Special Section: Unheard Voices:
Religious Perspectives on Access to Healthcare

A Protestant Perspective on Access to Healthcare

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In writing this paper I am reminded of a conference that I once attended. On that panel, the Jewish scholar spoke first. "Let me tell you what the Talmud says," he began, and he gave a wonderful talk full of references to the legal rulings and stories of the Jewish tradition. Then the Catholic priest spoke. "Let me tell you what the Magisterium says," he began, and he gave a wonderful talk carefully attentive to the moral tradition of the Catholic Church. Finally, a Protestant spoke. "You have heard what the Talmud says and what the Magisterium says," he began, "Now let me tell you what I think." I didn't know whether to laugh or cry, but now I find myself in a similar situation.

Protestantism is characterized by diversity; Protestant reflection about medical morality frequently defies generalization; moreover, there is not in Protestantism the sort of settled tradition that can be located in the codes or responses of rabbis or in the teaching authority of a magisterium. No one, therefore, can modestly claim to represent Protestantism. Even so, there is, I think, a Protestant tradition on access to healthcare; and efforts to describe it and the struggles of Protestants to be faithful to it can contribute to both public discussion of access and efforts to increase access. There is, after all—at least at the level of denominational statements—something like a Protestant consensus about access to healthcare.

Protestant Consensus on Access to Healthcare

The first thing I want to do is simply to call attention to that consensus. In recent years many "main-line" Protestant churches have issued statements calling for healthcare reform. American Baptists called for legislation that would assure "access to and funding for quality healthcare for all persons."[1] Episcopalians demanded "adequate healthcare for all";[2] they emphasized prevention and acknowledged the possible necessity of rationing. Lutherans have identified access to healthcare as a "substantive entitlement."[3] Methodists advocated a national healthcare plan that would "provide comprehensive benefits to everyone."[4] Presbyterians insisted, "free markets alone cannot provide for the adequate supply and equitable distribution of [medical] resources," and they urged "all groups of society, including government, . . . to insure equal access to [basic] health services."[5] These statements warrant, I think, the claim that there is a Protestant consensus about access to healthcare.

I would not overstate the case. There are Protestants who disagree vigorously with these denominational statements. Witness, for example, Pat Robertson and the Christian Coalition. Moreover, there is not a consensus about a particular

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policy proposal. Nevertheless, there is a consensus—a consensus that one critical test for any policy and for any policy proposal is whether it guarantees universal access to good healthcare, a consensus that the current practice of healthcare in the United States fails to meet that standard, and a consensus that finite resources will require of proposals for healthcare reform that they contain costs and acknowledge limits.

Consensus Not Accidental

The second thing I want to do is to claim that this consensus in Protestant statements is no accident. Although it is not easy to tell from the brief excerpts I have quoted, these statements are usually supported—in good Protestant fashion—by appeals to Scripture, and especially to the Gospels.

The stories of Jesus as healer have formed in many Protestants a virtue of compassion toward the sick and a vision of healthcare as a vocation, as a form of discipleship of the healing Christ. This Jesus, moreover, was not only a healer but a preacher of "good news to the poor" (Lk. 4:18, 7:22). Luke, the physician among the evangelists, makes the point elegantly. One who has read, for example, Luke's story of the rich man and Lazarus (Lk. 16:19–31) will hardly be content when the poor must scavenge and beg for crumbs from the richly supplied tables—or the richly supplied medicine chests—of the rich. One who has heard the story of the Good Samaritan can hardly be complacent when some who lie hurting and "half dead" today are passed by. One who knows the story of the sheep and the goats (Mt. 25:31–46) has a peculiar set of spectacles through which to see in the sick and poor and powerless the very image of the one called "Lord," and to see in what is done to them conduct done, in the Lord's words, "unto me."

