CONTEMPORARY ETHICS

THE SPIRITUAL CRISIS IN HEALTH CARE REFORM

By Courtney S. Campbell

MODERN PSALM

Medical science is my shepherd;
I shall not want,
It maketh me to lie down in hospital beds;
It leadeth me beside the marvels of technology.
It restoreth my brain waves;
It maintains men in a persistent vegetative state for its name's sake.
Yea, though I walk through the valley of the shadow of death,
I will find no end to life;
For thou art with me;
Thy respirator and heart machine they sustain me.
Thou preparest intravenous feeding for me in the presence of irreversible disability;
Thou anointest my head with oil;
My cup runneth on and on and on and on.
Surely coma and unconsciousness shall follow me all the days of my continued breathing;
And I will dwell in the intensive care unit forever.

—ROBERT FRASER

IT IS SURELY no secret that this nation's health care system is in need of drastic reform. Numerous bills are under consideration by the United States Congress seeking to combat the twin monsters of the health care crisis: (1) Some 39 million people, or 15 percent of the nation's citizens, have no health care insurance coverage, and (2) the rapid escalation in health care costs, which have consistently doubled the rate of consumer price inflation over the past fifteen years. Yet, for all the importance of reform at the political and economic level, our society has come to a crossroads because of a deeper crisis over the kinds of values we want our health care programs to embody. How much do we, as implied by Fraser's "Modern Psalm," look to technology as a savior for our medical ills? Does our societal bias toward critical care and rescue medicine at the expense of adequate funding for preventive, chronic, or rehabilitative care in fact reflect a quest for deliverance from death, and an anthropocentric immortality?

The crisis confronting us in health care reform is not only political or financial, but also moral and spiritual. Some members of religious communities in our country have found solace from this crisis in the New Testament narrative of Jesus' feeding the 5000 (Matt. 14:15–21): no matter how limited our resources become, we must express ultimate faith and trust that God will provide for our basic needs and care. While I acknowledge the deep religious sentiment that supports this view, I also believe that the state of our health care system has become so desperate that even providential intervention would not remedy it! As a community of believers and as citizens in a democratic society, we are called to a position of active responsibility and stewardship for our social institutions, including health care, rather than a form of passive fatalism. My guide through this moral and metaphysical morass be will those prophetic themes articulated by Micah—that righteousness consists in justice, mercy, and humility. (Micah 6:8.)

COURTNEY S. CAMPBELL is the director of the Program for Ethics, Science, and the Environment at Oregon State University in Corvallis, Oregon. *A version of this paper was presented to the American Public Health Association's Forum on Bioethics in October 1993.*

TWO TEMPTATIONS

To make all health problems sin and salvation, or to completely separate health from salvation.

THERE are some definite risks to portraying the crisis in health care as reflecting "spiritual" or "moral" dimensions. Such risks are pointedly suggested by the French existentialist Albert Camus in his masterpiece of meaning, *The Plague*. At one point in the novel, a Catholic priest and a physician, both of whom are engaged in fighting the bubonic plague that has isolated the Algerian city of Oran, reflect on their common work. The priest, Paneloux, comments to the physician, Rieux: "You, too, are working for man's salvation." To which Rieux replies: "Salvation's much too big a word for me. I don't aim so high. I'm concerned with man's health, and for me his health comes first."[1]

