What's Natural?

What do tummy tucks and Viagra have to do with the brave new world of genetic technology and wonder drugs? In today's debates over relatively commonplace medical matters, we can see the outlines of tomorrow's titanic clashes over technologies that promise to alter human destiny.

by Andrew Stark

Deborah Fuller was proud of her "long, brown ringlets" when she was a child. But as an adult she suffers from alopecia areata, an ailment that causes substantial, often total, hair loss from the scalp. Testifying before a state legislative committee in New Hampshire in 1992, Fuller asked whether she might remove her wig: "If it would not upset anyone," she said, "I would like to demonstrate what it looks like to have alopecia." The committee was considering whether the state should require private health insurers to pay for wigs for such patients. The question in New Hampshire and other states has been: Are wigs in such cases a "medical necessity"?

Yes, they are, Fuller argued. "There are people who consider suicide because of [alopecia]. I didn't because I am a strong person, but I will tell you that this," and she pointed to her wig, "replaces a shrink in a minute." The problem is that a proper wig can cost up to $3,000, and many patients cannot afford them without help from their insurance companies. Yet it could cost as much as $6 billion to provide wigs for the estimated two to three million women in the United States who suffer from the disease.

No one, including spokespersons for the insurance industry, would deny that cancer care or hip replacements are medical necessities and warrant insurance coverage—unlike, say, a visit to a spa in order to relieve stress. But between the poles of the clearly necessary and the plainly not, the terrain grows ever more contested, with patients arguing for medical necessity where insurers see none.

Indeed, what used to be a cold war has recently turned hot. During the past decade, legislatures in every state have considered bills that would mandate insurance coverage of everything from Viagra to abortion to wigs for alopecia patients. The amounts of money involved can be substantial. Viagra, which came on the market in 1998, now racks up $1.5 billion in sales every year. Infertility, a growing phenomenon in this age of delayed marriages, afflicts around 6 million American women and their partners; the cost of treatment ranges anywhere between $10,000 and $40,000, depending on the number of rounds needed. And in addition to legislative hearings, 40 states in the past few years have established external appeals panels: rosters of independent physicians who arbitrate disputes between patients and their health maintenance organizations (HMOs), making decisions—thousands of them annually—as to what's medically necessary in particularly hard cases.

Are today's new drugs and medical procedures restoring patients to their natural state, or are they doing something else? And what, after all, is a person's true "natural state?"

In the future, as researchers perfect medical treatments that are little more than dreams now—genetic and cellular manipulations to increase IQ or lifespan, advanced generations of human growth hormones or mood-altering drugs—debates over the meaning of medical necessity will grow even louder, and the answers will have much profounder implications for the human future. Insurers, unwilling to pay for these techniques, are going to deny that they are even remotely medically necessary, consigning them to the realm of "personal enhancement." That, however, is unlikely to sit well with people who feel they desperately need them.

Insurers sometimes claim to be agnostic about the medical necessity of the contested procedures. Their real concern, they say, is that each new covered service drives up the price of insurance. But if cost were the only issue, they would be covering contraceptives, which they don't, but not cancer care, which they do. In fact, insurers employ an arsenal of arguments in their struggle with patients in order to draw the boundary of medical necessity so as to exclude or

include various conditions. One of their weapons of choice is analogy: The insurers liken a proposed procedure to one that anyone would concede lies beyond the realm of medical necessity. If insurers were required to cover wigs for alopecia sufferers, what would be next? Would they have to cover wigs for male pattern baldness? Or long-sleeved shirts for eczema sufferers? Patients counter with analogies of their own: Since insurers cover ointments for alopecia, they have acknowledged that alopecia—unlike male pattern baldness—is a real medical condition. And since insurers cover wigs for chemotherapy patients, they have acknowledged that wigs—unlike long-sleeved shirts—are a genuine medical treatment. So how can insurers deny wigs for alopecia?

