DEHUMANIZATION OF THE CLINICIAN AND THE DEMISE OF THE HEALING RELATIONSHIP*

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ABSTRACT

Professional literature in health care ethics today frequently reports discussions on the multiple variables that threaten the human dignity and vulnerability of the sick person. Unfortunately, little attention is given to understanding how human dignity of the clinician is threatened and violated in the current health care environment.

Today's technologically and economically-driven health care environment is influenced by moral relativism, reductionism, and a clinical focus on specialization, technology and disease rather than on the human person who is sick and in need of healing. The influence of these principles has led to the systemic violation of the dignity of the clinician (and ultimately that of persons who are sick), created moral distress among clinicians, and the collapse of the healing relationship. Guided by the Church's teaching these violations can be addressed and corrected by applying the Church's moral tradition in health care, by re-affirming the principle of human dignity as the moral center of the healing relationship between clinician and patients. This paper will propose three strategies directed toward reclaiming the dignity of the human person and the re-humanization of the clinician, namely, formation of the clinician, creation of moral communities for clinicians, and implementation of the Pellegrino healing relationship model in clinical practice.

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The problem in question is that of understanding what happens to human dignity in the process of technicalization to which man today is delivered.

MARCEL[1]

Introduction

In the public media and in the professional literature in health care ethics today are reports appearing with increasing frequency on the discussions on the multiple variables that threaten human dignity and vulnerability of all persons across the whole continuum of life from the unborn to those nearing the end of life. At the same time little attention is given to understanding how human dignity and ultimately human flourishing of the clinician is also threatened and violated in the current health care environment.

Today's health care environment is becoming increasing overwhelmed by moral relativism fueled by the collapse of the citadel of ethics and the erosion of a moral compass, high technology, financial algorithms, and the governmental encroachment on the free exercise of one's conscience rather than on the dignity of the human person who is suffering and sick and in need of healing. An informed review of the emerging regulations of the Patient Protection and Affordable Care Act, approved in January 2010, fraught with obligatory rules that violate the freedom of conscience, the exercise of religious liberties, the requirement for faith-based organizations to follow the law regardless of their mission, and the use of an Independent Payment Advisory Board (e.g. the Death Panel) are only a few of the threats to human dignity and the healing relationship now memorialized in this law. Ironically but unknown to most Americans, the ACA does not now nor was it ever intended to guarantee a basic level of health care for Americans.

The epidemic and exponential influence of these forces on the current health care delivery system has led to the systemic violation of the dignity of the clinician (and ultimately that of the sick person), created moral distress among clinicians, alienated persons from receiving needed care, oftentimes resulting in the collapse of the healing relationship. Guided by the teaching of the Catholic Church these violations can be addressed and corrected by applying the Church's moral tradition in health care and by reaffirming the principle of human dignity as the moral center of the healing relationship between the person who seeks hope and healing and the clinician who promises to care and to heal. This work, protecting human dignity and freedom of all persons, remains at the critical center of the Church's health care ministry and the New Evangelization.

To begin I will first offer an overview of the factors that I believe are contributing to the dehumanization of the clinician and threaten the integrity of the healing

[1] G. Marcel, *The Existential Background of Human Dignity* (Cambridge, Massachusetts: Harvard University Press, 1963): 158.

relationship. I will then propose three strategies for reclaiming the dignity of the human person and, ultimately, the re-humanization of the clinician. These strategies are (a) the formation of clinicians in the meaning of the human person; (b) the development of moral communities of clinicians; and (c) the use of the Pellegrino healing relationship model as the preferential option to assure faithfulness to patients, in clinical practice, to faithfulness of the promise made to the sick person, and ultimately to the Church's moral tradition in health care.

Throughout this presentation when I speak about the clinician, I wish to include the nurse, the physician, and all other members of the health professions who have the privilege to bring healing and hope to the sick. Women and men of these noble professions have promised to care and to heal; only they can enter into this privileged encounter, the healing relationship with the sick that are in search of healing and hope.

