Chapter 7: Liberating Theological Ethics from the Invisible Hand: Paul Farmer, the World's Poor, and the Quandaries of the Fortunate

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> Take a look at "medical ethics," a staple of medical school curricula. What is defined, these days, as an ethical issue? End-of-life decisions, medicolegal questions of brain death and organ transplantation, and medical disclosure issues dominate the published literature. In the hospital, the quandary ethics of the individual constitute most of the discussion of medical ethics....How do you make a clear distinction between life and death, between death and prolonged coma, between two technologies with near-even chances of failure? These are subtle decisions and have weighty consequences. I would be the last to trivialize them. But their formulation assumes a great many givens—a wealth of clinical alternatives, a battery of life-support mechanisms, access to potentially unlimited care. These are the quandaries of the fortunate.
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> Paul Farmer, *Pathologies of Power* [1]

The "quandaries of the fortunate"—those words arced off the page like a flaming arrow, piercing the heart of my identity as a Catholic bioethicist. When I first read them in 2004, I had worked in the field of bioethics for over a dozen years. Add a heavy dose of gene therapy, genetic engineering, and stem cell research, and the above passage almost mirrored my scholarship and my syllabus. Granted, I sought to examine such issues

[1] Paul Farmer, *Pathologies of Power; Health, Human Rights, and the New War on the Poor* (Los Angeles: University of California Press, 2003), 175.

theologically, with some attention to their socio-economic dimensions.[2] But this phrase—the quandaries of the fortunate—crystalized for me a long-felt, nagging unease: that as trained by my discipline, I was propagating a discourse of the privileged to and for the privileged that helped them recursively reproduce structures of privilege and, correlatively and invisibly, structures of oppression.

That flaming arrow torched my *oeuvre*. I threw out my syllabus and started over from scratch. But its fire of judgement served equally as an illuminating light. Like infra-red night vision goggles, this phrase and Farmer's wider corpus made visible for me the determinative yet never-mentioned role of political economy not only for shaping illness, health, and health care delivery, but also in shaping the narrow range of what are considered "ethical issues" by mainstream US (and often, global) bioethics. In addition, I began to see how economics—particularly neoliberal economics—has shaped the conceptual apparatus of bioethics and, thereby, has subsequently reinforced neoliberal assumptions in health care and our broader social context.

Once one begins to see how neoliberalism has infused sectors not usually considered strictly economic—such as medicine and bioethics—the pervasiveness of its influence begins to come into greater focus. In this chapter, I suggest that Farmer's work—in relentlessly foregrounding the subterranean yet determinative role of neoliberalism in medicine and bioethics—presses us to ask: in what ways does it equally enthrall the disciplines of theology and theological ethics? In the first section, I briefly outline the key claims of neoliberal economics and highlight Farmer's critiques of how economic and neoliberal concepts have shaped the field of global health. I then detail how these concepts have pervaded the field

[2] A key early text for both my teaching and research was *Not All of Us Are Saints: A Doctor's Journey with the Poor* (New York: Random House, 1996), David Hilfiker's autobiographical account of practicing medicine among and with the homeless in Washington, DC that has deep resonances with Farmer's international counterpart. For my first encounter with Hilfiker's work see M. Therese Lysaught, "Who is My Neighbor? Commentary on David Hilfiker's Case Story," *Second Opinion* 18 (1992): 59–66, ecommons.luc.edu/ips_facpubs/10/.

of bioethics, perhaps even constituting the discipline from its inception and, perhaps, subtly positioning it as a tool for the neoliberalization of global health care. I then turn the lens to theological ethics, asking: has our discipline, too, been shaped by this invisible hand? If so, what can we do about it?

Political Economy as Root Cause Analysis

Farmer's attention to economics is just one piece of the rigorous analytical framework he developed to "discern the nature of structural violence and explore its contribution to human suffering."[3] Such a framework, which fused the insights of medical anthropology with those of liberation theology, must be, as he reiterated again and again, "geographically broad" and "historically deep," while simultaneously considering "various social 'axes' [in order to] discern a political economy of brutality."[4] A first step in his analysis was always to ask: how could the suffering of a particular patient in front of him be traced to the ways that the global neoliberal political economy had reshaped both local socio-economic contexts and health care delivery writ large? Such analyses, he maintained, provided a truer etiology for specific diseases—both in their individual manifestation and global footprints—and thereby were necessary for developing actually effective solutions.[5]

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[3] Farmer, *Pathologies of Power*, 42.

[4] Farmer, *Pathologies of Power*, 42–43. These axes include gender, race/ethnicity, and any other social or biological construct that "can serve as a pretext for discrimination and thus as a cause of suffering," such as refugee or immigrant status, and sexual preference.

[5] In other words, Farmer's methodology moves recursively back and forth between thickly described stories of particular patients and "the larger matrix of culture, history, and political economy" (*Pathologies of Power*, 41), detailing how political economy materially manifests itself in the bodies of the poor, with ripple effects across the lives of their families, communities, and countries. We see this from his earliest analyses of AIDS (*AIDS and Accusation: Haiti and the Geography of Blame* [Berkley: University of California Press, 1992]; *Women, Poverty, and AIDS: Sex, Drugs, and Structural Violence* [Monroe, ME: Common Courage Press, 1996]) to his final book on the Ebola epidemic (*Fevers, Feuds, and Diamonds: Ebola and the Ravages of History* [New York: Farrar, Straus, and Giroux, 2020]), and at every point in between. Across his corpus, he demonstrates how, in getting to true root causes, such

For those unfamiliar with neoliberalism, I begin with a brief history and conceptual overview. Birthed around the mid-1930s in Austria and developed over the course of the twentieth century through the work of the Chicago School of Economics and its European counterparts, neoliberalism catapulted to dominance in the global economic order around 1980 with the allied political programs of Ronald Reagan in the US and Margaret Thatcher in the United Kingdom.[6] Via the Washington Consensus, as this alliance was known, global economic policy administered through the international financial institutions established in the post-World War II era—the World Bank, the International Monetary Fund, and their satellite organizations—was radically reshaped to prioritize neoliberal philosophy and policies.

Neoliberalism has two key planks. The first is its anthropology, which imagines the human person as a radically individual chooser who must be free to maximize his preferences. I will discuss this anthropology further in the next section. The second plank is a corollary of this anthropology, namely, the radical minimization of government. Thus, neoliberalism relentlessly seeks to dismantle or delegitimate governmental structures, as well as any other robust social or community entities—such as schools, churches, unions, local economies—which might theoretically impede the freedom of the market. This anti-government ideology extends to all areas, save one: protecting the market's freedom. Neoliberal economists, as Michel Foucault notes, argue for an "active, multiple, vigilant, and

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an economic "epidemiology" might help to generate new and effective solutions for ending endemic structural suffering.

