Healthcare Allocation: an ethical framework for public policy

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Introduction

'Crisis' in the National Health Service

This Report is concerned to establish an adequate ethical framework for the allocation of healthcare, with particular reference to the UK. The need to do so has arisen largely because of what are perceived to be failures in the National Health Service which raise issues of resource allocation. So the Report begins by introducing the issues in relation to what is sometimes spoken of as a 'crisis' in the National Health Service.

The National Health Service (NHS) is today said to be in 'crisis.' Underlying the rhetoric of such claims there are some serious issues which challenge Christians and all people of good will. Whereas some countries are too poor to provide even the most basic standards of healthcare for their populations, and others, though prosperous, do not even try, the UK has long been notable for its attempt to provide healthcare for all its citizens. In the past few years, however, there have been an increasing number of complaints about equity and comprehensiveness of access. There is a disturbing frequency to cases in which the media report failures of care or other failures in the health service and, more often than not, the underlying issue raised concerns the proper allocation of finite resources. The same basic issue, in a variety of manifestations, recurrently arises in other countries.

In recent years there has been a growing volume of publications, including Government Reports (The Netherlands, New Zealand, Sweden), addressing the problems of resource allocation in health care. Some of these publications propose solutions based on an

inadequate understanding of the purpose of the health care system (such as: maximising 'health gain'), others propose solutions which are unsatisfactory because they fail to take account of all the principles which should govern the framing of allocation policy. It is common, for example, to claim that a policy is satisfactory if it satisfies the demands of equity and efficiency. But equity takes care of only some of the requirements of justice, and may fail to do even that in the absence of a true understanding of who it is who should be treated equitably.

It is not our conviction that there is a uniquely correct solution for the UK, still less for all similar economies, to the problems of healthcare resource allocation. Nor is it our conviction that there is a uniquely correct approach to finding solutions. So this Report does not seek to propound any one approach, still less any one solution, to resolving the problems of healthcare resource allocation in the UK.

It is, however, clear to us that much current thinking (and hence practice) in regard to resource allocation is intellectually and morally impoverished. The present Report seeks above all to contribute to remedying this situation. First, by identifying the inadequacies of some of the characteristic approaches to resource allocation; secondly, by explaining the relevance of a number of considerations that are often overlooked in formulating resource allocation policy. We hope that our effort to direct attention to these considerations will serve to inform public policy and so the general understanding of the common good.

1

Clarifying some central terms of the debate

This chapter begins by clarifying the idea of health as a necessary preliminary to defining what healthcare is. It goes on to consider what are included in the resources and systems which serve healthcare. The chapter concludes by distinguishing the general idea of 'allocation' from the more specific idea of 'rationing', which may be explicit or implicit. The levels at which rationing takes place within the overall system of the NHS are distinguished.

1.1 Introduction

If we are to discuss the *allocation* of healthcare we need to clarify the notion of 'healthcare'. We cannot be satisfied with the view that healthcare just is what 'healthcarers' do. A decision to count as healthcare whatever may be claimed to be healthcare overlooks the need to distinguish between genuine and spurious claims of that kind. If we deny the need to make such a distinction we might as well abandon the aspiration to establish a reasonable basis for decisions about allocating resources to healthcare. How can one defend allocating resources to a practice simply because people conventionally regarded as healthcarers carry it out? There is some recognition of the pertinence of this question, as is evident from the limited debates about the justifiability of funding treatments such as *in vitro* fertilization. But a normative conception of what is to count as healthcare will, as we shall see, call into question more practices than certain forms of infertility treatment.

1.2 What is health?

It seems clear that the notion of 'healthcare' needs to be elucidated through clarifying the notion of 'health' and the related notion of 'ill-health'. So we begin by offering some clarification of the idea of 'health'.

There are various understandings of health and ill-health advanced in our society. The World Health Organization defined health as 'a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.'[1] While this definition reflects what might be thought to be an admirable concern for the whole person, it amounts to equating health with happiness. Happiness (or the integral fulfilment of persons) is, as we shall see in Chapter 9, properly the object of all human activity. While health is, generally speaking,[2] a crucial element and precondition of human well-being or flourishing, human flourishing requires many other ingredient elements: moral and intellectual dispositions and a range of skills. And it is clear that not all evils experienced by human beings are manifestations of ill-health.[3] There is a particular danger in contemporary societies, impressed by the achievements of medicine, of 'medicalizing' the whole of human experience.

Too broad an understanding of health can result in vacuity: every dimension of human flourishing can be called 'health' and every kind of failure to flourish 'ill-health', so that a great variety of human activities are then deemed to be in some sense 'healthcare'. This can lead to an inappropriate analysis of situations and to the application of inappropriate 'solutions'. It can also lead to misdirection of the efforts of health professionals and misuse of medical resources. The health professions have developed with a particular history, mores, and goals internal to their practice, which leave their members ill-suited and ill-resourced to perform other roles and functions; to expect healthworkers to be omnicompetent about all that is required for human well-being is unreasonable and destroys the coherence of healthcare as a distinctive undertaking.

Another understanding of health, commonly proposed by psychiatrists and social theorists, is 'the ability to function well in society'. On the face of it health does seem to be 'relative' to people's own temperaments (their 'pain tolerance thresholds', or whether or not they are of sanguine disposition), their goals (paraplegia is likely to affect the life of a footballer rather more drastically than the life of a physicist), their physical environment (asthma and hay-fever depend upon

surrounding air conditions), and their social situation (until European settlement, dyslexia was no handicap among Australian Aborigines because they did not have writing). Yet all these factors only show the relativity (and even this, not absolutely) of the *significance* of health and sickness to people; they do not show the non-existence of somatic disabilities or of breakdown or impairment of functional capacities. Of course people can adjust in a better or worse fashion to their situations, and communities can assist or hinder that adjustment: but there remains something proper to the physical reality of that person which may require a response from others, and society's response may well tell us more about what is wrong with that society than about what is wrong with the individual. Were health judged purely in terms of social adjustment, all social non-conformity would or could be characterized as disease and would be 'treated' by 'medical' means such as quarantine, psychoactive drugs and psychological techniques: the fact that we deplore these very interpretations and practices by some tyrannical régimes reflects the fact that there is more to health than social adjustment.