Dehumanization of the Clinician

Within the current health care system is the growing phenomenon of the dehumanization of the human person, at times referred to as the violation of human dignity, which has existed since time began. Dehumanization in health care has become the focus of attention particularly in the rapid evolution of health care services and hyper-specialization in technology, accelerating costs, new barriers to access for health services especially for the uninsured and underinsured, the evolution of a disease-centered health care system, the unequal distribution of health services especially for those who are voiceless: children, the ill who cannot afford to pay for care, the elderly, persons of color, and those persons marginalized by the stigma of their illness or life style. While it is beyond the scope of this paper to explore the full range of underpinnings of this growing global epidemic, we can say that dehumanization in health care is enveloping every aspect of human life - individuals, families, communities, political bodies, societies and cultures.[2,3,4,5]

Faces of dehumanization of the human person appear in different forms, for example, consumerism, commodification and fungeability of the human person as a disposable item, the uninsured, exposure of the sick to untoward risks in providing care in unsafe environments, severe shortages in nurse staffing and the growing presence of moral distress among clinicians.[6,7,8,9,10]

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[2] M. Pawlikoswki, "Dehumanization of Contemporary Medicine," Neuroendocrinology Letters 23. (2002): 5-7.

[3] J.R. Kriel, "Removing Medicine's Cartesian Mask: The Problem of Humanising Medical Education Part II. Journal of Biblical Ethics in Medicine 3, 3 (1990): 6-11.

[4] E.D. Pellegrino, "Managed Care at the Bedside: How Do We Look in the Moral Mirror? Kennedy Institute of Ethics Journal 7, 4 (1997): 321-330.

[5] R.M. Friedenberg, "Patient-Doctor Relationships," Radiology 226, (2003): 206-308.

[6] J.J. Fins, "Commercialism in the Clinic: Finding Balance in Medical Professionalism," Cambridge Quarterly of Healthcare Ethics 16, 4 (Fall, 2007): 425-432.

[7] J. Needleman, "A Philosopher's Reflection on Commercialism in Medicine," Cambridge Quarterly of Healthcare Ethics 16, 4 (Fall, 2007, 433-438.

[8] D.R. Hanna, " Moral Distress: The State of the Science," Research and Theory for Nursing Practice 18, 1(2004): 73-93.

The phenomenon of dehumanization is being fueled by an ethical paradigm called moral relativism that embraces a set of personal and subjective standards that are applied independently in each situation; reductionist thinking; radical objectification; and the disappearance or absence all together of a universal set of standards, moral norms or principles that are understood as being consistently good or evil regardless of circumstances. The prevailing ethical paradigm diminishes the intrinsic dignity of the human person, violates autonomy and freedom of conscience and the right to make informed choices grounded in the natural law and a moral code that affirms and protects this dignity.

The dehumanization of the clinician, a tragic outcome of moral relativism, occurs when the promise made to the person who is sick through a covenant of trust, the moral center of the healing relationship, has been ruptured, resulting in the collapse of this relationship where the patient and physician are then strangers to one another. With more than forty-five years of professional practice in nursing as a clinician, educator, administrator, researcher, and ethicist, I believe this rupture is the result of multiple causes, for example:

1. the relentless pursuit of technological competencies and the diminution of interpersonal communications, that threaten human caring and the promotion of human flourishing, the telos of human dignity;
2. curricula in health professions education programs that focus largely on the science and treatment of illness and disease and minimize the important value of interpersonal communications and the humanities in forming the whole person;
3. the market demands of the current health care system to produce quantifiable rather than qualitative outcomes at less cost;
4. expectations that espouse the commodification of the human person;
5. treating the sick as data cohorts in actuarial algorithms;
6. substandard environmental and unsafe workplace conditions, i.e. inadequate staffing, faulty and out-dated equipment, ill-defined standards of practice that compromise human flourishing and the provision safe and appropriate health care services;
7. treatment decisions that discriminate on the basis of age, color, culture, religious preferences, moral values, station in life, the ability to pay for services and disease states;
8. moral distress and moral malaise among clinicians that leads to addictions, depression, marital and family discord, emotional burnout, suicidal thoughts and behaviors, resignation and burnout;
9. inadequate formation of conscience, dubious informed consents, unreported clinical errors, accidents and deaths; and

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[9] B. Steiger, "Survey Results" Doctors Say Morale is Hurting," The PhysicianExecutive (November-December, 2006): 7-15.

