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A Pathology of Medical Ethics: Economic Medical Rationing in a Morally Incoherent Society

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In Kurt Vonnegut's *God Bless You, Mr. Rosewater*, one of the main characters is a writer. And in one of his science fiction novels, he looked into the future to an "America in which almost all of the work was done by machines, and the only people who could get work had three or more Ph.D.'s. There was a serious overpopulation problem, too. All serious diseases had been conquered. So death was voluntary, and the government, to encourage volunteers for death, set up a purple-roofed Ethical Suicide Parlor at every major intersection, right next door to an orange-roofed Howard Johnson's. There were pretty hostesses in the parlor, and Barca-Loungers, and Muzak, and a choice of 14 painless ways to die. The suicide parlors were busy places, because so many people felt silly and pointless, and because it was supposed to be an unselfish, patriotic thing to do, to die. The suicides also got free last meals next door. And so on . . . One of the characters asked a death stewardess if he would go to heaven, and she told him that of course he would. He asked if he would see God, and she said, 'Certainly, honey.' And he said, 'I sure hope so. I want to ask Him something I never was able to find out down here.' 'What's that?' she said, strapping him in. 'What in hell are people for?' "

Such a story undoubtedly appears to be an odd way to begin an essay on "The Effects of Economic Medical Rationing on Ethical Problems in Medicine." After all, shouldn't such a topic focus on questions of DRGs and Medicare/Medicaid and malpractice litigation and catastrophic care coverage and non-profit versus profit hospitals and the like? I do not mean to deny the importance or relevance of dealing with such questions, and my essay will touch on some of them at least tangentially. But the issues of economics and medicine, particularly as they focus on contemporary moves toward containment and rationing, are bound-up in a rather bewildering maze of statistics, studies, arguments and counter-arguments, such that it is often difficult to know where to begin.

It is not possible in one essay to begin to sort out all of the empirical data or even to evaluate policy recommendations. But even if it were possible, I'm not sure how useful it would be. For I think that the real problems and issues lie deeper than questions of empirical data and public policy. Indeed I think the contemporary debate about economic medical rationing reveals a deeper and more fundamental set of questions than we often assume.

That is to say, I think that one of the reasons economic medical rationing seems to present such intractable problems in our society is that we have no real way of addressing the question "What in hell are people for?" For example, Michael Ignatieff contends that "We have created a new need, the need to live an examined life; we pursue its satisfaction in the full babble of conflicting opinions about what life is for, and we pursue it in a collectively held silence about the meaning of death."²

Three Sets of Issues

In what follows, I want to identify rather briefly three sets of issues which indicate why our society's failure to deal with "what people are for" has made not only the practice of medicine, but also medical ethics, problematic. At the end, I want to suggest how we — at least those of us who presume to be followers of Jesus Christ — might begin to envision an alternative way of thinking and acting. I do not have any grand solutions, or even the outline of one, but I hope that identifying the problems can help us get a clearer grasp of the issues.

The first set of issues surrounds the difficult time our society has in dealing with issues at the beginning and at the end of life. We don't seem to have a great deal of difficulty thinking about issues "between the 20-yard lines" of life; most of our bioethical attention is centered on questions of birth (e.g., abortion, genetic engineering, in vitro fertilization) and death (e.g., euthanasia, definitions of brain death, withdrawal of food and water). What makes those issues so seemingly unresolvable is that, as a culture, we are unsure "what people are for". In the absence of attention to that question, it is difficult to know how and/or what we should think and do about the beginnings and endings of life.

The trouble is that, with the advances in technology which we have seen in this century — advances that have (at least for the most part) resulted in improvements in health and the lessening of suffering — it has become increasingly possible to keep people alive. We have often presumed that one of the primary goals of medicine ought to be to prolong life. But if we do not know *why* we are doing so, and/or if we do not have means of understanding *when* we perhaps ought not to do so, then we run the risk of watching the costs of technology spiral out of control. That is true in general, and it is even more true given the increasing number of elderly in our society.