Another favorite tactic of both sides is to call attention to inconsistencies. Insurers will pay for a psychotherapist to deal with the suicidal thoughts that alopecia provokes, but not for a wig to deal with the physical hair loss. They'll cover the costs of depression associated with infertility, but not the costs of in vitro fertilization to remedy the infertility itself. Yet the same insurers who want to cover only the mental consequences of certain physical conditions also want to cover only the physical aspects of mental conditions such as bipolar disorder and attention deficit disorder. Insurers have fought hard, at the state level, to be required to cover mental conditions only to the extent that they have an immediate biological cause, something that doctors can attack with drugs rather than with Freud. But if the insurance industry pays for mental conditions only insofar as they are really physical, and physical conditions only insofar as they are mental, doesn't its position risk collapsing under the weight of the inconsistency?

We need to derive from the debate some coherent principles that may help us to locate the boundaries of medical necessity. As it turns out, legislators focus on whether a particular service is a necessity, not on whether it qualifies as medical. After all, legislators are not doctors but politicians, who are used to having to distinguish between genuine needs and mere desires. In contrast, appeals panels, because they are composed of physicians, tend to be uniformly sympathetic to what they view as a sea of undifferentiated need and, instead, make their distinctions by focusing on whether the service at issue qualifies as genuinely medical. The battle, in other words, has two theaters—one that focuses on the meaning of *necessity*, the other on the meaning of *medical*—and to understand what's at stake, you must spend time in each of them.

Much of the debate in state legislatures has been over whether it should be mandatory for insurers to cover prescription contraception for fertile couples, in vitro fertilization for infertile couples, and wigs for alopecia patients. But these debates inevitably lead those involved to consider the relative medical necessity of three other procedures: abortion, breast reconstruction after a mastectomy, and treatment with Viagra.

In most states, insurers generally don't have to pay for contraception, but they do pay for Viagra. They steadfastly resist covering in vitro fertilization for infertile couples who want kids, but a substantial majority of them cover nonthera-

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peutic abortion for women who don't want kids. The *Los Angeles Times* reported in 1998 that about "70 percent of health plans will pay for abortion, but only 17 percent will pay for in vitro," and there's no reason to think the figures have changed dramatically since. Finally, insurers, with the exception of those in Minnesota and New Hampshire, have not been mandated to pay for wigs for alopecia sufferers. But they have been mandated, in every state, to pay for breast reconstruction after a mastectomy. The seeming disparity prompted this response from Judy Horton of Nashua, New Hampshire, at a legislative hearing: "I hope this is not a cheap shot, but let's pretend . . . that each one of us women in this room has one breast and is wearing a breast prosthesis as well as a scalp prosthesis. Given a choice that you had to remove one and walk down Main Street today, which would you rather remove?" By Horton's measure, insurers appear to have their priorities backwards.

Is there a common principle at play in the patients' complaints? Consider the criterion that Norman Daniels, a philosopher at the Harvard School of Public Health, offers in *Just Health Care* (1985), the first—and still the most influential—philosophical treatment of these questions. Daniels defines our "important [medical] needs" as whatever is "necessary for maintaining [the] normal functioning" of human beings viewed "as members of a natural species." He argues that a "necessity" is whatever medical treatment "it is reasonable for persons to choose in a given society"—that is to say, it's what most of us would choose if we found ourselves faced with a certain health condition.

Daniels's natural-functioning criterion would overturn current private insurance practice on the grounds that it has indeed gotten things exactly backwards—on abortion, for example. Daniels has said that he would require insurance coverage of infertility treatment, because bearing children is part of our natural functioning. But he would not require coverage of abortion, because "unwanted pregnancy is not a disease" and miscarrying is not part of the natural functioning of our species.

VIAGRA USERS ARE NOT FULFILLING THEIR NATURAL FUNCTIONING, BUT THUMBING THEIR NOSES AT IT.

