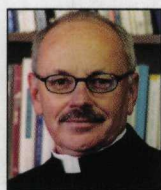


What Is “Prudential Personalism”?

Why Does It Matter?

Fr. O'Rourke Helped Retrieve a Vital Ethical Method in Catholic Theology



BY CHARLES E. BOUCHARD, OP, STD

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In one sense, there is nothing new about the theory called “prudential personalism” developed by Fr. Kevin D. O'Rourke, OP, JCD, STM, and his Dominican confrere, Fr. Benedict M. Ashley, OP, PhD, through successive editions of their book *Health Care Ethics (HCE)*.¹ It is the retrieval of an ethical method developed, at least in part, by Aristotle, refined and adapted to Christian life by St. Thomas Aquinas, and neglected and distorted by philosophers, reformers, and even the church itself. It was reappropriated in the 20th century by theologians and philosophers alike.

Its contemporary reappropriation began in the late 19th century with the publication of Leo XIII's encyclical *Aeterni Patris* (1879), which stimulated a renaissance of Thomistic thought, particularly in philosophy. The recovery of important theological ideas, and of St. Thomas himself as a theologian and spiritual master, came later and set the stage for the emergence of prudential personalism.

Because of these complex origins, it is impossible to describe this important concept fully in so few pages. What I will try to do is show where this ethical theory fits into the broader context of ethics and to highlight what makes it distinctive. I will then briefly suggest why it was abandoned in the mid-16th century, in the wake of the Council of Trent, and replaced with another, far less satisfactory approach to theological ethics. Then I will describe the most pertinent features of Fr. Ashley and O'Rourke's theory; and finally, because I know how important it is to make theory useful, I

will suggest several practical implications of this theory for medicine and health care ethics.

WHERE DOES PRUDENTIAL PERSONALISM FIT IN THE BROADER CONTEXT OF ETHICS?*

Ethics is a kind of knowledge, but it differs from scientific or technical knowledge because it has to do with “oughtness.” Ethics, whether based in religious faith or not, always tries to answer two questions: “What ought I to do?” and “What kind of person ought I to be?” These “doing” and “being” questions are at the heart of nearly every ethical system.

There are two basic ways of answering these questions, each of which has a variety of subsets or subcategories. The first basic system is called deontological or “duty-based,” because the answer to the “ought” question always refers to one's duty, and, by extension, to the laws and the lawmakers that impose the duty upon us. These systems are called “voluntarist” because they are rooted in the will (*voluntas*) of the lawmaker. They typically focus on obedience at the expense of understanding.

The second general category is teleological. This approach answers the “ought” question by asking, “What is the goal or purpose?” and “How do I achieve it?” This approach is rooted more in intelligence (thoughtful deliberation) than will. It presupposes belief in goal or purpose and the ability to see this goal and take intelligent steps to achieve it.

The Ashley-O'Rourke theory† (and Catholic ethics in general) are firmly rooted in teleology. The theory is called “personalism” because the

* Prudential personalism will hereafter be referred to as PP.

† The Ashley-O'Rourke theory will hereafter be referred to as AOR.

goal or purpose is the flourishing of the human person; since the human person is clearly one thing or set of things and one set of needs rather than another, it provides an objective norm that rescues it from total subjectivism. The theory is "prudential" because, unlike a deontological system, it maximizes human freedom and creativity, allowing diverse paths to the same goal or purpose, depending on circumstances. Because they focus on obedience and conformity of the will, deontological ethics often results in an impoverished view of the human person, one in which the person lacks autonomy and self-determination and has but a limited ability to integrate grace in the form of perduring moral qualities, or virtues.

A goal-based approach to ethics that is *theological* goes one step beyond earthly human flourishing by establishing God's own self (that is, "Happiness" with a capital "H") as the ultimate goal or purpose of human existence. To whatever extent we are able to grasp the goal of human happiness or flourishing on a natural, rational level, we have opened human nature to the possibility of grace. In the Catholic view, authentic human happiness and holiness (i.e., graced happiness) are always compatible.

Other approaches to ethics are described as "non-normative" because they rely on intuition or emotion. Intuition and emotion are both important ways of knowing, but neither of them is sufficient in itself. Both approaches lock moral decision makers in individualistic worlds (e.g., my moral "feeling" about a course of action may be just as valid as yours) and preclude the possibility of consensus based on shared values or needs. These approaches also reflect an inadequate view of the person because they neglect understanding and will.

