Christian Response to the Failure of Saving Life – Health Care?

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The floods of 2015 have proved that health is no more an optimal well being of the physical, psychological and social well being of the human persons. On the contrary, health seems to have promoted totally a different explanation in contrast to WHO's definition.

Healthcare units and centers or hospitals seem to be in negligence and remain irresponsible without protecting and preserving life at any cost. The medical practitioners seem to amass wealth at the cost of life and health. It is true that healthcare units need political support to establish themselves. Is it not necessary to be diplomatic or political in one's obligation to promote health and thus to protect and preserve life at any cost? Avoiding harm is a primary call of a physician under a principle of non-maleficence. How come a private hospital failed in even preserving 18 lives, and neglected its responsibilities to safeguard 18 lives of human persons. In what way the present Tamil Nadu Governance and the private hospitals will be held culpable on account of the loss of 18 human lives of human persons.

It is in the light of Christian response to this tragic event I would like to deal with the reality of health and question the priorities of healthcare centers and hospitals.

In my search for meaningful understanding, I would like to organize the article in the following manner:

a) The framework for decision about healthcare – focused on market model of medicine
b) Critique
c) The Question of Justice.

A short background in which market model emerges can be seen to know what this market model is meant for a reader. In Judeo Christian tradition there seem to be an evolutionary understanding of medicine as follows:

1. Beneficial Assistance Model
2. Eleemosynary Model
3. Market Model

In the beginning, be it healthcare or medicine, the understanding was to assist or the good of the other remained as of primary importance. Judeo Christianity bears witness to the beneficial assistance and thus medicine was a great service to the other's life in all altruistic dimension of an obligation. It paved a way for an origin of the existence of the principle of the subjective benefit of the patient.

This was also called the Hippocratic Oath of the 4th century B.C. The basic orientations are expressed in the formula: "I will apply measures for the benefit of the sick according to my ability and judgment: I will keep them from harm and injustice." Linked with this is the principle: "As to diseases, make a habit of two things –to help, or at least not to harm.[1] "Preventing harm" or "doing no harm" has to be interpreted as preserving life at any cost. One important twentieth century code of ethics which binds the physician to the preservation of live. This is the World Medical Association's

International Code of Medical Ethics (1949) and even in this the requirement is qualified so as to allow exceptions.[2]

Beneficial assistance also demands doing good to the other when we enjoy so much good from others. To assist at someone's discomfort illness becomes an obligation inasmuch as the others have a light to demand assistance in their inability. According to me it is how the principle of beneficial assistance promotes a deontological perspective of ethics. Thus the others have obligation to assist beneficially when the need arises too.

Thus Christians were confronted with the basic imperative: "Be compassionate as you heavenly Father is compassionate."(Lk6:30) The "utopian" reality was, then in some way, to be realized in this brutal 'real' world.

In the period of the early church, the Christian community adopted what has been called the approach of "compassionate accompaniment". The sick were accepted in Christian charity and kept integrated in the life of the community.[3]

In the second period, the first "hospitals" were set up, and the approach of "beneficial assistance" was adopted.[4]

A third period has seen a confirming move away from this model, sometimes called the Eleemosynary Model, from the word for almsgiving. Increasingly the "market model" is being adopted with a significant component of high technology. It does not seem that there is any neat fit between these successive stages and the different models of response to suffering. However, some suggestions are possible.

What is counted as valuable in the "compassionate accompaniment" model is above all, presence together with the sufferer. The sense of community seems to be grounded on the perception that the afflicted person

manifests the fragility and vulnerability which is the lot of all.[5] Suffering establishes a bond between those who actually suffer and those who may suffer.

In Richard McCormick's **Health and Medicine in the Catholic Tradition**[6] the topic suffering has an important place. Here suffering has a redemptive role. The theological response given here is expressed in citation from Michael Quoits:

> "But I came and I took all you sufferings upon me, as I took all your sins, I Took them and suffered them before you. I transformed them, I made them a treasure. They are still an evil but an evil with a purpose."

To conclude the different models, I pass on to the last of all the models as market model.

The Framework for decisions about healthcare – The Market Model of Medicine

Those who propose this model frequently do so because they believe that if the system of healthcare delivery were removed from extrinsic imposed plans and left to the control of the "market forces" it would function better. Exposure to "market forces", so it is argued, would lead to cutting back inefficient services and excessive costs and provide a solution to the problem of cost containment.

