

A Pastoral Voice In the Healthcare Wilderness

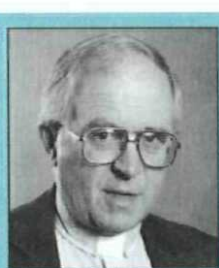
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When a complex question arises in the clinical conduct of a case, it should be resolved by a process of dialogue and discernment which, in addition to the patient and loved ones, includes an interdisciplinary team of professionals involved in various aspects of the patient's care. As part of this team, the pastoral care professional can help keep the focus on the spiritual dimensions of the human experience.

As pastoral care professionals seek to make a significant and unique contribution to this broader dialogue, their input may revolve around one or more of the following themes.

Spirituality/religion is a significant and honorable reality in the lives of many people. Under some circumstances spiritual considerations can become more important than even physical survival. Pastoral care professionals can testify to this reality, but some of us, in our eagerness to be accepted within the larger community of clinical professionals, have perhaps forgotten that spiritual and religious realities need to be taken just as seriously as physical, psychological, social, and economic ones.

In most, if not all of the world's religions, illness and suffering traditionally constitute a doorway into the spiritual. As our technical capacities for curing illness and alleviating physical suffering have expanded, we are more and more tempted to view an illness or hospital stay as simply an inconvenience—another secular, technical experience with no particular spiritual implications or opportunities. Only when healing or comfort is unavailable, delayed, or ambiguous do we turn to the spiritual—perhaps out of frustration at our inability to exercise control. The pastoral care professional seems naturally placed to call



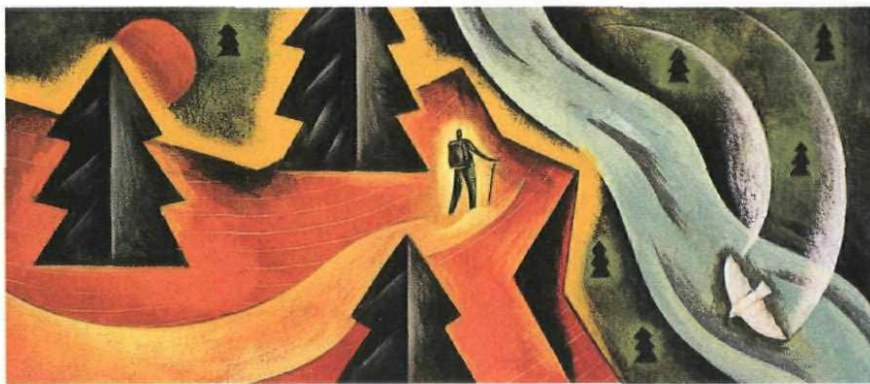
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attention to the spiritual dimensions of illness.

Present-day approaches to ethical discernment are notably different from those of even the recent past. One important difference is the tension between ethics as process/procedure and ethics as virtue. Until recently society has relied on the physician's professional expertise and virtue to produce outcomes that were generally humane and broadly accepted. But that time is past. As society has become increasingly pluralistic, achieving consensus about what constitutes virtue has become more difficult and contentious. Our common sense of trust in the beneficence of professionals, including physicians, clergy, and lawyers, has gradually eroded. So, despairing of our ability even to define virtue, we have come to rely on procedural standards to provide and enforce at least some guaranteed minimum of commonly acceptable practice. This approach affects not only clinical practice, but clinical ethics as well. It is unsatisfying because it does not deal with the practitioner's professional virtue and because clinical practice often outpaces the development of procedures and standards.

Some of the parties involved in the ethical dialogue need to remember and to speak for the notion of *ethics as virtuous practice*, based on the professional virtue of physicians and other healers. It is important to preserve the conviction—complementing our efforts to define ethical practice procedurally—that identifying and demonstrating such virtue is possible, however difficult. Further, being able to trust not just the technical competence but the professional virtue of the healer is a significant consideration from the perspective of the one in need of healing. It is more important than any

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guarantees that practice standards, institutional policies, economic sanctions, or legal requirements can provide.

