FEATURE ARTICLE

Health Care Reform: Six Ethical Elephants in the Room*

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On March 23, 2010, President Barack Obama signed into law the "Patient Protection and Affordable Care Act," which was the health care reform bill sponsored by the Democratic 111th Congress and the Obama Administration.[1] This was a momentous, albeit also a contentious, event in U.S. history. Though the ink has barely dried on this historic law, there have been movements and judicial proceedings afoot to repeal either the whole or parts of it.

Health care reform attempted to do several important things. First, it attempted to broaden the population that receives health care coverage through either public-sector insurance programs or private-sector insurance companies. Second, it sought to expand the array of health care providers among whom patients could choose. Third, it attempted to improve the access to health care specialists, e.g., neurologists, surgeons, etc. Next, it sought to improve the quality of health care in the US. Finally, its goal was to decrease the enormous cost and waste of health care and to create a health care system that is sustainable.

The debate was and is concerned with four very important issues. First, and for our purposes the most important issue, was whether there is a fundamental right to health care in the U.S. The second, and related issue, was concerned with who should have access to health care and under which circumstances. The third issue revolved around the crucial question about how to achieve quality in the health care system given the high sums of money spent. And, finally, there was the issue of sustainability of both expenditures and the very health care system itself.

There is no doubt that each of the four issues above was a driving force behind health care reform in the U.S. There are many in the U.S. who wanted to reduce the whole debate and its key components either to economics or to politics. Though it may seem somewhat obvious why this is so, I want to argue that what was not obvious in much of the health care debate were key ethical issues that were present but ignored. There is an ethical layer that was and continues to be underneath much of the debate on health care reform. However, like the emperor who was not wearing any clothes or the elephants that were standing in the room, very few people in the country wanted to acknowledge and address this ethical layer.

To make my point more concretely, I want to take several texts from two of the

more prominent physicians in the U.S. and then compare and contrast their views on the right to health care. One of these physicians, Robert M. Sade of the Medical University of South Carolina whose perspective on these issues tends to reflect that of American society, has argued vigorously against any right to health care. The other, Edmund Pellegrino of Georgetown University Medical Center whose views tend to reflect those of the Catholic social tradition, has ardently argued for such a right in the U.S. These two healers, both knowledgeable of what is at stake in this question, differed not merely in their conclusions but essentially on six background ethical presuppositions that shaped and informed their conclusions.[2] Some of these six presuppositions are directly ethical in nature, while others are more indirectly so. An analysis of these two physicians' positions will hopefully serve as a hermeneutic for making sense out of the tremendous division that continues to exist in the U.S. on healthcare reform and the right to health care.

Six Ethical Presuppositions to the Right to Healthcare

1. Views of Justice and Human Rights

Robert Sade has argued against any right to health care in the U.S. because he has construed justice as primarily "commutative justice," which is what one individual owes to another individual.[3] No other individual or entity is to be acknowledged in the relationship between a physician and a patient. In one way, Sade has adopted a notion of justice articulated by Robert Nozick. For Nozick, as long as one begins from a situation of fairness and proceeds in a fair manner, one is free to sell or distribute one's goods as one desires.[4] Thus, this entitlement theory of justice claims that whatever arises from a just situation by just steps is judged to be just. In other words for Sade, if the physician entered medical school fairly, graduated and completed internship and residency through just steps, then the physician is entitled to own his or her clinical knowledge and skills and can distribute healthcare to whomever he or she desires. Since justice is limited only to its commutative sense for Sade, then, as we shall see shortly, the just relations and obligations within which healthcare will be distributed is understood only to exist inside the physician-patient relation itself.

Sade has adopted what is the typical political theory on human rights within U.S. history. The U.S has only recognized political rights (e.g., right to free speech) and civil rights (e.g., protection from discrimination on such grounds as physical or mental disability) in its political heritage, and these rights, as found principally in the 27 amendments to the U.S. Constitution, are a class of rights and freedoms that protect individuals from unwarranted action by government and other private individuals. These rights are also considered "negative" rights or rights of non-interference. Rights of non-interference set up boundaries that others cannot cross to impede someone from freely and justly seeking some good, e.g., healthcare. Though the individual does not possess a

right to the good itself, he or she cannot be unfairly deterred from pursuing it. As Sade has stated the matter, "The concept of medical care as the patient's right is immoral because it denies the most fundamental of all rights, that of a man [sic] to his own life and the freedom of action to support it."[5] For Sade, then, what was justly earned by the physician by just means, viz., the clinical knowledge and skills in healthcare, is his or hers as an entitlement, and no one can make some claim to take it away without the permission of the healer (owner).