Market model of Medicine suggests two basic ideas if at all we apply this to healthcare delivery.

The first is the view that healthcare is simply a commodity like a loaf of bread or a mobile phone. You do not have a "right" to it, unless you actually pay for it. This Position is succinctly stated by Dr. Robert sale:

"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."[7]

The Second idea that we would have to accept would be the "Market model" itself. What would this mean? Warren Butt and Duncan Neuhauser explain this in an article entitled: "The Machine and the Marketplace: Economic Considerations in applying Healthcare Technology.[8] The authors describe what they call "the theoretical 'Competitive market.[9] The model proposed is that of "market place under conditions of pure competition.[10] The decision maker reconstructs conditions as they would occur in the market place, but brings knowledge and rationality to the process.[11]

The model includes certain requirements if such a system is to function properly. They are:

1. There are many independent buyers and sellers aiming at maximizing their own profit:
2. These buyers are all seeking to purchase the same product which has the same constant quality:
3. All these buyers are fully informed about prices, the product, its quality and their own preferences:
4. The buyers and sellers must be able to interact freely.[12]

The authors who support the market model describe health economics as a system of analysis and planning which takes "pure competition" as normative and is concerned with discovering how the actual market for medical care departs from pure competition and how misplaced allocations of Funds accordingly develop.

Departure from the model of "pure competition" occur when, for example, some people lack the resources needed to participate in the market,

external factors which interfere with the market. For example, poor persons cannot buy adequate healthcare in the marketplace.[13]

The result is that the competitive model does not guarantee minimum standards of care, simply because the poor do not have money to buy healthcare in the market. Other factors are scarcity, inadequate information which prevents people from making adequate choices about competing providers in healthcare.[14]

Because poor people cannot buy adequate healthcare, it is necessary that social security, city hospitals and government health payments for the poor (e.g.II Servizio Samitario Nazionale in Italy, Medicaid in the U.S.A., National Health in Britain). These measures according to the supporters of the market model are needed to patch up the defects in the system so that "the market" can work in real conditions.

Another factor is security.[15] The Market model of "pure competition" requires that there be sufficient goods available to be bought and that would-be buyer have sufficient money to buy them. Only in such a case there be real competition. However, in any real human society there will always be some lack of funds to buy healthcare, and some scarcity of healthcare. It would appear that this would help to keep down costs and restrict and control possible wastage of healthcare services.

However, this is not the case. Society may lack services, but individual may not. An individual may have insurance of some kind, for example, or benefit from Government funding, so that he or she is not subject restrictions in buying health services. Thus while others are restricted, certain individuals are not restricted at all. These individuals may pay for little or none of the treatment and thus have no incentive to limit their use of such treatments. Scarcity of resources thus does not place a limit on what is purchased by

this individual. (Others in fact pay for what she/he receives.) Thus, insurance etc., may lead to over allocation.[16] Inadequate information is also a factor.[17]

Unlike theoretical consumers, patients rarely understand the quality or cost of treatment alternatives. Our medical care system makes attainment of this information too difficult, time consuming, or expensive. But without proper understanding,patients cnnot be expected to make reasonable choices. These are some of the deficiencies which occur in real life situation, and which need to be corrected if the market is to function satisfactorily.

Critique:

What is to be said of the market model? This model sets aside considerations of justice except those which arise from contracts to buy and sell healthcare. Thus, those who require that healthcare be Governed by a doctrine of justice would find this proposal radically inadequate. In particular, the model is based on a fundamental individualism. Persons in Society are considered as radically individual, with no bonds to one another apart from those established by contract.[18]

There are number of further questions which have to be raised. Is health care merely a "commodity" or is it different and special? Since healthcare is very closely related to a person's capacity to pursue her or his own fulfillment and to participate in society so as to promote the good of the society, we must regard healthcare as more than a commodity for a sale. It is at the same time a personal and a social good. Society, through its agencies, has, therefore, a responsibility for Healthcare.[19] It could be argued also that the competitive market works for the survival of the fittest and assumes The individual has the necessary capacity to take care of herself or himself. But the sick and injured are not in a position to do this.[20]

The proposal to adopt the market model although it may appear to avoid the apparently unsolvable disputes about the meaning an requirements of the value and virtue of Justice, is not value neutral. It presumes that the efficiency or the cost reduction which the "market" is said to achieve is a value and social goal worth striving for.

