With the 2008 presidential race underway, healthcare reform is once again in the national spotlight. Thirteen years after the last attempt at reform, the number of uninsured in the United States is close to 47 million; the cost of insurance premiums is increasing at twice the rate of inflation; and battles over who should bear the burden of these costs are being waged in the nation’s legislatures and boardrooms. The debate over reform is focused principally on the kind of healthcare system Americans will accept (single payer, like that in Canada and some European countries; a mix of government funded and private insurance; health savings accounts, etc.) and how such a system would be funded. This is an essential part of the discussion, of course, but it is not enough.

One reason for the spiraling cost of healthcare, as Daniel Callahan and others long ago pointed out, is the ever-growing demand on medicine “to relieve the human condition” (McKenny). Buoyed by the medical successes of the nineteenth and twentieth centuries, we have created a healthcare system that “wants to conquer all diseases and stay the hand of death” (Callahan, 1990, 23). Yet in the face of human finitude, this is a futile goal. We will inevitably grow old and eventually die, and as we age, our bodies will decline. While it is certainly the appropriate role of medicine to seek to alleviate suffering caused by physical debility, no healthcare system can ease all the spiritual and emotional suffering that unavoidably comes with human finitude. Together with the debates about what kind of healthcare system is best for the United States and how to finance it, there must be discussion of the appropriate role of medicine in society. In this discussion, theological bioethics in general, and Catholic bioethics in particular, have important contributions to make.

Theological Bioethics and the Common Good

In her recent book, Theological Bioethics: Participation, Justice, Change, Lisa Sowle Cahill argues for a “theological bioethics...
that aims at social justice, defined as inclusive participation in the common good” (Cahill, 7). She proposes that such a bioethics must enter the public debate with its own “thick” discourse, formed by particular traditions, narratives, and symbols, as a way of dislodging “the thick discourses [of science, economics, and liberalism] that are so widely entrenched that their constituting narratives and practices are no longer directly observed” (Cahill, 27). The challenge for theological bioethicists, according to Cahill, is to expand their role of teaching and scholarship by entering into the fray of policy discussions and social activism, inserting into the debate the religious values and worldviews that are all too often sidelined in the ethical debates over issues such as stem cell research, end-of-life care, and reproductive technologies.

The values and world view that Cahill wants to insert into the debate are those found in the tradition of Catholic social teaching. She is sympathetic to social conservatives’ resistance to the “instrumentalization and commercialization of vulnerable life,” but maintains that opposing legalized abortion, stem cell research, or physician assisted suicide simply on the basis of the “rights of embryos, fetuses, the handicapped or comatose persons” does little to challenge the culture’s systemic individualism and consumerism, which underlie the objectification of human life (Cahill, 27). Instead, Cahill appeals for solidarity with those who are marginalized or excluded from the healthcare system, both nationally and internationally as the basis from which to work for greater distributive healthcare justice. This, she argues, will also more effectively enhance respect for the dignity of all human life.

**Empathy or Justice?**

The difficulty for Cahill and others who call for greater justice in healthcare distribution is the inescapable implication of their position: that to expand access to those currently excluded from the healthcare system, we must be willing to limit our expectations of what that system can achieve for any one individual. This is the specter of “rationing” that so effectively helped jettison reform efforts thirteen years ago. Those who call for limiting medicine’s ever-expanding reach into every aspect of an individual’s life in favor of greater justice in healthcare distribution are vulnerable to accusations that they lack empathy. Indeed, in the face of appeals from celebrities debilitated by Parkinson’s disease or spinal injuries, or even a family member’s slow deterioration from Alzheimer’s disease, it is difficult without seeming cold-hearted to argue against, e.g., stem cell research, which purportedly holds out the promise for a cure in favor of spending resources on expanded access to basic care.

Daniel Callahan makes this point in his review of Cahill’s book. He affirms Cahill’s vision and agenda for theological bioethics, but criticizes her lack of attention to the practical “nuts and bolts” application of such a vision to policy questions. His concern, he states, is how we “get there from here.” In his words, “while justice is a needed and legitimate language for theology, empathy remains a more important motivator of action; or perhaps justice without empathy (and vice versa) provides too thin a foundation for getting things done” (Callahan, 2007, 265). Yet it is precisely in its potential for creating the empathy necessary to break the existing stalemate in so many bioethical debates, including those about healthcare reform, that I see Cahill’s vision as being most useful.

Appeals for distributive justice in healthcare are not appeals to some abstract principle, as more and more of the middle class in the United States is discovering. It is no coincidence that calls for healthcare reform are reemerging at this time, when over one
third of those without insurance have a family income above $40,000 and two-thirds of the uninsured are in households with at least one full-time worker. As the middle class becomes increasingly vulnerable to the same loss of access to medical care as those living on the socioeconomic margins, questions of just healthcare distribution are all too concrete for many people.

Much more abstract, one could argue, are debates about the status of fetal and embryonic life, or whether respect for life demands indefinitely continuing artificial nutrition and hydration for patients in a permanent vegetative state. Moreover, as was all too evident in the recent Terry Schiavo case, such debates when framed in terms of competing individual rights, can lead to polarization and impasse from which nobody benefits. On the other hand, appeals to the very real sense of vulnerability among a growing segment of the American population could create common ground from which to shape a more inclusive vision of medicine's role in society. Theological bioethicists and the Catholic Church in the United States could play a vital role in initiating such a dialogue, and they have a tradition from which to draw in doing so.

**A Consistent Ethic of Life and Healthcare Access**

Prior to every presidential election since 1976, the Administrative Committee of the U.S. Catholic Conference of Bishops (USCCB) has issued a document aimed at helping the Catholic electorate go to the polls with a “properly informed conscience.” In it, issues relevant to the upcoming election are analyzed through the lens of Catholic social teaching. Since 1988, the moral framework proposed for addressing these issues has been the consistent ethic of life. As the bishops insisted in 2003, “for Catholics, the defense of human life and dignity is not a narrow cause, but a way of life and a frame-work of action.” Quoting the Congregation for the Doctrine of the Faith, they continue by asserting that “a political commitment to a single isolated aspect of the Church's social doctrine does not exhaust one’s responsibility toward the common good” (Faithful Citizenship, Section V).

In November 2007, the U.S. Bishops voted on a similar document to guide Catholic voters in deliberations about their choices at the polls. When it comes to the issue of healthcare reform, use of the consistent ethic of life is particularly fitting. As is becoming all too obvious to too many people, the individualistic focus of the existing healthcare system on alleviating every possible kind of suffering and extending life indefinitely for those who can afford it, leaves ever more people suffering and needlessly dying from a lack of access to even basic care. On the other hand, drawing on the empathy of those who fear exclusion from the current system for those who already are excluded, has the potential to help create a more just system that is respectful of all human life and dignity.

Callahan is right when he writes that theology “has to pitch in and join a messy world dealing with messy problems... allowing the grease found on the nuts and bolts of practicality to stain our hands” (Callahan, 2007, 466). But theology needs to do this in a way that builds common ground. One way, I suggest, is to shift the focus away from individual rights, as Lisa Sowle Cahill proposes, to our universal human vulnerability to suffering in order to build justice on a foundation of empathy. Without such a shift, the nuts and bolts of reform will be holding together a system doomed to collapse under its own weight.

**References**


