Bioethics Outlook

Plunkett Centre for Ethics

A joint centre of Australian Catholic University and St Vincent's Health Australia (Sydney)

Special Edition

Drive-Thru Healthcare: Is there more to medicine than supply and demand?

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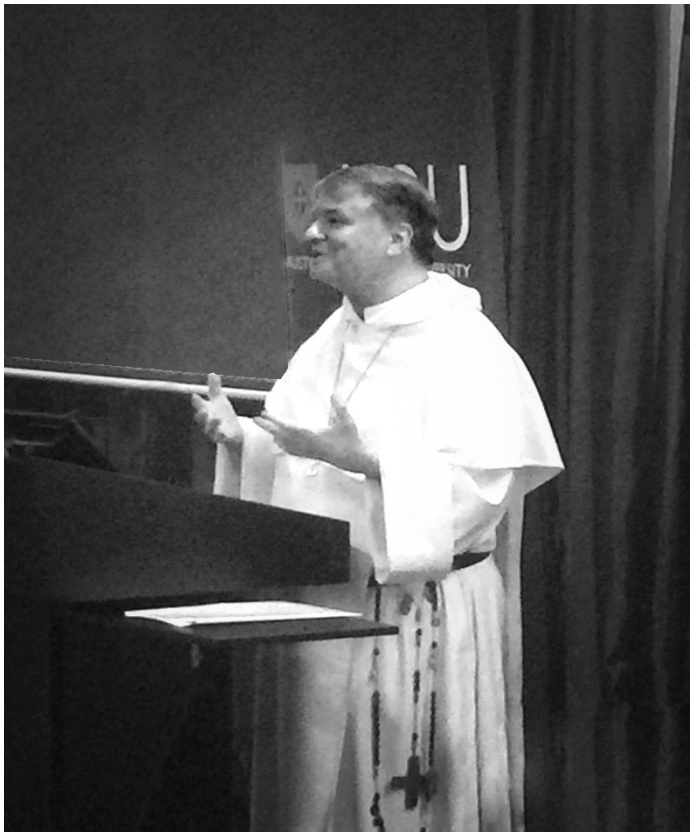

2017 PLUNKETT LECTURE

Overture to *Parrotman the Opera*

Over the last few years, Ted Richards – or Parrotman as he is now known legally – has undergone a number of procedures in order to resemble more and more closely a parrot. These have included numerous tattoos, injecting coloured dye into his eyeballs, surgically splitting his tongue and removing his ears, and the introduction of bone horns to his skull[1]. The process, on which this rather operatic ex-shoe-factory worker spends most of his pension, is not yet complete, as he plans to have his nose surgically modified to look like a beak and his eyes moved more to the sides of his head like his aviary friends.

Marc Pacifico, representing the British Association of Aesthetic Plastic Surgeons, says he's "absolutely horrified" by this case.[2] He thinks any self-respecting doctor should regard such requests as indicating an unhealthy mental state and refuse to cooperate. While healthcare is a service, it is not simply a matter of providing whatever the consumer demands: there are medical-ethical judgments to be made.

But what if Ted insisted that he was a bird trapped inside a human body? Shouldn't he be free to exercise such choice over his body? What if a psychiatrist insists there is nothing wrong with him or that being made more parrot-like would be good for him? What if Ted said he would be suicidal if denied such treatment? As Dr Pacifico himself admits, in today's climate whatever it is that you want, there's probably a doctor out there who'll do it for you. "Parrotman the opera" reflects a growing trend to 'drive-thru' medicine in which the body, agents, relationships, institutions and practices are conceived of as objects subject to the logic of supply and demand, transaction and consumption. A common shorthand for this is to speak of "healthcare as commodity", as something with no intrinsic end or ethic but, rather, something which individuals and communities invest with their own meaning and is provided on demand to those who can pay.

We could give many more examples of the commodification of medicine. The 'healing arts' are now regularly used not to heal but to harm: to kill unwanted children, remove unwanted organs, sterilise unwanted fertility, shorten unwanted living and dying, search for and destroy those with the wrong genes, and dispose of the sick and elderly.[3] Surgery or drugs may be

[1] Danny Boyle, "Man who cut off his ears to look like a parrot goes on *The Jeremy Kyle Show* and says 'it's normal'", *The Telegraph*, 5 November 2015; Will Grice, "Birdman of Bristol: Meet the man who's so obsessed with looking like a parrot he changed his name to 'Ted Parrotman' and cut off his own ears", 8 July 2016; Tilly Pearce, "*This Morning* viewers left stunned by Bristolian Parrot Man who has cut off his ears to look like a bird", *The Sun*, 21 October 2016; Olivia Wheeler, "*This Morning* viewers left 'squeamish' after guest who wants to look like a parrot", *OK! News*, 21 October 2016; "Extreme surgery to look like my parrots", *This Morning* https://www.youtube.com/watch?v=wfSsiS7HXVo

[2] "Who's a pretty boy? Parrot-obsessed man, 56, has his ears cut off to look more like his pets", *Daily Mail,* 16 October 2015.

