

# Virtual Mentor

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## From the editor

### “I was ill and you cared for me.” Matthew 25:30

These words are inscribed upon the wall of the medical school at Loyola University Chicago and are among the first things a newly matriculated student sees upon entering a career in medicine. To those of us who are part of the Christian tradition, it is a call, a charge we take up to continue Jesus’ ministry to care for the human person. For those of other faiths, it is a no less powerful reminder that we are trained as physicians with the foremost task of caring for those made vulnerable by illness. It is also a reminder that, from its earliest inception, the Christian faith has participated in the care of the sick. This may be no more apparent than in Catholic health care’s presence within the United States. The Catholic health system is second only to the VA (Veteran Affairs) hospital system in scope of services provided by a single organization, comprising some 16 percent of national health care, admitting nearly 5.4 million patients each year and attending to over 15.9 million emergency department visits and 88 million outpatient visits [1].

The Roman Catholic tradition has not only engaged the medical community as a source for health care, it has also occupied the intellectual acumen of philosophers, humanists and policymakers who have sought to define the goals and role of medicine in society. Drawing upon a rich tradition dating from the eras of philosopher-theologians Augustine (430 AD) and Thomas Aquinas (1274 AD), the Church has long reflected systematically on medico-moral dilemmas. While perhaps first formalized in the 15th and 16th centuries by theologians such as Banez, deLugo and deVictoria, theological reflection on medicine came to its most intense stage during the 20th century under Pope Pius XII. At that time the Church initiated a concerted effort to publish a number of statements regarding various topics in medicine in response to the rapid advance of such medical technology as mechanical ventilators. This effort catalyzed an expansive discussion among theologians that has continued to this day and has formed the backbone for theological reflection in which the Roman Catholic tradition participates.

In this issue of *Virtual Mentor*, we continue the church’s long and vibrant engagement with the medical community. Much of the issue focuses on the beginning and end of life, points in time that often serve as flashpoints for examination of moral values and beliefs. From there the issue explores the church’s contribution to medicine by concentrating not on a small number of prohibitions but rather on the true center of Catholic health care and its basic principles: a promotion of the goods within the profession of medicine that encourage, develop and lead to

the fruition of human well-being and flourishing and promotion of the common good.

Seven basic moral principles guide Catholic teaching about the role of medicine. First and foremost is the *principle of the intrinsic dignity* of each individual who has been created in the image and likeness of God (Genesis 1:26). This principle recognizes the worth of the individual patient who, because of illness or injury, seeks the help of the physician. Second, the *principle of solidarity* points to the common good of society. The common good principle is opposed to the radical individualism now so prevalent in the United States. Solidarity insists that there is a mutuality and an ongoing tension between the individual and society, and it points to the fact that each person's well-being is somehow connected to that of all others in society.

The need to expand access to basic medical services has become, in the last century, a dominant theme of Catholic health care reform. The third moral principle—the *principle of beneficence*—demands that we distribute health care resources equitably, not only within our society but also globally. Fourth is the *principle of due proportion*, which is applied at both the macroallocation and microallocation levels. Macroallocation strives to determine what proportion of community resources should be reasonably expended on health care relative to expenditures for other basic common goods. Microallocation, on the other hand, seeks to take the resources that have been set aside for health care at the macroallocation level and distribute them reasonably and justly. Fifth, Catholic health care employs the *principle of advocacy* for social change that looks beyond aid to individuals and focuses on the services and structures of society's health care practice. The *principle of subsidiarity* demands that *only* as much uniformity, centralization and regulation be institutionalized as is required to provide for the common good in society. Finally, there is the *principle of the preferential option for the marginalized*. Catholic ethical thought and teaching has given special attention to this principle since the last century when the widening gap between the haves and the have-nots became framed as a social justice issue [2].

It is my hope as editor of this issue of *Virtual Mentor* to provide an introduction to these principles and illustrate many of the contributions the Roman Catholic tradition has made to the profession of medicine, the richness of those contributions and the deep commitment the tradition places upon faith in action in the world.

## References

1. The Catholic Health Association. *Catholic Health Care in the United States*. St. Louis, MO: The Catholic Health Association of the United States; January 2006. <http://www.chausa.org/NR/rdonlyres/68B7C0E5-F9AA-4106-B182-7DF0FC30A1CA/0/FACTSHEET.pdf>. Accessed April 25, 2007.
2. Glaser JW. Health care. In: Dwyer JA, Montgomery EL, eds. *The New Dictionary of Catholic Social Thought*. Collegeville, MN: The Liturgical Press; 1994:438-442.

*Ad Majorem Dei Gloriam.*

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