Indeed that is the concern of Daniel Callahan, director of The Hastings Center and author of the widely-discussed *Setting Limits*.³ Callahan rightly insists that “medical need” is not a fixed concept but a “function of technological possibility and regnant social expectations.”⁴ In a death-defying and death-denying culture such as ours, that is a recipe for disaster. In response, Callahan’s argument is two-pronged. On the one hand, he wants to develop a social vision of the aged in which they have a recognized and valued status such that we are willing to accept increased moral and financial obligations for their welfare. On the other hand, he wants us to develop a sense of a “natural span of life” as a means of rationing our medical resources. Beyond a certain point, for Callahan around 75-80 years, we ought to say that a person has lived a full life. Hence that person ought not to have a claim on technological interventions designed simply to prolong life.

Points Worth Noting

This is not the place to go into an analysis of Callahan’s proposal in detail, but three points are worth noting about the structure of his argument. First, his diagnosis is important. The elderly are placing increasing demands on medical resources, and we are caught in the double-bind of claiming that everything that can be done ought to be done while simultaneously insisting that we don’t want to be the ones who pay for it.

Second, his analysis of the need for far-reaching changes is significant. He recognizes that we have an “almost complete inability to find a meaningful place in public discourse for suffering and decline in life,”⁵ much less death. Moreover, he recognizes that in order for us to begin to overcome the problems faced by advancing technologies, economic restraints, and large numbers of elderly people, we need to alter some of our society’s current presumptions (and lack thereof) about health, medicine, and the nature and purpose of human life.

But, third, Callahan’s prognosis of how we should go about doing so is unpersuasive. I do not believe that his notion of a “natural life span” is coherent in and of itself. He develops the notion of a “biographical” rather than a “biological” definition of life. I agree that we need to attend at least as much to people’s biographies as we do to their biologies. But what he

fails adequately to recognize is that people's "biographies" vary greatly as to the point at which life is fulfilled. Even more importantly, he fails to recognize that many people in our society — particularly the poor and the marginalized — are forced to live in ways that make any kind of biographical "unity" or "fulfillment" virtually impossible.

Even if Callahan's proposal for a "natural span of life" were developed in a coherent fashion, however, I still think it would be highly unlikely to win assent in our culture. Callahan underestimates the degree to which we as a culture are committed to technologically-developed crisis interventions designed to stave off death. Part of what makes questions of allocating medical resources so terrifyingly difficult — indeed, virtually incorrigible to social and moral reasoning — is that we are always willing to debunk technology in the abstract while simultaneously trying to ensure that the best technology will be available to us when we need it.

Callahan is to be commended for a courageous foray into the minefield of economics, technology, and medicine. Callahan, unlike so many who write about these issues, is aware of the complexities of the problems and the need for some dramatic rethinking of our approaches to health, medicine, suffering, and death — in short, for more attention to the question of "what people are for". But I think that ultimately his own constructive proposal is predicated on the kinds of presumptions that undermine any such rethinking.

A second set of issues surrounds the ways in which our failure to attend to the question of "what people are for" are affecting doctor-patient relations. Indeed this failure is part of the problem that is undermining such relationships and ultimately fueling the economic problems in medicine. At the heart of the classical understanding of medicine as a "profession" is the conviction that the physician is to be of service to the community by being present to, and caring for, his or her patients. This is based on the presumption that, though suffering isolates people from communities and often from themselves, we ought not to abandon those who are suffering.

Presence to Suffering

That commitment to be present to those who are suffering has undergone many shifts and changes over time. Over the past two centuries, as care has been increasingly moved from the homes of nuclear and extended family members to hospitals, and as there have been dramatic advances in scientific medicine, there has been a correlative shift in the presumptions about caring and curing. Increasingly the medical profession has been looked on not simply to care for people (and cure when they can), but rather as people charged with fighting illnesses and curing people. The story of these transformations in expectations is complex, and we do not as yet adequately understand how the story should be told.

Even so, one result of that story is that there has been a dislocation in the understanding of the relationship between physicians and patients. It has long been presumed that physicians and patients are bound to one another through such virtues as fidelity and trust. Increasingly, however, as the organization of medicine has become increasingly scientific, bureaucratic, and structured according to the canons of managerial and economic efficiency, the bonds between physicians and patients have been weakened and even sundered. It is not uncommon now, particularly in an era of medical rationing, to hear that physicians are simply purveyors of "goods and services" and that patients are consumers who enter into contract with such purveyors as they see fit.