[3] See for example Wesley Smith, *Culture of Death*: *The Age of 'Do Harm' Medicine* (New York: Encounter, 2016).

used to hide ethnicity or biological sex, or to enhance appearance, athleticism or sexual performance. Some seek to extend the human lifespan and capacities indefinitely, perhaps with organs or stem cells from dubious sources. Others propose a more comprehensive trans-humanist project. And while every sort of medicine is available on demand to those who can pay, those who most need genuine therapy often lack access.

In this lecture I will identity some of the ideas that underpin this phenomenon of 'drive-thru healthcare', consider some of its attractions and shortcomings, and then propose some more satisfactory melodies for healthcare going forward.

Act I: The idea of drive-thru healthcare

Act I, Scene I: The patient as an autonomous agent

The drive-thru conception of medicine is underpinned by three important ideas which have more than a bit of truth in them and are especially powerful in modernity. The first is the idea of *the patient as an autonomous agent who chooses the healthcare that suits her or him.* Agency – the self-governing, self-making and self-telling aspects of free choice – is rightly emphasised today in many areas of life and especially in medical decision-making.

Too often in the past, we are told, physicians assumed a paternalistic command-and-control approach and patients became passive recipients of whatever the doctor thought best. But only the patient themselves can fully appreciate their own wants and needs, experience and endurance, and so pursue the goods of life and health in reasonable ways within the context of their other pursuits and whole-of-life goals. And only the individual (in the family) can do the most mundane but crucial kinds of care in the areas of hygiene, diet, rest, exercise, substance use, simple self-nursing and self-medication, for themselves and their family members. Only when we are unsure what to do, or unable to do it for ourselves, do we turn to health professionals; and, even then, it is for advice and assistance in preventing health problems or responding well to them, rather than to ask professionals to assume control over our lives.

The emphasis on personal autonomy and responsibility in contemporary healthcare and bioethics also serves to highlight the importance of listening to and informing patients well, seeking their genuine consent, eschewing medical assault and paternalism, ensuring the observance of a range of patient rights, and avoiding intrusion by government, insurers, healthcare managers, health professionals, even family members where they should not. In an era of greater knowledge among patients of their healthcare options and greater affluence than in the past, it is not entirely unreasonable for people to expect to receive what they ask for. If people want to look like parrots or otherwise use medical care for their own purposes, then as long as they can pay and are not hurting others, they should be as free to do so as other people who do other socially unusual things.

Act I, Scene II: The doctor as supplier of a service for a fee

Related to the idea of the patient as an autonomous agent who chooses the healthcare that suits them is the conception of *the doctor as the supplier of a service* and thus *of the doctor-patient relationship as a service contract.* On this account healthcare is rather like school enrolment or legal services negotiated on particular terms between a service-provider and service-consumer. This view of the healing relationship plays out powerfully in lists of patient rights and professional responsibilities, making explicit the implicit deal by which doctors promise to inform their patients truthfully about their condition and prognosis, options and risks, to respect their choices as well as their privacy and confidentiality, and so on. It highlights the importance of respectful dealings with patients, good communication, and negotiation in decision-making.

Proponents of such a contractual view point out that much of contemporary reality has been medicalised, including matters previously dealt with by family, church and others; that much that has been medicalised has also been commercialised; and that in these changed circumstances old conceptions of 'fiduciary' relationships, 'covenants' or 'vocations' must give way to the negotiated preferences of producer and consumer. Physicians can no longer be presumed to be especially altruistic: witness their aggressive marketing, the 'kickbacks' many receive from third parties, the unwillingness to assist even at emergencies if this exposes them to legal or insurance risk, the 'closed shop' to newcomers from overseas, the chronic undersupply in poorer or remote areas, and the opposition of the profession that proposals to ensure or reform universal access to healthcare often meet. Instead of romanticising the motives of physicians and the basis of their decisions, we should face up to reality and ensure that they are, at least, faithful to their contractual obligations to their customers.

Act I, Scene III: Healthcare as an industry in a free market

If patients are viewed as autonomous agents who choose the healthcare that suits them, doctors as providers of a service-for-a-fee, and the healthcare relationship as one of supply-and-demand, *then healthcare will be seen as an industry in a free market.* Such a marketplace of multiple providers and consumers determines, through competition and free exchange, who gets what and how and when; it rewards long years of medical study, long hours of medical practice, research and development, and long investment in medical entrepreneurship and manufacture. Whatever of healthcare in more innocent times, today many would say it has indeed become a commodity, in the sense that it has a market price or relative exchange value, can be transferred on that basis and consumed.

What's more, in modernity, medicine is often a high-tech activity, delivered by teams of specialist providers of tests and treatments, often within highly complex institutions; the practitioners require professional education, use patented drugs and processes produced by multinational corporations, and are paid by consumers, insurers and others: all aspects of an industry. Entrepreneurship and competition are said to favour effective and efficient

healthcare, advances in medical technology and delivery, the capitalisation of healthcare infrastructure and research, and cost-containment in an area inclined to over-utilisation and exploding costs.