[6] For a succinct overview of the history and conceptual outline of neoliberalism, see Jim Yong Kim, Joyce V. Millen, and Alec Irwin, *Dying for Growth: Global Inequality and the Health of the Poor* (Monroe, ME: Common Courage Press, 2002). For more in-depth analyses of neoliberalism, see Wendy Brown, *Undoing the Demos: Neoliberalism's Stealth Revolution* (Cambridge, MA: MIT Press, 2015); David Harvey, *A Brief History of Neoliberalism* (Oxford: Oxford University Press, 2008); and David Stedman Jones, *Masters of the Universe: Hayek, Friedman, and the Birth of Neoliberal Politics* (Princeton: Princeton University Press, 2013).

omnipresent" government intervention aimed at creating the possibility for a market economy.[7]

Neoliberalism seeks to limit government via three key dogmas: deregulation, liberalization, and privatization. Since the late 1970s, these commitments have shaped the internal policies of the G-20 nations and formed the heart of "structural adjustment programs," sometimes referred to as "austerity" measures, that have been imposed on countries seeking global financial assistance. Thus, neoliberal regimes focus on eliminating regulations (ranging from safety measures to minimum wage laws to financial accountability), "liberalizing" or opening borders to maximize the free and efficient flow of capital (but notably not the free movement of people), and selling government-owned public goods (such as utilities, schools, health care institutions, etc.) to private, for-profit companies.

The extractive and socially-destructive impacts of neoliberalism have devastated local communities across the globe, fueling the global rise in reactive populism.[8] It has also undermined health and health care across the globe in three key ways: (1) it has materially impacted the structures of health care delivery and other socio-economic sectors that affect the health and well-being of the poorest and most marginal, such as agriculture, labor, education, and economies generally; (2) it has infiltrated the conceptual infrastructure of health care delivery; and (3) it has, in an allied way, transformed clinical rationality. Let me take each of these in turn, drawing where relevant on Farmer's work.

First, Farmer and his colleagues have relentlessly documented the material impact of neoliberal economic policies on the health and well-being of the poorest and most marginal via detailed studies of specific patients and communities (what anthropologists refer to as "thick description").[9] For example, structural adjustment conditions attached to

[7] Michel Foucault, *The Birth of Biopolitics* (New York: Picador Press, 2010), 160.

[8] See, for example, Brian Elliott, *The Roots of Populism: Neoliberalism and Working-Class Lives* (Manchester, UK: Manchester University Press, 2021).

[9] Farmer's work, as well as that of his colleagues, consistently details case studies that document the myriad of ways that complex historical and contemporary interactions between

the international financing needed by many post-colonial countries have required the dismantling—or privatizing—of public education and public health systems. "Liberalization"—requiring "open" borders and integrating "developing" or "resource poor" countries into global markets—has destroyed local agricultural economies (and therefore food self-sufficiency) and multiplied deeply oppressive, nationally-neutral "free trade zones," geographical areas within countries where transnational corporations can outsource sweatshop-like work. Deregulation has prohibited independent countries from establishing laws protecting minimum wage, benefits, or conditions for safe and humane working conditions in these zones. Dislocating workers from substantive communities of family, care, and support, such structures have exacerbated mental health issues and disease epidemics.

In addition to these macroeconomic policies, Farmer documents how neoliberal commitments have infused the conceptual infrastructure of health care delivery. He targets terms such as "cost-effective," "sustainability," "replicability," "efficiency," as well the now-ubiquitous and endless emphasis on "controlling costs." While such concepts seem reasonable or unassailable on their face, Farmer unpacks how they subtly import problematic philosophical presuppositions. "Cost-effectiveness," for example, does not function as a simple counsel of prudence; it presumes that the utility function—the central commitment of neoliberal capitalism—is ironclad, even if maximizing economic utility means that actual people will suffer or die.[10] Similarly, the efforts of Partners In Health

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international politics, economic policies, and transnational corporation have served as an underlying etiology for individual illness and have fueled horrific disparities in morbidity and mortality across economic gradients. These case studies provide templates for the kind of thick description that should ground work in theological ethics.

[10] As Farmer notes, "The tools of my trade—again, I'm an infectious-disease doc—have been termed 'not cost-effective' in an era in which money is worshipped so ardently that it's difficult to attack market logic without being called a fool or irresponsible. Treating AIDS in a place like rural Haiti, which lacks health infrastructure, is dismissed as 'unsustainable' or not 'appropriate technology.' Each of these ideas, from cost-effectiveness to sustainability, could be a means of starting conversations or ending them. But in my experience in international

to provide medications to patients with HIV or multidrug resistant TB was criticized for being "unsustainable" due to the cost of such medications and treatment regimens.[11] Farmer himself was frequently chided for the "inefficiencies" in his approach to patient care—for spending "excessive" time with particular patients or walking seven hours to make a home visit in Haiti.[12] As his analysis makes clear, the overarching conceptual framework structuring health care delivery distills and encapsulates economic commitments which take priority over people.[13]

This transformation of the conceptual structure of health care delivery—captured in its language—is thorough-going. As Farmer notes:

> It's complex, but suffice it to say that neoliberal approaches to public health and medicine involve the commodification and privatization of our services so that they become "products" to be purchased by "consumers." Patients become "clients" or even "customers." Public service becomes private enterprise—that's the neoliberal dream. I don't

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health, arguing that treatment is not cost-effective is largely a means of ending unwelcome conversations about the destitute sick" (*To Repair the World* [Berkley: University of California Press, 2019], 16; and similarly, 39). Again: "But this mantra was repeated without honest investigation of *why* the drugs, long off patent, were so expensive. Thus has the notion of cost-effectiveness become one of the chief means by which we manage (and perpetuate) modern inequality" (*Pathologies of Power,* 125, emphasis in original); "Certainly, distributing these developments equitably would be expensive. Certainly, excess costs must be curbed. But how can we glibly use terms like 'cost-effective' when we see how they are perverted in contemporary parlance? You want to help the poor? Then your projects must be 'self-sustaining' or 'cost-effective.' You want to erase the poor? Hey, knock yourself out. The sky's the limit!" (*Pathologies of Power,* 177).

[11] See, for example, Haun Saussy, "Introduction," *A Partner to the Poor: A Paul Farmer Reader*, ed. Haun Saussy (Berkeley and Los Angeles: University of California Press, 2010), 7, 11, and 13.

[12] Kidder, *Mountains Beyond Mountains*, 293–294. Kidder quotes Farmer: "If you say that seven hours is too long to walk for two families of patients, you're saying that their lives matter less than some others, and the idea that some lives matter less is the root of all that's wrong with the world" (294).

[13] Such conceptual commitments frame even "development" thinking, the "health transition model," and "social entrepreneurship." For Farmer's critiques of these approaches see *Pathologies of Power*, 155–157; and *To Repair the World,* 39–40.

> know if the commodification of public health is bad for everyone, but I know from long years in Haiti that it's bad for those who have no purchasing power: the poor. Those with no purchasing power tend to be the very same souls who bear the greatest burden of disease.[14]

While Farmer's focus has largely been on the poorest and most marginal communities across the globe, his insights apply equally to the US context. Where the Washington Consensus drove an agenda which largely dismantled universal health systems across the Global South, it did not simply export its vision across the world. It also targeted health care in the US, catalyzing a shift toward for-profit models and practices in health care delivery (even in "non-profit" health care), starting (again) just before 1980.[15] Prior to this, as David Feldman has detailed, the US medical system was highly regulated, but through the combined agency of government and private sector forces, a new regime of deregulation, market competition, direct-to-consumer marketing, and more, radically reshaped US health care delivery within a decade.[16] The result has been the

[14] Farmer, *To Repair the World*, 131. Or, as he says decades earlier, rather than understanding health care as a fundamental good or human right, "commodified medicine invariably begins with the notion that health is a desirable outcome to be attained through the purchase of the right goods and services" (*Pathologies of Power,* 152).

