of course, Daniels still has to tell us how we determine which resources are needed to protect opportunity. To do this, he adopted Christopher Boorse's definition of 'health' as normal species-typical functioning and claimed that individuals require normal species-typical functioning (health) to maintain a normal opportunity range. Protecting opportunity, then, requires providing individuals the resources they need to protect, maintain, and as much as is possible, restore, their normal species-typical functioning.

In sum, Daniels shows that our health care crisis constitutes a health care injustice. He also suggests how to fairly resolve the health care crisis that most medical ethicists identified. Consequently, Daniels' view became, and remains, the most widely accepted theory of health care justice in bioethics today.

WHAT IS WRONG WITH THIS PROPOSAL? IT IS FACTUALLY INCORRECT

Framing the U.S. health care crisis solely as a distributive justice problem is both factually and philosophically worrisome. It is factually incorrect because when we listen to what people are actually protesting in the U.S. health care system we discover that

while many are protesting their lack of access to health care resources (either because they do not have insurance or because their insurance denies them access to certain interventions), they are also objecting to the kind of treatment they receive within the health care system. Put differently, people do not simply want to be let *into* the system; they are demanding a particular kind of treatment *once they are in* the system.

Consider the cases that began this essay. First, Fran is not demanding access to a gynecologist, she is protesting the way that her gynecologist treated her; specifically that he abused and violated her because she is a woman and a lesbian. Second, while an element of Karen's objection is that she is not given access to her partner at a critical time, she is protesting the reason for this lack of access, namely institutionalized heterosexism in hospital policies. "Uncle Boy" is not trying to see a doctor, he is protesting the inherent racism in the medical system such that no matter which doctor he sees, he will likely encounter racism and inferior treatment. Finally, though Elise was given complete access to all available technology for her birth, she is still protesting because she received sexist and derogatory treatment during her birth. In fact, the entire debate about the medicalization of childbirth focuses not on getting women access to medical resources, but on the oppressive ideology underlying the medicalized model of birth that says that women require high technology births. These cases (and the many more like them) suggest that it is factually inaccurate to frame the United States' health care crisis exclusively as a distributive justice problem, as medical ethicists, like Daniels, have done. The crisis also encompasses what I call non-distributive justice, such as the kind of institutionalized oppression in health care these cases highlight.

WHAT IS WRONG WITH THIS PROPOSAL? IT IS PHILOSOPHICALLY INCOMPLETE

This factual misconceptualization of the U.S. health care crisis also reveals philosophical deficiencies in the current health care justice debate. Specifically, because medical ethicists understand our health care crisis as a scarce resource problem, it is seen exclusively as a question of distributive justice. Consequently, the current theories of health care justice, including Daniels', restrict the scope of health care justice to distributive justice concerns. However, using a distributive paradigm of justice as a basis for health care justice leads to serious problems.

First, health care justice is wrongly limited to distributive questions when it encompasses both distributive and non-distributive issues. Second, Daniels' model of health care justice ignores an entire area of health care injustice, non-distributive issues, which include, but are not limited to, institutionalized oppression in the form of racism, heterosexism, classism, and sexism in health care. Third, Daniels' theory misidentifies what constitutes a health care injustice and the problem at which theories of health care justice should be aimed.

In addition to the problems with non-distributive health care justice, relying on the distributive paradigm leads Daniels to have trouble addressing distributive health care justice questions. This is evident, for example, in the way Daniels' model could be used to determine whether justice requires providing the childbirth services mandated by medicalization. Because Daniels' theory cannot identify key issues in this case, such as the processes that created our current medicalized model of birth or the derogatory ideology on which this model is based, it can be used to support the claim that justice mandates distributing resources as medicalization directs. However, once these other

aspects of the medicalization of childbirth are revealed, it becomes apparent that such an allocation is unjust, as it reflects and perpetuates women's oppression. So, Daniels has problems addressing distributive health care injustice matters as well as non-distributive issues. Given the above, Daniels' theory of just health care is incomplete because it cannot and does not identify non-distributive injustices, institutionalized oppression in health care in particular.

My Proposal

Given these prefatory arguments, what is the solution? One place that may offer an answer to this question is feminist bioethics. After all, as I have already said, it is a long-standing principle in feminist theory that oppression constitutes an injustice. Despite this intuition, this literature does not offer this assistance. While feminist bioethicists have pointed out how bioethics, generally speaking, has neither acknowledged nor addressed oppression in health care, they have primarily criticized medicine and mainstream bioethics without constructing new frameworks.[10] This is especially true in the health care justice debate. While Susan Sherwin, Susan Wolf, Eva Feder Kittay, Hilde Lindemann Nelson, and James Lindemann Nelson have all criticized the traditional, distribution-based, framework of health care justice, they have not offered alternative frameworks.[11] Consequently, a theory of health care justice capable of

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[10] Hilde Lindemann Nelson points this out in, "Feminist Bioethics: Where We've Been, Where We're Going," *Metaphilosophy*, 31:5, October 2000: 493. It should be noted here that neither Nelson nor I are suggesting that feminists have not constructed new frameworks, as this is clearly false. However, Nelson suggests that feminist bioethicists have primarily focused on critique utilizing feminist theories and models within medicine (mostly to point out problems within medicine), as opposed to constructing new bioethics frameworks specifically.

[11] See Hilde Lindemann Nelson and James Lindemann Nelson, "Justice in the Allocation of Health Care," *Feminism & Bioethics,* Susan Wolf (NY: Oxford University Press, 1996) 351-370; Susan Sherwin,

identifying and addressing the full scope of health care justice concerns has yet to be developed by feminist or non-feminist bioethicists. I aim to change that with this project.

Specifically, I will propose basing a theory of health care justice on a foundation of social justice, rather than distributive justice. In this project I am defining 'social justice' as the active process of constructing a world without oppression. 'Health care justice' based on this social justice framework is the active process of creating a health care system without oppression. Health care injustice exists when the health care system perpetuates, reflects, or supports oppression. Conversely, a just health care policy, system, or practice is one that does not create, reflect, or perpetuate institutionalized oppression. I suggest that the above framework of health care justice would not be vulnerable to the problems Daniels' model faces and thus is a viable alternative to his approach. Before we can explore this larger claim, however, in order to be clear what social justice (and by extension, health care justice) aims to eliminate, we must clarify what constitutes 'oppression' and 'institutionalized oppression.'

THE LIBERAL DEFINITION OF 'OPPRESSION'

Liberal theories, such as, social contract theories, generally maintain that political agency is the result of conscious action. Likewise, political and societal institutions result from the free, conscious, and intentional actions of rational, autonomous individuals. This means that feelings and unconscious actions are private, and thus not politically significant, unless they violate the rights of others. 'Oppression,' if it occurs at all, is an individual phenomenon where one individual acts in an intentional way toward

"Feminism and Bioethics," Susan Wolf, *Feminism & Bioethics*, (NY: Oxford University Press, 1996) 47-66.

another individual such that one person treats another as if a morally arbitrary or accidental characteristic was efficacious.

Since the focus is on the way individuals intentionally choose to treat other individuals, this view assumes that if there is oppression, then people are deliberately and consciously treating others in an oppressive way. So, in a liberal framework oppression refers to conscious and intentional action only; it refers to a morally objectionable way that free and rational beings choose to treat each other. Private thoughts and sentiments do not amount to oppression. Acting in accord with those thoughts and sentiments does constitute oppression. For example, if someone is homophobic, then they are consciously and intentionally violating the rights of a gay person or persons on the basis of that persons "gayness," for example, by insulting them, by committing acts of violence against them, by purposefully not giving them jobs, education, etc. People are not homophobic (and thus, not participating in oppression) if they only think that gay people are inferior to heterosexuals or if they think that being gay is an unfortunate disease or is unnatural or if they think that heterosexual lifestyles are normal or preferable to homosexual ones.

For distributive theorists, then, oppression refers to conscious and deliberate actions between free and rational individuals.[12] Oppression is wrong on this conceptualization because people are not treating others according to who they are or in accordance with their actions and behavior. This is wrong because someone cannot choose the traits that others are singling out and thus, treating people better or worse because of these traits amounts to causing people to suffer because of her/his luck in the

[12] Notice that even if all members of a particular group are suffering from similar harms, they suffer as individuals who are independently suffering in similar ways (as opposed to suffering a group harm).

social or natural lottery. Consequently, some individuals suffer because of things that are not their fault, such as their race, sex, gender, sexuality, etc.[13] Allowing such suffering is unacceptable (and irrational) on a liberal model.

MARILYN FRYE'S CONCEPTION OF 'OPPRESSION'

One of the most influential conceptions of 'oppression' within feminist theory in contrast to the liberal conception just outlined is from Marilyn Frye's essay, "Oppression."[14] There, Frye explains 'oppression' by answering three questions. (1) What is oppression? (2) Why is it so difficult to see and identify oppression? (3) How can we tell who is oppressed or whether someone is suffering from oppression? It is Frye's conception that I utilize in this work so I will detail her answers to each question below.

What is 'Oppression?' Who is Oppressed?

The root of the word 'oppression' is "to press." "Something pressed is something caught between or among forces and barriers which are so related to each other that jointly they restrain, restrict, or prevent the thing's motion or mobility."[15] One element of oppression is being pressed by a systematic network of forces and barriers that are interrelated in a particular way such that they work *together* to reduce, immobilize, and

[13] One helpful discussion of how this works is Marilyn Frye's discussion in her essay "Sexism" that points out the common, but mistaken, view that sexism is treating women according to the "irrelevant" trait of gender (as opposed to being the result of the social and political systems and structures, such as the assumption that there are two biological sexes that is then used to justify certain political institutions).

[14] A few of the many feminist philosophers who utilize, rely upon, or assume Frye's definition are Iris Marion Young in *Justice and the Politics of Difference*; María Lugones in *Pilgrimages/Peregrinajes*; Sarah Hoagland in *Lesbian Ethics*; Rosemarie Tong in *Feminist Approaches to Bioethics*.

[15] Marilyn Frye, "Oppression," *The Politics of Reality*, (Freedom, CA: The Crossing Press, 1983) 2.

mold the oppressed. These networks of forces and barriers are not "accidental or occasional and hence avoidable, but are systematically related to each other in such a way as so catch one between and among them [the barriers and forces] and restrict or penalize motion in any direction."[16] Oppression, then, is a structural phenomenon; it results from relationships between social structures, not between individuals. Oppression neither happens in isolated instances nor results from a particular law, structure, or barrier to action. Rather, it arises when multiple barriers or structures are in a particular relationship to each other.

Even a network of barriers working together in a context that restricts and presses do not yet constitute oppression. After all, we all have our choices restricted by systems and networks of barriers in certain contexts, but everybody is not oppressed. One example Frye highlights on this point is traffic customs, such as having to drive one's car on a certain side of the road. While this may sometimes restrict our actions, "the restraint is imposed for our benefit, and does benefit us; its operation tends to encourage our *continued* motion, not to impede it."[17] This example suggests that we all face barriers (even barriers that cause us to suffer), but we are not all oppressed because we encounter barriers. So, we must distinguish between cases where restricting choices is oppression and cases where it is not. To do this, we need to know why a choice is restricted and investigate the kind of restriction that occurs in a context of oppression.

The concept of the double-bind allows us to distinguish the types of restrictions that are oppressive. When barriers are related in a way that their relationship creates a double-bind, which is when the oppressed's "options are reduced to a very few and all of

[16] Ibid, 4.
[17] Ibid, 11.

them expose one to penalty, censure, or deprivation."[18] Frye's example of how women are viewed in light of their choice to either engage or not engage in heterosexual intercourse illustrates a double-bind. In the United States, when unmarried, young women engage in intercourse with men, they are commonly labeled "whores." However, if they refuse, they are considered "prudes," "lesbians" (meant derogatively), "teases," and "man-haters."[19] No matter what any individual woman does in this situation, then, she generally faces negative consequences. Based on the above, we can augment our original definition. 'Oppression' is a macro-structural relationship between forces and societal systems enclosing, reducing, immobilizing, and restricting the oppressed by putting them in a double-bind such that no matter what they do, they face penalties.

Investigating why some face a double-bind demonstrates that people are not oppressed *as individuals*, but as *members of social groups*.[20] Put differently, individuals face particular sets of barriers that put them in a double bind *because* they are members of that group, rather than because of individual action. For example, if a woman does not get a job because she is a woman, she faces a barrier because she is a member of the social group, women. This case is an example of oppression. By contrast, if my friend Tami Ross does not get hired as an English teacher because she has no experience or training in the field (despite enormous support and resources that she could have utilized because she was one of the few women who was given excellent educational opportunities and her family's support) then her not getting the job is likely not an example of oppression, because the decision not to hire her was that she did not possess

[18] Ibid, 2.
[19] Ibid, 3.
[20] Ibid, 7-8.

the necessary qualifications for the job.[21] The key difference is that in the case of oppression, the individual women faced barriers because of their social group membership, whereas in Tami's case, she faced the barrier because of individual traits or actions (like job training). Determining who is oppressed requires examining why the network of barriers comes together to restrict people. If people face a barrier because of their social group membership, this could point to oppression, whereas if they face it because of individual actions, it is not oppression.

While barriers may inhibit certain actions of members of social groups, that a group faces barriers does not necessarily mean that group is oppressed. This is because barriers often exist to create more freedom and opportunity for certain groups at the expense of others. For example, barriers between neighborhoods prevent white people from going everywhere they wish, but they exist to protect white privilege.[22] One barrier privileged white people may face is that they live in a gated community that constricts their movements. However, that gate exists to protect their homes. On the other side, privileged whites often point out that there are certain "bad" neighborhoods that they cannot enter, however this overlooks certain points. First, whites can go to any neighborhood they wish, but may choose not to do so (whereas if a man of color enters a white neighborhood, he is often harassed by the police because he "does not belong there"). Second, upper and middle class whites have historically (and continue)

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[21] Of course if we discovered that Tami had no training as a result of oppression, this would not be so obvious. For example, if Tami did not receive training as a scientist or as an engineer because women and girls are consistently discouraged from such careers and are often not offered the opportunity to obtain training in these fields, than yes, while she would not have the qualifications, Tami's case may point to oppression. However, in the current example (of being a teacher) these issues do not arise, especially since one career to which women have often been given access is teaching and Tami had opportunities to pursue this career if she chose.

[22] Marilyn Frye, "Oppression," *The Politics of Reality*, (Freedom, CA: The Crossing Press, 1983) 12. The same applies to why men cannot be oppressed as men, namely that barriers exist to protect male privilege.

prevented people of color and poor people of all races from moving into "their" neighborhoods, for example to protect their property values. These are just a few instances that illustrate that while white-people may be constrained by a barrier, the barrier was constructed for their benefit (or at least the barrier's existence results in benefits for white people). If one is constrained by barriers that are instituted for their own benefit, then they are not oppressed. This means that determining who is oppressed requires asking both why a barrier is in place and who benefits (willingly or unwillingly) from the barrier's existence.

So, we evaluate who is oppressed by examining the barriers, their relationship to each other, who they affect, the side of the barrier that the social group members are on, who the barriers benefit, and why they are in place. Given all of the above, we arrive at the following definition of oppression: Oppression is a systemic structure of forces and barriers that are not occasional, accidental, or avoidable, and that enclose, reduce, immobilize and restrict members of social groups in a way that puts them in a double bind, because they are members of those social groups, such that the barrier's existence hurts rather than benefits these groups.

Why is Oppression Hard to Detect?

Despite knowing what 'oppression' is, it remains hard to detect. Frye explains that this is because most of our investigations focus on our own individual experiences, while 'oppression' occurs at the macro (or structural)-level. The macro-level, however, cannot be seen if we only focus our attention on the individual level on which we operate. Often, people examine instances in their own lives or their own actions to determine

whether oppression exists or whether a particular practice is oppressive. For example someone does not feel oppressed, then s/he argues that a certain type of oppression do not exist. Similarly, if someone does not intend to participate in oppression when s/he performs a particular action or participate in a particular system, s/he argues that the practice is not oppressive or that oppression cannot occur if it was unintended. Detect oppression, however, requires seeing individual actions and opinions in their structura context, which can only be done by focusing inquiry on the macro- rather than the mic level.

To illustrate why we cannot identify oppression by evaluating it from the perspective of individuals alone, Frye asks the reader to imagine a bird in a cage. Examining each wire of the cage individually without noticing the other wires, one cannot understand why the bird does not fly around the wire and out of the cage. We cannot even understand this if we look at numerous wires, because there are still many ways the bird could fly out. For example, the bird appears to be able to fly over or un the wires. Only after examining all of the wires together and seeing how they are rela does it become obvious why the bird cannot fly out, namely, as we said earlier, becau of the way these wires are put together. So, the relationship between the wires constit the oppression but this relationship is only visible when looking at the entire cage, not wires alone.

Likewise, when we ask whether someone is oppressed (whether someone is in cage), we often cannot detect or identify their oppression because, while we may see many barriers in that person's path, we cannot understand why they cannot be avoide is only after recognizing that there is a system of barriers constructed that are not

"accidental or occasional and hence avoidable, but are systematically related to each other in such a way as so catch one between and among [the barriers and forces] and restrict or penalize motion in any direction," that we realize why the person did not avo or overcome the barriers in her path.[23] Consequently, we can only detect oppression through macro-level (structural) evaluations.[24] Detecting oppression, then, requires focusing on how individual actions or behavior reflect or fit in with society's structures not individual actions alone.

INSTITUTIONALIZED OPPRESSION IN HEALTH CARE

Even given the above definition of 'oppression,' we still want to clarify what constitutes 'institutionalized oppression in health care,' as I maintain that both must be addressed by a model of health care justice. Institutionalized oppression exists in heal care when the health care system is structured so that those participating in the system will face oppression because they are members of a certain social group or they will perpetuate that oppression toward members of other social groups, whether they intend or not, simply by participating in the health care system. For example, many, including myself, argue that our current standard childbirth practices are oppressive (or at least ar very harmful) toward women because, among other reasons, they objectify women, invade their bodies, treat them as machines to be controlled, and send messages to women that they must be available to health care professionals and children for any

[23] Ibid, 4.
[24] Ibid, 5.

purpose.[25] Many OB/GYNS, of course, would be appalled to discover this and woul likely disavow any implicit or explicit sexism created by such practices. However, s the problem is with the standard protocol, any OB/GYN simply doing her or his job perpetuate women's oppression – even though they not only do not believe these sex ideas but they have the best of intentions (to help women and their babies) - because job is to perform standard childbirth practices (in fact, if they do not they are vulnera to malpractice actions). When a health care system includes practices or policies suc the above, where members of social groups face or perpetuate oppression just by participating in the system, institutionalized oppression exists in health care. When I propose that health care justice is about eliminating institutionalized oppression, I me must target oppression of the type just presented.

Outline of Chapters

Now that we have background on the project and its key claims, I will outline how the dissertation will proceed. I will begin by detailing the case of the medicaliz of birth. While I will refer to all of the examples that begin this introduction through the work, I will primarily utilize the case of the medicalization (represented here by Elise's case) to help illustrate and uncover both the problems in Daniels' approach a the advantages of my approach. For this reason, I will begin the project by outlining

[25] Some places where these ideas are suggested are: Robbie Davis-Floyd, *Birth as an American Rite Passage*, (Berkeley, Los Angeles, and London: University of California Press, 1992); Barbara Ehren and Deirdre English, *For Her Own Good: 150 Years of the Experts Advise to Women*, (NY: Anchor Press/Doubleday, 1979) especially chapter 3; Karen B. Levy, *The Politics of Women's Health Care: Medicalization as a Form of Social Control*, (Las Colinas, Texas: Ide House, 1992); Kathryn Pauly Morgan, "Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalizati in *The Politics of Women's Health: Exploring Agency and Autonomy*, ed. Susan Sherwin, (Philadelph Temple University Press, 1998); Diana Scully, *Men Who Control Women's Health: The Miseducatio Obstetrician-Gynecologists*, (Boston: Houghton Mifflin Company, 1980); The Boston Women's Heal Book Collective, *The New Our Bodies, Ourselves,* (NY: Simon and Schuster, 1998).

case in detail. First, I will define 'medicalization' as the *simultaneous* reconceptualization of a previously identified 'non-medical' condition as a medical or and elimination of other, non-medical, conceptions of that condition. Based on this, I will define, the 'medicalization of childbirth' as the reconceptualization of childbirth medical problems while *simultaneously* eliminating (or trying to eliminate) other conceptions of childbirth. Once we know what constitutes 'medicalization,' I will out the history and evolution of the medicalization of pregnancy and childbirth.

After introducing medicalization I turn to the arguments of the dissertation. In Chapter 2 I summarize Daniels' theory of just health care. Specifically, I illustrate Daniels' theory's relationship to the history of health care justice discussions, outline arguments, and propose some positive contributions Daniels' framework has made to health care justice debate. I will also outline how Daniels' model would be used to address (or in some cases, to permit us to ignore) numerous health care issues, includi the medicalization of childbirth.

After presenting Daniels' view, I turn my attention to supporting the claim tha theory cannot and does not identify key aspects of certain issues relevant for making j allocation recommendations. Specifically, I will defend the following criticisms of Daniels' theory. First, his framework wrongly limits health care justice to distributive justice and ignores an entire area of health care injustice, non-distributive issues. Sec Daniels misidentifies the aim of health care justice. Finally, because of these limitatio Daniels' model has problems evaluating distributive health care justice issues. I trace these problems to two sources, his reliance on the distributive paradigm of justice, and faulty conception of social groups which prevents Daniels from being able to accurate

identify phenomena involving social groups, such as oppression. Based on all of the above evaluations, I will conclude the chapter by arguing that Daniels' theory of health care justice is incomplete at best.

Showing that Daniels' view is incomplete is only part of my task, however, as I also offer an alternative framework based on social justice that will not fall victim to Daniels' problems. To this end, in Chapter 4, I will outline and defend a conceptualization of 'social justice' as the active process of creating a world without oppression. Based on this definition of social justice, I argue in Chapter 5 that a just health care policy, system, or practice is one that does not create, reflect, or perpetuate institutionalized oppression. Then, I will return to the stories of Fran, Uncle Boy, and Karen, and the medicalization of childbirth to show that this framework avoids the problems that plague Daniels' model, thus putting us in a better position to identify and address distributive and non-distributive injustices than Daniels' distributive model. In the end, I will show that it is time to move beyond *Just Health Care*.

Chapter 1: Case Study: The Medicalization of Childbirth

The medicalization of childbirth is a health care injustice that has been ignored by health care justice theorists, including Daniels. Many feminists argue that the medicalization of childbirth is unjust because, among other reasons, it disempowers and degrades women by alienating them from their own birth experience; it puts women and their future children in unnecessary danger; it reduces women's choices about what happens to their bodies; and it calls for an unjust distribution of health care resources.[26] Despite this, the health care justice literature has ignored this issue or it has implicitly and explicitly supported it by failing to question the process and by offering policy recommendations that support the medicalization of childbirth.

One reason that Daniels has ignored this health care injustice is that he assumes, rather than questions, the medical model.[27] Daniels would likely agree with the characterization that he assumes the medical model, but aside from this, his presumption of the medical model is obvious in his definition of a health care need, which is based on

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[26] Some places where these ideas are suggested are: Robbie Davis-Floyd, *Birth as an American Rite of Passage*, (Berkeley, Los Angeles, and London: University of California Press, 1992); Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 Years of the Experts Advise to Women*, (NY: Anchor Press/Doubleday, 1979), especially chapter 3; Karen B. Levy, *The Politics of Women's Health Care: Medicalization as a Form of Social Control*, (Las Colinas, Texas: Ide House, 1992); Kathryn Pauly Morgan, "Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization," in *The Politics of Women's Health: Exploring Agency and Autonomy*, ed. Susan Sherwin, (Philadelphia: Temple University Press, 1998); The Boston Women's Health Book Collective, *The New Our Bodies, Ourselves,* (NY: Simon and Schuster, 1998); Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, CT and London: Bergin & Garvey, 1995).

[27] I say that this is one reason because there are many reasons that feminists have proposed for overlooking this issue. For example, bioethics tends to focus on technology and "emergency" issues, rather than health concerns of daily life (Virginia Warren, "Feminist Directions in Medical Ethics"); bioethicists have remained largely uncritical of the patriarchal practice of medicine (Susan Sherwin, "Feminist and Medical Ethics"); bioethics has largely assumed liberal individualism and its research is dominated by focusing on finding universal principles as opposed to groups and their experiences (Susan Wolf, "Introduction" to *Feminism & Bioethics).* Still, for the sake of space I will not focus on these in detail here.

the disease as "a deviation from normal-species functioning."[28] This definition is that given by the bio-statistical model, which is the same model used by the medical mode define health and disease. This is significant because, as we will see in the next chapt Daniels determines both what constitutes a health care justice obligation and what constitutes a fair allocation of scarce health care resources using his definition of a hea care need based on this view of disease. Given that a major basis for Daniels' view re on the medical model's definition of disease, the medical model is a foundation for Daniels' theory and, consequently, it is presumed correct.

That Daniels presumes the correctness of the medical model is significant in th instance because, as I will show, the medicalization of birth (and its problems) arises from the medical model itself. The medical model assumes that the male body is norm and female body and its processes are conceptualized as deviations form the norm tha must be controlled.[29] This means that birth (as well as processes like menstruation an menopause) is considered a disease that must be handled by medicine.[30] The medicalization of childbirth is a consequence of this model of thinking. If the medicalization of childbirth is a consequence of the medical model and this model wi not be questioned on Daniels' framework, then the medicalization of childbirth is nev (and never will be) on Daniels' (and those using his view) radar screen and thus, he ignores this issue.

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[28] Norman Daniels, *Just Health Care*, (NY: Cambridge University Press, 1985) 28. This is taken from Christopher Boorse.

[29] For extended discussions of this and related topics see: Carol Johann Bess, "Gender Bias in Health C A Life or Death Issue for Women with Coronary Heart Disease," *Hastings Women's Law Journal*, no. 41-52; Emily Martin, *The Woman in the Body: A Cultural Analysis of Reproduction*, (Boston: Beacon Press, 1992); Abby Wilkerson, *Diagnosis Difference: The Moral Authority of Medicine*, (NY: Cornell University Press, 1998).

[30] Emily Martin, *The Woman in the Body: A Cultural Analysis of Reproduction*, (Boston: Beacon Press 1992) 42-45.

Daniels' presumption of the medical model is not the only reason that he wil question the medicalization of childbirth and its injustices. Another reason Daniels this is that his theory is an example of a distributive theory of justice. The distributi paradigm of justice asks the question: "Given our situation and our resources, how fairly divide those resources?" If this is the key question of justice for this model, th types of theories of justice will not question how our current resource allocation opt were created or why we have the choices of where to allocate those resources that w However, as I will show throughout the work, we must investigate the reasons that v distribute resources according to a medicalized conception of birth to uncover, ident and address the health care injustice in the medicalization of childbirth. Again, then Daniels' model is not equipped to raise these questions and thus, the medicalization childbirth and its injustices remain ignored on Daniels' model of health care justice.

Despite the fact that Daniels' theory ignores the medicalization of childbirth consequently, does not argue that it is a health care injustice), the medicalization of childbirth is fraught with problems. Moreover, the kinds of injustices in the medicalization of childbirth that are ignored, namely non-distributive injustice and institutionalized oppression in health care are not unique to the medicalization of childbirth. That Daniels ignores and cannot identify these kinds of injustices sugges that his model is an incomplete account of health care justice. So, if we want to ide and address a more complete range of health care injustices, we need a different mo health care justice, which I will argue is one based on social justice. I will analyze t issue of the medicalization of childbirth throughout this work to both illustrate the deficiencies in Daniels' view and show why the social justice view I advocate will b

able to avoid the difficulties Daniels' view encounters. But, before this case can be useful in these ways, I must define and explain to what I am referring by the 'medicalization of childbirth' and outline a concise history of this process. I will do this below.

What is 'Medicalization?'

While many use the term 'medicalization', it has not been uniformly defined.[31] In part, this is because medicalization is a dynamic process, and thus cannot be universally defined, and in part it is because its definition changes in different contexts. Consequently, I will review some suggested definitions, which I refer to as the "additive-surface," the "additive-causal," and the "additive/subtractive" definition and explain why I am employing the additive/subtractive definition in this work.[32]

The Additive-Surface View

The additive-surface view is the idea that 'medicalization' is the reconceptualization and/or treating a previously non-medical condition as a medical problem. Neither the reasoning about how or why something has been redefined as a medical problem, nor the causes or motivations for the category shift, is relevant on this

[31] For example Ivan Illich, Peter Conrad, and Karen Levy define medicalization as a mechanism of social control while others simply define medicalization specifically in relation to medical categorization and treatment. Peter Conrad and Joseph Schneider, *Deviance and Medicalization: From Badness to Goodness*, (Toronto, London: C.V. Mosby Company, 1980); Peter Conrad, "Medicalization and Social Control," *Annual Review of Sociology*, 18, 1992, p. 211; Karen B. Levy, *The Politics of Women's Health Care: Medicalization as a Form of Social Control*, (Las Colinas, Texas: Ide House, 1992); Laura Purdy, "Medicalization, Medical Necessity, and Feminist Medicine" in *Bioethics*, 15: 3 (2001); Ann Garry, "Medicine and Medicalization: A Response to Purdy" in *Bioethics*, 15:3 (2001); Kathryn Morgan, "Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization," *The Politics of Women's Health*, ed. Susan Sherwin, (Philadelphia: Temple University Press, 1998).

[32] I want to thank Judy Andre for helping me coin these terms.

view. Structures related to the reasons or effects of medicalizing a certain problem may be relevant to exploring medicalization's effects or merits but the structural context in which medicalization occurs is irrelevant to defining whether a phenomenon is medicalization. So, according to the additive-surface view, any condition that is now conceptualized and/or treated as a medical problem (for any reason) that was not previously identified or addressed as a medical problem has been medicalized.

