“Those who are well”: Lessons from COVID for non-crisis times via Matthew 9:9-13

Conor M. Kelly
Marquette University, USA

Abstract
As the world shifts to the next phase of the pandemic, bioethicists need to consider anew what moral responsibility looks like during non-crisis times. This article turns to the calling of Matthew (Matt 9:9-13) to provide biblical insights Christians can use to contribute to this bioethical conversation. Drawing on the narrative context, which buries this pericope within a section of the gospel focusing on Jesus’s healing ministry, this article explains how the calling of Matthew underscores the holistic vision of health and well-being animating Jesus’s work as a healer and adds to Jesus’s primary emphasis on restoration for the marginalized. Examining Jesus’s claim that “those who are well have no need of a physician,” this article argues that Christians can best embrace this broad vision of healing by prioritizing public health so that the community will be better prepared to weather the next health crisis, should it emerge.

Keywords
COVID-19 pandemic, mercy, public health, social determinants of health, solidarity

Introduction
My wife likes to say, only half-jokingly, that Matt 9:12 is her favorite scripture passage. The verse is toward the end of the Gospel’s recounting of the calling of Matthew and conveys Jesus’s response to the Pharisees who criticized his willingness to interact openly with sinners. Defending himself, Jesus offers a medical image to explain the priority he places on those who must still be called to conversion, reminding the crowds that “those who are well have no need of a physician, but those who are sick.” My wife, who is a pediatric nurse practitioner, loves to quote the first part of this line so she can remind her friends and colleagues of the valuable contributions nurses make to the health care system. In fact, when she worked in primary care, with its abundance of well child visits, she would often point to the passage as a theological endorsement of her own vocational trajectory. “Jesus was right,” she would playfully insist, “‘Those who are well have no need of a physician.’ They need a nurse practitioner!”

While my wife’s interpretation involves a slightly more dynamic translation of the original Greek than one typically finds, her commentary provides an important reminder of the fact that...
there is more to health and well-being, and thus health care, than the mere absence of disease. In theory, this insight should be a central component of a Christian approach to bioethics at all times, because Jesus’s own acts of healing were never oriented simply to the eradication of biological imperfections but also always included a dimension of social restoration for the sick, who were regularly isolated from their communities as a result of their disease.1 In this particular moment, however, as society slowly emerges from the worst of the COVID-19 pandemic, the deeply Christian insight that my wife’s quip served to highlight is even more pressing and ought to become a central element of the Christian contributions to the bioethical discourse about Christians’ moral responsibilities in a “post-pandemic” world. The point of this piece is therefore to discuss how Jesus’s words in the calling of Matthew (Matt 9:9-13) can help Christians learn from the tragedies of COVID to be able to build the kind of approach to health care in non-crisis times that will leave everyone better equipped to deal with the next health crisis whenever it emerges.

More precisely, the exposition builds on Jesus’s comments about “those who are well” to highlight the importance of turning from a health care system that prioritizes the treatment of diseases by physicians to an integrated public health infrastructure that promotes the well-being of all across the community. Then, this article shows how Jesus’s other reflections in this pericope, especially his closing admonition, “I desire mercy, not sacrifice,” can help Christians do the hard, collaborative work required to realize this shift. With these two parts, this article shows how to use biblical wisdom to learn the necessary lessons from the last pandemic if Christians want to avoid the next one.

**No need of a physician: Expanding health care priorities**

In the context of the calling of Matthew, Jesus’s comments about those who are well represent a straightforward response to the detractors who found his associations with tax collectors and sinners questionable. Scholars note that Jesus’s line has echoes of similar retorts found in the works of Greek authors that would have been circulating during his time. Diogenes, for instance, wrote that when the philosopher Antisthenes was challenged for consorting with “wicked men,” he retorted, “Physicians also live with those who are sick; and yet they do not catch fevers.”2 Jesus’s remark therefore builds on ancient parallels, but notably employs a different emphasis. Antisthenes’s comments, for instance, were meant to protect himself from the reputational damage that his critics believed he deserved as a result of his fraternization with less than savory characters. As the biblical scholar Daniel Harrington points out, in the Matthean text, “however, the focus is on those ‘who are sick’ (= tax collectors and sinners).”3 In contrast to the Greek parallels, then, Jesus’s justification called attention to the very people that led to his censure, focusing on their needs rather than his own social standing.

