Human Good and the Institutional Distortion of Values in the Field of Medicine: A Lonerganian Approach to Health Care Ethics in the United States

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HUMAN GOOD AND THE INSTITUTIONAL DISTORTION OF VALUES IN THE FIELD OF MEDICINE: A LONERGANIAN APPROACH TO HEALTH CARE ETHICS IN THE UNITED STATES

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ABSTRACT: The field of health care encompasses a myriad of ethical dilemmas surrounding the core conceptions of goodness and values. This thesis discusses the method of intentionality analysis, especially as it is explicated by Bernard Lonergan and his students, to raise awareness of a distortion of values related to health and health care in the United States. Health is a vital value that is meant to be upheld with absolute precedence by health care institutions. Values, of individuals and of institutions, as intentional responses to feelings, must be ordered in a specific way to align with the objective scale of values. Through the orientation toward, then the realization of true values, the good of order operates. Despite that health is the preferred value, health care institutions in the United States do not always operate in accordance with ordered values; there is a distortion of values experienced at the institutional level. In the United States, financial gain and greed compete with the execution and achievement of the true value of health and thus also of the terminal value. This disruption of the good of order contributes to the decline of human good, which may be remedied by conversion.

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ACA	Affordable Care Act
COVID-19	Coronavirus Disease 2019
HIV/AIDS	Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome
OECD	Organization for Economic Cooperation and Development
PPE	Personal Protective Equipment
SNH	Safety-Net Hospital

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INTRODUCTION

This thesis seeks to explore health care ethics in the United States at the institutional level through an analysis of the structure of the Human Good as posited by the Canadian philosopher, theologian, and Jesuit priest Bernard Lonergan, S.J., and his theory of the good of order. This topic will be explicated in two parts. The first part of this thesis is dedicated to methodological clarification and Lonerganian thought. We will explore why the method of intentionality analysis is important to human good and how we can engage in this. Through this method, we will examine feelings as intentional responses to values, the objective scale of values as well as the preferential scale of values, good and the human good, how these all relate through the good of order, how institutions are ordered and disordered, and why this is important to discuss in the context of health care. The second part of this thesis is dedicated to applying the theory reviewed in the first part to case studies specific to health care in the United States. The aim of this is to expose where values might not be realized within health care institutions and thus how the current system may serve to promote decline of human good. Then, we will discuss the potential for society to reverse the decline and begin to progress human good instead through the reordering of operative values, which will be made clear through Lonergan's framework of conversion. In this way, individuals and communities may find a way to obtain a greater awareness of values and how they must be ordered such that we can realize that which is good.

As we find, with Lonergan, the human good is concrete and the relationships between aspects of the human good through the ordering of values and feelings make up the good of

order. Thus, the good of order necessitates both the preference for and the realization of values within institutions. In the United States, the health care system is disordered. This institutional distortion of values becomes immediately evident upon even a cursory examination of the workings of the system, in which profit primarily drives the approach that institutions take toward patient care and the health of individuals as well as of society. This disorder is not inherent to the field of medicine, nor to health care, in which health is meant to be the primary value. So, we must investigate what institutions are involved, where disorder exists within the institutions, why and how it roots itself into the system, and finally, how the system might become ordered.

1.0 METHODOLOGICAL CLARIFICATIONS

To begin, let us establish our method. In the sense that we are using it, method refers to a way of analyzing how meaning and value emerge at all. By "method," we do not mean, then, a specific set of rules or even a determined way of acting, but rather the relation of conscious operations that are necessary to follow rules and to act at all. In short, our method is what may be called an "intentionality analysis" that means to bring to awareness conscious operations. In Edmund Husserl's terms, through intentionality, *noesis* becomes *noema*.[1] This is important for our present purposes because we claim there is a need to methodologically raise awareness in health care in order to lead to better operating institutions and a fuller realization of their values.

1.1 METHOD

The method that we employ in our investigation of health care is an intentionality analysis. By intentionality we mean the fact that consciousness is "of" some object. To make sense of this, we should stress, as Bernard Lonergan does, that consciousness is a presence to oneself, or that "there is an awareness immanent in cognitional acts."[2] It is true that there is an object of each intentional operation, namely, of experiencing, understanding, judging, and

[1] Edmund Husserl, *General Introduction to a Pure Phenomenology*, trans. F. Kersten, Ideas Pertaining to a Pure Phenomenology and to a Phenomenological Philosophy, 1st bk (The Hague ; Boston : Hingham, MA, USA: M. Nijhoff ; Distributors for the U.S. and Canada, Kluwer Boston, 1982), 205–22.
[2] Bernard J. F. Lonergan, *Insight: A Study of Human Understanding*, 1st ed. (New York: Philosophical Library, 1970), 320.

deciding; nevertheless, these are united through the subject's desire to know, which unfolds through these conscious operations.[3] So, through experiencing, and then executing intentional operations, namely, asking the questions to concretize the potential of understanding, judging, and, consequently, making choices which determine actions, one's own conscious presence is raised. However, this is different from objectifying one's self-presence itself. Lonergan's philosophy of self-appropriation, as he calls it, aims to make these operations explicit so that the subject may live according to the desire to know, and as such, live "authentically."[4]

As Lonergan explains, a philosophy of self-appropriation means "taking possession of one's own interiority, becoming aware, identifying and taking responsibility for moral obligation, deliberating, moral value judgments, decisions, and actions,"[5] with the use of case studies to aid in the raising of consciousness. Once again, to have a conscious experience is to exist in a state of awareness, to be self-present, but it is a different thing to objectify the operations of one's awareness. We can reflectively examine the experience in order to understand, judge, then value the experience. This process is called "intentionality analysis," and this is a matter of raising our conscious operations. Engaging in this process of raising awareness leads to a state of self-reflected consciousness in which one is able to pursue self-knowledge.

To further explicate how such reflection occurs, according to Lonergan, it is important to emphasize that our intention for being and the natural spontaneous ideal is pure desire to

[3] Bernard J. F. Lonergan, *Understanding and Being: An Introduction and Companion to Insight: The Halifax Lectures*, ed. Elizabeth A. Morelli and Mark D. Morelli, Toronto Studies in Theology 5 (New York: E. Mellen Press, 1980), 33–35.
[4] Bernard J. F. Lonergan, *Method in Theology*, ed. Frederick E. Crowe and Robert M. Doran, vol. 14, Collected Works of Bernard Lonergan (Toronto: Published by University of Toronto Press for Lonergan Research Institute of Regis College, 1988), 49.
[5] Brian Cronin, *Value Ethics: A Lonergan Perspective*, Guide to Philosophy 13 (Nairobi: Consolata Institute of Philosophy Press, 2006), 33–35.

know.[6] The pursuit of knowledge is an innate tendency. The desire to know is an ideal which becomes explicit through any pursuit of knowledge that is conscious, rational, and deliberate. However, self-appropriation is a matter of turning inward to attend to the interior operations of consciousness and attending to both sense and consciousness. Reflection on what one is doing when one is knowing involves asking questions, gaining insights, creating ideas, and formulating concepts. This act of reflection goes beyond a straightforward operation. It then leads to a sort of deliberate and rational control in knowing, for we grasp the ideal of knowledge: the desire to know. Method, in this sense, results in instances when a person can experience, understand, judge, decide, and act.

It may be said, following the above, that the desire to know is *a priori* and anticipates its fulfillment. As Beards, in his studies of Lonergan, puts it:

> Reality is anticipated by us as that which will be known through intelligence and reason – it is anticipated as the intelligible. The fact that reality is what is to be known through operations of intelligence and reason, that it is, therefore, the intelligible, is a fundamental metaphysical fact established through knowledge of our cognitional operations and our ability to know the real… judgements about reality are those that refer to the data of sense or consciousness as evidence, and that are answers to questions concerning real existence.[7]

Upon this, we may say that, insofar as we meet the interior demands of our conscious operations, there are progressive and cumulative results of knowing.

For example, perhaps someone is given a water bottle without the lid completely screwed on. This individual can understand this through sense experience, as the water splashes out from the top and makes their hand wet and they ask, "Why is my hand wet?" Then, upon noticing the lid unscrewed, the individual can judge that the cap is loose and decide to not

[6] Lonergan, *Insight*, 348.
[7] Andrew Beards, *Method in Metaphysics: Lonergan and the Future of Analytical Philosophy*, Lonergan Studies (Toronto ; Buffalo: University of Toronto Press, 2008), 81.

upturn the bottle. This unfolding of the desire to know is a simple example but suffices to indicate how Lonergan's understanding of method points to a basic fact in human knowing and doing.

Results are not always positive, however; individuals may make false judgments, have misunderstandings, or be inattentive, leading to failure in method. Continuing with the prior example, perhaps the individual is inattentive to the wetness of their hand, does not take note of the top being unscrewed or even incorrectly understands that the top is tight and makes a false judgment that the cap is screwed on enough for water to not leak and upturns the bottle, causing a spill. Still, even this can give data for further experience, understanding, and judgment. After all, the individual must learn from these new experiences; otherwise, the individual simultaneously discredits progress and furthers decline, in the sense that they allow inattentiveness, unintelligibility, and unreasonableness to continue.[8] Thus, through method, we must find decline in order to also promote progress. Indeed, we might say that decline is the failure of method. Decline may be exhibited, for example, if the individual cleans up the spill, refills the water bottle, replaces the lid loosely, then upturns the bottle once again expecting the bottle not to leak.

Progress and decline in the human sphere are complex, of course. There are shorter and longer cycles, and these are situated in various social and cultural conditions. Indeed, in the grander scheme, love supplants decline and, ultimately, God's agapic love offered to humans through grace transforms the longer cycle of decline into something good. We as humans try to participate and cooperate in God's plans and hope for redemption through promoting

[8] Lonergan, *Method in Theology*, 14:53.

progress, which occurs through "self-sacrificing love."[9] The promotion of progress must be identified where it is already at work and also where it might be furthered or introduced. To understand these points further, let us turn to Lonergan's treatment of the meaning of meaning and then of value.

