Healing Professions and Healing Institutions

Frs. O'Rourke and Ashley Have Called for a "Re-Personalization" of Health Care

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Fr. Kevin O'Rourke, OP, JCD, STM, is best known for his work in clinical ethics. He often engages issues related to end-of-life care, such as the morality of actions involving artificial nutrition and hydration, early induction of labor, and the use of contraception. For these scholarly efforts, he has received much acclaim as well as a few nasty e-mail messages. But we seldom identify his name with broader foundational areas of health care ethics, such as professionalism or organizational or institutional ethics. However, this is a mistake.

Fr. O'Rourke is by temperament and intellect a community-oriented thinker. The story is often told that when he completed his studies, he was asked what he wished to do and replied that he thought he would go into the area of health care ethics because he thought the church was going to need work in this area. This answer nicely illustrates how his sense of meaning and academic calling come from relationships with others, especially the church. Similarly, his approach to health care ethics must be seen as discussions of particular decisions embedded within a framework of relationships, a framework that is reciprocally shaped by the decisions made. Because of Fr. O'Rourke's focus on the relational nature of persons and the responsibilities it entails for health care professionals and health care institutions, there emerges from his work a critique of contemporary health care that is quite striking. It is a critique that sees contemporary health care as becoming enmeshed in forces that distract it from the fundamental healing that is health care's reason for being. The solution, Fr. O'Rourke argues, is that the professional must be "re-personalized."

I wish in this article to articulate Fr. O'Rourke's critique and its implications for people who are health care professionals, work in health care institutions, or educate such professionals. My approach will draw almost exclusively on the opening sections of Frs. Benedict Ashley and Kevin O'Rourke's text *Health Care Ethics: A Theological Analysis* (4th edition, 1997), as this comprises much, if not all, of what Fr. O'Rourke has written on the subject. Because I cannot separate the thought of Fr. Ashley from that of Fr. O'Rourke, I will simply assume that these themes belong to them both.

The Telos of Health Care

The person must be at the center of health care. The person is a unique being whose essence is embodied intelligent freedom (p.5). Uniqueness follows from the individual's possession and exercise of will and intellect. As will, one is free to make one's own choices. As intellect, one is able to apprehend the good for the type of being we are. The combination of the two means that one has responsibility to act in ways that promote one's well-being. Health is an important good for human beings, and the ultimate responsibility for promoting one's health belongs to each unique individual.

Of course, individualism is nonsense in the Thomistic and Catholic traditions. All that the person makes of himself is conditioned and dependent upon the accidental element of his or her birth into a particular society and set of circumstances. Of far greater importance, however, is the fact that achieving one's good is a matter of relationships. Sharing and participating in love of one's neighbor and the many communities that

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make up a life comprises much of the human good. To turn inward and cut oneself off from others is sin and evil. Perhaps the issue that complicates matters most is the fact that this effect of sin, separation from community, is also a primary effect of illness and can be difficult, perhaps impossible, to distinguish from it (pp. 38-43).

Illness can remove one from the public activities of daily living. Those things that give each day its meaning, such as contributing to the community and the good of others, no longer become possible. The sick individual often lacks the knowledge to make himself or herself well, but the problem may go even deeper. Psychological illness or addiction can deprive one of the ability to directly help oneself and can also impair insight into what constitutes one's own good. Fortunately, there are professions and professionals that directly deal with the essence of the person (p.72).

The Ashley-O'Rourke view is that health care professions (including mental health professions) exist to help restore the problems experienced in the interior life of the person. Because people cannot be separated into mind and body (although the two spheres are intimately connected), work on the intimate problems of the body and psyche aims at restoration of the full freedom of the patient. Health care professionals have especially demanding roles because they must, on one hand, respect a person's decision-making capacity, and, on the other, recognize that illness may severely compromise that person's freedom and corresponding responsibility (p.75).

Healing Professions

Members of the healing professions are asked to aim at the good of the patient, making their own interests subordinate to this goal. Frs. Ashley and O'Rourke clearly admire the healing professions in theory and healers in practice. However, they believe that although the professions' traditional ideals continue to thrive in many people's hearts and minds, those ideals are often contradicted by the actual social organization of U.S. health care and the rhetoric of the capitalist marketplace.

