Looking Forward

A Younger Ethicist Reflects on Fr. O'Rourke's Contribution to Catholic Health Care Ethics

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At certain moments in every person's life, that person is asked to do something for which he or she feels wholly unprepared. I can name a few such moments in my own life: going away to college at the age of 17; becoming a parent at the age of 24; assuming an ethics position for a large Catholic health care system at the age of 27. I've now been asked to do something similar here, this time at the age of 36. Though I may be slightly wiser and a bit more mature at this point in my life, I once again feel unprepared to tackle the task ahead of me, which is to reflect on the contribution of Fr. Kevin O'Rourke, OP, JCD, STM, to Catholic health care ethics.

How does a person with relatively little experience and knowledge critically analyze the work of such a man, a man who is not only a pioneer and giant in the field but also a former teacher, current mentor, and good friend? The truth is it is a darn near impossible task—but one that I will nonetheless attempt to accomplish with much hope and humility.

In what follows, I will outline what I believe are Fr. O'Rourke's three main contributions to Catholic health care ethics. The list is obviously not exhaustive, given the breadth and depth of his work, and it is quite possible that others would have a different idea as to what constitutes his three main contributions to the field. However, from my limited perspective, it appears that the points presented below rise to the top because, first, they have provided a corrective to some distortions in Catholic health care ethics, and, second, they signal directions for the future if Catholic health care ethics is to have relevance in our complex, changing world.

Under each of the three points, I will briefly describe Fr. O'Rourke's contribution, highlight its significance, and indicate what we might take from it as we move forward.

A Person-Centered, Inductive Approach to Ethics

At a methodological level, Fr. O'Rourke has made a significant contribution to Catholic health care ethics by developing an approach that starts with the human person as conceived in terms of basic needs that must be ordered and satisfied properly if he or she is to ultimately flourish as a person, those needs being understood theologically as love of God and neighbor.

By starting with the person and the goal of human flourishing, Fr. O'Rourke in his approach commits himself to an inductive, teleological method in ethical analysis, whereby virtues and ends are emphasized as much as deontological factors (laws, rules, principles) and human experience and the sciences play a crucial role.[1] Fr. O'Rourke and his coauthors, Fr. Benedict Ashley, OP, PhD, and Sr. Jean deBlois, CSJ, PhD, RN, describe this well in the most recent edition of their book, *Health Care Ethics: A Catholic Theological Analysis.*

> Morality [they write] is not merely a matter of obedience to rules but is the free and realistic choice of means to meet human needs in the order of their importance in achieving true personal and communal happiness. It is based, therefore, on a sound understanding of human nature and its needs attained through historical experience and enhanced by the modern life sci-

> ences. . . . Consistently good moral behavior, however, cannot be achieved without the development of a sound character, that is, through the development of virtue. Hence virtue theory supplies us with an analysis of what such a virtuous character consists of. Bioethics thus must be more than a set of general principles, but must be grounded in a sound anthropology and virtue theory.[2]

The significance of Fr. O'Rourke's approach cannot be overstated today, because Catholic health care ethics is on the verge of being too deontological, rule-based, and deductivistic in its methodology and approach to concrete issues. We have seen this trend developing in several areas in the past, most recently in the debate over forgoing artificial nutrition and hydration in the case of patients in a persistent vegetative state—an issue that, after bubbling up for years, finally spilled over in the wake of the Terri Schiavo case.

In such an instance, when the person no longer serves as the criterion of the morally right and wrong, subsidiarity and human freedom in the application of moral principles are undermined and human experience and the sciences have little to contribute to ethical discourse.[3] Ecclesiastical authority—as opposed to reason, dialogue, and consultative processes—dominates in such an environment, and the focus of ethics becomes so excessively narrow that, as we saw in the moral manuals, the emphasis falls on individual actions rather than on the broader social issues that more profoundly affect our ability to flourish as human persons. This is why Catholic health care, instead of addressing such issues as health care reform, allocation of resources, and disparities in health care, tends to focus on issues of cooperation related (for example) to sterilization, the mechanism of action of emergency contraception, and methotrexate in the treatment of ectopic pregnancy. Although important, these issues would, quite frankly, drop well down the list if we were assigning priorities in terms of overall impact on people and communities.