1.2 MEANING

We may determine the meaning of meaning by recourse to Lonergan's treatment of method. This is so because it is also related to consciousness. However, we may first note the conditions in which meaning emerges by referring to the elemental meaning of *we*. The notion of *we* is rooted in intersubjectivity; it is significant because our conscious operations appear in this basic, elemental condition. Lonergan recognizes the importance of human relationships in culture as well as their effects on feelings, values, and decision making:

> Its schemes of recurrence are simple prolongations of prehuman attainment, too obvious to be discussed or criticized, too closely linked with more elementary processes to be sharply distinguished from them. The bond of mother and child, man and wife, father and son, reaches into a past of ancestors to give meaning and cohesion to the clan or tribe or nation. A sense of belonging together provides the dynamic premise for common enterprise, for mutual aid and succor, for the sympathy that augments joys and divides sorrows… Finally, as intersubjective community precedes civilization and underpins it, so also it remains when civilization suffers disintegration and decay.[10]

So, as social beings, humans have an innate tendency to be with, identify with, and empathize with others, both consciously and unconsciously. This deep-seated, instinctive inclination to relate develops the *we*. This affinity is also not limited to intersubjective relationships but can

[9] Bernard J. F. Lonergan, *Philosophical and Theological Papers, 1965-1980*, ed. Robert C. Croken and Robert M. Doran, Collected Works of Bernard Lonergan 17 (Toronto ; Buffalo: Published for Lonergan Research Institute of Regis College, Toronto by University of Toronto Press Inc, 2004), 149.
[10] Lonergan, *Insight*, 237–38.

extend to establishing a global *we*. This means becoming aware of others such that there is a mutual care, a point to which we will return to soon.

Self-appropriation as method provides a basis from which we may find meaning, for our meaning constitution occurs through the dynamic process of knowing. Knowing is dynamic because, as inherently inquisitive, meaning-constituting beings, humans are never satisfied with any given answer. Even as a general answer is discovered, it remains that there is always something more to be learned. There is dynamism through the unfolding of consciousness.

So, our meaning constitution also unfolds through the levels of consciousness. First, we begin with empirical consciousness, which constitutes just perceiving, not intelligent or reflectively aware, and not attending to consciousness. This level gives data for potential meaningfulness. Where it begins to become actually meaningful is intelligent consciousness, in asking questions, such as "What is it?" This is where the data given at the first level gains a formal meaning, in the answer to what something is. Then, there is rational consciousness, which constitutes critical reflection which requires attending to and answering questions such as "Is it so?" Through these actions, we may exercise a fourth level of self-consciousness.[11] Again, this is where there is a full term of meaning, where something is such and so. With these levels of consciousness, it is possible to reduplicate them in self-reflection such that one can mediate the meaningful world with reflection on meaning.

Now, we can have insights into others' consciousness, but we cannot experience the operations of their consciousness. This is an important distinction to make because

[11] Bernard J. F. Lonergan, *Topics in Education: The Cincinnati Lectures of 1959 on the Philosophy of Education*, ed. Robert M. Doran et al., Collected Works of Bernard Lonergan 10 (Toronto Buffalo London: University of Toronto press, 1993), 82.

phenomenology requires insight into consciousness. To gain insight into the operations of consciousness, we must ask ourselves about experiences: "How is it that it happens?" and "How is it that I am knowing?" rather than just "What is it?" (although asking this question is the first step to insight). The heuristic structure in the context of discovering insights requires us to ask a series of questions, which brings us back to the idea of pursuit of knowledge being a dynamic process. Once we ask a question, we must reflect upon the process and the answer to that question to lead us to our next question, and the next, which leads us to insight. To pursue the unknown, we must first ask the explicit question, "What happened?" The consequent process of heading toward an unknown is a heuristic process. Moreover, we can invite others to do so as well, an important point for this thesis, since we seek to invite others into becoming aware of themselves in the setting of health care.

Lonergan uses the example of science and mathematics to explain understanding as a heuristic process.[12] Scientific and mathematical understanding are the possibilities of the pursuit of knowledge realized or put to action. Insights in science are about possibilities, based upon anticipation of intelligibility in acquired data which is finite. Insights in mathematics, however, are based upon necessity; there are certain laws and formulas that hold conceptually for infinite measurements. Furthermore, there is an ideal of knowledge in history. Knowledge is situated in these contexts; for example, there is Aristotle's consideration of ethics and logic, and Isaac Newton as a natural philosopher in his formulation of calculus and the foundations of modern physics, among others, who had excellent and eminent insights. All these refer, however, to the prior ideal, namely, the pure desire to know. The pure desire to know is the ideal, the anticipation, and that which is being realized in the historical ideals. Lonergan uses

[12] Lonergan, *Understanding and Being*, 60–69.

the term "notion" for this anticipation of being.[13] We, in philosophy, seek to make this pure desire to know thematic and methodological, and to extend an invitation to others to do the same.

In sum, then, the dimensions of meaning and method are important for us as we explore human being because self-appropriation makes thematic the immanent and operative norms according to which we live or do not live. An important dimension of human living to which we have not yet attended to is value. To do so, we must further explore what is meant by values, what is meant by the determination of true values, and if there is a scale of values.

1.3 FEELINGS

Let us begin by setting the stage that Lonergan says feelings are intentional responses to values.[14] In other words, feelings are that through which we become aware of the value. Feelings may thus arise before reflection upon the truth of the value, before the question, "Is this a true value?" The question of if it is true brings it to further awareness. Moreover, after careful reflection using Lonergan's heuristic process (with the questions for intelligence, "What is it?" and "Is it?"), feelings may be verified or even changed. This change, ideally, would result in becoming an intentional response that relates to a true value, therefore realizing the true value. The accumulation of all the feelings and values in each moment creates a horizon of feelings.

However, our understanding of feelings must not be limited to a transience, since they can also be states of being and become the "fount of all one's actions."[15] To introduce the most

[13] Lonergan, *Insight*, 348–50.
[14] Lonergan, *Method in Theology*, 14:32.
[15] Lonergan, 14:33.

important example of this, we may attend to loving: it is a deep and permeating force such that a true overflowing love, or what Lonergan sometimes refers to as *agape*, cannot be fleeting but is instead a constant condition underlying other more surface-level feelings. It is possible to be angry at a person but still deeply love that person, for example.

Although our feelings respond to value, we may not act according to the true value, even if we know it should be realized. Indeed, we can choose to act according to self-satisfaction. In other words, there are two possible standards: self-satisfaction and value. In order to consider whether an action is good, then, we must ask whether the standard is self-satisfaction, or the value itself.[16] Good actions are done because of a value and for their own sake. This does not mean that satisfaction cannot result from a good action. The key distinguisher here is that *self*-satisfaction relies on value, not for the value's sake, but instead treats the value as a means to an end; thus, here lies the importance of getting clear on the reason for choosing, or the reason for preferring this or that decision or action.

Lonergan also notes that there are preferences of values. Preference scales the order of values.[17] Before sketching the possible values, let us note that these may be well-ordered or disordered. When values are ordered, the scale of values and preferences of values are aligned; on the other hand, they can be disordered when there are distortions and perversions of feelings as realizing values. Additionally, for preferences of values to be ordered, one's feelings must also align with true values and not self-satisfaction. Fr. William A. Stewart, during a lecture given by Lonergan at St. Mary's University, illustrates this distinction between true values and self-satisfaction through a short story:

> There were these two good Scots in swimming together one day, and each bet the other a penny that he could swim under water the further. Both of them

[16] Lonergan, 14:50.
[17] Lonergan, *Philosophical and Theological Papers, 1965-1980*, 337.

> drowned! I think we laugh because the scale of values is a bit at odds with our own scale of values, or perhaps with your preferential scale of values: we don't equate a penny with a human life. But it's a long process we take, I think, to arrive at that scale of values; and our feelings as responses to values give us a scale of preferences, and the preferences, in turn, give us a scale of values. And this, as I say, to me is a very ongoing and collaborative process.[18]

This point brings us to the concept of *ressentiment*, which Lonergan describes as a *re*-feeling of a disorder of values, and to alienation.[19]

Briefly, alienation is "man's disregard of the transcendental precepts: Be attentive, Be intelligent, Be reasonable, Be responsible."[20] *Ressentiment* occurs when an individual clashes in value with someone superior physically, intellectually, morally, or spiritually; it describes, perhaps, the re-feeling of feelings of inadequacy, failure, or injury, of which the individual cannot let go.[21] This repressed type of animosity which results in acting as if the other person's value is overrated and unimportant can pervade into the individual's entire life. This then can extend further to cause a distortion of values not only in the individual, but in groups, culture, and society, and in fact, across generations; the good of order is disrupted thusly.[22] Lonergan mentions Nietzsche and Scheler's interpretations of *ressentiment* in reference to the degradation of values.[23] Such *ressentiment* can cause alienation from oneself, which can lead to poor decision-making and subsequently to actions that are contrary to values. Lonergan posits that the avoidance or correction of a distortion of values due to *ressentiment* calls for a criticism and education of feelings in which further clarifying questions must be asked.[24] This

[18] Lonergan, 147.
[19] Lonergan, 142.
[20] Lonergan, *Method in Theology*, 14:54.
[21] Patrick H. Byrne, *The Ethics of Discernment: Lonergan's Foundations for Ethics*, Lonergan Studies (Toronto: University of Toronto Press, 2016), 253.
[22] Lonergan, *Philosophical and Theological Papers, 1965-1980*, 142.
[23] Lonergan, *Method in Theology*, 14:34.
[24] Bernard J. F. Lonergan, "1968: Discussion 4," in *Early Works on Theological Method 1*, ed. Robert M. Doran and Robert C. Croken, vol. 22 (University of Toronto Press, 2010), 608.

then would lead to a person who has developed morally and, due to this maturing, is a better judge.[25]

In relation to health care, consider that, in a particular area, there might be a belittling of health in culture, and a belittling of those who are healthy or prioritize health by going to see a doctor. This rejection of health might spread through the social class due to a mindset that because health as a value is unattainable, it is simply intrinsically worthless. This community might also begin to harbor *ressentiment* or animosity toward those for whom health care is attainable and regard health as a value. Thus, health might become a disvalue in this situation. Since intersubjectivity involves feelings as felt, the understanding of the underlying meaning of feelings and the actions as related to feelings instead forms a basis for empathy and compassion between people.[26]

It is imperative to regard the ramification of biases, both subconscious and conscious. Biases may be internalized either directly through teachings or passively through observation. Feelings are based upon beliefs, which are built upon insights. However, these beliefs may be built on true insights or mistaken insights. Lonergan writes:

> A man does not learn without the use of his own senses, his own mind, his own heart, yet not exclusively by these. He learns from others, not solely by repeating the operations they have performed, but for the most part, by taking their word for the results. Through communication and belief there are generated common sense, common knowledge, common science, common values, a common climate of opinion. No doubt, this public fund may suffer from blind spots, oversights, errors, bias.[27]

[25] Bernard J. F. Lonergan, "1968: Discussion 3," in *Early Works on Theological Method 1*, ed. Robert M. Doran and Robert C. Croken, vol. 22 (University of Toronto Press, 2010), 602.
[26] Patrick R. Daly, "Understanding the Dynamics of Health: A Lonergan-Based, Person-Centered Approach" (Chestnut Hill, MA, 2022), 7.
[27] Lonergan, *Method in Theology*, 14:27.