It is not shocking, then, that there should be a consensus in the Protestant statements on access to healthcare. From Luther onward Protestants have claimed a conscience "taken captive by scripture."[6] The "old, old story"—and stories—that they love to tell they also long to live, to practice, also when they consider access to healthcare. To own such stories as one's own—whether in the vocation of healthcare or in the vocation of policy formation—is to be concerned that the sick poor receive good healthcare.

Moreover, the Protestant struggle to live the stories they love to tell has produced a tradition with which this consensus coheres. In the sixteenth century in Calvin's Geneva the poor were guaranteed access to both the hospital and a physician.[7] In the eighteenth century John Wesley supplemented his evangelism in America with a little medical care, and when, returning to England, he witnessed the sickness and suffering of the poor, he undertook a more regular practice. His desire to identify remedies available to the poor led to the publication in 1747 of *Primitive Physick*.[8] In the nineteenth and twentieth centuries Protestants responded to appeals to build hospitals, hoping to follow Jesus by their care for the sick poor.[9] At the turn of the century Walter Rauschenbusch, the founder of the Protestant social gospel in this country, penned a little prayer for doctors and nurses, petitioning for them a sense of their work as a "holy calling," as a form of discipleship to the saving Christ, and petitioning of them a sense that the sick child of poor immigrants is no less precious than the child of the rich, lest, as he said, they become "hirelings" who serve only for money.[10]

Given Scripture and such a tradition, the consensus in Protestant statements is no accident. To make and to defend that claim was the second thing I wanted to do.

Protestant Consensus and Public Policy

The third thing I want to do is to ask what this Protestant consensus can contribute to public consideration of access to healthcare and to efforts to increase such access. To pursue this third item in my agenda, permit me to return to the story of the Good Samaritan.[11]

Once upon a time, on the road between Jerusalem and Jericho a man was mugged and left "half dead" by the side of the road. Some passed by on their way to Jericho's market or to Jerusalem's temple, but one who saw him had compassion. A Samaritan it was who bent over the man and tended to his care, pouring oil and wine upon his wounds and bandaging them. Then he gently lifted the man, and brought him to an inn. When he could stay no longer himself, he gave the innkeeper two denarii with instructions to care for the man and with the promise to pay for whatever the wounded man required.

It's a good story, a story we still love to tell. And we do tell it. We tell it in the name we give the statutes designed to protect and to encourage such behavior, the so-called "Good Samaritan statutes." We tell it in the name of every hospital that calls itself Good Samaritan. And Christians tell it, of course, in the churches, where it is acknowledged as part of Scripture, part of the larger story by which Christians test the faithfulness of their conduct and character.

On the other hand, it's an old story and—in the context of modern medicine—an odd story. Compassion leads to costly care. That we understand well enough, perhaps better even than the Samaritan did, for we have today an assortment of technologies to help and to heal that make donkeys, oil and wine, and the binding of wounds seem simply quaint. Moreover, costs are attached to these technologies which make the Samaritan's two denarii seem laughable (even if it was two days' wages for an agricultural worker).

The Good Samaritan seems no longer quite so apt an image for the care of those who hurt, and the reason is simple. The Samaritan did not face the issue that healthcare providers and healthcare policymakers are forced to face today, the issue of scarcity. The *limitless* compassion of the Samaritan makes his story seem more odd than exemplary; unlimited care seems not a real option.

But suppose the oil and the wine and the stay at the inn left the wounded man in the story only "half alive." Would the Samaritan continue to pay for his care? Or suppose he encountered another neighbor on the side of the road when he returned to pay the bill for the first traveler. Would he do the same for the second neighbor? Suppose he encountered not just one other but more than his donkey could bear, more than his purse could afford, more than even the most hospitable innkeeper could receive. What would he do then? And could he continue to be a *good* Samaritan?

Suddenly he seems a tragic figure, forced to make unwelcome choices. Introduce scarcity into the story, and it no longer seems quite so old and so odd. But introduce scarcity, and it no longer seems quite the same story. Let this be the thought experiment for a Protestant contribution to consideration of access to healthcare: Can we continue to tell this story of the Good Samaritan as an image of care for those who hurt *and* acknowledge the limits of our resources?