When it comes to Viagra, which insurers widely cover, and contraceptives, which they do not, you might expect Daniels's natural-functioning approach to uphold the status quo. After all, Viagra aids the natural procreative functioning of the male, while contraception thwarts the natural procreative functioning of the female. But suppose we view "natural" sexuality in recreational, not procreative, terms. Since "most Viagra users are men aged 50–75, hardly peak biological years for procreation," a writer in the *Seattle Post-Intelligencer* pointed out a few years ago, "the specter of 'recreational' use is hard to ignore." Viagra users are not fulfilling their natural functioning but thumbing their noses at it. After all, as Robert Scheer wrote in the *Los Angeles Times*, "Isn't sexual impotence God's gentle way of saying to a 75-year-old man, 'You've had enough'?" Contraception, by contrast, enables a woman "to enjoy sex," Paige Shipman of Wisconsin Planned Parenthood told me, precisely by "eliminating a direct threat to her natural functioning: the ravages on her body that would result from having to bear 12 to 15 children."

So if sex is understood in procreative terms, Viagra promotes natural functioning and contraception thwarts it. If it's understood in recreational terms, Viagra frequently mocks natural functioning and contraception protects it.

Daniels suggests another way of establishing the meaning of natural functioning: Observe what most members of our species would choose to do when faced with a particular condition. It turns out that only 15 percent of American men over age 50 who suffer from impotence choose to seek treatment, while fully 90 percent of sexually active couples in their fertile years choose one of the five major reversible contraceptives. According to the natural-functioning approach, then, the status quo, in which insurers cover Viagra far more often than they do contraception, assigns precisely the wrong priority.

Daniels's natural-functioning criterion would also favor wigs for alopecia patients over breast reconstruction for mastectomy patients. Wigs serve a physiological function, in that hair and hair prostheses protect against loss of body heat from the head. But a reconstructed breast does not serve its natural function. According to Jay Mahler, an alopecia activist from Ann Arbor, Michigan, almost all women with total scalp hair loss would wear wigs if they could afford them. By contrast, the proportion of women who choose breast reconstruction after a mastectomy is estimated at between 15 and 40 percent.

Daniels's natural-functioning criterion suggests that there is something fundamentally perverse about the way the boundary of necessity is located under current insurance practice. There is, however, another principle, every bit as appealing as Daniels's, that could explain why the line is drawn where it is. This principle considers not how many people eligible for a particular procedure would choose to have it, but how many choices an eligible person would have *without* it. The principle assumes that necessity emerges as choice diminishes, and that a person can be said to need something because he or she has no alternatives to it.

The couple who lack access to Viagra have fewer choices in the pursuit of sexual gratification than the couple without access to prescription contraception. The couple without Viagra, says Tom Bruckman of the American Urologic Foundation, are "barred from engaging in a wide variety of mutually satisfying sexual activities." The couple without prescription contraception, by contrast, are barred "from only one kind of sexual activity—intercourse without the risk of conception," and even then, the risk can be controlled by nonprescription methods of contraception. Since "sex is impossible in the absence of virility, but not in the presence of fertility," Bruckman observes, there is a "significant ethical and moral difference" between the use of Viagra and the use of contraception.

Oddly enough, Bruckman's point has been made effectively, if unwittingly, by some advocates of contraceptive coverage. During hearings on a contraceptive mandate bill in New Hampshire in 1999, legislator Martha Fuller Clark, one of the bill's proponents, declared that it was "about choice"; her colleague, Candace White Bouchard, said she supported the bill "because women do not have real choices." In describing contraception as a choice, Clark and Bouchard used language very close to the rhetoric wielded by their main opponent, Blue Cross/Blue Shield of New Hampshire, whose spokesperson at the hearings dis-

missed contraception as a "lifestyle choice," unlike something that's clearly a necessity, such as insulin.