Lonergan acknowledges the influence of other people on our own judgments, beliefs, and feelings, as well as the consequent potential for erroneous judgments, beliefs, and feelings. In his philosophy, we are guided to discover how to become aware of these facts in order to make better decisions and to act more responsibly.

How do we, then, make good, sound judgments of value?

1.4 Scale Of Values

For Lonergan, as we suggested above, there is a *notion* of value. Analogous to the notion of being, this means a conscious anticipation of true values, which comes in an intentional response to the value in the way of feelings. We will also need to determine if those values are true, and if they come to a full term in judgment – is this *truly* valuable, worthwhile, and so on. First, however, let us consider the objective, rather than the subjective, aspect of value.

To reiterate, there are feelings and preferences that may or may not determine the objective value. We will move on now from feelings, which relate values to us, to how values relate to each other. In other words, we will examine the *objective* scale of values, how we can know it, and also how we can decide to act in accordance with it. Lonergan presents a scale of values, of five distinct types, that are in ascending order: vital values, social values, cultural values, personal values, and religious values.[28] Each of these aspects on the preferential scale of values are integral terminal values within the good of order.

Vital values are those that are basic to an individual's well-being: for example, health, strength, grace, and vigor. Social values are held above vital values of individuals in the good

[28] Lonergan, 14:32.

of order. These refer to the vital values of a social group. However, the value of society is to protect the weakest; society can only be as strong as its weakest link, or the most vulnerable individual. Cultural values presuppose both vital and social values but are held above them. Cultural values are important for the preservation of identity within a society and are passed down through symbols, traditions, and education. Personal values are most sacred; they are those of a person in self-transcendence and are fundamental to loving and being loved. They determine the manner and attitude with which a person will live their life. Personal values may also concern religious values, which relate a person's being with the universe, and orient them with God.[29]

The realization that perceived values may not be values at all, or that values are disordered, requires the heightening of awareness. While the notion of value is that which makes feeling possible, in order to make judgments of value, and thus discern true values, one must ask further questions until sufficient evidence is gathered to make the best decision possible after reflection. Still more, all actions, feelings, and values must be rooted in love, which is the highest good. At a larger scale, in order to judge a good of order, we must consider values and ask, "Is the order good?"

To understand this further, let us turn to a discussion of the good and the human good in order to clarify the ends which determine why we must act according to the scale of values.

[29] Lonergan, 14:32–33; Cronin, *Value Ethics*, 143–49.

1.5 Good And The Human Good

In *Method in Theology*, Lonergan begins discussion of "The Human Good" by stating "What is good, always is concrete."[30] This statement means to suggest that we must consider various relations in order to understand the good. For example, as human beings, we realize the order of goods in relation to ourselves and others. Several components enter into the human good: skills, feelings, values, beliefs, cooperation, progress, and decline. Good is achieved when self-transcendence is achieved, and when true being is realized. In fact, we may say that the two are synonymous. This is so insofar as self-transcendence leads to the knowing and realizing of the truly good rather than just self-satisfaction. Only after reaching a sustained self-transcendence can one be a virtuous and "good judge, not on this or that human act, but on the whole range of human goodness."[31]

Human good progresses when people raise their awareness and act in accordance with true values. When people fail in this regard, human good declines:

> …if he fails to will, then the obligatory course of action is not executed; again, if he fails to will, his attention remains on illicit proposals; the incompleteness of their intelligibility and the incoherence of their apparent reasonableness are disregarded; and in this contraction of consciousness, which is the basic sin, there occurs the wrong action, which is more conspicuous but really derivative.[32]

Brian Cronin outlines seven stages of moral decline: 1) faulty deliberation, 2) twisted reasoning, 3) corruption of intellect, 4) deformed feelings, 5) cycle of decline, 6) personal consequences, and 7) social consequences.[33] Similarly to the good of order, human good engages in intersubjectivity (the good of order is an end relating to the human good); the

[30] Lonergan, *Method in Theology*, 14:28.
[31] Lonergan, 14:36.
[32] Lonergan, *Insight*, 666.
[33] Cronin, *Value Ethics*, 373–77.

decline of human good created by an individual affects the human good as a whole as decline can become rooted in a society when bad habits, or bad states of character, are formed. Additionally, once the cycle of decline begins, it becomes increasingly difficult to halt or reverse the damage of the non-value of evil.[34]

Likewise, the scale of values is interconnected. Values cannot be disrupted in isolation without the occurrence of a causal sequence of decline:

> Not only does [decline] compromise and distort progress. Not only do inattention, obtuseness, unreasonableness, irresponsibility produce objectively absurd situations. Not only do ideologies corrupt minds. But compromise and distortion discredit progress. Objectively absurd situations do not yield to treatment. Corrupt minds have a flair for picking the mistaken solution and insisting that it alone is intelligent, reasonable, good. Imperceptibly the corruption spreads… [to] the reigning philosophies. A civilization in decline digs its own grave with a relentless consistency. It cannot be argued out of its self-destructive ways, for argument has a theoretical major premise, theoretical premises are asked to conform to matters of fact, and the facts in the situation produced by decline more and more are the absurdities that proceed from inattention, oversight, unreasonableness, and irresponsibility.[35]

Thus, to illuminate this by setting it in relation to health care, which at its most basic level tends to vital values but still is composed of cooperating groups, we must examine how the distortion of values within institutions causes decline, and how this decline might be halted or reversed. Hence, it becomes exceedingly important for us to first deliberate in the right way and then act accordingly in the right ways which tend toward final ends, which are of the good.

In order to understand what is good, we must examine the value and ask good questions. Asking and answering questions reveals to us how meaning and feeling relate. Our feelings must be in order so that our values are realized in the right ways. Good is qualitative, rather than quantitative. The processes required, namely the asking of further pertinent questions and

[34] Cronin, 377.
[35] Lonergan, *Method in Theology*, 14:53–54.

broadening of horizons in order to reach a self-transcending state, are intentional and discerning.[36] Lonergan calls this the notion of the good.

Lonergan also makes evident that good as an object and the good as a developing subject are distinct. Thus, the end goal of something which is good, the good which is sought, is not the only thing which is good, "but also the seeking, the capacity to seek, the skills that go into the process of fulfillment, and the fulfillment itself are good."[37] This implies also that the good is attainable in both thoughts and actions, consciously and unconsciously; that is, the good is inclusive of the goodness of the subject and of the object, leading back to the idea of the good as concrete.

Let us go further by determining how the structure of the human good can be divided into three aspects, namely, that of the particular good, the good of order, and value.

1.6 The Good Of Order

Lonergan states that "the human good is at once individual and social."[38] Thus, our good of order impacts the order of all other things because we act according to the way we order our values. This simultaneous nature of human good is imperative to understanding the way intersubjectivity permeates the human experience. First, let us discuss the structure of the human good, in general:

[36] Byrne, *The Ethics of Discernment*, 385.
[37] Lonergan, *Topics in Education*, 28.
[38] Lonergan, *Method in Theology*, 14:47.

Individual		*Social*	*Ends*
Potentiality	*Actuation*		
capacity, need	operation	cooperation	particular good
plasticity, perfectibility	development, skill	institution, role, task	good of order
liberty	orientation, conversion	personal relations	terminal value

Figure 1. The Structure of the Human Good.[39]

The human good considers two main groups, individual and social, which each lead to ends when values are ordered. The particular good, what is often referred to as *id quod omnia appetunt*, what everything seeks,[40] leads to the emergence of a good of order. Once this good of order is reflected on, there lies the notion of value in the wondering of whether or not the good of order is worthwhile.[41]

Human good as individual considers both human potential and actual actions. These take into account such things as skills, meaning, and value. Potentiality, which encompasses capacity and need, plasticity and perfectibility, and liberty, resides within the notions of being and value but is not equal to either.

Potentiality is related to actuation. For example, plasticity and perfectibility, when actuated, can lead to orientation and conversion, or the ordering of values. Orientation and conversion refer to the choosing of a true value. If the value is not true, there is considered to be a failure of ordering values stemming from a lack of self-transcendence. Liberty, or free will, refers to the potential to recognize values. The actuation of liberty might lead to

[39] Lonergan, 14:47.
[40] Lonergan, 14:33.
[41] Lonergan, *Topics in Education*, 40.

development or skill. Similarly, the actuation of operation and the development of skills leads to capacity and plasticity, respectively.[42] In this way, potentiality and actuation are integrally intertwined. The operations of individuals combine to realize instances of the particular good,[43] and this allows individuals to collectively contribute to groups by performing tasks and fulfilling roles within institutions.

Human good as social considers cooperating groups – cooperation, institution, role, task, and personal relations. Groups are collections of individuals that all have the capacity for individual potentiality and actuation. Individual skills, capacities, operations, and orientations in relation to each other form the basis of institutions, which are related to various social and cultural values, including that of health. Before turning to the institution directly, let us consider the good of order, toward which it operates.

The culmination of individual potentiality turning to actuation and the social aspect of human good leads to ends: "Individuals do not just operate to meet their needs but cooperate to meet one another's needs."[44] The actuation of ordered values and the collaboration of individuals to form cooperating groups leads to particular good, good of order, and terminal value. In other words, when the good of order operates functionally, which only occurs when people cooperate, there is a tendency toward a terminal value.[45] This terminal value, which according to Lonergan is that of the divine, can take the shape of God, love, full knowledge, and perfection. Ultimately, to achieve the terminal value is to be loved and be loving in return, and in all aspects of life to be guided by love as a value.[46]

[42] Lonergan, *Philosophical and Theological Papers, 1965-1980*, 148.
[43] Lonergan, *Method in Theology*, 14:48.
[44] Lonergan, 14:51.
[45] Lonergan, 14:50.
[46] Lonergan, 14:40.

In sum, the good of order is dependent on the recurrence of particular goods, without which there would be an absence of a good of order. Similarly, there is always a good of order underlying a regular occurrence of particular goods, and this recurrence occurs through coordinated human operations. Effective coordinated human operations normally result from the development of habits (cognitional, volitional, and skills) and from institutions, which are "like habits, but in the objective order" and exist as mechanisms to make decisions, material equipment, and personal status which arises from the structures of interpersonal relations.[47] Additionally, congruent with the human good, and within the human good, the good of order can also progress and decline.

In a way, the above gives a sketch of the good of order. That is to say, all the terms and relations above give us the terms and relations of the good of order. However, we must determine whether the good of order is potential or actual, or in other words, whether the values are truly being realized or not within the good of order, and in the cooperating groups within the good of order.

