MUTUALITY IN MEDICAL SERVICES

ABSTRACT. While available to a multitude, routine health precautions and basic, non-specialized medical services are lacking in many societies. This may in part be the outcome of attitudinal distortions, not only at the national and global levels, but fundamentally within the patient-physician encounter. Demands for a disturbance-free subsistence clash with values of power and control within health-care sub-systems resulting in an overall neglect of primary needs and a distribution of medical services that benefits select groups. True needs are misrepresented and an intensification of particular services does not fulfill one's duties toward those who realize little or no services at all. The entire institutional system of medicine requires a rebalancing of rights, intentions and outcomes, beginning with the correlative experiences of patient and physician.

Key words: Right to health, Health services.

Paternalistic orientations have often prevailed as health care, not universally considered a basic right, has been seen in the modern Western world as a service, accomplished in the interests of the sufferer or in the hope of avoiding the state of suffering. The relationship may be temporal or immediate, thereby supporting a contractual relationship or model [1]. For the most, however, an intent appears at the onset whereby both parties at least implicitly appreciate the potentiality of an indefinite relationship or agreement. Unfortunately, current public demands may be underscored by an elliptic view of a life without discomfort, i.e., universal relief of suffering and prolongation of life. Medicine may have been further seduced by such demands as part of a value system of Westernized society [2]. This need not be the case as mutualism in medical practice can embrace: health as a right that ought to be pursued [3]; equality of the members who contract 'the original position'; an outcome balanced toward everyone's advantage [4]. An underlying intention in this paper has been to consider some aspects of an institutional theory (Rawls' Theory of Justice) at the stratum of health care services.

The varieties of ways in which our culture looks at the concept of 'being healthy' may, in part, be responsible for the dilemma of generalizing health as a 'right'. An appreciation of health should suggest the relative biological, psychological and social harmony of the individual human organism. Therefore, the intent in supporting the thesis that all people have the right to expect others to promote the development of such a balance or harmony (which is dynamic, not static) infers that action to the contrary, i.e., acts of rational people which as their direct or indirect goal, disrupt the balance, are wrong or immoral actions. The point seems to be that I have a right to environmental and interpersonal
conditions which do not interfere with my desires for a balanced state of health, whether in fact it is ever possible for me to obtain such a balance. Although the application is directed here to the physician-patient relationship, relevance could hopefully be encouraged at the more universal plane of human behavior. Political norms accepted by nations too often result in varying modifications of the health balance as defined, e.g., unavailability to multitudes of fundamental nutritional intake.

However, the obsessive hope, promulgated by many leaders of society and the medical world, for freedom from 'unhealthy' discomfort is not considered a realizable end nor should it be: it is, itself, an example of attitudinal behavior which disrupts the balance. A rigid consequentialist view, embracing utility to the exclusion of people as inter-relating persons, may bear some responsibility for the imbalance in the delivery systems. In addition, egoistic satisfaction, entrepreneurship and bureaucracy play their respective roles. At first glance many programs or policies have, as their claimed intent, a restoration of health balance, but too often time and closer scrutiny reveal self-laudatory designs. I contend that a fundamental principle of health balance arises, by extension, from the basic norms of our society, e.g., simultaneously with provision of the conditions necessary for freedom of speech and thought. (Consider some societies that provide, by commission or omission, for balanced dietary benefit only to select groups!) Physicians often operate within systems which promote daily contradictions, e.g., a physician's correction of serious depression without considering the unavailability of the potential for meaningful employment for that depressed individual (unemployment or undernourishment as factors in ecological maintenance). A similar commonplace example is state preoccupation with deinstitutionalization of the mentally ill with less observable concern developed towards compensatory services at the community levels (including the education and acceptance of this program by the ordinary person) to maintain a new equilibrium for the discharged patient [5].

A right action would intend to restore that maintenance or coherence and this should only be approached by a balanced mutuality of effort and intent, aimed toward equal health opportunity as a right. The only exception to the consideration of equal health opportunity as a right would arise when the definition of health includes the aforementioned elimination of discomfort (disease) at a point in time. The tragic conclusion might then arise that any action which aims toward this ultimate end, enhances development of the right (assuming no other action does so with greater usefulness). One could under such a system, e.g., anticipate society's involuntary sterilization of congenitally defective children or adults. It appears to me, however, that this fails to support our considered moral judgments which would have a greater currency in society [6]. Most adults in principle would subscribe to a moral code urging availability of 'sufficient' health