In the present Report we accept the classical biomedical or organic understanding of health. Health, on this view, is the well-ordered organic functioning of the body, such as well serves a human being's survival and flourishing. In the human species this will include the biological prerequisites for its 'animal' activities, such as nutrition, sentience, motility and reproduction, and for its specifically 'human' activities, such as emotional responsiveness, understanding, judgement, choice, and the acquisition of these abilities, in association with the progressive mastery of language. An emphasis on bodily or biological health is not intended to deny the importance of other aspects of the human person (psychological, moral, or spiritual) or to deny the complex interdependence of these various dimensions of the person. Both in terms of cause and effect organic health will commonly be related to other dimensions of well-being.

1.3 What is healthcare?

Healthcare is the 'healing' arts (underpinned by science) of medicine and nursing and all that allied clinical activity which seeks the promotion, maintenance and restoration of health or the alleviation of distressing symptoms of ill-health. Traditionally it has first and foremost focused on disease and injury (which will have objective clinical

signs), as well as their associated psychological or emotional effects (illness, pain and suffering) and their effects on activity and social interaction (disability and handicap).

Not everything doctors and nurses do contributes to the restoration or maintenance of health and the alleviation of symptoms. Sometimes this is because what they do is futile or even harmful. At other times it is because some of the things healthworkers do have other ends in view: reducing non-medical suffering or inconvenience (by, for example, regulating fertility); providing non-medical consumer wants (cosmetic surgery, selecting characteristics of children, sex-change operations); 'health enhancement' (through the administration of drugs or by operations which aim not at correcting or alleviating defects of structure or function but at securing achievements beyond the otherwise healthy natural endowments of an individual); maximizing income, avoiding litigation or achieving research or career goals; or collaborating in social objectives such as eugenics. These activities are not true 'healthcare'; whatever merits they may be thought to have, their justification (if any) lies elsewhere.

Health is served by personal activities other than healthcare – such as eating and taking exercise – as well as by other human activities affecting the quality of housing, water, sewerage and the environment. Healthcare, on the other hand, is *clinical* care, a service generally provided by people with particular ends, skills and strategies, who belong to the health professions – although, of course, others might also supply the kind of care these professionals provide. In chapters 9 to 11 we will explore at greater length the importance of healthcare being seen as more than just the application of a technical skill in accordance with the idiosyncratic attitudes and wishes of doctor and patient. The complex interrelationship between health and other aspects of human well-being also means that 'holistic' care for real people will require more than simple 'body mechanics': good healthcare will reflect an awareness of the complexity of the persons it serves and will be co-ordinated with other kinds of care (with some of which it inevitably overlaps) such as social services, with other efforts to improve the physical and social environment, with counselling and chaplaincy, and so on.

1.4 Healthcare resources and healthcare systems

Healthcare resources are whatever is used in the provision of healthcare. This would include funding (NHS budgets provided from

consolidated revenues, private insurance payments, charity funds, out-of-pocket payments), infrastructure (hospitals, beds, technical equipment ranging from simple scalpels to MRI scanners), labour (the number, kind, time and energies of healthworkers, the posts in certain specialties, the opportunities for training and research), and items used (swabs, drugs, blood, organs for transplant). Particular procedures or therapies usually involve some combination of these.

The health system as a whole is a complex of resources, institutions, policies, practices, persons and actions which provides healthcare in a particular community. Commonly in Britain we use the term to refer to the NHS, but there are of course various healthcare activities outside the purview of the government funded and regulated system. Nor need the word 'system' here imply a simple or unified, 'systematic' or planned provision, or a clear and identifiable agent or group of agents directing the activity: a free market in healthcare or a mixed system involving some combination of public-and-free, public-but-for-a-charge, joint-public-and-private, private-but-regulated and private-and-unregulated services are all kinds of 'system'. (Since the 1991 reforms, the NHS has itself become a 'mixed system'.) Any health system necessarily overlaps with other social systems such as those providing welfare, housing, education, sewerage and water.

1.5 Healthcare allocation

The notion of 'allocation' may be used of any distribution of resources whether or not the distribution takes place as the result of a policy or of a decision made with precisely that end in view. By contrast the notions of 'rationing' and 'prioritization' imply decision-making which is more or less systematic in character.

The system which characterises rationing decisions may be implicit or explicit. When it is *implicit* it is there to be found in the pattern of decisions taken, but this pattern is not publicly acknowledged and justified. The general practitioner in his role as 'gatekeeper', allowing or barring access to specialist or other types of care, has been a principal agent of largely unacknowledged rationing in the history of the National Health Service. But there has been a certain pattern to such rationing exhibited, for example, in the widespread disinclination to allow elderly patients access to expensive medical treatments.

When rationing is *explicit* the bases for rationing decisions are publicly acknowledged and justifications for them may be offered.

In relation to the NHS it is helpful to distinguish the different levels at which rationing decisions take place.

The first and highest level is around the Cabinet table, where decisions are made about how much money to allocate to healthcare after assessing the competing claims on public finances of education, housing, social security, defence, the administration of justice, and so on.

The second level is the one at which the total budget allocation at the disposal of a health authority is divided among different sectors or care groups. What should go to the elderly? What should go to antenatal care? What should go to those suffering from renal failure? The UK Government declines to recommend priority setting principles, and has confined itself to setting targets for reducing the incidence of certain conditions (such as coronary disease and cancer) and for reducing waiting lists. Local health authorities are responsible for their own priority setting.

The third level of rationing is the level at which resources are allocated to types of organizational provision (e.g. hospital or community care) or to types of treatment (e.g. renal transplantation for those suffering from renal failure). The Government declines to exclude from NHS provision any particular service and has only very rarely sought to exclude a particular treatment. In theory local health authorities are free to do so; in practice a number of health authorities who have exercised this freedom have mostly found themselves obliged to reverse their decisions.

The fourth level of rationing is the one at which individual clinicians make decisions about how to use the resources available to them: i.e. decisions about *which* patients they are in a position to treat and about *how much* care or treatment to give to individual patients.