1.7 Ordered And Disordered Institutions

In *Topics in Education*, Lonergan defines an institution to be "a mechanism set up for making decisions… objective conditions that result from human apprehensions and choices and facilitate the flow of cooperating operations."[48] More simply, Lonergan notes that institutions result from an "already understood and accepted way of cooperating… [which] can be improved only slowly… [and] can be ruined in a very short time."[49] The role of an institution

[47] Lonergan, *Topics in Education*, 35.
[48] Lonergan, 35–36.
[49] Lonergan, *Philosophical and Theological Papers, 1965-1980*, 148.

directly relates to the good of order, reemphasizing the role of interconnectivity. An institution is composed of cooperating groups, each of which has a distinct role to play within the institution and, thus, also in the good of order, which is concrete.

The goal of an institution is to keep the good of order of the institution and of society. A well-ordered institution demands mastery of all working parts. In other words, an institution and the functioning of an institution are separate things.[50] An ordered institution makes good judgments of fact and good judgments of value, and hence realizes the good of order. It avoids allowing bias to get in the way of its doings.

Thus, a disordered institution could signify the disruption of the good of order on several levels: institutionally, culturally, socially, and individually. Discernment must be employed in order to understand what is going wrong and why, and then understand how to reorder values such that they become ordered.

Institutional problems in health care, and in general, are not confined to the United States; such distortions in value permeate globally, although further research for this topic must be done which exceeds this present work.

1.8 Relation To Health And Health Care

A comprehensive definition of the term "health" continues to be a point of contention by organizations and medical professionals alike. The World Health Organization defines health to be "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[51] The WHO's definition of health is a great starting point for

[50] Lonergan, 148.
[51] World Health Organization, "Constitution of the World Health Organization" (World Health Organization, 1946), 1.

defining this difficult concept, as it takes into account that health is more than just not being sick, but actually being well.

However, health and being healthy can be subjective matters based upon the individual. A twenty-year-old and an eighty-year-old will inherently have different definitions of health. If a twenty-year-old performed at a baseline level the functions of an eighty-year-old, we might call this "adult failure to thrive." This is because we need to take into account the natural process of aging.[52] However, health is not only individual.

Health is also societal, in that societies have different levels of individual health, and an individual's health is affected by the society, its societal structure, and its institutions. It is, however, notable to say that when we discuss health as a whole, such as the health of a society, it is unrealistic to expect zero incidences of disease. A society might be considered unhealthy if there was greater incidence of disease than expected, but not necessarily if disease exists at all.

Two culprits that act as a detriment to the state of health in the United States are access to health care systems and effects of social inequality. Social determinants of health are social and physical conditions into which individuals are born and come to develop across the life course that shapes their health. These determinants are tied to economic stability, neighborhood and physical environment, education, food, community and social context, and the health care system.[53]

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[52] Jackie Leach Scully, "What Is a Disease?: Disease, Disability and Their Definitions," *EMBO Reports* 5, no. 7 (July 2004): 650–53, https://doi.org/10.1038/sj.embor.7400195.

[53] Office of Disease Prevention and Health Promotion U.S. Department of Health and Human Services, "Social Determinants of Health - Healthy People 2030 | Health.Gov," Healthy People 2030, accessed April 13, 2023, https://health.gov/healthypeople/priority-areas/social-determinants-health.

Determinants of health tied to economic stability include employment, income, expenses, debt, medical bills, and availability of support. Determinants of health tied to the neighborhood and physical environment include housing, transportation, safety, parks, playgrounds, walkability, and geography. Determinants of health tied to education include literacy, language, early childhood education, vocational training, and higher education. Determinants of health tied to food include hunger and access to healthy options. Determinants of health tied to community and social context include social integration, support systems, community engagement, discrimination, and stress. Lastly, determinants of health tied to the health care system include health coverage, provider availability, provider linguistic and cultural competency, and quality of care. These conditions are tied to the relative social position of individuals which then accordingly derive the quality of health within societies. According to a schematic by the University of Cambridge which represents patterns of health and disease across societies, called the health gradient, as social status increases, so too does health state:

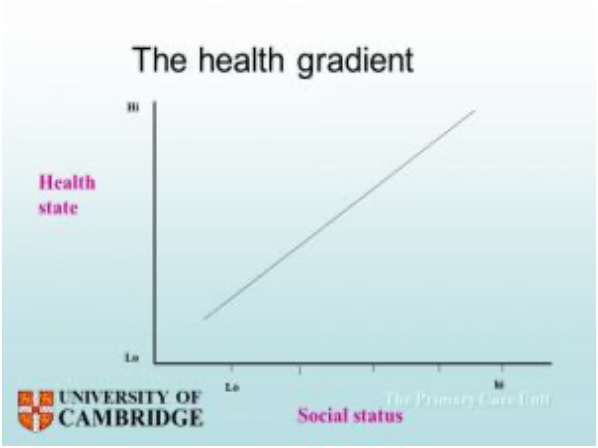

Figure 2. The Health Gradient.[54]

[54] Michael P. Kelly et al., "The Dynamics of Health Inequalities," *University of Cambridge: Department of Public Health and Primary Care: Primary Care Unit: News* (blog), June 26, 2017, https://www.phpc.cam.ac.uk/pcu/dynamics-health-inequalities/.

Dr. Patrick Daly, a Lonergan scholar at Boston College and a former physician who practiced internal and palliative medicine for thirty-five years, adopts a Lonerganian approach to the philosophy of health. This thesis will use Daly's heuristic meanings to discuss health and health care.

Daly posits that health is "intimately related to the notion of the good."[55] As such, fundamentally, we must pay attention to the *feeling* of being healthy. He notes that the feelings of being well or ill are instrumental to determining the adequacy of health care.[56] These concrete and meaningful feelings as felt possess elemental meaning which allows an individual to interpret data of consciousness to process an experience.[57]

He explains health as experienced as a self-correcting cycle of learning, dealing with inquiry, insight, action, and patterning of experience:

> In terms of Lonergan's theory, the notion of health relates to inquiry at each cognitional level. Our *experience* of illness gives rise to questions about health. At the level of *understanding*, insights that answer these questions set the stage for conceptual formulation of health in terms of normalcy for common sense and of probability (ideal frequencies) for theory. Understanding our experience of health as meaningful underpins *judgments* of value that direct our actions in order to stay well or get better.[58]

So, in this way, we may reiterate that insight relates to understanding feelings. If feelings are not aligned with true values, they can be corrected by learning through the asking of further questions. So, the interpretation of feelings and of experiences determine whether a person might be in a state of wellness or illness; for example, the experience of pain, while unpleasant,

[55] Patrick R. Daly, "A Theory of Health Science and the Healing Arts Based on the Philosophy of Bernard Lonergan," *Theoretical Medicine and Bioethics* 30, no. 2 (March 13, 2009): 151, https://doi.org/10.1007/s11017-009-9101-9.
[56] Daly, "Understanding Health," 3.
[57] Daly, 6.
[58] Daly, "Theory of Health Science and Healing Arts," 152.

suggests different states as determined by its source, whether it be from sore muscles or a body ache caused by disease.[59]

Health concerns both acute and chronic conditions. Acute conditions may onset suddenly and are shorter-term in nature. After treatment, the issue is resolved. Chronic conditions require more extensive care due to the long-term manifestations of illness. Chronic conditions may also be the cause of acute conditions. Examples of acute conditions include broken bones, the flu, and strep throat. Examples of chronic conditions include osteoporosis, arthritis, and diabetes.

The most straightforward definition of health care assumes the tendency to a vital value, which is health – the restoration and the maintenance of proper functioning of the body. Health as a vital value strictly refers to the function and dysfunction of corporal systems; the limited physical processes relating to birth, life, aging, and death. However, health can also be a social, cultural, personal, and religious value. Health is what we tend toward, what is valued and central to the human condition. When there is alienation from this value, vital or otherwise, in the institution or in the society, this is where we see disorder. We will further explicate this disruption of the good of order in the coming sections.

Health as a personal and religious value may be understood as rooted in the Ignatian principle of *cura personalis*, or "care for the whole person." This Jesuit ideal emphasizes the need for service within our daily interactions; in medicine, this means raising our awareness to recognize the needs of others, being cognizant of class, cultural, racial, and other sociological disparities, and responding in turn. Ignatian spirituality also affirms the importance of service as a way to deepen our relationship with God and as an expression of unhindered, authentic

[59] Daly, "Understanding Health," 4.

love. In relation to health, then, it makes sense that we need to be healthy ourselves so that we can then serve others.

So, in a Lonerganian sense, what is health? Daly explicates the nuances between health and well-being:

> Being healthy is obviously a state of well-being, but well-being is the broader term. It encompasses the well-ordered unfolding of creative schemes of doing and making as well as the well-ordered unfolding of homeostatic schemes of health and healing. This is not a strict dichotomy; creative and homeostatic schemes can certainly overlap in adapting to new situations.[60]

Furthermore, it is important to differentiate disease and illness:

> Disease involves the disruption of normal schemes of recurrence of a healthy organism, which impairs the ability of the organism to thrive… Illness is the experience of disease by an affected individual, known by common sense, and judged to be a matter of fact. The observer knows another's illness in the mode of subject-as-object; the affected individual knows illness introspectively in the same mode, subject-as-object, but in addition consciously experiences illness in the mode, subject-as-subject. In contrast to illness, disease is known in the mode of subject-to-object by observer and the affected individual alike.[61]

Another caveat to add to this heuristic definition of terms is that there is no objective rule to follow in labeling a condition or set of symptoms as disease. For example, if an individual reports the presence of a headache, the individual's experience of the headache makes evident that they are not in a state of full well-being. If the individual describes the headache as, say, a moderate, steady, dull pain in the head, a physician might offer the diagnosis of a tension headache. However, despite labeling the condition causing the patient's short-term impairment and regarding it as subject-to-object, it would be amiss to allege that the headache comprises a disease. Notwithstanding, another patient could report the same symptoms as the former but subsequently be diagnosed with hypertension with secondary headaches, which would

[60] Daly, 8.
[61] Daly, "Theory of Health Science and Healing Arts," 152.

reasonably be called disease. This distinction is made despite that both patients are ill as they know their experience primarily in the mode of subject-as-subject. Another patient might be asymptomatic and yet have early cancer, therefore having a disease despite yet having any knowledge of its presence. A clear distinction between what is disease and what is not disease cannot be made, such that no two experiences are exactly alike, and that subjectivity of experience must be accounted for. So, health cannot simply be reduced to being the opposite of or absence of symptomatology. Health must also actively comprise the state of wellness, physiologically and psychologically.

