

Advocate Health - Midwest

SHARE @ Advocate Health - Midwest

Historical Documents - Combined

Advocate Health - Midwest History

Making the Rounds, 1995, V1 N7, December 4

Advocate Aurora Health

Follow this and additional works at: <https://institutionalrepository.aah.org/alldocuments>

MAKING THE ROUNDS

IN HEALTH,
FAITH,
& ETHICS

VOLUME 1, NUMBER 7

PUBLISHED SEMIMONTHLY BY THE PARK RIDGE CENTER

DECEMBER 4, 1995

Christ and Customers in Health Care and the Church

David B. McCurdy

In the 1980s American business rediscovered the customer. Through close attention and consistent response to customer needs and wants, businesses such as Federal Express, Wal-Mart, and the Disney theme parks reaped spectacular results, both on the bottom line and in the all-important arena of public image.

Today this renewed emphasis on customer satisfaction, sometimes known as "customer focus," pervades corporate America. Moreover, the customer-focus movement has spread far beyond the for-profit sector and the corporate ethos or culture. It affects other cultures, including those of health care and even the church.

Customer focus, though still relatively new to health care, is helping many providers improve their competitive position through careful and sophisticated attention to customer "needs" and customer satisfaction. Church-related health care organizations have participated in the customer-focus movement, and many are reaping the fruits of successful programs. Although insurers and managed-care organizations have become significant customers in their own right, the voice of the individual patient-customer is both valued and sought out in today's environment (Bruss 1995).

Not all who are involved with health care, especially church-related health care, are happy with customer language. Health care professionals often find the customer-focus language and approach offensive. Many also find it diametrically opposed to religiously grounded missions that purport to serve persons for reasons other than their potential to enhance the organization's profit.

It is also true, and to many just as regrettable, that the customer-satisfaction ethos has invaded the institutional church and its congregations. Churches, too, feel the need to compete in an increasingly crowded marketplace. Insofar as congregations view attracting people to church as a matter of competing for an audience's limited time and attention, they may adopt customer-focus thinking—especially if lay leaders work every day in a competitive, customer-oriented atmosphere. Mega-churches such as the 20,000-member Willow Creek Community Church in a suburb of Chicago provide examples both of the success of customer-responsive church marketing and of the sharp criticism that such success can evoke.

David B. McCurdy is Co-Director of Clinical Healthcare Ethics Support Services at the Park Ridge Center for the Study of Health, Faith, and Ethics, Chicago, Illinois.

It is time for the church and its affiliated health care organizations to ask directly: What are we to make, both practically and theologically, of viewing and treating people as customers? Is this practice just another manifestation of the corrupting power of market forces and American individualism? Or does it have redeeming features? Can people of faith and their institutions, including those in health care, learn something from the ideas behind it?

From a Christian perspective, it is easy to find fault with customer language and ideas. The customer mind-set appears to diminish persons in an inappropriate, even demeaning way: those who are marvelously created in God's image are reduced to their function as buyers of a product or service. When the profit motive enters in—and health care not-for-profits do seek financial security in order to sustain their mission—people ultimately become objects rather than ends in themselves. It can be argued that even the most genuine care masks the profit-seeking that lurks behind the customer service.

Moreover, by using customer language, even a not-for-profit organization implies that it is in fact a business. Many already suspect that health care has become a business, and health a commodity. Cynics have long leveled similar charges at churches and religion. Does not the adoption of customer language only serve to confirm such perceptions—and compromise the integrity of the church or health care organization's ostensible mission?

Finally, doesn't the advent of customer focus oblige hospitals and physicians, churches and pastors, to cater to their newly discovered customers? Don't these customers have a right to *demand* satisfaction—however arbitrary their demands—or take their "business" elsewhere?

In principle, "needs" are inexhaustible when defined from the point of view of the patient or congregant. Many church leaders today see a church populated with "adroit players in the consumer society" who feel free to "shop churches, habitually switch brands, and consume religious products" to meet their perceived needs (Nash 1994:15, 17).

And in health care, widely publicized new medical technologies and successful marketing strategies have created extravagant expectations among many patients. Many physicians and administrators fear a latter-day version of patient autonomy that insists on "customer choice" in treatment decisions even if the treatments sought are

(continued on page 5)

Them that has, has . . .

"The Clinton administration's health care proposal foundered in part over the president's insistence that any reform plan provide coverage for the uninsured, with the cost to be borne by taxpayers, businesses and insurance companies.

"None of the presidential candidates, including Clinton, has dared broach this controversial idea again, even as the old 'Robin Hood' system of paying for the care of the indigent—cost-shifting by hospitals onto patients with traditional insurance coverage—disintegrates with the rise of HMOs.

"Most of the presidential candidates aren't adversely affected by the [current] changes in the health-care industry.