What has happened, at least in part, is that economic considerations and even economic language have become more and more central to the health care system.⁶ As Dennis McCann suggests, what has happened at the level of social policy is that "the health care preferences of the American people quickly sorted themselves out in two directions: on the one hand, we expected the government to pick up the bill for lavish expansion of health care services to all sectors of society, especially our own; on the other hand, we were appalled at the rapid inflation of health care costs and began to wonder whether we were getting our money's worth. Continually whipsawed between these conflicting sentiments, health care administrators in both private and public institutions have been forced to experiment with a variety of 'cost-containment' measures."⁷ Consequently, in the midst of such cost-consciousness and contractual relations, the *manager* has become the most important ideal not only for health-care administrators but, increasingly, for physicians as well. Unfortunately, ideals of managerial efficiency tend to preclude moral questions as irrelevant; hence moral questions rarely (if ever) arise in discussions of economic rationing in medicine.

The celebrated exchange of letters between Uwe Reinhardt, professor of Economics and Public Affairs at Princeton, and Arnold Relman, editor of *The New England Journal of Medicine*, centers on the question of whether the institution of medicine in general, and physicians in particular, can adequately be described in economic categories.⁸ Part of their disagreement turns on the descriptive question of whether physicians tend to act as "purveyors of goods and services." Reinhardt certainly has a point that the institution of medicine has brought some of the problems of perception upon itself. Its concern for economic self-interest and power and status, described quite powerfully by Paul Starr in his *The Social Transformation of American Medicine*,⁹ has sometimes led people to suggest that physicians are, in fact, little more than highly successful purveyors of goods and services.

An Important Point

But Reinhardt misses an important normative point about casting

physicians in managerial and corporate terms. Though Relman does not adequately characterize the point, his emphasis on the importance of medicine as a profession is a reminder that the relationship between physicians and patients must be understood differently from other producer-consumer relations, because medicine is fundamentally a *tragic profession*.¹⁰ The very nature of medicine is such that, no matter how virtuous and technically skilled is a physician, no matter how sophisticated is the technology we use, medical practice sometimes results in failure. Handicapped babies are born. People die.

These are tragic situations (not to be confused with malpractice), and they require the presence of communal bonds sufficient to sustain us through the tragedies. When those communal bonds are absent (e.g., when people do not have shared understandings about the meaning and purpose of human life), then the relation between physicians and patients becomes a contractual agreement which does not leave room for tragedy. Consequently, as Stephen Fowl suggests, "When the patient does not trust the medical profession to act in her or his own best interests . . . the patient will respond to tragic situations with litigation."¹¹

That can be seen perhaps most graphically with respect to OB-GYNs. In a society where we are not sure what it means to have children or why we are doing so, we place intolerable burdens on physicians. Couples now presume that they have entered into a contract with a physician, and the implied presumption of that contract is that the physician will deliver a "Gerber baby" — perfect in every way. When, as often happens, the baby is not a "Gerber baby", the couple presumes it must be the physician's fault and thus they typically sue for malpractice. The deleterious effects of such situations on the practice of medicine have been amply documented.

What is surprising, however, is that we have failed to recognize the ways in which economic presumptions about human life and human relationships undermine our ability to cope with the tragedies that are inherent in human life and, more particularly, in the practice of medicine. We have put physicians in a peculiar double-bind: we expect more and more from physicians in terms of cures and life-enhancing and life-extending technologies, but we also complain that the costs are too high and that physicians ought to quit trying to play God by keeping people alive at any cost. Is it any wonder that our conceptions of medicine seem to be rather chaotic?

A third set of issues surrounds our various forms of cost-containment. In good managerial fashion, we are trying to make medical care more efficient. But while there are certainly benefits to cost-containment (if by that we mean genuine institutional and systematic reforms designed to improve health), what we are doing is better described as "expenditure control". By that I mean that we are really focused more on reducing our expenditures than in reforming structures, and that is being done all too frequently in haphazard fashion. As Rashi Fein has noted, we are cutting costs by "defining people out of the health system and by shifting costs

among the various payers. But shifting costs is hardly equitable, and cutting back on Medicare, Medicaid, and private insurance is a form of rationing. The fact that access is allocated by an impersonal market and invisible hand may make it more acceptable. It hardly makes it more virtuous."¹²

What we have not developed and, in the absence of attention to those larger questions about the meaning and purpose of human life, what I think we will not develop, is a way of talking in our society about how to deal with the fact that we can provide only "finite care in a world of infinite needs."¹³ Were we to do that, we would need to attend far more carefully, for example, to what is known as "preventive medicine" as well as to the primary health care needs of the poor. That is unlikely to happen in our society at large, however. For if there is anything that seems to be clear, it is that we have agreed that we do not want to pay for equal access to health care — in any of the possible ways which could be understood.