Health care, aptly called, as it regards health and care, is the institution relating to the maintenance of the value of health. Now that we have discussed what health involves, we must do the same for care. Care is the practice of tending to the vital value of health. Care is composed of the intentional actions we take in order to both become healthy and remain healthy. In health care, society and culture serve a vital value, but they also serve the individual. This is because values are incarnate in persons.

Though health care tends to vital values, it regards the maintenance of health in general. Thus, the goal of a health care institution should not only be to treat the patient who is ill or injured, but also to keep patients out of the hospital long-term. Ideally, patients should be healthy and more often present to the hospital for regular checkups rather than for illness. This raises the distinction between preventative and responsive health care.

Preventative health care occurs when all levels of a patient's health and health care plan are aligned with the goal of maintaining health and preventing injury, illness, and disease. When preventative health care is realized, patients are routinely advised on lifestyle changes to better their overall health, vaccinated to prevent illness, and screened for conditions that

they may be predisposed to. On the other hand, responsive health care occurs when the patient is treated upon the occurrence of injuries and manifestations of acute or chronic illness or disease. There is less or no emphasis on preventing sickness from reoccurring or emerging in the future. Patients are solely treated for the conditions and symptoms for which they presented to obtain care for, rather than receiving holistic and systemic care.

It is important to distinguish that the term “institution” is not, and should not be, synonymous with “business.” Health care as a business is likely to be disordered as the preferred value of a business is not health, but likely financial gain. Thus, the values of a health care institution are not realized, which contributes to the decline of the good of order and the decline of human good in general. This position, too, will be discussed in the coming sections.

2.0 Applications Of Lonergan's Thought To Health Care Ethics

A health care system is a matter of the good of order. It does not concern the health of one individual, but rather the flow of health care and the direction of the flow of health care.[62] It is crucial to raise our awareness here. In the 'becoming aware,' we come to know the values of the system: firstly, how we need to become aware of the values, then where they are realized, valued, aimed at, and where they are not. Lonergan can help us to become aware of how to do so, and this analysis will help us to not only be attentive to becoming aware of the feeling of health as a value, but also how it fits with operating according to values. Such, we must investigate the institutions within health care and the institutions in which health care exists to determine why there might be an absence of the good of order, or where the system has gone awry.

My claim is that the core value of any health care related institution should be health. The problem we face with health care today is a focus on short-term health rather than long-term health. It is inevitable that individuals become acutely sick or injured at some point in time; the human condition dictates that we are subject to the common cold, ankle sprains, and stomach aches – to a plethora of illnesses and injuries that might debilitate our normal daily functioning.

The actions of an ordered institution must align with what is truly good, else the institution is disordered. Those in the field of health care and medicine must be called to a

[62] Lonergan, *Topics in Education*, 34.

higher value. Often, to perform in this capacity, the sacrifice of lower, vital values must be made for the benefit of the higher value. This higher value might be social, cultural, or religious. Health care professionals must ask themselves for what reason they work in the field and assess whether it is for the best value.

As we noted above, human actions arise from deliberation imbued with feelings. So, in somewhat of an Aristotelian fashion, in order to truly have value be the final cause, individuals must be able to distinguish between true goods and apparent goods.[63] The moving cause of correct actions associated with both values and ends must be choice, which follows good deliberation. This is in order to aim toward a final end in which values are aligned with the good of order.

Also, order has to do with sets of relations. In relation to health care, there is a flow to this regarding particular ends and goods of particular activities, and especially regarding the different parts of an institution. As this thesis focuses on the distortion of values in health care on the institutional level, we will narrow our focus to those. We will discuss especially about how a *means* to the value of health, namely, money, disrupts the realization of the value when it becomes the *end* rather than the value.

This also raises some questions that must be asked in each situation: how much are health care professionals responsible for the disorder of institutions? As those who are employed and dependent on these institutions to make a living, can individual health care providers realistically affect the way an institution is run and subsequently how the values of the institution are ordered? Can they provide insight into what is wrong with the institution? Is this a systemic, group, or individual issue?

[63] Beards, *Method in Metaphysics*, 307.

In order to have mastery, there must be a balance of humility and confidence among those who work in a well-ordered institution. Health care professionals require the humility necessary to avoid pretending mastery: the willingness to say, "I don't know" and then ask further questions to someone else who has mastery of the prior referenced subject. To that end, skills must be trained before application.

2.1 Health In The United States And Parameters Of The Health Care System

A global pandemic such as COVID-19 vividly illustrates how interconnected the world has become. The COVID-19 pandemic disrupted the flow of goods in a novel way. Work acts as a ripple effect: the products of one individual's labor can directly affect the ability of others to do their work, as exemplified by the pandemic's effect on the production of goods. Many industries experienced a shortage of goods as workers were sent home or laid off as a result of public health recommendations. We saw this happen with car chips, raw materials, and, notably, health care supplies and PPE because the supply chain was disrupted. The shortages not only disrupted the way our institutions operated but caused prices to skyrocket. Capitalism optimizes the flow of goods and money; this is not inherently bad. Supply and demand functions well when it is contextualized in a more even distribution of wealth, or at least a better circulation of wealth. When there is a markedly disproportionate distribution of wealth, we see a disruption in the good of order. Such, health care institutions are not solely responsible for the disorder within its good of order. Due to this interrelatedness and cooperation, the disorder of associated institutions on a national or even global scale can also contribute to the disruption of the good of order of health care in the United States.

A pertinent example of the institutional distortion of values in health care due to an inadequacy of a means, that is to say, money, is the operation of safety-net hospitals. The greater purpose of SNHs is the realization of equity within health care. SNHs cater to the most vulnerable in society and are often located in or near poor and underserved communities. As such, SNHs serve a larger volume of patients, often of ethnic or racial minorities, than private hospitals. SNHs rely on supplemental government funding and Medicaid reimbursements for the means to provide high quality care to these populations; however, budget cuts and insubstantial payment for treatments create challenges for these hospitals to remain operational and accessible.[64]

Even private hospitals face financial pressures which interfere with their ability to provide care. Tufts Medical Center, an academic medical center that has been recognized for its commitment to exceptional patient care and research,[65] opened a full-service pediatric hospital by the name of Tufts Children's Hospital, formerly the Floating Hospital for Children, in 1965. However, the forty-one-bed inpatient pediatric center was closed in 2022, only keeping certain outpatient pediatric services and the neonatal intensive care unit. The hospital cited an increased demand for inpatient adult beds as the reason for its closure,[66] despite the protests of patients' families and a petition to save the hospital which gained over 70,800

[64] Jennifer L. Hefner et al., "Defining Safety Net Hospitals in the Health Services Research Literature: A Systematic Review and Critical Appraisal," *BMC Health Services Research* 21, no. 1 (December 2021): 278, https://doi.org/10.1186/s12913-021-06292-9.
[65] Tufts Medical Center, "Top Boston Hospital Awards and Recognitions," Tufts Medicine: Tufts Medical Center, 2023, https://www.tuftsmedicalcenter.org/about-us/recent-awards-and-recognitions.
[66] Erin Lynn Mooz, "End of an Era: The Closing of Tufts Children's Hospital, Putting Inpatient Pediatric Care in Context | Tufts CHSP," *Tufts University School of Medicine: Center for Health Systems and Policy* (blog), April 8, 2022, https://sites.tufts.edu/chsp/2022/04/08/end-of-an-era-the-closing-of-tufts-childrens-hospital-putting-inpatient-pediatric-care-in-context/.

signatures.[67] As adult care has long been more profitable for hospitals than pediatric care,[68] Tufts Children's Hospital follows a larger national trend of pediatric inpatient unit closures.[69] Pediatric inpatient units decreased by 19.1 percent between 2008 and 2018,[70] and this decline was further accelerated by the surge of adult intensive care unit beds necessitated by the disproportionate effect on the geriatric population of the COVID-19 virus, from which children were largely spared from. This results in a difficult situation for pediatric patients and families who are seeking care, and again, disproportionately affects poorer populations. Following the closure of Tufts Children's Hospital, inpatient care was transferred over to Boston Children's Hospital, which, while a large, prominent, and high-quality pediatric center, is also the most expensive pediatric hospital in the state.[71] This results in fewer choices and higher out-of-pocket costs for families,[72] again demonstrating a disordered scale of values in which the commodification of health care causes an alienation from personal values.

It is important to note that health is regarded differently depending on the region. Without careful examination of its parts, it is not sufficient to wholly generalize health within the United States, which has an ever-growing population of greater than 334.6 million people,

[67] Concerned Parent, "Save Tufts Children's Hospital in Boston!," Change.org, 2022, https://www.change.org/p/save-tufts-children-s-hospital-in-boston.
[68] HCUPnet, "Healthcare Cost and Utilization Project | Inpatient Stays, National: Average Hospital Costs per Stay (in $) by Patient Age Group, United States, 2000 to 2020," Agency for Healthcare Research and Quality, 2023, https://datatools.ahrq.gov/hcupnet.
[69] Eli Cahan, "How Profit-Driven Hospital Closures Screwed Kids During the Tripledemic," *The New Republic*, January 17, 2023, https://newrepublic.com/article/170030/hospital-closures-kids-tripledemic.
[70] Anna M. Cushing et al., "Availability of Pediatric Inpatient Services in the United States," *Pediatrics* 148, no. 1 (July 2021): e2020041723, https://doi.org/10.1542/peds.2020-041723.
[71] Jessica Bartlett, "Tufts' Plans for Patients, Doctors Following Announced Closure of Its Children's Hospital Are Met with Mixed Feelings," Boston Globe, May 8, 2022, https://www.bostonglobe.com/2022/05/08/metro/tufts-details-plans-patients-doctors-following-announced-closure-its-childrens-hospital/.
[72] Priyanka Dayal McCluskey, "Pediatric Medical Care in Boston Is Consolidating as Boston Children's Expands and Tufts Shrinks," June 21, 2022, https://www.wbur.org/news/2022/06/21/children-medical-care-boston-childrens-tufts-hospital.

according to the United States Census Bureau.[73] While it is outside the scope of this paper to consider the bearing of health as a value in the different regions of the United States, the institutions serving diverse Americans of varying socioeconomic classes will be thoroughly investigated in order to determine whether health is regarded as a value in the United States as a whole.