[15] Given the decimation of health care in rural communities across the US, one could argue that the long-term outcome of the neoliberalization of health care in the US has been the same as in LIMCs—the effective dismantling of the public—and private—health care system. See, for example, Michael Ollove, "Rural America's Health Crisis Seizes States' Attention," *Pew Research Center,* January 31, 2020, www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/01/31/rural-americas-health-crisis-seizes-states-attention.
Notably, this piece was published prior to the COVID-19 pandemic, which both illustrated the problem and further exacerbated it.

[16] David Feldman, "The Emergence of Market Competition in the US Health Care System: Its Causes, Likely Structure, and Implications," *Health Policy* 6 (1996): 1–20. See also Samantha Sterba, *Neoliberal Capitalism and the Evolution of the US Healthcare System* (Doctoral Dissertation, U. Mass Amherst, December 18, 2020); and "Adam Gaffney, "The Neoliberal Turn in American Health Care," *International Journal of Health Services* 45, no. 1 (2015): 33–52. For an articulation of the relentless neoliberal agenda in health care see US Department of Health and Human Services, US Department of the Treasury, and US

transformation of every sector from mental health care, clinical trials, pharmaceuticals, to long-term care, and more with an attendant and unsurprising decline in health outcomes.[17] Even the Patient Portability and Affordable Care Act (also known as Obamacare) privileged competition and market mechanisms as the way to increase access to health insurance and, thereby, to health care.[18]

A third way that neoliberalism has negatively impacted human health and well-being is probably the most subtle: by transforming clinical reasoning. For example, as Bruce Rogers-Vaughn has helpfully illuminated, the neoliberal commitment to privatization has not only driven the dismantling of public health systems. It has also translated into shift toward "methodological individualism" in clinical practice—an approach which locates the causes, and therefore, solutions, for all illness and behaviors within individuals rather than in social structures.[19] Thus,

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Department of Labor, *Reforming America's Healthcare System Through Choice and Competition* (2017): www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf.

[17] For just a sampling of the literature see: Bruce Rogers-Vaughn, *Caring for Souls in a Neoliberal Age* (New York: Palgrave-Macmillan, 2016); Jill A. Fisher, *Medical Research for Hire: The Political Economy of Pharmaceutical Clinical Trials* (New Brunswick, NJ: Rutgers University Press, 2008); Edward Nik-Khah, "Neoliberal Pharmaceutical Science and the Chicago School of Economics," *Social Studies of Science* 44, no. 4 (2014): 489–517; Vincente Navarro, "The Consequences of Neoliberalism in the Current Pandemic," *Institutional Journal of Health Services* 50, no. 3 (2020): doi.org/10.1177/0020731420925449; and Haran N. Ratna, "Medical Neoliberalism and the Decline in US Healthcare Quality," *Journal of Hospital Management and Health Policy* 4 (2020): doi.org/10.21037/jhmhp.2020.01.0.

[18] Among other targets, Farmer singles out investor-owned health insurance plans noting that: "despite much talk of 'cost effectiveness' or 'reform,' the primary feature of this transformation has been the consolidation of a major industry with the same goal as other industries: to turn a profit" (*Pathologies of Power,* 163).

[19] Rogers-Vaughn, *Caring for Souls in a Neoliberal Age*. Rogers-Vaughn examines the impact of neoliberalism on the fields of psychiatry and behavioral health, marking a shift ~1980 from approaches that emphasized social approaches to psychiatric care toward those that located the cause of the problem within the patient—in their DNA or neurotransmitters—biological loci that were then targets for market-based pharmaceutical or clinical interventions. Likewise, liberalization grounds the increased clinical focus on 'economic efficiency'—privileging technological, product-based interventions that generate profits for corporations as more

since the 1970s, scientific research and clinical medicine have sought to find causes for illness within individual bodies—within, for example, genes, neurotransmitter imbalances, perhaps now the microbiome. Such biological targets not only deflect attention from social factors; they also provide sites for profitable pharmacological interventions.[20]

This methodological individualism is at the heart of Farmer's critiques of the "immodest claims of causality" that underly global approaches to most diseases. Consider, he suggests:

> the received wisdom—and the current agenda—concerning tuberculosis. Authorities rarely blame the recrudescence of tuberculosis on the inequalities that structure our society. Instead, we hear mostly about biological factors (the advent of HIV, the mutations that lead to drug resistance) or about cultural and psychological barriers [located within individual patients] that result in 'noncompliance.' Through these two sets of explanatory mechanisms, one can expediently attribute high rates of treatment failure either to the organism or to uncooperative patients. There are costs to seeing the problem in this way. If we see the resurgence or persistence of tuberculosis as an exclusively biological phenomenon, then we will shunt available resources to basic biological research which, though needed, is not the primary solution, since almost all tuberculosis deaths result from lack of access to existing effective therapy. If we see the problem primarily as one of patient noncompliance, then we must

'cost-effective' than time-consuming, inefficient relationships between patients and practitioners. See also Sanah Assan, "I'm a Psychologist—and I Believe We've Been Told Devastating Lies About Mental Health," The Guardian, September 6, 2022, www.theguardian.com/commentisfree/2022/sep/06/psychologist-devastating-lies-mental-health-problems-politics. For an account of neoliberalism's effects on the related field of neuroscience, see Jeffrey P. Bishop, M. Therese Lysaught, and Andrew Michels, *Biopolitics After Neuroscience: Morality and the Economy of Virtue* (London: Bloomsbury Academic, 2022).

[20] As Alexandre A. Martins has helpfully noted, this methodological individualism also undergirds the US approach to health care, which is hospital-centered and deflects attention from other social factors or sectors.

> necessarily ground our strategies in plans to change the patients rather than to change the weak tuberculosis control programs.[21]

Farmer debunked this methodological individualism in tuberculosis treatment via a simple clinical trial piloted in Haiti in 1989. One group of patients in the clinical trial received free standard TB treatment; a second group received free standard TB treatment as well as a surround of social supports—financial assistance ($30/month for three months), nutritional supplements, incentives to attend a monthly clinic (monthly reminders and travel expenses for clinic visits), and regular home visits by trained community health workers.[22] The latter approach had been recommended by community health workers but resisted by Western-trained physicians. The outcomes were statistically significant: 100 percent of the patients in the second group were cured and none died, while only 57 percent were cured and 10 percent died in the treatment-only group. For Farmer, this simple and inexpensive clinical trial confirmed that "in determining the efficacy of efforts to combat disease…many of the most important variables…are all strongly influenced by *economic* factors."[23]

In sum, a key legacy of Farmer's work is a commitment to rigorously illuminating the explicit and implicit ways that economic ideologies and policies shape both the practical and conceptual infrastructure of global health care delivery. If, per Farmer, neoliberalism has so startingly pervaded the practical and conceptual frameworks of global health delivery and has likewise transformed—or, rather—malformed—clinical rationality, could that health care-adjacent field—bioethics—have escaped unscathed? Or might it be that his critique of bioethics as "the quandaries of the fortunate" gestures toward something deeper?

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[21] Farmer, *Pathologies of Power*, 147-148.

[22] Paul Farmer, S. Robin, S.L. Ramilus, and Jim Yong Kim, "Tuberculosis, Poverty, and 'Compliance': Lessons from Rural Haiti," *Seminar Respiratory Infections* 6, no. 4 (Dec. 1991): 254–260.