It should also be noted that there is nothing in the logic of the market model which makes it Inevitable that it will reduce costs over all. Daniel Callaham observes: "Despite the politically Inspired, and not implausible, belief that competition among providers would reduce costs, it seems instead to have raised them."[21]

However, provide basic rights were protected; it would seem to be legitimate to encourage some "market mechanisms" as a way of promoting responsible decisions about healthcare expenditures on the part of consumers. According to Brian Johnstone, "the idea of 'common good' of a human society includes the good of the responsible participation by members in the interactions of that society. Those who support the idea that the common good of society should be a primary concern, do not mean that society ought to be engaged simply in a system of "hand-outs".[22]

Cost Effectiveness/Cost Benefit Calculations Others would not accept that healthcare delivery be left to the so-called "free forces of the market" but would r require that it be guided by some policy decisions. The problem is, who is to make such decisions? One possibility would be to leave such decisions to an "expert" such as a doctor o r physician. But not all are willing to entrust such decisions to the subjective decisions of another and call for formal criteria of decision-making which can be evaluated objectively. According to Johnstone, one model of such policy decision-making attempts to calculate the effectiveness of particular proposals and their costs. There are two basic concepts: Cost –effectiveness and cost Benefit calculations.[23]

Cost-effectiveness measures the output in non-monetary terms. Fo example, the years of life saved by a procedure are cost-effective measures. For example an organ transplant program could be judged cost – effective if it were shown to add an average of six years to the lives of those treated. The difficulty here is that one must compare two things which do not share a common denominator, namely six years of life and the costs of the transplant.[24]

Cost Benefit analyses are measured in financial terms. Thus, years of life saved must be given a monetary value for the purposes calculation. Giving a human life a value in terms of life or dollars may seem distasteful if not impossible.[25] However, some authors' have explicitly favored this approach as a realistic and feasible measure.

Cost-benefit provides a common factor that is a certain figure in rupees or dollars in such a way that otherwise quite different things can be easily compared and weighed against one another. Cost benefit analysis attempts to consider all parameters of medical care, including quality of life after treatment, ability to return to work and so on. To do this a common factor (dollars, rupees etc.,) is used. When benefits exceed costs the option is wise. When costs exceed benefits, the option is unwise.[26]

The difficulty of this first assessment is hidden behind the simple, direct comparison of two money figures such as dollars or rupees. The giving of a money value to life is not as strange as it might seem to be. We could save lives if we were prepared to spend more to make care safer, to install protective air bags etc. But these are judged to be too costly. We prefer to save the money, knowing that not spending the extra money will cost lives. There is here a clear judgment that the lives which could be saved are not equal in value to that extra money which would have to be spent.[27]

Both cost effectiveness and cost benefit calculations are calculations by results of consequences. As such calculations have a problem with "weighting" one kind of consequence against another. (The same kind of problem which we, as Christian Ethicists meet with in the moral method of Proportionalism). Cost benefit analysis tries to make this problem manageable by ascribing a Common element, namely money value, to the different consequences."[28]

According to John stone, these types of calculations seek to remove critical decisions from the presumed "expert" and to make them in the public sphere where the ways in which the decisions are made open and can be evaluated by all. This is surely a positive point. Furthermore, they attempt to base the decisions on what people want. Even the strategy of giving a money value to life is done by attempting to discover what people are willing to pay to save life: which is presumed to be an indication of what people actually want.[29]

Johnstone raises a question: should the State through its instrumentalities, seek simply to discover what people, in fact, want or what they are willing to pay and base its policies on those findings? Or should the State and its instrumentalities seek to be guided by considerations of justice?

Here upon the loss of lives at the private hospital and the numbness of the State draw one's attention to turn toward a major question and needs to be answered before we can proceed further.

The Catholic tradition would clearly not accept that the State be morally neutral and would rquire That State policies and laws be guided by moral law. This question arises frequently with regard to more dramatic moral questions such as abortion and experimentation. Recent floods and the loss of several lives too fall under the same category. (Donum Vitae in its section III of the instruction on the Dignity of Human persons and Dignity of Human

Lives? shows that the relationship between the moral and civil law is presented. According to the instruction: "The task of the civil law is to ensure the common good of people through the recognition of and the defence of fundamental rights and through the promotion of peace and public morality." The civil law, then, should recognize and protect specifically the right to healthcare.