Defenders of a free-market approach point out that while healthcare, like food or housing, may be a basic need, even a human right, no one suggests that food and housing should be free or normally provided by the state. Governments, churches and other voluntary organisations, and extended families, may provide safety nets to assist those who cannot otherwise obtain healthcare, but this does not warrant abandoning the free-market as its ordinary context. People should be free, individually or in groups, to choose the what, when and how of health insurance and care, without being pressured to conform to somebody else's grand plan or interests. Nor should it be presumed that free markets are arbitrary markets: they are in fact constrained by the cultural, ethical and legal assumptions of the participants. Free-market concepts, however partial, do assist in understanding how healthcare works today, and we should not overstate supposed contrasts between medicine and commerce.[4]

Intermezzo: A tale of Guillain–Barré Syndrome

At Christmas 2015 something provoked my immune system to attack my peripheral nerves. In less than 24 hours I went from being more or less normal to being almost totally paralysed. I had contracted Acute Motor Axonal Neuropathy, a very rare variant of the already-rare Guillain–Barré Syndrome. Thankfully, I had the best of medical, nursing and physio therapy here at St Vincent's. I spent the following five months in hospital, gradually repairing those nerves and rebuilding the wasted muscles, learning again to walk, climb stairs, use cutlery, write, hold the chalice. The purgatory of paralysis and neuropathic pain was compounded by the humiliations of total dependence. Blessed with the gift of faith and many years' reflection on life and death, sickness and health, I was probably better equipped than many to approach this unnerving condition. But this didn't take the suffering or mystery away.

I've long been persuaded by writers such as Alasdair MacIntyre and Stanley Hauerwas that we should think of the human person not as the self-sufficient, powerful agent of contemporary liberalism, but rather as always vulnerable, mostly needing help from others, and sometimes very dependent indeed.[5] For the first time since infancy I experienced that first-hand and intensively. When asked what sense I made of it all, I groped for answers as anyone would, and fell into silences as everyone should. But my reaction was significantly shaped by the example and wisdom of the family, friends, faith, and traditions that had long surrounded me.

[4] Dan Brock and Allen Buchanan, *Ethical Issues in For-Profit Healthcare* (Bethesda: National Center for Biotechnology Information, 1986), https://www.ncbi.nlm.nih.gov/books/NBK217902/; Victor Fuchs and Ricahrd Zeckhauser, "Valuing health – A 'priceless' commodity", *American Economic Review* 77(2) (1987), 263-68.

[5] Alasdair MacIntyre, *Dependent Rational Animals: Why Human Beings Need the Virtues* (Open Court, 2001);

For five months, as I was 'embedded' with people with Parkinson's or Motor Neurone Disease, quadriplegia or strokes, I puzzled with them through the experience of my body 'ignoring' my directions, and my spirit dissociating itself from this uncooperative body. Patients and carers taught me powerful things about the human spirit, perseverance in suffering, and transcending limitations. I had the comfort of knowing I would most likely very largely recover; many of my comrades knew they would only get worse. So I cannot pretend to know all they were facing; but that experience and my continuing recuperation add bite to my reflections on the human person, travail and care, on the allocation of resources to the disabled, elderly and dying, and so on. I hope that, having been such a fellow-traveller I will have gained in compassion for the weak and gotten a little wisdom along the way…

Act II: Doubts about drive-thru healthcare

Reflecting on that experience I have new reasons both to appreciate and to question the commodification of medicine, and the associated constructions of patients as customers, doctors as retailers, healthcare as a contract for a service, and health institutions as an industry in a free-market. Let me explain some of my misgivings…

Act II, Scene I: Doubts about patients as consumers (only)

When I arrived at hospital my body was packing up. In a few short hours I'd gone from feeling a tingling in my right arm to complete paralysis from the neck down. Next my lungs began to fail. Rather than worrying about dying, I was afraid of losing my ability to communicate – which probably tells you a lot about me. Alongside the pain and paralysis, there was the disorientation and powerlessness typical of many patients, and the willingness to hand over in trust to my physicians. To compare me with a shopper at a supermarket as some of the healthcare-as-commodity enthusiasts do would be to misunderstand my experience of healthcare altogether.

Much of the rhetoric of patient autonomy was intended to strengthen respect for the dignity of patients and empower them in various ways. Yet many patients today feel more disempowered than ever, or that their dignity is less well reverenced. The change in language and thinking from the 'patient' as a passive sufferer of disease and recipient of treatment to 'client' or 'consumer' of chosen services was supposed to promote greater responsibility for self-care and decision-making, and greater respect for this by professionals. But where words like patient were essentially *moral* ones – redolent of certain attitudes to suffering, endurance, trust and receptivity – words like consumer only indicate a kind of financial power. Seeing the sick as powerful contracting agents, rather than vulnerable others due special protection and care, may reduce not only overweening paternalism but also proper protectiveness; it may help us get what we want but not what we most need. While healthcare consumers may expect their contractual rights to be honoured, what the suffering most need is compassion-in-action.

Those wedded to liberal bioethics tend to valorise personal autonomy and patient preferences so highly that, despite talk of competing principles, rights or responsibilities, patient demands almost always 'trump' all other moral concerns. But as long explored in the Catholic moral tradition and some others, freedom is not only "freedom from" but also (and principally) "freedom for": even very free, informed and competent agents must choose well rather than arbitrarily, which drive-thru healthcare does not encourage.