"The four Republican senators in the race, for example, are covered by a federal employee health plan that during its open-enrollment period . . . will permit them to choose from a generous range of managed-care or traditional programs. The president is covered under the program as well, in addition to the care he receives from White House and military doctors."

("Quiet Revolution in Health Care," *Chicago Tribune*, 29 October 1995)

Hope from a wheelchair

In a sermon essay, Thomas W. Currie III celebrates the hope-filled life of a congregant who for years spent his days in a wheelchair because of chronic illness. "My friend was not waiting to walk again; he was not looking forward to that day when he could dance again to 'String of Pearls' or 'Tuxedo Junction.' If he had ever wished for that, his wish had died somewhere between the crutches and the wheelchair.

"No, what he was about was not wishing for what could never be, or even resigning himself to what he had lost, but hoping for more than he had ever known. Hope began for him in the wheelchair, not apart from that reality but embedded in it. That was where it began. Every day. It began with the all too vivid reminder that he could not *do* for himself, that he could not stand up, that he could not make things right."

Currie adds, "What happened to my friend was that he became a gift. In a way, it was terrible to behold. It included wheelchairs and medicines, frustration and weariness, all of which, for him, were a kind of dying. Just so, he made a good death. Just so, he was raised,

each day, to life, to be alive for others, to give his remarkable gift to them. He hoped for them. . . . His hope made us hopeful about ourselves, perhaps the hardest gift of all to receive and the easiest to dismiss as cheap."

(*Journal for Preachers*, Advent 1995)

Adding a voice to the conversation

Biologist Alvin Novick is concerned that the literature on physician-assisted death is written by "prosperous, functioning, life-joyous, non-suffering, intellectual professionals," such as physicians and ethicists, omitting the voices of dying and chronically suffering people with AIDS.

"We have chosen not to seek out, process, and understand the views of those who are dying or suffering and who choose to seek a peaceful and planned death. We don't hear them and we don't solicit their views—about their values, their lives, and their deaths. Is it too awkward? Is it irrelevant? What makes us the spokespersons? Where is the research?"

"Assisted death is probably fairly commonplace, even in our nation. People self-deliver; loved ones surely help. Physicians and nurses surely help. We all know that. Yet we have little research on that—largely because it's awkward to seek and collect data on stigmatized (and often illegal) behavior. If physicians assist their patients in death out of compassion, concern, and decency, we should know how and when and under what circumstances. What are the problems? What are the risks? What are the costs and benefits—including to the patients and their loved ones? If loved ones are assisting in death, what are the circumstances, the costs, the benefits, and the obstacles? How are they helped afterwards? What are their long-term burdens? Is it good?"

"If patients are assisting in their own deaths, should we not know more about how, why, and what their risks and benefits are? We know none of these things. . . .

"Our research has become too indoctrinated with a kind of professional distancing, posed and pretended, and self-conscious objectivity, and with looking at clients and subjects under a crude and unsatisfactory lens. We truly need to humanize our analyses by including clients and subjects, in particular because they are largely stigmatized, alienated, or patronized people whom we approach with disrespect."

(*Journal of Clinical Ethics*, Spring 1995)

Minnesota Medical Association opposes anencephalic organ donation

In an unusual move, the Minnesota Medical Association (MMA) has formally opposed a controversial opinion recently issued by the American Medical Association (AMA) that would allow the harvesting of organs from living anencephalic infants. (Anencephalic infants are those born without all or a major part of the brain and normally die within several days of birth.) Currently, "dead donor" laws in all 50 states prevent the use of anencephalic babies for this purpose. At MMA's annual meeting in September, its Council on Ethics and Medical-Legal Affairs unanimously voted to oppose the AMA's position, saying it "violates the prohibition against removal of organs from living persons" and would "undermine public confidence in the organ transplant system." The association then voted 93–80 to reject the AMA's position.

(*American Medical News*, 23–30 October 1995)

Reporting euthanasia

"Reported cases of euthanasia are increasing in the Netherlands, indicating growing openness and less fear among doctors who perform the procedure, experts say.

"The National Public Prosecutor's Office announced in its annual report that registered cases of euthanasia rose 9% to 1,439 in 1994 from 1,319 in 1993. . . .

"It's certain that they [doctors] are reporting more cases, but it's not sure that they are performing more euthanasia," said Juriaan Simonis, spokesman for the Prosecutor's Office. . . .

"Under the [government's] policy [adopted in June 1994], all mercy killings must be reported to authorities, and the practice can be carried out only at the informed and repeated request of patients who suffer unbearable, unrelenting pain. Physicians also must consult another physician before proceeding.

"Following those guidelines virtually assures physicians immunity from prosecution, since euthanasia is still technically a crime in the Netherlands. . . .