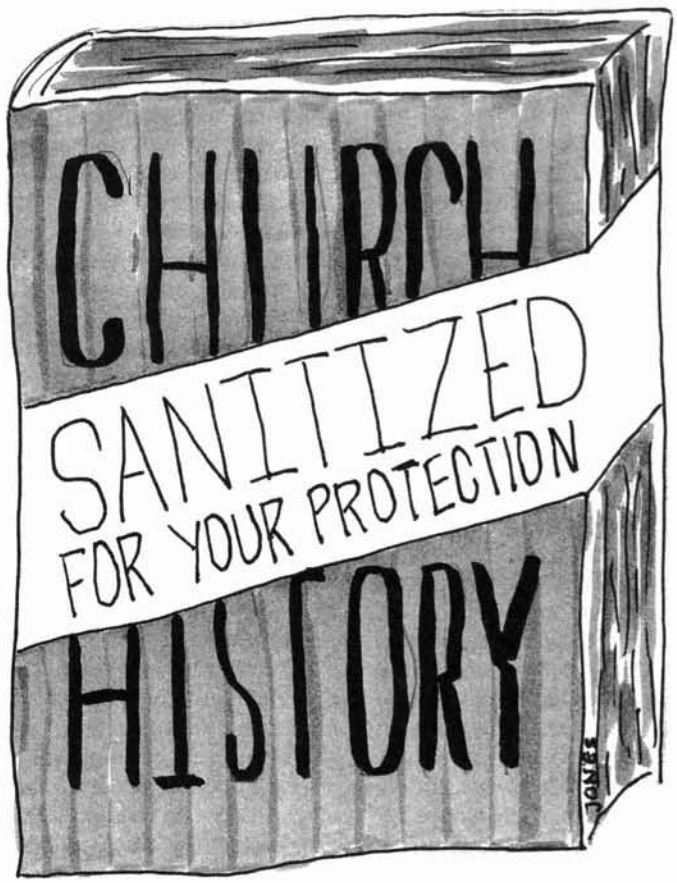
Suggested in this exchange are two temptations to avoid if we are to speak of a spiritual dimension to the health care crisis. The first is that we may often use the language of "health" to mask an underlying religious or ideological agenda, such as "salvation." There is a substantial danger when moralistic preaching informs our conception of a "healthy" lifestyle, as exemplified by the distinction in LDS ecclesiastical discourse between "innocent victims" of AIDS and those presumed responsible and guilty. Are the latter no less deserving of care, compassion, and human presence than the former? We might recall that Paul indicated that nothing could separate us from the love of Christ (Rom. 8:38–39), but our modern moralism sometimes suggests that culpability for illness and disease can.

The second temptation, however, is that we may completely separate and partition "health" and "spirituality," thus ignoring their profound interrelationship. There is a relationship between disease and existential disease that we neglect at great peril. In particular, we need enhanced consciousness of our communal interdependence and social nature as persons. Israeli sociologist Aaron Antonovsky inquired, in his research, why some 75 percent of disease incidence occurs among 25 percent of the population; that is, why is disease so maldistributed in the general population? Antonovsky's explanation concerned a "sense of coherence" and "con-

nectedness" between persons and their communities. Persons who feel a sense of being bound together with others for some common good or end, "in sickness and in health," in the language of the traditional wedding vow, tend to stay more healthy. By contrast, those persons who experience fragmentation and abandonment in their lives constitute the quarter of the population that is afflicted with three-quarters of the disease incidence.[2]

That is why it is important to note that Camus's physician character, Rieux, describes health as coming "first," but attention to health does not completely encompass either a professional's or a community's moral calling. For in confronting the experience of health, disease, and illness, we no less face the deepest questions of meaning and purpose in human experience. The common unity of spirit and body seems torn asunder by the afflictions of disease and illness, and our bodies, which are mediums of self-revelation, begin to assume an alien or foreign character. As the demographics of our society shift toward the "greying of America," we find ourselves forced to consider the meaning and significance of aging and dependency, a very difficult task in a culture that is prone to the worship of youth and independence. The experience of illness also leaves us vulnerable and, at times, in the throes of pain and suffering. How can and should we respond to pain and suffering that is not our own? The platitude that the afflicted person is emulating the suffering of Jesus may sound nice, but it is not likely to offer any consolation unless the words are accompanied by compassionate human presence. Modern medicine also has its own response to the problem of pain and suffering, which consists, as one theologian put it, of "relieving the human condition of the human condition," namely, relieving pain and suffering through an arsenal of sedatives, and if that fails, perhaps by assisted suicide or euthanasia. But if pain and suffering are part of our mortal lot, and indeed prerequisites to knowledge and joy, as suggested in LDS scripture (see 2 Ne. 2:11), then such a medical posture toward pain and suffering is itself dehumanizing. Finally, in our life's journey we must seek to make meaning of death and our destiny as human beings. An understanding of death as the "enemy" is embedded in our current health care system and in the ideology of modern medicine. It is an understanding that needs modification by spiritual perspectives that see in death a passage and a journey, and at times a blessed deliverer from mortal life.

To avoid the temptations of either making all health problems a matter of sin and salvation, or separating health and salvation so completely that they lose all connection, we need to draw on Micah's prophetic definition of righteousness and its themes of justice, mercy, and humility. Consistent with the biblical message that the last be treated first, I want to start by discussing the virtue and relevance of humility to the health care reform crisis.