Edmund Pellegrino, who believes that all have a right to health care within the U.S., has placed the whole discussion of health care within the framework of distributive justice, or that form of justice which governs what the state and society owe to each individual citizen. By appealing to distributive justice in the case of health care, Pellegrino has been able to broaden the circle of obligations that govern just relations. For Pellegrino, distributive justice "covers the responsibilities we owe each other as members of a society, or community, the claim each person has to some share in the public goods even if his direct participation in the production of those good may be remote."[6] If health care falls under the umbrella of what the state and society owe in justice to its citizens, then Pellegrino has been arguing for another set of human rights, viz., social and economic (welfare) rights. These rights, as understood in other industrialized nations and in the Universal Declaration of Human Rights adopted by the United Nations in 1948, are "positive" rights in the sense that they guarantee access to a certain amount of a specific good that defines human well-being and flourishing. As we will see later, for Pellegrino health care is one of those positive rights because health and health care are central to the wellbeing of humans. Thus, Pellegrino has argued that a basic level of healthcare is owed in justice to each eligible member of the U.S. society.

2. Views of Anthropology and the Person in Society

Consistent with his view of commutative justice, Sade has adopted an individualist or libertarian view of the human person and the person's relation to society. He has claimed that, "Man [sic] is a sovereign unto himself."[7] In this individualist or aggregate anthropology the individual is prior to both society and the state, and, for Sade, "To protect his basic right to provide for the support of one's own life, men band together and form governments."[8] It is important to note here that his libertarian view pits the well-being of individual against individual and does not address how people's wellbeing is interconnected.

Pellegrino has adopted a communitarian view of the self and the individual's relation to the state and society. Here the well-being of individuals is tied together in an interconnected fabric. He has claimed that we are social animals, and as such we partake in a mutual interdependence in which each can be fulfilled only in a communal life.[9] For him, then, the state and society arise naturally as an expression of our social

nature. Society is prior to the individual and shapes the self within community. What is of particular importance here, though, is the emphasis on solidarity as a social value that addresses our vulnerabilities of life. The U.S..distinguishes itself from other countries in its claims to the fundamental rights of life, liberty and the pursuit of (individual) happiness. Other countries, building on a European heritage, e.g., Canada, claim rights to life, liberty and solidarity. It is precisely the last right or good, viz., solidarity, that changes the fundamental understanding of our and the state's responsibilities to those who are vulnerable and in need of medical help. For Pellegrino, unlike Nozick and also Sade who followed him, it is not just "unfortunate" that someone is ill from birth through the quixotic gene pool of nature. The condition of being handicapped puts one in a vulnerable situation in which the state and society have some particular responsibility to respond in distributive justice.

3. Views of Health Care

The view of what health care is has been one of the most divisive issues in contemporary U.S. society. For Sade, health care is a commodity like any other good or service that is bought and sold between individuals in society. He has claimed that, "Medical care is neither a right nor a privilege: it is a service that is provided by doctors and others to people who wish to purchase it."[10] Frequently, Sade has fashioned an analogy between the physician and health care, on the one hand, and the baker and bread, on the other. Thus, the skills to heal and to provide health care, which have been acquired by the physician through just steps and by just means, not only belong to the physician, in a way similar to how the bread belongs to the baker in a similar just fashion, but the physician can also sell healthcare to whomever he or she wants, in a way similar to how the baker can sell bread to customers. The further ramification of Sade's view here is that health care is purely a private and personal good in the sense that it can be bought and used for one's own satisfaction and need without anyone else being involved or concerned. As Sade has repeatedly argued, it is a fallacy to hold that, "Health is primarily a community or social rather than an individual concern."[11] Individuals who are ill or injured choose to purchase healthcare, and when they are healed, that is the end of the matter.