The Additive-Causal View

Proponents of the additive-causal view, such as Laura Purdy, argue that it is not enough for a non-medical condition to simply undergo a category shift to be identified as having been "medicalized." Rather, medicalization occurs when the category change results from larger forces, whereas on the additive-surface view if an individual doctor decides to treat a particular patient's stress as a medical problem (because the patient requests medication to help alleviate his or her stress), stress has become medicalized. In contrast, stress would not be medicalized on the additive-causal view because the only way stress would be medicalized on the additive-causal view is if there was an institutional/political/systemic push to conceptualize and/or treat all cases of stress as medical problems. Since this was an individual doctor treating an individual case of stress medically in response to a patient's request, it is not an example of medicalization. The reason that the cause and motivation driving the medicalization are significant to the definition of medicalization itself is because according to the additive-causal view, without these outside forces driving the medicalization the category change from non-medical to medical problem would not actually occur. By contrast, the additive-surface

definition suggests that the category change can occur without the involvement of ou
forces. This suggests that a key difference between the two additive conceptions is a
underlying assumption about what constitutes a category change. Advocates of the
additive-surface view seem to hold that categories can be changed by and for individ
as well as by and for society at large, which is why medicalization can occur even fo
individual and even if only in an isolated instance. By contrast, the additive-causal v
insinuates that a category change can only occur on a larger or more systemic scale,
which is why structural forces must be involved for the category shift from non-medi
to medical to occur. Hence, on additive-surface view one person's actions can consti
a category change whereas for additive-causal the change must be made at a societal
level. So, it is not simply the fact that a condition is not part of the medical purview
previously was not that defines 'medicalization' on the additive-causal view, but also
reasoning and explanation of why and how a condition shifted categories.

THE ADDITIVE/SUBTRACTIVE VIEW

The two previous views define medicalization based on the addition of a
condition to the medical realm. By contrast, Ann Garry and other proponents of wha
refer to as the additive/subtractive view hold that medicalization consists in both addi
and subtractive elements. The additive element of medicalization is reconceiving a n
medical condition as a medical one as a result of structural forces. In addition, thoug
there is a subtractive element that simultaneously makes it exceedingly difficult to
understand or address the condition non-medically. When referring to subtractions, I
referring to both empirical subtractions (taking away resources from one domain and

moving them to another) and conceptual subtractions (taking away ways to think about something). Medicalization, then, does not simply shift resources, it changes the way we actually conceptualize things.

Still, how does this process of reconceptualization occur? Kathryn Morgan suggests that it occurs in five stages. Specifically, this occurs through the following processes: the conceptual, the macro-institutional, the doctor-patient interaction, 'micro-institutionalization,' and the assimilation of medicalized ideas into people's ordinary thoughts and actions.[33]

The conceptual component refers to how medicine gains epistemic, social, and political authority to define problems as medical, while at the same time producing and re-producing their own assumptions and methods so that other understandings of the problem at hand seem illegitimate.[34] Still, the medical establishment declaring something to be in their domain is not enough to claim that a condition has been medicalized because other institutions must support the reconceptualization as well; for instance, other domains must give up their authority over the problem under consideration. For example, for alcoholism to be considered a disease, legal institutions had to agree that it was no longer a crime and religious institutions had to agree that it was not a sin. This is where the second component, macro-institutionalization, enters. Macro-institutionalization occurs when societal institutions grant medical knowledge authority over other types of knowledge to explain certain events. For example, giving societal institutions medical authority to define *anorexia nervosa* exclusively as a

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[33] Kathryn Morgan, "Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization," *The Politics of Women's Health,* ed. Susan Sherwin, (Philadelphia: Temple University Press, 1998) 86-98.

[34] This is similar to Garry here.

disease/disorder, rather than giving such authority to feminist philosophers or sociologists who define it as, at least in part, a social problem.

Still, Morgan says, medicalization cannot continue if individuals are not convinced that a problem is in fact medical. Though a doctor may tell me that my desire to write a dissertation is pathological and requires medical intervention, if I and the rest of society reject this characterization, then dissertation writing has not been medicalized. So, how do individuals and society change their conceptions of a non-medical problem? This is answered by Morgan's final three components.

First, people's minds are changed in the doctor-patient encounter (component 3), for it is here where a doctor labels a patient's problem as a medical one. Since there is already a relationship between the doctor and the patient where the doctor is seen as having the authority to identify medical problems, once a doctor labels a patient's symptoms as a medical condition, the patient begins to believe that she has a medical problem.[35] Once the patient believes s/he has a medical problem, s/he takes on a "medicalized subjectivity" or a "medicalized agency," meaning that patients too understand their condition medically and demand access to medical resources to address their problems. This is Morgan's fourth component, micro-institutionalization. Finally, for medicalization to be complete, people must accept the medicalized story and incorporate it into their everyday understanding of themselves and others. This is the fifth component of medicalization, the assimilation of medicalized ideas into people's

[35] An interesting question here that Morgan does not deal with is that if people do not get a medical diagnosis when they think they should, they do not simply think that they no longer have a medical problem, they think the doctor was wrong. I am not sure how this affects her analysis though.

ordinary thoughts and actions.[36] By the time the process is complete, the condition has been reconceptualized in such a way that not only is a previously non-medical process understood as being part of the medical domain, but other understandings and methods of dealing with the condition have been severely limited if not eliminated.

Medicalization, then, is the phenomenon of both adding a condition to the medical field's purview because of structural forces *and* encroaching upon or invalidating competing or potentially competing non-medical practices, institutions, or conceptual models that explain or address the condition at issue.[37] Only if both elements are present has medicalization occurred. For our purposes, 'medicalization' is defined according to the additive/subtractive view.

WHY THE ADDITIVE/SUBTRACTIVE?

Though this additive-surface definition offers a clear criterion to determine whether something has been medicalized, there are numerous problems with this approach. First, one function of a definition is to capture the way a term is used. The additive-subtractive definition does not capture how most feminists use the term in their criticisms of the medicalization of childbirth. Second, the additive-surface definition is philosophically incomplete. One function of a definition is to outline ways to identify instances of the concept. However, a good definition must not only ostensibly determine to which cases 'medicalization' can be applied, it must also provide a context to understand when we are seeing a case of medicalization. Otherwise it is unclear how to

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[36] Kathryn Morgan, "Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization," *The Politics of Women's Health,* ed. Susan Sherwin, (Philadelphia: Temple University Press, 1998) 96-98.

[37] Ann Garry, "Medicine and Medicalization: A Response to Purdy" in *Bioethics*, 15:3 (2001) 264.

distinguish cases of medicalization from other phenomena where it may appear a category shift has occurred but it may not have, for example in cases of misdiagnosis, bad treatment decisions, or using medical resources to address a non-medical problem because they may be beneficial. The additive-surface definition, however, does not give the context to understand the extension of the term because it does not provide an explanation of how medicalization works or examine the causes or motives behind why something has become a medical issue. As a result, the additive-surface definition is philosophically lacking.

The additive-causal view, on the other hand, appears to offer a criterion to identify medicalization and it recognizes the involvement of structural elements. Still, most feminists do not use 'medicalization' in this way. Moreover, on this view, outside structures and forces drive or cause medicalization, but they are never conceptualized as part of medicalization itself. But this obscures the issue by making it appear as if as medicalization is not problematic when sexism is what drove the medicalization. In light of this, I argue that the additive-causal definition obscures the workings of the medicalization process as opposed to providing us with a clear definition.

The primary advantage of the additive/subtractive conceptualization is that it is derived explicitly from a survey of feminist work. Therefore, it captures the way most feminists discussing the medicalization of childbirth invoke the term. Since I am exploring the medicalization of childbirth specifically, it is appropriate to utilize a definition used by most who discuss this phenomenon. Second, this definition provides a more complete picture of medicalization than the previous conceptions because it examines more aspects of the process and so it has more explanatory power about the

workings of medicalization. Third, this definition provides both empirical information about how resources are distributed and conceptualizations are altered in medicalization and philosophical information about how the various elements of the concept relate that the other definitions do not.

Fourth, the additive/subtractive view has a practical advantage because it distinguishes between using medicine and medicalization, which explains many feminists' claims that they can consistently protest medicalization while trying to protect women's abilities to utilize medical resources for birth if they desire. For example, a woman may request access to certain medical technologies in her case but protest medicalized childbirth. As we will see, this is significant in exploring the problem with medicalization and finding solutions to the issue.

Finally, because it focuses on both the additive and subtractive processes, it helps show where we should look for harms besides simply the process or result of using medical resources to treat problems not previously so addressed. Unlike the additive-surface view, then, this definition does more than ostensibly identify instances of medicalization but guides the inquiry by presenting a definition which allows us to identify a context and understand when we are actually seeing cases of medicalization. For these reasons, we will utilize the additive/subtractive view.

The Definition of 'Medicalization of Childbirth'

With the additive/subtractive definition of medicalization in place, we can now clarify what we mean by the 'medicalization of childbirth.' Specifically, 'the medicalization of childbirth' is the *simultaneous* reconceptualization of pregnancy and

the act of giving birth from natural, social, or spiritual events and processes to medical problems, while eliminating or making it extremely difficult for other options or conceptions of these processes to be utilized. In this process pregnancy and childbirth are seen as requiring medical management but physicians are now the experts of childbirth instead of women and midwives.[38]

The United States uses more drugs and technologies during "normal births" than any other country in the world.[39] Childbirth in the United States has now been almost completely medicalized and it is more medicalized here than in any other country. However, this was neither the way birth always was in the U.S., nor need it be practiced in this way. So, how did we get to this place? To answer this question, I will offer a brief historical summary of childbirth practices in the United States below.

A Brief History of the Medicalization of Childbirth in the United States

Before the mid-18th century in the United States, birth was a social event that occurred in the home with the input of many of the birthing woman's friends and a midwife.[40] Childbirth was seen as the dominion and expertise of women, specifically midwives.[41] "The colonies accorded midwives considerable authority about women's

[38] Nurse-midwives are a different sort of case; they are trained on the medical model and must practice in a hospital with a physician practice, and thus are not really seen as experts in the sense that they have valuable and unique knowledge. Rather, they are seen as able to implement a medical model of birth well in uncomplicated births.
[39] The Boston Women's Health Book Collective, *The New Our Bodies, Ourselves*, (New York: Simon & Schuster, 1998) 468.
[40] Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, expanded edition (New Haven and London: Yale University Press, 1989) 4.
[41] Ibid, 6.

physical condition, trusted them to speak knowledgeably and reliably, and treated midwives as if they were servants of the moral and civil order of the state."[42]

Some women would give birth in hospitals, but only if they had complications and, usually, only if they were poor. Consequently, doctors only witnessed atypical births. In the 16th century, French physicians began to observe these difficult births, primarily of poor women. These physicians were not trying to re-categorize birth as a medical problem, as they considered birth to be a natural process. However, they wanted to understand that natural process better through 'objective' observations of the birth process. "The French achievement consisted primarily in finding a better understanding of birth rather than in discovering new techniques to aid it."[43]

At the same time as French physicians began making their observations, British doctors were working on developing surgical techniques for "barber-surgeons," men who are called in by midwives to assist in difficult births. Again, the intention was to lower the maternal and infant mortality rate as a result of the childbirth, not to bring childbirth into the medical purview. The most significant result of this research was the use of forceps. "Eventually knowledge of forceps spread in England and France and the question was when it was necessary and safe to apply forceps."[44] Despite the intention to only use forceps when needed and to study when such intervention was indicated, this was not actually formally investigated, and male midwives in the mid-1700s began using forceps in *every* birth. Moreover, these male midwives did not do so because they believed this was required to secure the woman or the baby's safety, but rather they

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[42] Ibid, 8.
[43] Ibid, 33.
[44] Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, expanded edition (New Haven and London: Yale University Press, 1989) 38.

primarily used forceps to shorten birth and give themselves an advantage over midwives so that they could attend women who wanted to avoid enduring long labors.[45]

Around the 1750s, upper-class men from the United States began studying in Europe with these doctors to learn their techniques and use them use them on U.S. women.[46] These physicians did not desire complete control over the birth process, but rather, they envisioned a new midwifery that would be a shared enterprise between themselves and trained midwives. Specifically, "doctors envisaged an arrangement whereby trained midwives would attend normal deliveries and doctors would be called to difficult cases."[47]

Of course, it was challenging for these male physicians to attend births in the Victorian U.S. where midwives remained the experts about birth and societal values stressed purity and modesty, which prohibited women from revealing their bodies (especially in the presence of men). "The physical examination during pregnancy, the manipulations in labor and birth, and the presentations of other female complaints were uneasy events, often causes for blushing shame and flustered apprehension in both patient and doctor."[48] In addition to the protests and taboos about revealing the body and the awkward encounters between the physician and the woman, it was difficult for male midwives to attend births because of public protests against using male midwives because of the possible sexual implications and because it was seen as unnecessary and often harmful, and especially since midwives were seen as perfectly competent to attend to

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[45] Ibid, 40-41.
[46] Karen Levy, *The Politics of Women's Health Care: Medicalization as a Form of Social Control*, (Las Colinas, Texas: Ide House, 1992) 81.
[47] Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, expanded edition (New Haven and London: Yale University Press, 1989) 44.
[48] Ibid, 77.

most births.[49] Protestors included physicians of the day. For example, Dr. Samuel Gregory said:

> The introduction of men into the lying-in chamber, in place of female attendant, has increased the suffering and dangers of childbearing in women, and brought multiplied injuries and fatalities upon mothers and children; it violates the sensitive feelings of husbands and wives, and causes an untold amount of domestic misery.[50]

Despite this resistance, in the 1800s the disappearance of female midwives from childbirth began because of numerous social and political factors, such as the following. First, competition from new male midwives led to the disappearance of female midwives. Since only male midwives had access to this technology, women who wanted to take advantage of this advance hired male attendants.[51] Second, doctors began convincing women that all births required intervention and that women should not let nature take its course – a view that took hold by 1810. This meant that in addition to simply competing with female midwives, male midwives convinced women that birth would be unsafe without the new tools. Therefore, it was seen as a matter of safety to use these technologies. Again, since only male midwives had training in these interventions, a woman had to have a male attendant to utilize these technologies.[52]

A third reason that female midwives disappeared was because of a change in the philosophy, beginning in the Victorian period. During this time there was the belief that women were naturally weak and that their place was in the home raising children. This led many male midwives to claim that "no 'true' woman would want to gain the

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[49] Scully, *Men Who Control Women's Health: The Miseducation of Obstetrician-Gynecologists*, (Boston: Houghton Mifflin Company, 1980) 27 and 78.
[50] Dr. Samuel Gregory, Quoted by Dianne Scully, *Men Who Control Women's Health: The Miseducation of Obstetrician-Gynecologists*, (Boston: Houghton Mifflin Company, 1980) 26.
[51] Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, expanded edition (New Haven and London: Yale University Press, 1989) 46.
[52] Ibid, 47.

knowledge and skills necessary [to attend births]."[53] Consequently, people began to see birth as out of the domain of women.

In addition, issues of classism and racism played a large role in the disappearance of female midwives.[54] Many upper- and middle-class women saw births attended by midwives as something only done by poor, ex-slave, and/or immigrant women. It was then both a status symbol and a requirement of race and class loyalty to be attended by a midwife from their own social class with technological skill. It was very difficult, however, to find female midwives of their own social class because they were not granted apprenticeships to receive the needed training. Consequently, they turned to male midwives.

In addition to the above factors leading to the disappearance of female midwives, doctors realized that their success seemed connected to their social position. Medicine was not seen as a prestigious field. Not only was there no formal medical training because physicians-in-training did apprenticeships, but medicine also lacked a theoretical basis for its practices and primarily confined itself to discovering diseases and the mechanisms by way they operate not on curing disease.[55] Then, in 1910, the Flexner Report was published, which said that 90% of doctors were without college educations and most went to substandard medical schools.[56] In response, medicine tried to establish itself as an elite and highly skilled specialty.

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[53] Ibid, 56.
[54] Ibid, 56.
[55] Barbara Ehrenreich and Deidre English, *For Her Own Good: 150 Years of the Experts' Advise to Women*, (NY: Anchor Press/Doubleday, 1979) 42-43. Also, women were excluded because male physicians did not accept females as apprentices.
[56] Ibid, 55.

Since the success of male midwives was dependent upon receiving value from the upper-class and the position of male midwives in attending birth was tenuous, the male midwives tried to stabilize their authority and client base in numerous ways. First, physicians tried "to convince large numbers of people that healing was a commodity – and that it was well worth paying for it."[57] To do this, doctors had to be very visible and their methods and techniques also had to be prominent so that patients could see what they were paying for and why it was worthwhile. To this end, doctors used drastic measures in births to obtain tangible results and display their unique and important skills, such as performing surgeries, giving drugs, using forceps to shorten delivery, and bloodletting. So, "even though well-educated physicians recognized that natural processes were sufficient and that instruments could be dangerous, in their practice that also had to appear to *do* something for their patient's symptoms. The doctor could not appear to be inattentive or useless," for his own survival.[58]

Second, doctors also turned to science, particularly biology and its germ theory of disease, to give their work legitimacy. They argued that they were using proven methods based on the universal principles of science and reason to help in birth, unlike midwives who simply relied on their own experience, which is merely individual and thus unreliable.

This combined with the final major step to secure itself as an elite profession, which was creating stricter and formally organized medical schools. The costs of medical schools were primarily incurred by private corporations, such as Rockefellers. These companies held that the only accurate view of health was rooted in science and so

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[57] Ibid, 44.
[58] Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, expanded edition (New Haven and London: Yale University Press, 1989) 64.

they would only fund schools that were "complete with laboratories in all sciences, salaried professors, etc. or close."[59] This led to the closing of many medical schools who did not have the money to reform their program.[60] Between 1904 and 1915, 92 medical schools closed or merged and schools that followed models of medicine other than those based in the science of the germ theory of disease, such as homeopaths or osteopaths also slowly closed. In the process, medicine began to establish itself as a profession while driving out those who were not elite, including women and midwives, who sought medical training but were not granted admittance. This helped provide medicine the legitimacy it required to claim authority over birth.

Still, being a respected profession was not enough to transform birth into a medical setting. After all, doctors had to show why they were the better option than midwifery. Midwives were not problems "so much [because they were viewed as] direct competition; the regular doctors were not interested in taking the midwives place in a Mississippi sharecropper shack ... It only makes sense to speak of 'competition between people in the same line of business and this was not the case with the midwives and the doctors."[61] Rather midwives were threats to doctors because they were obstacles to developing modern institutional medicine, particularly in training doctors, which requires access to observing patients. For example, a prominent Boston physician wrote in 1820: "if female midwifery is again introduced among the rich and influential, it will become

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[59] Barbara Ehrenreich and Deidre English, *For Her Own Good: 150 Years of the Experts' Advise to Women*, (NY: Anchor Press/Doubleday, 1979) 87.

[60] Ehrenreich and English also survey other "popular health movements," many of whose assumptions are being returned to today. What they show is that these other movements were just as successful as allopathic medicine at this time, but they did not have this popular, political, or financial support that the allopaths had and thus were driven out of the market. Though this is highly relevant to understanding medicalization generally, it is beyond the scope of this discussion.

[61] Barbara Ehrenreich and Deidre English, *For Her Own Good: 150 Years of the Experts' Advise to Women*, (NY: Anchor Press/Doubleday, 1979) 93.

fashionable and it will be considered indelicate to employ a physician."[62] They appealed to upper-class values and argued that women who attended births overreached their proper position in life and that women were unsafe to attend deliveries.[63] Though individual midwives resisted, there was a lack of organization among midwives to launch an effective counter-campaign.[64]

While some upper-class women chose male attendants, most women would not allow young males to observe birth. So, to receive training and display their skills, doctors needed access to poor patients. Since midwives cared for the poor population, they could continue to successfully show their expertise and thus stood in the way of doctor's training and opportunities to establish themselves, and thus medicine tried to rid itself of midwives. This sentiment was expressed, for example, by Dr. Charles Zeigler in the *Journal of the American Medical Association*:

> It is at present impossible to secure cases sufficient for the proper training in obstetrics, since 75% of the material otherwise available for clinical purposes is utilized in providing a livelihood for midwives.[65]

To get around this 'problem,' doctors portrayed midwives as dirty, hopeless, ignorant relics of the past (for example the domain of immigrant homelands). Midwives were also blamed for the high maternal death from puerperal sepsis, even though the death rate was no lower for physicians.[66] In contrast, doctors were portrayed as the new experts with rational, scientific, objective knowledge so that "birth came under the domination of the

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[62] Ibid, 55.
[63] Ibid, 56.
[64] Ibid, 47.
[65] Dr. Charles Zeigler quoted in Barbara Ehrenreich and Deidre English, *For Her Own Good: 150 Years of the Experts' Advise to Women*, (NY: Anchor Press/Doubleday, 1979) 95.
A side note, poor pregnant women are still referred to by physicians as "material" for their own training or their students, as was illustrated by Diane Scully in *Men Who Control Women's Health: The Miseducation of Obstetrician-Gynecologists.*
[66] Dianne Scully, *Men Who Control Women's Health: The Miseducation of Obstetrician-Gynecologists*, (Boston: Houghton Mifflin Company, 1980) 32.

new experts who not only perceived the process as problematic rather than natural, but who were also surgeons trained to intervene."[67]

In addition, birth moved from the home to the hospital on the grounds that it was safer to have a child in the hospital because the doctor had easier access to interventions in the hospital. Still, though 50-75% of urban births took place in a hospital by 1939 (compared with less than 5% in 1900), "doctors began to worry because hospital birth had not produced notably better results; women began to feel that the medical treatment and institutional care had alienated them from important birth experiences."[68] To counter this trend, physicians became even more scientific and they used even more interventions throughout the birth process.

Moving birth from the home to the hospital, establishing formal and stringent medical schools, and eliminating midwives as an option for poor women as well as wealthy ones, gave doctors the prestige and the access to patients to maintain that status. For example, hospitals were often affiliated with medical schools that cared for poor women for free. This gave medical students the opportunity to learn their techniques by practicing on poor women. Since doctors were trained to spot and address any difficulty in birth, they were constantly on the lookout for problems. "[And] they found a lot of trouble – so much, in fact, that they came to think that every birth was a potential disaster and that it was best to prepare the woman for the worst eventualities."[69] Given this, doctors began to argue that birth was inherently dangerous. As early as 1920:

> Doctors believed that 'normal' deliveries, those without convulsions, deformed pelves, protracted and difficult labor, the threat of sepsis or of tears in the

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[67] Ibid, 34.
[68] Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, expanded edition (New Haven and London: Yale University Press, 1989) 135.
[69] Ibid, 136.

> woman's perineum, were so rare as to be virtually nonexistent. The doctors saw every birth as varying from the normal, and thus, as potentially pathogenic, or disease-causing. They concluded, therefore, that routine interventions should be made during every labor and delivery in order to protect from trouble.[70]

For reasons already highlighted, by 1920 women trusted medicine as the authority in childbirth so if they were told that birth was safer in the hospital, in their desire to have safe births for themselves and their babies, they agreed to hospital birth as safer. So, childbirth in the 20th century is mostly characterized be medical interventions and hospitals.[71]

Of course, women have protested this birth process and medicine has adapted to these requests. For example, in response to the "natural childbirth" movement, where women wanted to have a birth without drugs, doctors redefined "natural" to mean "not having a Cesarean section."

> By the 1970s many doctors offered a more natural birth. Most often, however, it was a peculiarly American 'natural birth' they provided, for they routinely relied upon the arts of medicine. Episiotomy, outlet forceps, Demerol, and even epidural anesthesia were combined with the Lamaze method.[72]

Also, the alternative methods that were incorporated were those that helped the ideology of the medicalized model.

Women now think that it is their responsibility as good mothers to have a highly technical birth because they must produce the best baby possible and if anything goes wrong in that birth it is seen as the fault of the mother not medicine or not an unavoidable

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[70] Ibid, 141.
[71] Janet Carlisle Bogdan, "Childbirth in America, 1650-1990," in *Women, Health, and Medicine in America: A Historical Handbook*, ed. Rima D. Apple (New Brunswick, NJ: Rutgers University Press, 1992) 117.
[72] Ibid, 195.

part of nature.[73] In fact, starting in the 1980s, people became increasingly less willing to accept accidents of nature. Furthermore, as things such as pre-natal and genetic tests have become available and people have smaller families, more people think the goal of pregnancy is a perfect child. So, a disabled child is now seen as an avoidable tragedy and hardship for which the parents are potentially blameworthy.[74] We cannot say, then, that the medicalization of birth was imposed on women, rather women have assimilated the medicalized model and its ideas, and thus, many support such practices.

Methods that challenged this were not well accepted, but models like Lamaze breathing and those that called for the husband to be present through labor were welcomed because it made the medical model look as if it was accommodating patient needs, while the model was also not being challenged as valid. Moreover, the focus was removed from the mother and her needs to the doctor and his needs. "If a labor was going too slow for [the doctor's] schedule he intervened with knife or forceps, often to the detriment of mother or child. Teaching hospitals had additional bias toward surgical intervention since the students did have to practice something more challenging than normal deliveries."[75] Women birth in the lithotomy position not because it is best (as, except for being hanged by the feet, the supine position is the worst conceivable position

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[73] Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, expanded edition (New Haven and London: Yale University Press, 1989) 235.

[74] We can see this, for example, in discussions of what women must do to have the best pregnancy, fetal abuse cases, and discussions in bioethics about the responsibilities parents have to take "procreative responsibility" most recently expressed throughout the book co-authored by Allen Buchanan, Dan W. Brock, Norman Daniels, and Daniel Wikler, *From Chance to Choice: Genetics & Justice*, (Cambridge University Press, 2000). For an expanded discussion of this see Richard W. Wertz and Dorothy C. Wertz, "Creating the Perfect Child: The 1980s and Beyond" and "Epilogue: Everybody's Search for the Best," in *Lying-In: A History of Childbirth in America*, expanded edition, (New haven and London: Yale University Press, 1989).

[75] Barbara Ehrenreich and Deidre English, *For Her Own Good: 150 Years of the Experts' Advise to Women*, (NY: Anchor Press/Doubleday, 1979) 97.

for labor and delivery[76]) but because it is easier for the attendant. In fact, most interventions are used *not* because they benefit women, for they do not accomplish this goal in reality as we will see in later chapters, but rather, because it is easier for the doctor to control birth.[77]

While women have resisted some of these interventions, the medical model remains firmly in place and other methods and experts have been eliminated. Pregnancy and childbirth are seen as matters to be managed and childbirth continues to be portrayed as dangerous and possibly life threatening. Consequently, childbirth is seen as requiring the presence of physicians (not midwives) to assist and manage birth. The appropriate place for birth is not the home, which is dirty and far away from hospitals (and thus, puts women and babies in danger), but a hospital, whose conditions can be controlled for the optimal birth process and where physicians have access to their needed equipment such as fetal monitors, drugs, and surgical tools. Labor is seen as a process with distinct, observable stages, each one able to proceed on a time table, determined by physicians.[78] When that process is deviated from, physicians intervene. Interventions such as fetal monitors, IVs, drugs for controlling pain or inducing labor or delaying labor, and episiotomies are often employed. Also, Cesarean sections are often used, and even recently, have become more requested so that birth can be more predictable and "convenient" for the doctors and the mothers. The process which began in Europe has now developed into the medical model of birth through the stages described by Morgan.

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[76] Robert Caldeyro-Barcia, past president International Federation of Obstetricians and Gynocologists, in Robbie Davis-Floyd, *Birth As An American Rite of Passage*, (Berkeley, Los Angeles, London: University of California Press, 1992) 122.
[77] Robbie Davis-Floyd, *Birth As An American Rite of Passage*, (Berkeley, Los Angeles, London: University of California Press, 1992)
[78] The Boston Women's Health Book Collective, *The New Our Bodies, Ourselves*, (New York: Simon & Schuster, 1998) 469.

One question remains, however, which is why have women accepted this model of birth (especially given that there have often been, and currently are, movements to resist medicalization)? One theory of how the technocratic model of birth has been assimilated into American culture has been presented by Robbie Davis-Floyd. In her book, *Birth as an American Rite of Passage*, Davis-Floyd describes the technocratic model of birth as a set of rituals that are meant to transfer society's values to the initiate (women) in times of transformation. These rituals, argues Davis-Floyd, "work effectively to convey the core values of American society to birthing women."[79]

There are eleven characteristics of rituals.

1. The symbolic nature of rituals' messages
2. The rituals' emergence from a belief system
3. The rituals' rhythmic repetition and redundancy
4. The cognitive simplification that ritual works to engender in its participants
5. The cognitive stabilization that ritual can achieve for individuals under stress
6. The order, formality, and sense of inevitability established in ritual performance
7. The acting, stylization, and staging that often given ritual its elements of high drama
8. The intensification toward a climax that heightens rituals affective (emotional) impact
9. The cognitive transformation of its participants that is ritual's primary purpose
10. Rituals' importance in preserving the status quo in a given society

[79] Robbie Davis-Floyd, *Birth as an American Rite of Passage*, (Berkeley, Los Angeles, and London: University of California Press, 1992) Introduction.

11. Rituals' paradoxical effectiveness at achieving social change

Davis-Floyd argues that what we call "standard birth practices" are really rituals with all of the above traits (as opposed to being scientific responses to individual women's needs as has been portrayed). These rituals work to achieve their purpose by sending very clear and basic messages repeatedly that convey the society's core values.