Can we still be good Samaritans—or fair Samaritans—in the midst of the tragic choices imposed by scarcity? The answer, I think, is "Yes, we can. We can still be Good Samaritans—but not without attention to policy."

To be 'good,' a Samaritan who encountered stranger after stranger left "half dead" by the side of the road would have to give attention to policy. The Good Samaritan's compassion, or charity, would finally insist on some consideration of policy, perhaps increased police protection on the Jericho Road, but also, perhaps, a healthcare policy that would assure the needy access to an inn or at least not penalize a hospitable innkeeper. The very compassion, or charity, that moved the Samaritan to care for *one* who hurt would motivate attention to policy when *many* hurt.

The contemporary Good Samaritan will be attentive to policy. Let me quickly mention, however, two caveats. First, no particular policy about access to healthcare is simply given with the story. The details of policy are not magically provided by compassion. And the consensus among Protestants formed by Scripture and the tradition does not guarantee unanimity about policy. Second, the story and the tradition cannot be reduced to policy. The story is lived and the tradition continues not just in policy formation, but in the formation of healthcare ministries among the poor, in parish nurse programs and in neighborhood clinics staffed by contemporary Good Samaritans. The story is lived and the tradition continues not just where public programs are instituted, but where doctors and nurses learn to see their work, as Rauschenbusch prayed, as a "holy calling," as a form of discipleship that attends to the needs of the sick poor.

Although no policy is simply given with the story, and although the story cannot be reduced to policy, those who tell the story and delight in it should not neglect it when they consider public policy. The story not only *motivates* attention to policy; it also *forms* Protestant attention to policy.

It forms, first and most obviously, a prophetic protest against policies that lead to injustice in access to healthcare. The story is lived and the tradition continues when Protestant churches beat against injustice in healthcare with their statements, and when they encourage people to test policy recommendations not just against a standard of impartial rationality but against the plumb line of "good news for the poor," including especially the sick poor. Protestant churches contribute, then, to public attention to access to healthcare by speaking sometimes prophetically, raising their voice against injustices in healthcare delivery. Prophetic indictments of policy are significant contributions to public deliberation, but prophets do not necessarily make good managers. Prophetic voices are appropriate and important, but insufficient to policy.

The story also forms, however, the virtues and vision that policy cannot supply, but that are critically important to the formation of good policy and on which the success of any policy may depend. Can we still be Good Samaritans? Yes, we can—but not without attention to policy. And the contemporary Samaritan attentive to policy will require virtues besides compassion to be "good." The first of them is *truthfulness,* the readiness to acknowledge the truth about our world and our medicine, about the limits imposed by our mortality and by the finitude of our resources. The twin of truthfulness is *humility,* the readiness to acknowledge that we are not gods but the creatures of God, finite and mortal creatures in need finally of God's care, and watching finally for God's future.

Joined to both is *gratitude,* thankfulness for opportunities within our limits, opportunities to care for one regarded as among the least of these. We have come around again to *compassion,* to care. The Samaritan will never be good without compassion, without charity, but let it be said again: The Samaritan will never be good with just compassion.

That is, of course, precisely the wrong way to put it. The contemporary Samaritan will never be good with *only* compassion, but *just* compassion is indeed required. The virtue of *justice* is essential to those who would be good in the midst of scarcity. A readiness to do justice and to insist that justice be done is required of anyone who would be (even) a *fair* Samaritan. Protestant churches, then, can contribute to public attention to access to healthcare by speaking sometimes sagely, reminding their members and society of the virtues required of life in a mortal body and in a community, virtues like truthfulness and humility, gratitude, compassion, and justice.

