

THE SOCIAL DIMENSION OF HEALTH CARE ETHICS

When you hear “health care ethics,” I’m betting your mind goes right to clinical issues: at the bedside, in the intensive care unit, in the operating room, in the physician’s office. The more fully informed might think about rationing, access or insurance. But mostly, our notions of health care ethics are rooted in an idea of the person as individual.



FR. CHARLES
BOUCHARD

As Canadian bioethicist Francoise Baylis and her colleagues noted, “The core unit of analysis is the individual person...the concept of personhood that is assumed in most bioethical discussions is the liberal ideal of an independent, rational, self-interested deliberator whose values are transparent to himself/herself.”¹

But, as the authors noted, the difficulty with this picture is that “individuals are not really independent, purely rational, separate and self-interested. We are all social through and through.” Their view accurately describes Catholic anthropology, or our understanding of the human person. The older, individualist understanding of health care ethics is not going away. Each of us will still be faced with specific decisions about our health. But a number of factors are shifting the focus to a more public and social way of thinking. Let me cite several areas that are changing the way we think about ethics:

Scarcity and distribution of health care resources. In earlier times, health care resources were limited, but they were distributed relatively equitably. Hospitals largely were “charitable,” run either by religious groups or by the city or state. There weren’t a lot of high-tech treatments or centers of excellence devoted to one service line, but what we had was public.

Today, there is a lot more health care to go around, but it is not available to everyone. The best physicians and hospitals are clustered in big cities, the newest drugs often are not available except to those who can afford to pay for them. Even initial access to the health care system (except through the emergency department) is limited by one’s ability to pay. So ethical judgments about

justice no longer are limited to what a particular patient gets, but how to allocate these resources among various populations. The way we organize and distribute health care resources to groups is rapidly becoming more important than how we allocate these resources to individual patients. This was a primary concern for the Affordable Care Act.

Circumstances. Even when physicians treated one patient at a time, they were aware that wealthy patients tended to fare better than poor ones. They knew that wealth made a difference, but they didn’t fully understand why. Today, we know with considerable detail that socio-economic circumstances, race, poverty and even the environment correlate with the incidence of some illnesses (e.g., higher cancer rates in polluted areas, higher incidence of asthma in urban areas). We also know that these circumstances affect health care outcomes.² Writer and physician Atul Gawande, MD, made news in 2011 when *The New Yorker* magazine published his article, “The Hot-Spotters,” in which he showed how preventable readmissions were more common not just in certain ZIP codes, but even within certain residential buildings.³ The massive data we have been able to collect through the use of electronic medical records will reveal more correlations and shine the light on more disparities. This will enable us to treat not just one patient at a time, but whole groups that are at greater risk.

Genetic destiny. We all know about genetic defects that lead to certain specific, rare conditions such as Tay-Sachs disease or Down Syndrome, or how some racial groups are more susceptible to certain health issues (e.g., hypertension and kidney disease among African-Americans). But we are only beginning to understand that genetics plays a role in many other conditions as well. A report from the Institute of Medicine points out:

Although there are many possible causes of human disease, family history is often one of the strongest risk factors for common disease complexes such as cancer, cardiovascular disease (CVD), diabetes, autoimmune disorders, and psychiatric illnesses. A person inherits a complete set of genes from each parent, as well as a vast array of cultural and socioeconomic experiences from his/her family. Family history is thought to be a good predictor of an individual's disease risk because family members most closely represent the unique genomic and environmental interactions that an individual experiences.⁴

Genetics also is enabling us to see these hidden risk factors more clearly (e.g., mutations in the BRCA genes for breast cancer) and to “personalize” medicine so that we can target particular kinds of cancer for specific treatments.

Geography. Unless they were tropical disease specialists, doctors in the past rarely thought about geography when treating patients. Today, we are a global village in a flat world where everything — including infectious disease — spreads more quickly than it used to. It took years for AIDS to become an international health crisis, but the Ebola and Zika viruses spread much more quickly. In 2009, the first flu epidemic of the 21st century was identified in the United States on May 15. By June 11, it was declared a global pandemic. Epidemics in the U.S. have not been as widespread as in other parts of the world. That could all change if we are not aware of global disease vectors and the social nature of health.

Voluntary health risks. We all take voluntary health risks. As I wrote this, for example, I treated myself to a frosted donut. I know both my weight and my blood sugar level make that in-

advisable, but I did it anyway. It's not that frosted donuts pose more risk than they did before. The difference is that now we *know* about the risk.

In North America, we have become accustomed to large portions and diets high in fat, salt and sugar. Obesity is so widespread it constitutes a health crisis all by itself. Add to that the risks posed by alcohol, illegal and prescription drugs, and smoking, and we've got an even bigger problem. Dangerous pastimes (speeding cars, motorcycles, “extreme” sports and guns) make matters even worse. Most of these behaviors are the result of a willful individualism rooted in “the right to do what I want to do.”

Opponents of vaccination against measles, chickenpox, HPV and polio — which we had nearly eradicated — threaten their own lives as well as the lives of those around them. I can no longer say, “Well, it's my life, and I'll eat what I want” or “They are my kids, and I'll choose whether or not to vaccinate them.” If my eating habits make me sick, or if I contract a communicable disease, others share the cost. My health decisions affect our health as a society.

This growing awareness of the public, social nature of health care ethics is good, but it is not enough to sustain our momentum. We're also going to need a greater sense of solidarity⁵ and trust. The lack of those two virtues makes it difficult for us to shift our perspective from individual to communal or public. We want to see ourselves as independent, and we don't trust society (read “government”) to take our needs into account. This is why the Affordable Care Act is on the verge of repeal. The visceral reaction Americans have to any kind of hint of “socialized medicine” (with Canada and the U.K. being the most frequent objects of our scorn) is the spearhead of this attitude.

We were making progress in health care policy until recently. That is now in jeopardy. In light of the recent elec-

tion, we need to strengthen our commitment and our efforts so that we can help head off re-privatization of health care and use what we have learned about the social nature of health care ethics to keep us all healthy.

FR. CHARLES BOUCHARD, OP, STD, is senior director, theology and ethics, the Catholic Health Association, St. Louis.

NOTES

1. Francoise Baylis, Nuala P. Kenny and Susan Sherwin, “A Relational Account of Public Health Ethics,” *Public Health Ethics* 1, no. 3 (2008): 196-209. The authors of this excellent article are Canadian. Unfortunately, their view of the person is not prevalent in the U.S.
2. Jonathan Anomaly, “Public Health and Public Goods,” *Public Health Ethics* 4, no. 3, (2011): 251-59. Jonathan Anomaly, PhD, core faculty member of the University of North Carolina and Duke University program in philosophy, politics and economics, says he does not believe these “social determinants” are part of the task of public health, because “public health practitioners do not have the expertise,” and secondly, because “many of the so-called social determinants of health” bear little relationship to what we consider public health goals. To the extent that social determinants influence individual welfare rather than population health, or promote a particular social welfare agenda like increasing economic equality, “we should consider them outside of the domain of public health,” he says.
3. Atul Gawande, “The Hot Spotters: Can We Lower Medical Costs by Giving the Neediest Patients Better Care?” *The New Yorker* (Jan. 24, 2011).
4. Lyla M. Hernandez and Dan G. Blazer, eds., *Genes, Behavior, and the Social Environment: Moving Beyond the Nature/Nurture Debate* (Washington, D.C.: National Academies Press, 2006).
5. Baylis, Kenny and Sherwin, “A Relational Account,” 204. Baylis and colleagues describe their approach in terms of “relational solidarity.”

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