[10] H.T. Englehardt, Jr. & F. Jotterand (Eds). E.D. Pellegrino, "Commodification of Medical and Health Care," *The Philosophy of Medicine Reborn: A Pellegrino Reader* (Notre Dame, Indiana: University of Notre Dame Press, 2008): 101-126.

10. questionable truth telling, deception, and risk of loss of employment as a result of reporting unethical practices.

Threats to the Integrity of the Healing Relationship

Access to health services today must first meet the means test of legitimate need that is largely determined by the insurance industry and legislative regulations rather than imminent human need and the assessment of a competent clinician committed to healing the whole person. Managed care, for example, itself morally neutral, is essentially managed cost and remains a constant and ominous threat to the integrity of the healing relationship. Pellegrino states:

> An inevitable outcome of managed care, profit taking or even cost containment, is the built-in discrimination against the poor, and those with the greatest needs who use up resources disproportionately, i.e. the elderly, the very young, the chronically ill. From a strictly business and profit making point of view they are undesirable enrollees whose number must be kept to a minimum, disenrolled or not enrolled at all. From the marketplace point of view, the desirable enrollee is the young person who never becomes ill, pays health insurance premiums faithfully and on time, and then dies in an auto accident without ever needing any care.[11]

The outcome of this corporate business model partitions the person into illness and problem-based categories and promotes the image of the sick as containers of disease rather than free persons capable of making reasoned choices based on a model that promotes and protects human dignity. At the same time it partitions the personhood of the clinician, the principle protector and advocate for the sick; enables this role as a technician rather than a healer - a caregiver of the whole experience of the human person who is sick and in search of hope and healing.

As a result, this partitioning militates against the moral center of health care, the personhood of both the one searching for healing and the other who promises to heal physically, spiritually and psychologically. This is dehumanization of both the person who is sick and the one who promises to heal. The effects of moral relativism in health care leave us with a profound dilemma of cosmic proportions: who do we, as individuals, as citizens, a society, as a world community, really care about? Are we willing to actively advocate for change that will ultimately protect the unwanted and the unloved in our midst?

Reclaiming the Dignity of the Human Person in Health Care

In response to the growing threats of dehumanization and the demise of the healing relationship, three integrated strategies are offered, namely: (a) the moral formation of the clinician; (b) the development of moral communities of clinicians; and

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[11] E.D. Pellegrino, "Ethical Issues in Managed Care: A Catholic Christian Perspective," Christian Bioethics 3, 1 (1997): 55-73.

(c) the implementation of the healing relationship model in clinical practice. These are by no means meant to be the exclusive responses to address the challenges facing all of humanity and its healthcare delivery system. These strategies however, grounded in the natural law, are linked with the centuries-old moral tradition of the Catholic Church, and offer the best hope to respond to the culture of moral relativism that, unless removed from our world's current practice and ethical frameworks, will see the continuing erosion of the doctrine of human dignity and the exercise of freedom of conscience which belongs to every person who has ever been born.

Formation of the Clinician

Pope Benedict XVI, at the time then Joseph Cardinal Ratzinger, while serving as Secretary for the Congregation of the Doctrine of the Faith, delivered a critical lecture to an assembly of Bishops attending the Tenth Bishops' Workshop sponsored by the National Catholic Bioethics Center on *Catholic Conscience: Foundation and Formation*. In summarizing the major themes of this presentation, Dr. John Haas, President of the Center, identified four critical factors required for moral actions that can neutralize the influence of moral relativism in health care. These factors are (a) the proper formation and exercise of conscience; (b) the shared experiences of the community of which one is a part; (c) reality itself and finally; and (d) what God has revealed of His will for us.[12]

Explicating the Church's moral tradition and the principles that guide ethical decision-making in health care for clinicians is essential. However, in the absence of a solid grounding in the philosophical, theological and anthropological understanding of what it means to be a human person and in the formation of conscience, the presentation of the Church's moral tradition in health care alone is not likely to provide an enduring foundation for clinicians to respond to the ever growing array of ethical issues which will continue to confront us in clinical practice.