9

Towards a substantive conception of the human good

This chapter introduces some basic concepts fundamental to any adequate framework of moral understanding and indicates some of their implications for healthcare. Human flourishing (a term which generically identifies the goal of our living) is constituted by our sharing in an irreducible plurality of incommensurable '*basic goods*', among them life and health. The *basic* character of these goods means they possess the kind of worth in virtue of which they are ultimate reasons for choice and action: neither life nor health are merely instrumental goods, valuable only in virtue of other 'goods' they enable us to achieve. The fact that life and health are two among a *plurality* of basic goods means that they can be more or less the focus of attention in the actual life-plans of individuals. They may be the focus of professional care in the lives of some, while needing to be at least respected and in some measure cherished by everyone. *Positive moral norms* are intended to promote sharing in the basic goods; *negative moral norms* are intended to protect that sharing (by oneself or others) from choices which damage or impede it, and which therefore damage or impede human flourishing. Beyond moral norms, human beings need a range of virtues, that is dispositions readily to choose and act in ways which foster one's own and others' flourishing. The chapter specifies some of the norms and virtues important to the promotion and protection of life and health and the distribution of healthcare.

9.1 The notion of the good(s)

When we act, if we are acting humanly (freely and rationally), we do what we do – and refrain from doing other things – with some *goal* in mind: we hope to achieve something, to bring about some state of affairs, to obtain some kind of benefit, through or in the action. Why, for instance, does someone go to the doctor? Generally speaking: in order to 'get better'. The act of going to the doctor, the things doctors do, and the things we do or submit to on their advice, are largely to be explained by our desire for *life and health*, to which such activities are ultimately directed, whether self-consciously or only implicitly. Such ultimate goals behind our choices have been called *basic goods*. Others include friendship, knowledge, the exercise of skill in work and play, practical reasonableness and a right relationship to God. These goods make what we do intelligible; they are self-evident goals of human choice and fundamental to rational deliberation; they are aspects of human flourishing or happiness; and they are irreducible to other goods or ends.[1] We do not choose what these basic goods will be, even if we adopt our own personal hierarchies among them (what *I* think is the more important, what *I* will give most of my attention to); rather, our choices themselves presume and always seek our participation in one or more of these goods whether we realise it or not; the goods themselves are 'given' in our very nature and in the very nature of our choosing rationally.

9.2 Life and health as basic goods

Life and health, then, are basic human goods. Some people say, however, that life is only 'worth living', and health is only 'worth having', because of the *things they enable* – those conscious experiences, achievements and relationships which make life seem 'worthwhile' to us; when life and health fail to serve these other, more important ends, they are no longer valuable. If this is true then life and health are not truly basic goods: they are merely instrumental to some more important goods (such as certain conscious experiences). Life and health are often sought as means to such other goals; but it is also true that they are sought and enjoyed 'for their own sake'. That is why no-one expects us to give reasons for promoting life and health, avoiding sickness and death: we regard life and health as sufficient reasons *in themselves*, as *intrinsically* valuable. That is also why human life is said

to be 'inviolable' and 'precious', to have a 'dignity' which surpasses the uses we make of it.

People can be *more* or *less* healthy. The enjoyment of well-ordered organic functioning in the life of a person whose faculties are fully developed is clearly different from the experience of health in the life of someone who is underdeveloped, or from the experience of someone who, because of impairment, enjoys only an approximation to well-ordered organic functioning. Some human beings suffer such severe and extensive damage as to seem to have lost the capacity for well-ordered organic functioning. Nonetheless, just because they are alive they are to be respected as human beings. If we think of the life of a human being as valuable only in so far as it is the *means* to achieving what we deem worthwhile we lapse into a dualism about human life which we shall criticise in chapter 10.

To say that life and health are basic goods does not of course mean that their prolongation, maintenance and/or improvement should be pursued by everybody, all the time, in all circumstances, at any cost, and by every possible means – far from it. Life and health are *not* the only or even the most important values: there are, as we have seen, other basic goods, and these are just as important. Different individuals adopt various hierachies of values in their various actions, commitments and choices of vocation and the pursuit of life and health will not necessarily feature as their first priority. A single-minded devotion to life and health would be irrational given the range of goods which are basic to human fulfilment. Nonetheless, the good of life is an obvious prerequisite for attaining other basic goods. And without the good of health – of well-ordered organic functioning – our faculties are often not exercisable in the measure we require to attain some of the other basic goods. Any rational plan of life would make prudent provision, therefore, for those things necessary for life and health: to ignore them altogether while pursuing some other goal would in most circumstances be irrational and as such immoral.

Some people will go further and, in keeping with their particular gifts, tastes, circumstances and sense of 'calling', commit themselves to a particularly healthy life-style or to the study and life-long practice of health promotion, medicine or nursing: in doing so they are placing life and health high among their priorities. (We should note that a commitment to healthcare will also obviously require a commitment to the good of *truth* and to the good of *skill in work*.) Any such commitment will structure a large part of a person's life, consume a great deal

of his or her time and energy, and limit the pursuit of other goods such as play. Other people will focus their attentions elsewhere, perhaps risking or 'sacrificing' some of their potential life or health, accepting this loss as an undesired effect of their particular pursuit of skill, justice, religion or whatever. Neither choice of lifecourse would be unreasonable: as well as healthworkers there will naturally be mountaineers, soldiers and missionaries.

Without some such account of the value of life and health for people, healthcare is reduced to just one preference among many chosen as a matter of private whimsy or cultural conditioning rather than a rational pursuit within reasonable limits; if it is so viewed there is no basis upon which to assess what level and kind of healthcare is reasonably to be pursued and, as we shall consider below, reasonably to be expected from others. We shall consider in the next chapter the nature of the human person and the needs of persons; at this point, however, we might note that without some clear conception of the good it is far from evident why human needs should matter; they would enter into the description of the characteristics of rational animals but tell us nothing of any normative significance.

9.3 Why needs matter

We shall postpone to chapter 10 our consideration of the precise nature of human needs. But it is worth noting here that when people speak of 'needs' they usually mean to convey more than neutral information. When what is at stake are goods as basic as life and health we tend to treat those things necessary to their maintenance or improvement with particular seriousness. But why? One reason is anthropological, the other logical. First, while 'autonomy' or 'free will' is essentially a matter of our ability to fashion and refashion ourselves morally (and so, emotionally and intellectually) through our choices, there are undoubtedly certain logical and natural limits to self-creative choice. Needs are among these boundaries because we ignore them at our peril; they mark the points at which our choices or our negligence may harm, even extinguish, us, or at least disable us from pursuing our commitments and particular choices.

Secondly, as requirements for participation in particular basic goods and so for an aspect of human flourishing, needs are justificatory reasons for action which require no further justification; the pursuit

of the satisfaction of needs, like participation in basic goods, is self-evidently valuable. Because the satisfaction of certain needs is a prerequisite to discharging other duties – whatever they might be – it is also a *prima facie* duty.