The legislators' comments were an acknowledgment, and a revealing one because unintended, that sex with prescription contraception is but one of a number of choices for sexual expression or gratification available to a couple. Sex with Viagra, however, is far more often the *only* choice—which is why it's impossible to find anyone who argues for insurance coverage of Viagra on the grounds that it represents "a man's right to choose."

True, insurers cover abortion, and abortion is famously described as the fulfillment of "a woman's right to choose." But that happens in debates about abortion's legality, not in discussions of its subsidization through health insurance. Indeed, as independent scholar Rickie Solinger points out in *Beggars and Choosers* (2001), before *Roe v. Wade* in 1973, advocates of access to abortion rarely spoke of it in terms of choice; they spoke rather in terms of rights. If necessity is the opposite of choice, then there is an argument for insurers' covering Viagra, which is more of a necessity for sexual expression, even if they don't cover contraception, which is less of one.

Is it possible to justify the evident willingness of insurers to cover abortion but not in vitro fertilization? If we define a procedure as a necessity when those eligible for it enjoy few alternatives, it might seem that in vitro fertilization is actually more of a medical necessity than abortion. After all, one of the principal alternatives to in vitro—adoption—is usually not preferred to having a child of one's own through the fertilization process. When a pregnant woman who does not want a child considers her alternatives, putting the baby up for adoption would seem a more worthy choice than having an abortion. But it's also a tougher thing to do, as opponents of abortion are the first to acknowledge. Ed Rivet of Right to Life Michigan has said that "women indeed find it more emotionally wrenching to give up a child through adoption than undergo an abortion" because "they will have bonded with it and there's a real physical presence."

When it comes to infertility, adoption can actually be a more emotionally accessible alternative to in vitro fertilization. Jennifer Gosselin, spokeswoman for the Maine chapter of the national infertility-rights group Resolve, told me that she is glad that her in vitro was unsuccessful because the little girl she then adopted "was what was meant to be." In fact, many state bills mandating in vitro fertilization would require insurers to cover adoption expenses if in vitro failed—testimony to the relative ease with which adoption can be contemplated as an alternative to in vitro.

To say this, of course, is to say nothing about whether abortion represents the taking of life. But as long as the procedure is legal, an argument can be made that abortion is a greater necessity for women who do not want a child than in vitro fertilization is for women or couples who do.

Can one make an argument that breast reconstruction for mastectomy patients, which insurers cover, is more of a necessity than wigs are for those afflicted with alopecia? It's hard to dispute that most women would rather appear in public without a breast reconstruction than without a wig. In public situations, the sense of sight is dominant, so while the torso is clothed, the head is visible;

hence, a wig becomes more of a necessity than a reconstructed breast. There may be alternatives to wigs—hats, scarves—but they are neither as numerous nor as effective as the sartorial alternatives to a reconstructed breast.

But what about private situations, where the sense of touch may take precedence over the sense of sight? Susan Scherr of the National Coalition for Cancer Survivors, whose members often suffer both loss of a breast from cancer and loss of their hair from chemotherapy treatments, says that "in the privacy of a person's home, the first thing that comes off at the end of the day is the wig. In the intimacy of your own bedroom, having a normal body image is more important than hair on your head." When you touch a reconstructed breast in intimate situations, you touch a woman; when you touch a wig, you do not. In private settings, there is no alternative to the reconstructed breast, while the wig is no alternative at all to real hair.

We have found two possible criteria, then, for defining the meaning of necessity in tough cases. One criterion looks to natural functioning; as the philosopher Norman Daniels argues, a procedure is a necessity to the extent that most people eligible for it would choose to undergo it. The second criterion is the argument that a procedure is a necessity to the extent that people eligible for it would have fewer choices without it.