What's more, few sick people fit the bill of the idealised agent, making choices and contracts in full competence, knowledge and freedom. Many patients are only relatively competent, their ability to choose in their own best interests being compromised to some degree. No matter how excellent the information exchange between doctor and patient – and it is often far from excellent – patients have only a limited ability to receive and digest information about their condition and prognosis, treatment options and risks. They might think they know what they need on the basis of past experience, what they've heard from friends, or what they've seen on TV or the internet. But as one commentator put it: "most people have no idea if they need an x-ray… Buying healthcare is not a matter of reading online reviews and trying it out to see if you like it. For most patients, it's 'sure, whatever you say doc.'"[6]

Patients are also under all sorts of external pressures from friends, family, finances, culture and health professionals, and internal constraints due to illness, pain, time, debility, confusion, alienation, fear, and so on. When you're having a heart attack you can't shop around for services! It is unreal to compare many patients with shoppers.

Furthermore, only the relatively wealthy have the financial power to get whatever they want in healthcare. For most people healthcare needs are highly unpredictable but potentially very expensive. Private insurance is an effective device for risk-sharing between those who can afford the premiums and are admitted to the scheme, but there are many who would struggle to make the payments or have 'pre-existing conditions' that exclude them.[7] Without government assistance such as Medicare and charitable assistance such as Church hospitals still provide, some people will fail to get timely testing or treatment, and so end up being a greater burden to self, family and the system than they need have been.

Even those who take a rather sanguine view of patient autonomy recognise that there are situations in which carers, family or guardians can exercise a 'good paternalism'. Emergencies or compromised competence call for judgements by others as to what is in a patient's best interests. But even in less fraught circumstances, the healing relationship must be one of trust

[6] Nicholas Grossman, "5 reasons healthcare is different from every other commodity", *ExtraNewsfeed* https://extranewsfeed.com/5-reasons-healthcare-is-different-from-every-other-commodity-82c58a21a92e.

[7] Aggarwal, Rowe and Sernyak, "Is healthcare a right or a commodity? Implementing mental health reform in a recession" *Psychiatric Services* , 61 (11), 1144-5

and, indeed, patients often want their health professionals significantly to guide the decision-making.[8] The notion of 'shared decision-making' is gaining currency amongst some theorists in place of the more absolute view of patient autonomy previously esteemed,[9] and in my experience, whatever the legal or ethical theory of informed consent, what actually happens on the ground is at best shared information, dialogue and decisions, and the exercise of more than a bit of delegated or assumed authority by carers.

Act II, Scene II: Doubts about doctors as suppliers (only)

As contractual-commercial conceptions of relationships have colonised the most private areas of life in modernity, it is unsurprising that the types of motivation, decision-making and organizational structures characteristic of large-scale commercial enterprises tend to mark contemporary healthcare also. Doctors are often expected to respond like 'hired guns' to the demands of their customers or those who are paying, and some seem quite comfortable with this arrangement.

Nonetheless, as Dan Brock and Allen Buchanan have argued, the traditional patient-centred ethic is not yet "mere sham and rhetoric".[10] Ironically, the high salaries, "self-interested organised professional behaviour and institutional structure of medicine may have helped protect the possibility of altruistic behaviour on the part of the physician when guiding treatment of his individual patients". Many health professionals clearly care about more than just their hip pockets and the preferences of those who pay: put baldly, they're in it to do good – therapeutic good. Some cultural factors, inherited codes of practice, medical education, professional associations – and, I would add, institutions such as this one with a very particular culture – still militate against doctors becoming mere salesmen.

The risk with McDonald's Medicine, however, is that "it shifts the balance between self-interested and altruistic motivations on the part of physicians". Brock and Buchanan point out "it is especially important to the success of their partnership… that the patient believe that the physician will be guided in his recommendations solely by the patient's best interests."

[8] John Bruhn, "The lost art of the covenant: Trust as a commodity in healthcare", *Health Care Manager* 24(4) (2005), 311-19; Michael Calnan and Rosemary Rowe, "Trust and health care", *Sociology Compass* 1(1) (2007) 283-308; Susan Goold, "Trust, distrust and trustworthiness," *Journal of General Internal Medicine* 17(1) (2002), 79-81; Helena Legido-Quigley, Martin McKee and Judith Green, "Trust in health care encounters and systems*", Sociology of Health and Illness* 36(8) (2014), 1243-58.

[9] France Légaré et al, "Interventions for improving the adoption of shared decision making by healthcare professionals", Cochrane Review, 12 May 2010; Glyn Elwyn, "Shared decision making and the concept of equipoise: the competences of involving patients in healthcare choices", *British Journal of General Practice*, 50 (2000), 892-97; A.M. Stigglebout et al, *British Journal of Medicine*, "Shared decision-making: really putting patients at the centre of healthcare", 344 (2012).

[10] Brock and Buchanan, *Ethical Issues in For-Profit Healthcare.*

Patients want to be able to rely on the truthfulness of their doctors and trust their recommendations. And that is harder in a situation of increasingly commodified healthcare.

Act II, Scene III: Doubts about healthcare as a market commodity (only)

Most people are uncomfortable with commodifying the body as if it were purely an object upon which various mechanical and chemical processes may be performed, or merely a collection of useful parts to be mined for use by others, used for research or even patented by corporations.[11] They prefer that blood and organ transfers be genuine donations rather than sales or confiscations, and that human persons, including their bodies, be treated with greater respect than ordinary commodities.[12] Likewise, few are happy with the reduction of healthcare to just another industry.