9.4 Moral norms

Our own personal preferences among the goods and our commitments will obviously have implications for our choices. But certain specific moral norms or guidelines will be required if we are to judge which ways are reasonable ways of pursuing these. If the fundamental and overarching requirement of our life is to 'do good and avoid evil', the existence of the various basic goods leads to the specification, in a number of norms, of what is involved in that fundamental requirement. Some will be positive ones, directing us to behave in certain ways, such as 'respect the dignity and equality of others', 'follow the Golden Rule' ('Do unto others as you would have them do to you'), 'preserve life', 'look after your health', 'help those in need', 'foster the common good', 'redistribute surplus wealth' and 'use efficient means'. Other norms are negative, forbidding us to act in certain ways, such as 'Do not intentionally kill the innocent', 'Do not deliberately harm', 'Do not abandon those in your care' and 'Do not lie'. These positive and negative norms make up the bulk of what has been described as 'commonsense morality' or 'common' morality.

Such moral norms will have particular applications to the situations and relationships specific to healthcare. Amongst the principles recognized in the Hippocratic tradition have been positive norms such as: 'act always for the benefit of the sick', 'deal justly and honestly with the patient' and 'respect professional confidences'; and negative norms such as 'never kill or assist the killing of a patient', 'never deliberately harm or take undue risks with a patient's health' and 'never abuse a patient sexually' – a code which is as relevant today as it was in the past even if it is by no means exhaustive.

Sometimes in medical or nursing care, as elsewhere in life, one is confronted with an immoral option which has its attractions. For example: one way of aiming for 'efficiency' in allocating healthcare resources would be to deny them to all severely handicapped, unproductive and elderly people. Such a choice would, however, amount to the abandonment of moral reason or to collusion between reason and prejudice or selfishness – hence the importance of moral norms such as

the Golden Rule for sound reasoning and good living. At other times people have good objects but adopt immoral means to them – means which violate some basic good which is integral to the flourishing of persons. Since respect for persons requires respect for the whole range of goods constitutive of the flourishing of persons, we ensure that respect through observing certain norms: 'never act to destroy, damage or impede a basic good (i.e. a basic feature of human well-being)'; 'never treat a person as a means only but always as an end'; 'evil may not be done that good may follow'. These norms are the basis of inviolable human rights.

9.5 Moral virtues

Virtues are character traits which harmonize our feelings, intuitions, judgments, choices and actions with the pursuit of the good. They are essential to a well-lived life because they dispose us to want to do the right thing; they direct appropriately those feelings which contribute to moral perception of situations; they enable people to make good decisions quickly and to follow them through, without having to deliberate at length, always and at every moment, on what to do next; and they assist the identification of those options which best fit the agent's particular personality, situation, purposes, commitments and plan of life. Moral norms give direction to moral virtues, and moral virtues alert our perception to the applicability of moral norms.

Virtues which have an important bearing on the allocation of medical care include: *respectfulness* and *fellow-feeling*, which ensure an inclination always to treat one's patients as one's moral equals and to seek their good, especially their life, good health and comfort; *practical wisdom*, which enables quick, responsible decisions (e.g. about treatment); *courage and patience*, which include coming to terms with limitations of life-span, health, technology and circumstances; *moderation*, which includes resisting excesses in one's life-style which threaten one's good health and limiting one's expectations and demands of the health system to genuine needs; *justice*, which will make one fair and concerned for the common good in healthcare allocations as elsewhere; *mercy*, which looks beyond strict rights and duties and responds out of generosity and compassion to present 'crying need'; *fidelity* and *gratitude* towards those with whom one has a special relationship of care, such as one's own family, the elderly or patients; *truthfulness*

which, without being insensitive or cynical, tells patients the facts (e.g. about the basis of healthcare allocations) and critically examines practices in this area; and *efficiency* which disposes one not to waste opportunities but to seek the most efficient and effective ways to achieving reasonable purposes.[2] Such virtues among healthworkers, patients and the general population are crucial to limiting demand for public medicine and ensuring its best distribution.[3]

Vices are the opposites of virtues: they organize various aspects of the human personality contrary to the pursuit of the good, so that the agent is torn between a will toward true flourishing and desires for mere fragments of it. Vices which might adversely affect the allocation of healthcare include: *partiality* (actively preferring patients of a particular race, age-group, social class...); *maleficence*, *infidelity* and *impiety* which incline people to harm or neglect patients; *meanness* on the one hand and *wastefulness* on the other; *imprudence* and *indecision*, which dispose one to act inappropriately if at all, e.g. regarding treatments and health systems; *cowardice*, which includes unreasonable fear of sickness, disability, healthcare or death or, in the face of sickness and care, assumes the posture of victim and passive recipient; and *intemperateness*, which allows passion or impulse to govern the agent as he or she lives an intemperate life-style or immoderately pursues various pleasures, the perfect body, independence, profit or all that is technologically possible.

9.6 Conclusion

In this chapter we have begun to introduce some of the fundamentals of the moral framework needed for understanding what is at issue in healthcare allocation: basic goods, moral norms and moral virtues. Healthcare is important to human flourishing. Our flourishing as human beings involves our successful sharing in a range of basic goods, including the good of life and the good of health. If we are to thus flourish we need to heed both the positive norms which guide our active sharing in basic goods and the negative norms which protect us from choices which subvert both our sharing and our capacity to share in those goods. If we are to be well-disposed to choose and act rationally in this regard we need a range of virtues.

Health is a basic good. Choices made and actions taken to promote health need to be consistent with respect for other dimensions of human flourishing involving other basic goods.

11

The nature of human community and the provision of healthcare

This chapter is concerned with the relationship between human beings and human communities as the moral foundation of duties to meet the healthcare needs of others. The conception of community we present is radically opposed to atomistic views of human association. All of us are profoundly dependent on relationships of cooperation for our existence and the possibilities of flourishing as human beings. Hence the important truth that to promote the common good of the community is to promote one's own good.[1] Since cooperative relationships are a moral necessity they give rise to duties to sustain and create the conditions of flourishing which should exist at different levels of community. These general truths are exemplified in the character of the duties to provide healthcare proper to different levels of community.

The most fundamental level of community is the family. The family has duties of healthcare precisely because of the character of the commitment to faithful love between spouses and for children proper to a family founded on the marriage relationship. But these duties are limited by a family's resources and other serious commitments. Sophisticated and expensive healthcare can be made available only through a higher level of social organization. Hence the provision of healthcare is an important feature of the common good of societies, i.e. one of those conditions of human flourishing which complex levels of social cooperation exist to serve.