It's hard to deny the appeal of the natural-functioning principle as an argument for covering certain of the procedures in question: contraception, which nearly all eligible couples choose and which protects the natural functioning of a woman's body from the "ravages" of serial pregnancy; in vitro fertilization, which a substantial percentage of infertile couples pursue and which serves the purposes of the natural reproductive function; wigs for alopecia sufferers, which nearly all eligible women would choose and which fulfill the natural function of retaining body heat. And yet, natural functioning doesn't manage to encompass all that we commonly understand by necessity. For if necessity is viewed instead as arising when a person eligible for a particular procedure would have no other choices without it, then it does indeed extend to other items in question: abortion, the use of Viagra, and breast reconstruction after a mastectomy. The fact is that *each principle*—the one based on natural functioning, the other on absence of choice—contributes something important to our understanding of necessity in the border zone.

NATURAL FUNCTIONING DOESN'T MANAGE TO ENCOMPASS ALL THAT WE COMMONLY UNDERSTAND BY NECESSITY.

But the critical term *medical necessity* consists of two words, not one. What about "medical"? After all, we can concede that breast reconstruction belongs in the category of necessity and still ask whether it's a medical necessity or rather merely a cosmetic one. As it happens, the question of what constitutes a "medical" procedure gets debated most ferociously in the other theater of battle: independent physician appeals panels that render decisions when patients challenge an insurer's denial of coverage for a particular procedure.

A relatively small number of conditions figure prominently in the cases these panels hear: scars, the disfiguring birthmarks known as port-wine stains, the shape and size of breasts, the apron of abdominal skin known as the panniculus that develops after gastric bypass surgery for obesity. In each case, insurers try to push the condition from the domain of the medical into the domain of the cosmetic.

In rendering judgment, external reviewers are likely to invoke the criterion of natural functioning. If, in other words, these surface imperfections are impeding natural functioning—port-wine stains, for example, can be associated with abnormal blood-vessel development—appeals boards will deem their correction a medical matter and force insurers to cover it. But if such conditions "impair no functioning" or "constitute [no] functional deficit" (to quote some recent decisions), then treating them is deemed not a medical but a cosmetic matter, and the patient's claims are denied.

But two recent cases involving this "natural functioning" approach induce a sense of unease. In May 2001, a Massachusetts boy who had suffered severe lacerations on the left side of his face in a skiing accident appealed his insurer's refusal to pay for the necessary scar-revision surgery on the grounds that it would not be a medical procedure. "In the absence of any functional deficit," the physician-reviewer declared, "the insurer's decision to deny coverage is upheld." In July 2001, another physician-reviewer turned down a Massachusetts girl's request for laser surgery to deal with a large port-wine stain that extended from her left arm to her upper chest. The insurer defined the surgery as "cosmetic," designed to "improve appearance, not to restore bodily function," and the physician-reviewer agreed, noting that the stain posed no "functional impairment." Both judgments force us to ask whether natural functioning may be too dogmatic a criterion. And if it is, what other might we invoke?

The boy's facial scars were the result of a trauma visited upon him. His skiing accident diverted him from a personal state of normality—which means that we know what it would take to restore him to his old self. A port-wine stain, on the other hand, is congenital. It hasn't diverted the girl from some previous state of personal normality; it *is* her state of normality. The girl can offer no notion of what she, as an individual, would have been like without the stain. But although there's no personal norm, there's a social norm to which she can refer—the norm of what most people are like—on the basis of which she can ask for a medical correction.

If our intuitions lead us to sympathize with the boy and the girl, it's because we have been influenced by certain moral principles. When someone suffers a disease or trauma—in the boy's case, facial lacerations—that deflects him from a state of personal normality, we want to restore him to that state. When someone is deprived congenitally or developmentally from achieving the social norm—in the girl's case, by the port-wine stain—we want that norm to be hers. Unlike the external reviewers, most of us would consider these cases to fall properly within the realm of legitimate *medical* need.