There are, however, some further points to be made. The first is a recognition of the reality of the Contemporary political community. According to Johnstone,

> "(In) discussing changing conceptions of justice in the United States, Alasdair Maclntyre proposed two models or types of persons.[30] Type A is concerned with his or her desserts. This person has earned his moderate wealth over the years. He argues that he is entitled to what he has earned and regards the threat to his projects posted by taxes as unjust. He is unwilling to pay more taxes to support expensive medical programs. The Theory that corresponds to the convictions of this type of person is that of Robert Nozik which basically upholds rights to property.[31] A person of Type B is disturbed by the arbitrariness of inequities in the distribution of wealth. He or she regards this as unjust. He might argue from the needs of the persons.

Machlntyre argues that modern politics cannot be a matter of genuine moral consensus. Indeed, in his view, modern politics is civil war carried on by other means.[32] If this is indeed true, the persons Have radically different perceptions of their justice commitments. It would, then, be difficult, if not impossible, for decision –makers to justify their policies by reasons which would appear to all members of the community. At this point it would be necessary to investigate the commonly accepted notions of justice which influence the debates on these issues in Europe. This work has yet to be done.[33]

It would appear that there are basically three contending approaches to the question of deciding how much society should pay for healthcare.

The first holds that there is no way of discovering this, so that can deal onlty with what society has chosen to pay or "willingness to pay"[34]

The second position holds that there is a way of discovering a just pattern for distribution. That is, in principle, we can determine what society ought to pay.

The third position holds that while we cannot discover any obligatory pattern for distribution, we can determine criteria for a just procedure of decision-making.[35]

The Catholic tradition would not accept the first view. It would accept the second as has been indicated above, namely that the State and its instrumentalities should be guided by moral considerations and specifically by justice in such questions as human rights. But there is a question about the scope of the State's duty to follow justice.

One can distinguish two views which could be called the broad and the limited view. The instruction *(Donum Vitae)* cites the Declaration of Vatican II *Dignitatis Humane* (On Religious Liberty), #7

This later document, in the place referred to, makes a distinction between "public order" and "common welfare". Public order is said to be "the basic component of the common welfare." But public order is not identified with common welfare or common good. Public order is a more restricted term of which the components are: (1) "public peace"; (2)"good order and true justice" and (3)"public morality". There is a very important question there which is closely connected to our understanding of the role of the State in the political order.[36]

One view, the "broad view" holds that the State through civil legislation, should promote the common good of the community by implementing the natural law.[37] The second , limited view, Would argue that the State has a more limited role of public peace, good order and justice and public morality.

An important discussion was there at the Second Vatican Council at the above-said point. Some of The fathers of the Council thought that the notion that the role of the State was limited to "public order" reduced the State to the role of the "corner policeman" of 19th century liberalism and would deny the role of the State in the areas of economic and social justice. If this view of the function of the State were accepted, it would mean that Roman Catholic thinking was winging in the direction of the "liberal model" discussed above. It was pointed out, In reply, that the Council document was concerned with the religious freedom of persons in relation to the role of the State, the right of the State to intervene in the areas of social and economic justice.[38] Thus the consensus within the Roman Catholic tradition would favour and require State intervention, when necessary, to protect and promote justice in healthcare.

Johnstone observed that following the first view, we could argue that once it has been determined what the natural law, in particular justice, requires in terms of protecting rights regarding healthcare, the State is obliged the pluralism of modern society. In this view the State should ensure a basic floor of public peace, basic justice and public morality, but beyond this protect freedom.[39] As the Declaration of Religious Liberty states:"for the rest, the usages of society are to be the usage of freedom in their full range. These require that the freedom of man be respected as far as possible, and curtailed only when and in so far as necessary."(#7)

In protecting the lives of people and their well-being, State plays a vital role to ensure public peace, public order and public morality. The

retrospective effects of the responsibility of the State demand answerable dimensions when the necessity arises. State ought to have surveillance to protect and preserve lives. State ought to check before offering licence to the healthcare centres and specialty hospitals. Off late the complaints are on the lack of allotment of places and allocation of resources.