Because every human being has a claim to flourish, the social resources of healthcare should be distributed justly, which in the first place means *fairly* in relation to need. The requirements of justice in distributing resources may be expressed in terms of rights and duties. Societies do not have to arrive at uniform solutions to the problem of providing healthcare in order adequately to recognise the right to it. One kind of solution rather than another will be imposed by a society's distinctive tradition and culture, and a range of such solutions may satisfy the requirements of justice. The chapter ends by clarifying one extremely important type of constraint on distributional arrangements. Healthcare practice properly understood should be informed by respect for moral values, observance of moral norms, and the practice of the relevant virtues. Arrangements for healthcare provision which have the effect of undermining the character of the moral commitment of doctors and nurses are contrary to the interests of all, especially patients.

11.1 The need for a substantive conception of community

If persons have, generally speaking, duties to attend to their own healthcare needs by reasonable means, do others have a duty to co-operate in satisfying these needs, and if so, to what extent? What is it reasonable to expect from the members of the communities in which one lives? Is there a right to healthcare, and if so to how much?

Most people belong to several communities, such as those of the nuclear and extended family, of the neighbourhood, of the workplace, of town and of nation. Each involves a sharing of life and purposes supported by nature, mutual expectations, customs, and formal or informal agreements. The more the parties involved are joined by 'affective' bonds (of blood, friendship, piety, loyalty, patriotism, gratitude...), have common interests and goals, engage in joint projects and activities, the more common life they share. Basic goods provide reasons for action by a person even when such action is with a view to another's benefit or their joint benefit. Norms requiring impartiality and service of the common good, and associated virtues, commend action with a view to serving the good of others, including their life and health.

A 'communitarian' or 'social' consciousness runs contrary to that asocial 'individualism' many see implicit in 'liberal' conceptions of the person, the community and the good examined in Part II. On these liberal accounts, people's highest-order interest is in 'getting their own way' (achieved through the exercise of 'autonomy', the capacity to frame, revise and pursue one's own, privately chosen preferences or conceptions of the good, whatever these might be) and society is a loose conglomeration of individuals each pursuing his or her private interests either in competition or for certain mutual benefits. Several commentators have noted the power of such 'individualism' in medical practice, especially in America, but even here in Britain the change in social temper and ideology in the last two decades of the twentieth century has meant a move towards a more 'privatised' view of people's interests and relations, in healthcare as elsewhere.

We would argue, however, that relationships and co-operation of various sorts are essential not only to the achievement of many purposes and thus to self-realization: they are also in part constitutive of the very self which is realized and fulfilled. People's sense of identity, commitments and personal values to a large extent come with their ties to family, work-place, village or neighbourhood, class, party, church, club, nation and so on. With this range of attachments comes a variety of debts, inheritances, expectations and obligations which constitute the 'given' of life, its 'moral starting point', and give it much of its 'moral particularity'. People's goals and commitments are also unavoidably interrelated. Basic goods such as life and health, for instance, we come to have in virtue of relationships; knowledge of the truth we acquire in virtue of the intellectual labour of past generations and our participation in institutions of learning; a good such as friendship is essentially social; these and others are in some degree necessary to human flourishing. Even in the most 'liberal' and atomised society, certain basic goods, needs, relationships and responsibilities will remain fundamental to human nature and choice, and to the very possibility of community itself. And on this natural commonality will be built various shared understandings through which members of a community come reasonably to expect mutual assistance especially in meeting crucial needs.

Yet another reason supporting a richer conception of community than that proposed by the theories examined in Part II is that the diverse commitments of individuals are much *influenced* by those of others. No one simply decides 'out of the blue' to become a health professional: people do so because they see and are attracted by this

practice in action and perhaps by certain 'icons' of it; and they do so by joining a group and a tradition with 'its own ways'. Institutions such as hospitals, the National Health Service, the medical Royal Colleges and the Royal College of Nursing are bearers of traditions which partly constitute the common life of their members by a continuous (and evolving) 'argument' as to what a good health system, hospital, medical or nursing practice might be.[2] People are also subordinate characters in the life-stories of others, such as their spouse, parents, children and work colleagues. Thus the settings for our own plans of life and particular choices and actions are limited and shaped in ways not entirely fixed by us but given by a prior history of other people's life-plans and choices, and by those responsibilities which result from our unchosen as well as chosen relationships.

Principles of justice and social institutions built on individualistic and adversarial conceptions of human relations may well serve only to promote such an orientation. But if one accepts that persons are related more profoundly and in morally more significant ways than individualistic liberal accounts allow, one will reject any simplistic claim that 'I am not my brother's keeper'. The *common humanitarian duty of care* includes both negative duties (not to harm, treat negligently or with disrespect) and positive ones (to rescue, help or otherwise show kindness to people where it would not require an unreasonable burden). Just how far duties to help others will extend depends on a variety of factors such as: how closely the parties are related (formally or in affection or in custom); what prior undertakings have been given or implied; whether the person in need of care can provide for him or herself; whether there are others with a greater responsibility to provide the care; and the agent's other resources, goals and responsibilities.

11.2 Healthcare begins at home

We have argued that the primary responsibility for healthcare is the individual's. This responsibility is commonly extended to the individual's family. The special kind of unity that the family founded on marriage has constitutes it as a special kind of community[3] – one of physical connection (through procreation, and therefore in genetic constitution, through physical and temperamental resemblances), of cultural bonds (by common experience, knowledge, language, views), and of commitment (devotion to finding part of one's self-fulfillment in helping the other members to flourish).[4]

Though families vary in their expectations, depending upon both natural circumstances and cultural mores, yet individuals and societies – from the richest to the poorest, the most 'primitive' to the most 'advanced' – will almost always rely upon the family as the first provider of needs as basic as healthcare.

The family is the first community of healthcare because it is the family members who (normally) feel and accept as their natural responsibility the care of the other members of the unit. Families quite naturally engage in all sorts of health-related activities, supporting the pregnant mother, feeding and washing the children, applying plasters to wounded knees, caring for the one in bed with the 'flu, calling the doctor, paying the medical bills (where necessary), and so on. We regard it as a mark of the functional family that it provides its members with various things which are indispensable to the pursuit of good health and long life: security and consolation in illness; sensitivity to each other's state of health and basic needs; communication of inherited wisdom and personal experience of basic principles of self-care (safety, diet, hygiene, medicine, the warning signals as to when to seek care from others and so on); and a willingness and ability to sacrifice much in the way of time, care and resources to ensure the good health of the members.

