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Anxiety about perfection

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Michael Sandel's book *The Case Against Perfection: Ethics in the Age of Genetic Engineering*[1] is based on a 2004 essay published in the Atlantic Monthly. The book, which is handbook size, contains an expanded version of this essay at 100 pages in length and also an epilogue on the ethics of stem cell technology. The main essay is divided into five short chapters. Despite the title, it is not an essay solely concerned with genetic engineering but concerns itself with enhancement of various types from drugs in sport to early and intensive training of children. The position that underlies Sandel's criticism of these instances of enhancement is that there is a moral difference between cultivation of natural abilities and the artificial enhancement, or creation, of abilities and that such artifice is unethical.

Sandel begins by writing:

> *Breakthroughs in genetics present us with a promise and a predicament. The promise is that we may soon be able to treat and prevent a host of debilitating diseases. The predicament is that our newfound genetic knowledge may also enable us to manipulate our own nature – to enhance our muscles, memories, and moods; to choose the sex, height, and other genetic traits of our children; to improve our physical and cognitive capacities; to make ourselves 'better than well'. Most people find at least some forms of genetic engineering disquieting. But it is not easy to articulate the source of unease.*[2]

In this issue

David Langsford and Helen McCabe are the authors of our two articles. Dr Langford's is a discussion of Michael Sandel's view of genetic enhancement. Dr McCabe's is a discussion of Thomas Faunce's view of the role of the market in the provision of health care.

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Sandel's task is a large one: unfold the nature of this moral unease and demonstrate the unease hangs on an important moral concern. Sandel acknowledges a number of possible explanations of this moral unease. I will not detail all of Sandel's criticisms of other possible explanations. However, one common concern about genetic engineering (and indeed reproductive cloning) does require some attention. It is that position that parental genetic engineering leads to a loss of autonomy of the child and a decrease in the responsibility the child has for the shape of their life. Sandel does not pause to grapple with the nature of autonomy in question and quickly proceeds to dismiss this concern on two grounds:

1. At present, no child can determine their own phenotype, and thus genetic engineering cannot entail a loss;

2. This position does not account for the moral unease around adults engaging in genetic engineering for themselves.[3]

Sandel does not object to genetic engineering by appeal to the principles of autonomy or dignity, nor, as we shall see, does he reject genetic engineering on utilitarian grounds. With regard to concerns about autonomy and dignity, Sandel concludes:

> *It is commonly said that enhancement, cloning, and genetic engineering pose a threat to human dignity. This is true enough. But the challenge is to say* how *these practices diminish our humanity. What aspects of human freedom or human flourishing do they threaten?*[4]

The use of language such as 'flourishing' broadly evokes a virtue ethics approach. In this vein, chapter two on genetic engineering in athletes is guided by the appeal to the existence of a *telos* of sport and how genetic engineering may, or may not, fit with that *telos*. Moreover, while Sandel wants to analyse the issue of artificial enhancement of athletes for its own sake, the analysis also stands as an analogy of genetic engineering of human beings *per se*. As such, I will consider how use of the notion of *telos* may form the basis of a philosophical objection to genetic engineering in general and will start with Sandel's views on enhancement in sport.

Consistent with his dismissal of loss of autonomy as the explanation of our unease, Sandel also rejects the hypothesis that genetic engineering leads to a diminution of human agency. Perhaps, should athletes be increasingly engineered, athletes' ownership of their achievements will pass increasingly from the athletes to the engineers. Sandel, however, argues it is not the implied loss of agency that is alarming but rather the contrary: the promotion of "hyperagency".[5] The term 'hyperagency' is supposed to capture the idea of a drive not only for man to be the measure of the world but also for man to be the maker of the world. Our unease about drugs in sport, for example, is not explained by the belief that drugs decrease the need to strive hard for success; rather, it lies in the amplification of striving to such an extent that the striving no longer fits with the *telos* of sport.

The content of the *telos* of sport is surely a subject of dispute. Sandel, himself, advances that it is the celebration of excellence. Sporting excellence can be arrived at by striving and hard work or (not mutually exclusively) built primarily upon natural abilities. Witness, for example, the twin brother cricket players Steve and Mark Waugh: Steve, the dogged, persistent striver, to whom cricket did not appear to come easy but was one of the great players; Mark, a graceful player for whom it appeared that cricket came too easy, whose natural abilities people around the world celebrated. Sandel argues that the issue of enhancement in sport is that it is akin to the surely mistaken celebration of Steve, because of his constant striving, at the expense of ignoring Mark's natural gifts. The unease with enhancement is then not that an enhanced Steve (seeking to copy the natural gifts of his brother) would lose agency, but that the exemplified amplified striving disparages that which comes naturally in favour of that which we can create: it is a hyperagency, the disposition to celebrate ourselves as the maker (or improver) of ourselves and our world.