During the floods of last December 2015, the loss of innocent lives and the loss of persons were due to the lack of allocation of resources.

Allocation of resources depends on allocation decisions. Allocation decisions are matters of Ethics. They reflect a society's values. In a democratic society, governmental policies on resources allocation should reflect the values of the people and the value of life. There are questions of macro allocation and micro allocations.[40] In macro allocations, the questions are: what resources (time, money, and energy) should be put into healthcare in comparison with other social needs, such needs such as education, environmental protection, and defence? And once the budget for healthcare is determined, how much should be allocated for prevention and how much for rescue medicine? In micro allocation, there are questions like, within either preventive or rescue medicine, who should receive resources such as vaccines or artificial hearts when we cannot meet everyone's needs?

If medicine and healthcare units are meant as services that have been set up for the benefit of others, then they should respond to human need whenever and wherever it occurs and try to treat everyone fairly, appropriately and justly. The problems of resources allocation have to be solve by specifying what basic health needs people have and society agrees to meet. It involves careful Testing of the success of different treatments and drugs and setting priorities about patient care and treatment.

Hereupon a failure on the part of the private hospital and the governance of the State could be pointed out. It is the failure of proper business ethics

and an erroneously culpable conscience of the State. At this juncture, it calls for a study on theories of justice in the context of healthcare and medicine.

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Endnotes

1. Robert M. Veatch,A Theory of Medical Ethics, New York: Basic Books,1981,p.2
2. Veatch, Theory, p.22
3. Lino Ciccone, "Salute & Malattia" Questioni di morale della vita ficica(Milan: Edizioni Ares,1986),p.17
4. Ciccone, Salute, p.17
5. Brian Johnstone, Unpublished notes on Introduction to Biomedical Ethics(Roma, Italia:1991),p.14
6. (New York:cross Roads,1984),p.11
7. Robert Sale: " Is Healthcare a Right ?" in Contemporary Issues in Bioethics, ed. Tom Beauchamp and Lerot Walters,2nd ed. Belmont, California: Radsworth, 1982): 386-89,p.387.
8. In the Machine at the Bedside: Strategies for using Technology in Patient care, ed. By stanle joel Raifer and Michael Aubar, London: Cambridge University Press, 1984,pp.135-51.
9. Ibid.p.136
10. Ibid.p.136
11. Ibid.p.139
12. Ibid p.136
13. Ibid p.137
14. Ibid p.136
15. Ibid p.137
16. Ibid p.137
17. Ibid p.137
18. Brian Johnstone,p.129
19. Ibid p.129

20. Joe Holland and Peter Henriot S.J. in Social Analysis:Linking Faith and Justice,Revises and enlarged edition (Washington:Orbis Books and the Centre of Concern),1981,p.137
21. Daniel Callahan,Setting Limits:Medical Goals in an Aging Society,New York: Simon and Schuster, 1967. P.125.
22. Johnstone,p.130
23. Johnstone, p.131
24. Callahan, Setting Limits, p.140
25. Ibid p.140
26. Johnstone, p132
27. Ibid
28. Ibid
29. Ibidp.29
30. Alasdair Maclntyre, After Virtue:A study in Moral Theory,2nd ed (Notre Dame: University of Dame Press, 1984)p.244
31. Ibidp.2441984)p. 239
33. Johnstore,p. 133
34. Johnstore.p.135 cf.Paul T.Manzel,Costs:More Choices: A Philosophy of Health care Economics in America(New Haven and London: Yale University Press,1983).
35. H. Tristan Engelhart, The Foundation for Bioethics (New York :Oxford University Press,1986), p.67,pp.336-369
36. Johnstoe,p.136
37. Cf.Charles E. Curran, Civil Law and Christian Morality: Abortion and the Churches" in Ongoing Revision in Moral Theology(Note Dame: Fides/Claritian,1975):107-143.
38. Richard J. Regan,Conflict and Consensus:Religious Freedon and the Vatican Council (New York:Macmillan, 1967),p.124
39. Johnstone,p.37
40. B.James Nelson and Joanne Smith Rohricht,Human Medicine, (Minneapolis, MN:Augsberg Pubishing House,1984),p123.