According to Davis-Floyd, a core value of U.S. society is the belief in the superiority of technology over nature. By this Davis-Floyd means that we see nature as unpredictable and inherently flawed while we see technology as being able to improve those flaws by controlling natural processes in ways that make them predictable. Birth challenges these views, however, as regardless of technology, birth is a natural and unpredictable process and consequently, birth makes it impossible for us to have a consistent worldview that matches our experiences. This, says Davis-Floyd, raises eight dilemmas that American Obstetrics has tried to resolve in ways that make it appear that birth supports, rather than disproves, society's core values. These eight dilemmas are:

1. How to make the natural process of birth appear to conform, instead of refute, the technocratic model?
2. How to create a sense of cultural control over birth, a natural process resistant to such control?
3. How to generalize an individual transformation – that is, how to turn the natural birth experience which, left unshaped by ritual, would remain a purely individual transformation, into a rite of passage?
4. How to "fence in" the dangers associated with the liminal period in birth, while at the same time allowing controlled access to their revitalizing power?

5. How to enculturate a noncultural baby?

6. How to make birth, a powerfully female phenomenon, appear to sanction patriarchy?

7. How do you remove sexuality from sexual process of birth?

8. How to get women in a culture that purports to hold gender equality as an ideal, to accept a belief system that inherently denigrates them?

Obstetrics has responded to all of the above by creating a set of rituals that designed to create any inconsistencies. For example, they move birth from everyday life into a hospital; they perform interventions, such as those already described, such as giving pitocin, epidurals, performing Cesarean sections, and episiotomies; they tell women how unsafe birth is for them and their future children so that they feel they must agree to these interventions; they remove the focus of birth from the woman to the hospital (for example by saying that doctors "deliver" babies as opposed to the woman who is actually delivering the child), etc.[80] Through the performance of these rituals, doctors send various symbolic messages to women like: their bodies are machine-like; birth is to be controlled by technology, which is superior to the woman's body; birth is managed by doctors, who are the experts in technology and thus birth, not women; that problems arising in birth are the fault of the woman's already deficient body not doing its job (i.e. "your uterus is not contracting strong enough," "your labor is too slow," etc.) and thus fixing those problems requires doctors; and that birth is dangerous. More important for our purposes, it sends the message that the way to have a baby is in the hospital with interventions. This combination of the rituals and their use of societal values suggests why women may accept a medicalized model.

[80] Ibid, 61-70.

Given the above, we can see how the process of the medicalization of childbirth has occurred in the United States. First, the terms used to discuss and describe childbirth were changed from a natural or social event to a medical one. So, the description used terms that made it appear that medicine had discovered a cure for something (be it pain in birth or difficult deliveries for which forceps could be used). Second, medicine claimed expertise in birth and argued that midwives lacked such skill and expertise. Third, medicine sought and received support for its authority by using other social institutions, like social class, racism, social values of the day, and key social leaders, such as the Rockefellers, to fund medical schools. Once they achieved this, physicians then used that authority to cultivate relationships between their patients to make it appear that they were meeting their patients needs (for example, by providing ether when requested or allowing husbands in the delivery room). In these processes, women began taking on a medicalized subjectivity and assimilating the medicalized message that birth was dangerous, their bodies were unpredictable, that birth could be controlled, and that birth was a technological rather than a natural process. They also incorporated other values, such as having the perfect child, which supported their views that they had to do all that was possible to achieve a healthy baby.

We have now arrived at a place where other conceptualizations and approaches have been obscured and, in some places, eliminated. Birth is now a medical event rather than a social or religious one (as in the past). In addition, these and other ways of seeing birth have been encroached upon or eliminated. The medicalization of childbirth has hit the United States in full force. But should this continue? Is it just to allocate scarce

health care resources toward these standard childbirth practices in a way that supports the medicalized model of birth?

I argue that the answers to both questions is "no." However, if we follow Daniels' model of health care justice we will fail to question this practice. This will happen in two ways. First, using Daniels' theory will never identify medicalized childbirth as a health care injustice that requires rectification because it presumes the accuracy of the medical model. Second, we can use Daniels' model to argue that we must allocate resources according to the medicalized model of birth. Consequently, we will not only ignore the injustices it raises, which will allow them to continue, but we are vulnerable to making allocation recommendations that will perpetuate this injustice. I argue that this suggests that we need a health care justice framework that will avoid these problems and address this and similar injustices. Before defending these claims, however, I will now outline Daniels' theory of just health care.

Chapter 2: Daniels' Theory of Just Health Care

As stated in the introduction, prior to Norman Daniels' theory of just health care, the medical ethics debate on how to address our nation's health care crisis focused on establishing a universal a right to health care. Proponents of a right to health care, such as Allen Buchanan, claimed that the existence of a right to health care entails a moral obligation that mandates society to provide health care.[81] Conversely, opponents, such as Tristram Engelhardt, argued that because a right to health care does not exist, it is morally impermissible for the government to provide resources for health care.[82]

Understanding Daniels' theory of just health care and its significance in the health care justice debate requires reviewing the context in which it was constructed. So, I will first briefly review the debate in the 1970s and early 1980s. After this I will detail Daniels' theory and offer examples to illustrate how Daniels' framework would be applied. Finally, I will point to the positive contributions Daniels' theory makes to the health care justice debate such that it has gained much prominence among bioethicists.

Health Care Justice Before Daniels: The Debate Over The Right To Health Care

A Right To Health Care Does Not Exist: Engelhardt's Approach

As a libertarian, Tristram Engelhardt holds that personal liberty is the most important value. Therefore, the state's primary obligation is to protect that liberty; it must always protect its citizens from interference by others. On this view, it is also unjust for the state to create any programs that would or could infringe on personal

[81] Allen Buchanan, "A Right to a Decent Minimum," *The President's Commission Report*, 1983.
[82] Tristram Englehardt, *Foundations of Bioethics*, (NY: Oxford University Press, 1986) chapter 8.

liberty. Consequently, libertarians argue that people would only agree to join a minimal state that enforces negative rights (rights to be free from interference) because only such a state would protect liberty without imposing a particular vision of the good on to its citizens. Thus, only a minimal state is just.

On this view, justice only requires following the principles "of just acquisition, just transfer, and retribution for past injustices in acquisition or transfer."[83] In essence, these principles state that if property and resources were acquired justly (e.g. they were not gained through fraud or coercion), then individuals are entitled to have and utilize those resources however they choose. Put differently, on a libertarian view, a right to a resource is created by having acquired that resource in accordance with the principles of just acquisition and transfer. The state is only justified in ensuring that the initial conditions of acquisition adhere to the principles of transfer and acquisition. After this resource transfer has begun though, the state is not permitted to interfere with those transactions if the initial conditions of acquisition were fair. Consequently, it is unjust for the state to reallocate resources after the initial allocation in these circumstances, regardless of the level of need by society or another person for someone's resources.

Given the above, when determining whether a right to health care exists, we must identify what kind of right health care is (positive or negative) and whether it is just to reallocate resources to protect that right. Engelhardt classifies health care as a positive right. This means that it is a right to receive goods and resources for health care (as opposed to being left alone to spend one's resources on health care as they see fit). This is a problem for Engelhardt because protecting a positive right is unjust on a libertarian view because it would require infringing on people's personal liberty, namely, it would

[83] Ibid, 394.

be telling people how to spend their justly acquired resources for the purposes of achieving a social good that is determined to be a "good" because of a particular conception of morality or a good life and with which individuals may or may not agree. The state cannot do this, however, because people (according to Engelhardt) acquired their resources justly, even if it would help many people to redistribute resources. From this, Engelhardt draws two conclusions. First, there is no secular right to health care, meaning that there is no right to health care that can be defined from a theoretical conception that does not rely on a comprehensive view of the good.[84] The only way to claim that a right to health care exists is to appeal to a particular standard of the good and acting on such a standard would violate some people's beliefs and liberty. Second, since no right to health care exists, the government cannot intervene to remedy the current health care crisis by redistributing society's resources (which are individuals' tax contributions, and thus, are essentially citizens' resources) because those without health care have no justified claim on other's people's resources.[85]

An opponent of Engelhardt may argue that society's members without health care do have a claim on others' resources because those with resources for health care did not, in fact, acquire their money according to the principles of just acquisition and transfer, but rather, by coercion. For example, some of the wealthy acquired their resources by exploiting their workers, who now lack health care. Consequently, the state can (and must) intervene here and redistribute resources to health care as a matter of justice, even on a libertarian view.

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[84] Ibid, 376.

[85] Of course, libertarians allow people to spend their resources as they desire; some may choose to give to those who need health care out of their own personal obligations to charity or beneficence. Therefore, even if there is an obligation to ensure the equitable distribution of health care, it would be one of beneficence and it would not be an obligation of the state.

Even if this is true in some cases, Engelhardt would argue that *if* a claim existed, then it would be between individuals (as opposed to being a claim on society).[86] For example, worker X may have a claim against boss Y, but worker X only has a claim on boss Y's resources and boss Y is only responsible for worker X. So, even if an individual has a claim against another individual, this does not translate into a societal obligation to provide health care because all members of society did not hurt that particular individual. For Engelhardt, while it may be unfortunate that others do not have health care, society is not justified in reallocating fairly acquired resources to give other people health care. [87]

A Right To Health Care Does Exist: Allen Buchanan and The President's Commission

Allen Buchanan suggests a strategy to show libertarians that the obligation to ensure an equitable distribution of health care exists. He concedes that a *moral* right to health care may not exist. However, unlike libertarians, who interpret this as proof that there is no state obligation to provide health care, Buchanan suggests there is a strong moral case for a legal entitlement to health care based on beneficence.[88] Put differently, the principle of beneficence can establish that a legal right to health care exists, and thus, the state must provide health care.

The first step in Buchanan's argument is to point out that, though libertarians claim that the government is never justified in using coercive measures to support a

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[86] It is not obvious that a libertarian would agree that a claim existed here anyway if the workers agreed to the circumstances, but this is not the issue here. The claim is that even if a claim could somehow be made, it would still not justify claims of the individuals in question on society's resources.
[87] Tristam Engelhardt, *The Foundations of Bioethics*, 381.
[88] Allen Buchanan, "The Right to a Decent Minimum of Health Care," *The President's Commission Report*, (1983) 214.

particular principle, this is not true. Buchanan argues that using such measures to redistribute resources is permissible in either of two circumstances: (1) to enforce rules of social cooperation and (2) to contribute to the production of a public good.[89] If providing health care will either help the rules of social cooperation or contribute to the production of a public good, then the state is justified in using society's resources to provide health care.

Second, Buchanan assumes that most agree that they are obligated by beneficence demands that we help those in need if we have the means. Since our society has the resources to help meet people's health care needs, Buchanan says we agree that we are obligated based on beneficence to give resources to health care. Moreover, giving our resources to health care would be consistent with, rather than a violation of, our society's values.

Still, this only shows why individuals should agree to freely give their money for health care, not why there is a societal obligation to provide health care such that society can use coercive measures to redistribute wealth in a way that provides everybody with health care. This leads to the third step in Buchanan's argument, where he claims that people serious about their donation will want to ensure that their gift is effective and used as they intended. But, because of the problems just stated, those who wanted to contribute resources for health care will not because they will worry that their donation will not be used as they intended. Therefore, people will not donate resources to provide health care because they won't be confident that their resources will help those to whom they are directed. In this situation, people will lose confidence in the system and not engage in social cooperation to provide health care at all. Consequently, the state is

[89] Ibid, 232.

justified in taking resources, even via coercive means in this case because the social cooperation needed to bring about health care is impeded and health care needs cannot be met in any other way. Consequently, the state must provide some health care resources to enforce rules social cooperation, which are otherwise hindered.

Still, Buchanan does not stop his argument there, but rather goes on to argue that the situation in health care also meets the second criterion for interference, because health care is a public good. Health care is a public good, argues Buchanan, because the situation described above will prevent it from being distributed (or even from becoming available) if there is no requirement to force people with resources to contribute to it. If we see health care as a public good because voluntary contributions alone would never be sufficient to meet health care demands, then health care qualifies under the principles Buchanan presented that justify imposing coercive measures to make people give to health care if they have the resources, even in the absence of a moral right to those resources. Given these circumstances, Buchanan argues that people will agree to establish a coercively-backed principle specifying certain health care programs and requiring people with the means, to contribute to them.[90] In other words, under these circumstances, where charity alone cannot meet health care needs even if everyone participated and where people agree that they have obligations based in beneficence to provide health care if they have the means, people would agree to impose "enforced beneficence" that would require people to contribute to the health care of others.

Enforced beneficence, then, creates an enforceable principle where all who are able must contribute to the health care of others. Furthermore, since the principle of enforced beneficence is based on values members of society already share, then it is not

[90] Ibid, 234

coercive in the sense that it requires people to use resources in a way that conflicts with their personal morality. So, the state can justifiably demand people contribute to health care for others. So, Buchanan suggests that the principle of enforced beneficence establishes a legal right to health care. Even better, it does so in a way that avoids libertarian concerns. Based on this principle, we can argue that society must ensure the equitable distribution of health care, even if there is no moral right to health care.

Daniels' Response to the Health Care Justice Debate Based on Establishing a Right to Health Care

While establishing a moral or legal right to health care may seem appealing, Daniels argues that it is not the best way to address the U.S. health care crisis and achieve health care justice. The first reason for this is that even if a legal or moral right to health care exists, this alone does not, and cannot, tell us which health care inequalities require remedy. The second reason that debating a right to health care is unhelpful in addressing the U.S. health care crisis in that claims to "a right to health care" have different meanings. For example, it could be the right to health or to health care services. Even if we agree with Daniels that this right is best interpreted (or at least best defended) as a right to health care services, this clarification is unhelpful because the right to health care could be construed as a general right or a system-relative right.

A system-relative rights claim means that people are entitled to a certain level of resources in relation to what that society has available. If a particular system has the resources to provide everyone with kidney transplants, for example, then the people of

that society have a right to kidney transplants. However, those same people would not have such a right if they lived in a society where kidney transplants were unavailable.

System-relative rights may be contrasted with general rights. In this type of claim, regardless of society the right to health care would entail providing all with a particular level of health care services. In this case, if a general right to kidney transplants exists, then all people, regardless of the society in which they live or their society's resources, have a right to a kidney transplant.

Since each class of rights entails different obligations, without clarifying which type of right health care constitutes, simply establishing that a right to health care exists will be unhelpful in guiding us toward a just resolution of our health care crisis. Theoretically, of course, we could try to resolve these difficulties, but Daniels says we cannot yet achieve this because he thinks these ambiguities and the resulting difficulties result because the right to health care has not been grounded in a broader framework of distributive justice. Therefore, we must derive a right of health care from a broader framework of distributive justice, which is Daniels' project in *Just Health Care*.

A Theory of Health Care Needs

Daniels says that the first step in creating a theory of health care justice is knowing why health care is the kind of good that must be equitably distributed. After all, many goods are unequally distributed in our society, but we do not think this is unjust or requires rectification. So, why does justice require distributing health care equitably? Why is health care special? According to Daniels, answering this requires a theory of health care needs.

Daniels defines a need as "the means necessary to reach any of our goals."[91] Of course, for a theory of health care justice we are only concerned with health care needs, which Daniels defines as those that are "necessary to achieve or maintain species-typical normal functioning."[92] Daniels derives this conception of health care needs from Christopher Boorse's definition of disease as "a deviation from normal functional organization of a typical member of a species."[93] For Daniels, health is the absence of disease. Therefore, health is maintaining normal species-typical function. Thus, "health care needs will be these things we need in order to maintain, restore, or provide functional equivalents (where possible) to normal species functioning."[94] Using this definition, Daniels claims that the following are health care needs: 1.) Adequate nutrition, shelter; 2.) Sanitary, safe, unpolluted living and working conditions; 3.) Exercise, rest, and some other features; 4.) Preventative, curative, and rehabilitative personal medical services; 5.) Non-medical personal and social support services.[95]

DANIELS' NEW APPROACH TO HEALTH CARE JUSTICE: THE FAIR EQUALITY OF OPPORTUNITY APPROACH

Now that we know what health care needs are, we must return to our original question: Why must we ensure that health care is equitably distributed? In light of the definition of health care needs we can rephrase the question as: Why does justice require helping people maintain normal species-typical functioning? Daniels answers based on the relationship between health and opportunity, specifically that if health is impaired, then an individual's normal range of opportunity is reduced.

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[91] Norman Daniels, *Just Health Care*, (NY: Cambridge University Press, 1985) 27.
[92] Ibid, 26.
[93] Ibid, 28.
[94] Ibid, 32.
[95] Ibid, 32.

In our society, a person's must have a 'normal opportunity range' to pursue her or his life goals. Daniels argues that maintaining this opportunity range requires having one's health care needs met. If people are ill and/or worry about their health, then they have fewer opportunities to choose the kind of life they want to lead. The relationship between health and opportunity range is what makes health care special; it is why we must distribute health care fairly. For example, if a person has debilitating migraine headaches, then that person cannot work and has a diminished employment opportunity range. If this person was treated for those headaches, however, then she would have the same opportunity as all others to compete for the jobs of her choosing.[96]

Daniels has now answered why the U.S. health care crisis is an injustice that must be remedied, but he also wants to construct a theory aimed remedying these injustices. To accomplish this goal, Daniels returns to the relationship between health care and opportunity. Generally speaking, the level of contribution from treating a particular health care need for maintaining the normal opportunity range for the affected individual determines which health care services justice requires society to provide. The more significant a particular health care need is to preserving normal range of opportunity, and the more successful the treatment of that need, the more important it is to protect and the greater the likelihood society must provide it to its members. Daniels argues that society is not obligated to meet every health care need. It is only mandated to address those health care needs that affect opportunity.

At this point, someone may question: Why does justice require protecting individuals' opportunity ranges but not normal species functioning? After all, if we want to protect health as Daniels defines it, are we not obligated to maintain normal species

[96] More accurately, her health would not be a factor constraining her opportunity range.

functioning? Daniels answers in the negative because health is not inherently good, but is valuable because of its *instrumental* role in helping people utilize and maintain their opportunity range. The problem, then, of ill health is not a lack of species-functioning *per se,* but when that lack of function negatively affects a person's ability to pursue her or his conception of a good life. For example, dyslexia may be a deviation from normal species-typical functioning, but it only affects normal range of opportunity in cultures that require reading. In the case where a person is not in such a society there is no justice obligation to restore such functioning because there is no adverse effect on the dyslexic person's life goals in that society. However, there is an obligation to address dyslexia in a society such as our own because then such a condition would negatively affect one's ability to pursue her or his life goals. So, justice does not mandate meeting all health care needs (i.e. it does not require maintaining normal species functioning in all cases). Even if this is true, however, it does not mean that we *do* have justice obligations to remedy health care inequities or to protect normal opportunity range.

To demonstrate why justice directs society to provide health care that maintains or restores normal opportunity range, Daniels must show that protecting health related to opportunity is within the scope of justice. To do this, Daniels appeals to John Rawls' theory of justice. Specifically, Daniels argues that we can derive a social obligation to meet health care needs from Rawls' requirement to guarantee fair equality of opportunity.[97]

Rawls argues that justice is concerned with the obligations of the basic institutions of society.[98] For Rawls, a just society is one whose basic institutions adhere to the

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[97] Norman Daniels, *Just Health Care*, (NY: Cambridge University Press, 1985) 39.
[98] John Rawls, *A Theory of Justice*, (Cambridge, MA: Harvard University Press, 1971) 7.

following principles. First, "each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all."[99] Second, "social and economic inequalities are to be arranged so that they are both (a) to the greatest benefit of the least advantaged ... and (b) attached to offices and positions open to all under conditions of fair equality of opportunity."[100] Rawls' second principle of justice, then, establishes society's obligation to protect fair equality of opportunity. Since Rawls' principles of justice require the basic institutions of society to protect fair equality of opportunity, and since a certain level of health care is required for protecting that opportunity, then Rawls' theory of justice provides the foundation to claim that justice demands that society provide health care.[101]

According to Daniels, the obligation to provide health care is not a negative dictate (it does not just require removing barriers to equal opportunity). Rather, he says that "positive steps should be taken to enhance the opportunity of those disadvantaged by such social factors, such as family background."[102] With respect to health care, if we do not take these positive steps, like providing a certain level of health care, then we would allow diseases or health conferred by 'natural' or 'social lottery' determine opportunity.[103] Doing so would essentially allow people to suffer or be rewarded because of their draw in the natural lottery (over which they have no control), which is precisely what justice is supposed to protect against. So, Daniels uses Rawls to provide a foundation for why society must supply a certain level of resources for health care services, namely, the amount needed to protect fair equality of opportunity. This means

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[99] Ibid, 250.
[100] Ibid, 302.
[101] Norman Daniels, *Just Health Care*, (NY: Cambridge University Press, 1985) 45.
[102] Ibid, 46.
[103] Ibid, 46.

that Daniels has now shown why the current U.S. health care crisis is unjust and points to what society must do to resolve this crisis justly.

It is important to clarify that Daniels is not suggesting that we must eliminate all health differences among individuals.[104] Rather, justice only obligates society to provide people health care services that maintain or restore normal species-typical functioning. Society must provide a *basic tier* of health care to its members, which "would include *health-care services that meet health care needs, or at least important health care needs – as judged by impact on the normal opportunity range.*"[105] But, what kinds of services, specifically, are included in Daniels' basic level? Daniels answers this by outlining the following schema of what must be included in the basic tier of a just health care system, in order of priority.

The first layer of a just health care system is providing preventative medicine because these services act to minimize departures from normal species functioning. The second layer provides medical and rehabilitative services that restore normal functioning. For example, physical therapy services that will return a person to normal-species functioning after an injury, or prescribing antibiotics and other medications that can cure illness would be included in this level. The third layer are treatments to maintain as close as possible to normal species-typical functioning for chronically ill and disabled people. In these cases, though normal-species functioning cannot be completely restored, we still must provide services that can return someone to as close to normal species functioning as possible. Services such as physical therapy, prosthetics, pain medication to control symptoms of chronic diseases are included in this category. Because terminal patients

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[104] Ibid, 46.
[105] Ibid, 79.

will never be restored to normal-species functioning, nor will their level of normal species functioning be improved, there is no obligation of justice to offer terminal care. Health care systems can offer such care as a matter of beneficence, but they do not have to do so as a matter of justice.[106]

Daniels' outline of which goods justice directs society to provide its members gives us a way to determine which services must be offered and a way to evaluate the relative strength of claims to health care resources. A claim is stronger for resources that will have a greater effect on opportunity range than for resources that have little or no effect of opportunity. Also, the justice claim a person has on that health care resource strengthens when the relationship of the health care need and opportunity is deeper and when our ability to correct that health departure increases. Finally, A's claim to resource R strengthens when R can correct a health departure that is required to maintain A's fair equality of opportunity. By extension, while someone, A, may want a particular scarce resource, R, A's claim to R will be weaker if someone else's, B's, opportunity range will be restored to a greater degree, by R than would be A's.

Daniels' theory, then, explains both why the U.S. health care crisis (where millions of people cannot get access to needed health care resources because of lack of insurance, underinsurance, or high costs) is an injustice and he has constructed a theory to try to remedy that injustice. But how do we utilize Daniels' view to gain guidance on how to address these problems? To help give us an idea, I will present a couple examples.

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[106] Ibid, 47-48.

EXAMPLE 1: ALLOCATING TRANSPLANTABLE ORGANS

Imagine that there are two individuals, 33 and 76 years old, both of whom are in kidney failure. Aside from this, neither individual has other health problems. The 33 year old will not only be able to extend her life 20-30 years by having a kidney transplant, but will also be able to continue working and participating in activities that she enjoys. The 76 year old could extend his life 10 years, but given his age is vulnerable to an earlier death. He is a very active member in his community and helps care for his grandchildren. Is society obligated to provide both people with kidney transplants given that we can only perform a finite number of kidney transplants each year because we only have a limited number of transplantable kidneys? Daniels would answer affirmatively because in both cases the patient's normal opportunity range to pursue their value of the good life will be advanced by providing transplants.

EXAMPLE 2: LEFT VENTRICULAR ASSIST DEVISE

A 62 year old person in the late stages of Alzheimer's Disease is in congestive heart failure and requires a Left Ventricular Assist Device (LVAD). Such a device costs about $100, 000 and the patient would survive in her or his current state for two additional years with the LVAD. Is society obligated to provide such a device? Daniels would likely argue no because there is no **effective** opportunity being gained by this device in the sense that the individual has no functional interests (as defined by society such as working, being able to play chess, spending time with one's family as one wishes, playing the saxophone, cannot read their favorite books, etc.) that can be benefited by the

LVAD, because of the Alzheimer's. Therefore, the individual has no just claim on resources.[107]

EXAMPLE 3: KAREN AND SHARON'S CASE

Sharon Kowalski is in a coma in the hospital after being in a car accident. Her partner of four years, Karen, is unable to see her because she is not considered "immediate family." For Daniels, Karen and Sharon's case represents an infringement of their equal opportunity to have access to their partners in the health care system. If there is an injustice here it would be preventing Karen from having access to her partner for morally arbitrary reasons. If Daniels identified being gay as the reason for being denied access to Sharon, Daniels would likely argue that this denial of access is unjust because the denial is based on morally arbitrary traits that Karen and Sharon have as a result of their draws in the natural lottery. Since health care access is not to be determined by such factors, Karen is being treated unjustly. On the other hand, if Daniels argued that access was denied because Karen is not "immediate family," and this kind of refusal of access is done to help Sharon, then it is not clear Daniels would argue that there has been an injustice here because Karen is receiving her treatment for morally justifiable reasons, namely, the best interest of patient. So, Daniels' decision would depend on the way one reads this case. The key, however, is to realize that, for Daniels, the issue is one of access. Specifically, was it just to deny Karen access to her partner?

[107] I want to thank Leonard Fleck for this example.

EXAMPLE 4: FRAN'S CASE

Fran went to see her gynecologist for a routine visit. During the exam, the doctor was intentionally extremely rough with Fran and used a speculum that was too large. Consequently, Fran experienced great discomfort during her exam and complained to the doctor. Upon hearing Fran's concerns, however, the doctor replied, "I was just trying to change your mind."

Since the question for health care justice is how to fairly distribute health care resources, and Fran is referring to her treatment by a particular doctor who, while morally reprehensible, is not representative of a systemic problem in health care justice. Fran has access to the health care system and can choose to change doctors if she wishes. But there is no issue of health care justice in her case as far as Daniels is concerned.

EXAMPLE 5: UNCLE BOY'S CASE

Uncle Boy explains that people of color are treated badly by their physicians. He explains that he is not listened to or treated with dignity by his doctors because all people of color "are Niggers to the white folks." He then lists numerous stereotypes he faces that prevent people from seeing him for what he is, "a sick black man whose job made his health bad." Since the question for health care justice is how to fairly distribute health care resources, and Uncle Boy is expressing problems that have to do with the way he is treated after being given access to the health care system, Daniels would argue that this is not a case of health care injustice.

EXAMPLE 6: THE MEDICALIZATION OF CHILDBIRTH

Finally, let's examine how Daniels would evaluate the medicalization of childbirth case. Since we have already outlined this practice in the last chapter, we can immediately turn to Daniels' analysis. Before evaluating how Daniels' model would handle medicalized childbirth if he was asked to do so, however, we must note that it is questionable whether Daniels would ever take up the issue of the medicalization of childbirth in the first place because it is seen as being out of the scope of health care justice for two reasons.

The first reason that Daniels would not take up the issues of the medicalization of childbirth is that, as I noted in the last chapter, Daniels' model presupposes the medical model; it does not question whether medicine's characterizations of conditions are accurate or problematic, but rather assumes that they are correct (or the best explanations we have available for those conditions at this time) and then he starts his analysis from that point. His health care justice recommendations, then, are based on the medical model. For this reason, Daniels' theory would not question whether something, in this case, childbirth, should be seen medically (or, strictly as a medical problem). However, part of the question in the medicalization of birth is: "Should birth be classified as a medical problem?" Since Daniels would not be concerned with this question, medicalized childbirth would not arise as a health care justice issue on his framework. This does not mean that Daniels would necessarily ignore issues of childbirth altogether, but rather that *if* Daniels' theory evaluates the medicalization of childbirth, it does so from a strictly distributive stance. On this reading, Daniels supports the medicalization

of childbirth as just by presuming that it is correct, but this support is not explicit in his theory. In light of the above, if Daniels (or someone using his framework) were asked to evaluate the medicalization of birth, what would this model suggest? Put differently, does Daniels' model support distributing health care resources in the way that the medical model of disease dictates?

Even with this narrower question, someone may argue that the medicalization of childbirth is out of the scope of Daniels' theory's purview because birth is not a health care need. In other words, Daniels would not focus on distributing resources for birth at all because birth is a normal activity, not a disease or a health care need. This is because "health care needs [are] things we need in order to maintain, restore, or provide functional equivalents (where possible) to normal species functioning."[108] Since pregnancy and birth are not deviations from normal species-functioning of survival and reproduction, they are not health care needs to be addressed and issues pertaining to them are out of the scope of health care justice.

Despite this argument, I suggest that Daniels would include pregnancy and childbirth within the scope of health care justice because, though childbirth and pregnancy are not diseases in the Boorsian sense, they are health care needs on Daniels' view because they affect health. For example, pregnant women experience symptoms, such as morning sickness, dizziness, fatigue, high blood pressure, indigestion, preclampsia, diabetes, and complications in childbirth such as bleeding and infection.[109] In rare and extreme cases, childbirth may lead to life-threatening health conditions such as excessive bleeding or the uterus bursting. So, even if pregnancy and childbirth are not

[108] Norman Daniels, *Just Health Care*, (NY: Cambridge University Press, 1985) 32.
[109] The Boston Women's Health Book Collective, *The New Our Bodies, Ourselves*, (New York: Simon & Schuster, 1998) 438-443.

themselves diseases, they certainly affect women's health and they may be considered "things we need in order to maintain, restore, or provide functional equivalents (where possible) to normal species functioning."[110] At minimum, because of these possible side-effects and risks, one could argue that we treat pregnancy and childbirth as part of preventative care.[111] So, pregnancy and childbirth can be considered health care needs on Daniels' account, which means that if the issue of childbirth was raised to Daniels, his theory would consider it within its scope.