Embracing these two principles would still exclude from the domain of the medical a good many procedures on the surface of the body. In particular, it would mean a thumbs-down on procedures that mix modes. Consider, for example, a

case involving a 50-year-old Connecticut woman who underwent gastric bypass surgery for obesity, a procedure that removes or closes off part of the stomach. Her insurer paid for the operation because obesity, by heightening the risk of cardiac disease or diabetes, directly threatens natural functioning. The woman lost 125 pounds but was left as a consequence with a fold of loose abdominal skin, as is often the case after major weight loss. There was no impairment to natural functioning, no health-threatening abdominal-wall strain, and no rash—the woman just very much wanted to have the skin removed.

The requisite procedure is called a panniculectomy or, more colloquially, a "tummy tuck." In this particular patient's case, the procedure would have mixed modes. Even if her obesity was congenital, the bothersome tummy was not. It resulted from a trauma inflicted on her—the invasion of her body by a scalpel—that diverted her from a previous state of personal normality, just as the Massachusetts boy's lacerations resulted from a trauma that diverted *him* from a previous state of personal normality. But unlike the boy, the woman seeking a tummy tuck was not asking to be restored to her own personal state of normalcy. She wanted, rather, to have her abdomen fashioned according to the social norm. As Sacramento plastic surgeon Jack Bruner says, the "kid with lacerations is trying to be restored to what he was before," while the tummy tuck is a "cosmetic case; she would have been obese to start with."

Now consider mode mixing of another kind. A woman, for congenital developmental reasons, has breasts she considers too small. Like the girl with the port-wine stain, she can invoke no state of personal normality to which she might be restored. Indeed, she hasn't departed from her personal norm. All she can ask, as did the girl with the port-wine stain, is that she be brought to a social norm. But breast implants, as distinct from the removal of a port-wine stain, would not bring the woman seeking them to a social norm. Some might say that's because there's no such thing as normal breast size, but another reason is that a sac of silicon gel or saline solution or even transplanted abdominal fat isn't normal breast tissue. Implants might constitute this particular woman's personal view as to how she would like her breasts to be, but an implant is not a normal breast. She has a congenital developmental issue, but she's asking, as the girl with the port-wine stain is not, to be refashioned according to her personal view of what's desirable. The correct verdict: no insurance coverage.

> WHY DO SO MANY BATTLES OVER MEDICAL NECESSITY HAVE TO DO WITH SEXUAL ATTRACTIVENESS OR ABILITY?

What about breast reduction for women who believe their breasts are too large? In the absence of functional issues such as back strain, appeals panels usually deny coverage. Yet as Dr. Elvin Zook, chair of plastic surgery at Southern Illinois University, acknowledges, there's no question that "people are more sympathetic to claims for breast reduction, even when there's no impairment of function, no rash or spinal issue, than to breast enlarge-

ment." The procedures for both reduction and enlargement respond to congenital developmental discontents, and with neither of them can the woman point to a personal norm from which she has been deflected. But in the case of breast reduction, there is an achievable social norm. What remains after a breast reduction, and not after a breast enlargement, is a body part that corresponds to the social norm of a breast: Breast tissue has been removed, but nonbreast tissue hasn't been added.

We are also more sympathetic to insurance coverage for breast reconstruction after a mastectomy than to coverage for breast enlargement. We regard the reconstruction as both a necessity—because other options don't exist—and legitimately medical. But why so? After all, in both enlargement and reconstruction procedures, nonbreast tissue is generally added. But in the case of reconstruction, the woman has been subjected to a trauma, breast surgery, that diverted her from a personal norm that had existed previously. If, in her own view of what it means for her to be normal—to be restored to herself—breast implants are required, then that should be her call. When a Massachusetts woman seeking insurance coverage for a breast enlargement in 2001 declared that she was simply asking for "surgical correction of the same nature as that required by mastectomy patients," the physician-reviewer turned her down—and rightly so, for the analogy does not hold.