Immediately, any interlocutor must ask: is there a real distinction between natural and artifice? This is not only a semantic question, but also a metaphysical and ethical question. Restating in specific settings can aid in bringing this out. In medicine it can be restated as, 'is there a difference between treatment to restore the natural and treatment to enhance it?'. The nature of 'the natural' is not a mere definitional problem and, as we shall see later, is an important metaphysical issue to be settled within Sandel's problematic. It will also be important to determine if a distinction between natural and artifice is not only metaphysically significant but also ethically significant. Indeed, it is how these questions are answered that forms the core of Sandel's objection to genetic engineering.

Unfortunately, Sandel himself is not alert to all of the difficulties in ensuring this distinction holds, metaphysically or ethically. Nonetheless, his argument about the unethical nature of enhancement can be quickly recounted. During Sandel's analyses of sporting skill he distinguishes between cultivation of natural abilities and artificial enhancement. The criterion of this distinction is the *telos* of the sport involved. If a particular activity improves a sportsperson's skills and that activity is consistent with the *telos* of the sport then such activity is cultivation of ability and both that cultivation and sporting natural ability are to be celebrated. Moreover, those activities that are inconsistent with the *telos* of the sport, such as the use of EPO or testosterone in cycling's Tour de France, "depreciate the natural talents and gifts that the greatest players display" (37). The Tour de France demands of cyclists that they be built for and fit for riding long

distances and up mountain slopes for days in succession over three weeks. The ability to recover from one day's cycling and to saddle-up the next day is part of what it is to win the race. If a rider achieves that by drug enhancement then that rider has (potentially) exempted himself from that sport by failing to aim at the *telos* of the sport and his participation detracts from the celebration of the natural, and fairly cultivated, talents of those 'clean' cyclists around him.[6]

If it is possible that an appeal to the *telos* of sport can delineate between natural achievement and artificial enhancement in sporting success and thus aid us in determining the types of activities in sport that are acceptable, might the *telos* of medicine aid in distinguishing between preservation and restoration of the natural and artificial enhancement? Sandel writes:

> *Although medical treatment intervenes in nature, it does so for the sake of health, and does not represent a boundless bid for mastery and dominion. Even strenuous attempts to treat or cure disease do not constitute a Promethean assault on the … [the natural]. The reason is that medicine is governed, or at least guided, by the norm of restoring and preserving the natural human functions that constitute health.*[7]

Heroic medical efforts in the face of death and dying and potentially serious illness, ongoing rigorous scientific and clinical research may all be consistent with this norm (or *telos*). However, genetic engineering no matter how heroic and rigorous, claims Sandel, is inconsistent with the *telos* of medicine. According to Sandel, those activities which aim to restore and preserve natural human health are to be encouraged; those that aim, often no less heroically and creatively, to exemplify a desire to be the measure and maker of our nature and world are acting inconsistently with that *telos*, and perhaps the *telos* of human life itself. It is surely no easy task to determine, firstly if Sandel is correct in his rendering of the *telos* of medicine and, secondly, which activities are consistent with it. For Sandel, however, no matter what specific 'improvement' is aimed at by genetic engineering, whether it is better intelligence, better memory, more height, strength, compassion, genetic engineering cannot be justified for it is an activity, he claims, that is grounded in an aiming for perfection at the expense of the awareness of the natural. That is to say, if the *telos* of medicine is to promote and restore the natural then aiming at another goal that is associated with a turning from the natural is to encourage an activity that is not in his rendering of the *telos* of medicine and, consistent with the medical *telos* and as such, claims Sandel, is unethical.

Sandel acknowledges that his position has its critics, and that others take a distinctly different approach to evaluating genetic engineering. I very briefly touched on the appeal to the principles of autonomy and dignity earlier. One of the other approaches is utilitarian, as sketched by Julian Savulescu. Sandel summarises Savulescu:

> *Some people argue that a parent's obligation to heal a sick child implies an obligation to enhance a healthy one, to maximize his or her potential for success in life. But this is true only if one accepts the utilitarian idea that health is not a distinctive human good, but simply a means of maximizing happiness or well-being.*[8]

For Savulescu, no matter the shape of the *telos* of human life, if genetic engineering can possibly increase quality of life then it ought not only be permissible but also be obligatory for parents. This is his principle of "procreative beneficence": "the principle of selecting the best child of the potential children one could have".[9] Savulescu's position entails that there is no moral difference between protecting and cultivating a child's health and natural abilities and actively engineering them at the embryonic stage of development. Importantly, for any evaluation of the debate on genetic engineering, Savulescu does not collapse Sandel's distinction by examining the basis for that distinction, but rather by avoiding that particular distinction and concentrating on demonstrating that benefits outweigh costs. In a forthcoming chapter on genetic engineering, Savulescu writes:

> *I want to argue that far from being merely permissible, we have a moral obligation or moral reason to enhance ourselves and our children. Indeed, we have the same kind of obligation as we have to treat and prevent disease. Not only can we enhance, we* should *enhance.*[10]

And:

> *If the outcome is the same, why treat biological manipulation differently to environmental [diet, education, training] manipulation? Not only may a favourable environment improve a child's biology and increase a child's opportunities, so too may direct biological interventions. Couples should maximise the genetic opportunity of their children to lead a good life and a productive, cooperative social existence.*[11]

Notice here that Savulescu views environmental manipulation as leading to **indirect** biological changes and as such he finds there are no good arguments for preventing **direct** biological manipulation (e.g., genetic engineering). On the other hand, Sandel can admit the relationship between a person's environmental influences and biology and still resist Savulescu's conclusions by insisting that biology does not capture all of what he is concerned with. Sandel does reject Savulescu's consequentialist approach, recognising that it collapses his (allegedly morally important) distinction between cultivating and enhancing[12], but problematically omits to flesh-out a central part of his own theory: that of the nature of the 'natural', indeed of 'human nature', which must involve a way of describing human life in terms not reducible to biology. Without such an account it is difficult to appreciate how cultivation can be distinguished from enhancement. If both activities are simply different ways of manipulating the same stuff then unless there is something about that stuff that excludes certain forms of manipulation then Sandel's argument cannot go through. Moreover, it is difficult to imagine why we would exclude biological manipulation of our biology. Thus, unless we ourselves are more than biology, it can be difficult to resist the general thrust of Savulescu's arguments.[13]

I have argued that Sandel's argument turns on his answers to two questions: 1. Is there a difference between real and artifice? 2. Does such a distinction have moral significance? Sandel answers 'yes' to both questions; however, as I pointed out above, there remains much philosophical work to be done, in particular how the distinction between natural and artifice is a robust one given a certain account of the nature of the 'natural'.

I will now try to elucidate Sandel's understanding of the 'natural'. Sandel writes, at the end of chapter four on eugenics:

> *Even if it does not harm the child or impair its autonomy, eugenic parenting is objectionable because it expresses and entrenches a certain stance toward the world – a stance of mastery and dominion that fails to appreciate the gifted character of human powers and achievements, and misses the part of freedom that consists in a persisting negotiation with the given.*[14]

As can be seen from the above quotation, the key feature of the 'natural' is 'giftedness'. The natural ability of the sportsperson can be diminished if cultivation of skills is superseded by enhancement driven by the aim to be the master and maker of the world. The preservation of health, analogically, becomes (impermissible) enhancement when it is driven by the aim to be the master of the natural, to be able to create it according to our interests, rather than cultivating that which we find ourselves with. It is, however, difficult to discover what more Sandel has in mind when he writes about 'giftedness', such a key concept in his argument. By way of development of this, at one point he writes approvingly of Habermas' suggestion that to think of ourselves as free and ethical beings is to conceive of our beginning, our natality, as an event that is not subject to our control or indeed control by others.[15] Sandel's too brief sketch is one of a transcendental argument: the condition of the possibility of free and ethical behaviour is that there is in the origin of human life 'something' (of unclear ontological or metaphysical or ethical status) that is not a power at my disposal or the disposal or others. If this position were to be upheld then activities consistent with denying this condition for the possibility of free ethical life would be unethical. As Sandel appears to believe a version of this argument can be upheld and that it is somehow to be tied to the 'gifted' nature of any human life, then Sandel appears to mean for us to conclude that attempting to exert mastery over the gifted nature of human life is unethical. That is, by aiming at making the world and ourselves in accordance with our powers and failing to acknowledge that our natality implies something about human life that is not a power open to disposal forms a framework for discussing artifice and its unethical features.

Sandel wants us to accept that there is some feature of human nature that permits an ethical distinction between cultivation and enhancement. He does not settle the question of how to make that distinction in any one case, nor does he account for the feature of human nature he relies upon in any convincing philosophical manner. There are only hints of a further exposition. Towards the end of the book, he writes:

> *I am suggesting … that the moral stakes in the enhancement debate are not fully captured by the familiar categories of autonomy and rights, on the one hand, and the calculation of costs and benefits, on the other. My concern with enhancement is not as individual vice but as* ***habit of mind and way of being.***[16]

Does this reference to 'way of being' help us to understand what Sandel is trying capture with his term 'giftedness'? Perhaps, but it is remains obscure what Sandel means by 'way of being'. We are left then with a worthy attempt to explore why we feel a moral unease about genetic engineering, an attempt that gives us reason to pause and reflect. We can also see that by delimiting discussion of genetic engineering in terms of the biological only will obscure and evade the questions that Sandel raises. Nonetheless, Sandel himself does not have philosophically satisfying answers to the questions that he raises.