Of course, this does not tell us how Daniels' model would handle the medicalization of birth, only that childbirth could be considered a health care need on his account. For Daniels not every health care needs must be met, only those affecting opportunity. So, do the health care needs generated by pregnancy and childbirth affect pregnant women's opportunity? The answer is yes. For example, if pregnant women are feeling ill, their ability to work or study may be hindered. This, in turn, could threaten their professional, economic, and educational opportunities. In addition, the act of giving birth can be dangerous. Therefore, the act of giving birth potentially threatens women's lives (and if they cannot survive, they certainly cannot live their life as they choose). Moreover, if women are afraid to give birth because society does not provide resources, then we are hindering their opportunity to decide whether to have children. Since pregnancy and childbirth often affect health and pregnant women's opportunity range, then, pregnancy and childbirth are within the scope of health care justice on Daniels' account.

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[110] Norman Daniels, *Just Health Care*, (NY: Cambridge University Press, 1985) 32.
[111] Thank you to Leonard Fleck for helping me see this point.

Now that we have established the above, how would Daniels evaluate medicalization? In this context, the medicalization of childbirth is a distributive question; it is a question of whether the distribution of resources it calls for positively protects or hinders pregnant women's opportunity ranges. According to the medicalized model of pregnancy and childbirth, a fair allocation of resources demands that: women deliver their children in hospitals and be able to stay in hospitals for days; have access to physicians and clinics for all pre-natal vitamins and tests, such as ultrasounds or amniocentesis; and have access to any needed medications, for example those that help alleviate morning sickness. Moreover, all of these are seen as necessary to make birth safer. For example, here are some medical explanations for how certain technologies make birth safer:

Staying in Bed:[112]

- Protects women from falling
- Easier for nurses to keep track of patients
- Allows for fetal monitoring, which allows physicians and nurses to respond immediately to any possible problem with the baby

Not Allowing Women to Eat:[113]

- Reduces the chances of a woman vomiting in case the woman needs a general anesthetic and she inhales undigested stomach contents
    - If a woman did swallow these contents, it could lead to many complications, such as pulmonary edema (swelling of the lungs) and partial lung collapse and sometimes death

External Fetal Monitor:[114]

- Monitor baby's heart rate to detect fetal distress as early as possible and act
- Allows us to rescues babies from death or brain damage

[112] Robbie Davis-Floyd, *Birth As An American Rite of Passage*, (Berkeley, Los Angeles, London: University of California Press, 1992) 86.
[113] Ibid, 89.
[114] Ibid, 104.

Epidural:[115]

- Alleviate, preferably eliminate, pain without compromising the woman's mental faculties

Lithotomy position:[116]

- Ideal position for the attendant to deal with any complications that may arise in the birth

Episiotomy:[117]

- Shorten pushing stage of labor
- Reduce chance baby will suffer oxygen deprivation
- Maintain vaginal tightness for sexual partner
- Enlarge vaginal opening
- Prevent jagged tear

Because all of the above issues affect pregnant women's fair equality of opportunity, and medicalized childbirth makes birth safer, Daniels would likely agree that distributing resources according to the medicalized model of childbirth was a dictate of justice. Put differently, justice requires giving pregnant women the medical resources demanded by the medicalized model of birth in order to help them have a "successful" pregnancy – a pregnancy that results in a healthy baby and mother. The argument that would support distributing resources as is dictated by medicalization based on Daniels' model could be summarized as:

Premise 1: It is not a particular woman's fault that she was born a woman or that women must bear children. So a woman is in this circumstance because of her draw in the natural lottery.

Premise 2: Birth is, or can be, dangerous.

Premise 3: Birth is made safer by standard childbirth practices. This means that we are able to protect women from these risks.

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[115] Ibid, 113.
[116] Oxorn and Fotte, 1975 text as in Davis-Floyd, 122
[117] Ibid, 127.

Premise 4: Women's opportunities to live according to their conceptions of the good can only be protected if we fund medicalized childbirth practices.

Conclusion: A fair health care system is one that provides all women with medicalized childbirth treatments as a matter of fair equality of opportunity.

In fact, since medicalization demands access to technologies, the health care injustice would not result from giving women access to the technologies that medicalization has brought into the pregnancy and childbirth process, the health care injustice is denying women these medical resources because society would be unjustifiably hindering women's opportunity ranges by withholding these technologies. Therefore, the medicalization of childbirth is just according to Daniels because it meets pregnant women's health care needs and protects opportunity.

Advantages of Daniels' Theory of Just Health Care

Daniels' theory of just health care has advanced health care justice discussions. First, Daniels' theory moves beyond the health care justice debates that focused on establishing a right to health care. In doing so, Daniels explained *why* some health care inequalities are unjust and in the process, re-defined the nature of health care justice. Health care inequalities are not unjust because people are unable to realize their rights, but rather because they violate the principle of fair equality of opportunity. This both clarifies why the U.S. health care crisis is so problematic and explains which health care inequalities society must redress.

Daniels' view also helps us address what has become the primary focus of health care justice discussions, namely, how to distribute scarce medical resources with limited health care resources. Most bioethicists now agree that health care rationing has become inevitable. Though some, such as Lawrence Brown, argue that "[waste, inefficiency, and overpayment of doctors] are the problems that really need to be addressed through health care reform before anyone has the moral right to embrace rationing,"[118] most agree with Leonard Fleck, who argues that eliminating waste and inefficiency will not help in the ways Brown suggests. This is because "it is the flood of emerging medical technologies, more than anything else, [that] pushes health care costs upward [not using resources inefficiently]. Thus, getting rid of waste and inefficiency in the health care system can only reduce the base of health expenditures without altering the trend."[119] In 2003, the U.S. spent $1.7 trillion on health care.[120] Moreover, recent projections suggest that health care costs will likely increase at an annual rate of 7.3% between 2001-2011. Health care expenditures are expected to grow 25% faster than the GDP.[121] A major reason for these cost increases, as Fleck states, is that we use, demand, and develop high cost, highly technological care. For example, we are now experimentally testing in patients a Totally Implantable Artificial Heart (TIAH). Each transplant would cost $180, 000 (in 2003$) and if these procedures were done, they alone would add $65 billion to the cost of health care per year if these transplants were given to all of the estimated 350, 000 persons per year who would need them.[122] This trend of developing and using high tech, expensive

[118] Leonard Fleck, "Just Caring: Health Reform and Health Care Rationing" in *Journal of Medicine and Philosophy*, 19 (1994) 436.
[119] Ibid, 436
[120] Health Affairs website
[121] M Kent Clemens, Stephen Heffler, Sheila Smith, and Greg Won, "Health Spending Projections For 2001-2011: The Latest Outlook," *Health Affairs*, (Chevy Chase, MD), Mar/Apr (2002).
[122] I thank Leonard Fleck for this example.

treatments will not change even if we diminish waste. If Fleck is correct, we have reached a point where health care rationing has become inevitable. If that is the case, how should we ration health care? Daniels' theory of just health care answers this question by providing a way both to distribute scarce resources and to prioritize between stronger and weaker justice claims through their relationship to restoring normal species functioning relevant to one's opportunity range discussed earlier. This makes Daniels' theory useful to those making health care policy in addition to philosophers.

In summary, Daniels' theory of just health care provides a way to define and identify health care injustice and offers a way to set policy that will remedy those injustices. Despite these positive elements, Daniels's theory is seriously flawed. As a result, Daniels will have trouble evaluating distributive and non-distributive health care justice cases. I will elaborate on and defend these contentions in the next chapter.

Chapter 3: Daniels' *Just Health Care* and the Distributive Paradigm

Daniels' theory of just health care is an example of a theory in the distributive paradigm. In this chapter, I will argue that the distributive paradigm of justice is problematic and incomplete. One of its most serious limitations is that it unjustifiably restricts the scope of justice to distribution. Since Daniels' framework is part of this paradigm, it has the same limitations. Consequently, Daniels' framework ignores key aspects relevant to determining what constitutes a just resource allocation as well as non-distributive health care justice matters, such as institutionalized oppression. After reviewing some of the basic tenets of the distributive paradigm and their connections to Daniels' theory of just health care, I will illustrate the problems I highlight above using the case of the medicalization of childbirth.

The Distributive Paradigm and Daniels

Justice has been understood in modern political philosophy according to the distributive paradigm. The distributive paradigm defines justice as "the morally proper distribution of the benefits and burdens amongst society's members."[123] A just society is one whose institutions distribute its resources in the morally proper way. If a society fairly distributes its resources, then it is fair, regardless of other issues that society faces.[124]

The distributive paradigm assumes that we have a scarce resources to meet our needs. The problem for justice is how to fairly divide those scarce resources in a way

[123] Iris Marion Young, *Justice and the Politics of Difference*, (Princeton, NJ: Princeton University Press. 1990)
[124] Ibid, 18.

that "will protect each individual's right to a fair share of the available resources while simultaneously allowing him or her the maximum opportunity for autonomy and self-fulfillment."[125] According to the distributive paradigm, "all situations in which justice is at issue are analogous to the situation of persons dividing a stock of good and comparing the size and the portions individuals have."[126] The issue at hand for justice, then, is:

> *Given our current resources and our current options for where we can allocate such resources, how do we divide our resource pie?*

Philosophers answer this question differently. For example, egalitarians claim that fairness requires distributing resources equally amongst society's members. Marx argued that we should distribute goods according to need. Aristotle suggested that we distribute goods proportionally so that we treat equals equally and unequals unequally. The most favored current response, however, is provided by John Rawls. Since Rawls' work is not only the most influential in modern political philosophy, but also the basis for Daniels' framework, I will focus on his reasoning here.

For Rawls, a just society distributes its benefits and burdens amongst its members so that people do not suffer for things that are beyond their control. We see this contention in two places in Rawls. First, when outlining the original position from which the principles of justice will be chosen, Rawls says that "no one should be advantaged or disadvantaged by natural fortune or social circumstances in the choice of [the] principles [of justice that must be followed in a just society]."[127] A just society, then, is constructed so that these types of advantage or disadvantage (the kinds derived merely from one's

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[125] Alison M. Jagger, *Feminist Politics and Human Nature*, (NJ: Rowman & Littlefield Publishers, 1988) 33.
[126] Iris Marion Young, *Justice and the Politics of Difference*, (Princeton, NJ: Princeton University Press, 1990) 18.
[127] Ibid, 18.

draw in the natural lottery) cannot occur. Rawls defends this idea in more detail when he defends his second principle of justice.

Rawls says that he assumes that the arrangements of distribution in a well-ordered society presuppose "a background of equal liberty ... [and] they require formal equality of opportunity."[128] However, the initial distribution of society's goods "for any period of time is strongly influenced by natural and social contingencies."[129] However, allowing distributions to be determined by people's natural ability or by social contingencies, neither of which people can control seems unjust. Rawls says "the most obvious injustice of the system of natural liberty is that it permits distributive shares to be improperly influenced by these factors so arbitrary from a moral point of view."[130] Since the injustice on this framework is allowing *a system of natural liberty* to distribute resources in a certain way, we can imagine that the job of justice is to fairly distribute society's resources in a way that mitigates effects of brute bad luck, where 'brute bad luck' is one's draw in the natural lottery or one's circumstances based purely on social contingencies, rather than any action that individual took to be in that position. To this end, "the two principles seek to mitigate the influence of *social contingencies and natural fortune* on distributive shares."[131] The job of justice, in other words, is to distribute resources in a way that mitigates the effects of people's draw in the natural lottery.[132]

It is this (Rawlsian) distributive paradigm of justice of which Daniels' theory is an example. As we saw, this view understands justice as being about distributing society's

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[128] Ibid, 72.
[129] Ibid, 72.
[130] Ibid, 72.
[131] Ibid, 73, emphasis added.
[132] Note that it is permissible from the perspective of justice to suffer certain consequences that result from one's freely chosen actions on this view.

resources in a way that mitigates the influence of one's draw in the natural lottery. The scope of justice, and by default, health care justice, then, is the distribution of society's resources.[133] As stated in the introduction, the major question on which medical ethicists, such as Daniels, have focused is: Given our current health care resources and practices, what is the fair way to divide the health care pie?

Now that we have been reminded of the basic tenets of the distributive paradigm, why should it not serve as the basis for a theory of health care justice? In short, this approach has limitations that Daniels inherits and that cause his theory to have problems dealing with both distributive and non-distributive health care injustices. I will demonstrate this by returning to the case of the medicalization of childbirth.

What is the Problem? What is this Analysis of the Medicalization of Childbirth Missing?

Again, it should be noted that Daniels' theory would not raise the question whether something should be medicalized because of his implicit commitment to the accuracy of the medical model. Rather, Daniels' model focuses on distributing resources. So, if medicalization of childbirth is to be addressed using his framework, we would focus on the distribution questions around the medical model of birth. This would require asking: Given how childbirth is practiced, should we fund it? If so, which services in childbirth should we fund? Recall the reasoning for arguing that justice does require funding such services:

[133] Rawls' first principle is concerned with protecting equal liberties and takes precedence over the second principle. However, it could be argued that even this is understood to be a distribution question; it is an issue of distributing rights and liberties as opposed to material resources and opportunities. So, even with this addition, the scope of justice remains distributing society's resources.

1. People should not have fewer opportunities to live their lives according to their conception of the good.

2. Women would be at risk for having fewer opportunities to live their lives as they choose if they did not receive the services medicalization dictates because:

    a. Childbirth is potentially dangerous to mother and child
    b. The services dictated by medicalization would substantially reduce this risk to mother and child.

3. So, providing these services would then protect women's lives, and thus, their opportunity to live in the way they chooses (for example, as a mother).

4. In fact, not providing these resources would be unjust because it would be equivalent to saying that women must suffer risks and effects for things out of their control (like having the biological ability to bear children).

Although this is a valid argument, it is unsound and the analysis of the medicalization of birth using Daniels' model is flawed as a result. In addition to asking whether we should divide our current resource pool in a way that funds our current childbirth practices, Daniels also must question: "How did birth come to be done this way?" and "Are our childbirth practices effective in the way we think they are?" Examining the above questions reveals that the claims that our current childbirth practices make birth safer for women and protect women's opportunities (the reasons Daniels would argue that distributing resources according to the dictates of the medicalized model) are, at best, tenuous, and at worse, false. Consequently, the claim based on applying Daniels' analysis to this problem is that justice mandates distributing medical resources toward services dictated by the medical model of birth to protect women's fair equality of opportunity is also highly questionable. To support this, I will ask these other questions and show what doing this reveals.

How Did Birth Practices Evolve in the United States?

When we review the history and evolution of medicalized childbirth in the U.S. we see that, despite many beliefs to the contrary, our childbirth practices primarily developed because of social, economic, and political ideology rather than through objective scientific investigation and the desire to make birth safer for women. First, interventions in birth, such as forceps or hospital birth, became standard procedures not because the new male midwives thought they were required, but rather because new physicians wanted to display their technological skill "to convince large numbers of people that healing was a commodity – and that it was well worth paying for it."[134] Doctors used drastic measures to obtain tangible results and display their skills, such as performing surgeries, giving drugs, using forceps to shorten delivery, and bloodletting. So, "even though well-educated physicians recognized that natural processes were sufficient and that instruments could be dangerous, in their practice they also had to appear to *do* something for their patient's symptoms. The doctor could not appear to be inattentive or useless," for his own survival.[135] This illustrates one example of how interventions that are now standard on a medicalized model of birth took hold as a result of economic factors.

The move from home to the hospital provides another historically significant moment where politics, competition, and social ideas established our standard medical procedures. While physicians claimed that birth needed to occur in a hospital to give them unfettered access to their tools so that they could make birth safer, the motivation

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[134] Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 years of the Experts' Advice to Women*, (NY: Anchor Books, 1979) 44.
[135] Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, expanded edition (New Haven and London: Yale University Press, 1989) 64.

behind this was also to guarantee them access to a steady clientele and an opportunity to hone their skills. After all, if doctors were going to gain access to upper- and middle-class births, they had to practice their skills and gain proficiency. Moving birth to the hospital gave them this opportunity to practice on poor women and then use their skills to eventually attend to wealthy women.

The medicalized model also took hold because of its use of scientific and technological advances. Our society values science and technology, while at the same time it fears and devalues nature, which is seen as imperfect and dangerous. Part of the reason so many accept and use a medical model of birth is that medicine claims that technology is necessary to control the dangers of nature and to improve upon natural processes. In this case, science and technology are seen as controlling the danger of, and improving upon, childbirth.

Fourth, as pointed out earlier, sexism, racism, and classism played a strong role in the evolution and adoption of the medical model of childbirth. Male midwives could not have gained access to upper- and middle-class women's births without the classist and racist views that midwives were a relic of the past used by immigrants and former slaves. Women were portrayed as unfit for attending birth because they were too weak intellectually and physically. In addition, male doctors refused to take on female apprentices or admit female students to medical school. These factors combined to make it near-impossible for a woman to find a female attendant from her own class with access to technology. Since upper class and middle class women only wanted a birth attendant from their own class, and there were very few women from this class who could attend births, these women turned to male midwives. Even in cases where class was not an

issue, but rather the issue was that women wanted access to technology, like forceps, since only male midwives had access to these technologies, women chose males to attend their births. In either case, this again shows how our current medicalized model developed in response to factors other than proven science or the desire to make birth safer for women. When combined with other examples we see that, contrary to popular belief, the medicalized model did not evolve from a desire to make birth safer, but rather, it evolved for political, social, and economic reasons.[136]

Even if I am correct, however, some may argue that this does not necessarily mean that we should not fund services mandated by the medicalized model. After all, regardless of how they developed, they do keep birth safe. Since this was a major part of the reasoning to support allocating resources in this way it is unclear how asking the questions that I highlight about the historical process of the evolution suggests a problem in Daniels' framework. Put differently, Daniels' model does not direct us to examine the evolution of childbirth practices because it is concerned with whether it is a just allocation of our current resources to fund our current practices. Moreover, because of the nature of distributive justice, its focus is also on whether a just allocation of our current resources would mandate funding our current health care practices. This means that any distributive model of justice will fall victim to these same problems and fail to ask these important questions about *how* our childbirth practices developed. Since the reasoning for funding our current practices still holds, namely that birth is made safer by these technologies, it is not obvious that just because these practices have a questionable beginning that they should not be funded now. I will turn to this issue next.

[136] And, of course, this is only a very brief account of these other forces. The main idea here will be to question the development of the process of medicalization.

ARE OUR CHILDBIRTH PRACTICES EFFECTIVE? /DO THESE SERVICES DO WHAT DANIELS THINKS THEY DO?

The claim that we should distribute resources as mandated by the medicalized model is predicated on two premises. First, it assumes that birth is dangerous. Second, it assumes that childbirth services dictated by the medicalized models alleviate these dangers and, consequently, make birth safer. Neither assumption is obviously true.

First, childbirth is only dangerous in very rare circumstances (fewer than 5% for either the mother of the fetus).[137] Childbirth is a natural process, which means that we cannot always predict what will happen at any individual birth. Medicine interprets this to mean that even though birth is generally safe, because of its unpredictability, all births are potentially dangerous. Given this, medicine puts forth the view that we must intervene in *all* births just in case one woman is part of the fewer than 5% of women who will face problems in birth.[138]

However, unpredictability does not make something dangerous or risky. Furthermore, the risks of certain interventions either have never been investigated, have not been proven effective, or are worse than the risks incurred by giving birth (for example, episiotomies are more risky than the tears from which they are supposed to protect).[139] So, despite views to the contrary, childbirth is not dangerous in the majority of cases, which means that it is not warranted to act as if birth (and especially, a specific

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[137] The Boston Women's Health Book Collective, *Our Bodies, Ourselves For the New Century*, (NY: Simon and Schuster, 1998), chapter 20; Howard Brody and James R. Thompson, "The Maximin Strategy in Modern Obstetrics," *The Journal of Family Practice*, 12: 6 (1981).

[138] Howard Brody and James R. Thompson, "The Maximin Strategy in Modern Obstetrics," *The Journal of Family Practice*, 12: 6 (1981) 977-978.

[139] Howard Brody and James R. Thompson, "The Maximin Strategy in Modern Obstetrics," *The Journal of Family Practice*, 12: 6 (1981) 978-984; Robbie Dais-Floyd, *Birth As An American Rite of Passage*, (Berkeley, Los Angeles, London: University of California Press, 1992) especially chapter 3; Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, Connecticut, London: Bergin & Garvey, 1995); Judith Rooks, "Evidence-Based Practice and Its Application to Childbirth Care for Low-Risk Women," *Journal of Nurse-Midwifery,* 44: 4, July/August (1999)

woman's birth who has no signs indicating the contrary) is *likely* dangerous. Therefore, giving women resources to protect them from the dangers of childbirth is simply directing resources to protect women from problems that most do not/and will not face.

In cases where childbirth can be dangerous, most medical interventions do not address those problems. Medicine often points out that it is successful for handling birth because infection and death rates have been reduced in the last hundred years. However, infection -- most notably puerperal fever -- primarily resulted from poor sanitation practices, not dangers related to childbirth.[140] So, reduced infection rates (and by extension, reduced complication and deaths associated with infection) were not due to medical interventions (as is claimed by the medical profession), but to improved knowledge and sanitation.

Even in cases where medicine mitigates dangers in childbirth, medicine is often treating risks or side effects from the interventions themselves.[141] In these cases, the medical practices, not the risks of childbirth, create the need for intervention. So, in this context, it seems that medicine is only protecting women from its own practices, not from the dangers of birth. For example, if the doctor determines that a woman's labor is "stalled," s/he will likely say that the woman needs drugs to speed up her labor to be safe. However, the normal duration of labor is not agreed upon using research and the decisions to use medication and/or other interventions like Cesarean sections to "speed up" labor "are highly subjective and are influenced by many factors that have nothing to

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[140] Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, expanded edition, (New Haven and London: Yale University Press, 1989) chapter 4.

[141] One discussion of the interconnectedness between interventions is found in Figure 1 of Howard Brody and James R. Thompson, "The Maximin Strategy in Modern Obstetrics," *The Journal of Family Practice*, 12: 6 (1981) 979. This is also discussed in the article as a whole. More generally, this phenomenon is referred to as the "cascade of interventions."

do with the mother."[142] For example, one study found that the decision to use interventions when labor was "slow" or "stalled" correlated with physician age and experience.[143] Another study reported that "almost one third of the women in [the] study were given a diagnosis of abnormal progress or disproportion. This proportion is so high that one wonders whether the criteria used to define "normal" adequately reflect the actual variations in labour patterns among women."[144] Despite these variations in standards and practices, however, women are told that they "need" medications to accelerate birth. In this case, it is not clear that birth is being made safer since it is unclear whether there was a genuine problem with birth that was endangering the woman. Moreover, it is not obvious that in cases where there is a problem of slowed labor that the medical interventions used, most commonly prescribing medications like pitocin or oxytocin, are best or even required. This is echoed in a study put forth by Crowther et al in 1989 stating:

> [I]t does not appear that liberal use of oxytocin augmentation in labour is of benefit ... this does not imply that there is no place for oxytocin augmentation in slow progress of labour. It does suggest, however, that other simple measures, such as allowing the woman freedom to move around, and to eat and drink as she pleases, may be at least as effective and certainly more pleasant for a sizeable proportion considered to be in need of augmentation of labour.[145]

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[142] For example, a "normal" labor time in some hospitals is under 20 hours, while in others, and certainly in the presence of midwives, it is not uncommon for a woman to labor for over 40 hours. This is documented by numerous studies summarized in Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, Connecticut, London: Bergin & Garvey, 1995) 87-104.

[143] GS Berkowitz et al, "Effect of Physician Characteristics on the Cesarean Birth Rate," *American Journal of Obstetrics and Gynecology*, 161 (1989) 146-149.

[144] PJ Stewart et al, "Diagnosis and Management with Cesarean Section Among Primiparous Women in Ottawa-Carleton," *Canadian Medical Association Journal*, 142: 5 (1990) 459-463.

[145] Crowther et al, "Prolonged Labor," in Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, Connecticut, London: Bergin & Garvey, 1995) 83.

These studies suggest that it is at least not obvious whether the intervention used to "fix" the problem was necessary or helpful.[146]

The problems induced by medicine are not restricted to unnecessarily medicating women. Often using one intervention creates the need for other medical interventions that may not have been needed if the birth process had been allowed to proceed without intervention. For example, when a woman enters the hospital, she is ordered into bed, given an IV, and attached to a fetal monitor that requires her to stay in bed. However, keeping women in bed reduces the strength of her contractions, so labor will slow.[147] In response, doctors order pitocin. But, while pitocin speeds up labor, it also increases pain in labor. Alleviating labor pain, though, requires that women be able to move. However, they can often not move around (either because of regulations or because of space limitations) or because they are attached to monitors in hospitals. So, when women are in hospitals it is very difficult to control their pain. This leads more women to seek pain control, such as epidurals. However, especially with epidurals, women can no longer feel contractions and/or their contractions are weakened by the medication. So the pitocin does not have a desired effect and it is more difficult for women to deliver vaginally. Pain medications, at least in certain doses, then, increase the "need" for interventions like vacuums or forceps or Cesarean sections.[148] However, many of these births would not have required these technologies if interventions were not utilized in the first place. This again suggests that, despite claims that medical technology makes birth safer, it does not

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[146] Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, Connecticut, London: Bergin & Garvey, 1995) 83.

[147] Robbie Davis-Floyd, *Birth As An American Rite of Passage*, (Berkeley, Los Angeles, London: University of California Press, 1992)

[148] For example, this is described in The Boston Women's Health Book Collective, *Our Bodies, Ourselves For the New Century*, (NY: Simon and Schuster), 1998, p. 469. Studies about this are also cited in Howard Brody and James R. Thompson, "The Maximin Strategy in Modern Obstetrics," *The Journal of Family Practice*, 12: 6 (1981) 981. This was also seen in the movie, "Born in the USA"

obviously protect against the dangers of childbirth. Rather, often the interventions only prevent problems created by other medical interventions.

Worse than not making birth safer, these interventions may make birth more unsafe. To support these points beyond the above discussion, below is a list of standard birth procedures dictated by the medicalized model and the additional risks they bring to, rather than eliminate from, birth.

Staying in Bed:

- Reduces mother's cardiac output
- Reduces blood circulation
- Reduces blood supply to the baby, which could cause fetal distress and C-section
- Contractions in this position are less efficient
- Increases mother's pain[149]

Not Allowing Women to Eat:

> *From the sparse data available, we conclude that [eating and drinking in labor] is generally a safe, healthy, and natural practice*[150]
>
> *The policy of forbidding food and drink in labor because general anesthesia may unexpectedly be necessary depends on these assumptions: that aspiration (vomiting and inhaling the vomitus into the lungs) is a common problem, that a policy of nothing by mouth prevents aspiration, and that IV fluids are a harmless way to replace oral intake. However, none of these assumptions are correct*[151]

- Fasting does not guarantee an empty stomach
- Starvation in labor causes ketosis, which associates with longer labor, oxygen use, forceps delivery, and fetal acidosis[152]
- Aspiration is rare and most do not die from it
- Could increase risk of aspiration, actually, because gastric juices are more acidic, and likelihood of ingesting these increased by other interventions and lithotomy position[153]

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[149] Robbie Davis-Floyd, *Birth As An American Rite of Passage*, (Berkeley, Los Angeles, London: University of California Press, 1992) 86-7.
[150] McKay and Mahon, as cited in Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, Connecticut, London: Bergin & Garvey, 1995) 21.
[151] Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, Connecticut, London: Bergin & Garvey, 1995) 221.
[152] Ibid, 224.

External Fetal Monitor:

Twenty-five years after electronic fetal monitoring became a part of intrapartum care, ... it has yet to be proved of value in predicting or preventing neurologic morbidity[154]

- Questionable since no standard fetal heart rate range has been established to evaluate what monitor shows
- Study of 34, 995 births found no differences in stillbirths or fetal health between the universally monitored and selectively monitored groups
- Increases likelihood of C-section birth[155]
- Few instances of brain damage originate in labor
- Abnormal FHR readings correlate poorly with brain damage and markers of oxygen deprivation
- The "cure" for fetal distress – C-section or forceps – can cause the exact same problems that fetal monitoring is trying to avoid[156]

Epidural:

Reported maternal complications of epidural analgesia ... include: dural puncture; hypotension; ... increased use of operative delivery; neurological complications; bladder dysfunction; headache; backache; toxic drug reactions; respiratory insufficiency; and even maternal death. The fetus may also suffer complications as a result of maternal effects (for example, hypotension) or direct drug toxicity[157]

- Substantially increase the incidence of oxytocin augmentation, instrumental delivery (which increases the incidence of deep perineal tears), and bladder cathertization ... though the latter may depend on OB management
- They may not relieve the pain
- Epidural anesthetics "get" to the baby
- They cause abnormal fetal heart rate
- May cause neonatal jaundice[158]
- Lowers blood pressure
- Weakens contractions

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[153] Robbie Davis-Floyd, *Birth As An American Rite of Passage*, (Berkeley, Los Angeles, London: University of California Press, 1992) 89.
[154] Rosen and Dickinson, 1993 in Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, Connecticut, London: Bergin & Garvey, 1995) 131.
[155] Robbie Davis-Floyd, *Birth As An American Rite of Passage*, (Berkeley, Los Angeles, London: University of California Press, 1992) 104-6.
[156] Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, Connecticut, London: Bergin & Garvey, 1995) 131.
[157] Simkin and Dickerson, 1989, in Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, Connecticut, London: Bergin & Garvey, 1995) 249.
[158] Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, Connecticut, London: Bergin & Garvey, 1995) 254-55.