The American health care system is extremely variable. Most developed countries have universal health coverage, national public care programs motivated by the goal of providing affordable health services to all citizens.[74] Unlike countries that employ universal health care and socialized medicine, the United States employs a mixture of health care programs, ranging from single-payer coverage, and private coverage, to no health care coverage at all. In 2020, 31.6 million Americans, or 9.7 percent of the United States population, were uninsured.[75]

For the prevention of illness to be a value, the entire scale of values must be ordered. The global *we* in relation to health and health care is really an intersubjective experience of vulnerability.[76] When health fails, we are inherently vulnerable to disease, illness, and sometimes even death. This confrontation with our human finitude is a deeply unsettling and frightening experience. Thus, empathy and compassion for others who are ill naturally breed from our own experience and knowledge of illness, creating the *we*.

[73] United States Census Bureau, "U.S. and World Population Clock," United States Census Bureau, April 13, 2023, https://www.census.gov/popclock/.
[74] New York State Department of Health, "Foreign Countries with Universal Health Care," New York State Department of Health, June 2022, https://www.health.ny.gov/regulations/hcra/univ_hlth_care.htm.
[75] Amy E. Cha and Cohen, Robin A., "Demographic Variation in Health Insurance Coverage: United States, 2020," National Health Statistics Reports (National Center for Health Statistics (U.S.), February 11, 2022), https://doi.org/10.15620/cdc:113097.
[76] Daly, "Understanding Health," 7.

2.2 Exploring The Values Of The United States Health Care System As An Institution

Once again, there is a distinction between operative values and the objective scale of values. Operative values are those which we use to guide the way we live our lives. These must be ordered so as to align with the objective scale of values. The objective scale of values is hierarchical and does not change. This and the next section investigate the order of values that is at work as they relate to the United States health care system and how they relate to the objective scale of values. We must examine where the values are realized and where they are not realized, and how these human good and the good of order progresses and declines accordingly.

The Organization for Economic Cooperation and Development, which the United States is a part of along with thirty-six other countries with market-based economies, collects data with the intent of promoting the world economy. The United States spends almost twice the OECD average per capita on drugs and non-durable medical care.[77] This demonstrates that the United States has a greater priority for producing new technology and drugs than actually implementing them within the health care system. Neither disease prevention nor health optimization are prioritized over financial gain, indicating a distortion in the scale of values. Furthermore, according to the World Health Statistics 2013 report generated by the WHO, an average hospital stay costs almost three times more in the United States, at $18,000, as compared to the OECD average of $6,200.[78] Similarly, the comparative costs of both medical

[77] Organisation for Economic Co-operation and Development, "Health Expenditure and Financing, Share of Gross Domestic Product: 2010-2021" (OECD.Stat, April 15, 2023), https://stats.oecd.org/Index.aspx?DataSetCode=SHA.

[78] James Hamblin, "How Is U.S. Health Care Bad? [Chart]: An Illustration of World Health Organization Data on How the United States Compares to 16 Other Countries," *The Atlantic*, September 4, 2013, https://www.theatlantic.com/health/archive/2013/09/how-is-us-health-care-bad-chart/279334/; World Health

and surgical procedures in the United States are eighty-five percent higher than that of the average in other OECD nations.[79]

We must consider proportionality when discussing matters of cost: does a higher quality of care justify a higher cost, and to what extent? However, this question is still not applicable to American health care in light of the truth: health care costs are disproportional in the extreme since the corresponding quality of care, measured by affordability, administrative efficiency, equity, and outcomes, received by patients is lesser than that of other countries with lower costs.[80] This fact is made abundantly clear with a figure by the OECD comparing life expectancy in years with health spending per capita:

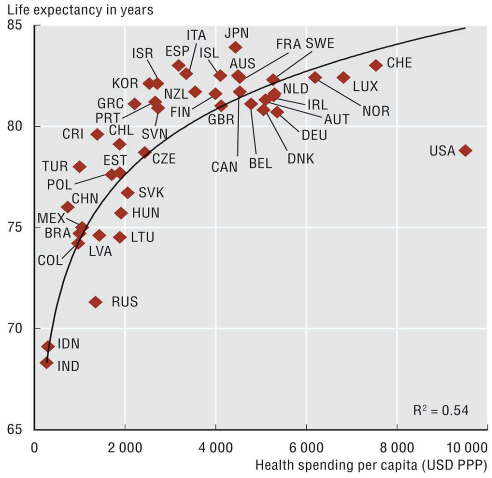

Figure 3. Life expectancy at birth and health spending per capita, 2015 (or nearest year), based off of OECD data[81]

Organization, *World Health Statistics 2013*, *Statistiques Sanitaires Mondiales 2013* (Geneva: World Health Organization, 2013), https://apps.who.int/iris/handle/10665/81965.

[79] Jason Kane, "Health Costs: How the U.S. Compares With Other Countries," *PBS NewsHour*, October 22, 2012, sec. Health, https://www.pbs.org/newshour/health/health-costs-how-the-us-compares-with-other-countries.

[80] Eric C. Schneider et al., "Mirror, Mirror 2021: Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries," Improving Health Care Quality (The Commonwealth Fund, August 4, 2021), https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly#:~:text=The%20U.S.%20ranks%20last%20overall,age%2060%20(23.1%20years).

[81] OECD Health Statistics, "Life Expectancy at Birth and Health Spending per Capita, 2015 (or Nearest Year)" (OECD iLibrary, 2017), https://www.oecd-ilibrary.org/sites/health_glance-2017-6-en/index.html?itemId=/content/component/health_glance-2017-6-en.

The United States is an outlier from the general trend, with the largest residual compared to other countries. Such, it is clear that the United States has the largest health expenditure per capita out of all of the countries shown yet has a lower life expectancy at birth than many countries with much lower spending, translating to lower quality health care for a higher price. The values of the institution are clearly not being realized. The material cause of health care, which whittles down to money, is simply so: a means to a value. Money should not be an end in itself. When this occurs, there is a shifting away from a vital value, leading to the disruption of social, cultural, and personal values. The proper, objective scale of values is not realized.

Additionally, we see the rise of chronic diseases. As life expectancy increases in the United States, so does inefficiency later in life, leading to increased associated costs. In 2016, end-of-life care comprised a whopping thirty percent of total Medicare spending.[82] The United States fails to deliver care which corresponds with good quality of life for its citizens. Again, values are not being realized.

In 2017, administrative costs comprised 34.2 percent, totaling $2,497 per capita, of the $3.5 trillion spent annually on health care in the United States, as compared to 17.0 percent, totaling $551 per capita, in Canada.[83] This is a colossal amount devoted to shuffling papers rather than being allocated toward health care itself in terms of drugs and treatments. This gargantuan cost is indicative of how fractured the health care system is. The National Academy of Medicine, formerly known as the Institute of Medicine, estimates that the American health care industry wastes $750 billion annually in unnecessary medical spending, comprising about

[82] Thomas Cornwell, "Home-Based Primary Care's Perfect Storm" (Home Centered Care Institute, December 2019), 2, https://www.hccinstitute.org/app/uploads/2020/03/Perfect-Storm_200302.pdf?x75163&x31299.
[83] David U. Himmelstein, Terry Campbell, and Steffie Woolhandler, "Health Care Administrative Costs in the United States and Canada, 2017," *Annals of Internal Medicine* 172, no. 2 (January 21, 2020): 134, https://doi.org/10.7326/M19-2818.

thirty percent of the overall expenses of the industry.[84] This can also be tied back to the concept of proportionality, as there is no standardization of cost within institutions, much less on a national scale, for different procedures. There is extreme variability across the nation, noted by a 2015 Blue Cross Blue Shield report which showed that the cost of a knee joint replacement can vary 515 percent, and similarly, a hip replacement 553 percent.[85]

France, Germany, and Japan, nations with similar socioeconomic cultures to the United States, all report better health outcomes than the United States and utilize a common fee schedule.[86] In these countries, there are few methods for establishing costs, namely political and legal in nature, which means that costs cannot be raised on a whim. This is in contrast to in the United States, where there is a flexible response to costs, as exemplified by the "market covenant" exploited by Partners HealthCare in Massachusetts,[87] a context to which we will return to later. Two notable exceptions to this flexibility in the United States are Medicare and Medicaid, which require congressional approval to change.

A relatively recent development in the United States is the introduction of the Affordable Care Act, more colloquially known as Obamacare, signed on March 23, 2010. The ACA guarantees health insurance for Americans with household incomes between one hundred percent and four hundred percent of the federal poverty level with the aim of making health

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[84] Committee on the Learning Health Care System in America and Institute of Medicine, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, ed. Mark Smith et al. (Washington (DC): National Academies Press (US), 2013), http://www.ncbi.nlm.nih.gov/books/NBK207225/.

[85] Blue Cross Blue Shield Association and Blue Health Intelligence, "A Study of Cost Variations for Knee and Hip Replacement Surgeries in the U.S.," The Health of America (Blue Cross Blue Shield, January 21, 2015), 4, https://www.bcbs.com/the-health-of-america/reports/study-of-cost-variations-knee-and-hip-replacement-surgeries-the-us.

[86] Michael K. Gusmano et al., "Getting The Price Right: How Some Countries Control Spending In A Fee-For-Service System: Study Examines Mechanisms Commonly Used by Some Countries to Set and Update Health Care Prices.," *Health Affairs* 39, no. 11 (November 1, 2020): 1867–74, https://doi.org/10.1377/hlthaff.2019.01804.

[87] Scott Allen and Michael Bombardieri, "A Handshake That Made Healthcare History," Boston Globe, December 28, 2008, https://www.bostonglobe.com/specials/2008/12/28/handshake-that-made-healthcare-history/QiWbywqb8olJsA3IZ11o1H/story.html.

care more accessible and affordable.[88] The ACA implemented a medical loss ratio law called the 80/20 rule. This means that, by federal standard, insurance companies are required to spend at least eighty percent of the dollars obtained from health care premiums on clinical care by way of paying for medically necessary claims. If this quota is not met, insurance companies must provide annual rebates to its program enrollees on a pro rata basis.[89] Prior to its enactment, particularly in individual markets, low amounts of costs associated with health care actually went toward care, as compared to post-ACA, which has shown increased insurer efficiencies and lower out-of-pocket health care expenditures for American consumers. This discrepancy was emphasized during the Senate Hearing in the 113th Congress:

> We used the industry's own data to make this point. We looked at the percentage of every premium dollar health insurance was spending on healthcare versus the percentage they were spending on administration, commissions, dividends, and other non-healthcare related items. In the health insurance industry, this measurement is called medical ratio. What we found back in 2009 was a mixed bag. In some markets, insurers were efficiently spending 90 cents or more of each premium dollar on patient care. Let that be understood. Some were doing it right. But in other markets, especially the market for the individual health insurance, the numbers were shockingly low. Some insurance companies were pocketing as much as 50 cents on every premium dollar… To date under the ACA, consumers and businesses have received nearly $1.6 billion in rebates from insurers whose MLRs exceeded the ACA thresholds.[90]

Despite this, the ACA is not designed well to reduce health care costs. Health insurance, while meant to make health care accessible, has just the opposite effect as the costs continue to skyrocket. Health insurance in the United States is primarily tied to employment. Health care

[88] U.S. Centers for Medicare & Medicaid Services, "Affordable Care Act (ACA) - Glossary," HealthCare.gov, accessed April 27, 2023, https://www.healthcare.gov/glossary/affordable-care-act.
[89] 111th Congress, "Compilation of Patient Protection And Affordable Care Act [As Amended Through May 1, 2010]" (Office of the Legislative Counsel, June 9, 2010), 22, http://housedocs.house.gov/energycommerce/ppacacon.pdf.
[90] 113th Congress, "Delivering Better Health Care Value to Consumers: The First Three Years of the Medical Loss Ratio" (Senate Committee on Commerce, Science, and Transportation, May 21, 2014), https://www.govinfo.gov/content/pkg/CHRG-113shrg91652/html/CHRG-113shrg91652.htm.

premiums cost Starbucks more than coffee beans,[91] and General Motors and Ford more than steel.[92] Unfortunately, the immense costs associated with health care in the United States is far from being the sole contributor to institutional disorder within the system.