As we move forward, we Catholic ethicists need to continue to approach ethical issues in health care from an inductive, teleological angle, because this best supports human dignity, the common good, and our pursuit of human flourishing in complex, changing circumstances. However, we also need to build on and refine such an approach because, like anything in this life, it has an unfinished character. One area that we might consider looking into further is how experience really comes into play in shaping understanding of what it means to be human, what basic human needs are, and how those needs can best be fulfilled when the overall goal is human flourishing.

Without denying a universal quality to human nature and the innate needs of human persons, we need to ask ourselves just whose experience is accounted for in our theological anthropology and our methodological approach to ethical issues. Have we, in seeking to shape our collective understanding of these things, really taken seriously the insights of people from diverse cultures? Has our understanding of the many issues considered in health care ethics really been shaped by their experiences? The truth is, our understanding probably has *not* been sufficiently shaped in that way. But what would happen if it were? Perhaps it would open us up to new ways of understanding human nature and the hierarchy of human needs. This, then, could very well change not only the way we view issues, but also the types of issues we consider as well as the conclusions we draw.

We may also want to consider incorporating some of the principles of Catholic social teaching into our methodological approach to health care ethical issues. Why do we in health care ethics limit ourselves to such concrete principles as double effect, cooperation, informed consent, confidentiality, and so on? What would happen if we took seriously the concrete principle in our social teaching of, say, solidarity and used it in health care reasoning? Would this require of us that we stand with our vulnerable brothers and sisters in helping shape a more just health care system? Would this change our focus and provide us with the impetus for sustained reflection on social justice issues related to health care? What about the principle of subsidiarity? If we were to give this principle its due, how would that alter the landscape? Would it mean that the primary task of the

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church's magisterium and its theologians and ethicists would change—that, rather than problem solving or doing quandary ethics, the central task would be illuminating and educating?

Would such a change of emphasis also provide more subjective leeway for individuals and communities to decide what is best in light of their conception of what it means to be human and to flourish? These are questions for which there are no easy answers. But they are nonetheless questions that we must grapple with as we move forward.

A Holistic View of the Person

Another major contribution that Fr. O'Rourke has made to Catholic health care ethics is his understanding of the human person. He has consistently described the person in holistic terms, as an integrated whole who is at once physical, psychological, social, intellectual, moral, and spiritual. All of these dimensions coalesce in making us who we are as human persons, and they must be taken together when considering ethical issues in health care, even if, at various times, more value is attributed to one dimension or another, depending on the circumstances.

For example, a patient experiencing excruciating pain may choose to increase her or his pain medication, even to the point of unconsciousness, at the expense of being present to loved ones. Likewise, a patient may refuse potentially life-extending chemotherapy treatment that entails being institutionalized and financially burdensome to her or his family, choosing instead to spend more time at home in familiar surroundings and at less cost.

While Fr. O'Rourke's holistic view of the person is obviously closely aligned with his inductive, teleological approach to ethics, it has far more practical significance than his methodology, especially in terms of how medicine is practiced, how patients are viewed, how early human life is perceived,[4] and how end-of-life treatment decisions are made.[5] In all of these areas, Fr. O'Rourke's view of the person contrasts with that of those who reduce the human person to one or more of its constitutive parts, whether it be the physical (as we sometimes see in medical care and end-of-life treatment decisions) or the intellectual (as we sometimes see in discussions of the moral status of the embryo).

Fr. O'Rourke's holistic view allows him to honor the dignity and sacredness of human life without descending into one extreme (in which, for example, people must be kept alive at all costs so long as their physical condition can be maintained: i.e., vitalism) or the other (in which, for example, embryos can be treated carelessly because they are said to be nonpersons, lacking as they do rationality, self-consciousness, a sense of future, or some other arbitrarily defined criterion of personhood not currently apparent).

We ethicists will need to continue to emphasize the holistic nature of the human person to combat (a) a mechanistic view of the person that is still prevalent in medicine and medical thinking, in which the patient is perceived in strictly (or at least primarily) physical terms or bodily functions; (b) the pervasive disrespect seen in societal attitudes toward early human life, which although it probably took root in the 1970s following *Roe v. Wade*, has become more widespread in recent years, as is evidenced in the debates over embryonic stem cell research; and (c) a creeping vitalism that has sprung up in Catholic ethics concerning the end of life, especially since the March 2004 papal allocution on caring for patients in a persistent vegetative state.[6] Failure to maintain our focus on the person, holistically considered, could have a devastatingly negative impact on patient care, public policy, and end-of-life decision making.