WHY WAS THIS APPROACH DISTORTED AND ABANDONED AFTER THE COUNCIL OF TRENT?

Until the late middle ages, there was no distinct discipline known as "moral theology." Morality was seen as connected to, or even the same as, "spirituality." St. Thomas Aquinas, for example, writing in the 13th century, included everything we would consider as spirituality and morality in the second part of his *Summa Theologica*. He

begins that section by asking whether humans act for a purpose or an end, and he identifies that end as happiness. Succeeding sections of the *Summa* focus on how various human abilities ("faculties") cooperate toward the identification of and search for that happiness. Acquiring the habitual ability to think, judge, feel, and act in certain ways created virtues, or personal qualities, which "naturally" led persons to fulfillment and happiness.

Shortly after the Council of Trent (1545-1563), a number of events transpired to put this traditional approach to ethics out of fashion. These events and their consequences have been amply described by many different scholars.² The philosophical trends of nominalism (which emphasized individual acts over continuity and purpose) and voluntarism (which, in an attempt to preserve the freedom of God, stressed authority and obedience) provided theoretical underpinnings for the change. The subsequent need to regularize the sacrament of penance led to the establishment of a "short course" on morality, designed to help confessors determine the nature and gravity of sins and assign penance, which, in turn, led to a focus on individual sins rather than on virtue.

In the interest of practicality, this short course neglected many of the specifically theological aspects of morality that were the heart of the earlier approach. The idea of beatitude (happiness) as the goal of morality, as well as the treatises on grace and the Gifts of the Holy Spirit, were relegated to a new discipline of "ascetical theology" (which was reserved for the spiritual elite) or eliminated altogether. The virtues, which represented a far richer moral anthropology—and which had been the organizing principle of morality from Augustine until the Reformation—were replaced with the Ten Commandments, which were more suitable to an obedience-based approach.

These shifts, admirably aimed at improving auricular confession, created a new understanding of moral theology that focused on moral obligation, obedience to the law, and adjudication of individual sins.³ In the end, this approach diminished responsibility and reduced the moral life to a series of "stills," losing the narrative.⁴

**A "personalistic" ethic is one that is based
in the real goods and needs of actual human persons.**

This "manualist" paradigm of moral theology dominated Catholic thought for more than 300 years.* Although at least a few moralists raised questions about the whole enterprise as early as 1922, it was not until the mid-20th century that the Redemptorist Bernard Häring broke the mold and opened the door to a fresh new approach.⁵ The history of moral theology since then has been a process of restoring Scripture, Christology, spirituality, and virtue theory to their rightful place. PP is one fruit of this renewal.

WHAT ARE THE KEY DISTINGUISHING FEATURES OF PRUDENTIAL PERSONALISM?

The first half of the 20th century witnessed a constant flow of renewed scholarship in the moral thought of St. Thomas, especially in the area of virtue and the Gifts of the Holy Spirit. Catholic education at the secondary and undergraduate levels was at its apex, and the number of publications in Thomistic theology and moral catechesis on both scholarly and popular levels was staggering.⁶ Frs. Ashley and O'Rourke were both introduced to theology during this particularly dynamic and fertile time in Dominican intellectual history.†

PP has deep roots in this cultural and theological milieu. Although it is not, as I have already indicated, a new theory, it was shaped by and in response to various cultural and theological trends (e.g., proportionalism and the emergence of American individualism) that still remain challenges. PP has several important distinguishing characteristics.

Personalist We typically use the word "personal"

to mean individual, private, or customized (e.g., a PDA is a "personal digital assistant"). In ethics, however, "personal" refers to an ethical system in which the person is a real, historical entity rather than an abstraction. AOR note that the person is a "vast, ever-increasing body of information gathered by the behavioral sciences and humanistic disciplines" (*HCE*, p. 7). Although some aspects of personhood are transcultural and transhistorical, there are others that are developmental and evolving. A personalistic ethic is one that is based in the real goods and needs of actual human persons; these goods and needs can be verified scientifically and experientially, and they can change from one historical or cultural context to another.