Edmund D. Pellegrino, long an advocate for teaching humanities in clinical education programs, identifies the three central contributions of the humanities to medical education, "to free the mind, to free the imagination, and to enrich the experience of being human."[13] The formation of the clinician in the understanding of the human person is best placed early within the basic education program that leads to the first professional degree. In order to avoid the risk of compromising critical content and learning outcomes from which to build upon in later courses in the curriculum, instructional content should be presented in stand-alone courses rather than simply included as introductory units or as appendices of other courses. The authentic formation of the clinician further requires the achievement of learning outcomes that facilitate the integration of critical content into the very character and behaviors of clinicians.

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[12] J.M. Haas, "Forward in *On Conscience*, ed. Edward J. Furton (San Francisco: Ignatius Press, 2007): 3.

[13] H.T. Englehardt, Jr. & F. Jotterand (Eds). E.D. Pellegrino, "The Humanities in Medical Education," Care," in *The Philosophy of Medicine Reborn: A Pellegrino Reader* (Notre Dame, Indiana: University of Notre Dame Press, 2008): 340.

While there are several excellent certificate and degree-granting programs in Catholic health care ethics available, these programs sometimes presume that students come prepared with prior knowledge and a familiarity with the philosophy, theology, and anthropology of the human person and the natural law and then immediately begin the discussions of specific ethical dilemmas. Such a presumption places the uninformed clinician at risk in practicing in a health care system that is morally neutral or may well have ethical relativism or utilitarianism as its moral mission.

More often than not educational programs that prepare beginning clinicians as well as those available to the more experienced practitioners focus primarily on interventions of disease states of patients rather than first, about persons who are ill and in need of health care and treatment. These programs seldom address human dignity and personhood of the clinician. What is even more alarming are the findings that Haidet et al. discovered in their research that physician-patient relationships are not emphasized in medical schools. Students admitted to schools of medicine were found to be highly idealistic, initially, but the idealism declined after two to three years leaving students with a doctor-centered rather then a patient-centered paradigm for clinical practice.[14]

Without such preparation, clinicians can find themselves in very vulnerable and easily compromised positions with little or no support from their colleagues or health care administrators which then leads to moral distress, burn-out, abandoning the active practice of medicine or nursing for other positions in health care or leaving their practices all together. Schools of the health professions need to critically review their admission criteria, curricula, course and program outcomes and clinical competencies for graduates to determine how these programs ought to be revised to assure that strategies for protecting human dignity and freedom of both the patient and the clinician are well understood and embraced as a critical outcome of clinical practice. Admittedly, this will be an enormous challenge. It has and continues to be my experience that physicians, in far greater numbers than nurses, are more hesitant to acknowledge their own vulnerabilities and limitations or to recognize that there are some events in human life and health care for which there are no known answers this side of the Resurrection!

Response to Moral Relativism

At first glance, constructing a response to the culture of moral relativism seems daunting if not incomprehensible. The means to re-orient the current culture of death and, in some instances, indifferent disregard for the sick, to a culture that promotes life for all persons is grounded in the heart of the moral tradition of the Catholic Church. It must begin with the re-affirmation of the doctrine of human dignity. This doctrine can be found in the encyclicals and pastoral letters of the Popes, Vatican Dicasteries and Bishops' Conferences and more recently in the encyclical, *Evangelium Vitae*[15] and in the *Ethical and Religious Directives for Catholic Health Care Services*.[16]

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[14] P. Haidet, J.E. Dains, D.A. Paterniti, et al. "Medical Student Attitudes Toward the Doctor-Patient Relationship. Medical Education 36 (2002): 568-574.

[15] John Paul II, Encyclical Letter *Evangelium Vitae* (March 25, 25, 1995).