Finally and at risk of muddying the waters, I suggest that we may find some resources for the answers that Sandel seeks by posing the more general question about human unease with technology in general. This may be achieved, not with reference to Habermas but with reference to Heidegger and his essay on technology.[17] For Heidegger, the 'essence of technology' is that it is a 'way of being' in which nature is rendered orderable and calculable and, in being so ordered, investigable, manageable and changeable. Technology, as a kind of 'way of being', which is far more than a *techne*, brings us, says Heidegger, "to the very brink of a precipitous fall".[18] Human beings, as the orderer of nature, risk themselves becoming that which is ordered, technology is a 'way of being' of human beings that delimits the being of humans as that which is ordering and ordered. The unease with technology is not accounted for by reference to the instruments of technology and what they can do, but rather that "the actual threat has already affected man in his essence".[19] Genetic engineering represents for us, in the twenty-first century, a literal ability to order human nature, and as such it is a *techne* that discloses more readily a certain 'way of being', a 'way of being' that for Heidegger is divorced from truth.

I will not discuss Heidegger further and recognise that the above is far from a *précis* of Heidegger's essay. However, my gesture towards Heidegger serves to raise a question that escaped Sandel. Sandel set himself the task of articulating the nature of the moral unease with genetic engineering. I wonder whether this moral unease is a manifestation of an anxiety not specific to genetic engineering but about the relationship between human nature and technology *per se*. Perhaps it is an anxiety about a loss and a forgetting of truth in the face of a technological 'way of being'; an anxiety about technology that can be more pressingly disclosed in a setting in which through technology human nature is rendered as that which masters and is inescapably that which is masterable and possibly mastered.

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Footnotes

[1] Belknap, 2007
[2] Sandel, 5-6
[3] Sandel, 6-8
[4] Sandel, 24
[5] Sandel, 26
[6] Possibly the use of drugs may be consistent with the *telos* of sport. That is not a matter I intend to settle here. It is important only to point out, for Sandel, what is crucial is that we can ask about which activities are consistent with the *telos* of sport, or any particular sport.
[7] Sandel, 46-47
[8] Sandel, 47
[9] Savulescu, J. In defence of procreative beneficence. *Journal of Medical Ethics.* 2007; 33: 284-288 (284)
[10] Savulescu J. Genetic interventions and the ethics of enhancement of human beings, forthcoming
[11] Savulescu, forthcoming
[12] Sandel 47-48
[13] Francis Kamm's review of Sandel's argument is interesting to consider on this point. Kamm renders Sandel's understanding of hyperagency in medicine as the scientific attempt to be the master of the biological. Kamm then demonstrates that the consequentialist arguments for genetic engineering (in general, if not in any specific case) is a powerful one that can account for Sandel's argument if his idea of hyperagency is just mastery of the biological. (Kamm FM. What is and is not wrong with enhancement? *Faculty Research Working Paper Series, John F Kennedy School of Government, Harvard University May 2006* at http://ksgnotes1.harvard.edu/Research/wpaper.nsf/rwp/RWP06-020)
[14] Sandel, 83
[15] Sandel, 79-83
[16] Sandel, 96. My emphasis
[17] Heidegger, M. The question concerning technology. *Basic Writings Revised and Expanded Edition.* ed. DF Krall. London, Routledge: 1978 (311-341)
[18] Heidegger, 332
[19] Heidegger, 333

Who Owns Our Health?

Helen McCabe

Thinking about health or providing for health care need can be a daunting task, given the complex and myriad aspects of this venture. That most thinkers cut this task down to manageable, subject-specific portions is, then, to be expected. So, we find some commentators addressing the politics or sociology of health care provision, others turning to the legal or economic implications of the task, many training their focus on scientific, psychological or technical aspects of the matter, and still others delving into the philosophy and ethics of a range of factors raised by illness, disease and injury. Generally, on studying the problems of health and its care, we are likely to find, also, varying degrees of particularity within these projects in keeping with increasing levels of specialisation.

So, picking up Thomas Faunce's recently published book, *Who Owns Our Health?*,[1] is a novel experience: addressing the issue of health on a global scale, it tackles a broad array of concerns from the perspective of an even broader array of specific academic endeavours. That Faunce can attempt this project is reflective of his background and interest in medicine, the law, politics, economics, philosophy, and, as well, the instructive force of literature. Presently, Faunce is senior lecturer in both the College of Law and in the Medical School at the Australian National University. He is also the Director of two significant ARC grants, one of which investigates the safety and regulation of nanomedicine,[2] while the other is concerned with the effects of international trade agreements on Australian pharmaceuticals policy.[3] And together with practical experience of both clinical medicine and legal practice, Faunce has written extensively on health law and bioethics. The reader of *Who Owns Our Health?* embarks, then, on a hectic but illuminating journey through the vast breadth of the author's learning and experience.