Even though persons are distinguished from other animals by reason, it would be a mistake to assume that "human" means "rational" in a narrow sense. A full and adequate understanding of human nature is not only rational, deductive, and logically sound; it also takes account of emotion, intuition, and even imagination (*HCE*, p. 181).

Social and Political Post-Enlightenment views of the person tend to stress individuality and autonomy. AOR's understanding of the person, however, is essentially *social*. Human persons do not exist except in society, they say; "the human person can be healthy and whole only in a human community, because to be a person is to be capable of interpersonal relations"; the "correlation of person and community is not merely superficial; people need a community not only because it provides them with certain instrumental needs (food, housing, clothing and defense), but because their personalities can be fulfilled only in the act of communication and sharing" (*HCE*, p. 8).

The political aspect of personalism follows naturally. Although "political" is today the last word one would want to apply to health care, politics, when properly understood, is no more than the art or virtue of living together in society. That being the case, it is clear that health care ethics *must* be political (as opposed to individualistic or merely economic). If persons are essentially social, then the basic goods and needs they have must be arbitrated politically, that is, in intelligent conversation and negotiation aimed at the

* The "manualist" approach (so-called because it used a codified "manual" to train confessors) was developed largely by the Jesuits as part of their "cursus brevior" in moral theology. Dominicans tried to keep morality in a theological context, as St. Thomas had done, but their attempts to write virtue-based manuals of moral theology were few and relatively unsuccessful.

† Frs. O'Rourke and Ashley both lived with and knew Fr. Walter Farrell, OP, perhaps the most important popularizer of Thomistic scholarship in the English-speaking world in the 1940s and '50s. In the '50s, Fr. Kevin studied canon law at the Angelicum, where the faculty included many noted scholars in the area of spirituality.

common good. This insistence on the social and political dimension of ethics poses a stark challenge to prevailing ideas of individual rights abstracted from human society, of which human persons are *essentially* a part.

Theological AOR acknowledge that PP is “natural law based” and therefore accessible to any reasonable person of good will. But their approach is also *theological* because the human person has not only a natural and material end but also a supernatural one. While many post-Tridentine ethicists tended to undervalue the supernatural destiny of persons, AOR believe that morality is a search not only for “happiness” but for “Happiness.”

The theological basis of PP is evident in the way it links human community to the divine community of the Trinity. Thus AOR conclude that “the Christian health care professional, in his or her effort to heal another human being, is a minister of God helping that patient to share more fully in the everlasting community of the Father,

Son and Holy Spirit” (HCE, p. 9). They also invoke the theological virtues of faith, hope, and charity. For AOR, these virtues are not just piety or theological icing on the cake; they also include important methodological tools. The virtue of prudence, for example, is “faith in its practical aspect,” and includes



Prudence

conscience, informed consent, the principle of double effect, cooperation, and professional cooperation. The virtue of hope encompasses stewardship, inner freedom, and the idea of “personalized sexuality.” Christian charity (love) defines motivation, human dignity in community, participation, and the principle of totality and integrity. Finally, Jesus himself is the fullest example of human personhood.

Prudential Common usage of “prudence” suggests caution. In the virtue tradition derived from Aristotle and Aquinas, however, prudence means

bold deliberation and discernment. Prudence is rooted in freedom, autonomy, and creativity rather than mere obedience; it is intelligent rather than voluntaristic because it asks “why?” rather than merely “what?” The virtue of prudence requires perfection of multiple human abilities, including memory, imagination, foresight, counsel, firmness of purpose, and common sense.

The richness of the virtue of prudence is marvelously displayed in an allegorical sculpture of the virtue that appears on a tomb in the French Cathedral of Nantes. It portrays a prudence figure with two faces: On the front is a young beautiful woman meant to suggest youth and imagination; on the back is an old man with a long flowing beard, meant to suggest experience and memory. The young woman holds a mirror, which suggests self-reflection and the ability to learn from our mistakes.* Prudence is related to but distinct from conscience because it is a virtue rather than an ability, and because it provides continuity and consistency to the moral life.

Prudence is essentially the virtue of *knowing what ought to be done in this situation*. It asks, “How does this action *in its context* contribute to the growth of persons *in community*” (HCE p. 170, emphasis added).