[16] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care*

In response to the address of John Paul II to *Participants in the International Congress on Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas*, I have written elsewhere that:

The Holy Father's position needs to be carefully, thoughtfully and thoroughly examined in light of continuing scientific discoveries in medicine and nursing so that the interaction between faith, moral reasoning, and science remains inseparable in protecting and defending the dignity of the human person especially when this person is made vulnerable due to illness or disability. It is this first principle of the Catholic moral tradition, that is, the protection of the dignity of the human person that must never violated or lost in the details of the clinical debates when determining care and treatment for the sick. The centuries-old doctrine of human dignity serves a uniquely dual role in health care: it provides the moral, ethical, scientific framework that guides critical analyses of clinical issues while at the same time remaining as the telos of medicine and health care.

Threaded through the Holy Father's statement is the persistent and constant theme that marked his pontificate, that is, the value and dignity intrinsic to every human person regardless of the circumstances of the person's life or the reason for illness. While the allocution is specifically directed toward the consideration of life-sustaining care and treatment of persons in persistent vegetative states, the document has a much wider and universal mission. It is explicitly calling all of us (ethicists, bishops and other clergy, physicians, nurses, ethics committees, families, and patients) entrusted with the serious moral responsibility (not simply a gentle reminder or admonition) to provide care and treatment for the sick with the understanding that no illness ever diminishes the intrinsic dignity and value of the human person. Regardless of the reason for his illness or his decisional capacity, a living person, as Pope John Paul II noted, is never less than fully human.[17]

The doctrine of human dignity and the centuries-old moral tradition of the Catholic Church remain the consistent foundation and benchmark for the moral re-construction of health care. The writings of Pope Benedict XVI indicate that much foundational work remains to be accomplished in providing the infrastructure for human dignity and human freedom to flourish in the current cultures of our global world. Such work is vitally important in the early educational formation of students, but especially in programs for the healing professions such as for physicians and nurses.

Dignity of the Person

Contributing to the advance of moral relativism and the dehumanization of the clinician is the absence of a well-developed understanding of the human person. Without this fundamental understanding, present and future applications of well-founded ethical

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Service (4th ed.). (Washington, DC: U.S. Conference of Catholic Bishops, 2001).

[17] I. Perkins, "The Dignity of the Person: A Colloquy on the Address of John Paul II to the Participants in the International Congress on Life-Sustaining Treatments and the Vegetative State: Scientific Advanced and Ethical Dilemmas" The National Catholic Bioethics Quarterly 4, 2 (Fall, 2004):455-456.

principles, grounded in the Church's rich moral tradition that guides clinical decisions in a rapidly evolving technologically advanced world, become weak, ineffective or are simply set aside.

In preparing for his pastoral visit to Bavaria, Germany in 2006, Pope Benedict XVI affirmed the importance of the need for continuing moral development when he stated:

> Progress becomes true progress only if it serves the human person and if the person grows not only in terms of his or her technical power, but also in terms of his or her moral awareness. I believe that the real problem of our historical moment lies in the imbalance between the incredibly fast growth of our technical power and that of our moral capacity, which has not grown in proportion. That is why the formation of the human person is the true recipe, the key to it all, I would say, that this is what the Church proposes. Briefly speaking, this formation has a dual dimension: of course, we have to learn, to acquire knowledge, ability, expertise, as they say. In this sense Europe and in the last decades America has done a lot, and that is important. But if we only teach know-how, if we only teach how to build and to use machines and how to use contraceptives, then we should not be surprised when we find ourselves facing wars and AIDS epidemics; we need two dimensions simultaneously: we need the formation of the heart, if I can express myself in this way, with which the human person acquires points of reference and learns how to use techniques correctly. And that is what we try to do. Throughout Africa and in many other countries in Asia, we have a vast network of every level of school where people can first of all learn, form a true conscience and acquire professional ability which gives them autonomy and freedom. Nevertheless, in these schools we try to form human beings capable of reconciliation, who know that we must build and not destroy, and who have necessary references to be able to live together.[18]

The specific details of a program of formation must first explicate the moral development of the human person and include for example, an understanding of the person endowed with freedom and an inner life capable of knowing and loving; the union of body and soul; the powers of the rational soul and its immortality; human passions and temperaments; complimentarity of the sexes; and the theology of the body.