Faunce's project is aimed at revising the regulatory and ideological context in which health is pursued; specifically, he attempts to renegotiate the place of health care professionals, policy-makers, the law and the corporate health care sector so that health is removed from what he calls a 'market state' and re-situated within an 'integrated professional regulatory system'. In doing so, the author wants to retain what he sees as the benefits of corporate competition while, at the same time, regaining and protecting professional conscience and virtue. Employing a Rawlsian method of 'coherence reasoning', Faunce goes about accommodating a range of roles, purposes and ideals within a global health care system in which the *prima facie* duty is the relief of patient suffering. Overall, Faunce attempts, imaginatively, to construct and devise principles of professional leadership in global health care, improve outcomes of all relevant stakeholders and, ultimately, create a 'more genuinely cosmopolitan, egalitarian and sustainable global civilisation'.[4] This is, to say the least, a very ambitious project.

In *Who Owns Our Health?* we find an astute and lucid account of health care arrangements in the contemporary world. This is to be welcomed, given the lack of

perception and awareness in regard to this matter generally; indeed, with the exception of the United States, those nations which have maintained the appearance of a universally-funded, public health care system have also, to at least some extent, rendered opaque the role and influence of the market in health care arrangements. Faunce offers a remedy to this failing by describing and clarifying the contemporary role and expression of the market in what was, traditionally, the distinct realm of professional health care.

However, this is not the primary purpose of the book; instead, it is an endeavour to move beyond present difficulties and into a strongly liberal vision in which a plurality of values, virtues, ideologies and aspirations is to be pursued in conformity with a proposed regulatory framework. The explication of Faunce's egalitarian and pluralist vision occupies a large part of the book. And it is a vision which is (at least practically) reflective of the egalitarianism espoused by Rawls. However, while Faunce is loyal to Rawls' requirements of procedural justice, he disagrees with Rawls that justice (understood as fairness) should be the overriding liberal value. Similarly, he disagrees that the overriding liberal value should be either equality[5] or liberty, as others would have it. Instead, Faunce attributes that place to the concept of human rights.[6]

Of course, egalitarians must avoid any prior commitment to substantive values, such as to health; instead, the (moral) right is held prior to the (moral) good. In keeping faith with the tenets of egalitarianism, Faunce proposes that health is a human right and it is for *this* reason that the value of health finds a place of importance in Faunce's scheme. Throughout his book, we find the author occupied with setting in place the principles and laws by which the differing values pursued by medical professionals, government, the 'health industry', managers and patient groups[7] are to be regulated. In this way, the outline of a global social contract for upholding (what the author considers) a right to health is sketched.

An outline of Faunce's project

In the first chapter, by way of introduction, Faunce looks critically at contemporary 'market fundamentalism' and, moreover, the increasingly indistinguishable interests of government and the global market. He notes that the market state engenders a range of anomalies in respect of medical professionalism: it undermines ethical medical practice and research (through, for instance, the distorting effects of corporate interference in both the publication of research findings and in the development of clinical guidelines), and it gives rise to wide discrepancies in health status between the wealthy (and privately insured) and the poor. As well, in a market state, the interests of the community in maintaining universal public health care systems are increasingly overlooked; instead, the profit-making interests of private corporations are promoted by government. For at least these reasons, Faunce notes the need for a 'new social contract' between medical professionals, government, the global health care industry, managers and policy-makers.

In chapter 2, Faunce constructs an integrated regulatory framework for governing the terms of that contract and, generally, for addressing the problems of an increasingly privatised global health care system. He draws on norms of 'private morality', the virtues, institutional medical ethics and bioethics, legislation, judge-made law and the principles and commitments of international human rights conventions to serve as a framework for regulating standards of 'medical professionalism'. At the foundation of this system, he appoints loyalty as the regulatory virtue; further, he nominates 'loyalty to the relief of patient suffering' as the guiding principle of his integrated regulatory framework.

Faunce points out that, in a market state, the autonomous role of the patient is largely fictional, as are the ideas that governments 'arise from free elections' and 'represent the

collective will of their citizens'. For this reason, the regulatory independence of the medical profession becomes necessary when, as is the present case, public interest disclosure requirements are overridden by such corporate laws as involve commercial confidentiality clauses and other restrictions suppressing publicity. Faunce also points out that, in a market state, the influence of legal positivism has served to favour the interests of private corporations over and above the requirements of medical professional morality. While he is keen to preserve the 'predictability and certainty' of legal positivism, Faunce also wants to preserve what he considers a universal right to health. His proposed 'integrated professional system', characterised by a 'probabilistic structure of principles observed by conscience', is an attempt to achieve this much.