Organizations Which are Significant

And yet, it is significant that there are organizations such as the Catholic Physicians' Guild. Presumably the fact that there are physicians who are Catholic or, more generally understood, that there are physicians who are Christians, is significant to their identity as physicians. I think it is so and ought to be so. The fact that organizations such as the CPG exist, may provide a context in which we can begin to look at these issues in a somewhat different light.

Christians have — or at least ought to have — a witness about each of the sets of issues I have identified. We are a people who believe that we have glimpsed in the life, death, and resurrection of Jesus of Nazareth an understanding of "what people are for." That is to say, Christians believe that the stories of our lives — however incoherent and/or fragmented they may be — are bounded by a narrative more determinative than anything we can create. That narrative is the story of God's creation, redemption, and promised consummation of the Kingdom. That gives us a lens through which we can understand both the great importance of medicine and also its limited task.

Christians should know that medicine cannot be expected to save us from death, for only God can do that. We should know that death is not the worst thing that can happen to a person, that far more important than whether we live or die is that we be faithful to God. Given that presumption, we ought to be willing to forego extraordinary means of extending life in the knowledge that death does not have the final word about our lives.

Moreover, Christians should know that there are tragedies which happen, and that we can cope with those tragedies if we are willing to be people who know how to embody forgiveness and reconciliation. That requires that we be people of virtue, people capable of the kinds of

communal bonds which animate physician-patient relations at their best. That requires not only that physicians be virtuous people (which is often understood to be important), but also that patients be virtuous (to which we pay considerably less attention). Without the formation of such communal bonds, we are likely to be caught in cycles of vengeance and self-deception as we seek to protect ourselves from becoming vulnerable to other people's intrusions.

Christians should also know that such bonds entail that we learn to see things from the perspective of those who suffer. We cannot rest easily with any systems of medical care which fail to attend to the primary health care needs of the poor and those who are ill. We are, or at least ought to be, people who would rather accept our own death than use up precious resources if preventing our death would mean that others will go without care.

I do not pretend that the theological perspectives I have been suggesting will resolve any of the problems I have identified or that physicians face in their practices. But I do want to suggest that *if* we are going to make any progress at all in dealing with ethical problems in medicine and the effects of economic rationing on those problems, it will be done by recovering the distinctive witness of Jesus Christ. How we go about doing that in relation to contemporary issues in medicine is a complex matter, and would require another (and different) essay.

Even so, I think that recovering such a witness would entail, so it seems to me, that the hospitals founded by various churches (and, in different ways, synagogues) ought to reclaim their identities as institutions designed to be of service to God. It would entail that physicians who are Christians reclaim the significance of that identity for their vocation. And perhaps most determinatively, it would also entail that all of us who are Christians, health-care workers and laity alike, be willing to revise and reform our understandings of life and death and our expectations of the medical care system such that we might be able to provide a witness to a world which knows not God.

References

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3. Callahan, Daniel, *Setting Limits* (New York: Simon and Schuster, 1987).
4. *Ibid.*, p. 134.
5. *Ibid.*, p. 32.
6. Cf. Eli Ginzberg, *American Medicine: The Power Shift* (Totowa, NJ: Rowman and Allanheld, 1985).
7. McCann, Dennis, "Am I Still My Brother's Keeper? Theological Reflections on the Crisis in Health Care Management," *Second Opinion* 8 (1988), p. 91.
8. The exchange can be found in Bradford H. Gray, ed., *For-Profit Enterprise in Health Care* (Washington, D.C.: National Academy Press, 1986), pp. 209-223.

9. Starr, Paul, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

10. For a powerful description of medicine as a tragic profession, cf. Stanley Hauerwas, *Truthfulness and Tragedy* (Notre Dame, IN: University of Notre Dame Press, 1977), pp. 184-203.

11. Fowl, Stephen, "The Problematic Practice of Medicine in a Fragmented Society," manuscript p. 9. My thinking on tragedy and community in relation to medicine is indebted to Fowl's paper.

12. Fein, Rashi, *Medical Care, Medical Costs* (Cambridge: Harvard University Press, 1986) p. 215, cited in Callahan, *op. cit.*, 213.

13. I owe this phrase to Stanley Hauerwas.