- Can lead to oxygen deprivation, increase of acidity in baby's blood, and poor muscle tone[159]
- Increases the need for episiotomies[160]

Lithotomy position:

Except for being hanged by the feet, the supine position is the worst conceivable position for labor and delivery[161]

- Increases length of labor and narrow pelvic outlet
- Compresses major blood vessel
- Contractions tend to be weaker, less frequent, and more irregular in this position
- Increases risk of blood clots in the legs[162]
- Increases the need for episiotomies[163]

Episiotomy:

Like any surgical procedure, episiotomy carries a number of risks: excessive blood loss, haematoma formation, and infection ... There is no evidence ... that routine episiotomy reduces the risk of severe perineal trauma, improves perineal healing, prevents fetal trauma or reduces the risk of urinary stress incontinence[164]

Routine or prophylactic episiotomy (as opposed to episiotomy for specific indication such as fetal distress) is the quintessential example of an obstetrical procedure that persists despite a total lack of evidence for it and a considerable body of evidence against it.[165]

- Episiotomies do not prevent tears into or through anal sphincter or vaginal tears
- Deep tears almost never occur in the absence of an episiotomy
- If a woman does tear, it will be no worse than episiotomy
- Episiotomies do not prevent relaxation of the pelvic floor so they do not prevent urinary incontinence or improve sexual satisfaction

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[159] Robbie Davis-Floyd, *Birth As An American Rite of Passage*, (Berkeley, Los Angeles, London: niversity of California Press, 1992) 114.
[160] Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, onnecticut, London: Bergin & Garvey, 1995) 279.
[161] Robert Caldeyro-Barcia, past president International Federation of Obstetricians and Gynocologists, in obbie Davis-Floyd, *Birth As An American Rite of Passage*, (Berkeley, Los Angeles, London: University California Press, 1992) 122.
[162] Ibid, 122.
[163] Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, onnecticut, London: Bergin & Garvey, 1995) 279.
[164] Sleep, Roberts, and Chlamers, 1989 in Henci Goer, *Obstetric Myths Versus Research Realities: A Guide the Medical Literature*, (Westport, Connecticut, London: Bergin & Garvey, 1995) 275.
[165] Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, onnecticut, London: Bergin & Garvey, 1995) 275.

- Episiotomies are not easier to repair than tears, nor are they less painful
- Increase blood loss
- Increase risk of infection for mother and child[166]

Given the above, the claim that distributing goods according to the requirements of medicalization is required by justice to protect women and their fair equality of opportunity, is tenuous. Childbirth without high-tech medical intervention is not dangerous to most women. Furthermore, the technologies that are used in standard medicalized birth do not obviously alleviate the dangers of childbirth and the dangers they do alleviate are often created by medical intervention. In these cases, the only thing medicine is protecting women from is itself. It makes little sense to say medicine protects women when there is no problem from which women need protection. So, it is unclear how medical intervention in childbirth is protecting women or their opportunity.

Regardless of the above, some may still say that we must distribute resources to the services used in medical birth because women seek them. In fact, many women want even more technology, such as induced labor on pre-chosen days or planned Cesarean sections. In these cases, at the least, it seems that justice requires distributing resources as the medicalized model dictates in order to respect women's choices and their opportunities to realize their conception of both a good life and a good birth.

In response, the mere fact that patients request or use resources does not mean justice requires providing that resource. If a patient had an infection and wanted York Peppermint Patties to cure it, it is not obvious that she should be given Yorks because Yorks do not address the health care need. Analogously, if the medical interventions in childbirth do not address a health care need (since the vast majority of the time childbirth

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[166] Ibid, 279.

is not complicated, let alone dangerous) or make birth safer it is not clear why these services would be provided. The mere fact that women are using and/or requesting resources does not justify distributing health care resources according to the medicalized model. The fact that women request resources in this instance merely demonstrates the medical profession's success in propagating the myth that all births are dangerous; it does not suggest a justice obligation to allocate resources in a particular manner. It also ignores some of the larger societal reasons that women may feel that they must control their birth process, such as a hostile work environment toward women. As a result, we do not see that it is not obvious that women "want" these resources, but rather feel pressured to use them to protect their jobs and status. Consequently, we would not be following women's desires by providing these resources, but rather hindering their opportunities to have a birth of their choosing free from coercion of other factors.

Beyond this, even if women use medicine and its tools to alleviate their suffering and their fears, this does not mean that they endorse medicalization (which is the issue at hand). Recall that 'medicalization' is the *simultaneous* reconceptualization of childbirth as medical problems *and* the elimination, or near elimination, of other options or conceptions of childbirth. Under this definition women can both use (and even request) medical resources and protest medicalization. For example, women may want the option to use medical resources if they choose to, but at the same time, want to retain the option to use a variety of other methods to deliver their babies if they prefer. They want to retain the *choice* to deliver babies and care for their bodies and their future children in the way that *they* deem appropriate for them, not be told by the medical profession how they

must give birth, which is the case with medicalization. So, even if women ask for and/or use these technologies, it does not mean that they support medicalization.

In summary, Daniels' model can be used to endorse a justice mandate to direct our scarce resources toward funding standard childbirth practices required by the medicalized model of birth. It does so on the grounds that these practices make birth safer for women and baby, and thus, funding them protects women's opportunity. However, when we asked how these practices evolved, we found that the answer was only coincidentally related to improving women's health or the safety of birth. Worse, upon further inquiry, we discovered that medicine's claim that these practices make birth safer is questionable. So, distributing resources according to the dictates of medicalization does not obviously protect women.

Despite the fact that our expanded investigation revealed that it may be unjust to distribute resources as Daniels' model suggests, his framework endorses these practices. At this point a proponent of Daniels' view could argue that now that all of these facts have been uncovered, he would no longer make such a recommendation. After all, given what I have said, distributing resources according to the medical model of birth does not obviously protect opportunity. Therefore, Daniels' model would not necessarily be endorsing such a distribution pattern and may actually endorse the opposite conclusion.

Even if it is true that Daniels' view would not support allocating resources in the way dictated by the medical model, though, the problem is that Daniels could never have identified the key elements that "changed his mind" using his own theory. If we only used his method, in other words, we would have never seen that the distributive patterns based on medicalized models are unjust. So, using Daniels' framework in this case

would have led to Daniels' theory endorsing unjust distribution schemes (that even he may be uncomfortable with once all of the issues have been revealed). This suggests that Daniels' framework has difficulties addressing distributive health care justice concerns.

Why Does Daniels' Analysis Fall Short in These Ways? Focusing on Distributive Patterns Rather Than the Processes that Create and Give Meaning to Those Patterns

One reason that Daniels' analysis of the medicalization of childbirth specifically, and his theory of health care justice, generally, is flawed is because they fall victim to a serious limitation of all theories of the distributive paradigm, namely that the investigations are too narrow in scope. The theories of the distributive paradigm wrongly restrict the scope of justice to distributive patterns as opposed to the processes that create those patterns.[167] As a result, distributive theorists neither question certain practices that should be scrutinized nor consider that the structures and contexts themselves may be part of the problem. This will lead to problematic allocation recommendations like the one we saw with the evaluation based on Daniels' model of how to distribute resources to childbirth.

Like its fellow distributive models, Daniels' view evaluates health care justice by examining end-patterns, rather than the processes that lead to those patterns. This focus leads Daniels to misidentify the problem that health care justice must remedy. Recall, health care justice on Daniels' model is "analogous to the situation of persons dividing a stock of good and comparing the size and the portions individuals have."[168] Claiming that some policy or state of affairs is unjust is a claim that "a person, or more usually a

[167] Iris Marion Young, *Justice and the Politics of Difference*, (NJ: Princeton University Press, 1990) 20.
[168] Iris Marion Young, *Justice and the Politics of Difference,* (NJ: Princeton University Press, 1990) 25.

category of persons, enjoys fewer advantages than that person or group ought to enjoy ... given how other members of the society in question are faring."[169] So, Daniels' approach focuses on what bundles of goods people have compared to others, and then asks whether that division of goods (in this case health care resources) is fair. Because of this understanding, the question of health care justice for Daniels is: What is a fair way to divide our stock of health care resources so that when we compare bundles, all will agree that their share is fair?[170] This is a faulty conceptualization of health care justice.

Because it focuses on creating a fair distributive pattern of our health care resources so that all persons are satisfied with their health care resource bundle, Daniels' analyzes what constitutes a fair distribution of health care resources without scrutinizing the social, historical, political, and economic processes that created those distributive patterns. In saying this I am neither claiming that Daniels acts as if health care resource distribution occurs in a bubble nor that he ignores the fact that part of the job of health care justice is determined by the larger social context or processes. In fact, in assessing what constitutes a just allocation scheme, Daniels must determine whether inequalities are permissible in a just health care resource distribution, which requires investigating the process that cause the inequalities. If inequalities in health care access exist because of circumstances out of an individual's control, then they are unjustified. By contrast, inequalities in access resulting from individual choices are permissible. Since determining which types of inequality are permissible requires examining why that inequality exists, and since doing this examination requires assessing the processes that

[9] David Miller, *Principles of Social Justice*, (Cambridge, MA: Harvard University Press, 1992) 1.
[0] Iris Marion Young, *Justice and the Politics of Difference,* (NJ: Princeton, University Press, 1990) 18.

created the inequalities in question, Daniels could claim that he focuses on the process that created the distribution scheme.

Despite this, I still maintain that Daniels' theory does not consider processes. First, Daniels' argument for health care justice is a Rawlsian argument. As we saw, for Rawls, the aim of justice is "to mitigate the influence of *social contingencies and natural fortune* on distributive shares."[171] The injustices to be remedied are natural misfortune and social contingency. Using this foundation, the focus of health care justice, according to Daniels, is to protect members of society from being the victims of circumstances *beyond their control* by providing a certain level of health care resources. To this end, he appeals to Rawls and says:

> The point ... is that none of us *deserves* the advantages conferred by *accidents of birth* – either the genetic or social advantages. These advantages from the 'natural lottery' are morally arbitrary, because they are not deserved, and to let *them* determine individual opportunity – and reward and success in life – is to confer *arbitrariness* on the outcomes. ... if it is important to use resources to counter the advantages in opportunity some get in the natural lottery, it is equally important to use resources to counter the natural disadvantage induced by disease.[172]

Since the point is to provide the goods necessary to counter the advantages conferred upon individuals by the natural lottery, we do not need to know anything about the socio-political circumstances that created our situation to devise a just allocation scheme for health care resources. All we must know is what resources are required "to mitigate the influence of *social contingencies and natural fortune* on distributive shares" and, specifically, to "counter the natural disadvantage induced by disease." After we discover this, our job becomes to provide these resources. In the sense that the processes

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[171] John Rawls, *A Theory of Justice*, (Cambridge, MA: Harvard University Press, 1971) 73, emphasis added.

[172] Norman Daniels, *Just Health Care*, (NY: Cambridge University Press, 1985) 46. Emphasis added.

re seen as irrelevant to determining and implementing a just solution, then, I argue that Daniels' focuses on distributive patterns and ignores the processes that create and maintain that distributive pattern.

In addition, my claim that Daniels does not focus on processes means that Daniels ignores social processes (either by seeing them as irrelevant to what constitutes a just allocation or by wrongly identifying social processes as natural ones). By 'social processes' I mean processes that created social practices, structures, and distributive patterns. When Daniels says that processes are relevant to his decisions, however, he is referring to 'natural' processes; those of the natural order. The criticism that Daniels ignores processes, then, is that Daniels ignores social processes that create distributive patterns by misidentifying social processes as natural ones, and as a result of this error, he misidentifies the purpose of health care justice.

Our distributive patterns and the processes that create them are not simply matters of nature. Rather these patterns and their meanings as being 'good' or 'bad' result from institutions and social processes. Elizabeth Anderson states this by pointing out that, people, not nature, are responsible for turning the natural diversity of human beings into oppressive hierarchies,"[173] meaning that while certain people may not be able to control their genetic or other natural endowments, whether these conditions will cause people to suffer a loss of opportunity results from certain social and power structures, not from the fact of having the condition.[174] For example, having a particular disability is not inherently unjust. In fact, those who are disabled and protest their unjust treatment are not asking "that they be compensated for the disability itself. Rather, they ask that the

[3] Elizabeth Anderson, "What is the Point of Equality?" *Ethics*, 109: 2 (January 1999) 336.
[4] I thank Lisa Schwartzman for pointing this out to me.

social disadvantages others impose on them for having the disability be removed."[175] Disability, then, is not unjust, society's reaction to it is the injustice. In other words, while it is clear that there are some conditions that cause pain and suffering to individuals, it is not the disease or the disability that is problematic from a perspective of social justice (which is concerned about creating a certain kind of society). The injustice is the way society conceptualizes and reacts to those conditions.

Rawls identifies the system of natural liberty as the injustice that requires societal remedy. Similarly, Daniels' approach to health care justice identifies one's unlucky draw in the natural lottery as the problem to be remedied by health care justice, but this is both incorrect and it obscures the reason that people are suffering in the first place. Our society's social structures distribute society's benefits and burdens, not nature. Our society's social structures are what prevent people from realizing their dreams and having opportunities taken away only because they have certain conditions, not simply their draw in the natural or social lottery. To accurately account for these social processes, we must focus on those processes, and reject the idea that the *natural processes* alone distribute talents or luck or genes. Therefore, the job of health care justice is not obviously to provide resources to maintain opportunity, but rather, it is to remedy unjust social structures and help achieve a certain kind of society where people do not lose opportunities such that they must be compensated.

Because Daniels ignores these social processes, he misidentifies the aim of both justice and health care justice. As a result, his theory of health care justice will be aimed at the wrong injustices and thus, will be vulnerable to permitting health care injustices to continue. Second, by not focusing on these social processes, Daniels will not ask the

[175] Elizabeth Anderson, "What is the Point of Equality?" *Ethics*, 109: 2 (January 1999) 334.

necessary questions to determine whether justice requires allocating resources to certain practice. Consequently, his framework has trouble identifying unjust health care distribution patterns and addressing distributive health care justice concerns generally speaking. As a result, Daniels' theory may advocate or defend unjust allocations and thus, his framework would unwittingly promote, rather than correct, health care injustice, as we saw in the case of the medicalization of childbirth.

Daniels Ignores Non-Distributive Health Care Injustices

In addition to the problems raised above, Daniels' theory of just health care ignores non-distributive health care injustice. Since Daniels would not deny this point, since he does not think that such things are injustices, and thus, he is ignoring what does not actually exist. I will offer an example of a non-distributive health care injustice ignored on Daniels' framework, institutionalized oppression in health care, to illustrate what is being ignored or permitted because of this oversight.[176] Then, I will point out a reason that Daniels cannot recognize this type of injustice, even if he wanted to expand his theory of health care justice, namely because he employs a faulty conception of social groups.

Daniels Ignores Oppression in Medicalization and Other Cases

As we have already seen, 'oppression' is a systemic structure of forces and barriers enclosing, reducing, immobilizing and restricting members of social groups

[176] Daniels would not deny that he ignores non-distributive justice since he does not think he must address such issues since they lay outside the scope of health care justice. He would, of course, take issue with the notion that this is problematic, which is why I offer the example to show why Daniels must not negate the possibility of non-distributive injustice.

because they are members of that social group in a way that puts them in a double bind.[177] I argue that institutionalized oppression exists in health care when the health care system is set up in such a way that those participating in the system will face or perpetuate that oppression, whether they intend to or not, simply by participating in the health care system. For example, as we have seen, the case of the medicalization of childbirth suggests to some that our current standard childbirth practices are oppressive toward women because, among other reasons, the medicalized model of birth suggests that women are inferior; are simply incubators for the perfect child and thus, their bodies can be violated, mutilated, cut, or interfered with as medical professionals see fit; are invisible; and that their bodies should be available to medical professionals.[178] While I cannot survey the messages of every practice here, I will outline a few practices discussed earlier and how they send the above derogatory messages.[179]

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[177] Marilyn Frye, "Oppression," *Politics of Reality*, (Freedom, CA: Crossing Press, 1983)

[178] Some places where these ideas are suggested are: Robbie Davis-Floyd, *Birth as an American Rite of Passage*, (Berkeley, Los Angeles, and London: University of California Press, 1992); Barbara Ehrenreich and Deirdre English, *For Her Own Good: 150 Years of the Experts Advise to Women*, (NY: Anchor Press/Doubleday, 1979) especially chapter 3; Karen B. Levy, *The Politics of Women's Health Care: Medicalization as a Form of Social Control*, (Las Colinas, Texas: Ide House, 1992); Kathryn Pauly Morgan, "Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization," in *The Politics of Women's Health: Exploring Agency and Autonomy*, ed. Susan Sherwin, (Philadelphia: Temple University Press, 1998); The Boston Women's Health Book Collective, *The New Our Bodies, Ourselves,* (NY: Simon and Schuster, 1998); Henci Goer, *Obstetric Myths Versus Research Realities: A Guide to the Medical Literature*, (Westport, CT and London: Bergin & Garvey, 1995).

[179] While outlining this in detail here will take us beyond the scope of this paper, I want to mention that there is debate about whether utilizing certain technologies can send these messages (as opposed to the technologies being neutral and society sending messages). One example of this debate is found in the disability rights literature where Adrienne Asch, Susan Wendell, and Laura Hershey, for example, argue that using medical technology to determine whether a child will be afflicted by a disability for the purposes of deciding whether to abort that fetus if it does have certain disabilities sends the message that "we do not want any more of you here." James Lindemann Nelson and Allen Buchanan disagree with these claims. Nelson argues that, at best, the derogatory message is sent by society and thus, the solution is not to limit access to the technology but rather to educate the public to change social attitudes. Using this line of reasoning, someone may argue that the technology used in childbirth is not inherently problematic, but rather , at best, society sends these derogatory messages to women. Therefore, the solution is not to blame the technologies as I do or limit women's access to these technologies. Instead, we should educate the public and change social attitudes toward women.
First, the above suggests that a false dilemma – that we can either change society's attitudes or limit women's access to technologies, and this is simply not true. We can do both at once, for example. Apart

First, the requirement that women be in bed sends them the message that they are weak, sick, and dependent on the hospital. This message is expressed by Elizabeth Fisher:

> *It's funny – it seems so normal to lie down in labor – just to be in the hospital seems to mean "to lie down." But as soon as I did, I felt that I had lost something. I felt defeated. ...It was as if, in lying down my body as I was told to, I also laid down my autonomy and my right to self-direction.*[180]

External fetal monitoring (as well as other monitoring) sends women the message that they are invisible and unimportant. These sentiments are expressed by Diana Crosse and Patricia Hellman.

> *As soon as I got hooked up to the monitor, all everyone did was stare at it. The nurses didn't even look at me anymore when they came into the room – they went straight to the monitor.*[181]

> *[They put me in bed and] put on the fetal monitor. I didn't want fetal monitoring either. That was something else they agreed to. But they put it on "just to check"*[182]

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from this, though I certainly agree that we should educate society about birth practices and how to act in non-sexist, non-racist, non-classist ways, one cannot separate technologies and their messages from each other or from the society in which they are used. The technologies and their meanings, in other words, are shaped by and shape society in general. So, even if it were true that society sends the derogatory message, that does not mean that the technology does not also send a derogatory message as well.
The fact that technologies and their meaning shape, and are shaped by, society also explains why medicalized birth technologies are offensive while other interventions, such as heart surgery, are not; the social context in which these interventions are performed differs. For example, in medicalized birth, there is an assumption that there are two patients and that one patient (the woman) should give anything to ensure the welfare of the second patient (the child) based on societal stereotypes on gender roles, etc. As a result of this, women often lose the right to refuse treatment that other patients possess. And, when a woman does refuse, she is vulnerable to lawsuit or court order requests to invade her body. By contrast, we do not seek court orders to force people to undergo heart surgery because in those cases, we see heart surgery as only pertaining to the individual, who can control her or his body without interference from others. Birth technologies are then attached to oppressive social norms in a way that heart surgery is not. So, even if society sends messages, since technoliges cannot be separated from the society in what they are employed, the technologies do send messages.
For more on how messages are sent through technology and ritual, see Robbie Davis-Floyd, *Birth as an American Rite of Passage*, (Berkeley, Los Angeles, and London: University of California Press, 1992) Introduction.

[180] Elizabeth Fisher, in Robbie Davis-Floyd, *Birth as an American Rite of Passage*, (Berkeley, Los Angeles, and London: University of California Press, 1992) 87.

[181] Diana Crosse, in Robbie Davis-Floyd, *Birth as an American Rite of Passage*, (Berkeley, Los Angeles, and London: University of California Press, 1992) 107.

[182] Patricia Hellman, in Robbie Davis-Floyd, *Birth as an American Rite of Passage*, (Berkeley, Los Angeles, and London: University of California Press, 1992) 107.

The epidural sends the message to women that doctors are experts and that technology can improve birth over their inferior bodies. Robbie-Davis Floyd also suggests that in numbing a woman, we are sending a message that we can do birth without her.[183] If this is true then, again, it sends a message that the woman herself is invisible.

The experiences in the delivery room send the above messages along with others that imply that women's bodies must be completely accessible to medical personnel. This is evidenced not only by tying women down so that they cannot resist during the actually delivery, but also in the position in which women are placed. Women are put on their back with their feet in stirrups and their vaginas and buttocks totally exposed. Moreover, these practices imply that women are dirty and dangerous to their babies (whereas the hospital is safe and clean and can transform women in this way so that they can be good new mothers). These feelings are described by Judy Sanders:

> *They strapped my hands down with all three of my births. I thought it was awful. The second two they did loosely so – I mean the first one it was like I was in prison or something. And so I said: "You know, that really hurts ..." [The reply was] you might touch something sterile." Here is it* your *baby and they don't want you to even ...You'ld think that they would show a little respect for you and treat you... You know, treating you like you're not very bright, like you don't really know what's going on with your own body.*[184]

What the last sentence of Judy Sanders' comment suggests is that, in addition to what was already pointed out, the medicalized model devalues women in a way that causes others to question whether they can be "true knowers." Susan Sherwin describes how medicalization and being subjected to medical subjectivity alters women's attitudes

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[183] Robbie Davis-Floyd, *Birth as an American Rite of Passage*, (Berkeley, Los Angeles, and London: University of California Press, 1992) 115.
[184] Judy Sanders in Robbie Davis-Floyd, *Birth as an American Rite of Passage*, (Berkeley, Los Angeles, and London: University of California Press, 1992) 127.

toward their own bodies and transforms women "into objects to be constantly monitored and regulated, rather than experienced directly as aspects of the self."[185] Women, in other words, are not seen as persons who possess reliable knowledge of their own bodies. Rather, they need others to confirm what their experiences already told them before they are validated. For example, a woman was having a very strong contraction and was screaming. The nurse told her she was not having a contraction, though, because it was not registering as a contraction of the monitor.[186] In this sense, women lose epistemic authority theirs, and others, eyes.

Finally, the message sent by other interventions such as episiotomy, forceps, and Cesarean section delivery is that women's bodies are not only defective, but that those defects can be addressed in any way that the physician sees fit, even if they amount to violations and mutilations of the woman's body. Surgically violating women is seen as necessary and acceptable, regardless of how the woman feels. This, however, at minimum, violates women's bodily integrity, informed consent, and autonomy. It also leaves many women feeling violated.

> *After the birth I felt just miserable, agonizingly miserable. ... And ashamed. I felt so ashamed of myself for screaming, and for not being able to do it. And you know, I had a friend who gave birth a few days later, and her labor was longer than mine, and she ended up with a perfectly normal labor. And I spent months and months comparing our experiences – going over the times and what happened to each of us step by step. And it just didn't make any sense to me. The doctor said it was "CPD" [cephalo-pelvic disproportion, a condition in which the baby is too large to fit through the mother's pelvis and "failure to progress." But her baby was bigger than mine, and I'm bigger than she is, and she was in labor longer than me. And then I had so many questions that I started to read some more. More and more. And I started to admit to myself that I felt humiliated by my birth. And then when I realized that I probably hadn't even needed a*

[185] Susan Sherwin, "Feminism and Bioethics," in *Feminism & Bioethics: Beyond Reproduction*, (NY: Oxford University Press, 1996) 55.
[186] A former nursing student of mine shared this story with me.

Cesarean, I started to realize that I felt raped, and violated somehow, in some really fundamental way. And then I got angry.[187]

So, the medicalization of childbirth is riddled with sexist messages and ideology that suggests that women are inferior, their bodies defective, and that their bodies must be accessible to medical practitioners, even when medical practices degrade women or, worse, mutilate or violate women physically and emotionally. Moreover, all of these affect individual women only because they are women, not because of any specific risk that they display or action they took.

Many OB/GYNS, of course, would be appalled to discover all of the issues raised above and would likely disavow any implicit or explicit sexism created by such practices. This is because the problem is with the standard protocol, and as a result, any OB/GYN simply doing her or his job will perpetuate women's oppression – even though they not only do not believe these sexist ideas but they have the best of intentions (because their job is to perform standard childbirth practices. In fact, if they do not, they are vulnerable to malpractice actions. After all, most obstetricians enter the field to help women and have their (and their baby's) best interests at heart. However, because the system is constructed such that the medicalized model is standard, these physicians will send these messages and contribute to sexism even though they most likely disagree with these positions personally. So the issue is *not* that individual physicians are immoral or bad people; they are not. The issue is the way that structures are set up to send such messages and have doctors participate in oppression regardless of their strong moral characters and

[187] "Elise" in Robbie Davis-Floyd, *Birth as an American Rite of Passage*, (Berkeley, Los Angeles, and London: University of California Press, 1992) 233-234.

good intentions.[188] When a health care system includes practices or policies such as the above, institutionalized oppression exists in health care.

That Daniels ignores non-distributive issues is not only apparent in his investigation of medicalization, but also in how his approach deals with the cases that I cited in the Introduction. In Karen and Sharon's case, the justice issue would be about access to loved ones in the health care setting. However, Daniels would not identify the institutionalized homophobia at the root of Karen and Sharon's case as a health care injustice because it is out of the scope of health care justice. Daniels' framework would not identify what happened to Fran or Uncle Boy as injustices at all (despite the institutionalized sexism, homophobia, and racism alluded to in each case) because these parties have access to health care resources. Of course, Daniels would *not* agree with the treatment any of these individuals received, but he would argue such treatment was immoral, not unjust. Again, then, Daniels' narrow focus on distributive issues leads him to ignore key aspects of health care justice, namely non-distributive injustice issues.

Though most would agree that a health care system cannot be fair with institutionalized oppression of the sort I just described, these issues are ignored on Daniels' model because they are identified as being out of the scope of health care justice. Worse, because he identifies them as out of the scope of health care justice, they can be allowed to continue in what Daniels would identify as a just health care system.[189]

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[188] Of course, some doctors will be immoral people, but for the point here, the issue is that this is oppression and systemic in the health care system, not that a few doctors are bad.

[189] Of course, some readers may question whether what I have highlighted constitutes sexism or oppression. Still, even if one disagrees that medicalized childbirth is an example of oppression or injustice, the issue that I am raising is that we cannot even have the debate about whether the practices I highlight above are oppressive or unjust because they are beyond Daniels' scope of justice. That Daniels ignores these issues entirely is what is objectionable, not that we may disagree about whether this example illustrates a true case of oppression. So, even if one does not think the medicalization of childbirth is oppressive to women, this alone would not invalidate my current point about Daniels' model and its weaknesses.

Of course, Daniels would object to such practices and would likely readily concede that many forms of discrimination have "corrupting influences" on the health care system, but he would deny that oppression in health care is in the realm of health care justice.[190] So, non-distributive issues, such as institutionalized oppression, are ignored on Daniels' view because they are out of the scope of health care justice. This is problematic for a theory of health care justice because this model allows for health care injustice to exist while claiming to be providing a model to eliminate health care injustice.

The problem for Daniels' framework is not simply that it neglects these concerns because he restricts his conception of health care justice to distributive justice, thus denying the possibility of non-distributive injustices, but that he cannot address these issues given his Rawlsian foundations. Specifically, Daniels' assumes a faulty conception of social groups that conceptualizes such groups as being collections of free-choosing, rational, individuals in his theory of health care justice. Consequently, he is unable to accurately conceptualize and address oppression. I will explain this link below.

THE LIBERAL CONCEPTION OF SOCIAL GROUPS

Liberal theorists acknowledge that social groups exist but contend that these groups are simply collections of free, rational, independent individuals. In other words, while individuals cannot control their social location or groups to which others identify them, their group membership is not constitutive of individual identity. So, individuals constitute groups, not the reverse.

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[190] My thanks to Leonard Fleck for helping me accurately conceptualize this concern.

The metaphysics on which liberalism (and social contract theory in particular) relies begins with an ontological picture of independent, free, self-interested (though not completely egoistic), and rational beings.[191] These beings are capable of independent existence, both because of their inherent freedom and because of their capacity to reason and make decisions according to that capacity, and thus, can live with or without others. Moreover, these individuals are said to have rights which are grounded in their ontological constitution as free, independent, and rational beings. Namely, because these individuals are rational, then they have the right to exercise that rationality to whatever ends they see as being in their interests, even if others disagree.[192] The rights that liberal individuals have, then, are grounded in their natures and allow individuals to express those natures.