A few years ago, the nation was transfixed by Oregon's attempts to reshape Medicaid, the public insurance program for lower-income people. After much passionate debate, what tended to be deemed less medically necessary were treatments that have little impact on a condition, such as certain kinds of back surgery, some transplants, or some end-of-life care, and conditions that resolve themselves on their own, such as measles, viral sore throats, and minor bumps on the head. America's debate over private insurance cuts much closer to the bone. Impotence, facial scars, and infertility are not conditions that will resolve themselves without treatment. And Viagra, revision surgery, and in vitro fertilization do not fall into the class of treatments that will have little or no impact on these conditions. Precisely for that reason, the debates surrounding them come closer to really grasping the nettle—to calling forth our deepest understandings of *necessity* and of *medical*.

What's notable about so many of these battles waged on the borders of medical necessity is that they have to do with matters of sexual attractiveness or ability. Why is that? Perhaps it's because, as Sigmund Freud famously observed, we're creatures who work and love. What's medically necessary for work is now taken care of by workers' compensation and workplace disability laws (which have generated their own prodigious debates). Now that the workplace has been attended to, love has become the frontier where the fiercest contention occurs over the meanings of *medical* and *necessity*. We're evolving richer understandings of both words, and it's time that those new insights modified the natural-functioning criterion. For no matter what the philosophers and the physician-reviewers may say, natural functioning and medical necessity by no means always coincide, and they are even less likely to do so as new genetic, hormonal, cellular, and pharmaceutical therapies develop.

Imagine a new super-Prozac designed for individuals who are not clinically depressed. Suppose that—like today's ordinary Prozac—this super-Prozac is not a "happy pill" that makes people euphoric. Instead, suppose that it would simply do unerringly what Dr. Peter D. Kramer, in his best-selling *Listening to Prozac* (1993), says that Prozac currently does only in a hit-or-miss way: substitute completely for psychotherapy. People with self-punishing neuroses—those who erroneously believe that everything they do is doomed to failure—would, by taking super-Prozac, lose their diffidence. Those with ego-protecting neuroses, who deludedly believe that all's right with them and their world, would shed their complacency. This imagined super-Prozac would simply present reality to us unencumbered by neurotic baggage. More than that, it would allow us to cultivate the capacity for acceptance that comes from a non-neurotic ability to acknowledge failure. And it would foster the trait of humility that comes from a non-neurotic capacity to embrace success.

Could this drug be a medical necessity? From the natural-functioning perspective, the answer would be no. After all, everyone is neurotic in some way. And so super-Prozac would seem to extend or enhance natural functioning, not preserve or restore it.

But since insurers are reluctant to pay for extended psychotherapy, many people might enjoy no alternative to super-Prozac; so in that sense super-Prozac could well be a necessity. And it would, arguably, be a *medical* necessity for all those whose neuroses result from a trauma that diverted them from a personal norm. But what about the rest of us garden-variety neurotics, who just grew up that way—whose neuroses weren't caused traumatically but developmentally?

Here, we would need to embark on a public conversation about what the social norm really is. Normal neurosis, as many have pointed out, has its good points as well as its bad. A neurotic fear of failure often leads to great artfulness; a neurotic belief in one's own infallibility frequently induces surpassing boldness. Those are valuable things. But boldness is not as valuable as strength, and strength is what gets cultivated when we face our failures in a non-neurotic way. Nor is artfulness as valuable as imagination; yet imagination is what we develop when we embrace our successes in a non-neurotic way, knowing that we will then have to find a way to transcend them. To aim for strength and imagination instead of boldness and artfulness is not, necessarily, to alter the social norm. It may be to realize that norm more fully.

There are no ready answers to many of the questions that confront us. Yet it's helpful to see and contemplate ahead of time the kind of public conversation about moral psychology that super-Prozac and, in their own way, other new genetic, cellular, and pharmaceutical treatments could induce. It's a conversation that would be precluded by the natural-functioning approach that's come to dominate so much contemporary thinking. But as the wisdom emerging from America's current grass-roots debates in hearing rooms and legislative chambers over the borders of medical necessity amply demonstrates, we would be the worse for not engaging in it. ❑