The author is convinced by the tenets of Rawlsian egalitarianism; accordingly, he conceives of ethics as, for the most part, consensus and that, through a process of 'coherence reasoning', health professionals, industry representatives and policy-makers would all reach some kind of agreement as to the social and professional virtues, ethical principles, laws, and ideals that are to be linked in a regulatory system. Further, should any dissonance between the law and morality accompany so-called 'hard cases' (such as abortion, euthanasia, withdrawing or withholding treatment, and not-for-resuscitation orders), Faunce suggests that virtue and conscience would overcome such dilemmas, thereby realising 'better ethical outcomes'.

In order to concur with Faunce's view, however, we would need to be convinced of three assumptions: that we can identify what a 'better ethical outcome' would be independently of any particular conception of the good, that 'better ethical outcomes' necessarily follow from wide consensus, and, even if such wide consultation were practically feasible, that a great degree of consensus could, ultimately, be reached. Or, at least, it is to be wondered if broad consensus could be reached on a range of issues and views, given the differing (and strongly-held) views of many different individuals, cultures and professions. Faunce believes it *is* possible to 'meld' a range of values, ideologies and principles emanating from differing worldviews and traditions: 'socially endogenous' religious values, international human rights, medical professional ethics, bioethics, and free market ideology are all thought to cohere somehow once they become subject to the contractual operations of a Rawlsian (global) social contract. However, this is highly disputable, a point to which I shall later return.

In chapter 3, Faunce proposes that students of the health professions, together with students of such disciplines as health policy and law, learn the principles of medical professionalism and their relationship with the principles of the 'corporate-controlled market state'. Faunce offers some suggestions here for teaching future generations of medical professionals.

In chapter 4, Faunce proposes that medical professionalism be 'renegotiated', 'democratised', and 'revitalised' so as to reflect the ideals that the community expects to be embodied by both professionals and the health care system in general. This envisioned scheme is to be structured in ways that are exclusive of 'legalism', industry self-regulation, the standard 'centralised' expressions of ethics (ethics committees, peer review boards, health care complaints organisations and so forth), and the shaping of professional regulation by commercial realities. Instead, all facets of the sector, including the law, need to be focused on the relief of patient suffering. To do this, Faunce rejects the primacy that Pellegrino grants to the role of the doctor-patient relationship, proposing instead a 'very broad based medical professionalism'[8] to which a range of professions concerned with health is subject. In this sense, he promotes a kind of institution-patient relationship.

In chapters 5 and 6, Faunce continues the task of constructing his regulatory

framework, requiring policy-makers to be loyal to the relief of patient suffering by acting to protect patient trust and medical loyalty from the 'callous insincerity' of the market. In this sense, he favours a more coercive role for government. He also requires that health ministers have professional experience of, and personal commitment to, his principle of loyalty to the relief of patient suffering. In this way, Faunce also re-imagines the credentials of those who assume a governance role. Further, government is required to desist from deploying religious ideology (as Faunce believes it does) for the purpose of 'counteract[ing] suspicions' of the decisive influence of profit-seeking commercial corporations in government deliberations. This point, however, raises some questions; for it is not clear if, by making this claim, Faunce is pointing out deception on the part of government or intrusion on the part of the church into what might be, properly, state matters. And it must also be asked: in what way can 'religious ideology' be used for concealing commercial priorities? Or, at least, the author's point is not clear.

Earlier (in chapter 3), Faunce encourages the practice of a form of secular meditation, noting its effects of both promoting 'virtue-building applications of principle in the face of obstacles' and of counteracting the 'instrumental use' of 'spiritual and religious philosophies and techniques in clinical decision and health policy-making'. The latter problem he believes to be 'deeply offensive to some patients'.[9] However, one is left wondering what is meant by these claims; what is a spiritual or religious 'technique', for instance, and why would a form of secular meditation overcome such problems if they do, in fact, exist? These points require clarification and elaboration if the author's intention in raising these concerns is to be understood.

Faunce is concerned to promote a right to health, including to the conditions which promote health. For this reason, he holds a place for medical professionals to challenge those ('market fundamentalist') policies which include promoting militarism, contributing to the widening gap between the rich and the poor, and permitting the use of land mines and torture. And he attributes this duty to medical professionals on health *and* human rights grounds. In this respect, Faunce foresees an important role for medical professionals as human rights defenders and patient advocates, in addition to promoters of health. So, his view differs from those who object to the involvement of medical professionals in such activities as torture on the grounds that it violates the professional integrity of those professionals so implicated; instead, he promotes this role on the grounds that medical professionals bear responsibilities to prevent those activities and conditions which can harm health. In this sense, a great many human endeavours are subsumed under the notion of health in ways that are disputable.