Christians ought to be similarly motivated by Jesus’s example, using his comments to ask how to be at the service of the needs of others instead of worrying about their own status. Of course, Jesus used the relationship between the well, the sick, and the physician as an analogy to make a statement about spiritual care and healing, but Christians can embrace the same spirit today in thinking about those who are literally the well and the sick. This way of thinking is particularly appropriate given that Matthew sandwiches this pericope between accounts of Jesus’s healing miracles, making it part of a broader segment (Matt 8–9) discussing the role of healing in Jesus’s

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1. John Dominic Crossan, *The Birth of Christianity: Discovering What Happened in the Years Immediately after the Execution of Jesus* (San Francisco: Harper Collins, 1998), 293–96.
2. Diogenes Laërtius, *The Lives and Opinions of Eminent Philosophers*, trans. C. D. Yonge (London: George Bell and Sons, 1901), 219.
3. Daniel J. Harrington, *The Gospel of Matthew* (Collegeville: Michael Glazier, 1991), 126.
ministry. Just as importantly, the narrative context of this segment reveals that its presentation of Jesus’s healing is not meant to be strictly descriptive but is also designed to serve a normative function, “provid[ing] a model for the disciples to follow in their own ministry.” Hence, although the immediate referent of Jesus’s words in the call of Matthew is spiritual sickness and health, the broader context in which these words appear indicates that the allusions to sickness and healing are not an accident, but a pertinent correlation that informs the interpretation of what it means for Jesus’s followers to imitate him in pursuit of a distinctive form of healing. Read in light of these connections, the calling of Matthew underscores the importance of attending to the marginalized in the ministry of healing, for this is the message Jesus sends by his example in this pericope and in his acts of healing more generally.

The emphasis on the care for the marginalized that emerges from this story certainly supports the idea that Jesus’s followers have a duty to become the physician who cares for the sick, because this is a crucial way of providing healing and help to those in need. It also represents the most obvious application of Jesus’s reminder that the sick are the ones who need a physician. At the same time, the commitment to the marginalized invites an examination of how Christians can similarly be of service to those who are well, for it has become increasingly clear that the things that turn the well into the sick are often unequally distributed across the community and frequently affect the marginalized to a disproportionate extent. This disparity was clearly and painfully on display during the COVID pandemic, when the essential workers who were most likely to be exposed to the virus but who also had the least protection, at least during the early stages of the pandemic, were people who had some of the lowest paying jobs. They were also, not coincidentally, far more likely to be members of marginalized racial and ethnic groups in the United States. As a result of these conditions and other social trends, COVID death rates have been lower for White persons and higher for Latinos, Native Americans, and Black persons (when controlling for other demographic variables) throughout the pandemic.

Significantly, the relationship between marginalization and worse health outcomes was not something COVID created; rather, it was a preexisting link that COVID simply exacerbated. Public health researchers have demonstrated that the “social determinants of health,” which include the non-medical dimensions of a person’s background (e.g., race and ethnicity, socioeconomic status, educational attainment, and the like), exert an extraordinary influence on an individual’s health status. Indeed, typical estimates attribute anywhere from one-third to more than one half of the root causes of health outcomes to the social determinants of health. By comparison, medical care is estimated to contribute only around 20% to health outcomes. Illustrating the link, a much-remarked 2016 research project found that something as seemingly innocuous as a zip code could change a