Leaving medicine to the market means leaving it to the happenstance of the health, wealth, preferences and natural endowments of the participants. It means that many will lack access to a decent minimum level of healthcare, however grave their need. Others will obtain care, but only at the cost of their home, relying upon charity of others, or bankruptcy, as happens all too often in the United States. Markets give insurers and providers strong incentives to 'cherry pick' the healthiest and wealthiest patients, or those easiest and cheapest to treat, leaving behind the poor, remote, indigenous and chronic cases. Thus almost all Western countries have a mix of for-profit and non-profit healthcare, funded and provided by a mix of individuals and their families, governments, private insurers, churches and charities.

Many healthcare providers and commentators observe that left to the market, healthcare will be significantly overutilised in some cases and underutilised in others, and there will be little emphasis on health promotion and early intervention; this will have both therapeutic and equity implications; and there will be blowouts of costs, poor planning, and shortages of services as well.[13] It is often observed, for instance, that the relatively free market for

[11] E.g. Katrina Bramstedt, "Age-based healthcare allocation as a wedge separating the person from the patient and commodifying medicine", *Reviews in Clinical Gerontology* 11 (2001), 185-88; Ezekiel Emanuel, "Is Health Care A Commodity?", *Lancet*, Vol. 350, No. 9091 (Dec., 1997), pp.1713-1714; Mark Hanson, "Biotechnology and commodification within healthcare", *Journal of Medicine and Philosophy* 24 (3) (1999), 267-87.

[12] On which see my "Transplants: bodies, relationships and ethics" in Anthony Fisher, *Catholic bioethics for a new millennium* (CUP, 2012), ch. 7.

[13] Daniel Callahan, "Medicine and the market: A research agenda", *Journal of Medicine and Philosophy* 24 (3) (1999), 224-42; Stephen Duckett, "Private care and public waiting", *Australian Health Review* 29(1) (2005), 87-93; Ezekiel Emmanuel and Victor Fuchs, "The perfect storm of overutilization*", Journal of the American Medical Association* 299(23) (2008), 2789-91; Deborah Korenstein et al., "Overuse of health care services in the United States: An understudied problem,"

healthcare in the United States has seen an escalation in health spending, such that Americans spend far more per person on healthcare than anyone else, yet fail to get value-for-money in terms of population coverage or health results. The 'common good' of the conditions for the flourishing of all the members of a community will only be served if there are effective mechanisms alongside the free-market to ensure the provision of this social good to those who cannot easily afford it. Australians, Brits and Canadians with their universal coverage get better value for money and better coverage than Americans in many respects, but face many parallel challenges.

Act III: Back to basics

In this last part of my paper I want to suggest three aspects of our medical-moral tradition that might help healthcare recover a healthier sense of its identity and mission.

Act III, Scene I: Healthcare is about people in need of care

The parable of the Good Samaritan has been the text most influential in shaping Christian understandings of healthcare. It presents one person's suffering and another's response. It tells of our common humanity, of the social glues of empathy and mercy, of virtuous character and of the principle of caring for neighbours in need. It is a very practical story: the bashed and forsaken Jew receives essential nursing assistance from the rescuing Samaritan, there is 'referral' to an inn-keeper, and a third-party payment. But this does not reduce the relationship and behaviour to a commodity transaction valued only for its medical efficiency or economic worth. Rather, we witness a story of intervention for the sake of the one rescued: damaged and desperate humanity is saved by God; the suffering body or soul healed by Christ the Physician; the sick, ever since, cared for by Christians responding to Christ's command to "Go and do likewise".[14] As awareness of needs and ability to assist increases, so do the opportunities for neighbourliness: as the Second Vatican Council suggested, "today there is an inescapable duty to make ourselves the neighbour of every person, no matter who they are, and if we meet them, to come to their aid in a positive way".[15]

Healing the sick and suffering was a major focus of Christ's ministry and served, alongside his preaching, to proclaim the coming of God's kingdom. The blind, deaf, mute, haemorrhaging, paralysed, leprous, even deceased, receiving his healing touch. 'The beloved physician': Luke recorded that from the beginning Jesus saw his mission as bringing

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Archives of Internal Medicine 172(2) (2012), 171-78; Joshua Perry*, A Mortal Wound for Physician-Owned Specialty Hospitals? The Legal and Ethical Prognosis for Market-Driven, Entrepreneurial Medicine in the Wake of 2010 Healthcare Insurance Reforms* (2010) SSRN: https://ssrn.com/abstract=1607029 or http://dx.doi.org/10.2139/ssrn.1607029; Rhema Vaithianathan, "A critique of the private health insurance regulations", *Australian Economic Review* 37(3) (2004), 257-70.

[14] *Lk* 10:25-37.

[15] Vatican Council II, *Gaudium* et spes 27.

good news to the poor and sight to the blind, and that he later compared himself to a physician and a nurse.[16] At his invitation, Christians see in every suffering person a brother or sister in need, indeed Christ himself, and serve him in them.[17]

In faithful imitation and continuation of that ministry, Christians have served the sick, suffering and dying throughout history through monastic pharmacies, hospitals and hospices; orders of hospitaller-knights caring for sick pilgrims, nuns nursing mothers and others, or religious brothers caring for the mentally ill; medical and nurse training schools; lay faithful dedicated to healthcare as their vocation; sacramental and other pastoral care for the sick; systematic reflection on healthcare ethics. On this view of healthcare as an expression of neighbourliness toward the needy, there is surely more we could do for Parrotman than cut off his ears.