[23] Farmer, *Pathologies of Power*, 151.

The Option for the Rich: US Bioethics as a Neoliberal Project

History again provides a starting point. Bioethics, as most practitioners know, is a relatively young discipline, emerging as the discipline we now know in the US in the mid-to-late 1960s.[24] Via a series of government commissions convened during the 1970s, a normative scaffold for bioethics was developed and promulgated in the 1979 Belmont Report. As I have narrated elsewhere, this scaffold quickly—and somewhat inexplicably—morphed in 1980 into what popularly became known as the "Georgetown Mantra," an approach that spread virally to become the dominant framework for bioethics in the US and, subsequently, across the globe.[25] Although classically described as a four-principle framework, centering the principles of autonomy, beneficence, justice, and nonmaleficience, a fifth principle was present from the start: utility, a generally-unnamed partner whose elision is not insignificant.

Given the history narrated earlier, one must ask: is it simply a coincidence that the dominant conceptual framework for bioethics emerged in 1980—at the moment that neoliberalism became the dominant global economic (and eventually social) ideology? Of course, correlation does not equal causation, but this correlation presses us to examine the question further. Since a detailed analysis of this question is beyond the scope of this paper, I simply highlight three aspects of the field that suggest a need for further study.

First, the operative conceptual framework of bioethics largely distills neoliberal logic. Although theoretically five principles should be in play, over time, two have come to dominate bioethics in practice: autonomy and utility. Bioethics, as it emerged from the 1970s, conceptualized the patient as an autonomous subject, a rational agent empowered to choose amongst

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[24] For one of those canonical histories, see Albert Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1998).

[25] M. Therese Lysaught, "Respect: or, How Respect for Persons Became Respect for Autonomy," *Journal of Medicine and Philosophy* 29, no. 6 (2004): 665–80, doi.org/10.1080/03605310490883028.

an array of medical options (an analogy for commodities?) as a way of pursuing the good as they define it. The primary tool for decision-making—not only for the patient, but equally for physicians, ethics consultants, hospitals, and health systems—is the principle of utility, operationalized as cost-benefit analysis, a variant of "cost-effectiveness." Thus, the operative anthropology in bioethics is that of neoliberalism—a rational chooser who freely maximizes utility-based preferences.

From the start, this anthropology catalyzed bioethics as a growth-industry, seeding an endless series of quandaries and dilemmas. Why? Because, of course, many (most?) patients have lost (temporarily or permanently) or not yet attained the ability to be rational, utility-preference-maximizing choosers. Thus, from the outset, bioethics has been premised on a bifurcated anthropology, with some humans meeting the criteria for fully-functioning persons—whose rights to choose their own good is sacrosanct—and a wide-swath of others who lack that ability, and whose status as persons is correlatively called into question.[26] I return to this point shortly.

In addition, as bioethics has extended its sway as a global normative framework, the discipline has more explicitly embodied neoliberalism's three dogmas. The individualism presupposed by the anthropology of bioethics has been deepened by the neoliberal commitment to privatization. Incarnating Rogers-Vaughn's 'methodological individualism,' every decision is the patient's alone, inherently private, cut off from even family or community, except by choice (e.g., HIPAA regulations).[27] Likewise, as physicians have morphed into providers and

[26] See, for example, another now-canonical text in the field, H. Tristram Engelhardt's *The Foundation of Bioethics* (New York: Oxford University Press, 1996), where he actually proposes a five-tiered anthropology based on individuals' rational abilities.

[27] The flip side of this is responsibilization—a feature of neoliberal ethics where responsibility for actions previously under the aegis of social or political agents is relocated to the character or agency of the individual. For example, contemporary rhetoric might responsibilize victims of gun violence who refuse to arm themselves (Trent Steidley, "Sharing the Monopoly on Violence? Shall-Issue Concealed Handgun License Laws and Responsiblization," *Sociological Perspectives* 62, no.6 (2019): 929–947, doi.org/10.1177/073112141986), or even road safety

patients into consumers, resistance to government limits on patient preferences has increased. Thus, a key focus of secular bioethics has been the deregulation of medical practice and clinical research—e.g., from challenges to traditional prohibitions on euthanasia or physician-assisted suicide, to the ongoing challenges to regulatory oversight over practices like embryonic stem-cell research or commercial products posed by bodies such as the FDA, sometimes in the name of market efficiency and innovation, though often framed in terms of 'saving lives.'[28] And, the dogma of liberalization underlies arguments facilitating the push to open new markets for reproductive services, organs, and human research subjects.[29]

Second, an argument could be made that the neoliberal logic of bioethics is not accidental; rather, since the 1980s, it has served to facilitate the neoliberalization of medicine described earlier, in part, by masking the thorough-going economization of the sector. Since health care delivery began to shift to for-profit logics in the 1980s, the sector and its many subcomponents have experienced explosive growth. In the US, health care expenditures grew from ~$684 billion in 1980 (adjusted 2020 dollars) to

(Erik Hysing, "Responsiblilization: The Case of Road Safety Governance," *Regulation and Governance* 15 (2021): 356–336, doi.org/10.1111/rego.12288), and everything in between.

[28] For just a few examples from the vast literatures on these topics, see: L. Doyal, "Why Active Euthanasia and Physician Assisted Suicide Should be Legalised," *BMJ* 323, no. 7321 (2001): 1079–1080, doi.org/10.1136/bmj.323.7321.1079; Alexander M. Capron, "Stem Cell Politics: The New Shape to the Road Ahead," *AJOB* 2, no. 1 (2002): 35–37, doi.org/10.1162/152651602317267835; and. James J. Hughes, "A Defense of Limited Regulation of Human Genetic Therapies," *Cambridge Quarterly Healthcare Ethics* 28, no. 1 (2019): 112–120, doi.org/10.1017/S0963180118000440.

[29] Again for just a few examples from the significant literatures on these topics, see: Casey Humbyrd, "Fair Trade International Surrogacy," *Developing World Bioethics* 9, no. 3 (2009): 111–118, doi.org/10.1111/j.1471-8847.2009.00257.x; Charles A. Erin and John Harris, "An Ethical Market in Human Organs," *Journal of Medical Ethics* 29, no. 3 (2003): 137–138, doi.org/10.1136/jme.29.3.137; and Rosamond Rhodes, "Rethinking Research Ethics," *American Journal of Bioethics* 5, no. 1 (2005): 7–28, doi.org/10.1080/15265160590900678.