Such a failure could, moreover, further diminish the relevance and credibility that Catholic health care ethics possesses in our morally pluralistic society. As is well known, one of the most widely accepted elements of our Catholic moral tradition, as it relates to health care, is our balanced approach to end-of-life decision making. What would happen if this tradition were supplanted by a rigid, deontological approach that required the use of certain forms of treatment until death was imminent or the patient's body simply rejected the treatment altogether? We have already seen glimpses of this as many, within and outside Catholic circles, strongly opposed some of the conclusions drawn in the aforementioned allocution.

Pastoral, Practical Sense in Responding to Issues

Perhaps one of the most noteworthy contributions Fr. O'Rourke has made to Catholic health care ethics comes not through his writing but

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through his witness and way of being. Originally trained as a canon lawyer, Fr. O'Rourke was granted a sabbatical in the early 1970s, during which time he immersed himself in moral theology and ethics, studying at the University of Chicago while the great Protestant ethicist James Gustafson was there and the renowned Catholic moralist Fr. Richard McCormick, SJ, was at the nearby Jesuit School of Theology.[7] Soon after this sabbatical, Fr. O'Rourke took an ethics position at CHA, where he spent six years, and then in 1979 he moved on to become the director of the Center for Health Care Ethics (CHCE) at Saint Louis University (SLU).*

Fr. O'Rourke's time at the CHCE afforded him an opportunity to really come to understand the clinical reality and the complex nature of health care delivery. Not only was he able to participate in medical and nursing education at SLU; he also took part in clinical rounds, sat on ethics committees, and provided consultation services at SLU Hospital, as well as at SSM Cardinal Glennon Children's Medical Center. Fr. O'Rourke talked with and listened to clinicians, met with patients and families, and learned about the environment in which health care decisions are made. As a result of these experiences, he became intimately familiar with the medical and nursing cultures, the complex problems faced by patients, and the ever-challenging circumstances in which Catholic health care must be delivered. This cultivated in him a pastoral, practical sense that has made him a compassionate, well-informed, and realistic ethicist who also has always remained faithful to the church and its teachings.

The significance of this practical experience is twofold. First, as ethicists we owe Fr. O'Rourke a debt of gratitude. By being on the frontlines as he so often has been, and having the impact that he has, he has lent credibility to ethicists in general and to Catholic health care ethics in particular. People have been able to see ethics in action, and that has given meaning and added value to the field. Having worked in Fr. O'Rourke's considerable shadow at Cardinal Glennon, I can report that his impact is still being felt and that my own path would have been much more difficult had he not paved the way for me. More than this, however, Fr. O'Rourke showed us who we ought to become as ethicists and how we ought to conduct ourselves in such a role.

Second, Fr. O'Rourke's pastoral, practical sense has import not just for ethicists in Catholic health care and other settings but also for the church and its leaders. Very often today, the church's magisterium seems to respond to issues from an overly theoretical standpoint, and, as a result, its observations and conclusions sometimes seem out of touch with the reality faced by people in concrete situations. The papal allocution mentioned above seems to be a case in point, given the reaction to it by ordinary Catholics and the medical community. The reality is that most bishops and their theological consultants lack clinical experience and, unfortunately, many do not engage sufficiently in sustained dialogue with the health ministries in their dioceses. While the responsibility for this goes both ways, the unfortunate consequence is that bishops tend not to fully understand the complexity out of which very difficult decisions facing clinicians and hospital and system administrators must be made. Immersion in or increased contact with the clinical reality, so well exemplified in Fr. O'Rourke's career, would offer a different perspective and, perhaps, better insight and understanding as to why clinicians might deem it necessary to provide emergency contraception to a female victim of sexual assault, or consider a pastoral exception to the church's general prohibition against sterilization in certain tragic situations where it might be medically indicated, for example.