Development of Moral Communities of Clinicians

The second strategy I propose for re-claiming the dignity of the human person and the re-humanization of the clinician is the development of supportive moral or intentional communities of clinicians. Often times, society holds clinicians in great positive regard, especially respectful of the knowledge and positive power they posses to bring healing and hope to the sick and dying. Clinicians, too, experience this sense of power and

[18] Benedict XVI. "Interview of the Holy Father in Preparation for the Upcoming Journey to Bavaria (August 5, 2006, http: www.vatican/va/holy_father/benedict_xvi/speechjes/2006/august/documents/ hf_benxvi_spe_20060805_intervista_en.html.

autonomy, yet they are also subject to being vulnerable when faced with ethical dilemmas for which easy solutions are elusive or unclear all together.

According to Haas, a unique component of Pope Benedict XVI's conceptual model is the value of the "shared experience of the community of which one is a part."[19] This component has significant importance for the moral development, continuing formation and clinical practice of clinicians in preventing and reducing moral distress and effectively promoting positive changes needed within the health care professions to re-claim human dignity as the first principle of health care. With the demands placed on clinicians in practice settings today, the unparalleled development in health care technology and the growing phenomenon of moral relativism in our culture, there is often little time to seriously reflect on the myriad of moral challenges that impact upon the practice of medicine and nursing.

What is proposed is the development of local support groups of clinicians who can form moral communities in order to provide immediate and continuing support, advice and counsel, for example, on urgent clinical issues in health care; on how to prevent and respond to moral distress in clinical practice; how to develop or re-establish moral courage when confronted with conflicting and difficult issues; and on the process for establishing and sustaining healing relationships with persons in need of health services.

Catholic health care organizations, (e.g. the Catholic Health Association of the United States; the Catholic Medical Association; and the National Association of Catholic Nurses) have demonstrated significant influence in re-shaping and effecting positive change in health systems, among third party payors, and in state and federal legislative initiatives, and raised the moral conscience on a myriad of issues. It is the clinician alone, however, who enters into the healing relationship with the sick person, not a health care organization, not a health care facility, not the hospital administrator, or the head of a group practice or the federal government. It is to the patient and then to the family that the clinician, in a covenantal relationship of trust, not a contractual one, who has promised to care and to heal.

Without any doubt, organizations hold an important value in advancing the moral mission of Catholic health care, but their structures do not always provide for ready availability, easy access and opportunities for a clinician who is faced with an emergent moral dilemma in practice. Without this type of support, the clinician often faces the ethical issue alone. Additionally, because the mission of the particular health care facility may be indifferent or not supportive of the moral tradition of the Catholic clinician or others of good will, access to the facility's ethics committee may not be an attractive or even a feasible option. The experience of being alone especially when human life hinges on the decisions of clinicians can lead to moral distress, insensitivity and numbness about the issues, surrender of one's own autonomy and freedom, compromising of care, and a rapid and sometime safe retreat into the role of a technician rather than that of a healer.

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[19] J.M. Haas, "Forward" *in On Conscience*, ed. Edward J. Furton (San Francisco: Ignatius Press, 1007):3

Gathering together clinicians who share a common commitment to the moral tradition of the Church and who possess a rich collection of narrative experiences that can be shared, provides the needed support of a community of faith where the presence of the *Digitus Dei* is ever in their midst. It in within this context and discourse where the moral tradition of the Church can be better understood and embraced by clinicians who wish to practice within the tradition of the Church. Forming moral communities of clinicians to provide the forum to address their common concerns, to support one another in their decisions in light of the teaching of the Church and to develop strategies that promote moral courage, especially in re-shaping the current tenets of the Affordable Care Act, when confronted with conflicting issues, is an example of where the Church is dynamically alive and effective in proclaiming its Gospel of healing. This is an excellent example of the vocation of the clinician.