$4,124 billion in 2020—a growth of 600 percent in forty years.[30] Similarly, pharmaceutical R&D—an industry that stood at $1 billion in 1970 and $2 billion in 1980 skyrocketed to $49 billion by 2004, an increase of approximately 2,450 percent in thirty-four years.[31] Estimates suggest that the number of human subjects enrolled in clinical research trials was approximately seven million in 1992 and had increased to approximately twenty million in less than a decade (2001).[32]

Similar statistics could be cited across health care sectors. Yet, bioethics has kept the lens of ethics largely focused on "the clinical context."[33] As we

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[30] Kaiser Family Foundation, "How Has US Spending on Healthcare Changed Over Time?" *Health System Tracker*, February 25, 2022, www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Total%20national%20health%20expenditures,%20US%20$%20Billions,%201970-2020. See also Austin Frakt, "Reagan, Deregulation and America's Exceptional Rise in Health Care Costs," *New York Times*, June 4, 2018, www.nytimes.com/2018/06/04/upshot/reagan-deregulation-and-americas-exceptional-rise-in-health-care-costs.html; and John E. McDonough, "US Health Care in Our Neoliberal Era," *The Milbank Quarterly*, June 24, 2020, www.milbank.org/quarterly/opinions/us-health-care-in-our-neoliberal-era/. Importantly, over against the frequent assertions that "free" markets are self-sustaining, it is clear that in health care, as in every instantiation, neoliberalism is a deeply extractive ideology, siphoning funds from the public sector into private pockets. See, for example, Patrick P.T. Jeurissen, Florien M. Kruse, and Steffie Woolhandler, "For-Profit Hospitals Have Thrived Because of Generous Public Reimbursement Schemes, Not Greater Efficiency: A Multi-Country Case Study," *International Journal of Health Services* 51, no. 1 (2021), doi.org/10.1177/00207314 20966976.

[31] Fisher, *Medical Research for Hire*, 5.

[32] Philip Mirowski and Robert Van Horn ("The Contract Research Organization and the Commercialization of Scientific Research," *Social Studies of Science* 35 [2005]: 504–548) cite Davies that 20 million subjects were enrolled in trials run by contract research organizations (CROs) in 2001, at a point when CROs—a new entity that emerged after 1980—had garnered approximately 80 percent of the market share in clinical trials away from academic medical centers (506). See also Adriana Petryna, "Globalizing Human Subjects Research," in *Global Pharmaceuticals: Ethics, Markets, and Practices*, ed. Adriana Petryna, Andrew Lakoff, and Arthur Kleinman (Durham, NC: Duke University Press, 2007), 33–60.

[33] The COVID-19 pandemic in 2020 made this deflective role of bioethics painfully clear. As I have recounted elsewhere, as the pandemic unfolded, the discipline of bioethics focused almost exclusively on traditional questions regarding allocating scarce resources under triage conditions (to both patients and health care practitioners), end-of-life treatment issues in the

saw with clinical rationality, the methodological individualism fostered by neoliberalism restricts the parameters of "health care" to physician-mediated, biologically-focused interventions on individuals provided in a hospital or medical clinic. Bioethics has followed suit, limiting its focus almost entirely to issues and interventions in the clinical setting and to those who have the economic resources to consume clinic-based health care services. In so doing, it has assisted in keeping the powerful hand of economics largely invisible. For the most part, economic questions have been shoehorned into the narrow question of *how* to get people 'access' to the newly emerging neoliberal health care system.[34]

Even more peculiarly, amidst this explosive growth in spending across these sectors, bioethics has continued to further the presumption that the health care context is one of scarcity—and that a key task of bioethics is to assist practitioners and health care organizations to make "difficult decisions" (i.e., choose between patients' lives) in contexts of scarce resources. It is no accident that "the Trolley Problem" is foundational to

ICU, or questions about individual autonomy (re: mask-wearing). The same framework was deployed when the COVID-19 vaccines became available; see M. Therese Lysaught, "Sacramental Biopolitics after COVID-19," in *The Routledge Companion to Christian Ethics*, ed. D. Stephen Long and Rebekah Miles (Philadelphia: Routledge, 2022), 372–388. A few analyses did try to draw attention to global disparities in vaccine allocation, but these were in a minority. See, for example, M. Therese Lysaught, "Vatican: It's Unjust (and Dangerous) for Wealthy Nations to Hoard the Covid Vaccine," *America,* January 27, 2021, www.americamagazine.org/politics-society/2021/01/27/covid-vaccine-distribution-united-states-vatican-239797; and Christopher Ahlbach, Teresa King, and Elizabeth Dzeng, "The COVID-19 Pandemic and Ethical Challenges Posed by Neoliberal Healthcare," *Journal of General Internal Medicine* 36 (2021): 205–206.

[34] See, for example, even texts like *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Allen Verhey and Stephen P. Lammers (Grand Rapids: William B. Eerdmans, 1998), which siloed economic questions to its nineteenth and final chapter entitled "Allocation and Distribution." In doing so, *On Moral Medicine* followed most other bioethics textbooks published to date. This was one issue specifically addressed in the third edition of *On Moral Medicine,* ed. M. Therese Lysaught and Joseph Kotva (Grand Rapids: William B. Eerdmans, 2012).

bioethics pedagogy—in fact, as one bioethicist puts it, it "should be considered of great importance in medical ethics."[35]

As Farmer notes:

> the fight over "scarce resources" involves no small amount of chicanery. There are enough resources on this planet to do the job right. These resources are far less than those required to wage wars whose justifications are never quite as good as their champions make them out to be. When you are bold in pressing for the right to health care rather than arguing how best to spend paltry sums that could never do the job, or even half the job, you advance the cause of public health.[36]

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[35] Gabriel Andrade, "Medical Ethics and the Trolley Problem," *J Med Ethics Hist Med* 12 (2019): 3, eCollection 2019. The trolley problem is a philosophical "thought experiment" standard in medical school ethics curricula where students are posed with a choice: to allow a group of people (5–10) to be killed by an oncoming trolley or to save them by pulling a lever and diverting the trolley which will, unfortunately, kill one person. Entirely an exercise in utilitarian formation, the scenario helpfully captures many of the problematic assumptions of utilitarianism and bioethics: the omniscient, meta-perspective of the decision-maker; the constrained, emergent time frame (the decision must be made within seconds); the focus on an immediate act instead of upstream factors; the faceless nature of the people whose lives are at stake as well as the erasure of their voice; and so on. As one reviewer of an early draft of this chapter noted, "The central question in an ethics of scarcity is 'who has to die so I/we can do what we want to?"

[36] Farmer, *To Repair the World*, 142. Or, as he notes elsewhere: "We allow not only the continuation but the entrenchment of inequalities. The justification of this sad state of affairs is usually economic: we're told that we live in a time of 'shrinking health resources.' But is this really so? Look at profits in the managed-care companies. In the mid-1990s, the Wall Street Journal described these companies as 'money machines so awash in cash that they don't know what to do with it all.'...The trend has continued unabated, as a recent Families USA report points out: 'With costs of health care coverage soaring, one aspect of health plan company expenses has kept pace: compensation packages for top executives'" (*Pathologies of Power*, 173). And: "The hypothesis that we lack sufficient means to cure all tuberculosis cases, everywhere and regardless of susceptibility patterns, is not supported by the data. There is plenty of money—even in poor countries. The degree of accumulated wealth in the world today is altogether unprecedented, but this accumulation has occurred in tandem with growing inequality" (*Pathologies of Power*, 172).