This all points us to what we might want to consider as we move forward. Interestingly, one of the critiques that I've heard of Fr. O'Rourke's work is that he is not always consistent in his application of his theory (or methodology) in dealing with various issues. I've thought about this for some time now, and I do not believe the criticism is warranted or accurate. The truth is, Fr. O'Rourke comes to the logical conclusion that his methodology leads him to on most, if not all, issues. What confuses people, I think, is that his pastoral, practical sense sometimes allows

* Fr. O'Rourke retired as the CHCE's director in 1999 and eventually moved on to become professor of bioethics at the Neiswanger Institute for Bioethics and Health Policy, Stritch School of Medicine, Loyola University Chicago.

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him to support a person who acts in a way contrary to the conclusion drawn from Fr. O'Rourke's methodology. Fr. O'Rourke is able to do this because he upholds the traditional distinction between the "objective" and the "subjective" in ethics. Readers who are not familiar with this distinction might consider the following example.

Objectively, a woman who undergoes a sterilization procedure, in the absence of a present and serious pathology, is, according to church teaching, engaging in a morally illicit action that cannot be justified by either her intention or the circumstances surrounding her situation. Subjectively, however, the fact that she has seven children already; has a serious cardiac condition that would threaten her life should she again become pregnant; and intends only to protect herself, not to render herself infertile, mitigates her moral culpability or responsibility. She could be said to be doing something objectively wrong, but—on the subjective level—her moral responsibility is diminished, given her intention and the circumstances. This distinction has for years allowed those who espouse certain natural law methodologies to honor church teaching while at the same time responding pastorally to a person in need.

As we move into the future, we may want to think about how we can better integrate the pastoral, practical sense in our theory or methodology. We can start by asking ourselves whether the objective-subjective distinction is adequate. Are these two dimensions of morality really distinct enough to uphold the traditional distinction? Does it still make sense, if culpability can be diminished by intention and circumstances, to say that the resulting action is objectively wrong? Why is it that the circumstances and intention do not alter the moral meaning of the action? These questions, of course, are not new, but I think we need to have a sustained, collegial, and open discussion about them. If we do not, I fear that our teachings on some ethical issues in health care will forever remain at odds with our pastoral practice and that the validity of such teachings will be further challenged, as will the credibility of the church's magisterium.

By way of conclusion, let me just say that it is a privilege to know Fr. O'Rourke and an honor to write a reflection on his behalf. I have limited myself to what I see are his three main contributions to Catholic health care ethics. I could have included others, most notably, his collegial style and openness to dialogue (which is something sorely needed in the current church environment), and his commitment to teaching and learning, which contrasts with the present approach of some in the church, who seem more inclined to exercise their authority than to study, listen, and change hearts and minds.

I should say before closing that the thoughts outlined with regard to future directions are offered in a spirit of openness to the exploration of ideas and are meant only to stimulate dialogue so that Catholic health care ethics will remain relevant and even flourish well into generations of ethicists to come. ■

NOTES

1. R. A. McCormick, *Corrective Vision: Explorations in Moral Theology,* Sheed & Ward, Kansas City, MO, 1994, p. 15.
2. B. Ashley, J. deBlois, and K. D. O'Rourke, *Health Care Ethics: A Catholic Theological Analysis,* 5th ed., Georgetown University Press, 2006, Washington, DC, p. 31.
3. McCormick, p. 6.
4. See, for instance, K. D. O'Rourke, "The Embryo as Person," *National Catholic Bioethics Quarterly,* vol. 6, no. 2, Summer 2006, pp. 241-251.
5. See, among others, K. D. O'Rourke, "The Catholic Tradition on Forgoing Life Support," *National Catholic Bioethics Quarterly,* vol. 5, no. 3, Fall 2005, pp. 537-553; and "Reflections on the Papal Allocution Concerning Care of Persistent Vegetative State Patients," *Christian Bioethics,* vol. 12, no. 1, April 2006, pp. 83-92.
6. Pope John Paul II, "Care for Patients in a 'Permanent' Vegetative State." This allocution can be found on the Vatican website (www.vatican.va/holy _father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_ 20040320_congress-fiamc_en.html) or in *Origins,* vol. 33, April 8, 2004, pp. 737 and 739-740.
7. See K. D. O'Rourke, "As Time Goes By: Twenty-Five Years of Bioethics," *Cambridge Quarterly of Healthcare Ethics,* vol. 11, no. 4, 2002, pp. 380-387.

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