Public health crises such as the HIV/AIDS epidemic or the recent coronavirus global pandemic are difficult situations for everyone affected but prove to be substantially more challenging for those who experience oppression. The term "oppression" is not limited to totalitarian control of government but refers to circumstances in which people are treated unjustly and caused distress, whether purposefully or unconsciously. Those without adequate access to food, water, clothing, shelter, medications, sanitation supplies, childcare, or income, as well as those impacted by structural oppression, are highly more susceptible to contracting a disease or illness than the general population. Additionally, the most economically vulnerable are likely to experience devastating financial effects due to a health crisis. If they become ill, they also have fewer resources to deal with serious illness and risk furthering the spread if they do not have to benefit of paid sick leave, the ability to work remotely, or fear reprisal if they miss work because they are sick or afraid to get sick. In a country without universalized health care, the standard for necessitating a doctor's note for excused absences to work, school, and other commitments is inherently classist, as access to health care, regardless even of the quality of care, is limited. Hence, the United States health care system disproportionately affects the most vulnerable in society.

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[91] Beth Kowitt, "Starbucks CEO: 'We Spend More on Health Care than Coffee,'" *Cable News Network*, June 7, 2010, sec. CNN Money, https://money.cnn.com/2010/06/07/news/companies/starbucks_schultz_healthcare.fortune/index.htm.

[92] Dave Chase, "You Run a Health-Care Business Whether You Like It or Not," *CFO*, November 7, 2017, https://www.cfo.com/corporate-finance/2017/11/run-health-care-business-whether-like-not/#:~:text=Warren%20Buffett%20said%20it%20all,health%20care%20than%20coffee%20beans.; Bloomberg, "Ford Health-Care Costs Said to Top $1 Billion," *IndustryWeek*, March 12, 2019, https://www.industryweek.com/talent/article/22027289/ford-healthcare-costs-said-to-top-1-billion.

Structural oppression refers to oppression that is built into the societal structure or into the framework of an organization that intentionally or unintentionally marginalizes certain groups of people. Structural oppression can be built off of cultural imperialism, in which the dominant group's experience is universalized and established as the norm, although that is not always the case; members of the dominant group are seen as individuals, whereas minority oppressed groups are seen as a collective stereotype, rendering them invisible to society. The oppressed social groups are typically composed of individuals in similar societal and institutional situations that affect their life chances.[93] Due to structural oppression, minority groups are less able to afford quality medical care when needed and are treated unfairly even when they can afford it. Racism is a form of systematic structural oppression that hinders minorities due to both conscious and unconscious biases against people who are different from the dominant group. Structural oppression, and racism, extend to health care; for instance, one study showed that when black babies are cared for after birth by black doctors, the mortality rate decreases by half, as compared to the base mortality rate of white newborns.[94]

Urgent care centers do not have the same obligations as an emergency room; because they are not bound by the Emergency Medical Treatment and Labor Act, urgent care centers have the ability to turn people away if they do not have the means to pay for treatment, especially if a patient does not have health insurance. Due to the elevated costs of going to the emergency room, millions of Americans do not have the option to seek treatment from one, even in a dire state.[95] So, with this, we see that the medical-industrial complex, dubbed to

[93] Iris Marion Young, "Five Faces of Oppression," in *Justice and the Politics of Difference* (Princeton, N.J: Princeton University Press, 1990).
[94] Brad N. Greenwood et al., "Physician–Patient Racial Concordance and Disparities in Birthing Mortality for Newborns," *Proceedings of the National Academy of Sciences* 117, no. 35 (September 2020): 21194–200, https://doi.org/10.1073/pnas.1913405117.
[95] Bill Fay, "Emergency Rooms vs. Urgent Care Centers: Differences in Services & Costs," Debt.org, accessed April 13, 2023, https://www.debt.org/medical/emergency-room-urgent-care-costs/.

represent the "growing rapport between the health industry and the health services delivery system,"[96] including conglomerates related to drugs, hospital supplies and equipment, health insurance, as well as nursing homes and hospitals,[97] promotes a for-profit approach to health care which ultimately contributes to disorder.

The schema of bourgeoisie versus proletariat is too simple to apply directly to current American class structures. However, we can explain through a Marxist lens why this scheme as it pertains to health care goes unquestioned and unchanged. Those of the dominant class have a monopoly on creating ideologies simply due to the fact that they have the means of production and the leisure time to develop the dominant ideology. In the same way, in the setting of health care, patients of lower socioeconomic backgrounds do not have access to creating or changing dominant ideologies. So, the vital value of health is also a social value, and the good of order becomes disordered in that collaboration between social groups cannot exist when those who are disadvantaged are silenced. The operative values of the institution and of the social groups within the institution are not aligned with the objective scale of values. The values which are actually being pursued are related to the acquisition of apparent goods such as profit and efficiency of business rather than aimed toward true goods such as the health of the individual, the health of the institution, the health of the society, and consequently, the health of the good of order, leading to the progression of human good by and large.

[96] Health-PAC, "The Medical-Industrial Complex," in *The American-Health Empire: Power, Profits, and Politics* (New York: Random House, 1971), 122.
[97] Health-PAC, "The Medical-Industrial Complex."

2.3 Further Investigation Of The United States Health Care System

Due to the inherent difficulty of the path to enter the field of medicine, as well as the difficulties faced upon entering the field, it may be inferred that the vast majority of health care professionals enter into the health care industry for the right reasons, being aimed toward the good. Given this, we must explore why and how the operative values of the American health care system become distorted. This will be explored in the context of financial motivation and the commodification of health care.

Let us discuss the fetishization of commodities. Under capitalism, health care as a value no longer serves humans. Humans become commodities that serve the apparent end of profit. Health care is not exempt from this fetishization of human bodies under capitalism. Materialism is the philosophy that the material reality of human lived realities should be given primacy. This means that under capitalism, in which the material reality of the economy fetishizes human beings as commodities, there can be no possibility of creating an idealized health care system without changing the economic reality itself.

In recent years, we have seen the commodification of humans in health care in the context of the COVID-19 pandemic. During the pandemic, and arguably still so in its aftermath, hospitals capitalized on health care workers by commodifying them as heroes while failing to actually protect workers and their families from risks presented by the virus or provide employees with basic benefits. A similar theme that has persisted in the industry, preceding the pandemic but has perhaps been exacerbated since, is physician wellness as a nonvalue. Sick physicians cannot deliver optimum care for their patients, but physicians nonetheless are expected to work through stress, illness, sleep deprivation, and other detrimental factors to their own health:

> Physicians are important citizens of health-care systems, and evidence indicates that many physicians are unwell… Growing evidence points to important negative consequences of physician ill health to health-care systems by affecting recruitment and retention of physicians, workplace productivity and efficiency, and quality of patient care and patient safety.[98]

Physicians endure a multitude of stressors, both personal and work-related. Practicing medicine presents distinct pressures on physicians who suffer heavy workloads due to increased patient care demands, work as many as fifty to sixty hours each week when not on call, and are exposed frequently to overwhelming and emotionally charged situations. Physicians not only suffer physical fatigue, but also cognitive fatigue as the job requires the quick processing of large quantities of information for long periods of time in a high-stake setting. Many physicians also report workplace dissatisfaction as some hospitals place organizational restrictions on the decision making of physicians in their patient care, stripping physicians of some of their autonomy on the job.[99] As such, burnout is commonplace in physicians, and the work itself seems to contribute a large factor to which is detrimental to their health. Unfortunately, the sacrifices of physicians both too often goes unseen and also inadvertently hinders the care delivered:

> Perhaps of even greater concern is the direct effect of physician wellness on quality of care and patient safety. Firth-Cozens and Greenhalgh, examined physicians' perceptions of the link between work-related stress and patient care. 57% of participants believed that tiredness, exhaustion, or sleep deprivation negatively affected patient care, and another 28% believed that pressures from being overworked were negatively related. Work-related stress led to 50% reporting reduced standards of patient care (eg, taking short cuts, not following procedures), 40% reporting irritability or anger, 7% reporting serious mistakes not leading to patient death, and 2.4% reporting incidents in which the patient died. Tiredness and overwork were most often judged to be responsible for these outcomes, especially the most serious ones.[100]

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[98] Jean E Wallace, Jane B Lemaire, and William A Ghali, "Physician Wellness: A Missing Quality Indicator," *The Lancet* 374, no. 9702 (November 2009): 1714–21, https://doi.org/10.1016/S0140-6736(09)61424-0.
[99] Wallace, Lemaire, and Ghali, 1715.
[100] Wallace, Lemaire, and Ghali, 1717.

These compelling statistics demonstrate strikingly the importance of physician wellness to the wellness of the health care system in general. In order for the institution to be ordered, all working parts of the institution must be ordered, too.

The values of the United States health care system are influenced by several factors, including the legal system. Although this is an important factor, I will only briefly explicate the matter, emphasizing one important point: law is mediated by culture, and vice versa. H. L. A. Hart's theory of legal positivism states that normative beliefs in general culture as well as particular social groups profoundly impact the development of law.[101] This is not to say that all laws fail to reflect moral values, but that the existence of a law does not imply the existence of any kind of moral backing to the law. Law is situated in a sociohistorical context. Because social contexts are ever-changing, those who adjudicate and interpret the law must find ways to apply laws that were written in the past to apply to current contexts. To make a point, health care in 2023 should be different from what health care was fifty years ago. However, legal positivism does not always prove to be true in all cases; sometimes, a society might have an awareness of the true values and lack the means to enforce the execution of the values, often due to a more powerful entity that lacks the same awareness. An example of injustice relating to this theory is a health reform law passed in Massachusetts in 2000 dubbed the "market covenant."[102] Since then, Massachusetts insurance premiums have increased by nine percent every year, more than double the cost as before the market covenant. This is because hospitals and insurance companies negotiate the cost of procedures on an individual basis rather than having a fixed cost for procedures.