HUMILITY

A self-awareness of our limits and aspirations.

HUMILITY is not a virtue readily recognizable in our liberal democratic political traditions, which have historically emphasized the assertion of "rights" and "entitlements." A preoccupation with claiming "my" rights, however, leaves me much more prone to pride than humility.

The words for human, humility, and earth itself all have the same etymological root ("humus"). Humility reveals who we are—our self-identity—and the profound connection and interdependence of our being with earth and nature. Perhaps it is only the meek or humble that inherit the earth because they recognize that they are of the earth. We simply create an illusionary picture of who we are unless we recognize our dependence upon and interdependence with the natural world, a recognition that presupposes a disposition of humility.

Humility also conveys a self-awareness regarding the limits of our aspirations and achievements and a corresponding acknowledgement that there are powers and forces, both internal and external to the self, that are beyond our control and mastery. We may experience these powers as creative, sustaining, and redeeming, or as arbitrary, abusive, and cruel, but what we cannot do is deny their existence. Their presence is never more recognizable than in the diminishment of our embodied selves that we experience through disease and death. Our personal limits of vulnerability and mortality are then brought home to us with a vengeance.

What, however, has the virtue of humility to do with the health care crisis? Just as humility requires acknowledgement of personal limits and a giving up of pretensions to immortality achieved by our own lights, humility also requires a moral modesty about the aspirations and achievements of modern medicine. It was Francis Bacon (1561–1626)

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who articulated the ideology of modern science in his maxim that "knowledge and mastery of nature is power." The culture of Western medicine has pursued that ideology for the last four centuries, to the extent that we have achieved many of the powers of the gods, including the power to create, to sustain, and to end life, through advanced technological methods. Moreover, we have tended to measure "progress" in medicine through our capacity to "conquer" and win the "war against _____" (fill in the blank) disease, and thereby, ultimately, through technology, defer and postpone, if not yet defeat, death. While our knowledge has indeed brought us power, it is unclear whether it has given us the practical wisdom to make judicious and compassionate use of this technology. Indeed, as many have suggested, contemporary medicine is guided more by a "technological imperative" (if we have the technology, we must use it) than any constraining moral imperatives.

There is an engulfing spiritual crisis in health care reform when we begin to see it through the perspective of humility. At a theological level, it reveals itself as an inability, both personally and socially, to confront our mortality and its meaning (won't technology deliver us when things get really bad?). At a social level, this unwillingness to accept with humility our mortal limitations plays itself out in the tremendous disproportion of resources our health care system invests in curative, critical care, and rescue medicine. The prophetic theme of humility, by contrast, requires us to affirm caring, compassion, and human presence, rather than the marvelous miracles of technology, as *central* to the calling of medicine and to the reform of our health care system. Indeed, humility in Christian and LDS traditions means that we are part of a religious community in which we learn what it means to die early.

JUSTICE

Limiting health care resources so others may have some.

JUSTICE is the prophetic principle that presupposes limits and scarcity, of which health care reform is a constant reminder. Aristotle taught that justice requires that we give a person his or her due. Yet, determining what is due a person with respect to health care is a complex problem. Would we say that what is due a recipient of health care is *health*? That might seem a reasonable expectation, but it is also fallacious, because there is little correlation between the provision of health care and the attainment of good health. Far more important conditions of good health are the quality of the natural environment (the level of toxic wastes, pollutants, etc.), heredity and genetics, lifestyle (including diet and nutrition), and the quality of the social environment (including its political, economic, cultural, and religious dimensions).

Perhaps we might say that justice requires that we provide not health, nor even health care, but what former Secretary of Health, Education, and Welfare Joseph Califano refers to as *sick care*. I have argued above that our entire priority system in health care is geared toward curing and the progressive eradication of disease: our health care system does a commendable job assisting us when we experience illness, but it is less helpful when it comes to keeping us healthy in the first place. A sick care system is no adequate substitute for a health care system.

At minimum, justice requires a dramatic shifting of priorities to preventive and primary care medicine. The ability to perform technological miracles must become secondary to the provision of compassion and authentic "health care" for more persons in our communities. Our current priorities are so skewed that preventive and primary care medicine is the least funded of any form of medicine, yet it has the greatest impact on health.