In chapter 7, Faunce provides an excellent account of the health care market in the United States, including a clear, concise account of managed care corporations and their influence on health care standards and availability. Specifically, he discusses the freedom with which pharmaceutical and medical device companies can set research agendas, determine safety standards, increase 'consumer' demand for their products, bribe government officials and doctors, set prices, and promote increasing levels of privatisation, emphasising the cooperative relationship between government and industry necessary for explaining the rise of these anomalies. In this chapter, Faunce also clarifies further the influence of international trade and economic organisations on health care regulation and resource distribution globally. And he joins the chorus of commentators critical of the use of market language in the health care domain, rejecting as false the notion of patient as 'consumer'.

Importantly, it is not Faunce's intention to discredit the market state so much as it is his intention to draw that state into his envisioned regulatory framework which, in turn, would impose upon the state the responsibility of coming 'to the aid of vulnerable populations', including by 'protecting and fulfilling the

preconditions for health'. In a sense, then, it can be assumed that the author proposes to reinvigorate the legitimate role and responsibilities of the state. However, as distinct from Walzer's (alternative) egalitarian worldview in which clear and strong boundaries are drawn between the social spheres of the market and the state, Faunce welcomes, 'multinational health care corporations into negotiations for a ... global social contract supportive of professional virtues and principles'. Accordingly, the moral boundary between the spheres of state and market collapse under the weight of an ambitious conception of cosmopolitanism, as well as the broadest conception of health.

In chapter 8, Faunce completes an account of his vision for the future, sweeping aside nation states, 'culture' and (what he calls) 'narrow religious ideology' to make way for some kind of model of 'cosmopolitan allegiance' in which both corporate profits and global public goods can be fostered and in which, also, pharmaceutical research and development can be 'better focused on the global burden of illness'. Health professionals and policy-makers would take the lead in this process. In making this proposal, Faunce is mindful of the objection of paternalism: he attempts to avoid the charge by 'getting more doctors to strive for good character' and, also, to uphold the 'principle of loyalty to the relief of patient suffering'. In turn, this would assist in the development of an institutional ethos characterised by the 'consistent performance of duty' interpreted according to 'a broad range of moral, ethical, legal and human rights traditions'. Faunce wants to see this arrangement sustained over 'millions of years'.

Ultimately, Faunce concludes that in an age beyond the market state, most will recognise that the 'path to contentment' will involve 'conscience-directed work'.

Commentary

In *Who Owns Our Health?* Faunce is responding, for the most part, to the deleterious effect that a largely unregulated market has on health. His account of what he dubs the 'market state' is both lucid and revelatory in a world often blinded to its operations and ambitions. This aspect of the book is particularly instructive: students of a range of relevant disciplines, such as the health care professions, politics, social science, and health management would gain much from reading the relevant chapters. Other aspects of the book, however, take the reader on a journey into a future of the author's imagination. While it proves an interesting adventure, there would be many whose views would differ from those of the author.

Faunce's largely egalitarian approach assumes that consensus can be found about a range of matters, including about the guiding force of a particular underlying principle, about a range of specific social and professional virtues, as well as about other ethical principles, laws, and ideals, including of democratic legitimacy and international human rights. And he assumes the possibility of reaching such consensus on a global scale. But, why *does* Faunce assume, for instance, that a proponent of free market ideology, a commercial corporate executive, a medical professional, a person suffering from an illness of one sort or another, and a democratic policy-maker would *all* agree that human beings have a right to health or, even, a right to health care?[10] Also, why *does* Faunce believe that those same individuals would *all* agree that their primary duty is to remain loyal to the relief of patient suffering, particularly if they also have a duty to shareholders, as commercial corporations invariably do? Moreover, as has long been the case, no real consensus has yet been found as to the definition of health, or to what is owed to those in health care need. So, agreement on the most fundamental terms of health care arrangements is lacking in ways that the author does not seem to notice. Moreover, the lack of agreement among these different groups would present a major obstacle to the author's project.

Of course, there may be *some* consensus on a range of issues even if that consensus is not unanimous. Perhaps Faunce, along

utilitarians of various persuasions, would be prepared to accept a majority decision as sufficient for determining a law or policy. However, should this be the case, the ethical and political problems which accompany utilitarian schemes would necessarily arise, including the 'tyranny of the majority' problem. Faunce offers us no defence in this respect. Indeed, the problems arising out of Rawlsian egalitarianism necessarily accompany Faunce's controversial book; to these objections, Faunce pays little heed other than to respond to accusations of paternalism, as already noted.