As with the duty of the individual to care for his own health, so that of the family to care for its members' health is not absolute. Families have no responsibility to spend all their energies and resources on keeping each other alive and healthy: they properly have other goals as well. But family healthcare is a very special instance of the 'common humanitarian duty of care' described above. Thus while the common law recognizes no general duty to intervene as a Good Samaritan and help another (even if morality to some extent does), it nonetheless holds that those who by nature or choice have assumed the care of others do have a greater responsibility to provide such positive care.[5] Familial provision of healthcare is thus an expression of friendship and affection, a communal pursuit of goods such as life and health, and a response to natural or chosen duties of care supported by social institutions such as law.

11.3 Healthcare is also a social good

Life and health, we have argued, are goods common to members of any community, and these are pursued through various collaborative

ventures including the provision of healthcare. They are also part of 'the common good' of communities, for several reasons. First, joint action is usually the most efficient and effective way, and commonly enough the only way, of achieving these goods. Health and life are subject to (largely) undeserved, unpredictable, costly, and unevenly distributed dangers which few can adequately cover from their own resources alone. If it is a function of society to attempt to ensure the conditions of flourishing for all, then individuals and families will naturally look to others for assistance when they cannot themselves meet needs as fundamental as basic medical and nursing care.

Secondly, ill-health is sometimes contagious and thus a threat to the good of others or even of all. But even where it is not contagious it presents a threat to the community. The good health and long life of its members is usually a benefit to a community, and the ill-health or death a loss, to particular others in that community (dependants, loved ones, fellow-workers...) and to the community as a whole which suffers the loss of the activity and society of that member.

Thirdly, the disposition to act readily as the Good Samaritan did in response to need is one which there are good practical reasons for encouraging in health professionals and others – it helps them to deal well with emergencies, and to cooperate in the advance of medical care. The 'common humanitarian duty of care' (or the duty to be a 'Good Samaritan') is not only a conclusion of the understanding of morality expounded here: it is embodied in documents ranging from the Bible and Koran to the International Covenant on Economic, Social and Cultural Rights, in many different theories of morality, religious and secular, and in many historical practices of our society including of course the establishment and support of the NHS. Acts of rescue are symbolic demonstrations of crucial social values, such as respect for the dignity and equality of persons. Thus there may be rather more to a health service than first meets the eye: for a health system functions not only as a mechanism for health improvement but as a stage on which are set and enacted important values of the community.

For all these reasons and others the provision of healthcare is part of the common good of any society, part of what society is for. This does not determine exactly how much healthcare, how provided and for whom, but it does run contrary to views, such as some examined in chapter 6, that the state must remain 'neutral' and uninvolved in such matters (see 6.2). Experience suggests that reliance upon the free market alone in healthcare will fail to satisfy those requirements of the common good just outlined (see 5.3). Most states have some

historical experience of undertaking a substantial rôle as co-ordinator, regulator and provider of healthcare, even if some governments have been scaling down their involvement in recent years. Healthcare continues to be viewed as an 'essential service' similar to others which are nationalized or at the least heavily regulated and subsidized in most societies because public interest in their just and efficient provision is so great – services such as law and order, defence, education, energy, transport and communications.

11.4 Healthcare is a matter of distributive justice

Recognition of the fundamental dignity of every human being entails recognition of the claim of each to flourish as a human being. The end of political society is the fulfillment of all its members, including provision for their needs where the market or their own resources fail to satisfy. That being so, societies and their institutions have healthcare responsibilities similar to those of the individual and the family: to use reasonable means to attend to needs in order of importance; to set healthcare high among social goods; to moderate this provision according to appropriate norms and virtues, while bearing in mind other responsibilities of the state.

Since individuals in their relations with each other, both immediate and mediated through institutions, constitute society, they have obligations to favour and foster the common good of their communities, i.e. that set/ensemble of conditions which enables the members of a community to attain for themselves reasonable objectives through which they come to flourish as human beings. Societies are not to be viewed reductively as mechanisms for the pursuit of the interests of particular persons or groups: they should embody arrangements conducive to the good of all. Community membership should expand the range of possibilities for individuals pursuing basic goods such as life and health but it can also erect new obstacles to that pursuit. Various responsibilities will arise under law, public policy, private contract, debt, fellowship, family tie, custom, position of authority, and so forth; and responses to these, as well as to one's personal goals, will be shaped by the web of relationships in which one is involved and by the coinciding and conflicting hierarchies of values which others in those relationships have and pursue.

Distributive justice is that part of justice concerned with problems of distributing resources and opportunities which are essentially common

but which for the sake of the common good must be appropriated to individuals.[6] For the reasons we outlined in chapter 5 (5.3.2) healthcare is just such a 'resource' or 'opportunity': for it is largely a co-operative enterprise, indeed a social creation – the product of accumulated knowledge and skills, publicly funded professional training, public hospitals, state accreditation and licensure and so on – and must be 'appropriated' to particular individuals if it is to occur at all.[7]

If healthcare *is* a distributable resource, the next question that arises is on what basis it should be distributed. Fundamental to communal morality are norms of impartiality and solidarity, especially the Golden Rule. This principle involves both a recognition that basic goods are to be shared by all human beings and an active but impartial concern for others, modelled on concern for self and those one loves. It includes respect for the dignity of others as persons, as one's moral equals, trust in them, a concern to avoid harming them or thwarting their legitimate interests, a desire in various ways to co-operate with and serve them, and to achieve as far as possible basic harmony with them. Applied to our present concerns the Golden Rule so understood might suggest the following tests: Would I think the healthcare budget and its distribution was fair if I (or someone I loved) were in healthcare need, especially if I were among the weakest in the community (i.e. sick with a chronic, disabling and expensive ailment, and poor and illiterate)? Would I think it were fair if I were one who would go without under the proposed arrangements? Would I think it fair were I a healthworker, healthplanner, taxpayer and/or insurer?[8] Answering these questions requires adopting a proper form of imaginative identification with the points of view of all others affected by the distribution in question. From this we can conclude that the primary basis for healthcare distribution will be need for healthcare where satisfaction of that need is compatible with the fulfilment of similar and more important needs of other members of that community.[9] And one of the functions of community provision of healthcare will be to act as a conduit from those who have more than they need to those who have less than they need.[10]