Act III, Scene II: Healthcare is about people who care for health

Contemporary Western societies entrust to professionals much of task of healthcare on the understanding that theirs is a practice with particular internal goals and ethics, inherited knowledge and skills. Without these things in the background, the authority we invest in physicians would be unintelligible. But what does it mean to be a *profession*? Is this just a name for a posh job, with a closed-shop, worldly respect and a high salary? No, as commentators such as Leon Kass and Alasdair Macintyre have explained,[18] 'profession' is an *ethical* notion entailing:

- a conviction on the part of would-be and actual practitioners about the importance of their particular service to others and their suitedness to giving such service
- provisional acceptance of a would-be practitioner into the community of actual practitioners for immersion in that practice, calling forth devotion of character and life
- education that includes not only transmission of knowledge and skills but apprenticeship in mission and practices (here: genuine therapy), reception of certain practical principles (here: the evolved Hippocratic-Christian tradition of bioethics), and the development of certain virtues of character (here: fidelity, respectfulness, empathy, active compassion, practical wisdom, persistence, humility, generosity, moderation, truthfulness, discretion…)
- public 'profession' by the practitioner on assuming office that she or he freely undertakes this tradition of practice and will thereby serve not only herself but her clients and the wider community

[16] *Lk* 4:17; 5:31; 7:22-23; 10:29-37.
[17] *Mt* 25:31-40.
[18] Leon Kass, *Toward a More Natural Science: Biology and Human Affairs* (New York: The Free Press, 1985); Alasdair MacIntyre*, After Virtue: A Study in Moral Theory* (3rd ed., University of Notre Dame Press, 2007).

- public recognition by the community that this practice is an expression of its core values and that these people are suitable practitioners and deserving of public respect and reward
- self-regulation by the practitioners of its own professional standards according to that inherited ethic.

Sad to say, the profession has not always guarded these ethical dimensions of medicine. Sometimes professional associations behave more like monopolists seeking to protect the income and privileges of existing members. Nonetheless, a conception of health practitioners as professionals helps underline that they are not merely 'hired guns' doing the bidding of customers, government funders, insurers, managers or the market, but must make their own independent and principled judgements about what is good for the health of their patient and accords with the mission and ethic of their profession.

For Christian carers even talk of being 'professionals' limps somewhat. They reach for a word like 'vocation' to describe their sense of a transcendent mission to save, heal and care; they have heard Jesus' call to be Good Samaritans.[19] Only the consciousness of such a divine mission "can motivate and sustain the most disinterested, available and faithful commitment" of health professionals, and it is this that gives their work a salvific, even priestly value.[20] This model of physicians as responders to a divine calling to rescue and care stands in stark contrast to drive-thru medicine in many respects. So inspired, healthcare can be a powerful demonstration of values such as spontaneous generosity, respect for the dignity and equality of persons, the sanctity of human life and health, special concern for the vulnerable and powerless, solidarity with and compassion for those who suffer; a commodity conception of healthcare will tell a different story. That said, we observe that the Good Samaritan pays his bills to the innkeeper and is not the only model offered us by Christ: the wise steward, for instance, is also praised.[21] Christian health professionals, institutions and systems might be said to combine the merciful healer and wily steward.

[19] Examples of recent texts include: John Paul II, Evangelium vitae (1995), 27; Pontifical Council for Health Workers, *Charter for Healthcare Workers* (1994) 3,5 (a new edition of this document will soon appear); J.A. Di Noia, "The virtues of the Good Samaritan: Health care ethics in the perspective of a renewed moral theology", *Dolentium Hominum* 31 (1996), 211-14.
[20] Pontifical Council for Healthworkers, *Charter for Healthcare Workers 3*; S. Hinohara, "Medicine and religion: the spiritual dimension of health care", *Humane Health Care* 1(2) (2001), E2.
[21] *Mt* 24:45; cf. 10:16; 25:1-13; 25:14-30.

In *A Balm for Gilead* Daniel Sulmasy draws on our spiritual tradition to illuminate how the healing art is integrally tied to our sense of interconnectedness with others and with the divine. Reflecting upon sickness and suffering, sinfulness and spirituality, he argues that health professionals cannot persevere healthfully in their practice without a solid spirituality. When I was gravely sick last year it was my instinct to ask people to pray that I be given courage, patience and hope through my sickness and recuperation; meanwhile I prayed a parallel prayer for my health professionals. One eight-year-old boy wrote to say: "Dear Archbishop Anthony, I hear that you are sick. I'm here to make you better. I'm going to pray for you, but in the meantime you should take lots of nurofen."