Frs. Ashley and O'Rourke anticipated the current "new professionalism" movement by noting that the health care professions, especially medicine, have a great and noble tradition of service yet, at the same time, often misuse professional autonomy to avoid public accountability and to serve the practitioners' own interests.[1] As a result, Frs. Ashley and O'Rourke seek to "re-personalize" the medical profession. We can surmise at least three points from their discussion.

Jesus Is the Standard First, the ideal healer, and the ethical standard for physicians, is Jesus Christ (p.80). When considering whether the physician's obligation to an AIDS patient is lessened by the fact that the patient may have contracted the disease through illicit behavior, Frs. Ashley and O'Rourke find it sufficient to note that Jesus did not, before he healed them, ask people how they became ill (p.102). Although physicians and other professionals are sometimes asked to make sacrifices, they are rewarded with the opportunity to emulate Christ in their vocation.

Healing, Not Wealth, Is Medicine's Telos Second (and related to the first point), economic and other perquisites the professional obtains must not be seen as market commodities, but, rather, evaluated in terms of their conduciveness to the telos of medicine—the healing of patients. Thus not even a physician's salary should be seen as compensation in accordance with what the market will bear, but, rather, as a stipend that allows the physician to carry on his or her work without distraction (p.97).

Nothing Should Block Physician-Patient Communication Third, "re-personalizing" requires a surrender of the elitist trappings that create a distance between doctors and patients and can thereby impede communication (p.70).

Unfortunately, technical expertise has been emphasized in medicine while its interpersonal aspects have been neglected. Frs. Ashley and O'Rourke believe this is reflected in the lack of time devoted, in the training of health care professionals, to medicine's interpersonal aspects, as well as in the relative rewards accorded to physicians when compared to those accorded to other health care professionals, such as nurses. Nurses, working at the bedside, have a great deal more interpersonal interaction with patients and deliver much more of the direct, hands-on care to them, than physicians do. But such services are not highly valued, and nurses typically must move

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into administration or education in order to have their careers "advance" (p.125). In other words, the functions that are closest to the essence of healing are of secondary importance in the scheme of rewards. As we have seen, it is not the intrinsic value of monetary rewards or recognition that is at issue; the problem is that such things are symbols of what is valued.

Healing Institutions

Frs. Ashley and O'Rourke's Christian vision places the professions in the context of larger healing institutions, such as hospitals and health systems. A person who suffers from an illness may need the assistance of no more than a single medical professional. But a profoundly ill patient, requiring rather total support, may need help from an entire institution—the hospital. In a sense, when illness cuts a person off from the mainstream community, the small-scale community that is the hospital serves to replace the mainstream community's functions in the patient's life (p.125). The ethical principle at the heart of a community's life is the principle of subsidiarity, also known as "the principle of participation." This principle holds a special place not only in governing the affairs of a health system but also in the interactions of health systems and their patients.

The principle of subsidiarity tells us that "[e]ach individual . . . in order to fulfill human need has a moral obligation to contribute to the common good and a right to share in it" (p.114). The principle of participation requires the participation of the person in advancing the life of the community, but it also calls on the community to foster the participation of those who constitute the community. Because people are essentially intelligent freedom, their dignity requires the opportunity to exercise these capabilities within the community—to help set goals and plans and make choices to help implement them. From the principle of subsidiarity, it follows that hierarchical organizations should seek to allow decisions to be made at the lowest levels compatible with the sound running of the organization. Furthermore, when the higher levels of an organizational structure intervene in and assume responsibility for affairs and decisions normally made at a lower level, they must have as a goal of that intervention the restoration of people's ability to reassume the responsibilities in question (p. 115).

From the principle of subsidiarity, several ethical precepts about the organization of health care follow.

Prevention and Education Are a Priority First, preventive medicine and health education would seem to have a moral priority. Because people have the ultimate responsibility for their health, and because their dignity is respected in helping them to care for themselves, the community must give first priority to empowering them to address their health needs. This is most directly done in providing the kinds of information, and encouraging the kinds of habits, that help maintain health and avoid disease.