Thus, bioethics has created blinders that have prevented the conceptualization of larger structural and economic questions in the moral analysis of medicine and health care delivery. It has stood passively by as health systems have commodified health care practitioners, driving the practitioner burnout and exodus from the field that had already begun prior to the onslaught of the COVID-19 pandemic.[37] Instead of challenging this, it has often championed neoliberal values, for example, quantifying its own efficiency in "bioethics dashboards" in order to justify health system support of this non-revenue generating unit.[38]

Bioethics' ontology of scarcity returns us to neoliberalism's underlying anthropology. For not only does bioethics forward an anthropology bifurcated between those who can rationally choose and those who cannot. It also forwards the economized anthropology of capitalism, which bifurcates human persons in a different yet analogous (and often overlapping) way—namely, via the assumption the poor are not "worth" as much as the rich. As colleagues and I have detailed elsewhere, from the beginning of the history of capitalism, we hear a resonance with the anthropology of bioethics—that there are some humans who have the freedom to rationally maximize their preferences via the principle of utility and others who do not possess such a freedom.[39] More broadly, those who possess such freedom are, simply, those with means to maximize—namely, the wealthy. The poor, lacking goods to weigh via the principle of utility, have—for all practical purposes—no opportunity to exercise their

[37] See, for example, before the COVID-19 pandemic, Herbert L. Fred and Mark S. Scheid, "Physician Burnout: Causes, Consequences, and (?) Cures," *Texas Heart Institute Journal* 45, no. 4 (2018): 198–202, doi.org/10.14503/THIJ-18-6842; and after the COVID-19 pandemic: A. Bhardwaj, "COVID-19 Pandemic and Physician Burnout: Ramifications for Healthcare Workforce in the United States," *Journal of Healthcare Leadership* 14 (2022): 91–97, doi.org/10.2147/JHL.S360163. Similar studies trace burnout in the nursing and allied health professions.

[38] See, for example, Mark Repenshek, "Continuous Quality Improvement Initiatives in Ethics: A Proposed Communication Tool," *HCEUSA* (2012): www.chausa.org/docs/default-source/general-files/a68cc1d110cd46dea26c57c2e548751d1-pdf.pdf?sfvrsn=0.

[39] See Bishop, Lysaught, and Michels, *Biopolitics After Neuroscience*, 142–195.

autonomy, to rationally and freely choose their good. Their option—and, in fact, their responsibility—is to work in bondage as wage laborers; from David Hume in the eighteenth century forward, wage laborers—and worse, the "undeserving poor"—are described in language that approximates them as beasts, or at least less than fully human.[40]

In the history of economics, the poor—with no assets to maximize—are denied access both to the system of wealth and to full personhood. Within the ethical rhetoric surrounding neoliberal medicine, the poor—with no assets to offer—as well as those whose capacities are diminished due to circumstances or illness, are likewise often excluded both from full moral agency and from basic care. "We are urged," Farmer notes, "to avoid 'wasting' resources on groups of people who are not expected to make significant improvement."[41] "The poor," he continues, "are saddled with the greatest share of disability and disease even as they are deemed less worthy objects of health care by a medical establishment that privileges ability to pay over need."[42] Millions upon millions of poor people—both within the US and across the globe—are, in other words, "fungible," "disposable" and invisible to bioethics.[43] Farmer cites Edmund Pellegrino's "acidic commentary" to encapsulate his point:

> There is no room in the free market for the non-player, the person who can't "buy in"—the poor, the uninsured, the uninsurable. The special needs of the chronically ill, the disabled, infirm, aged, and the

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[40] See Wendell Berry's *The Hidden Wound* (Berkeley, CA: Counterpoint, 2010) and *The Need to Be Whole: Patriotism and the History of Prejudice* (Berkeley, CA: Shoemaker and Company, 2022), among other writings, for the ways this attitude toward those who work the land is foundational in American racist and anti-rural ("white trash") stereotyping and policy. I thank Brian Volck for this connection.

[41] Farmer *To Repair the World*, 4.

[42] Farmer, *To Repair the World*, 4.

[43] Farmer, *Pathologies of Power*, 163, 167; and *To Repair the World*, 78–80. One lens throughout Farmer's work is the lens of race, though particularly mentioned in *To Repair the World*, 17–18. The relationship between US health care, bioethics, and racial capitalism merits further exploration.

> emotionally distressed are no longer valid claims to special attention. Rather, they are the occasion for higher premiums, more deductibles or exclusion from enrollment. There is no economic justification for the extra time required to explain, counsel, comfort, and educate these patients and their families since these cost more than they return in revenue.[44]

Farmer poignantly summed up this insight in what now stands as one of his signature phrases: "The idea that some lives matter less is the root of all that's wrong with the world."[45]

Et tu Theological Ethics?

Farmer's relentless attention to the distortive effects of neoliberalism on health care delivery in the US and globally lays the groundwork for examining the neoliberal malformation of the very field that should have served as a stopgap against these distortive effects: bioethics. Finding its dark shadow there raises a further spectre: has it likewise infiltrated the disciplines of theology and theological bioethics? Does our theology function as an "option for the rich" discipline?

Farmer's legacy turns our attention to macro methodological issues, many of which have been raised in recent decades by scholars formed by liberationist perspectives. Does our theology and theological ethics draw primarily on *sources* produced by the economically privileged that have served (intentionally or unintentionally) to maintain social structures of privilege and oppression? If so, how do we critically complicate them? Does our discourse address primarily a privileged *audience*, focusing largely on issues of relevance to the 1 percent or 5 percent?[46] Do our

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[44] Farmer, *Pathologies of Power*, 163, citing Edmund Pellegrino, "The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic," *Journal of Medicine and Philosophy* 24, no. 3 (1999): 253.

[45] Kidder, *Mountains Beyond Mountains*, 294.

[46] Elsewhere, I have detailed how the field of Catholic theological ethics functions primarily as a racially-segregated White space, but a similar analysis would likely confirm that it largely imagines its audience as economically privileged (M. Therese Lysaught and Cory Mitchell,

theoretical frameworks prioritize abstract, theoretical *concepts* in a way that often renders invisible the social and material realities of the issues being analyzed? Does, for example, the discourse in, say, the ethics of marriage and family, mirror that in bioethics—focusing on a narrow array of issues (e.g., contraception, divorce, abortion, euthanasia) analyzed via select abstract principles (the inextricability of the unitive and procreative dimensions of the conjugal act; the conditions for annulment; the sanctity of life) applied in timeless, decontextualized ways? I hope the foregoing makes clear that a theological ethics, learning from Paul Farmer, will begin to reimagine our methodologies in ways that are geographically wide, historically deep, and take serious account of the material ways that neoliberalism has radically changed the broader socio-political realities under which actual people live.

We must also ask: what ends and larger projects do our analyses serve? Christian morality frequently positions itself as "counter-cultural," but has our work subtly been co-opted into neoliberalism's larger cultural project? How, we might ask, do we understand the growing Christian and Catholic support for homeschooling or charter schools (privatization) or against critical race theory (deregulation)? Is this, perhaps, the US version of the neoliberal priority of dismantling public education across the globe? Or what of the focus in Catholic moral theology on sexuality? As colleagues and I have traced elsewhere, part of the disciplinary apparatus aimed at controlling the "deserving" and "undeserving" poor invented by nascent capitalism in the sixteenth century has been a Christian virtue discourse hyper-focused on the sexual and labor-related vices of the poor.[47]

"Vicious Trauma: Race, Bodies, and the Confounding of Virtue Ethics," *Journal of the Society of Christian Ethics* 42, no. 1 [2022]: 75–100, doi.org/10.5840/jsce202281660, specifically 80-86). As we note, the virtue ethics literature tends to focus on a narrow range of issues, e.g., alcohol and American college life, plagiarism, premarital sex, euthanasia, homeschooling, and consumer choices—issues relevant to those with access to higher education, health care, and economic surpluses.