Act III, Scene III: Healthcare is about a community that cares[22]

Some economists have argued that certain goods should be regarded as 'public' or 'social' goods: such as air, water, national defence, policing, firefighting, environmental protection, public health measures, and perhaps healthcare more generally (including medical education, research and delivery). So essential are these goods to all the members of any community, they should not be treated as mere commodities, subject to the whims of the market and those with market power.[23] Various secular philosophies have sought to make the case for healthcare as a universal human right and therefore a communal responsibility, and to articulate the limits and scope of that right, who owes what to whom, and so on.[24]

Healthcare has likewise been viewed in the Christian tradition as an entitlement in justice.[25] The Second Vatican Council,[26] St John XXIII,[27] Blessed Paul VI,[28] and St John Paul II[29] asserted that there is a universal right to healthcare. Benedict XVI likewise taught that

[22] In this section I draw upon material presented more fully in Anthony Fisher, "Catholic social teaching and the allocation of healthcare", in M. Therese Lysaught and Joseph Kotva (eds), *On Moral Medicine: Theological Perspectives in Medical Ethics* (3rd ed., Grand Rapids: Eerdmans, 2012), 130-138.
[23] Tyler Cowen, "Public Goods", *The Concise Encyclopedia of Economics* (2nd edn, Liberty Fund, 2007); Bruce Jennings and Mark Hanson, "Commodity or public work? Two perspectives on healthcare", *Bioethics Forum* (Fall 1995), 3-11.
[24] *Universal Declaration of Human Rights* (1948), 25*; International Covenant on Economic, Social and Cultural Rights* (1966), 12; Tom Beauchamp and James Childress*, Principles of Biomedical Ethics* (7th ed., OUP, 2013), 270-93.
[25] *Catechism of the Catholic Church*, 2213, 2288, 2407, 2443ff; Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church* (2004) 5, 166, 182, 222, 245, 447, 478.
[26] Vatican Council II, *Gaudium et Spes* (1965) 26.
[27] St John XXIII, *Pacem in Terris* (1963), 11.
[28] Blessed Paul VI*, Message to the World Health Organization on its 20th Anniversary* (1978) and *Message to the World Health Organization on its 25th Anniversary* (1983).
[29] St John Paul II, *Homily at Mass in Recife, Brazil*, 4 August 1980; Evangelium vitae (1995) 26.

Health is a precious good for the person and the community to be promoted, preserved and protected, dedicating the necessary means… [so] more people may benefit from it… Still today many of the world's populations have no access to the resources they need to satisfy their basic needs, particularly with regard to healthcare… It is necessary to work with greater commitment at all levels to ensure that the right to healthcare is rendered effective by furthering access to basic healthcare. In our day, on the one hand, we are witnessing an attention to health that borders on pharmacological, medical and surgical consumerism, almost a cult of the body, and on the other, the difficulty of millions of people in achieving a basic standard… If it is not to become inhuman, the world of healthcare cannot disregard the moral rules that must govern it.[30]

Praising the work of doctors serving in the African missions, Pope Francis recently remarked:

I thank you for what you are doing to promote the fundamental human right to health for all. Health, indeed, is not a consumer good, but a universal right which means that access to healthcare services cannot be a privilege. Healthcare, even basic treatment, is in fact denied — denied! — in various parts of the world and [especially] in many regions of Africa. It is not regarded as a universal right, but rather still a privilege for the few, those who can afford it. Accessibility to healthcare services, to treatment and medicine is still a mirage [in those places]. The poorest are unable to pay and are excluded from hospital services, even from the most essential and basic. This shows how important your generous work is in support of an extensive network of services, designed to meet the needs of the populations.[31]

The sources of this communal responsibility for healthcare are several: reverence for the goods of life and health for every person, and acknowledgement of the human need for healthcare if we are to flourish; our nature as interdependent and our supernature as graced for service; the obligation to express care and respect in concrete acts; the need for large-scale community contribution if healthcare is to be delivered at a decent minimum level; the natural expectation ('right') of members of a community to such assistance as necessary for their participation and flourishing; and the particular concern ('preferential option') of Christians for the most disadvantaged, as 'God's little ones', including the sick poor.[32] Of

[30] Pope Benedict XVI, *Message to 25th International Conference of the Pontifical Council for Healthcare Workers,* 15 November 2010.

[31] Pope Francis, Address to *"Doctors with Africa",* 7 May 2016; cf. *Message to the 31st International Conference of the Pontifical Council for Healthcare Workers*, 12 November 2016; *Discorso ai Commissione Carità e Salute della Conferenza Episcopale Italiana,* 10 February 2017. Likewise, Pontifical Council for Healthcare Workers, *Charter for Healthcare Workers* 63; United States Catholic Conference, *Health and Healthcare: A Pastoral Letter of the American Bishops* (Washington DC: United States Catholic Conference, 1981), 11.