Relationships between individuals are seen as primarily contentious such that the actions of other individuals are seen as potential threats to the interests and freedom of all other individuals. Given this, their rationality often directs these beings to choose to give up some of their inherent freedoms, out of self-interest, to form a state (or choose to become part of an already formed state) that will simultaneously protect them and promote their freedoms. Of course, as I stated above, the ontology of these individuals will remain unchanged, so the question becomes if these beings choose to be part of a state, what kind of state can we construct to accommodate these individuals in the ways that they are seeking? Put differently, we need a state to both protect these free, independent, rational, and self-interested beings and their inherent rights to express their

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[191] We see this idea throughout the social contract tradition in Hobbes, Locke, and Nozick to name a few. In addition, Rawls offers this description of the parties in the original position in *A Theory of Justice*, (MA: The Belknap Press of Harvard University Press), 1971, p. 118.

[192] Alison M. Jagger, *Feminist Politics and Human Nature*, (NJ: Rowman & Littlefield Publishers, Inc., 1988) 33.

rational desires while simultaneously manage the inherent conflict between them so that they will not be too threatened by each other or by the state itself.

So, the metaphysical starting place for liberals is the individual; the individual is the primary social unit from which all other institutions and groups in society are built. Their identities as free, equal, and rationally self-interested beings are already formed and thus, who they are as individuals (namely, rational, self-interested, autonomous agents) is unaltered by other social attachments or circumstances.[193] Liberal individuals "see themselves, rightly, not primarily as members of a group with a common good and shared values, but as individuals with independent identities and separate, often opposed, interests."[194]

This does not mean that there are no relationships between individuals on this view, but rather that they are freely chosen from a wide range of alternatives and are detachable, independent of the self, and thus, are not inherently part of the self. [195] People may choose to form groups in two ways. First, they may form associations because they have common interests.[196] Some examples of associations are churches or political parties. Second, they can choose to form aggregates, where members (or others) group people together around a characteristic or attribute that all members of the group possess, but that characteristic is not identity constitutive, such as eye color or profession.[197] The idea is that social groups are simply composites of individuals and their actions. In other words, the individual is ontologically prior to the group. Any

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[193] Samuel Freeman, "Introduction," *The Cambridge Companion to Rawls*, ed. Samuel Freeman, (Cambridge: Cambridge University Press, 2003) 3, 5.
[194] Peggy A. Weiss, "Feminism and Communitarianism: Comparing Critiques of Liberalism," in *Feminism and* Community, ed. Peggy A. Weiss and Marilyn Friedman, (Philadelphia: Temple University Press, 1995) 170.
[195] Ibid, 164.
[196] Iris Marion Young, *Justice and the Politics of Difference*, (NJ: Princeton University Press, 1990) 43.
[197] Ibid, 43-44.

larger group affiliation, like race, gender, and sexuality are incidental to (as opposed to inherent to or ontologically part of) the individual's identity. If a group exists, it must have been freely created by already formed individuals.

An Improved Conception of Social Groups: Combining Young and Lugones

Young rejects the liberal understanding of social groups and instead argues that a social group is, "a collective of persons differentiated from at least one other group by cultural forms, practices, or way of life."[198] According to Young, social groups are expressions of social relations and only exist in relation to at least one other group.[199] The group 'white' exists because there is a contrast group of 'black,' or 'Latina.' When groups interact and become aware of their contrasting beliefs or practices, their differences become apparent, which leads to group identification.

Given these criteria, social groups can emerge and disappear. However, "while groups may come into being, they are never founded," meaning that they are not the products of individuals who choose to create them as liberals assert (those things exist but they are not social groups) but rather, they come into being via social structures, context, and history.[200] For example, the groups 'homosexual' and 'heterosexual' did not exist as recognized social groups one hundred fifty years ago, despite the existence of sexual desire for, and engagement with, members of one's own biological sex throughout time.[201] This is because of the historical context; for example, John D'Emillio suggests

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[198] Ibid, 43.
[199] Ibid, 43.
[200] Ibid, 46.
[201] John D'Emillio, "Capitalism and Gay Identity," *The Material Queer*, ed. Donald Morton (Boulder, CO: Westview Press, 1996).

that the rise of a homosexual identity arose with the rise of capitalism and the shift of labor from rural to urban centers. The key, then, is that these groups were not formed by individuals who just happen to share similar desires for similar sexual practices and decided to organize and officially form a group. Rather, social context, history, and so forth lead to these groups appearing.

Social group membership partially defines its members' identities. Often, one can neither choose to which groups they belong, nor can they easily leave a group. Consequently, individual identity is partially shaped by group memberships; people are partially constituted by certain senses of history, affinity, or separateness with groups.[202] Thus, despite liberal claims, individuals do not enter groups as fully formed individuals who freely choose to join other individuals by forming a group. Rather, some groups exist before their members and group membership affects their members' lives and identities.

While Young is correct on the above points about the nature of social groups, her account is incomplete because, as María Lugones points out, she conceives of groups and their members as being fragmented and separable. Yes, Young acknowledges that people belong to numerous social groups simultaneously. For example, Young says that "in highly differentiated societies like our own, all persons have multiple group identifications."[203] Still, Young does not account for multiplicity because she sees group affiliations as explicitly identifiable and separable such that groups members are fragmented (part woman, part Jew, part gay, part Latina, and so forth). Young sees group differences as "cutting across each other" as opposed to blending into and affecting each

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[202] Iris Marion Young, *Justice and the Politics of Difference*, (NJ: Princeton University Press, 1990) 45.
[203] Ibid, 49.

other.[204] When we examine this metaphor of two things cutting across each other, though, we can see that the two things do not have to even stop and acknowledge each other as they pass through the night as they just have to cut across and go around each other. When applied to groups, this suggests that while many group affiliations exist within an individual, they need not meet (they may, but they need not). Moreover, if we continue to imagine the metaphor of cutting we can recall that cutting is something we do to separate wholes. For example, we cut a loaf of bread into slices or we cut a whole cake into pieces. Therefore, while it is possible that these affiliations may meet and work together, this is not inherent to Young's view.[205]

The picture of social groups that Young presents as multiple, but separable and fragmented, however, is false as group members are multiplicitous (meaning all of these parts are intertwined with, and inseparable from, each other). According to Lugones, members of social groups, "realize that separation into clean, tidy things and beings is not possible for [them] because it would be the death of [themselves] as multiplicitous and a death of community with [their] own and each person is multiple, non-fragmented, embodied."[206] We cannot split people up into the various parts that constitute them because the subject is not 'constructed' in that way; the subject is multiple and thus, cannot be that subject if fragmented and split. It is meaningless, for example, to look at me as a free, rational person who also happens to be a woman + Jewish + white + ...

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[204] Ibid. 49.
[205] I develop this idea based on a talk given by Barbara Ransby entitled "Black Feminist Intellectuals and Policies of Engagement: Washing Political Laundry in Public" at Michigan State University in 1999. There she highlighted the problems with the term 'intersection' as not requiring actual interaction but rather that all simply be present and able to avoid each other. It should also be noted that Young did not object to this characterization of her position in a personal communication in Spring 2000.
[206] María Lugones, "Purity, Impurity, and Separation," *Signs,* 19: 2 (University of Chicago Press), (Winter, 1994): 469.

because these parts do not exist as separable entities in the first place. All of these affiliations exist simultaneously, overlapping, supporting, and resisting each other.

"When seen as split, the impure/multiplicitous are seen from the logic of unity, and thus, their multiplicity can neither be seen nor understood. But splitting itself can be understood from the logic of resistance and countered through curdling separation, a power of the impure."[207] In other words, when we try to understand multiplicitous individuals as if they were unified and complete, we erase the subject and replace it with a fiction. In the process, the actual subjects are never seen or studied, nor are their problems recognized or understood. In other words, not understanding this multiplicity will lead to a faulty picture of both individuals and social groups that will prevent us from seeing individuals and groups for who they are, and thus, we will not be able to recognize oppression and other phenomena. So, we need a conception of social groups that retains Young's conception's strengths, while more accurately defining social group members. I think we can do this with the following understanding of social group that combines Young's and Lugones' views.

As Young argues, groups are ontologically prior to individuals, they come into and go out of existence, and group affiliations are important parts of their members' identities. The groups 'heterosexual,' 'bisexual,' and 'homosexual,' exist because of the ways that the groups relate to and conceive of each other and themselves.

In addition, Lugones shows, there are many group affiliations present within an individual at the same time. However, as relationships and interactions affect individuals in particular ways, depending on context, it is not the case that all groups affiliations affect all of their members in the same way at all times. One affiliation may play a

[207] Ibid, 468. The point is also made by Elizabeth V. Spelman in "The Erasure of Black Women."

salient role at one point while others do so at another time. Moreover, groups exist as a result of interactive relationships between groups and their members as well as interactions with each other. Furthermore, one's relationship to the groups to which one belongs also shapes that group. For instance, the way that certain women relate to 'womanhood,' determines how the group, 'woman,' is constructed. All of the above define a social group.

The way that groups operate according to this ontology can be visualized by thinking of the material in lava lamps (which I creatively and technically refer to as blobs), and these blobs represent generic social groups (group A, B, C, etc.). In the lamps, these blobs all overlap and blend with each other. They transcend the borders between blobs such that the specific outlines of each are barely visible, and at times completely disappear. They blend to create more blobs, which, in turn, eliminates others. Since all of the blobs operate at the same time, that movement affects the next pattern and content of future blobs.

Analogously, there are many group affiliations (blobs) constantly operating in and constituting individual's identities and life paths. These group affiliations work together to shape that individual in a given context. This is not to say that some affiliations will not oppose each other, as that will happen. But, the tension will also work to shape that individual. Each affiliation plays a different role at different times, thus affecting individuals differently in various contexts. This is why heterogeneity exists in what may appear to be very specialized groups. Sometimes a group affiliation is very prominent (the blob is large) compared to other memberships, while in other contexts, a different

group (or set of groups) is salient. This is why someone may understand her group membership one way in some contexts and another way in other contexts.

DANIELS' VIEW OF SOCIAL GROUPS

Daniels adopts the liberal conception of social groups and thus falls victim to its limitations. Specifically, he cannot accurately conceptualize social groups, and consequently, he cannot identify oppression. Social groups, not individuals, are oppressed. The reason that someone is oppressed is not related to individual talent or merit, handicap, or failure, but because one is a member of a certain social group.[208] In other words, "the 'inhabitant' of the cage is not an individual but a group."[209] So, if an individual is oppressed, they face that oppression as a member of a social group, not as an individual *per se*. If social groups and their members are who is oppressed, rather than individuals, then "to recognize a person as oppressed, one has to see that individual *as* belonging to a group of a certain sort."[210] That means that we must be able to accurately conceptualize what constitutes a social group (or, at minimum, understand that social groups construct individuals, rather than simply being collectives of individuals) to be able to recognize when someone is oppressed and when oppression exists. Daniels, however, does not assume this conception of a social group. Consequently, his framework cannot recognize oppression given its liberal, individual-focused tenets *even if he decided that non-distributive injustices exist* and that institutionalized oppression was one of these injustices. In addition to ignoring non-distributive injustices, such as

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[208] Marilyn Frye, *The Politics of Reality*, (Freedom, CA: The Crossing Press, 1983) 7-8.
[209] Ibid, 8.
[210] Ibid, 8.

institutionalized oppression, then, Daniels' model cannot identify oppression because it relies on a framework that inaccurately conceives of social groups.

This deficiency also explains why Daniels' model would have trouble identifying the injustices I highlight in the medicalization of childbirth. The issues I point out all happen to individual women *because they are women*, not because of any individual action or condition. For example, Patricia Hellman was not put on a fetal monitor because she needed it, but because all women in labor are given that treatment. Likewise, Judy Sanders was not tied down because she did anything, but because the medicalized model demands that all women receive such treatment. Finally, women such as Elise do not receive any variety of technologies because they require them, but because of the general claim that all women require these treatments, regardless of their individual cases or physical indications. To recognize this, and the injustices therein, Daniels would need a different conception of social groups.

Apart from the medicalization context, we can also see how this faulty conception of social groups affects Fran, Karen, and "Uncle Boy." Fran and Karen did not face the treatment that they did because of their individual actions, but because they are lesbians. Moreover, Uncle Boy is explicitly saying that he receives the care that he does because of his race, not because of his health condition. Again, these are cases of oppression where people face (or perpetuate) oppression because of their social group membership. If we cannot conceptualize social groups accurately, then we cannot recognize the injustices that I am highlighting here. Since Daniels does not operate with an accurate conception of social groups, then, he cannot recognize, let alone interrogate, practices such as the ones I have laid out above. Therefore, Daniels ignores institutionalized oppression in

health care (even if this is not his intention) because he cannot conceptualize or recognize such oppression as a result of his conception of social groups.

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In summary, because of his understanding of the health care crisis and his foundations in Rawls and the distributive paradigm, Daniels' theory faces many limitations. Specifically, it ignores key issues required for determining what constitutes a just distribution of health care resources by focusing on distributive patterns rather than the social processes that create those patterns and he ignores non-distributive health care injustices. Consequently, Daniels approach allows for injustice to continue in the health care system. All of these limitations suggest that Daniels view is, at best, an incomplete account of health care justice and, at worst, an account that allows or perpetuates health care injustice (an absolute problem for a theory purporting to give a theory that, if followed, would lead to a system free of such injustice). Consequently, I argue that we move beyond *Just Health Care*. Specifically, I suggest utilizing a social justice framework in health care justice would address these areas that Daniels ignores, which I will now outline.

Chapter 4: What is Social Justice?

As I just illustrated, Daniels' theory of just health care is flawed. It unjustifiably limits health care justice to distribution. Consequently, it misidentifies the objective of health care justice, ignores non-distributive health care justice completely, and cannot identify key issues relevant to making fair distributive justice recommendations. Since I claim that these problems are the result of Daniels' theory being within the distributive paradigm of justice, I suggest that if we want to avoid the difficulties in Daniels' approach, then we should employ a different framework of justice, namely a social justice model.

The social justice model differs from the distributive justice model in various ways. First, whereas the distributive model defines justice as the morally proper distribution of benefits and burdens amongst society's members, the social justice model defines justice as the active process of constructing a world without oppression. Second, the social justice model asks different questions than the distributive model. Third, the social justice model identifies the problem of justice differently. Fourth, in contrast to the distributive model of justice, the social justice model incorporates both distributive and non-distributive justice concerns. Finally, the social justice model focuses on social structures, social groups, and the social order in general, rather than on the workings of the natural order and the patterns that result. In this chapter, I will detail and defend this conception of social justice.

What is Social Justice?

As I just stated, I am defining social justice as the active process of constructing a world without oppression. If justice requires trying to construct an oppression-free world, then we must know what constitutes oppression. While I have already outlined this in detail, I will begin by briefly reviewing that concept here to clarify the content of social justice.

'Oppression' is a systemic structure of forces and barriers that are not accidental, occasional, or avoidable that come together to enclose, reduce, immobilize and restrict members of social groups in a way that puts them in a double bind, or "situations in which options are reduced to a very few and all of them expose one to penalty, censure or deprivation."[211] Moreover, these barriers and forces are in place in a way that benefits certain social groups and hurts the social group facing oppression.

Oppression neither results from individual action nor happens to individuals. This means that while individuals are oppressed, they do not face oppression as individuals. Rather, individuals are oppressed based on their social group membership. The targets and perpetuators of oppression are social groups such that the reason that someone is oppressed is not related to individual talent or merit, handicap, or failure, but rather is related to one's social group membership.[212] For this reason, we argue that oppression places social groups and their members in double binds, rather than individuals as such.

Oppression, then, is a structural phenomenon; it results from relationships between social structures, not between individuals. Oppression neither happens in isolated instances nor results from a particular law, structure, or barrier to action. Rather,

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[211] Marilyn Frye, "Oppression," *The Politics of Reality*, (The Crossing Press, 1983) 2.
[212] Ibid, 7-8.

it arises when multiple barriers or structures are in a particular relationship to each other. Furthermore, oppression is something experienced, targeted toward, and perpetuated by, social groups, not individuals.

With this review of the nature of oppression, we can discuss in more depth the scope of social justice. If justice is about constructing a society that is free of oppression and if oppression is a phenomenon of social structures, then the focus of social justice is social structures and social processes. Justice focuses on power relations in society and how those power relations reflect, create, and maintain our social structures and power relations.

Given this conception of social justice, it is apparent that there are key differences between distributive justice and social justice. First, the goal of justice differs according to the two conceptions. According to the distributive paradigm, the goal of justice is to distribute resources in a way that mitigates or compensates individuals so that they do not suffer for things out of their control, such as their position in the natural or social lottery. The unfortunate workings of the natural order are the injustice to be addressed on this view. By contrast, the objective of justice on a social justice framework is to eliminate oppression in society. So, for a social justice model, the workings of the social order are the source and focus of injustice as opposed to the natural order.

Second, the scope of justice differs on each paradigm. Whereas the distributive paradigm only includes distributive issues within the scope of justice, the social justice model identifies the scope of justice as all social structures and processes. Oppression includes both distributive and non-distributive issues. While oppression certainly

involves distributive issues, it is not reducible to distributive problems. To help us understand this point, let's examine the example of sexism.

Sexism has distributive elements because women are disproportionately poor in our society, and are paid less in their jobs, which means that they are in a worse position in society. However, sexism is not simply not having one's fair share, it also refers to the power structure in society that holds men as the norm, the power structures that assume (and even argue) that women must be sexually available to men, the social system that threatens women's safety, and the ideology that places women in a systematically less powerful position in society only because they are women. Sexism is also a social process that declares that there are naturally two distinct biological sexes, each with their own natural abilities that create a natural division where some are dominators and the other subordinators.[213] Sexism is a system that describes "cultural and economic structures which create and enforce the elaborate and rigid patterns of sex-marketing and sex-announcing which the divide the species, along lines of sex, into dominators and subordinators."[214] Sexism, then, is part of a system that not only constitutes oppression, but makes that oppression seem natural and thus, unavoidable and beyond moral judgment. These issues go beyond improper resource distribution, and thus, no resource distribution alone can address these systems. For example, there is no amount of money that, by itself, can make a woman in a sexist society immune to violent treatment. Likewise, there is no resource distribution that can change society's belief that women are inferior, that men are the "standard" human, or that there are two distinct biological sexes whose biological make-up determine their social position and talents. This

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[213] Marilyn Frye, "Sexism," *The Politics of Reality*, (Freedom, CA: The Crossing Press, 1983) 34.
[214] Ibid, 38.

suggests that while there are distributive elements to sexism, sexism is not reducible to distributive questions; likewise, while there are distributive elements to oppression, oppression is not reducible to distributive problems. Since justice is about creating a world without oppression, and since oppression refers to distributive and non-distributive issues, the scope of social justice must also include both distributive and non-distributive issues.

Third, the focus of justice differs on the two views. While distributive justice focuses on the results of social processes, social justice focuses on both those processes and their results. Because of the aim of distributive justice is to mitigate the problems caused by the natural order, it focuses on determining what resources are required to accomplish this task. The focus is on determining what constitutes a fair distribution pattern of society's resources. By contrast, because the aim of social justice is to remedy oppression by addressing social processes and structures, the focus of social justice is both social processes and the resource patterns that they create.

Because of this different scope and focus, the two theoretical frameworks will ask different questions. Where the distributive paradigm asks: Given this stock of goods and the options we have, what is the fair way to divide our stock of goods amongst our options? A social justice model makes different inquiries. With respect to distributive questions, the social justice model asks: What is the relationship of this distribution to oppression? How did we get the particular stock of goods that we currently possess? How did these become our options for dividing our stock of goods? With respect to non-distributive questions, the social justice model investigates: How are our social structures

created and maintained? What is the relationship between social structures and specific social practices?

Finally, social justice is an activity. Distributive theorists conceptualize justice as a noun, as a thing. Specifically, justice is the end point of a process; justice is an end-product. For distributive theorists, it is either a product of a thought experiment or of legislation or of deliberation, but in all cases justice is a result; the thing we get when we are finished with other processes or activities. Justice is a result of processes, not a process in itself; it is a noun.

By contrast, I suggest that justice is a verb; it is an active process. We learn the kind of activity justice is from the claim that justice is concerned with eliminating structures of oppression. Doing this suggests that justice is the activity of developing, creating, and changing the structures of society in a way that fights oppression. Justice, then, will be an activity that breaks down relationships between structures that support or perpetuate or maintain oppression and constructs non-oppressive structures of society, not simply a product of deliberation or other passive processes.

Now that we know some key difference between these two conceptions of justice, we must outline the relationship between these two understandings. I maintain that distributive justice is both an element of, and dependent upon, social justice. Distributive justice cannot be achieved in a socially unjust world because social processes create and maintain distributive patterns and their meaning. At the same time, social justice cannot be realized without distributive justice because distributive justice is part of what constitutes a socially just world. Put differently, if oppression exists in society, we can achieve neither distributive nor social justice. One reason for this is that oppression has

distributive consequences. Consequently, achieving distributive justice requires attaining social justice. For example, if sexism exists, then women will not receive their fair share of resources. So, we need to rid society of sexism to achieve distributive justice for women. At the same time, we cannot have an oppression-free world without fairly distributing society's benefits and burdens. Returning to the example of sexism, if women do not receive their fair share of resources, sexism will remain in the society. In light of the above, I argue that distributive justice is both dependent on, and element of, social justice. Neither social justice nor distributive justice can be reached without the other also being attained.

In summary, justice is not a product of processes but rather is a process in itself of creation, development, and change.[215] Social justice is the activity of constructing a world without oppression. The scope of justice includes distributive and non-distributive questions because oppression involves both distributive and non-distributive elements. Moreover, since oppression is a systemic phenomenon, the scope of justice incorporates social structures, their activities, and their meanings. Given this scope, social justice identifies the workings of the social, rather than the natural, order as the focus of justice. Moreover, social justice is not simply concerned with remedying the results of our social processes, but is also concerned with not continuing to generate those results and with creating a certain type of world where no position would cause one to suffer for things out of their control. This does not mean that social justice abandons distributive issues, rather distributive justice is an element of social justice and social justice is dependent

[215] I would like to thank Jennifer Benson and Barry DeCoster for helping bring these various metaphors to my attention.

upon distributive justice as well. Social justice is the activity of constructing a world without oppression.

What is My Justification for This View? Young and Anderson

I derived this definition from two sources: from the protests of those demanding social justice and from feminist writings, particularly those of Iris Marion Young and Elizabeth Anderson.[216] From the perspective of protesters of injustice, we learn that while people are objecting to distributive injustice, they are also fighting to receive certain kinds of treatment. For example, African Americans and their allies are not repudiating racial profiling because of its distributive consequences. Rather, they are arguing that it is wrong for society to be set up to abuse African Americans in this way. Similarly, while distributive issues are important, queer folks are not simply asking for their share of society's resources, but rather are asking to be treated in a certain way. These, and those groups like them, are fighting oppression as a whole, not just resource deprivation or misallocation alone. This indicates that justice involves fighting oppression that creates distributive and other injustices in addition to distributive battles. These sentiments are echoed throughout feminist scholarship, but since I draw most from Young and Anderson, I will summarize the key elements of each of their positions below.

YOUNG

Iris Marion Young argues that determining what constitutes justice requires examining the situation from the perspective of those who are being treated unjustly, as

[216] The moral legitimacy of this bottom-up approach has been defended extensively in the feminist literature on both political and epistemological grounds. In addition, Young also defends this in the Introduction to *Justice and the Politics of Difference.*

opposed to examining the issues abstractly (as traditional theories have done). Based on testimonies from participants in various social movements of the 1960s and 1970s, Young argues that groups who face injustice are not simply protesting distributive inequities, but are also fighting against systematic oppression and domination.[217] This suggests to Young that justice encompasses both distributive and non-distributive issues. Specifically, Young suggests that in addition to questions of resource distribution, justice is concerned with processes of decision-making, division of labor, and cultural practices that perpetuate, reflect, or support oppression and domination.[218] Based on this, Young maintains that justice is the absence of institutionalized oppression and domination.[219] Since institutionalized oppression and domination are social processes, if justice is aimed at eradicating oppression then it must examine the processes that form and reproduce oppression. This means that "any aspect of social organization and practice relevant to domination and oppression is in principle subject to evaluation by ideals of justice."[220]

ANDERSON

While Anderson takes the same approach as Young does to discover the point of justice (by turning to social and political movements), Anderson arrives at a more detailed account than Young by returning to the aim of egalitarian political movements. With respect to this group, Anderson says:

> Inegalitarianism asserted the justice or necessity of basing social order on a hierarchy of human beings, ranked according to intrinsic worth. Inequality

[217] Iris Marion Young, *Justice and the Politics of Difference*, (Princeton, NJ: Princeton University Press, 1990) 7
[218] Ibid, 15, 22-24.
[219] Ibid, 15, 37.
[220] Ibid, 15.

> referred not so much to distributions of goods [as current theories do] as to relations between superior and inferior persons. ... [Egalitarians] base claims to social and political equality on the fact of universal moral equality. ... negatively, egalitarians seek to abolish oppression. ... Diversities in socially ascribed identities, distinct roles in the division of labor, or differences in personal traits, whether these be neutral biological or physiological differences, valuable talents and virtues, or unfortunate disabilities and infirmities, never justify the unequal social relations listed above. ... Positively, egalitarians seek a social order in which persons can stand in relations of equality. [221]

Like Young, but unlike the traditional theories of equality, then, the aim of what Anderson refers to as "democratic equality" is to abolish oppression from society and to create a social order where people can see and treat others in non-oppressive, non-dominant ways. Justice or equality does not focus, in other words, in compensating people for injustice generated by the natural order, but rather it seeks to abolish injustice caused by the social order (oppression). To justify this, Anderson argues that while the equality of fortune views focus on equality as a certain kind of distribution pattern, democratic equality conceives of equality as a kind of social relation.

> Equality of fortune regards two people as equal so long as they enjoy equal amounts of some distributable good. ... Social relationships are largely seen as instrumental to generating such patterns of distribution. By contrast, democratic equality regards two people as equal when each accepts the obligation to justify their actions by principles acceptable to the other, and in which they take mutual consultation, reciprocation, and recognition for granted.[222]

Unlike the equality of fortune theorists, Anderson continues, "democratic egalitarians are fundamentally concerned with the relationships within which goods are distributed, not only with the distribution of goods themselves."[223] Goods must be distributed in a certain way that shows respect for all people. Equality, then, is a matter of social relations and processes, not a matter of using society to remedy nature's missteps.

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[221] Elizabeth Anderson, "What is the Point of Equality?" *Ethics*, 109: 2 (January 1999): 312-313.
[222] Ibid, 313.
[223] Ibid, 314.

Since the aim is creating a society with certain kinds of social structures and power relations, not remedying people's suffering from a random distribution of attributes and talents, a certain pattern or position in society is not inherently good or bad, but rather it becomes so because of the particular social meanings attached to those positions.[224] For example, having or not having a car is not inherently valuable. If one lives in a society without roads or gas stations or, simply where people can walk everywhere easily and safely, not having a car is unproblematic. But, if one cannot function in her society without a car, this is a big problem. So, it is the society and its functions and relationships that determine whether goods or bundles are valuable, not the goods themselves.[225] Consequently, we cannot make judgments about justice by examining patterns apart from the processes that create and maintain them. What the above means is that "the distribution of nature's good or bad fortune is neither just nor unjust. Considered in itself, nothing in this distribution calls for any correction by society."[226] If the distribution of nature's fortunes is not the focus of justice, then, what does Anderson say is the focus? Her answer is: what people do in response to nature's distribution.[227] For example, the job of justice is not to compensate a disabled person for her or his disability. After all, there is nothing inherent to being disabled that is unjust or creates a claim for compensation on others. What is unjust is a particular societal

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[224] I am drawing here from Elizabeth Anderson, "What is the Point of Equality?" in *Ethics*, 109: 2 (January 1999)

[225] Now Daniels could point out here that he explicitly acknowledges this in his account of prioritizing health care needs, such that we only need to fund certain needs that affect opportunity and since that effect is society-dependent, he acknowledges this fact. Still, Daniels' thinks that some things are inherently bad or inherently make someone's quality of life worse, such as certain disabilities. So, while Daniels acknowledges that justice may not have to remedy all brute bad luck, he still argues that there are things that, if one has them in certain societies, the afflicted individual would have bad luck. However, as Anderson highlights, how disabilities affect people is not a matter of luck, it is a result of social processes. This is the point Daniels obscures in his conceptualization.

[226] Elizabeth Anderson, "What is the Point of Equality?" *Ethics*, 109: 2 (January 1999): 318.

[227] Ibid, p. 331.

response that excludes disabled persons, or other socially imposed disadvantages that disabled persons face, because of our society's reaction to their disability. In fact, if one pays attention to the claims of, for example, the deaf community, they are not asking to be compensated for their deafness, but for the oppression they face in society, for example, where people assume that deaf people have a diminished quality of life *because of their deafness*.

So, Anderson proposes a view of democratic equality that:

> 1. Conceives of justice as a matter of obligations that are not defined by the satisfaction of subjective preferences.
>
> 2. Applies judgments of justice to human arrangements, not to the natural order. It locates unjust deficiencies in the social order rather than in people's innate endowments.
>
> 3. Conceives of equality as a relationship among people rather than merely as a pattern in the distribution of divisible goods. So, social norms as well as distributive patterns are subject to critical scrutiny. Moreover, this lets us see how some injustices may be better remedied by changing social norms and the structure of public goods than by redistributing resources.

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According to the above, then, both Young and Anderson give arguments supporting the notion that justice is the elimination of oppression. This is not only consistent with feminist theory, generally speaking, but also with the protests of many who claim to be victims of injustice. Based on these arguments, I maintain that social justice is constructing a world without oppression.