Pellegrino has adopted a radically different view of health care. For him, "Health care is among those goods governed by the principle of distributive justice, since, without health, it is difficult or impossible to participate in society. In this sense, health is a precondition of a fully human life."[12] This physician has maintained that health care is indeed both a private and personal good, but, in addition, he has argued that health care is also a public and social good for which the state and society have some interest on behalf of its citizenry. In his list of "public" goods, for which the state and society have some interest, he lists security, social services, a clean safe environment, protection of natural resources, health care, housing, and nutrition.[13] If health and health care

are intrinsic human values and social goods, then for Pellegrino the state and society must recognize that they have obligations to individual citizens grounded in distributive justice.

4. Views of the Physician and the Medical Profession

Consistent with his view of health care as a service or commodity, Sade has argued that physicians, like bakers, are entrepreneurs who own their services and who are willing to sell them to whoever is willing to purchase them.[14] This entrepreneurial image of the physician and the corresponding careerist paradigm of the medical profession adopted by Sade entered into U.S. society and the medical establishment around the late 1960s, and they have been responsible not only for the transformation of the identity of physicians but also for some of the divisiveness surrounding healthcare reform.

For some,[15] including Edmund Pellegrino himself,[16] medicine has undergone a paradigm shift or "descent"[17] from a profession and vocation into a career. The etymology of the English word "career" is from the Latin *carrus*, which means wagon. The word "car" obviously has its derivation from the same Latin word. Careerists are like those who travel in a car and go wherever they want, whenever they want and by whatever highway they want, as long as they obey the laws of the road. In a similar way, careerists are free to pursue their own self-interest, and, if they are entrepreneurs, they are completely free to sell their services to whomever wants to buy them. In addition, for Sade, health care is proprietary to the physician because he or she has earned the knowledge and skills through just steps and by just means. This emphasis on self-interest rather than altruism, and the shift from a professional to a careerist model have become deep in the fabric of modern U.S. society and have become the seedbed for much of the division over health care reform.

Pellegrino, on the other hand, has argued consistently against the entrepreneurial image of the physician and the careerist model of medicine. In their place, he has called for a return to the images of "profession" and "vocation," both of which have deep historical roots. For him, what separates a profession from a career is the act of publicly avowing or professing that one will use for the benefit of another, rather than for one's own self-interest, the knowledge and skills one has learned and gained. Pellegrino has also argued that, in addition to being a profession, medicine is a vocation or a calling to transcend one's own self-interest, even if that self-interest is legitimate.[18] He frequently has interpreted vocation in very specific Christian language such that the physician is called by God to serve the needs of the poor.[19]

5. Views of the Physician-Patient Relationship

Sade has adopted a social contract theory of government and of society. Such a view, of course, is quite consistent with his libertarian or individualist anthropology and his insistence that only commutative justice governs the interaction between a "seller" (physician) and "buyer" (patient).

A new model for interpreting and informing the clinical encounter in the U.S. began to emerge in the 1970s and 80s, and this new model is what has been called the contractual or commercial model of medicine.[20] Contractual models of medical professionals and of their work imply that there are two relatively free, autonomous and knowledgeable individuals[21] who come together to engage in a commercial relationship governed only by the terms of the contract as viewed through the prism of commutative justice. A consumer needs some type of commodity, and so he or she seeks out someone who possesses the commodity to purchase it according to the terms established, in this case, in the medical insurance policy. The physician is not only an entrepreneur in this model, but he or she owns the goods (clinical knowledge and skills in health care) that are to be sold to a consumer (patient).

Pellegrino has been strongly opposed to the reduction of the physician-patient relationship to a mere contract. He has attempted to retrieve the ancient notions of "profession," "vocation," and "covenant" to counteract what he has deemed a descent into careerism.[22] For Pellegrino, there is an existential inequality between the physician and patient, and so the contractual understanding of this relationship, which must assume a relative equality, is false.[23] He has sought to reimage this moral relationship between healer and patient by situating it within the context of a covenant that binds two people together in a common cause, viz., the healing of the patient. Covenants have growing edges to them; they are not restricted merely by the codes or contracts that bind people together for their own interests. In the end, the retrieval of the ancient notions of profession, vocation and covenant have been attempts on the part of Pellegrino to ground again the physician-patient relationship in an "ethics of trust," wherein the codal ideal of philanthropy is replaced by covenantal indebtedness and self-effacement.[24]

6. Views of the Just Society

This final issue concerning the nature of the just society is the culmination of the previous five issues; in one way, it has been the trajectory of the analysis from the very beginning. What is the just society in which medicine can be practiced and patients healed through access to health care?