4. Walter T. Wilson, *Healing in the Gospel of Matthew: Reflections on Method and Ministry* (Minneapolis: Fortress, 2014), 15.
5. Francois P. Viljoen, “Hosea 6:6 and Identity Formation in Matthew,” *Acta Theologica* 34.1 (2014): 214–37 (232).
6. Bryan N. Massingale, “The Assumptions of White Privilege and What We Can Do about It,” *National Catholic Reporter*, 1 June 2020, www.ncronline.org/news/opinion/assumptions-white-privilege-and-what-we-can-do-about-it.
7. See Latoya Hill and Samantha Artiga, “COVID-19 Cases and Deaths by Race/Ethnicity: Current Data and Over Time,” Keiser Family Foundation, 22 February 2022, www.kff.org/coronavirus-covid-19/issue-brief/covid-19-cases-and-deaths-by-race-ethnicity-current-data-and-changes-over-time/.
8. “Social Determinants of Health,” World Health Organization, www.who.int/health-topics/social-determinants-of-health#tab=tab_1.
9. Carlyn M. Hood, Keith P. Gennuso, Geoggrey R. Swain, Bridget B. Catlin, “County Health Rankings: Relationships Between Determinant Factors and Health Outcomes,” *American Journal of Preventative Medicine* 50.2 (February 2016): 129–35.
newborn’s life expectancy by as much as 20 years.10 If Christians are indeed motivated by a concern for the marginalized and genuinely want the well to stay well, then Christian bioethics must do more to address the social determinants that first create marginalization and then harm health and well-being as a result.

The logical question is, of course, how to address these underlying social determinants of health. This issue is complex, eluding quick solutions and instead requiring a long-term commitment at the societal level. Jesus’s insistence that “those who are well have no need of a physician” can help with this challenge, though, by orientating action away from the traditional medical model, with its focus on treating individual patients after they have shown symptoms of a disease, toward a public health model, which prioritizes interventions that can promote health and well-being across entire populations before disease strikes.

Again, the COVID pandemic is instructive in appreciating the significance of this shift. Data show that variations in the strength of a country’s public health system were closely correlated with differences in COVID infection and death rates, such that nations with stronger public health systems had lower infection rates and fewer deaths while those with less investment in their public health infrastructure fared far worse. For instance, one comparative analysis of the United States and Cuba found that COVID death rates in the United States were more than 10 times higher than the rates in Cuba, not because the latter spent more money on health care but because Cuba already had a public health system oriented to population-level well-being in place before the pandemic and was thus able to implement more preventive measures earlier than the US’s decentralized health care system could manage.11 Another international analysis, meanwhile, found that the spread of COVID was linked more to the number of public health measures put in place than it was to the environmental factors that some experts initially thought might slow the spread of the disease.12 Perhaps most significantly, the comorbidities, such as diabetes and obesity, that left people most at-risk for serious consequences and even death from COVID are closely tied to one’s social context and socioeconomic status, pointing again to the importance of looking beyond the work of the physician to the issue of the social determinants of health.13

Using Jesus’s words to help see these trends, then one can quickly see the need to improve public health networks in the United States. Pursuing this outcome can start with a greater investment in primary care clinics so that more people, especially those on the margins, would be able to access preventive care and thus remain in better shape to weather any subsequent health emergencies that might arise. The success of such an endeavor, however, would require a dramatic shift in thinking. The prevailing mind-set in the United States views access to health care as an individual’s personal responsibility, leaving it subject to the vagaries of the marketplace and often contingent on an individual’s access to another major social determinant of health: gainful employment. Increasing access beyond the current ceiling will only happen if people accept that the task of broadening access is a collective responsibility. Happily, a few states have already started to adopt...
this perspective in the aftermath of the pandemic, so there is reason to hope that such a shift might actually be attainable.14

Notably, creating additional entry points into the existing health care system will only get the United States so far, because this strategy still treats prevention as part of the disease model that Jesus’s healing ministry rejects. A second part of the solution must therefore be an expansion of the public’s conception of what it means to support health and well-being. If those who are well truly do not need a physician, then one way in which Christians can encourage public health resilience and improve preparedness for the next crisis is by treating an investment in other public goods like education, safety, and even green space management as an investment in health and well-being. Implementing a change like this in the United States would be particularly powerful, for health policy scholars argue that

inadequate attention to and investment in services that address the broader determinants of health is the unnamed culprit behind why the United States spends so much on health care but continues to lag behind in health outcomes.15

By looking for ways to provide more social services to more people, communities could tackle this problem and reorient health care infrastructure toward the tools that meet basic needs. This change would have the effect of pulling people from the margins and, by extension, would help improve health care for all.