[47] Bishop, Lysaught, and Michel, *Biopolitics After Neuroscience*. Kelly Johnson has deftly narrated precisely such an influence in the omnipresent but theologically-troubled concept of stewardship (Kelly Johnson, *Fear of Beggars: Stewardship and Poverty in Christian Ethics*

Have—or how have—Christian accounts of sexuality contributed to this problematic construct?

Thirdly, there are troubling signs that neoliberal logic has infiltrated theology and theological ethics in ways analogous to clinical rationality and bioethics. Most benignly, the term "values"—omnipresent in the discourse of Christian ethics—is term that has been smuggled into ethics from economics.[48] More darkly, in his recent book, *Catholic Discordance: Neoconservatism vs. the Field Hospital Church of Pope Francis*, Massimo Borghesi narrates in exquisite detail the "strident Catho-capitalism" that has taken shape in the US since the 1990s, refashioning Catholicism as an apology for neoliberalism.[49] I have elsewhere suggested that a second "pillar" of this Catholic Americanism—which Borghesi describes as comprised of "neo-traditionalists" who have long "take[n] morality as their battleground"—likewise is an offshoot of the same neoliberal ideology.[50] These culture warriors forward an understanding of morality deeply infused by methodological individualism—either championing distorted notions of conscience or condemning the sick and poor for their

(Grand Rapids: William B. Eerdmans, 2007). See also M. Therese Lysaught, "Beyond Stewardship: Reordering the Economic Imagination of Catholic Health Care," *Christian Bioethics* 26, no. 1 (2020): 31–55, doi.org/10.1093/cb/cbaa002.

[48] See, for example, Mark Schroeder, "Value Theory," *Stanford Encyclopedia of Philosophy* (2021), plato.stanford.edu/entries/value-theory/.

[49] Massimo Borghesi, *Catholic Discordance: Neoconservatism vs. the Field Hospital Church of Pope Francis* (Collegeville, MN: Liturgical Press, 2021).

[50] It is worth noting that despite their self-claimed moniker, these neo-traditionalists spout a novel ideology, having isolated and sentimentalized certain aspects of mostly Tridentine Catholicism as "The Tradition" while ignoring everything that that narrow container does not hold. One might also suggest that since they, in good neoliberal fashion, pick and choose what constitutes "The Tradition" they reveal themselves as heretics (αἵρεσις) rather than catholic (καθ' ὅλον). I thank Brian Volck for this insight. See further, M. Therese Lysaught, "War or Peace? Toward a Better Kind of (Bio)Politics," *Vatican II, Pope Francis, and the Way Forward*, The Hank Center for the Catholic Intellectual Tradition, Loyola University Chicago, March 25, 2022, www.luc.edu/media/lucedu/ccih/formsdocumentsandpdfs/Lysaught%20Remarks.pdf. See also M. Therese Lysaught, "Reclaiming the Catholic Moral and Intellectual Tradition from the Culture Wars," *NCR*, April 7, 2022, www.ncronline.org/news/opinion/reclaiming-catholic-moral-and-intellectual-tradition-culture-wars.

own moral failings. They vociferously decry government regulation—be it of health care, public schools, workplaces, the environment, the franchise—working strenuously to undermine and dismantle these and any other substantive public goods. And what of virtue ethics—which reemerged around 1980? While Alasdair MacIntyre is decidedly not a neoliberal, his communitarian vision for ethics has been co-opted into the Ayn Randian "Benedict Option" advocated by pundits and clerics.[51]

In the end, Farmer's legacy poses critical methodological questions for our field. But as importantly, he charts a constructive way forward. He witnesses in his life and his work to what medicine looks like when grounded in and infused by an alternative (theological) economics—namely, charity. To be clear, this is not the distorted, reductive, economized notion of 'charity' that is the heritage of capitalism.[52] Farmer is rightly critical of what usually passes for charity within global health and other practices of Christian outreach: namely monetary donations and second-hand castoffs, distributed without any relationality, that do not address the root causes of problems and often create many more serious difficulties.[53] This he calls the "charity approach" to global health, a framework that he rejects.

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[51] On MacIntyre as not a neoliberal, see M. Therese Lysaught and Daniel P. Rhodes, "Whose Revolution? Which Future? The Legacy of Alasdair MacIntyre for a Radical Pedagogy in Virtue," *Explorations: Interdisciplinary Studies in the Humanities* 14, no. 1 (2020): 97–125, expositions.journals.villanova.edu/article/view/2528/2471. On those pursuing Ayn Rand's vision, see Rod Dreher, *The Benedict Option: A Strategy for Christians in a Post-Christian Nation* (New York, NY: Sentinel, 2017); and the Texas-based Veritatis Splendor project promoted by a Catholic bishop (www.ncregister.com/news/massive-catholic-center-planned-for-east-texas, www.simchafisher.com/2021/03/03/catholic-megadevelopment-veritatis-splendor-is-long-on-rhetoric-short-on-details/) that to date has failed spectacularly (thedeaconsbench.com/what-happened-to-the-ambitious-veritatis-splendor-project-in-texas/).

[52] Johnson, *Fear of* Beggars; and Lysaught, "Beyond Stewardship."

[53] As he notes: "charity medicine too frequently consists of second-hand castoffs—leftover medicine—doled out in piecemeal fashion" (*Pathologies of Power,* 154). For an account of the problems with medical device donation, see Bruce Compton, David M. Barash, Jennifer Farrington, Cynthia Hall, Dale Herzog, Vikas Meka, Ellen Rafferty, Katherine Taylor, and Asha Varghese, "Access to Medical Devices in Low-Income Countries: Addressing

But he also challenges the tired and omnipresent contemporary dichotomy between charity and (social) justice. After identifying some serious flaws in a charity-only model of addressing global suffering, he notes,

> It is possible, however, to overstate the case against charity—it is, after all, one of the four cardinal virtues, in many traditions. Some holier-than-thou progressives dismiss charity when it is precisely the virtue demanded. In medicine, charity underpins the often-laudable goal of addressing the needs of 'underserved populations.' To the extent that medicine responds to, rather than creates, underserved populations, charity will always have its place in medicine. Unfortunately, a preferential option for the poor is all too often absent from charity medicine.[54]

Thus, for Farmer, charity and social justice necessarily work hand-in-hand.

With these caveats in place, I would argue that Farmer's legacy demonstrates at least two critically important constructive points. The first is that economics—via both traditional forms of charity as well as public investment—is a key and necessary engine of social justice and social transformation. While much of his early work in Haiti was funded via traditional methods of charity, the annals of Partners In Health are speckled with various stories of Farmer's creative approach to what he

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Sustainability Challenges in Medical Device Donations," *National Academy of Medicine*, July 16, 2018, nam.edu/access-to-medical-devices-in-low-income-countries-addressing-sustainability-challenges-in-medical-device-donations/.

