my. The new economic models that stress the importance of intangibles, among them people, were developed in response to the realization that intangible assets are the primary drivers of value (i.e., wealth) in the new economy. These models are promoted as necessary for business success, not because of any expressed conviction about the intrinsic value of the person, but because they drive value (i.e., wealth). Nevertheless, they are welcome theories and tools in the hands of health care managers who do believe in the importance of people *as* people and who can use them to more adequately integrate the important stewardship function in health care services.

The tension between the market and the professional paradigms in health care is not a battle between health finance personnel who are concerned only about money and caregivers who care only about the health and well-being of people. It is not a statement about the irrelevance of health care costs in the face of more important human realities. I believe that the tension is an unexpressed realization that the philosophical underpinnings of the market and those of health care are incompatible, and that the *uncritical* application of market tactics in the health care sector jeopardizes the very essence and purpose of that important realm of human activity.

The tension is, in one sense, inevitable because health care is carried out within two frameworks: a *moral* framework set by the nature of the person fully understood and an *economic* framework shaped by the market with a different anthropology. The social teaching of the Catholic Church offers, in broad strokes, insight into the resolution of this problem when it insists that the economy and production are for the good of the person and the community—not the other way around. Economist Robert Heilbroner has put it this way: "the market is a good servant, but a terrible master." ■

NOTES

1. Robert Kuttner, *Everything for Sale: The Virtues and Limits of Markets*, The University of Chicago Press, 1998.
2. Kuttner, p. 129. Such is "a social goal beyond the comprehension of markets."
3. David J. Rothman, "Medical Professionalism: Focusing on the Real Issues," *New England Journal of Medicine*, April 27, 2000, pp. 1284-1286. Rothman suggests that, in fact, the profession has not lived up to its professional standards and that professionalism today has to be invented, not restored.
4. Mike Brogioli and Lisa Smith, "Privatization of Social Services: Perspectives from Catholic Charities USA," *Charities USA*, First Quarter 2000. For-profit enterprises are now in the business of determining welfare eligibility.
5. Kuttner, pp. 5-6.
6. Max L. Stackhouse, Dennis P. McCann, Shirley T. Roles, and Preston N. Williams, editors. "Introduction: Foundations and Purposes," *On Moral Business: Classical and Contemporary Resources for Ethics in Economic Life*, William B. Eerdmans, Grand Rapids, MI, 1995, p. 16.
7. Shari Mycek, "Leadership for a Healthy 21st Century," *Healthcare Forum Journal*, July/August 1998, p. 26.
8. Richard E.S. Boulton, Barry D. Liebert, Steve M. Samek, "Cracking the Value Code: How Successful Businesses are Creating Wealth in the New Economy," HarperBusiness, New York, 2000.
9. Boulton, p. 29.

PATIENT ADVOCACY

BY JULIE ANDREWS

Patient advocates are people who must not lose sight of the patient and the family despite the herd of elephants stampeding through the halls of our organizations. We struggle on a daily basis to balance potentially conflicting missions. Despite these distractions, we need to stay focused on the patient and gently remind coworkers why they chose their noble professions. Health care providers are simply honored guests in the lives of patients and their families, and as such they must earn patients' respect.

We advocates act as liaison among patients, staff, and physicians. Our job is to recognize and remove institutional barriers in order to provide high-quality care. Our goal is to help patients and family members push the envelope: to question care decisions, be included in care delivery, and challenge bureaucratic rules.

As we make our daily rounds, we look for people in trouble. We look for unattended elders left in the emergency department by nursing homes, unattended children, repeat admissions, patients with sickle cell anemia, and patients who are dying. We look for those with cultural and language barriers, those with poor prognoses, and those with a history of noncompliance. Most often overlooked are the quiet elders. When I ask a typical quiet elder how he is, he says, "How are you, my dear?" They are silent people who may be in trouble.

We ask everyone to be on the alert for high-risk patients, to be an advocate, and to question the ethics of all our actions. As patient advocates, our goal is to work toward our redundancy. We ask everyone to have the courage of their convictions, such as advocating on behalf of a patient being discharged prematurely. When a patient's rights are

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, September-October 2001