Application of Pellegrino Healing Relationship Model

The third strategy is not new to medical practice, but the use of the Pellegrino healing relationship model offers what I believe is a theologically, philosophically, and anthropologically-grounded model which is highly congruent with the Church's moral tradition and its ministry in Catholic health care. Support for the healing relationship is to be found in the *Ethical and Religious Directives for Catholic Health Services* when it states:

> The Church's moral teaching on health care nurtures a truly interpersonal professional-patient relationship. This professional-patient relationship is never separated, then, from the Catholic identify of the health care institution. The faith that inspires Catholic health care guides medical decisions in ways that fully respect the dignity of the person and the relationship with the health care professional.[20]

The centerpiece of the relationship is covenant of trust, not a contract, between two persons, one person who is sick and searching for healing and hope and another person, the clinician, who has promised to care and to heal.

Developed by the noted physician and ethicist, Edmund Pellegrino,[21,22,23] the healing relationship is a dynamic interaction developed over time and involves two persons: one person, who is vulnerable, exploitable, suffering, and seeking help, and the other who offers to help and to heal. The outcome of the healing relationship is a good healing action that restores health and wholeness. This relationship consists of three integrated components.

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[20] Ethical and Religious Directives for Catholic Health Care Services (4th ed.): 18

[21] E.D. Pellegrino, "Toward a Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness," The Journal of Medicine and Philosophy 4, 1 (1979), 32-56.

[22] E.D. Pellegrino, "The Healing Relationship: The Architectonics of Clinical Medicine," in Earl E. Shelp, ed., *The Clinical Encounter: The Moral Fiber of the Patient-Physician Relationship* (Boston: D.Reidel Publishing Company, 1983), 153-172. .

[23] E.D.Pellegrino, "Toward a Virtue-Based Normative Ethics for the Health Professions," Kennedy Institute Of Ethics Journal 5.3. (September 1995):253-277.

The first component, the fact of illness, is the reality of the patient's experience of being sick. An assault on the person's integrity occurs in which the person recognizes that this change in physical or psychological health status makes it difficult of not impossible to pursue normal activities. The person experiencing the movement from wellness to illness, evidenced through pain, discomfort, anxiety or stress, comes to a conscious awareness that help is needed in order to regain or maintain health status. This change is both experiential and existential and places the person in a position of vulnerability and exploitability.

The second component, the promise to care**,** the moral center of the healing relationship, expressed by the person who has been called to heal, affirms the intrinsic and extrinsic dignity of the one who is suffering and in need of help. During the encounter between the one who is sick and the other who promises to care, the healing relationship is established through the words "how can I help you." By stating this simple, yet profound question, the healer freely enters into a helping relationship with the person who is sick. The clinician assures the sick person of a commitment to help and heal; that through the gift of his person, the clinician will use his knowledge and skills to the sick person's advantage. The clinician establishes a covenant of trust and assures the patient that he will not be abandoned during the course of his journey.

The third component, the act of healing, or the restoration to health, fully engages the sick person and the healer in the specific activities of the clinical encounter. Within this event, the commitment of the healer to actively engage in the act of healing, further helps achieve the ends of the healing relationship, that is, restoration to health, and when this is not possible, restoration to wholeness. The act of healing more concretely unites the healer with the sick person in the healing relationship.

Implementation of these three components of the healing relationship requires a calculus of moral values of the sick person and the one who cares for him. Of special importance is the responsibility of the healer to affirm the full personhood of the one who is sick, particularly in light of his degree of vulnerability and exploitability. Through this affirmation the personhood of both the one who is sick and the one called to heal and to care is enriched, blessed, and made whole.

The outcome of the healing relationship is the spiritual, psychological, and physical good of the person who has asked for healing, not just the biomedical good of the patient. In this relationship, the healer, bound to the sick person through beneficence and trust also experiences affirmation of his own personhood. He too may come to an experience of vulnerability, of suffering, and healing in this encounter. Not to have some experience with the pain and suffering of the sick person or to be unwilling to encounter the person in the fact of illness inhibits the development of the healing relationship and restricts it to a series of tasks and technical activities.