Decision Making Should Be Diffused Second, hospitals and health systems should respect the dignity of those who contribute to the system, encouraging them to contribute to the decision-making process. A hospital cannot thrive in its mission if it is seen as being run by a small group of executives or a board of directors. Since the hospital's mission is to provide patient care, it must empower those who deliver the care to be key decision makers in their daily work. Conversely, these caregivers must internalize the hospital's mission and incorporate its values in their daily decision-making process. Thus they will bring this mission to each patient encounter.

Health Care Should Be Not-for-Profit Third, health care should be a not-for-profit venture (p.112). Health care organizations aim at promoting the common good by empowering people to maintain their health and by restoring the ability of people to participate in society. Sometimes such institutions must simply become substitute communities for people who are unable to become well again. This promotion of the common good is incompatible with ventures that seek private good, because the pursuit of private profit can run counter to fostering the common good. Institutions that make profitability their central measure may be tempted to seek mechanisms that exclude patients whose treatment is unprofitable and to devalue important aspects of care.

Re-Personalizing Health Care

By placing the person at the center of health care,

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Frs. Ashley and O'Rourke articulate a vision of the healing professions and healing institutions that is both mundane and profound. Its mundane character follows from making the patient's welfare the *goal* of health care. Saying "putting the patient first is what ethical health care is about" sounds like a truism. However, the vision is profound because it is not about unmitigated advocacy for the rights of particular patients. It is about the reciprocal relationship between the person who contributes to the common good, on one hand, and the communities that sustain and restore the person, on the other.

Frs. Ashley and O'Rourke are not naïve about the likelihood that these values will soon come to dominance in health care professions and institutions. Although the person may be the end (or telos) of medicine, the person must also be medicine's proximate cause. That is, only *particular* persons can breathe life into our overly bureaucratized and commercialized medical system (p.127). As we have noted, such persons will swim against the mainstream currents—but they will share in the imitation and healing ministry of Jesus Christ (p.135).

Health care institutions that choose to live their mission focus will also face many challenges in today's marketplace. However, such healing institutions will not only help their patients and support their professionals and staff; they will also be living the tradition of witness to the healing ministry of Jesus Christ. It is this witness, to which Catholic health care must aspire, that justifies according the title *Catholic* to these institutions.

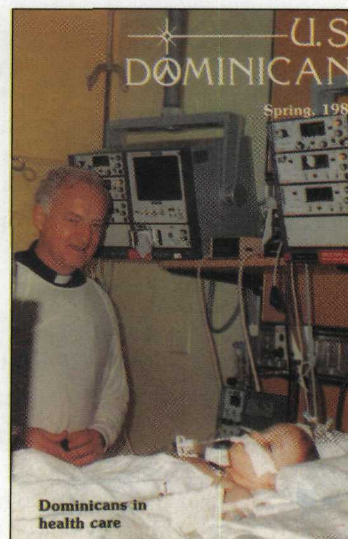
In the struggle to fulfill their healing mission, health care institutions are dependent upon the people who steward them. As a result, as Frs. Ashley and O'Rourke often point out, such institutions need to pay increased attention to ethics and communication skills in the training of medical students, residents, and, indeed, all health care professionals.

One may wonder, however, whether education in the way it has traditionally conceived will be sufficient. Frs. Ashley and O'Rourke's emphasis on the need for professionals of character—who understand ethical precepts and moral directives and can apply such matters with prudence—is suggestive of a deeper kind of education. The analogy of medicine with the clergy hints that what is needed is something more akin to *formation,* a process that seeks to mold the inclinations and habits of heart and mind. One can only begin to speculate what such a process might entail in practice. But if healing institutions are dependent on hearts and minds, then it is imperative that both be trained and nourished. It is, perhaps, this task that will be the legacy of Frs. Ashley and O'Rourke to the next generation of educators of the health care professions. ■

NOTE

1. Delese Wear and Mark G. Kuczewski, "The Professionalism Movement: Can We Pause?," *American Journal of Bioethics,* vol. 4, no. 2, 2004, pp. 1-10.

1992, presenting two of his books to Pope John Paul II.



1983

2004, 50th Jubilee of ordination celebration with former classmates.