A second requirement of justice is particularly important in religious communities. The biblical narratives witness that justice involves a preferential concern for the marginalized and oppressed, for the voiceless and vulnerable in a society. The Holy Qu'ran of Islam offers its own vision of righteousness: The righteous person is one "who, though he loves it dearly, gives away his wealth to kinsfolk, to orphans, to the helpless, to the traveller in need, and to beggars, and for the redemption of captives." (Sura 2:176–177.) One source of preferential justice for the oppressed is our condition of existential equality: no person is self-created, but all of us, LDS scripture relates, are beggars who rely on powers and resources beyond our control for life and sustenance. (See Mosiah 4:19.)

Moreover, embodied in the homeless, the stranger, the ill, the captive, the vulnerable, and the voiceless, the prophetic eyes of preferential justice discerns the very image of the divine. (See Matt. 25:34–40.)

The practical implication of the spirit of preferential concern for health care reform is that those persons and communities who have sufficient resources for their needs *limit* their consumption to make available more resources for distribution among the vulnerable and oppressed, and, in particular, the vast numbers of medically indigent persons who live their lives in a shadow of fear because of a lack of insurance coverage. It is scandalous that as a nation we will consume nearly $1 trillion in health care services this year, while 15 percent of our fellow citizens will gain access to health care only via the emergency room. Limiting our consumption of health and sick care based on sufficiency will enable early intervention so that the stranger in our medical midst can be welcomed at the front door of our health care institutions rather than ushered in on a gurney through a side door.

MERCY

We must "suffer with" the person who suffers.

THE virtue of mercy involves a commitment to community between the well and the ill, and a responsibility of non-abandonment. The ill, particularly in liberal societies with pretensions to self-sufficiency and self-determination, often become sources of stigmatization; thus, we create barrier institutions, known as hospitals and nursing homes, to keep out of sight what we wish to be out of mind. Besides, the ill are discomforting to us because they remind us of our own vulnerability and mortality. It should come as little surprise, then, that a frequent complaint among the ill is that they receive "impersonal" care.

There are few better symbols of our commitment to share burdens and to a common good than in offering mercy and compassion to the ill. The exemplary biblical story of love of neighbor narrates how the good Samaritan "showed mercy" to the wounded stranger. Thus, the ill ought not be sources of stigma, but occasions for service and stewardship.

Mercy and compassion mean that we "suffer with" the person who suffers. We offer the resources of technological deliverance when appropriate, but always the genuineness of human presence. Suffering is not a "problem" that can be solved by medicine as much as it is a condition of our mortal experience that we live through. Suffering tends to be seen as an incorrigible evil in modern medicine, not even susceptible to amelioration by the best of our technologies; thus, in some jurisdictions, the problem of suffering is resolved by assisting the sufferer in suicide by medical means. The virtue of mercy, however, requires us to ask not "What should we do?" but "How should we rise to the occasion?" When another suffers, what is needed is human presence to the sufferer by touch, sight, conversation, and compassion.

Thus, for the health care professional, mercy requires that care be personalized, that persons replace paperwork in the daily walk of medical life. For the community of believers, the challenge is to be continually present to the ill, who are themselves symbols of divine grace and mercy, in the face of potentially estranging technological methods of control of one's life or one's dying.

It is easy, in the political battle that will rage this year over health care reform, to focus only on the bottom line. My claim, however, is that any health care reform must be leavened by the virtues of humility, justice, and mercy if we are to have the moral and spiritual resources to sustain a healing and caring medicine, and to manage a health crisis that is no less spiritual than it is economic.

NOTES

1. Albert Camus, *The Plague* (New York: Vintage Books, 1972), 203.
2. Aaron Antonovsky, *Health, Stress, and Coping* (San Francisco: Jossey-Bass Publishers, 1980), 160–81.

SOME DAYS TOO BEAUTIFUL
After a Winter of Loss

I only wanted
to lie open and empty
in the spring sun, to see
what the light would do.
In the quiet yard,
climbing roses, red enough
to wound, made such clamor
against the white slab of fence
that I looked away.

Even the sky refused to gauze itself—
blue of the deepness
of drowning, a long,
blank thirst for breath.
So I closed my eyes and warmed
until my pores had filled
and were seeping.
The world a white coma, the light
bore me like a loose buoy
back in to the house,
shrunken pupils oppressed
to stares, the aurora in my veins
turned to heaviness I would carry
toward the dark mirrors
and hunched desk,
the caves of my rooms.

—DIXIE PARTRIDGE