Based on where Robert Sade has stood on the previous five issues, he has argued that the truly just society is the one in which entitlements of individuals are protected by the government.[25] A just society exists when people's rights to their possessions are protected by a limited government against those who would take their possessions away by force. He has stated, "The concept of medical care as the patient's right is immoral because it denies the most fundamental of all rights, that of a man [sic] to his own life and the freedom of action to support it."[26] Thus, a just society must protect both the fundamental rights of entitlement, i.e., goods that were acquired by a just means and by just steps, and the freedom to support, i.e., buy or sell, those goods.

Thus, preserving entitlements is the goal of any just society.

A just society for Pellegrino is fundamentally different from Sade's view. For him, the just society is the one in which the common good, made up of the various public goods over which the government has some interest on behalf of its citizens, is protected and enhanced by the mutual cooperation between individuals in society and the state or government. More specifically, a just society is the one in which the responsibilities we owe to one another as members of community are fulfilled by making sure that each person has some share in the public goods (healthcare), even if each individual does not have any direct participation in the production of these goods.[27] Distributive justice imposes moral obligations on both society and the state to ensure adequate access to and a possession at a minimal level of those public goods that define human well-being and flourishing.

Conclusion

Two very prominent physicians were chosen as the representatives in the very polarized debate about health care reform. These two clinicians did not simply disagree on the conclusion about whether citizens in the U.S. have a right to health care. Rather, they have radically disagreed on six important ethical presuppositions.

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1. The full text of the PPACA can be accessed at: http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf. Accessed on December 8, 2010.
2. There are actually more ethical issues at stake, but space only allows for a discussion of these six.
3. Robert M. Sade, "Medical Care as a Right: A Refutation," *The New England Journal of Medicine* 285 (December 2, 1971) 1288-1292.
4. Robert Nozick, *Anarchy, State, and Utopia* (New York: Basic Books, 1974).
5. Sade, "Medical Care as a Right," 1289.
6. Edmund Pellegrino, "Health Care: A Vocation to Justice and Love," *The Professions in Ethical Context: Vocations to Justice and Love*, ed. Francis A. Eigo (Villanova, PA: Villanova University Press, 1986) 108.
7. Sade, "Medical Care as a Right," 1288.
8. *Ibid*., 1289.
9. Pellegrino, "Health Care," 108-109.
10. Sade, "Medical Care as a Right," 1289.
11. *Ibid*., 1291.
12. Pellegrino, "Health Care," 109.
13. *Ibid*. Emphasis added.
14. Sade, "Medical Care as a Right," 1289.
15. See William F. May, "The Beleaguered Rulers: The Public Obligation of the Professional," *Kennedy Institute of Ethics Journal* 2 (1992) 25-41, and Robert Bellah and William M. Sullivan, "The Professions and the Common Good: Vocation/Profession/Career," *Religion and Intellectual Life* 4 (Spring 1987) 7-20.
16. Edmund Pellegrino, "Professional Ethics: Moral Decline or Paradigm Shift?" *Religion and Intellectual Life* 4 (Spring 1987) 21-39.
17. *Ibid*., 22.
18. Pellegrino, "Health Care," 111, 114 and 121.
19. Pellegrino, "Professional Ethics," 32.
20. See David Ozar, "Three Models of Professionalism and Professional Obligation in Dentistry," *Journal of the American Dental Association* 110 (February 1885) 173-177.
21. Pellegrino, "Trust and Distrust in Professional Ethics," *Ethics, Trust, and the Professions: Philosophical and Cultural Aspects*, ed. Edmund Pellegrino, Robert M. Veatch and John Langan (Washington, D.C.: Georgetown University Press, 1991) 76.
22. Pellegrino, "Professional Ethics," 22.
23. Pellegrino, "Health Care," 104.
24. William F. May, "Code, Covenant, Contract, or Philanthropy," *The Hastings Center Report* 5 (December 1975) 31.
25. Sade, "Medical Care as a Right," 1289.
26. *Ibid*.
27. Pellegrino, "Health Care," 108.