SEMINAR ON HEALTH CARE THEOLOGY AND ETHICS

A. THEOLOGICAL PERSPECTIVES ON THE HEALTH CARE OF THE POOR IN THE UNITED STATES

In his presentation Laurence O'Connell provided an analysis of the "preferential option for the poor" and its potential impact on the current debate on health care in the United States.

The "preferential option for the poor" has emerged from a frankly theological discussion that is very much colored by its origin in the Third World. The distinctiveness of its religious roots and cultural context may perhaps limit its direct applicability to the public debate over health care in the United States. But despite its potential limitations, the preferential option for the poor may appeal to some as a forceful analogy, if not an authoritative norm. Since the concept itself is similar to theories currently advanced by some American ethicists (e.g., John Rawls' principle of fair equality of opportunity), the preferential option for the poor may prove quite suggestive.

Why, however, would a concept associated with poverty and misery among the marginalized and exploited masses of Latin America find currency in the debate concerning health care in the United States? The answer to this unsettling question lies in the changing nature of health care in this country, according to O'Connell.

Health Care in the United States

The health care system in the United States is in the midst of a revolution that is transforming its very nature. There is a definite shift away from the traditional view of health care as a social good that is exempt from market forces and towards a view that health care is an economic commodity subject to the influence of supply, demand, and price. Concepts like cost containment, competition, consumer attitudes, and capitation arrangements presently shape the discussion of health care in the United States.

It would be difficult to deny that today health care is largely driven and shaped by economic considerations. Consequently, the participants in the U.S. health system—providers, consumers, payers, and policy makers—have begun to relate to one another and to health care in ways that reflect the prominence of economic considerations. For example, many hospitals are offering a wide array of new, economically profitable services to provide sources of income, maintain their share of the so-called hospital market, and meet competition from physician groups and entrepreneurs. Physicians, in an effort to guard their own economic interests in a competitive environment, have begun to carve out market niches by providing a

variety of speciality services. And large American corporations are increasingly aggressive in their demands for cut-rate health care services, while at the same time the federal government is focusing on limiting its financial outlays and is continuing to distance itself from the notion that government should ensure access to health care for all. Undeniably, health care has moved into the marketplaces.

Health care is still widely available in the United States but that availability, and certainly the quality and extent of care, is usually linked to an individual's ability to pay or an institution's willingness to adopt the strategies and practices of the marketplaces. It is no surprise, then, that there are millions—perhaps as many as 55 million— health care poor in the United States. Indeed, it is ironic but nonetheless true that this affluent nation, with its substantial resources, exhibits a third-rate attitude towards the poor, particularly in the area of health care.

The Preferential Option For The Poor

After a preliminary description of the concept itself, as well as some objections to it, O'Connell went on to suggest possible lines of connection between the church's preferential option for the poor and the plight of health care in this country. O'Connell insisted that, despite its otherworldly inspiration, both theologically and culturally, the preferential option for the poor is clearly compatible with other perspectives on the problem of poverty and structural injustice.

For instance, the preferential option for the poor displays striking similarities to certain features of the philosopher John Rawls' principle of fair equality of opportunity. In this theory Rawls' justifies unequal (preferential) treatment for many classes of person (e.g., the handicapped and materially disadvantaged) on the grounds that they cannot be held personally reponsible for the conditions that prevent them from obtaining a reasonable share of certain basic or primary social goods.

Rawls' theory, according to O'Connell is genuinely analogous—somewhat the same, yet different in many details—to the preferential option for the poor. The two approaches, one religiously inspired and the other philosophically grounded, share some common ground. Thus, they can be considered in tandem: they mutually reinforce and illuminate each other, even if indirectly by way of analogy.

Furthermore, their compatibility, and even mutual reinforcement, makes an important point: Secular and religious perspectives, although sometimes quite different in many details, are not always mutually exclusive. They are often complementary viewpoints that are fundamentally related. Therefore, secular perspectives can and do play a role in religious inquiry, while religious perspectives can and do support secular understanding of certain issues.

Continuing, O'Connell spelled out the relevance of certain elements the preferential option of the poor to the secular analysis of the plight of the health care poor. For example, the preferential option clearly highlights the systemic dimensions of change. The emphasis that the preferential option for the poor places on the revision of social structures as the central vehicle for achieving a decent provision for the poor suggests that the ethical precepts we develop to govern the production and distribution of health care must be social as well as personal in character. Changing one's personal perspective is good, and indeed may be the

necessary prerequisite to a changed social perspective. But without social change very little will be done to improve the lot of the poor, particularly in regard to health care.

O'Connell concluded by citing other areas where the preferential option for the poor is relevant to the current state of health care in the United States. He noted that his brief presentation was an invitation. If that invitation leads to further exploration and the preferential option is adopted as a genuinely suggestive analogy, the effort to relate a frankly religious theme to a civic debate will have been worthwhile.

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B. REPRODUCTIVE ETHICS: THIRD PARTIES IN PROCREATION

Advances in reproductive technology make it possible today for third parties to be involved in procreation as sperm donors, egg donors, embryo donors or as surrogate mothers who donate a uterus for the gestation of the embryo/fetus. Richard McCormick, SJ, analyzed the ethical problems raised by such third party donations. The Vatican Instruction on *Respect for Human Life in its Origin and on the Dignity of Procreation* (1987) bases its position on both deontological and teleological principles. The document teaches that "the fidelity of the spouses in the unity of marriage involves reciprocal respect of their rights to become a father and a mother only through each other" (par. 23) and regards involvement of third parties as " . . . a violation of the reciprocal commitment of the spouses and a grave lack in regard to that essential property of marriage which is its unity" (24).