BUT, DISTRIBUTIVE JUSTICE HAS ALWAYS BEEN THE WHOLE OF SOCIAL JUSTICE, SO WE SHOULD MAINTAIN THIS TRADITION

Many distributive theorists, like David Miller, argue that distributive justice is the whole of justice; a socially just world is one that is distributively just and a distributively just world will be socially just.[228] Miller, for example, argues that when philosophers are arguing about social justice, they are "discussing how the good and bad things in life should be distributed among the members of a human society."[229] Social justice, then, "has to do with how advantages and disadvantages are distributed to individuals in a society."[230] Moreover, says Miller, this view is supported by the writings of most contemporary political philosophers.[231] Since social justice is simply distributive justice, there is no such thing as non-distributive justice. Consequently, my claim that the scope of justice encompasses both distributive and non-distributive issues is, at best, inaccurate, and, at worse, non-sensical.

Miller supports his contentions by claiming that contemporary political philosophers define social justice and distributive justice interchangeably. Despite his contention, however, the only political philosopher Miller cites is Rawls.[232] In fact, when we examine conceptions of justice throughout the Western philosophical tradition, as opposed to simply Rawls and his followers, we see that justice has almost always been concerned with non-distributive and distributive questions. Moreover, the aim of justice has not always exclusively been to remedy suffering for things out of one's control, but rather to create a certain kind of society. Given this, if the objection is that my proposal

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[228] David Miller, *Principles of Social Justice*, (Cambridge, MA: Harvard University Press, 1999) 1-2.
[229] Ibid, 1.
[230] Ibid, 11.
[231] Ibid, 2
[232] David Miller, *Principles of Social Justice*, (Cambridge, MA: Harvard University Press, 1999) footnote 1, "Introduction"

of social justice is inaccurate because it conflicts with the way we have traditionally conceived of justice in philosophy, the objector is incorrect. My proposal is consistent with philosophical tradition in many ways. To show this, I will highlight key elements of how justice has been historically conceptualized in Western philosophy.

Plato

In *Republic*, Plato explores the meaning of justice. Specifically, he asks what constitutes a just state. After dismissing proposals from Cephalus, who argued that justice is "to speak the truth and pay back one's debts,"[233] and from Thrasymachus who claims that justice is "nothing else than the advantage of the stronger,"[234] Socrates suggests that justice is "doing one's own." Specifically, justice is "having and doing of one's own and what belongs to oneself."[235] For Plato, a just city is one that is harmonious. A state is harmonious when all people are doing the specific task to which they are best suited.[236] So, when those meant to be carpenters do carpentry, those best suited to medicine are doctors, and so forth, the city is harmonious and just. For Plato, then, justice is doing one's own part for the whole.

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[233] Plato, *The Republic*, trans. G.M.A. Grebe, (Indianapolis: Hackett) reprinted in *What is Justice? Classical and Contemporary Readings*, 2nd edition, Eds. Robert Solomon and Mark Murphy, (New York: Oxford, 2000) 23.
[234] Plato, *The Republic*, trans. G.M.A. Grebe, (Indianapolis: Hackett) reprinted in *What is Justice?: Classical and Contemporary Readings*, 2nd edition, Eds. Robert Solomon and Mark Murphy, (New York: Oxford, 2000) 25.
[235] Plato, *The Dialogues of Plato*, trans. Benjamin Jewett, 3rd ed. (London: Macmillan, 1896) reprinted in *What Do We Deserve? A Reading on Justice and Desert*, eds. Louis Penman and Owen McLeod, (New York: Oxford, 1999) 13.
[236] Ibid, 13.

Aristotle

"For Aristotle, [justice] is not an abstract principle [as it was for Plato], it is a state of character, a cultivated set of dispositions, attitudes, and good habits."[237] In particular, justice is a state of being "that makes us doers of just actions, that makes us do justice and wish what is just."[238] Of course, this does not yet tell us what constitutes justice in a concrete sense (as Aristotle acknowledges). Aristotle suggests that discovering this requires examining how we use the terms 'just' and 'unjust'. When we perform this reflection, we will see that "justice and injustice seem to be used in more than one sense."[239] For example, Aristotle said that "we regard as unjust both a lawbreaker and also a man who is unfair and takes more than his share, so obviously a law-abiding and a fair man will be just."[240] Based on these two different uses of justice, Aristotle suggests that there are two types of justice, general justice (which deals with law-following) and particular justice (which deals with fairness and equality).

General justice is concerned with the whole of injustice, which Aristotle refers to as lawlessness. For Aristotle, laws are created to benefit the greater good for society by directing us to act not only on our own behalf, but also on others' behalf.[241] As a result, general justice (law-abiding) "is complete virtue or excellence ... in relation to our fellow man ... It is complete because he who possesses it can make use of his virtue not only by himself, but also in his relations with his fellow man."[242] What sets justice apart, then, is that it is directed at improving society, not simply individuals. Individuals act justly

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[237] Robert Solomon and Mark Murphy, *What is Justice? Classic and Contemporary Readings*, Robert Solomon and Mark Murphy eds. (New York: Oxford, 2000) 35.
[238] Aristotle, *Nichomachean Ethics*, 5.11, 111
[239] Ibid, 112.
[240] Ibid, 112.
[241] Ibid, 113.
[242] Ibid, 114.

when they act for others and society, rather than acting simply for themselves. For Aristotle, this occurs when society's laws are followed. General justice is then achieved by following society's laws.[243]

General justice is not the whole of justice, though, because justice also refers to issues of fairness and equality. These areas fall under the realm of particular justice. Justice is related to the notion of desert in the sense that justice will be getting what one deserves. Furthermore, determining what one deserves is related, for Aristotle, to whether the parties involved in the justice transaction, so to speak, are equal or not. To account for both circumstances (those where the parties are equal and those where they are not) Aristotle divides particular justice into two components: distributive and rectificatory justice.

For Aristotle, distributive justice is "the distribution of honours of material goods, or of anything else that can be divided among those who have a share in a political system."[244] In short, it is the area of justice that cuts up the resource pie. According to Aristotle, justice does not require that everyone receive equal shares of society's goods (where 'equal' means the 'same shares'). To the contrary, justice directs that goods be distributed proportionally according to the worth of the parties. A just distribution is one that divides society's resources so that equals are treated equally (they receive the same share) and unequals are treated unequally (receive different shares).

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[243] Some have questioned whether Aristotle's account of general justice is similar to a social contract approach. I disagree with the interpretation that these two accounts are similar. First, Aristotle does not think that the laws are created by society's members, but rather by an elite group of people. Second, law-following is not justice because the laws create our obligations of justice, but rather that justice will be achieved by abiding by the law, where justice is an abstract virtue that exists apart from whether members of society recognize what constitutes justice or not. These are two significant departures from social contract theory.

[244] Aristotle, *Nichomachean Ethics*, 5.11, 117

Notice that Aristotle presumes the parties to distributive justice are unequal.[245] Because people are unequal, Aristotle presumes that they do not deserve to receive equal shares of society's goods. Put differently, since Aristotle presumes the parties to distributive justice are unequal, they are not all equally deserving of society's resources. Given this, on distributive justice, justice is treating equals equally and unequals, unequally, and injustice is treating all people equally when they are not.

Whereas distributive justice assumes that the parties to justice are unequal and tries to maintain that inequality, rectificatory justice assumes all parties are equal and aims at maintaining and/or restoring that equality. Because of their equality, the parties in question deserve to be treated as equals. When one party is treated unequally, then, this requires restoring the status of the offended parties. The goal of rectificatory justice is to "right wrongs" that one party has done to the other; it is a corrective to the damaging actions to restore equality between parties. The job of rectificatory justice, then, is to try to restore the equality between the parties that existed before the damage was done.

This idea that justice is getting what one deserves is long-standing and popular in both Christian and Western philosophical traditions. Despite this, the difficulty of determining what people deserve is an arduous task that many philosophers decided could not be accomplished. So, in the seventeenth and eighteenth centuries, the notion of justice as getting what one deserves received less emphasis (even though the idea continues to influence all justice discussions) and two new strands of justice theories emerged: social contract theory and utilitarianism. I will first outline classical liberalism/social contract theory, utilitarianism and then the social contract tradition as it has been expressed in Rawls' work.

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[245] Ibid, 118.

The Social Contract Tradition: Classical Liberal and Libertarians (Hobbes, Locke, and Hayek)

The social contract tradition was established by Thomas Hobbes in his treatise, *Leviathan*, where he tries to justify the authority of the state. Social contractarians contend that individuals are inherently self-interested and unconnected to each other (they only form connections through contractual agreements). While there are numerous accounts of a "pre-social contract" existence, they generally agree that though individuals were free to do as they wished, they always felt threatened (either for their own safety of for their property). Since this existence was so stressful and awful, individuals chose to enter society for their own benefit, where they agreed to give up some of their inherent freedom and follow laws to which they consented.[246] In exchange for the state's protection, which is granted by enforcing the agreed upon laws, the state cannot act without the consent of society's members, because if they had this power, people would fear that the state would encroach upon their liberties and not protect them. Since people only joined the state for their own protection, they would only legitimate a minimal state.

This story is significant because it explains how we determine what constitutes justice on this view, in this case, a minimal state. According to social contract theory, justice is determined by the consent of the parties to the contract. As a result, if we want

[246] For example, the Hobbesian version of the social contract argues that before society was established, these self-interested, unconnected individuals lived in a state of war where lawlessness prevailed and people had unrestrained liberty (in the sense that no outside force of government constrained their freedom); they lived in constant fear for their safety. Therefore, they entered into a contract to form society to protect their life and liberty. Locke's conception gives a similar account of people living in fear, but on this view, people did not live in a state of lawlessness, rather they lived according to the laws of nature and self-interest. In order to protect one's life, liberty (and in Locke's case, property) they entered into a society.

to know whether justice obligates society to do something, we need to know to what the contractors would consent.

With this background, we are now able to understand the libertarian position. Libertarians, such as Friedrich von Hayek and, later, Robert Nozick, argue that the parties to the social contract would not agree to sacrifice their liberties for any purpose other than their own protection and safety. Any attempt to impose ideas of justice or the good, for example, through creating programs like public education funded by tax dollars, is an unjustifiable infringement on individual liberty that cannot be allowed. This is because it requires people to give up their freedoms (to choose how to spend their money) for a purpose other than their own personal safety and freedom.[247] Inevitably, then, bringing about social justice requires imposing on individual freedom, to which the contractors would never agree. Consequently, von Hayek argues, this violates the social contract and we can infer that justice only requires society to protect individual freedom.

Utilitarianism (Mill)

Utilitarianism defines justice in terms of social utility. Justice is what yields the greatest good for the greatest number. Justice is then determined by the consequences of actions, not the paths taken to realize those consequences. So, a just society is one that acts according to the benefit of the majority of its members, where every member's interests have equal worth. Justice is then whatever is good for the greatest number of people.

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[247] Friedrich von Hayek, *The Mirage of Social Justice,* in *What is Justice? Classic and Contemporary*, 2nd edition, eds. Robert C. Solomon and Mark C. Murphy, (New York: Oxford University Press, 2000) 182.

John Stuart Mill defends this idea in *Utilitarianism.* There he argues that justice requires treating people as they deserve (or, at least, most people seem to have this intuition among all other possible definitions of justice employed).[248] However, Mill argues, this moral duty to treat people as they deserve, rests on the foundation of utility, or, the greatest happiness principle, which says that "one person's happiness ... is counted for exactly as much as another's."[249] While justice is distinct from utility, it is really a subset of utility.

Mill maintains that while all people have a right to be treated as they deserve, this right can be overridden when society requires. This is not because principles of justice are merely secondary to social utility, but rather because in the context of achieving a certain social good, following the principles of justice would be unjust in certain contexts.[250] In other words, there are some social duties that are "so important as to override any one of the general maxims of justice."[251] For example, says Mill, it may be a duty to steal necessary food or medicine to save people's lives in a certain context, despite the general claim that it is unjust to steal.[252] So, we act justly when it does not interfere with a larger social obligation and when a conflict between social needs and justice arises, it is more just to act according to social utility. In all cases, then, acting according to social utility is acting justly. In this sense, justice is doing the greatest good for the greatest number.

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[248] John Stuart Mill, *Utilitarianism*, in *What is Justice? Classic and Contemporary Readings*, 2nd edition, Robert C. Solomon and Mark C. Murphy eds. (NY: Oxford University Press, 2000) 169, 173.
[249] Ibid, 173.
[250] Ibid, 174.
[251] Ibid, 174.
[252] Ibid, 174.

The Social Contract Tradition: Rawls

Rawls can be seen as trying to combine the strengths of both libertarianism and utilitarianism, while trying to avoid their respective weaknesses. Along with libertarians like von Hayek, Rawls agrees that justice should focus on protecting certain individual liberties. Still, he maintains that some outcomes of resource distribution are unacceptable in a just society. In this respect, Rawls agrees with Utilitarians that consequences of society's actions are important to justice. Still, Rawls does not totally endorse Utilitarianism because actions for the greatest good without thought to individual freedom allows individual's people's liberty to be sacrificed for the benefit of others, which is unacceptable because all people have certain rights that cannot be sacrificed for any reason, as Libertarians contend.[253] Rawls' theory of justice, then, can be understood as a blend of Utilitarianism and Kantian Libertarianism, where justice consists in following a series of principles which will both protect liberty and distribute society's benefits and burdens in a way that is mindful of the results of those distributions.

Of course, we still must be told how we arrive at these principles and how they will accomplish these tasks. Rawls says that we determine how to fairly distribute these benefits and burdens based on what people behind the veil of ignorance in the original position would choose. There, the parties are trying to determine how a society, of which they will be a part, would fairly distribute its benefits and burdens. However, they do not know any details about themselves, particularly their religion, race, or economic class. Rawls maintains that such parties would argue that a fair society is one whose basic structures adhere to two principles of justice. The first principle states that "Each person is to have an equal right to the most extensive total system of equal basic liberties

[253] John Rawls, *A Theory of Justice*, (Cambridge: Harvard university Press, 1971) 3.

compatible with a similar system of liberty for all."[254] In other words, all individuals have certain liberties that cannot be taken from them in any circumstance. This principle reflects the influence of classical liberal theorists such as Kant and Locke. The second principle states that "social and economic inequalities are to be arranged so that they are both (a) to the greatest benefit of the least advantaged, and (b) attached to offices and positions open to all under conditions of fair equality of opportunity."[255] The second principle creates a standard that considers the outcome and consequences of the distribution, which reflects the Utilitarian influence. The two principles are lexically ordered so that people's liberty can never be restricted except for the sake of greater liberty (such that overall liberty will improve for all).

Given the above, despite Miller's and other distributive theorists' claims to the contrary, justice encompasses both distributive and non-distributive elements. Plato argues that justice is "the having and doing of one's own and what belongs to oneself."[256] This picture of justice as doing one's own or as harmonious living does not obviously refer simply to resource distribution. Aristotle argued that there are two types of justice, general justice and particular justice. Furthermore, particular justice consists of distributive justice and rectificatory justice. Again, then, justice is not exclusively distributive on an Aristotelian account.

The Greek philosophers were not the only ones to conceptualize justice as encompassing more than distributive issues. Bentham and Mill defined justice in terms of social utility. Libertarians such as von Hayek and Nozick argued that a just society is

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[254] Ibid, 250.
[255] Ibid, 302.
[256] Plato, *The Dialogues of Plato*, trans. Benjamin Jewett, 3rd ed. (London: Macmillan, 1896) reprinted in *What Do We Deserve? A Reading on Justice and Desert*, eds. Louis Penman and Owen McLeod, (New York: Oxford, 1999) 13.

one that protects individual freedom above all else. Finally, feminist philosophers, such as Iris Marion Young and Elizabeth Anderson, argue that justice is the absence of institutionalized oppression and domination. There is no obvious reason to interpret any of the above conceptions as being restricted to distributive justice. Given that justice has been viewed from numerous areas of philosophy as encompassing more that distributive justice and that there is no argument that justice should be restricted to those issues, it is at least reasonable to conclude that justice is not merely about the distribution of scarce resources.

A Worry: Does Expanding the Scope of Justice This Way (To Include All Social Structures) Eliminate the Differences Between The Scopes of Justice and Morality?

Some may worry that expanding the scope of justice beyond distribution erases the border between morality and justice. Specifically, expanding the scope of justice the way I am proposing would mean that the scope of justice includes all social structures and processes. However, since these structures could include morality, it seems that my suggestion erases the difference between justice and morality.

Despite this worry, justice and morality remain distinct on my view. The realm of justice refers to issues or actions involving or resulting from societal structures and their development, whereas morality refers to individually-based actions (or actions that occur between individuals as a result of the particular characteristics, actions, or opinions of the individual parties to the interaction) and individual character development. For example, if a parent treats a child differently than her siblings because they like their younger daughter better, then this would be in the scope of morality. This is because the action as I have described it occurs between individuals on the basis of their individual

characteristics, preferences, and opinions. However, if they treated their daughter differently than their sons solely because they are boys while she is a girl, (or they treated the oldest child different than the youngest because of the social meanings of birth order) this would be a matter of justice because in this case the actions between individuals do not have anything to do with the specific individuals at all, but rather with social norms, ideas, or values. Therefore, the relationship between actions and the larger social structures determines whether an action is within the scope of justice or morality. The general distinction, then, between morality and justice is based on their relationship of actions and ideas to societal structures. Justice refers to social structures and their development while morality refers to individual behavior and development.

Even if my objector is content that the distinction between morality and justice is maintained on my view now, they still may dispute the specific way that I draw the distinction. For example, some may suggest that justice is about how people, as individuals, treat each other, and thus, it is individually, not societally, focused. If this is true, then my distinction would fall and we will return to the place of concern from which we began this discussion. Luckily, this will be unnecessary because there is plenty of support for the distinction as I have drawn it here.

One source of support for this distinction is that justice has been conceptualized throughout the history of political philosophy as referring to social structures. Given this, I am not proposing anything new in claiming that the scope of justice is social structures and their development, I am simply repeating a long-held view in philosophy. For Plato, the search for justice was the search for a just society. Aristotle held that the issue that set justice apart was that it was aimed at others and society at large, rather than at oneself.

Moreover, his prescriptions about justice focused on structuring society in a way to get people what they deserve, not on individual actions. So, justice is about structuring society in a certain way. Utilitarians focus on achieving a just society by focusing on doing what will bring about the greatest good for society. Rawls explicitly states that the scope of justice is the basic structures of society. Finally, Young and Anderson both state that the focus of justice is social structures and their development. Throughout philosophy, then, justice has referred to social structures. So, if we are judging the scope of justice based on how the concept has been defined throughout the history of philosophy, the claim that justice focuses on social structures is not controversial.

Even if the scope of justice is limited to the structures of society, some may still disagree with my distinction between justice and morality because the scope of morality could be expanded to social structures. After all, my objector would say, we consistently apply moral criticisms to social institutions by saying, first instance, that a society is 'unkind' or 'uncaring'. In fact, we often say that a society is immoral even if it has met all of its justice obligations. This suggests that the scope of morality extends to social structures, which would again challenge my distinction.

My first response is that just because people apply moral language to social structures it does not mean that morality extends to social structures. Rather, I suggest that people are simply using moral language to express a justice claim. For example, an unkind society is one that allows injustice to flourish by not providing its people with certain levels of food or shelter, or by violating the human rights of certain groups or people. Even though we may use moral terminology in this criticism, the above are really social justice claims that society is structured unjustly. So, applying moral

language to societies does not show that social structures are in the realm of morality as opposed to the realm of justice.

Second, the objector suggests that a society could be unkind after it meets all of the dictates of justice. However, this is only possible if justice is defined as distributive justice. If society's only justice mandate is to provide a certain package of resources to its citizens, then that society may allow other non-distributive injustices. As I have already shown, however, this is a faulty view of what justice demands. It is not possible for a society that meets all of the requirements of social justice and also be unkind. This is not to say that there would not be unkind or immoral persons in a socially just society, but the socially just society would not be structured in a way that allowed for the kinds of acts, like human rights abuses, starvation, corruption, and so forth that we argue make a society unkind. In fact, calling a society "unkind" assumes that injustice exists within that society because a society could only be identified as "uncaring" or "unkind" if it neglects, ignores, or worsens the situations of victims of injustice.[257] If a society is uncaring because of the way it treats victims of injustice, then it is impossible that one could claim that a society is uncaring without also claiming that injustice exists. After all, if there was no injustice, there would be no victims of injustice to whom society is

[257] Leonard Fleck objects here that if a society ignores victims of natural misfortune it is unkind but not unjust. I disagree with this for a couple of reasons. First, as I have cited throughout this work, both Rawls and Daniels see the job of justice as preventing benefits and burdens from being arbitrarily distributed by nature. On this view, a society that does not help victims of natural misfortune is unjust, not unkind because it would be allowing nature to distribute benefits and burdens arbitrarily to society's members. Second, Fleck takes the view that societies must help victims of natural disasters because all are vulnerable to these disasters and nobody can control whether they occur or whether they will be victims or not. To allow people to suffer by not offering help from this type of event would be unkind. However, I contend that a socially just society is one set up such that people would not be put in a position so that they suffer sustained (unaddressed) significant loss from any cause, including natural disaster. Even if this was not the case, justice would require helping victims of natural disaster because not helping them could place certain groups in a position of being oppressed, which is unjust. So, if society is socially just, it would help victims of natural misfortune as a matter of justice. Again, then, a society that would not help victims of natural disaster would again be unjust, not unkind.

unkind. So, again, even though we may apply moral terminology to societies, it does not mean that the scope of justice is not social structures and the scope of morality individual action and development.

Another way the claim that society is uncaring could be interpreted is that it is directed at the individuals who run the society, not the society itself. On that interpretation, morality is directed at individual action, not at societal structures; it applies to those individuals who run society. In this case, then, the distinction between morality and justice as I have drawn it still holds.

Given the above, the account of social justice I propose does not destroy the classic distinction between morality and justice, as was alleged. The scope of justice is social structures and their cultivation, maintenance, and development, while the scope of morality is individual actions and character development. Since societal structures are involved with more than distributive issues, the scope of justice is broader than distribution.

ANOTHER WORRY: MY CONCEPTION OF JUSTICE ERASES THE POSSIBILITY OF BENEFICENCE

Even if someone agrees with the distinction between the scope of justice and morality as I have drawn it, an additional concern may arise, which is that the scope of justice I propose erases the line between justice and charity (or beneficence). Traditionally, ethical theory, and especially health care justice discussions, have maintained a distinction between obligations of justice and those of charity. One key issue that is often assumed is that duties of justice must be honored and can be enforced,

whereas those of beneficence are superogatory and unenforceable.[258] The worry is that if justice obligations are generated in relation to social structures, then there will be no room for beneficence. In health care justice, especially, this is of great concern because without such a distinction, it is argued, we will not be able to distinguish the kinds of health care that society *must* provide from the care it *could* provide it its members so desired and resources were available.[259] If we cannot make this distinction, however, health care justice will not be able to offer practical advise for resolving the scarce resource problem in health care because it will simply say that people have a right to health care (as was done before Daniels).[260] My objector then argues that since my proposal appears to erase a long held distinction in ethical theory and health care justice, there is a deficiency in my proposal.

In response, while I agree that this distinction has often been appealed to in both ethical theory and health care justice discussions, it is not obvious that it plays the crucial role that the objector claims. Allen Buchanan argues that despite the assumption that the division between duties of justice and those of charity is crucial for ethical theory, theories actually do not require it be in place. For example, Buchanan says:

> It has long been known that in utilitarianism the distinction between justice and charity is not of fundamental importance: the ultimate justification for both principles of justice and principles of charity is that acting on them maximizes social utility. ... Thus in utilitarianism the important distinction is between those duties to aid others that may be enforced and those that may not, "duties of charity" merely serving as a convenient label for the latter.[261]

He says similar things about the role of the distinction in Rawls' work. According to Buchanan, while Rawls says that his method for deriving principles can accommodate

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[258] Allen Buchanan, "Justice and Charity," *Ethics*, 97 (April 1987): 558.
[259] Among the advocates of this position are Norman Daniels in *Just Health Care* and Leonard Fleck
[260] I will not rehearse it again here but the discussion of the problems with this view is found in Chapter 2.
[261] Allen Buchanan, "Justice and Charity," *Ethics*, 97 (April 1987): 574.

this distinction, "he does nothing to substantiate these claims."[262] Buchanan continues, "indeed, nothing in the description of the original position either reflects or seems capable of generating a distinction between principles of justice and principles of charity."[263] So, despite the intuition that the distinction between justice and charity is crucial for ethical theory, Buchanan shows that this is not obviously true. In light of this, I could respond that even if my proposal of social justice does break the barrier between charity and justice, this is not problematic.

Even given the above, however, I think it is important to show that the proposal I offer does preserve the line between justice and beneficence because of the practical issue in health care justice that for such a theory to be useful, it cannot require that society provide unlimited goods. Still, my proposal does not destroy this distinction. On my view, justice requires that society try to eliminate oppression by not perpetuating, creating, or maintaining it in its policies and practices. However, society has no justice duty to address issues that are unrelated to oppression. They can do so, however, as a matter of beneficence. As we will see, society is obligated on my view to provide health care resources required to prevent, reflect, or perpetuate institutionalized oppression. However, it need not provide resources that are not required to accomplish this goal. For example, society must provide access to basic antibiotics for all, but not have to provide access to a very expensive technology (that will not contribute to oppression if it is provided or denied) that can help very few people. But, if there are resources, they may choose to do so as a matter of beneficence. The criterion of oppression, then, can accommodate the distinction between justice and charity and my critic need not be

[262] Ibid, 575.
[263] Ibid, 575.

concerned that this important ethical and bioethics distinction will be lost on a social justice view.

Social Justice as Constructing a Society Without Oppression

Given the above arguments, I maintain that social justice is constructing a world that is oppression-free. In this light, the aim of justice is not to protect people from suffering for things out of their control, like their draw in the natural or social lottery, but to remedy the social structures that constructed a society where people suffer for having certain characteristics. It does this by examining both the results and the social processes that led to those results in a way that aims to create a society without oppression. Because oppression encompass distributive and non-distributive issues, the scope of justice includes distributive and non-distributive concerns.

Recall, however, that the reason we are defining social justice here is to present an alternative framework of justice on which we can base a theory of health care justice. We are doing this for two reasons. First, I argue that the currently most widely accepted view, Norman Daniels' theory of just health care, is flawed. As a result, we need a model that avoids the limitations in his view. Second, I argue that the source of the problems in Daniels' view is the foundation on which it rests, the liberal political model in general and the distributive paradigm of justice, more specifically. If Daniels' theory's difficulties are rooted in his foundation, then constructing a theory that avoids his difficulties requires a new foundation. I suggest those new foundations are found in the social justice view I have just outlined. Still, what would a model of health care justice

look like based on this view? Would such a model avoid the problems Daniels faces? Answering both of these questions will be the focus of the next chapter.

Chapter 5: Beyond Distribution to a Social Justice Framework of Health Care Justice as Constructing An Oppression-Free Health Care System

Since I am defining social justice as the active process of constructing a world without oppression, I suggest that a just health care system, policy, or practice is one that does not perpetuate, reflect, or create oppression within, or outside of, the health care system. Here I will clarify what I mean by this definition of health care justice. Then, I will show that this social justice-based approach to health care justice avoids the problems that Daniels encounters, especially in the analysis of the medicalization of childbirth that following his framework suggests.

A Social Justice Model of Health Care Justice

Using the definition of social justice as the activity of constructing a world without oppression, I suggest that health care justice is the active process of creating of health care system without oppression. When the health care system perpetuates, reflects, or supports institutionalized oppression, health care injustice exists. Institutionalized oppression exists in health care when the health care system is set up so that those participating in the system will face or perpetuate oppression, whether they intend to or not, simply by participating in the health care system. Based on this, I maintain that a just health care policy, system, or practice is one that does not create, reflect, or perpetuate institutionalized oppression. This idea that health care justice is so defined is not only supported by the social justice framework, but is also the conception underlying the claims of those protesting their unjust treatment in health care.

Those facing health care injustice are not only seeking access to health care resources, but are also protesting their treatment once they are given such access. Put

differently, they are not simply asking to be let *into* the system, but rather are asking for a particular kind of treatment *once they are in* the system. Again, Fran is not asking that she be given access to a gynecologist, but rather, is protesting the heterosexism, sexism, and homophobia in medicine that was exemplified by her doctor. Karen is not asking simply to have access to her partner, but to not face homophobia in the health care system. Uncle Boy is not asking to get medical treatment, he is protesting institutionalized racism in health care. Finally, women protesting the medicalization of childbirth are not trying to get access to these resources, they are protesting sexist messages on which medicalization is based and that it sends and reflects. These examples and many more suggest that even though the allocation of health care resources is important, it is not the whole of health care justice; both distributive and non-distributive issues are important. This supports the conception of health care justice that I am advocating.

Since the focus of health care justice is the curbing and elimination of oppression in health care, this framework of health care justice would focus on numerous concerns ignored by Daniels' approach. First, since oppression happens to groups and their members, health care justice will note the role of social group membership in whatever issue is under investigation. This is important not only for identifying oppression in health care, but also for understanding the problems of health care injustice. For example, Fran, Karen, Uncle Boy, and millions of pregnant women face the treatment they do because of their social group membership (be it race, gender, or sexual preference). So, we cannot address those issues if we act as if these are all just unlucky individuals. Rather, addressing these problems requires focusing on the social processes

that made those in these social positions vulnerable. The health care justice model I am proposing will accomplish these goals.

We also must focus health care justice investigations on social processes, rather than patterns because oppression is a structural phenomenon. Consequently, to identify and eliminate oppression we must evaluate health care systems, policies, and practices from a macro-scopic, rather than an individual, level. Instead of looking at a policy in isolation, we must examine how and why the policy (or system or practice) was created and examine how it would work with, affect, and be affected by other policies and social processes. For example, instead of looking at whether we should provide resources for a medicalized childbirth and pregnancy, we should ask which resources are required, why they are being requested, what providing the resources would achieve, and so forth. Again, the model I suggest achieves this objective.