However, it does not appear to be Faunce's intention to defend his approach as much as it is to simply offer a new (and somewhat) utopian vision of a world in which, controversially, the problem of human health takes centre stage. So, we are left wondering *why* we would value (among other things) health to this degree. And we are left without an explanation as to *why* we would subsume an array of distinct concerns under the mantle of health (capital punishment, torture, other human rights violations, wealth disparities among populations and so forth), as Faunce is keen to do. Some commentators would hold to the view that, while such concerns may affect an individual's health, it does not follow that they can be subsumed, entirely, under the concept of health without rendering that concept largely meaningless or, moreover, without diminishing the significance of the distinct moral values of human dignity, justice, compassion and so forth. Conversely, in reducing a number of distinct vices to a problem of illness, we not only distort the requirements of morality but we distort, also, the concept of illness in a way that renders *it* meaningless. On these matters, the author is silent.

Faunce eschews a commitment to any overarching conception of the good, even the good of health. Further, he avoids the use of moral imperatives or overt exhortations to do one thing or another: indeed, the word 'ought' is not to be found on any of the 266 pages in the book. While the author identifies ethical concerns with the corporate movement towards privatisation, he attempts, nonetheless, to 'tame' this ambition towards coherence with 'foundational social and professional virtues' rather than to exclude a role for the industry as such. As well, Faunce refrains from allocating individual responsibility for medical negligence; instead, 'instances of alleged medical negligence' are to be set into the broader institutional context in which they might arise. In this way, notwithstanding his references to conscience and virtue, Faunce ultimately relies not so much on the integrity of the individual, but on the operations of the legal system for protecting the interests of patients. In at least these respects, Faunce differs from proponents of (among others) a virtue ethics approach to medical morality, such as that espoused by Pellegrino.[11]

Faunce foresees a greater role for the law in the future of health care arrangements; his faith in the practical effectiveness of the law in general and in international human rights law in particular for achieving 'better ethical outcomes' is considerable. Questions remain, however, as to whether that degree of faith in the law is well placed, given the impossibility of impelling virtue, given already demonstrated limits in safeguarding recognised human rights, and given the obscurity surrounding the expression 'ethical outcomes'.

Nonetheless, Faunce's attempt to grapple with what are (most likely) the lasting effects of (for want of a more concise concept) globalisation is admirable; he is somewhat of a pioneer in contributing a range of ideas for protecting the value of health in this changed world. And whether the elements of Faunce's vision concur with the views of others, or not, they open up a much needed debate on the future of health care. For this reason, students of (among other disciplines) the health professions, politics, economics, and the law could do well to familiarise themselves with the background information and proposals which form the content of this book.

To embark on any quest to achieve universal agreement and cooperation in relation to *any* matter requires both an adventurous spirit and more than a large measure of optimism. Reading *Who Owns Our Health?* is most certainly an adventure; however, it is somewhat difficult to share the author's optimism with regard to achieving global consensus on a range of matters concerning health. Nor is it necessarily desirable to achieve consensus; there may be good reasons for rejecting some of what Faunce envisions. However, notwithstanding the controversial nature of the project, Faunce alerts the reader to a wide range of concerns with regard to the problem of illness, disease and injury. In this regard, the book is instructive. Among other of its virtues, each chapter is followed by a useful summary, as well as two case studies, the structure and content of which capture precisely the ethical and legal points the author intends to make. These additions add to the merits of the book for use as a student text.

In general, *Who Owns Our Health?* can be recommended for anyone interested in the current debate on arrangements for the provision of health care: and that is a wide readership indeed.

Footnotes

[1] T. Faunce, *Who Owns Our Health?*, 2007, University of NSW Press, Sydney.
[2] See, for instance, T. Faunce, 'Nanotherapeutics: new challenges for safety and cost-effectiveness regulation in Australia', *Medical Journal of Australia*, 2007, Vol. 186, No. 4, pp. 189-91.
[3] See, for instance, T. Faunce, 'Reference pricing for pharmaceuticals: is the Australia–United States Free Trade Agreement affecting Australia's Pharmaceutical Benefits Scheme?', *Medical Journal of Australia*, Vol. 187, No. 4, 2007, pp. 240-42.
[4] T. Faunce, op. cit., p. 31.
[5] See, for instance, M. Walzer, *Spheres of Justice: A Defence of Pluralism and Equality*, 1983, Blackwell, Oxford.
[6] There are some much-debated difficulties that arise for liberalism in grappling with a commitment to both pluralism and the overriding place of substantive values. For a discussion of this matter, see (for instance), J. Kekes, *The Morality of Pluralism*, Princeton University Press, Princeton, 1993, pp. 199-217.
[7] T. Faunce, op. cit., p. 37.
[8] T. Faunce, op. cit., pp. 75-6.
[9] T. Faunce, op. cit., p. 97.
[10] Libertarians argue against the view that health care is a human right. See, for instance, H. T. Engelhardt, *The Foundations of Bioethics*, 1986, Oxford University Press, Oxford, pp. 336-74.
[11] See, for instance, E. Pellegrino & D. Thomasma, *The Virtues in Medical Practice*, 1993, Oxford University Press, Oxford University Press, Oxford.

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