Christian communities should be spearheading this effort, not only because it represents a creative way of acknowledging Jesus’s assertion that those who are well need something other than a physician but also because it embodies the fundamental spirit at the heart of Jesus’s healing ministry. As Matthew’s healing narratives demonstrate, healing for Jesus was about far more than helping a sick individual get better physically, but instead encompassed a holistic transformation. While contemporary Christians should not expect to achieve the same degree of eschatological significance that Jesus’s healings entailed, they can nevertheless push the notion of healing beyond the narrow confines of the medical profession to include the activities that bring people back into community and sustain them all therein.16

As described above, implementing such an expansive view of healing will not be easy, because this task requires upending some well entrenched conventions in the realm of medicine. Fortunately, the calling of Matthew can do more than paint a prescriptive vision for what Christians should do to transform the reductionistic vision that tends to define healing in the contemporary social context. It can also provide some useful conceptual tools to facilitate the conversion of heart and transformation of mind-set that will be necessary to make this newfound commitment to public health a reality.

**Mercy over sacrifice: Creating the foundation for change**

The useful tools for conversion and transformation contained in the calling of Matthew can be found in a unique element that the evangelist added to Mark’s story about the calling of Levi

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14. Noah Weiland, “In This Michigan County, Pandemic Stimulus Funds are Remaking Public Health Programs,” *The New York Times* (April 9, 2022), www.nytimes.com/2022/04/09/us/politics/michigan-pandemic-stimulus.html; Lisa Rab, “The Medical Crisis that Finally Convinced Republicans in North Carolina to Expand Medicaid,” *Politico*, 14 August 2022, www.politico.com/news/magazine/2022/08/14/new-moms-converted-republicans-to-expand-medicaid-00049534.

15. Elizabeth Bradley and Lauren Taylor, *The American Healthcare Paradox: Why Spending More is Getting Us Less* (New York: Public Affairs, 2013), 3.

16. On the eschatological impact of Jesus’s healing ministry in Matthew, see Wilson, *Healing in the Gospel of Matthew*, 156–57.
(2:13-17), which appears to have been part of the source material for Matthew’s pericope. Whereas Mark’s account ends immediately after Jesus’s comments about how those who are well do not need a physician, Matthew includes a “substantive” update with the introduction of a quotation from Hos 6:6.17 The message is simple: “I desire mercy, not sacrifice.” The implications, however, are profound and provide a twofold rationale for a reinvigorated commitment to solidarity that can sustain the pursuit of a broader vision of health care.

The first way in which this exhortation to mercy can become a resource for embracing solidarity is in its juxtaposition with sacrifice. As a response to the critical challenge of the Pharisees, Jesus is both telling his disciples what to do (i.e., show mercy) and what not to do (i.e., impose demands on others that would require them to make sacrifices for the sake of demonstrating their dedication). The line is thus an invitation to adopt a compassionate disposition to others that allows followers to expand their circle of “fellowship.”18 This ability is essential if society is ever going to realize a shift toward public health, because the only way people can change their perspective to account for the well-being of the whole population is if they readily accept that everyone in that population is as worthy of their concern as they consider themselves to be. By calling his followers to compassion and turning them away from sacrifice, Jesus is reminding his followers that people do not have to prove their worth through a series of tests that establish their dedication. Instead, they deserve to have their worth honored because it belongs to them as children of God.