When healing or restoration to health is not possible, amelioration of suffering, adaptation, or coping with chronic or fatal illness become the ends of the healing relationship. In this relationship, the clinician, bound to the sick person in a profound and

interpersonal way, fulfills the "promise to care," the clinician's commitment to the inviolability of the healing relationship and the profundity of this promise in the character of the clinician.

It is the threat to the very integrity of the human person, the moral center of the healing relationship, which is of imminent concern as we discuss the dehumanization of the clinician in today's health care service systems in the United States. And the affirmation and protection of this vital moral center, the healing relationship between the one who is sick and dying and the one who has promised to heal and to care, requires the competence of a virtuous clinician; one who brings more than rules and duties to the clinical encounter; a clinician who is willing to offer the very best gifts to the care of the sick and dying, i.e. the fullness of the clinician's own personhood.

Health Care Services and a Preferential Option for the Human Person

Effecting global and systemic change to re-affirm the dignity and freedom of the human person and those who care for the sick necessitates a radical paradigm shift. The three strategies presented in this paper are offered from the optic of a clinician who has for many years worked at the bedside of the sick, the dying, and the unloved and those who care for them.

As clinicians committed to the Catholic health care ministry, we are the privileged inheritors of a centuries-old moral tradition which has proclaimed its historic commitment to the dignity and freedom of every person since the time Christ walked among lepers and the despised of his own time. The work of the initial and continuing formation of clinicians aimed at reaffirming their own human dignity and freedom, and that of those entrusted to their care, enhancing a healing relationship with the sick while working for positive change in health care systems, must engage a new propaedeutic if these efforts are to bear fruit and be sustained. This work is centered in the Church's teaching mission and the New Evangelization, not simply to teach but to proclaim Jesus Christ by one's words and actions, that is, to make oneself an instrument of his presence and action in the world.[24] Women and men who collaborate in the Church's healing ministry as clinicians are authentic ministers of the Gospel.[25]

The Catholic health care ministry is often the only one, but the authentic, voice speaking on behalf of the unborn, the sick, the dying, the abandoned, and those who care for them. It is a privileged ministry that is perpetually joined with the Church especially as it accomplishes its Christian vocation and its mission in responding to all persons who are unwanted and unloved, those brothers and sisters of ours who live in families, communities, societies and under oppressive situations that crucify humanity, in its flesh and in its unity.[26]

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[24] Congregation for the Doctrine of the Faith. *Doctrinal Note on Some Aspects of Evangelization (December3, 2007)*

[25] U.S. Conference of Catholic Bishops, "Co-Workers in the Vineyard of the Lord," (Washington: U.S. Conference of Catholic Bishops, 2005).

[26] T. Radcliffe, 'Sing a New Song: The Christian Vocation," (Springfield, Il: Templegate Publishers,

John Paul II's monumental encyclical, *Ex Corde Ecclesiae*, offers this challenge for clinicians in the Catholic health care ministry as we work with others to re-claim the dignity and freedom of the human person:

> It is essential that we be convinced of the priority of the ethical over the technical, primacy of the person over things, of the superiority of the spirit over matter. The cause of the human person will only be served if knowledge is joined to conscience. Men and women of science will truly aid humanity only if they preserve the sense of the transcendence of the human person over the world and of God over the human person.[27]

As I have written elsewhere:

> As a model of Christ's life and messenger of his words, the Catholic physician has been charged to embrace the promise to care that is an authentic encounter with Jesus Christ. The care of the sick, the highest form of the *Imitatio Dei*, when viewed in partnership with Jesus, the author of all life, is a very special aspect of the stewardship of creation because it cares for the summit of creation, human persons, nurturing the life that is in them, easing the pain that diminishes them, and accompanying them in their ultimate journey.[28]

Let us continue this noble work of caring for the masterpieces of God's creative act.

1999):242

[27] John Paul II, Apostolic Letter *Ex Corde Ecclesiae* (August 15, 1990): N. 18

[28] I. Perkins, "The Physician in the Moment of Grace," Ethics & Medics 33.9 (September 2008): 1-3.