[101] H. L. A. Hart, *The Concept of Law*, 3rd ed., Clarendon Law Series (Oxford, United Kingdom: Oxford University Press, 2012), 185.
[102] Allen and Bombardieri, "A Handshake That Made Healthcare History."

As stated before, method is progressive and cumulative. So, how can we know if laws and the values of cultures are good? The norm should reflect the values of the culture at all times, but it should also shift with the times. Thus, we need to ask questions in order to become aware. In relation to health care and associated rising costs, we must consider the economy of scale: has care increased proportionately? Unfortunately, the evidence points to no; referring back to the context of the market covenant in Massachusetts and the expansion of Partners HealthCare, "When Partners decides to expand… the prediction would be it will not add to the well-being of the population… It will add to cost."[103] If this indeed is the case, then values are not being realized. Values have not shifted for health to be prioritized. The norms of the culture have been shifted and need to be corrected to reflect values. Unfortunately, in the United States, access to health care in various forms (i.e., medications, referrals, tests) is restricted by insurance companies through the denial of claims, as the business venture of insurance companies prioritizes reduction of cost over the actual care that a policyholder receives.

The health care system mediates culture as well. For example, the costs of health care mediate national health in that it changes the actions and values of people based on its affordability. Additionally, the values of personnel are mediated by the values of the institution. Individuals tend to choose to work for employers who share their same values, and as noted before in explicating physician wellness, individuals tend to experience workplace dissatisfaction and chronic stress when the values of the institution are not aligned with the values of the individual, and also with the objective scale of values. Through Lonergan's approach, further concrete investigations must be done in order to determine more specifically other arenas where values may also be disordered within health care.

[103] Allen and Bombardieri.

However, through the examination of health care in the United States done in this work, it is clear that there arises the need for progress. So, how do we find a way to progress? Succinctly, the next section will speak of becoming aware of the values and finding a way to realize them in their proper order through what Lonergan calls *conversion*.

2.4 Potential To Progress As A Society Through Reordering Operative Values

People are vessels for change. Lonergan's idea that the good in this world arises out of evil, in that it triumphs over evil in a dynamic process,[104] gives hope that the United States health care system may become more aligned with the good. There is much potential for the good. We can realize this potential through conversion: intellectual, moral, and religious.

Conversions occur when the horizons of an individual are challenged with deep feelings through which arise the need for something more extreme than even dialectical change, which Lonergan describes to be "a concrete unfolding of linked but opposed principles of change."[105] Still, prior to conversions, people must become oriented toward the good:

> As orientation is, so to speak, the direction of development, so conversion is a change of direction and, indeed, a change for the better. One frees oneself from the unauthentic. One grows in authenticity. Harmful, dangerous, misleading satisfactions are dropped. Fears of discomfort, pain, privation have less power to deflect one from one's course. Values are apprehended where before they were overlooked. Scales of preference shift. Errors, rationalizations, ideologies fall and shatter to leave one open to things as they are and to man as he should be.[106]

Byrne emphasizes the dynamism in and intentionality behind conversions:

[104] Lonergan, *Topics in Education*, 30.
[105] Lonergan, *Insight*, 242.
[106] Lonergan, *Method in Theology*, 14:51.

> Conversions are radical types of decisions. Yet, at least in Lonergan's technical sense, conversions are not arbitrary decisions; rather, they are authentic decisions that respond to the tensions in our horizons of feelings. They are normative responses to objective values as they are intended in unrestricted value questioning and unrestricting being-in-love. Conversions begin processes of fundamental reorganization of our horizons of feelings. Conversions move us towards properly ordered horizons of feelings. Still, decisions of conversion are only the beginning points for sustained resolutions of the fundamental tensions in our horizons of feelings… Conversion is a decision we have to keep on making.[107]

It can be concluded by this that conversion is a difficult process to instigate, not just in an individual, but especially for a society en masse.

Intellectual conversion refers to the process of raising awareness itself. This is the changing of understanding from what an individual sees subjectively to what is true objectively. Intentionality analysis can lead to intellectual conversion. To this point, Lonergan, in the 1958 article "Insight: Preface to a Discussion," distinguishes between an individual's "own real world" and the "universe of being."[108] Intellectual conversion occurs upon accurate reflection. This means that a judgment of value has to be made prior to conversion such that the decision made by an individual is a result of deliberation. The individual then turns toward that which is good and simultaneously turns away from that which is not; in this way, the individual's horizons are oriented properly, and the individual is apt to make true judgements of fact and also realize true values.[109]

Moral conversion involves a shifting to values that transcend the interests of mere individuals or groups, to what is akin with the good of order. The displacement of a more selfish attitude, to what is concretely right, allows good to surface. Lonergan describes this as

[107] Byrne, *The Ethics of Discernment*, 224–25.
[108] Bernard J. F. Lonergan, "Insight: Preface to a Discussion," in *Collection*, ed. Frederick E. Crowe, 2nd ed., vol. 4, Collected Works of Bernard Lonergan (Toronto: Univ. of Toronto Press, 1993), 148.
[109] Byrne, *The Ethics of Discernment*, 225–26.

changing "from a self-regarding to a self-transcending orientation… an exercise of vertical liberty."[110] However, this is not to say that an individual who chooses correct actions necessarily engages in moral conversion; if that individual prefers apparent values over true values, they still then have a distortion of values despite choosing true values over satisfactions.[111] As Patrick Byrne puts it: "It is a decision to accept the fact that deciding always occurs within the structure of ethical intentionality with its unrestricted intention of all values. *Moral conversion is the decision to cooperate with this dynamic structure of activities in its rich pursuit of all values.*"[112]

In engaging in intellectual and moral conversion, one implicitly engages also in religious conversion; this is to extricate oneself from a kind of self-centeredness to shift and see God to be the center of everything. The gospel asks us to desire conversion because it is a gift: "One turns from one way of thought and lie and toward another, to escape a more limited horizon and enter a broader one."[113] Religious conversion, in this way, also facilitates both intellectual and moral conversion:

> Self-knowledge is a religious value because God has given us human beings the responsibility to create ourselves by freely thinking, deciding, believing, and acting. What we become results from the use, misuse or neglect of these God-given gifts. If we do not take responsibility for our lives, we will probably conform to opinions we do not examine, thinking what others think, doing what others do, and never asking what is true or false, good or bad.[114]

Moreso, religious conversion encompasses the falling in love with the source of the human good; this is to say, falling in love with the good itself, that is, with God. Michael Rende notes

[110] Lonergan, *Philosophical and Theological Papers, 1965-1980*, 343.
[111] Byrne, *The Ethics of Discernment*, 227.
[112] Byrne, 229.
[113] David M. Hammond, *Lonergan and the Theology of the Future: An Invitation* (Eugene, Oregon: Pickwick Publications, 2017), 47.
[114] Hammond, 49–50.

how God's unconditional, perpetual agapic love permeates our lives and encourages humans to seek out the good:

> God's grace is poured into that part of our consciousness which is concerned with personal existence. Indeed, the indwelling of God's love occurs concurrently with our discovery of our true selves. The true self which we discover is worthwhile and significant… Since God's unrestricted love has convinced us of our worth and significance, there is no felt need to establish our value by diminishing others. Indeed, our inner peace and freedom permit us to more clearly perceive the true and mysterious value of other persons. Consequently, we can actually do the good with ease because we are in love.[115]

Thus, it can be inferred that conversions are especially crucial to the realization of values in medicine and the health care field. Without conversion, the good of order, and consequently, the human good in general, cannot progress. Conversion is a dynamic and ongoing process. Yet, there is no simple "fix" for the problem plaguing health care. It is certainly a complicated and difficult task for the multitudinous citizens of a nation, particularly a nation as diverse and as populous as the United States, to collectively engage first in correct orientations, and then in conversions, and take human responsibility for failures of the good of order. So, the first step to incite progress, in health care, but undoubtedly encompassing much more, is the raising of consciousness. Through awareness, we become oriented in the right ways such that our values are ordered, and we can cooperate in the right ways which aim at terminal value.

[115] Michael L. Rende, *Lonergan on Conversion: The Development of a Notion* (Lanham: University Press of America, 1991), 178–79.

CONCLUSION

Through an exploration of the current state of health care in the United States, we have found that the institutions are not only disordered, but that such disorder has tangible negative consequences for those who rely upon this system. The underlying problem which causes these issues is not one which can be solved via the calculation of one policy over another on the merit of their consequences. Ineffective health care in the United States is a problem of not realizing values, first and foremost, which impedes care, and not just of politics or sociology. As such, any solution cannot be isolated to an analysis of specific policies, but rather must be rooted in a deeper understanding of the end of health and health care, and therefore, the good of order of such a system.

To that end, we claimed that the structure of the human good described by Lonergan, and its subsequent elaboration through intentionality analysis, should be utilized fully by those with the means of reshaping the institution of health care in the United States. We showed that the health of a community is crucial to its continued flourishing, and an ordered system of health care must prioritize the objective value of health and, more exactly, the health of individuals, which can be measured via successful outcomes, at the center of its mission. Furthermore, the understanding of the correspondence between feelings and values illuminates the objectivity of values in the light of the human good. Feelings such as frustration and discontent upon reflection of the current system of health care, which may arise after orientation, signify a burgeoning awareness that health, the care of the whole person in order

to live well, biomedically, psychologically, and spiritually, is a true value which is not being realized.

A disordered health care system which prioritizes increased profit margins above all else does not realize the objective scale of values. This distortion of values may prove beneficial for a handful of board members, but as has been thoroughly explicated, harms both the well-being and the financial independence of many more, including, disproportionally, the most vulnerable members of our society. Furthermore, such a disordered system does not reflect treatment outcomes better than more well-ordered systems; in terms of equity per capita and quality of treatment, the higher health care expenditure in the United States correlates generally with statistically worse levels of care than seen in other nations. Though further work is necessary to establish the precise ways in which the good of order may be brought to fruition, the incorporation of Lonerganian thought into discussions of how to restructure the system of health care in the United States not only would be appropriate, but indeed is crucial to promoting a real and discernable reorientation of the values of institutions within health care in order to progress the human good.

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