The second way that Jesus’s citation of Hosea can deepen a commitment to solidarity is related to the first. In part because the citation ends with Jesus’s addendum that “I have come to call not the righteous but sinners,” this passage serves as a stark reminder of how all human beings stand as equals before the eyes of God. To the extent that readers can see themselves as those who are called by Jesus, they are left with the logical conclusion that they are not “the righteous” but sinners, and this humble self-identity can make it easier to shed the Pelagian notion that some followers are better than others because they have done more work to merit a closer relationship with God. Pope Francis exemplifies the orientation to equality that this realization of one’s sinfulness can empower. When he became pope in 2013, Francis chose as his pontifical motto a line from Saint Bede’s (d. 735) description of the calling of Matthew, stressing the mercy Jesus showed to Matthew when he called the tax collector to follow him. Reflecting on this choice, Francis has remarked that it helps him remember who he is at his core, namely, “a sinner whom the Lord has looked upon.”19 Jesus’s summons to mercy, not sacrifice, encourages everyone to see themselves the same way, allowing people to set aside any haughtiness that might separate them from God and neighbor and to replace it with a sense of equality in imperfection. Upon adopting this perspective, humankind will find it easier to look upon others with a spirit of mercy and compassion, for people can recognize their own need for God to look upon them in this way. The natural result of this process is the profound awareness of solidarity that can emerge when a group of people finally recognizes that they are all in this together.

The call to solidarity is essential if the goal of comprehensive care for the marginalized is to be realized, because the changes needed to ensure everyone has a chance to be well and not need a physician will not be easy to implement. In fact, they will likely be costly, particularly for the people who have access to the health care system now or who find that the social determinants of health currently work in their favor. For example, the expanded access to primary care described above might translate into fewer opportunities for specialized treatments as the health care system tries to rebalance its resources to meet shifting demand. Likewise, the new investments in

17. Harrington, Gospel of Matthew, 127.
18. Viljoen, “Hosea 6:6 and Identity Formation,” 222–23.
19. Antonio Spadaro, “A Big Heart Open to God: The Exclusive Interview with Pope Francis,” America: The Jesuit Review, 30 September 2013, 15–38 (16).
education, transportation, parks, and more that are required to address disparities in the social determinants of health will not be cheap if they are going to be effective. Consequently, these initiatives will impose a cost on communities and individuals, and this cost will, by necessity, almost certainly fall more heavily on the shoulders of those who have the most resources now. If those individuals think only about a narrowly defined self-interest, they will likely balk at this expectation, creating a profound obstacle for the success of this new pursuit of holistic healing. When they start from a place of solidarity, however, and operate with “a firm and persevering determination to commit oneself to the common good,” they are more apt to see the importance of making these changes, even if it threatens their financial standing.20 The reminder of mercy and the spotlight on one’s sinfulness found in the calling of Matthew are thus both essential pieces in the larger effort to use Jesus’s words about those who are well to pursue a holistic form of healing grounded in public health.

Conclusion

In reflecting on Christian responsibilities for the post-pandemic world that is best described in eschatological terms (i.e., already and not yet), Christians would do well to consider what the calling of Matthew, that peculiar pericope squeezed among healing narratives, has to teach about the best way to enact Jesus’s holistic healing ministry now. This consideration should pay particular attention to the idea that those who are well do not need a physician, because this idea can serve as a reminder that other needs, even those still related to healing, can and should be addressed by something more than the practice of medicine alone. Those attuned to this reality will ultimately be able to learn the valuable lessons COVID revealed about the importance of public health and the necessity of working together to achieve healthy communities and not just isolated pockets with some healthy people. When also using the calling of Matthew to recognize the equality of all before God and neighbor, Christians will be better positioned to put these lessons into practice, thereby contributing to health, healing, and wholeness as the pandemic subsides and society searches for a better way of living together in non-crisis times.

Author biography

Conor M. Kelly is Associate Professor in the Department of Theology at Marquette University. He regularly teaches a medical ethics course for undergraduates and has written about health care ethics at the end of life and in everyday contexts. He is the author of The Fullness of Free Time: A Theological Account of Leisure and Recreation in the Moral Life (Georgetown University Press, 2020) and Racism and Structural Sin: Confronting Injustice with the Eyes of Faith (Liturgical Press, forthcoming).

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20. John Paul II, Sollicitudo Rei Socialis, 30 December 1987, 38, www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_en_30121987_sollicitudo-rei-socialis.html.