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Who has a Right to What Services? - A Response  

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We are each entitled to at least one vote on whether there is any ethical justification for today's mixed bag of medical-care delivery systems. My vote is no, there is none. As Stan Reiser pointed out, what makes sense for half the country also makes sense for the other half.  

Until universal health care is one of the reasons for paying taxes to Washington DC, all three branches of this country's Federal government will remain ethically challenged in a most serious way.  

We can easily tell how far we've come, and how much further we have to go, by one of the campaign promises the President made at his nomination for re-election.  

He got one of his strongest positive responses for proposing that the delivery of every newborn baby automatically and by law be worth two days in the hospital for mother and child.  

This means that if the President is re-elected, and if the Congress agrees to pay for it, we may yet see our country offer universal health care by right in this millennium, but only for the first 48 hours of life.  

Sad to say, that would be an improvement over where we are today, but why not just move the threshold up a bit, until voting age, perhaps?  

The usual reason given for our sorry state of affairs is money: universal health care would cost too much. I am no economist, but the evidence of successful programs in other industrialized countries suggests that this may not be the only reason for our country's difficulty, nor the only grounds for change.  

David McCurdy and Gerald Wolpe raised a second and unexpected reason to mobilize for change; to improve medical care for those already covered. The reason is plain: medical care as a purchasable commodity is bad medicine.  

I do not mean to minimize the issues of equity and cost, but to raise a different, and to my mind, a prior question.
Perhaps a comparison of medical care to food might be helpful in seeing the difference. Food and medical care both sustain life. We buy and sell medical care today the way we buy and sell food, so we tend to focus on finding ways to assure that everyone has the medical equivalent of food stamps.

The difference I am arguing for is ethical, and very dramatic: a doctor is not a farmer, because we are not vegetables or cattle. We and our health care providers are all one species, all people; and we all suffer the same way.

Medical care is not food because, whatever else health care may mean at a given moment of technological advancement, we cannot have our suffering alleviated without human contact of an emotionally rich sort.

When the doctor, the nurse, the counselor are forced by the iron hand of market competitiveness to act as the distributors of a commodity, a patient becomes at best a purchaser. In the case of capitated managed care, the patient is not even a customer; he or she is a problematic drain on a prepaid account.

In either case, the emotional distance necessary to making a proper business decision puts the emotional needs of the patient at great risk of going unmet.

When a farmer bales hay, he or she--many of the farms around me in Vermont are maintained by women--does not have any ethical obligation to the hay, nor to the cattle it feeds, beyond satisfying the hunger of the latter; not much of an burden on the farmer, especially if the cattle are destined to be steak.

While a cow may or may not be a commodity, a person should never be so reduced. We are obliged, instead, to work to protect the moment of shared mortality and even love that passes between two people when one is in a serious state and the other--who may or may not be able to help--is there only to try.

That moment must be guarded from the distractions of the market; we must all resist novelties of management that require commodification of the patient. I see no other way to protect this aspect of medical care, no stable structure that sustains the ethics of the moment, but universal, government-supported health care by right.

Rabbi Wolpe and Dr. Reiser each pointed this way, from very different directions. I come to it from the third dimension of medical care, the world of basic biomedical science. It is common in designing the future of medical care, to turn to basic research and its technological advances to save the day.
But we are going to remain people no matter what we discover, invent, patent or diagnose in each other’s bodies. As humans, we will remain in need of human contact, of human love, of altruistic caring.

No matter what tools are available—and believe me, I value these tools of medicine more each day, not less, as I grow older—any dream of the tool that will cancel the need for the attention of another person, is at best a daydream, and at worst a nightmare.

Rabbi Wolpe's stunning phrase—technology-dependent people—reminds us that dependence on a machine is not the desired end-point, only the compromise we must all accept sooner or latter.

Technology cannot cure us of dependence on itself, and only the continued attention of other people can make that dependence bearable. We should not ask science—nor allow technology—to take away the eye-contact, nor the touch of a person's hand.

Religion can help here. Medical science and established religions share a vision of the universe that allows the hope of eventual improvement despite almost universal evidence to the contrary. The human contact that forms the core of medical care is one source of this hope.

The additional requirement of many religions—that the universe be the product of design rather than the accumulation of small random events—tends to keep scientists apart from religion. If we simply set this issue aside for the sake of those in need of care, then there really is no barrier to medical science and religion working very closely together here.

David McCurdy's "God is not a gatekeeper" could serve as a motto for those of us who want to build such an alliance; and Rabbi Wolpe's "Death as a safety-valve" could be the reminder of what we all need to work against.