11.5 Different communities will give differing degrees of priority to healthcare

We have argued that 'efficiency within reason' is a requirement of morality: this is as true for societies as it is for individuals. Communities

must seek to bring about good in the lives of their members by actions, institutions and programmes which are efficient for their reasonable purposes. So, for instance, where one medical care programme offers all the benefits of another plus more, the more beneficial programme is to be preferred other things being equal. Most often, however, there will be some benefits and burdens in one possible programme and some in another, and neither will be compellingly preferable. Incommensurability restricts the possible operation of cost-benefit analyses here as elsewhere in human choice. There is no compelling reason for thinking that health, for instance, is one and a half times as important as defence and is thus to be granted one and a half times as great a budget. Nor could a community rationally hold that truth must be compromised for the sake of health-maximization (by, for instance, deliberately exaggerating the 'dire' risks of certain activities in a health scare campaign), as if truth can somehow be weighed against health according to some common denominator. We need not rehearse here the logical and practical difficulties of any such consequentialist calculus: they have been treated in chapter 8 (see 8.5).

Are the choices communities make between, say, health and defence, or between the old and the young, or between preventative and acute care, purely arbitrary then – properly the product of happenstance, powerful interest groups and the horse-trading that is the stuff of ordinary politics? Or is there some more rational standard from which one might criticize the results of such a process?

We think there is. First, communities, like individuals, will face a range of morally *unreasonable* options. Communities and their leaders, like private individuals, must be fair, impartial, willing to help. Thus social policies will be excluded which involve intentionally killing or harming the innocent, unreasonable discrimination, punitive motivations, disrespect for conscience or autonomy, lying, and so on (see further chapter 14).

Secondly, amongst the range of *reasonable* options in areas such as healthcare allocation, a community will adopt one which is in keeping with its reasonable commitments linked to customs, traditions, shared values and various kinds of negotiation and consensus. These commitments will sometimes be formally expressed in constitutions, treaties, laws, policies, 'patient charters', established codes of professional conduct, and the like; at other times they will be manifested more informally in customs and more or less unquestioned expectations. Then some sorts of fairly rough and ready cost-benefit analysis of the various possible institutions and programmes might

be possible and advantageous, sometimes yielding some determinate 'best solution' to a particular problem, at other times a range of more or less satisfactory solutions. So a community might reasonably ask: 'will this proposal contribute to the war effort?' and 'will this alternative contribute more to the war effort?' – though sometimes, of course, such questions will not make sense. But even a community not so strongly focused as one at war will be able to ask: 'are we satisfied with our level of defence spending?', 'could we not afford to spend more on care of the elderly?', 'does not the cutting of spending on mental health conflict with our avowed egalitarianism and concern for the disadvantaged?' and so on.

What we are suggesting here is that any society such as the UK shares a common if often hazy and ill-defined vision of what kind of a community it wants to be. Aspirations to being 'a safe society' and 'a caring society' have, for instance, often been articulated here by political leaders and others, and might be said to be manifest in various welfare programmes. Our health system may be thought to embody some commitment to the following values (though in some cases the commitment is manifestly defective to the point of subverting those values): the dignity and equality of persons, the sanctity of human life, the importance of health, special concern for the vulnerable and the suffering, respect for the elderly, the importance of family life, and the value of community. Such notions as we find them realised – however unfocussed or fuzzy or defective their embodiment might be – amount to culturally particular expressions of the principles of justice, establish standards of aspiration, criticism and debate, contribute to our self-understanding, and underpin many of our institutional arrangements. The radical difference between the universal healthcare system of the UK and the prevailing free market (supplemented by some government aid) in the US reflects deep ideological differences. But as long as neither is a necessarily unjust system (though it is clear that at present some aspects of both systems surely are unjust), it is fitting that each community will choose the system which better reflects its temper, history and enduring values.

11.6 Socio-cultural differences do not serve to call in question a right to healthcare

The language of 'rights', suitably underpinned by an adequate

understanding of justice, can be used to express many of the requirements of justice.[11] Rights are two-sided. From the perspective of the right-holder they amount to claims about what he or she can reasonably expect (is 'due') from others by way of their acting and forbearing to act; if a right remains unsatisfied, the right-holder is reasonably aggrieved, has cause for complaint. From the perspective of the duty-bearer, rights amount to claims about what he or she reasonably owes to others by way of action and restraint. Both the right-holder and the duty-bearer can be an individual, a group of particular individuals, a whole community or its representative institutions, but in each case rights claims are claims about how people should, in justice, treat each other.

Sometimes rights represent constraints on the behaviour of individuals and communities (e.g. the right not to be arbitrarily arrested): such rights may be 'trumps' or have an absolute veto power, in that they cannot morally be set aside even at the behest of majorities or for what one might suppose to be the overall good of society. At other times rights will have some degree of precedence over other interests, but will not be absolute, e.g. the right to shelter. Insofar as assistance from others in the provision of healthcare is reasonably expected it is *prima facie* matter for this second kind of right. When one talks of a right precisely what is at issue needs to be specified by clarifying who the right-holders and duty-bearers are, what the content of the right/duty is (in terms of unambiguous descriptions of activities, including the times and other circumstances and conditions for the applicability of the duty), and any conditions under which a right/duty might be lost or waived.[12]

We have identified the holders of the right to healthcare as all members of the community (both the presently sick and the potentially sick), especially those with conditions which exceed their own capacity (and that of their family) to help cure or satisfactorily mitigate, and the bearers of the duty to provide healthcare as the individual (regarding his own health), his family and near neighbours, the health professions, and the various communities of which the right-holder is a member, up to the level of the state. We have clarified the content of this right/duty as a duty to provide (and a right to expect) access to appropriate healthcare but only insofar as this is consonant with fulfilling certain negative duties (not to kill, harm, abandon, lie... see chapter 14), certain positive duties (to respect, care, promote health, observe the Golden Rule...), certain moderating virtues, and certain individual and communal hierarchies of values; in chapters

12 and 13 we shall examine the specific allocation criteria designed to ensure access to healthcare consonant with these conditions and to help sort the claims of competing rights-holders.