SO WHAT? PRACTICAL IMPLICATIONS OF PRUDENTIAL PERSONALISM

Let me venture to suggest some of the most important implications that this theory has for Catholic health care today.

Virtue and Professional Character Until recently, “codes of ethics” in our culture have tended to be summaries of “what we usually do around here.”

Modern scandals have shown the inadequacy of this approach. As a result, there has been deeper reflection on ethics and on moral character. This is particularly important in health care, where the relationship between the patient and the health care provider is so intimate. “Personalism” refers not only to patients but to health care providers as well,

*A line drawing of this sculpture by Fr. Martin Erspamer, OSB, appears on this page. The original, in the Cathedral of Nantes, France, is one of four, each representing a cardinal virtue, that surround the tomb of Francis I, Duke of Brittany.

The fact that personalism has a supernatural dimension is the reason why excellent spiritual care is essential, and why we are not obliged to use every means possible to preserve physical life.

because providers must understand that their work involves not just technical skill but also certain qualities of character.⁷

The Patient in Community One of the key ideas in AOR's theory is that the person exists only in community. This means that even though patients have the primary responsibility for their own health care and for decisions about their treatment, these decisions can never be made in a vacuum. This is reflected in the possibility of durable power of attorney, in which one delegates one's own care to the prudential judgment of another. Patients should be encouraged to consider family and relational issues when they make choices about health care. A choice of several months of good health, without medical intervention, for example, can be perfectly legitimate from a moral perspective if it is made out of a concern for the experience of relationships with family, community, and God.

This notion of patient-in-community has implications for the allocation of health care, too. Although we correctly speak of "just allocation" of health care resources, this does not mean mathematical or absolute justice where every person receives exactly the same allotment. True justice must give "each his due," relative to the needs of the community. This means that, in some cases, we might legitimately choose to allocate more health care resources to one group of persons (e.g., children) than to another (the frail and elderly). These are difficult choices to make, but prudent decisions based on the presumption of "the person-in-society" require us to allocate goods on a proportional rather than an absolute basis.

The social nature of the human person also makes public health concerns at least as important as individual health care. Unfortunately, we often equate public health measures with government interference or high taxes; but if we believe that persons are essentially social, then public health concerns probably have a higher logical priority than individual health care. Health care in the United States is woefully lacking in the way it allocates resources to public health issues. A major public health crisis (e.g., a flu pandemic) would quickly show us that the boundary between public and private health concerns is far more permeable than we thought.

Prudence and Health Care Choices Moral norms are general and "for the most part," and, as Aristotle says, they fail the more one descends into detail. Prudence, on the other hand, is a virtue oriented to the particular, to judgments about specific cases here and now. It is the link between the general norm and the specific situation. This means two things.

First, those who have care for the welfare of all (including physicians) must be able to take general norms of justice and good health care and apply them prudently—that is, wisely—to specific cases.

Second, because prudence is specific and particular, it values maximum participation. Health care professionals should rarely make decisions for patients; their duty is to enable the patient's own prudence so that he or she can make health care decisions confidently and peacefully. Most health care decisions are based on uncertain facts and contingencies. Prudential judgment involves the ability to make a solid—if not absolutely certain—decision.

Person as Supernatural Mystery Science demands empirical verification. However, not all things can be scientifically verified, and not all outcomes are transparent. This is because there are certain unverifiable or mysterious dimensions to the person "fully and adequately" considered. The person is first of all a subject, not just a case study or a mass of tissue to be manipulated. The person described by AOR is a *living-breathing-thinking-feeling-intuiting-hoping-believing entity*. As such, he or she has multiple capacities and multiple needs including the hope of eternal life.

The fact that personalism has a supernatural dimension is the reason why excellent spiritual care is essential, and why we are not obliged to use every means possible to preserve physical life. We are created to "know, love and serve God in this world, and to be happy with Him *in the next*."^{*} This means that patients have the right to forgo even life-saving treatments when they judge

^{*} This deceptively simple statement from the *Baltimore Catechism* has profound eschatological implications. It says (in language a child can understand) that our physical life is important but not all-important. The reason we were created, in the last analysis, is to enjoy God's presence face to face.

that the treatment would impose more of a burden than a benefit and they make that judgment out of hope rather than despair.