The use of third party donors further "violates the rights of the child . . . (depriving) him of his filial relationships with his parental origins . . . and can hinder the maturing of his personal identity" (24). This deontological approach is complemented by teleological considerations related to the potential for damage to the personal relationship of the spouses resulting from the rupturing of the genetic-gestational-rearing unity of the family. Such threats to the unity of the family are a source of "dissension, disorder and injustice in the whole of social life" (25).

McCormick explained his substantial agreement with the Vatican's teaching, a position he originally enunciated in his dissent from the conclusions reached by the Ethics Committee of the American Fertility Society.[1]

Third party donation of sperm, ovum, or womb is ethically inappropriate because: (1) as a violation of the marriage covenant in which exclusive, non-transferable rights to each other's person and generative acts are exchanged, it severs

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[1]Ethics Committee of the American Fertility Society, *Ethical Considerations of the New Reproductive Technologies* [1986] (2131 Magnolia Avenue, Suite 201, Birmingham, AL, 35282) Appendix A, 82S.

procreation from the marital union; (2) it brings into the world a child with no bond of origin to one or both marital partners, thus blurring the child's genealogy, and compromising the child's self-identity; (3) it may foster attitudes in which adulteries are multiplied to the detriment of marriage; (4) it supports, with subtle moves toward eugenics, the stud-farm mentality; (5) it may absolutize sterility as a disvalue and childbearing as a value, distorting and threatening basic values of life, marriage and family. McCormick concluded that when individual benefit is weighed against institutional risk of harm, the latter should take precedence. McCormick acknowledged that this position may represent a minority view in the U.S. In fact, artificial insemination by donor (AID) has been practiced in the U.S. for several decades.

There are two distinct analyses contained in the above reasoning. First, third party involvement violates the marriage covenant, regardless of potential for harm or benefits. However, the view that the "sphere of responsible procreation" is marriage (Paul Ramsey) raises uneasy questions about the definition of marriage, the evaluation of serial marriages, of relationships between nontraditional couples, trial marriages, marriages-in-stages, and broken marriages. Are the intention and capacity for rearing offspring more central to responsible procreation than is marriage?

Second, genetic, gestational, and rearing components of procreation ought to be included in the notion of marital exclusivity because any relaxation in this exclusivity could harm the marriage as well as the prospective child. For example, genetic asymmetry in the child's relationships to father and mother resulting from use of donor sperm could have damaging psychological effects. Further, separating procreation from marriage in principle opens the door to troubling possibilities, such as insemination of single women, lesbian couples, etc. Although we do not have empirical data demonstrating harmful consequences, the risks and potential harms urge us toward caution and moral rules that guard against abuse.

In summary, McCormick admitted the possibility of counterstatements to his analysis, but insisted on the importance of drawing an ethical line at some reasonable place.

Following the presentation, discussion focused on the unity of marriage, the role of technology in reproductive therapy, questions of rights in marriage, the translation of moral conviction into public policy, and the feminist perspective on technological interventions in procreation.

The unity of marriage is in the order of symbol. Is the essential unity broken by the absence of biological unity? Does the utilization of genetic material from outside the married couple compromise the essential unity? On the other hand if the symbol is moved too far from the genetic reality, it will be difficult to preserve the symbol. One point of view suggested, in the language of Louis Janssens, that donors represent an ontic disvalue, to be tolerated only in the interests of avoiding another evil or of achieving a greater good.

Regarding the use of technology in procreation, it was questioned whether God's plan for marriage and generation of human life is not violated by the introduction of the new technologies. However, the Vatican intention not to condemn technology as such is clear; and the tradition of medicine as practiced in the Chris-

tian western world has incorporated the best of technological advances in the interest of healing, of preventing disease, and restoring health.

The discussion of rights raised a number of considerations. The right of the child to be born of an act of marital intercourse without the intervention of third parties or technology is difficult to defend since the subject of rights does not yet exist. The right to have basic needs met can be separated from the right to be born of a particular unitive act. However, we lack empirical data regarding the threat to such rights and the consequences for individual self-identity when there is such a separation. This is an issue that must be considered in relationship to a whole set of circumstances, including the child, the family, society.

How do moral convictions regarding human reproduction translate into public policy? This is a particularly difficult matter in a pluralistic society, where public consensus is required for the enactment of law and public policy. It is evident that at this time there is lacking such a consensus and, in any case, that the principles and positions enunciated by the Vatican do not enjoy broad public support in the U.S.

Finally, it was noted that the feminist views of the new reproductive technologies are situated within the context of violence against women: the subordination and manipulation of women's bodies in the hyperovulation, invasive surgeries, etc. that are required in technologically assisted reproduction. In a practice like surrogate motherhood, motherhood is disembodied from one woman by being distributed to several women, thus dividing women from each other and promoting on a biomedical level division between women. The very language that is used is dehumanizing: discussion of "harvesting," "uterine environments," "surrogate" (more appropriately applied to father, since gestational mother is indeed the mother). In addition, infertility diminishes self-esteem, and women become vulnerable to social pressure to subject themselves to the technologies in order to reproduce. Commercialization of surrogacy practices is especially insidious, with women serving as "fetal containers" who are paid upon deliverance of a baby. It is interesting to observe that fetalists and feminists often concur in their opposition to third-party reproductive practices, but for different reasons. For the fetalists, the fetus is supreme, and its concerns must take precedence; for feminists, the woman's needs have priority, and her right to choose and to control her body override concerns about the fetus.

Without attempting to resolve the ethical issues involved in third party involvement in procreation, the tradition of the Iroquois Indians was offered for reflection; when faced with a major and difficult problem, the tribe came together in Tribal Council and asked the question: "What will be the effect of the act taken today on the seventh generation of our children?" The council would not decide the issues until they could answer that question. Perhaps a similar caution is appropriate in a matter as important as the future and destiny of our children.

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