The community has a legitimate voice in the making of decisions about clinical matters. In today's clinical environment the value of individual autonomy is in practice accorded a near-absolute status. Other recognized values—beneficence, truth-telling, and justice—are often considered secondary to it. The interests of family, faith group, and professional or public communities are hardly mentioned other than as footnotes. The debate about physician-assisted suicide, for example, is framed principally as an issue of personal autonomy; the question of whether society as a whole has a stake in the outcome is effectively ignored.

Since our society holds autonomy as highly as it does, we witness the development of ethical dilemmas that fall within the boundaries of the complex relationship between individuals and their overlapping communities: what moral theologians have traditionally called issues of distributive and social justice. In present-day healthcare, these are issues of access, equitable treatment, and resource allocation.

The world's spiritual traditions typically carry within them some developed sense of the mutual relationship between the community and the individual. Raising the issue of community as a relevant item in the interdisciplinary dialogue is a service to the whole, whatever form it may take.

The reality of limits is an integral part of human experience. We must face limits to the sustainability of human vitality, limits to the usefulness of human effort and the desirability of initiative, limits to the prerogatives of the individual and society vis-à-vis each other. Too often current language and practice appear to ignore these limits as if death could be held at bay indefinitely, or as if all efforts to sustain life were imperative simply because they are available. We develop technological capacities with little or no reflection on their desirability from a philosophical, ethical, or generally humane perspective. We allow

little room for discussion of communal responsibility while readily discussing the correlative value of individual autonomy.

Most religious professionals are accustomed to evaluating human effort and experience in the light of values that transcend the immediate realities of life as we know it. Simply bringing these values to the table and articulating them constitute an important contribution, a counterbalance to the headlong speed and technological arrogance to which we are tempted.

But if the clinician needs to deal with the reality of limits, so does the patient. Stanley Hauerwas has commented somewhere that as a culture we are not very good patients, precisely because we are so impatient. We are impatient with suffering, impatient with things that take time, impatient with anything less than perfection, impatient with the limitations of medicine and science, and impatient with our own mortality.

Care of the sick and dying is fundamentally a service, not a commercial enterprise. Any attempt to construe or manage it as a commercial enterprise will result in ethically flawed processes, decisions, and outcomes. For the greater part of human history it has been assumed that care of the sick and dying is a service. The healer is accorded respect and is usually compensated in some practical way for his or her efforts; but the notion of healing as commerce to acquire wealth is foreign to most philosophical and religious traditions. Yet this notion shapes our present practice.

Our language reflects this. The "client," who used to be the "patient," is now the "consumer" or the "customer." The physician, nurse, or therapist is the "provider"—as if care for our health were a commodity that could be bought and sold at will. We contract for it, litigate over it, argue about its portability, and generally treat it as an object of commerce. The notion that promoting health, caring for the sick and dying, and preventing or curing illness might be an endeavor of common interest is almost entirely absent from our contemporary consciousness. Yet this awareness is firmly rooted in the major

spiritual traditions.

The patient enters the physician-patient relationship as a vulnerable person, obliging the physician not to exploit or take advantage of the relationship for power or personal gain. Present-day commercialization of the healing relationship has created an entire system that exploits the circumstances of illness for profit. To the extent that healthcare has become a commercial enterprise, it accumulates wealth by exploiting the vulnerability of the sick, and is thus fundamentally unethical. To that extent, all of us who are part of that system may be said to be living in sin, meaning that we are part of a system that is morally compromised. We need to admit this instead of deluding ourselves with self-congratulatory rhetoric about the nobility of the healing arts, and we need to cultivate the courage and stamina to live with our distress, allowing ourselves to be troubled by the ethical predicaments of the environment in which we work.

While we can tell ourselves that problems are caused by outside forces (such as government interference) or by some other segment of the system (the for-profit sector), we must also ask to what extent we are all accomplices in what we might call Big Medicine. If we don't, we lose our capacity for self-critique and our power to make changes for the better.

It is not my intent that pastoral care professionals should live in daily misery, hanging our heads at the moral compromises of the system, or leave the clinical setting in outraged piety. Instead, we must approach our healthcare system with at least some of the skepticism it deserves. We must also realize that our spiritual perspectives need to be articulated clearly and eloquently within the broader interdisciplinary dialogue, for the sake of our common professional integrity, and for the sake of how we will treat our patients and each other. □

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