[32] *Catechism,* 1936: "On coming into the world, man is not equipped with everything he needs for developing his bodily and spiritual life. He needs others. Differences appear tied to age, physical abilities, intellectual or moral aptitudes, the benefits derived from social commerce, and the distribution of wealth. These 'talents' are not distributed equally. These differences belong to God's plan, who wills that each receive what he needs from others, and that those endowed with

course, the ethical claim people have on their community in general, and health professions in particular, has its limits: we have no right to expect that everyone else go without so that we can have the best of everything.[33]

Against the background of this teaching tradition, the Second Vatican Council and the recent popes have criticized as scandalous the excessive economic and social disparities between individuals and societies, and called for responsible stewardship of the goods of creation in service of the common good. Pope Francis has been especially critical of the risks of avarice, acquisitiveness and waste in 'throw-away' societies, the leaching of such attitudes to commodities into our attitudes to each other, the indifference of many of the affluent toward the poor and suffering, and the withdrawal of governments from welfare provision to an 'economic rationalism' that encourages selfishness.[34]

In arguing that healthcare should be regarded as a public good rather than being privatised as a commodity for exchange and consumption, Bruce Jennings and Mark Hanson contrast children fighting over cookies with communicants receiving the Blessed Eucharist. To conceive of this sacramental experience as one of production, valuation, exchange and consumption would be to radically misunderstand the sacred liturgy. So too, they argue, some secular public works "establish relationships among individuals that are not transactional or consumptive, but involve a cooperative and participatory effort to produce something of common value. This value is not appropriated exclusively by one of the parties to its creation, no one is simply a 'provider' or a 'consumer', and the value is realised by communities as much as by individuals."[35] Conceiving of healthcare as a vocation and profession, as a social good and responsibility, and even as a kind of communion, challenges the 'pharmacological, medical and surgical consumerism' that the popes since St John XXIII have critiqued.

Postlude

"No margin, no mission" has been a catch-cry of recent years, suggesting that unless we are practical about the realities of healthcare delivery today, we will not have the 'fat' to devote

particular 'talents' share the benefits with those who need them. These differences encourage and often oblige persons to practise generosity, kindness and sharing of goods; they foster mutual enrichment."

[33] I examine this much more fully with Luke Gormally in *Healthcare Allocation: An Ethical Framework for Public Policy* (London: Linacre Centre, 2001).

[34] Vatican Council II, *Gaudium et Spes* 26, 29, 63, 66, 69; *Catechism*, 2423-25; St John Paul II, *Sollicitudo Rei Socialis* (1987), 28; *Redemptoris Missio* (1990), 30, 59; *Centesimus Annus* (1991), 24; *Evangelium Vitae* (1995), 12ff; Pope Benedict XVI, Spe Salvi (2007), 21, 35*; Caritas in Veritate* (2009), 25, 40, 65ff; Pope Francis, *Evangelii Gaudium* (2013); *Message for World Day of Peace* (2014); *Letter to Prime Minister of Australia on the Occasion of the G20 Summit* (6 November 2014); and many others. Cf. Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church* (2004) and Angus Sibley, *Catholic Economics: Alternatives to the Jungle* (Liturgical Press, 2015) and Philip Keane, *Catholicism and Health-Care Justice: Problems, Potential and Solutions* (Paulist, 2002).

[35] Jennings and Hanson, "Commodity or public work?" 6-7.

to our lords the sick and poor. But if "No margin, no mission" is true, "No mission, no mission!" is even truer.[36] We need to know what healthcare is before we can do it well, let alone profitably. In this lecture I have examined three underlying assumptions in the drive-thru conception of healthcare: that patients are autonomous agents who choose the healthcare that suits them; that doctors are merely contracted providers of that service for a fee; and that healthcare is therefore just a free-market industry like any other. There are many reasons for thinking these claims are right. On the other hand, my own experience and philosophical reflection suggest that patients are not much like ordinary consumers or doctors like ordinary producers; that the practice of healthcare and the doctor-patient relationship are only very imperfectly compared with manufacture and retail of a product; and that the medical ecology is rather different to that of a supermarket. I have argued that for all its strengths and difficulties, the drive-thru conception of medicine impoverishes the practice by neglecting core understandings of healthcare as a vocation to serve the needy, a profession with internal goals and received ethic, and a social good that grounds rights and responsibilities in a community. There are important truths in these three traditional understandings of healthcare worthy of recovering today in the face of its continued commodification.

Cathleen Kaveny makes the point that as a corporal work of mercy healthcare *"finds its purpose in offering comfort, care, and a pledge against the final loneliness to those whom medicine can no longer cure. In the end, that will be each and every one of us. For much of human history, this… aspect of healthcare was its dominant one. In the contemporary era… we see [it] in the hospice movement. Yet at its core remains the call to solidarity, as witnessed in the work of Mother Teresa"*[37] – and, I would add, that of the Charity Sisters and their colleagues who built the St Vincent's Group. Drive-thru medicine has its advantages, but it cannot inspire such compassion or motivate such corporal works of mercy. If we want a world in which the Mother Teresas will do their stuff, we need space for an alternative conception of the patient, the carer, the relationship and the surrounding institutions.

Bioethics Outlook
A quarterly bulletin of the Plunkett Centre for Ethics

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and St Vincent's Health Australia, Sydney

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[36] Cf. Josh Freeman, "Health is not a commodity: Let us get the language right", *Physicians for a National Health Program* http://www.pnhp.org/news/2012/ november/health-is-not-a-commodity-let-us-get-the-language-right

[37] M. Cathleen Kaveny, "Developing the doctrine of distributive justice: Methods of distribution, redistribution, and the role of time in allocating intensive care resources", in H.T. Engelhardt and M.J. Cherry (eds.), *Allocating Medical Resources: Roman Catholic Perspectives* (Washington DC: Georgetown University Press, 2002), 177-99, at p. 183.