Let me underscore the significance of story to policy here by attending briefly to other stories. Consider, first, that wonderful American and medical story of the frontier.[12] The story is that we have continuously encountered new frontiers and are constantly overcoming new obstacles and securing new horizons. It's an optimistic story, and it forms an optimistic character. But the story also helps to explain something of what's wrong with the healthcare system. The story of the frontier does not train those who tell it to be content with limits, and when discontent with limits spills over onto the limits of human mortality and finite resources, then medical expectations become boundless. The story of the frontier celebrates the rugged individualist, alone against nature and the odds, and it celebrates the technical innovations that extend human mastery over nature and help one to beat the odds. The frontier knows justice, of course, but it is a tight-fisted justice that looks out for number one. And it knows tragedy, the sad story that in the battle against nature and the odds we sometimes lose. But it trains us to respond to tragedy by battling on.

Or, consider the omnipresent American story of the marketplace. In this story the seller gets rich by supplying what the buyer wants. This story shapes character too. It frequently creates incentives—and characters—for productivity and creativity, and that can advance the interests of everyone in society. However, when the marketplace is the story of medicine, then medicine becomes a commodity like cookies or cars. Marketplace medicine tends to become a medicine for the rich and powerful while the weak and poor watch and pray. Moreover, the marketplace story of medicine will not sustain the dispositions of care and trust that have sometimes marked the covenant of physician and patient.

If these are the stories we tell, then the policies we make will understandably be formed by our discontent with limits, by our individualism and tight-fisted sense of justice, by our suspicion of nature and our confidence in technology. It will be the same old story.

Obstacles and new possibilities remain of course, and there remain markets. But the story is lived and the tradition continues in humble and truthful acknowledgment of limits, and in gratitude for opportunities within those limits to care. For we are not just strangers but neighbors and known to be such in compassion. We are to acknowledge the limits but also to share, to care, and to do justice. Our test for justice is not a pinched view of individual entitlement but the care given to the poor and weak.

These notions of care, or charity, and justice introduce a third contribution of the story to policy deliberation about access to healthcare. The story nurtures prophetic voices; it sustains a vision and virtues important to policy; but it also informs moral analysis of the notions we bring to consideration of access to healthcare. No one doubts, I suppose, that charity and justice are relevant to our deliberations about access to healthcare. But what is 'charity'? And what does 'justice' mean?

I remind you that the story of the Good Samaritan follows the commandment to love God and the neighbor. Jesus was asked, "But who is my neighbor?" and he replied with a story and with a question, "Who was a neighbor to the one left half dead?" Note two things here: First, the Samaritan was a neighbor, not just stranger, not simply enemy. The story is that we *are* neighbors to each other, even to those we do not know or care to know. Second, the answer to the question "Who is my neighbor? To whom do I owe the duties of charity?" comes indirectly, not so much by theoretical analysis as by a readiness to care for another as though she or he *were* a neighbor.

Or, consider 'justice.' In John Rawls's *A Theory of Justice*[13] 'justice' means "maximum freedom" and "presumptive equality." I like that, frankly, but there is a story there too, a story of a social contract of strangers, a story of an "original position" and a "veil of ignorance" in which self-interested individuals consent to certain constraints on their liberty and entitlements for the sake of protecting themselves. In this story justice can only be felt as a restraint, as a limit to my pursuit of individual interest. There is a different story of justice in Scripture, a story of God's justice, a story of one who hears the cries of those who hurt and rescues them, a story of exodus and the liberation of slaves, a story of manna and an economy in which none had too little and none too much, a story of a community in which people were friends, not just clients and patrons. And to own that story was—and is—to celebrate that justice and to own the vocation to do justice, to hear the cries of those who hurt, and to form a policy attentive to them.

Protestants contribute to the deliberation about access when they nudge the analysis of moral notions in the direction of the story they love to tell and struggle to live. The contemporary Good Samaritan will be attentive to policy. Let me repeat, however, the first caveat: No particular policy is simply given with the story. The story nurtures prophetic protest. It sustains a vision and virtues important to policy. It informs the analysis of moral notions relevant to policy. But it does not simply provide policy.