AN INFLUENTIAL THINKER

Health care today is under enormous pressures. Economic pressure threatens research, allocation, and patient care itself. Technology drives advances but carries the risk of objectifying the patient and compromising patient autonomy. Law and politics, and especially the threat of litigation, affect medical judgments in ways that do not benefit the patient. The need for scientific objectivity can lead to a scientific reductionism that neglects the spiritual aspects of the person.

Prudential personalism is based on a solid and evolving understanding of the human person, and it draws on the full range of human decision-making capacity. It reminds us that health care has to be person-centered; that the person is a complex, social being with multiple needs; and that health care choices, even when made without the certainty one might like, *can* be made confidently and with hope.

It is possible that no one has influenced the shape of Catholic health care ethics in the last 50 years as much as Fr. Kevin O'Rourke and his colleagues. For his retrieval and application of the principles of prudential personalism, we owe him an enormous debt of gratitude. ■

NOTES

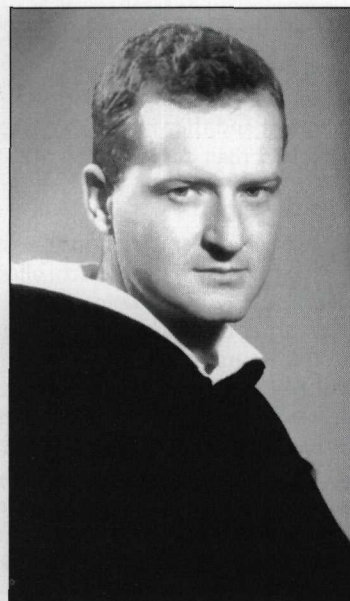
1. The first edition was published in 1978. The fifth edition, written by Frs. Ashley and O'Rourke and Sr. Jean deBlois, CSJ, PhD, RN, appeared in 2006.
2. See, for example, John Mahoney, *The Making of Moral*

Theology, Oxford University Press, New York City, 1987; and John Gallagher, *Time Present, Time Future*, Paulist Press, New York City, 1990. Their emphases vary, but they agree that the post-Tridentine period was marked by critical shifts of perspective that created a new discipline of "moral theology," which was distinct from spirituality.

3. See Mahoney, p. 27: "The place of confession in the development [of moral theology] has historically influenced the subject in three ways . . . a preoccupation with sin, a concentration on the individual, and an obsession with the law."
4. Mahoney, p. 31: This created "an approach to the moral life as discontinuous, 'freezing' the film in a jerky succession of individual 'stills' to be analyzed, and ignoring the plot."
5. Bernard Häring, *The Law of Christ: Moral Theology for Priests and Laity*, Edwin G. Kaiser, trans., Newman Press, Westminster, MD, 1961. In the preface to his manual of moral theology, the Dominican Dominic Prümmer noted that "previous manuals have been too concerned with casuistry" (*Manuale Theologiae Moralis*, Herder & Co., Friburgi Brisgoviae, 1935). In 1922, the Jesuit Arthur Vermeersch noted (in *Principes de Morale Sociale*, Action Populaire, Paris) that just as the church fathers had been concerned with revelation and the scholastics with the use of philosophy, so our age should be concerned with the insights of psychology. This was quite a revolutionary insight for the time.
6. See my article, "Recovering the Gifts of the Holy Spirit in Moral Theology" (*Theological Studies*, vol. 63, September 2002), which cites both scholarly works by Dominican moral theologians and popular works designed for high school and college students and well-informed Catholic laity.
7. AOR treat issues of professional character in Chapters four and five of *HCE* ("The Health Care Profession" and "Personalizing the Health Care Profession"). See also Edmund Pellegrino and David C. Thomasma, *The Virtues in Medical Practice*, Oxford University Press, New York City, 1993; and James F. Drane, *Becoming a Good Doctor: The Place of Virtue and Character in Medical Ethics*, Sheed and Ward, Kansas City, 1988. Drane cites virtues of benevolence, truthfulness, respect, justice, religion, and friendliness.



1978, with his sisters, Winnie, Mary, Noreen, Agnes, Kathleen, and Rita.



1954, ordination, Dominican Order of Preachers.



1978, five-year service award at CHA.

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