[54] Farmer, *Pathologies of Power*, 154. His criticisms of the charity-based model include that it is often premised on the bifurcated anthropology that we have discussed, namely, the "tendency—sometimes striking, sometimes subtle, and surely lurking in all of us—to regard those needing charity as intrinsically inferior" (a form of methodological individualism); a resignation to structures of injustice based on the presupposition that "there will always be those who have and those who have not"; the erasure of the twentieth century's "marked tendency toward increasing economic inequity"; and an allied form of methodological individualism which, by calling "compassionate conservatives" to address poverty through personal acts of charity absolves social agencies from responsibility to do so.

called "redistributive justice"—what has been referred to as his Robin-Hood approach to appropriating expensive resources from well-heeled Boston health care institutions to care for the poorest of the poor in Haiti and Peru.[55] "Borrowing" needed multi-drug resistant tuberculosis (MDRTB) drugs from the Brigham Women's and Children's Hospital pharmacy in 1994—to the tune of $92,000—enabled him and Jim Kim to conduct their clinical trial in Peru and develop an alternative paradigm for treating TB and MDRTB that ultimately transformed the World Health Organization's approach and subsequently has saved countless lives. These initial infusions of resources not only saved the lives of individual Peruvians; they led to longer term changes in the global pricing and production of MDRTB drugs, radically altering the economics of 'essential' pharmaceuticals.

Thus, repeatedly throughout Farmer's work, we see how initial acts of "economic" charity can be a critical seed for social transformation. This dynamic should not, however, be misconstrued as a neoliberal argument for philanthropy—a practice which, in part, justifies extreme wealth disparities by providing a path for the rich to cleanse their consciences via the (again) methodologically individualistic act of donation from their excess.[56] Rather, Farmer's witness preserves a place for the traditional Christian practice of almsgiving—a practice redescribed by Hume and the architects of capitalism from the seventeenth century forward as a vice.[57] But he pushes us to begin to reimagine what a properly Christian practice

[55] Kidder, *Mountains Beyond Mountains,* 90 and 149.

[56] For just a sampling of this critique, see: Michael E. Hartmann, "Philanthropy in *The Rise and Fall of the Neoliberal Order*," *Philanthropy Daily*, May 19, 2022, www.philanthropydaily.com/philanthropy-in-the-rise-and-fall-of-the-neoliberal-order/; Juanjo Mediavilla and Jorge Garcia-Arias, "Philanthrocapitalism as a Neoliberal (Development Agenda) Artefact: Philanthropic Discourse and Hegemony in (Financing For) International Development," *Globalizations* 16 (2019) 857–875, doi.org/10.1080/14747731.2018.1560187; and Adam Saifer, "Racial Neoliberal Philanthropy and the Arts for Social Change," *Organization* (online first December 7, 2020), doi.org/10.1177/1350508420973327.

[57] See Bishop, Lysaught, and Michel, *Biopolitics After Neuroscience*, 142–195.

of charity—in concert with a broader framework committed to redistributive policies and social justice—can and should look like.

Secondly, beyond helping us reimagine what we normally understand by the word charity, Farmer more importantly *embodied an alternative anthropology*—not the anthropology of neoliberalism, but the anthropology of *caritas,* of self-gift. As captured so well in *Mountains Beyond Mountains*, as well as other narratives about his work, Farmer's story demonstrates what authentic *caritas* looks like. The initial generative step that led to Partners In Health and its transformation of global health was Farmer's decision to move to the margins, to work for no pay in the "poorest country in the Western hemisphere." This constant practice of donation characterized his life, remaining as he did "in the habit...of giving all his money away to the poor even faster than he earn[ed] it."[58]

One might ask: were these acts of charity or solidarity? Farmer might answer: that is a false construct. For he helps us see how traditional Christian practices—presence, friendship, solidarity, hospitality, and other crucial ways of embodying *caritas*—are at the same time deeply 'economic.' This is captured in one of his signature practices: walking hours to visit patients in their home. A hallmark of Farmer's work is that he *spent time* with patients, with the poor, as persons. Farmer's personal *caritas* was the seed, scattered on the unlikeliest of soil, that produced more than a hundred-fold. He did not consider himself above his patients, better than them; he resisted the subtle economization of his time and actions, refusing to consider his time "too valuable" (as many others argued) to "spend" on people who were poor. We could say, he did not consider his stature as a physician at the Brigham "something to be grasped" but rather emptied himself to meet the poor as equals—or, rather, as those to whom he deferred as more important than himself, given what they had suffered, given how Christ was present in them. Here Farmer points us to the heart of a truly theological economics—the gospel proclamation of kenotic self-

[58] Jennie Weiss Block, *Paul Farmer: Servant to the Poor* (Collegeville, MN: Liturgical Press, 2018), 7.

emptying. Here, "gift" is equally an act of solidarity; the practice of solidarity is equally a gift.

Conclusion

In this chapter, I have argued that Paul Farmer poses a deep—but constructive—challenge not only for global health and bioethics but equally for theology and theological ethics. I hope the foregoing account has provided a window into how Farmer's legacy presses all of us to rigorously analyze the ways that economic assumptions and ideologies—particularly the regnant neoliberal political economy in which we all live and work—have subtly shaped and deformed our own conceptual frameworks as well as those of our disciplines. Economics and political economy have shaped Christian theology since Constantine, and enmeshed with those political economies, Christian theology has too often served to bolster structures of privilege and oppression. As with bioethics, here the damage is doubly-problematic. For as our disciplines become co-opted by these frameworks, they not only fail in their mission of being a bulwark against precisely the myths and mystifications necessary to sustain structures of sin and violence; tragically—and scandalously—they imperceptibly become agents of those same myths and mystifications.

A first step forward out of this troubling history is to begin to analyze the economic infrastructure that shapes our own work. Not only do theologians need to become conversant in the histories, commitments, and practices of economics; we need to ask hard questions: is our theology an "option for the rich" theology? Do our disciplines serve as a tool for social control, or do they instead upend the discourses that create the vast amount of suffering that remains so invisible? Have we become unwitting pawns of neoliberalism, even when we appear to be 'counter-cultural'?

Engaging in such analyses is not an easy task since the invisible hand of economics likes to stay invisible. Even when it begins to come into view, as when one turns off the infra-red night vision goggles, what was seen slips back into invisibility. "Social and economic questions are," as Farmer

notes, often so easily "erased."[59] Yet, it is a crucial task for at least three reasons. First, if we do not accurately understand the root causes of issues that our disciplines engage (from assisted reproduction to public policy to ecclesiology), our analyses will range from inadequate to false. Second, it is crucial to identify the ways that neoliberalism has co-opted the intellectual infrastructure of our disciplines if we are to resist and overcome the ways that it deforms our concepts and hermeneutics. Finally, it is necessary to see how neoliberalism operates in order to follow Farmer's lead in concretely reimagining alternative practices.

Farmer demonstrates that a key tool for resisting a nihilistic economics is, instead, a theological economics—the thick practice of God's kenotic grace in the world captured in an anthropology of self-gift. Thus, in his work, we find a thickly theological and embodied account of charity, one that break downs the silos separating "economics" from the ways that it is deeply interwoven into our embodied social practices and institutions. It demonstrates how the Christian tradition grounds a different "economics," one that privileges gift, that challenges narratives of 'scarcity,' and that understands that this alternative economics is a necessary key to dismantling structural violence.[60] It is hard not to see in Farmer's legacy a concrete embodiment of Pope Francis's vision of social friendship, a practical instantiation—in personal actions, social practices, and public policy—of the virtue of *caritas* (love) that catalyzes via self-gift an economy that gives life over against globalized neoliberalism, which he has so aptly named, "an economy that kills."[61]

[59] Farmer, *Pathologies of Power*, 17.

[60] "We think we've fared well in large part because we fight the violence around us not with weapons but with food, water, schools, clinics, and hospitals" (Farmer, *To Repair the World,* 185).

[61] Pope Francis, *Fratelli Tutti*, 2020.

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