Policy is always developed within particular conditions.[14] Policymaking remains the art of the possible. The good and the right are always relevant, but always relevant under the constraints of the possible. The story is lived and the tradition continues not only when Protestants speak sometimes prophetically, not only when they speak sometimes sagely, and not only when they speak analytically of moral notions, but sometimes when they speak politically, using policy analysis and compromise to preserve or to accomplish some little good for those who hurt and to avert some great harm toward which selfishness always tilts a society.

There is a Protestant consensus on access to healthcare. The consensus is not accidental. The Protestant contribution to deliberations about access is formed by the story it loves to tell and struggles to live. So, let the conclusion of this paper be the conclusion of the story of the Samaritan: Go and do likewise.

Notes

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5. *Minutes of the 201st General Assembly of the Presbyterian Church (USA), 1989*. Louisville, Kentucky: Presbyterian Church (USA), 1989:524. See also Christian responsibility and a national medical plan. *Minutes of the 203rd General Assembly of the Presbyterian Church (USA), 1992*. Louisville, Kentucky: Presbyterian Church (USA), 1992. (Available from the Presbyterian Distribution Management Service, 100 Witherspoon Street, Louisville, KY 40202–1396.) See also Vaux K. Biomedical ethics in the Reformed tradition. In: Lustig BA, ed. *Bioethics Yearbook: Volume 1. Theological Developments in Bioethics: 1988–1990*. Dordrecht: Kluwer Academic Publishers, 1991:201–13; Weist WE, ed. *Health Care and Its Costs: A Challenge for the Church.* Lanham, Maryland: University Press of America, 1988.
6. When Luther was called before the Diet of Worms in 1521 by Charles V and ordered to recant, he refused, stating that his conscience had been "taken captive" by Scripture and that, unless he were convinced by the testimony of Scripture or clear reason, it would not allow him to recant. "Here I stand," he said, "I can do no other."
7. See Calvin J. Draft ecclesiastical ordinances. In: Reid JKS, trans. *Calvin: Theological Treatises,* The Library of Christian Classics, Vol. xxii. Philadelphia: Westminster Press, 1954:65. See further Smylie JH. The Reformed tradition, health and healing. In: Weist WE, ed. *Health Care and Its Costs: A Challenge for the Church.* Lanham, Maryland: University Press of America, 1988:182–3.
8. See, further Holifield EB. *Health and Medicine in the Methodist Tradition*. New York: Crossroad, 1986:32–3.
9. See, for example, note 8, Holifield 1986:53–7.
10. Rauschenbusch W. *Prayers of the Social Awakening*. Boston: Pilgrim Press, 1925 [1909]:81–2; reprinted in Lammers S, Verhey A. *On Moral Medicine: Theological Perspectives in Medical Ethics*. Grand Rapids, Michigan: Eerdmans, 1987:5.
11. The following paragraph is a summary and paraphrase of Luke 10:30–37. Some of the commentary on this passage was published previously and developed more fully in Verhey A. The Good Samaritan and scarce medical resources. *Christian Scholar's Review* 1994;xxiii(3):360–73. See also Childress JF. Love and justice in Christian biomedical ethics. In: Shelp E, ed. *Theology and Bioethics*. Dordrecht: D. Reidel Publishing Company, 1985:225–44, especially 225–6.
12. See further Verhey A. The Health Security Act: policy and story. *The Christian Century* 1994; Jan 26:74–7.
13. Rawls J. *A Theory of Justice*. Cambridge, Massachusetts: The Belknap Press of Harvard University Press, 1971.
14. See Gustafson JM. *Varieties of Moral Discourse: Prophetic, Narrative, Ethical, and Policy* (The Stob Lectures of Calvin College and Seminary, 1987–1988). Grand Rapids, Michigan: The Stob Lectures Endowment, 1988.