In summary, then, I propose that the social justice framework is a strong foundation for constructing a model of health care justice. Using this definition of social justice as constructing a world without oppression, we see that a fair society is one that tries to eliminate oppression. Based on this view of social justice, health care justice is the active process of creating of health care system without oppression. Given the above, a just health care policy, system, or practice is one that does not create, reflect, or perpetuate institutionalized oppression. Because its primary focus is the elimination of oppression in health care, health care justice evaluation will not only concentrate on allocating resources fairly, but also on creating structures that do not treat people in a way that creates, reflects, or perpetuates oppression. Given this extended focus, health care justice evaluations will not only look at results of processes, but also processes that

created those options, those resource pools, etc. In addition, any allocation will be explored in relation to its effects on oppression, not merely opportunity.[264] Consequently, this approach avoids the problems Daniels has, as is shown by the case of the medicalization of childbirth.

How a Social Justice Framework Would Analyze Childbirth Practices in the U.S.?

THEORETICAL ADVANTAGES

Recall that I argued that Daniels' framework mishandles the case of the medicalization of childbirth because its focus is too narrowly restricted to distributive issues. Specifically, this focus leads Daniels to ask: Given our resource pie and our options for how to divide it, what is the fair way to spend our scarce health care resources. This paradigm is not concerned about how the pie was formed or why we have the options we do for dividing it, but rather with how to fairly address the situation in which we find ourselves. As a result of this narrow focus, Daniels' framework is not able to evaluate health care justice issues like medicalization completely.

Given this, whatever theory I propose must, at minimum, be able to avoid these problems. My proposal achieves this goal. On the view that a just health care policy, system, or practice is one that does not create, reflect, or perpetuate institutionalized oppression, we would evaluate the medicalization of childbirth in a way that improves upon Daniels' analysis. In general, we would ask different questions than the ones Daniels did and thus, we would discover different information about the medicalization of childbirth and avoid the problems I have identified with Daniels' framework.

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[264] One facet of oppression results in decreased opportunities, so it is not that opportunities are ignored on the view I propose. Rather, the focus is not only on opportunity as is Daniels.

Specifically, we will ask: How did the medicalization of childbirth evolve and develop? Upon asking this question, we will be prompted to ask other questions like: Is the medicalized model our best option (or even an effective one)? And: How does the medicalization of childbirth create, reflect, and perpetuate oppression?

Since social justice focuses on both social processes and their results we will interrogate the processes that led to the medicalization of birth. So, where Daniels asks: Given our options of a medicalized birth and our resources, is it just for a society to dedicate resources toward these childbirth services? I would also ask: How have we come to a point where our childbirth options have almost exclusively become the options of a medicalized birth? This requires interrogating the history of childbirth in the United States and the evidence supporting or refuting the effectiveness of childbirth practices. Doing so would uncover the political, economic, and social factors that led to our current situation. This discovery would likely cause doubt about whether our current practices are similarly justified (i.e. by politics, not science or effectiveness). So, we would ask whether birth is really dangerous and whether the medicalized services make birth safer, as is claimed. Remember that the major justification of the distributive paradigm to fund standard childbirth was that these services make birth safer, and thus, would protect pregnant women's fair equality of opportunity. But if birth is not dangerous, it is unclear whether distributing resources in the way the medicalized model mandates would protect opportunity. So, we would evaluate the evidence and discover that the claim that medicalized birth is safer than non-medicalized birth is tenuous at best. Moreover, we would uncover facts that would make Daniels' own recommendation questionable since we would interrogate the relationship between the medicalized model's birth practices

and oppression. So, we would provide a more complete analysis of the distributive question in medicalization than Daniels' model does by using the social justice model.

In addition to these distributive questions about getting women access to certain resources, a social justice paradigm would also focus on non-distributive issues. Specifically, because a just health care system, policy, or practice aims to eliminate oppression within the health care system, we would evaluate the relationship between medicalized childbirth and the oppression of women. In doing this, we would uncover the derogatory messages about women perpetuated by the medicalized model of birth cited earlier using Daniels' model.

This element of the social justice approach would uncover the other elements, namely the non-distributive ones, that Daniels ignores. In particular, by asking about the relationship of medicalization to oppression, we again would be pointed to the historical evolution of the medicalization of childbirth to ask how oppression contributed to this evolution. We would especially note three issues: the connection between the need to control nature and its processes and the need to control women's bodies; the connection between views that women are inferior by nature and the theory of disease; and the relationship racism and classism played in both bringing birth into the hospital and eliminating the female midwife attendant from birth.

Given that I discussed this in previous chapters I won't rehearse it here, except to point out that oppression underlay the evolution to medicalization and this should be considered when analyzing the role of oppression in today's practices. To this end, we would also evaluate the relationship between oppression and the maintenance of the medicalized model today by asking questions such as the following. First, what

oppressive ideology continues to underlie childbirth in the United States? Second, we would interrogate the relationship between women's oppression and women's attitudes to request highly technological birth. For example, are women requesting highly technological birth because they believe that their bodies are inferior? Are they doing so because of fears of losing professional and social status? Are they doing so because they believe it is safer? Again, these are questions Daniels' approach ignores because it only focuses on distributive elements. However, these are the questions that we must consider to discover whether oppression is present in our current health care approach to birth.

In summary, when we take a social justice view and examine the processes that lead to the current situation in childbirth we discover various factors not uncovered or considered in Daniels' analysis. First, we would discover other options for birth exist besides the medicalized model, rather than taking for granted the effectiveness of the medicalized model. Second, we would discover that there is not a one size fits all model for birth. Therefore, a just health care system would offer education about various birth options and provide a variety of birth services, such as access to midwives, home birth, different birthing positions in the hospital, and so forth. However, women would *not* be able to choose a medicalized birth, or demand technologies in her birth that have not been medically indicated, given the relationship between this type of birth and oppression outlined previously.[265]

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[265] This is not to say that a woman whose health indicates the need for certain technologies will not have access to those technologies. For example, if a woman has developed pre-eclampsia, then she has physical indications that most would acknowledge require medical treatment and she would have access to that treatment. The key to what I am claiming is two-fold. First, based on the definition of medicalization, we know that other options for birth could not be available for a birth to be medicalized. So, in the cases to which I am referring, the concern is really whether women will still have access to the technologies offered on a medical model of birth, while also having access to other types of births. The answer is not when there are no indications that such technologies are required. This leads to the second point, which is that determining whether a woman receives medical technology in birth or not depends on two factors, whether

Now that we have seen what a social justice framework would uncover and on what it would focus, I am going to describe a socially just birth to illustrate the difference between it and a medicalized birth. Imagine a pregnant woman named Michelle. She has investigated her options into having her care overseen by a midwife, a physician, or both. Michelle realizes that while there is a risk in birth, for most people this risk is slim, including herself. She has received childbirth education classes about numerous ways to give birth, for example: natural childbirth, Lamaze, technological birthing, etc. She has also read many books about a variety of childbirth practices and has been told of the history of childbirth. Michelle has investigated the research on various methods of childbirth, has received pre-natal vitamins free of charge, has exercised, and has eaten a strong diet. She has not been offered ultrasounds or other tests, such as amniocentesis, because there has been no indication that there is a problem with Michelle's pregnancy.

Now, it is time for Michelle to deliver her baby. When Michelle goes into labor, she will have a choice of remaining at home or delivering her child in a birthing center. In either case, she will gather her support network of friends and family around her for the birth, as this not only makes her emotionally more secure, but it also helps labor because it keeps the woman calm. The midwife or doctor will meet Michelle at her house and will sit with her, massage her, give her some pain relief, monitor the child and

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there is another way besides technology to accomplish the same goal and whether the woman actually experiences problems. In the first instance, for example, someone may argue that we must monitor fetal heart rate and thus give access to women for fetal monitors. However, even if we agreed with this controversial claim, midwives can (and do) monitor fetal heart rate with no monitor. So, it is unclear whether women need that technology to achieve that goal. With respect to the second aspect, on a medical model, birth is assumed potentially dangerous and thus any risk is interpreted as an indication for technology. On the social justice model I propose, the symptoms requiring remedy must be documented. When such things are noted, the woman can have access to the technology. However, a woman cannot choose technology or a model of birth that will contribute or reflect oppression on my view.

contractions through a portable devise that allows Michelle to stay mobile, and act as an emotional support system.

If Michelle chooses to go to a birthing center she will not necessarily go immediately, but may choose to wait, eat something at home, walk around, take a bath, etc., since she cannot do this in the hospital but knows that this is often better for her pain control and her emotional state. Then she will go to the birthing center when she feels ready. Upon arrival at the birthing center, all of Michelle's friends would be with her if she chooses. She will not be separated from her partner (unless she wants to be) and she will not change clothes or take an enema. Michelle will have access to pain relief, such as epidurals, if she chooses, but may not demand interventions, such as pitocin, fetal monitors, or a C-section, without medical necessity. Michelle will not have access to elective procedures, such as planned induction or Cesarean section. If Michelle develops complications or if her baby requires assistance, she will have access to medical technology to address these issues (as the birthing center or midwife will be so equipped). However, she will only be given such access if something actually indicates that a problem in fact exists (as opposed to if someone thinks a problem *could* arise but has not) and the interventions to which she has access will be aimed at addressing the problem at hand. If the needed resources are not available at the birthing center, then Michelle may be transferred to a hospital. So, the social justice model would support a very different birth process than a medicalized model supported by Daniels' model; one that is more just.

Objection: Even if a Social Justice Approach is Strong, it is Not the Appropriate Foundation for Health Care Justice

Even if we should use a social justice approach in general, some may object to using it as a foundation for health care justice. One reason for this is that the particular problems of health care justice (the allocation of scarce health care resources) are distributive problems, and thus, the most appropriate model to address them is the distributive paradigm. Below I will show why this objection is unconvincing.

First, the explanation that we should use the distributive model because the problems in health care justice are distributive begs the question. It (wrongly) defines the problems of health care justice as scarce resource issues and then claims that the distributive model is the most appropriate to address those problems. This begs the question of whether this is an accurate characterization of health care justice problems in the first place.

Interestingly, Daniels does not defend using the distributive paradigm. Instead, he admits that he is relying on the "optimistic assumption that we know how to apply general distributive theories to problems in the design of health-care institutions."[266] So, Daniels is not debating whether to use theories of distributive justice, but rather he assumes that we can and should apply such theories to health care discussions.[267] Consequently Daniels assumes, rather than justifies, restricting the scope of justice. This assumption is unwarranted, however, and given the lack of defense for this approach, it does not discredit my position to the contrary.

Many may accept the above but still object to expanding the scope of health care justice because they worry that doing so will no longer give us a theory of *health care*

[266] Norman Daniels, *Just Health Care*, (NY: Cambridge University Press, 1985), 10.
[267] Ibid, 10.

justice, but rather, another theory of justice that treats health care as a good like any other. This cannot be acceptable, though, say my objectors, because a theory of health care justice must highlight why health care is a special good; we must know "what [health care's] functions and effects are and why we might think these make it differ in moral importance from other things which improve our quality of like in various ways," in order to explain why it must be equitably distributed when other social goods need not be.[268]

This requirement that health care be seen as a special good is derived from early debates about whether health care distribution is a matter of beneficence or justice. Libertarians did not see anything special about health care and thus argued that it could be distributed according to market forces. To counter this, health care justice theorists had to first establish that health care was *not* a good like others and therefore, it was inappropriate to leave its distribution of market mechanisms. So, to maintain this idea that health care is a justice concern, theorists want to ensure that any health care justice theory make clear that health care is 'special.'

The second source of this objector's concern that we must retain the uniqueness of health care in a theory of health care justice is rooted in the notion that we need to know the special nature of health care in order to make allocation decisions. For example, if health care is special because it protects fair equality of opportunity, then (according to a Rawlsian model) we must distribute health care in a way that is required to protect opportunity. So, we need to understand why health care is "special" to make allocation decisions and we also need to know which types of health care is in the scope of justice rather than beneficence.

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[268] *Ibid,* 10.

Still, even if a theory of health care justice must show that health care is "special" my proposed view of social justice also highlights the "specialness" of health care in a way that includes Daniels' criteria about opportunity and expands on those criteria.[269] Specifically, health care is special because of its relationship to oppression. To eliminate oppression we must maintain a healthy population. This cannot be done if people are ill or have no access to health care services. First, ill health makes it harder to fight oppression, and second ill health is often a direct consequence of oppression. For example, gender, race, and class all affect health and susceptibility to disease because of deficiencies in health care research, living conditions, occupations, workplace environment, racism, classism, sexism, and homophobia in medicine.[270] More specifically:

> * Latin Americans who are poor generally exhibit a higher risk for unrecognized and untreated hypertension. In addition, Latin Americans are at increased risk for lung cancer and tuberculosis than are whites.[271]
>
> * A 34% differential exists between the percentage of Latin Americans admitted for hospital inpatient care and the percentage for whites; the gap between African Americans and whites is 9%.
>
> * Minorities have difficulty obtaining care because there are few providers and facilities where they live. For example, "throughout the 1980s, hospitals that historically served the African American community either closed, relocated to predominantly white areas than in minority neighborhoods."[272]

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[269] Part of oppression is not having the opportunity to live one's live in accordance with her or his conception of the good as Iris Marion Young points out in *Justice and the Politics of Difference.* This means that the criteria of oppression includes Daniels' criteria and expands it (as opposed to displacing it completely).

[270] See, for example, Erica Goode, "For Good Health, It Helps to Be Rich and Important," *New York Times,* 1 June 1999; Council on Ethical and Judicial Affairs, American Medical Association, *Journal of the American Medical Association*, 266 (1990): 559-562; Council On Scientific Affairs, "Hispanic Health in the United States," *Journal of the American Medical Association*, 265: 2 (Jan. 1991): 248-252.; Greggory Pappas, "Elucidating the Relationships between Race, Socioeconimic Status, and Health," *American Journal of Public Health,* 84: 6 (June 1994) 892-893.

[271] Council On Scientific Affairs, "Hispanic Health in the United States," *Journal of the American Medical Association*, 265: 2 (Jan. 1991): 248-252

[272] Ibid.

* Physicians appear to prescribe significantly fewer treatments for their minority patients than they prescribe for their white patients who have similar or the same condition.[273]

* There are increasing discrepancies in life expectancy between blacks and whites. The life expectancy of African Americans was 70.2 years, 6.6 years shorter than whites.[274]

In all of the above, oppression contributes to the ill health of the social groups in question. In these cases, part of our project of health care justice requires righting the wrongs of oppression.

In addition to these links between oppression and health, oppression makes it difficult for people to remain or become healthy. For example, if exercise is required for being healthy but we live in a society that allows violence against women, then women cannot exercise or have the same opportunity to retain or become healthy as men.[275] So, oppression contributes to ill health by making it more difficult for oppressed groups and their members to become or remain healthy.

Finally, oppression contributes to ill health in the context of the biomedical model, by identifying certain things (such as being a woman or being homosexual) as diseases that are simply deviations from societal norms. Research has historically excluded most women and continues to do so. As a result, the standard remains a 70 kg male body and, as the research protocols suggests, research conducted on young white men is applied to both men and women, as if to suggest that males are the generic

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[273] Sidney Dean Watson, "Minority Access and Health Reform: A Civil Right to Health Care," *Journal of Law, Medicine, and Ethics,* 22, (1990): 127-137.
[274] Greggory Pappas, "Elucidating the Relationships between Race, Socioeconimic Status, and Health," *American Journal of Public Health,* 84: 6 (June 1994): 892-893. Also in American Nurses Association Position Statement on Racism in Health Care.
[275] Laura Purdy, "A Feminist View of Health," *Feminism & Bioethics: Beyond Reproduction*, ed. Susan Wolf, (New York: Oxford University Press, 1996) 175.

humans.[276] "Normal" on this view, then, becomes "male." If normal is being and functioning as a male, then being and functioning as a female is a deviation from "normal." This identifies all females as "abnormal," simply by virtue of their not being male.[277] In cases where women are identified as ill, the women who are labeled ill may feel perfectly fine but are classified as sick because of oppression.

Ill health is then a consequence of oppression, and society is obligated to right that wrong by providing resources to protect health, which will both improve health and reduce oppression. If justice requires that we aim to eliminate oppression, and if doing so means trying to rectify ill health, then justice obligates societies to provide services that can help accomplish this objective. However, the services provided cannot reflect, create, or perpetuate oppression, or we will violate the larger goals of justice. So, the relationship between health and oppression retains the uniqueness of health care that my objector seeks because health care is the kind of good that society must provide out of justice rather than beneficence because of its relationship to oppression.[278]

A third reason some may object to expanding the scope of justice in the way I advocate is that doing so would make it virtually impossible to address health care injustices. Even if racism, sexism, heterosexism, and other forms of oppression exist in health care, they say, they also exist throughout all of society's institutions. Given this, we will never be able to eliminate them from health care. Therefore, identifying these

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[276] Carol Johann Bess, "Gender Bias in Health Care: A Life or Death Issue for Women with Coronary Heart Disease," *Hastings Women's Law Journal*, 6, 41-52.

[277] In addition, this is a category mistake to define women as simply not men. However, this view of biology supports defining women simply by their biology and as simply "not men." While I cannot go into this here, there are many who have proposed constructing the category of women positively, or define women as such as opposed to simply in relation to men. For more on this see Marilyn Frye, "The Necessity of Difference," *Signs*, Winter, 1994.

[278] This is a similar argument to the one Daniels provides for why health care is special. Daniels argues that health care is special because of its relationship to opportunity.

structures of oppression as health care injustices and then addressing those structures as such (rather than addressing the effects of oppression) is impractical and futile. On the other hand, the distributive model allows us to address allocation and access issues in a way that makes the health care system *just enough,* meaning that the effects of these larger societal problems and practices are not felt throughout the health care system. For example, we can distribute health care resources fairly so that even if a person faces racism within the health care system, she will still receive needed medical services. So, the distributive model allows us to do all we are able to do and thus we will receive no practical benefit from changing to a social justice model.

There are a few responses to this concern. First, the objector mistakenly thinks that taking a distributive approach will mitigate the effects of racism, sexism, heterosexism, and other structures of oppression in the health care system (which is why a distributive approach will at least make the health care system just enough). However, these phenomena are so integrated into the system that they and their effects will remain undetected. Since we cannot identify oppression or its problems, on a distributive view alone, we cannot design programs to mitigate the effects of these oppressive structures in health care.

Beyond this, though, it is fallacious to conflate addressing oppression with addressing the effects of oppression. Even if our objector finds a way of identifying and dealing with the effects of oppression, it does not change the fact that we are certainly not addressing the problem of systematic oppression in health care. At best, we are addressing some distributive consequences. However, if our goal is to address *oppression* in health care, this cannot be achieved using only the distributive model for

reasons already stated. So, the health care system will not even be just enough if we do not expand the scope of justice in the way I suggest.

In addition, the objection implies that we should not follow a framework of health care justice that argues that the objective of health care justice is to eliminate oppression in health care because this is impossible. However, even if it were impossible to reach a point where we have a health care system without oppression (a claim with which I disagree), a framework aimed at this goal still holds many advantages. Most clearly, as I have shown above, we will get closer to justice following this path than a distributive path alone because we will identify more issues and facts about our world. So, even if we cannot achieve the ideal in the proposal of social justice I suggest, this does not mean that the theory falls, it just means that we have a lot of work to do. For all of the reasons argued in this work, I suggest that my proposal sets us on a better course to begin that work.

Finally, my objector may maintain that oppression is too abstract a standard for practical use. We use the word 'oppression' in many contexts, often solely for political gain. For example, some members of the religious right argues that they are oppressed because they cannot lead prayer in public school or because they cannot place the Ten Commandments in front of a public courthouse. Many wealthy white men argue that they are oppressed because they cannot cry. Both of these, and many similar claims, are highly suspect. Because of this, oppression is too vague a concept to be useful as a guide for a theory of justice or health care justice, and we should not adopt the approach I am supporting here.

This objection is unconvincing. First, oppression is no more abstract or vague (and I argue, even less abstract) than the concept of opportunity, which the objector defends. The debate about affirmative action is one case that illustrates that there is no agreement on what constitutes fair equality of opportunity. Beyond this, while I outline a framework of oppression to help us guide discussions, there is no such framework in Daniels or Rawls, so the concept of opportunity is even more subject to individual interpretation than is oppression.

While I am not claiming that it will be easy to adopt a health care justice framework with a broad scope (in fact, I am sure it will be difficult to implement), my suggestion is no more or less practical or applicable than others. For example, some argue that Daniels' approach is practical because it connects to a core value in U.S. society, fair equality of opportunity.[279] However, I also contend that a core value is to have a society without oppression. So, Daniels' theory is not more practical than mine because it connects to core values since the view I present accomplished the same task.

Even if I was granted this, my objector may persist by arguing that Daniels' framework is more practical because it offers a way to distribute scarce resources. In response, my theory also offers such a formula. Specifically, we prioritize among resources based on their value for challenging oppression. Since health is often best improved with improved education, work safety standards, or other societal programs and investments, justice will require that we not direct resources to the health care system *per se*, but rather to public health programs, education. In addition, we prioritize between limited health care resources based on the degree to which those resources improve health and fight against/do not perpetuate, create, or reflect oppression. Resources that

[279] Leonard Fleck, personal communication October 2003

will improve health problems and not contribute to or perpetuate oppression, such as antibiotics for stapholocus infections or streptokinase for strokes, will be given the highest priority. Resources that perpetuate or reflect oppression will not be provided in a just health care system. Resources that, if withheld, would perpetuate oppression, may be provided, even if there is little effect on the patient's health, for example providing palliative care to the terminally ill. Resources that are aimed at righting a wrong of oppression and health will be provided. As a result, the claim that we should reject my proposal of justice because the concept of oppression is vague, and thus, impractical, is unconvincing.

Finally, notice that this objection does not suggest that my analysis is incorrect, only that its goals will be difficult to achieve. If nothing is philosophically problematic about my suggestion, philosophers should not be objecting to this account. This being said, in cases of applied philosophy I do think a theoretical framework must be useful and I have now shown why mine is not impractical as the objector claims.

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In summary, I propose that health care justice is the active process of creating of health care system without oppression. A just health care system, policy, or practice as one that does not perpetuate, reflect, or create oppression within, or outside of, the health care system. This framework will avoid the problems Daniels' view encounters, as was illustrated by the fact that it addresses all justice concerns Fran, Karen, Uncle Boy, and Elise's cases raise. Since my aims were to provide a theory of health care justice that

accomplished these objectives and the approach I propose does this, I suggest that we utilize the social justice model of health care justice.

Conclusion: Toward Social Justice Inside and Outside Health Care

I have argued that Daniels' theory of health care justice has serious limitations. It: (1) wrongly limits health care justice to distributive justice, thus ignoring an entire area non-distributive issues, including, but not limited to, institutionalized oppression; (2) misidentifies the aim of health care justice; and (3) has problems evaluating distributive health care justice issues. In addition, using a series of case studies, most notably the case of the medicalization of childbirth, I traced the roots of these limitations to the theoretical foundations of Daniels' view, the distributive paradigm of justice. Since Daniels' problems lay with his foundations, avoiding his difficulties requires creating a different framework of health care justice based on a model of social justice.

'Social justice' is the active process of constructing a world without oppression. By extension, 'health care justice' is the active process of creating of health care system without oppression. The social justice model differs from the distributive justice model in that it: (1) defines justice differently than does the distributive model; (2) asks different questions than the distributive model; (3) identifies the problem of justice differently; (4) encompasses both distributive and non-distributive justice concerns; and (5) focuses on social structures and processes, social groups, and the social order, rather than on the workings of the natural order and end-state distribution patterns. These differences allow the social justice model to avoid the problems Daniels encounters. So, I did not stop at pointing out the faults in our existing health care justice framework, but also presented a way to address those limitations.

I accomplished the above by bringing together various literatures that too rarely meet; the bioethics literature, radical feminist literature, anti-racist literature, and the

claims of larger social justice movements, such as the gay rights movement. In the process of bringing these works together, I have not only uncovered limitations in health care justice and offered a solution to those deficiencies, but I have also shown that these other literatures offer bioethicists important insights because of the connections between health and oppression. For example, the feminist, social justice, and anti-racist literature show that medicine is a social/political institution (connected to other similar institutions). Given this, health care justice discussions cannot proceed without considering the role and affects of these larger social structures on medicine. In addition, the "bottom-up" epistemic approaches used in feminist and anti-racist literature helps identify problems in health care justice that would not be seen using Daniels' theory of just health care. This work, then, assists us in identifying health care justice concerns that have been wrongly ignored up to this point. So, health care justice theorists must engage in the social justice, feminist, anti-racist, and other liberation philosophies to achieve their aims.

Of course, I have neither simply demonstrated how Daniels' framework is flawed or why health care justice must engage more with feminist work, nor have I simply brought the work of these feminists to bear on a very male distributive model that has not yet (at least not within medical ethics) been sufficiently analyzed and criticized from a feminist lens. In addition, my project suggests that feminists must also actively scrutinize and address both health care structures and the male-dominated theoretical foundations of health care justice work. So, I do not simply point~~ing~~ out deficiencies in the health care justice discussion, but I am also calling radical feminists and other social justice activists to engage in health care justice discussions more than they have up to this point.

While feminists have offered strong criticisms of, and alternatives to, liberal frameworks of justice in political philosophy and some of the basic tenets of the field of bioethics, they have heretofore not yet focused sufficient energy exploring how those criticisms relate to the health care justice. However, given the strong connections between oppression, health, and the health care system, this lack of engagement cannot continue. My project provides a framework to pursue these investigations but it is only a beginning since there are so many health care injustices that my model can be used to investigate that have yet to be examined or identified. A few of these areas in serious need of further scrutiny include: medical education, the division of labor and hierarchical structure in the medical profession, the definitions of 'disease' and 'health,' and the treatment of conditions such as infertility, disability, and HIV/AIDS.

The medical education system (both what is taught and how it is taught) is arguably fraught with injustice. This system and its curriculum not only perpetuate certain oppressive (and inaccurate) ideas about different groups, but it is also structured in a way that privileges some groups and not others, both in its requirements and in its ideas about what constitutes valid, authoritative knowledge.[280] Related, as we saw with the case of the medicalization of childbirth, the definitions of 'health' and 'disease' used in the medical system must also be scrutinized, as they too arguably reflect oppressive ideologies.

Apart from the medical education system, the social justice approach to health care justice would scrutinize, rather than presume, the power structure in medicine.

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[280] For example, medical education favors a scientific model, which claims that it is objective and most advanced. At the same time, it labels other forms of healing, such as indigenous healing, herbal healing, etc. as "Quack medicine," "complimentary medicine," or "superstition." Many argue that these distinctions carry very euro-centric as well as racial and gender biases that pervade medicine and must be challenged. We should investigate these concerns.

There is not only a division of power between nurses, physicians, physician assistants, technical assistants, and so forth, but this division often corresponds to gender and class (as nurses and other professional are often women and receive much lower salaries and authority within medicine). Feminists and other social justice activists should investigate this and its connection to other oppressive structures from a health care justice perspective.

Finally, as I did with the case of the medicalization of childbirth, the social justice model provides a foundation for helping us examine and determine whether certain conditions *should be* conceptualized and/or treated medically, and if so, to what extent? Conditions such as infertility, disabilities, and HIV/AIDS are all cases ripe for this type of investigation. Infertility, for example, is not obviously a medical problem and the role of infertility treatment in furthering women's oppression is deeply worrisome.[281] Similar questions about how to fairly conceptualize and address disability must be addressed from the perspective of health care justice. Finally, while there is certainly a medical component to treating HIV/AIDS, HIV/AIDS is also the result of countless social factors, especially relating to women's oppression and homophobia, that are ignored from a strictly medical model. The relationship to these and many other issues to health care justice needs further work and my framework provides a foundation to begin such investigations.[282]

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[281] Susan Sherwin has begun to examine this, along with other authors, but not from the perspective of health care justice in "Feminist Ethics and In Vitro Fertilization," *Canadian Journal of Philosophy*, Supplementary Volume 13 (1987) 276-284.

[282] Again, there is discussion of these other components, but not from a perspective of health care justice. For example, Lesley Doyal discusses these ties in *What Makes Women Sick: Gender and the Political Economy of Health*. Albert Mosley also discussed this in a presentation to the Association of Practical and Professional Ethics in the Spring 2003.

Beyond the work in health care justice, my project also accomplished another task, namely elucidating a key point about the relationship between feminists who primarily work in bioethics and those who do not. While feminist bioethicists see themselves as feminists engaging in an important element of the feminist project, most of these theorists are too often seen strictly as bioethicists by feminists who do not investigate bioethics, as opposed to being seen as feminists in their own right.[283] Consequently, their work is often ignored or seen as less important in feminist circles (just as feminist bioethics is marginalized within mainstream bioethics). My work here shows why we cannot maintain this division within feminism any longer. Health care justice is a radical feminist and anti-racist project just as much as it is a bioethics project because of the relationship between health care and oppression.

I started this project to discover why voices have not yet been heard and in the process I have shown that all of us (bioethicists, feminists, social justice advocates, and patients in the health care system) need to hear each other. While we certainly have a long way to go in constructing a just health care system - a system where people like Karen, Fran, Uncle Boy, and Elise no longer have the claims they do - I have offered a way to begin constructing that system. When feminists and bioethicists engage with each other we can move beyond *Just Health Care* to socially just health care and a socially just world.

[283] For example, while it is very common for feminist bioethicists to attend feminist philosophy conferences, such as meetings for the Society of Women in Philosophy and FEAST, feminists who do not routinely engage in bioethics or attend bioethics conferences, such as the meeting of the Feminist Association of Bioethics.

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