By what standard are we to judge whether a particular community's present specification and demarcation of healthcare rights, as in its healthcare institutions and policies, are reasonable? Liberal protestations notwithstanding, one cannot avoid assessing these against some substantive understanding of the good of persons in community, some 'pattern' or range of 'patterns' of ideal human character, conduct, and interaction in community, while making appropriate provision for individual initiative and interaction and appropriate differences between traditions and cultures, as these will affect such a pattern.[13] Such a standard of criticism will hold in dialectic, as it were, the 'objective' standards of promoting individual flourishing in community proposed in the present chapter (including the claim that health is better than illness, and the objective of ensuring universal access to some decent minimum level of healthcare) while allowing plenty of scope for a range of reasonable but culturally or situationally specific solutions to the attainment of such goals. A society such as ours must, then, debate openly and freely its particular solutions to these problems, seeking to achieve some level of consensus or at least compromise within the range of reasonable options, settling the various competing claims by some appropriate and recognized decision-making process, and remaining open to renegotiation and revision.

Our account of the principles of justice in the allocation of healthcare requires a great deal of specification of healthcare entitlements by legislative and executive institutions formulating policy in the light not only of these principles but of the specific needs of their citizens, the availability of resources, and the practicalities of modern healthcare delivery. The need to ensure adequate provision for healthcare needs might warrant the establishment of some sort of positive (legal) rights for patients and of codes of conduct among the health professions which would include allocational principles. The positive rights of citizens to medical and nursing care might then be satisfied by a mixture of the market-place (through self-provision, fee-for-service and insurance schemes) and state provision through the NHS, and any decisions by the state to limit its involvement would be recognized as either a (more or less reasonable) reliance upon the free market to allocate or an abdication of responsibility in this area.

11.7 Towards a substantive conception of healthcare practice

Contemporary Western societies entrust to the medical and nursing professions much of the task of healthcare. They do so on the understanding that *professional* healthcare is a particular kind of calling and practice, with particular skills, approaches, ethics and ideals. Without such a background the authority of a profession would be unintelligible.[14] Notions such as 'vocation' and 'profession' are specifically ethical ones, and entail:

- a conviction about the importance of a particular service of others and one's 'suitedness' to it;
- preparation for and training in the practice and acceptance into the practice by fellow practitioners;
- some kind of implied or actual profession on the part of the professional that he or she freely undertakes continuing devotion to that way of life in active service of a high good which will call forth a certain devotion of character and life; and
- public recognition (accreditation, licensure, membership of a society, privileges and emoluments) that the professional is trained and competent to act in a particular way.[15]

All this requires a certain baseline of agreement, certain shared values which allow for cohesion amongst the members of the profession and for a kind of 'objectivity' or impersonality of judgment that transcends personal preference. It also founds those mutual expectations, duties, loyalties and norms which are the conditions of freedom to practice a particular 'art' and of public confidence in the practitioner.

Thus just as individuals and communities need norms, virtues and commitments in order to live in accord with moral wisdom, so do health professionals. Many norms applicable to healthcare which are the substance of 'bioethics' codes are translations to the healthcare situation of norms more generally applicable in human action. These include:

- duties to refrain from certain actions in dealings with patients, such as intentional killing, violence, non-consensual interference, manipulation, exploitation, neglect, abandonment, lying, breaches of confidentiality, and unjust discrimination;

- positive duties to act in certain ways with respect to patients, such as with equal respect, in keeping with the trust which should characterise the doctor-patient relationship, responsive to needs and their relative import, with reverence for life, with a view to saving, curing and caring, encouraging people to live responsible and healthy lives, giving special care to the most disadvantaged; and
- duties to act in certain ways with respect to fellow healthworkers and the community, e.g. stewarding common resources justly and efficiently.

Thus the Declaration of Geneva,[16] a modernized version of the Hippocratic Oath, requires physicians to consecrate their lives to the service of humanity; to make the patient's health their first concern; to prevent 'considerations of religion, nationality, race, party politics, or social standing coming between my duty and my patient'; to 'maintain utmost respect for human life from its beginning'; and not to use medical knowledge 'contrary to the laws of humanity'. Any reasonable plan for allocating healthcare, insofar as it involves healthworkers, will have to accommodate such norms.

The virtuous person does not simply observe certain moral norms: he or she is distinguished by having a certain kind of character. Likewise in healthcare: the good physician or nurse is not merely the one who obeys some ethical code but one with certain dispositions. While all of us need all of the virtues to live well certain dispositions have a particular importance in the life of a doctor or nurse: *Good Samaritanism* (which disposes one to do one's best to save, heal and care for others even at some self-sacrifice or apparent inefficiency); *courage* (which imports a willingness to confront the challenge represented by grave and perhaps seemingly incurable illness in others); and *justice* (which ensures that one is not self-seeking, prejudiced or evasive in the exercise of one's healthcare responsibilities but concerned always for one's particular patients and the common good). A persistent temptation for healthworkers, as indeed today for the community more generally, is to medicalize the whole of life and to create ultimately unfulfillable expectations. Thus one virtue of particular relevance to our present concerns is *practical wisdom*: applied to medicine, an understanding of what truly lies within the competence of doctors, and an ability to see not merely what is outside the province of medicine but also when medical treatment itself becomes futile. And in view of the grave problem for healthcare

allocation of demand created by supply there is a need for *moderation*: for researchers, developers, marketers, health reporters and health-workers to act and speak with appropriate restraint.

Several recent writers have called for a re-emphasis on those values and virtues crucial to the practice of medicine which, if lost, will vitiate the traditional character of the doctor-patient relationship as a healing encounter or 'covenant'. They argue that beneficence towards one's particular patients, solidarity with all who suffer and concern for the common good are values more in keeping with the ethical roots of medicine than are autonomous individualism, profitability or economistic efficiency (see chapters 7 and 8). On this view, consistent with that proposed in the present chapter, healthcare is about sustaining and enlarging the realisation of certain basic goods in the lives of persons in ways which make for the flourishing and well-being both of those who are cared for (patients) and those who care (nurses and doctors). Healthcare is not about fulfilment of preferences, or the maximization of measurable efficiency. Alternative proposals, such as a shift from patient-centred to procedure-driven medicine, or from Hippocratic to market ethics, would require a radical redrawing of medical practice as traditionally conceived and a similarly radical transformation of medical ethics – one which, on the account presented here, would be contrary to the good of persons and of the profession itself. And this means that health professionals must be ready and willing to take part in leadership and social criticism to help ensure that the health system or their own profession does not slide in undesirable directions.