(*American Medical News*, 16 October 1995)

Editor **Martin E. Marty**
Associate Editor **Barbara Hofmaier**
Managing Editor **Sandy Pittman**
News Editor **Ann L. Rehfeldt**
Case Stories Editor **Arthur W. Frank**
Design/Production **Micah Marty**
Publisher **Laurence J. O'Connell**
Associate Publisher **John F. Taylor**

Making the Rounds in Health, Faith, and Ethics (ISSN #1082-1015) is published semimonthly, except monthly in July and August, for \$29.95 per year (\$40.00 for institutions) by the Park Ridge Center for the Study of Health, Faith, and Ethics, 211 E. Ontario, Suite 800, Chicago, Illinois 60611. Application to mail at second class is pending in Chicago, Illinois, and additional entry. POSTMASTER: Send address changes to *Making the Rounds*, The Park Ridge Center, 211 E. Ontario, Suite 800, Chicago, Illinois 60611, attention subscription fulfillment. © 1995 The Park Ridge Center, an affiliate of Advocate Health Care. Printed on recycled paper. TO SUBSCRIBE: send a check for \$29.95 per subscription (\$40.00 for institutions) per year (payable to the Park Ridge Center; please add \$20.00 per year for non-U.S. subscriptions) to the above address or call 312/266-2222 to order with Visa or MasterCard. Back issues are available for \$2.00 each (includes postage and handling).

Non-heart-beating Organ Donors: Are We Redefining Death Again?

Felicia Miedema

Kennedy Institute of Ethics Journal 3, no. 2 (June 1993), special issue: Ethical, Psychosocial, and Public Policy Implications of Procuring Organs from Non-Heart-Beating Cadavers (guest editors, Robert M. Arnold and Stuart J. Youngner).

Wolf, Zane Robinson. "Nurses' Responses to Organ Procurement from Nonheartbeating Cadaver Donors." *AORN [Association of Operating Room Nurses] Journal* 60 (December 1994): 968-81.

Youngner, Stuart J., and Robert M. Arnold. "Ethical, Psychosocial, and Public Policy Implications of Procuring Organs from Non-Heart-Beating Cadaver Donors." *Journal of the American Medical Association* 269 (1993): 2769-74.

In health care, challenging clinical situations arouse academic interest. The account that follows challenged a team of health care providers, an institutional ethics committee, and a duo of clinical ethics consultants to examine the literature on a debate that may herald a new era in organ transplantation.

John Maxwell (not the patient's real name) was 52 years old. He had a tenured position at a prestigious university, a wife of 27 years, and three children. His youngest had just begun his freshman year at Duke. A long-awaited second honeymoon was planned for January. Dr. Maxwell knew he had high blood pressure, but with medication the condition seemed to be under control. Then he had the stroke. His students said his speech had been a little garbled that day, almost two weeks ago, when he suddenly slumped over during a lecture. Now, out of the blue, the Maxwells' life has been turned inside out.

At this writing John Maxwell lies perilously close to death in the intensive care unit. Twelve days of aggressive treatment to reduce the swelling in his brain have yielded no improvement. Comatose and unresponsive to pain or noise, he lies still, dependent upon medical technology for breath and for sustenance. Even his blood pressure varies wildly because the necessary mechanisms in the brain have been damaged. The doctors predict that he will never recover. CT scans of his brain show that his brain structures have shifted violently in the confines of the skull. The resulting swelling has certainly caused irreparable damage. But John is not what we commonly refer to as "brain-dead."

John's family knows that he would not wish to live if he could not enjoy the independent life he was accustomed to. He left specific instructions when he named his wife as his health care agent that he was not to have his life prolonged artificially. Now, speaking for her husband, Mrs. Maxwell has requested that the ventilator be withdrawn. Her request seems reasonable to the team of physicians and nurses caring for John. It's her second request that challenges them:

Felicia Miedema, R.N., M.A., is a clinical ethics consultant at Lutheran General Hospital—Advocate Health Care, Park Ridge, Illinois.

she has asked that her husband's organs be donated to someone whose life may be saved as a result. This final act of giving would be what her husband would want. It would give some meaning to this tragedy.

John Maxwell is not a typical organ donor. Because his heart continues to beat and because he retains some brain function, albeit severely impaired, he cannot be declared dead. Potential organ donors are normally declared brain-dead when all function of the brain has irreversibly ceased. Such persons are medically and legally recognized to be dead. But relatively few patients ever meet the stringent criteria that determine brain death. Many more people are like John Maxwell, severely and permanently brain-injured. As the public becomes more aware of the need for organ donors, the options for creating advance directives, and the realities of life-support treatments, more requests like Mrs. Maxwell's can be expected. Many health care professionals, however, are uncomfortable with the issues that such requests raise.

When Christiaan Barnard performed the first transplantation of a human heart in 1967, the concept of brain death, or death by neurologic criteria, was only beginning to be accepted. This new distinction between death by neurologic criteria and more traditionally accepted methods of determining death by cardiac criteria thrust medicine, bioethics, and the law into a debate that ultimately led to the

Uniform Anatomical Gift Act; each set of criteria was recognized as sufficient to determine death. Since that time, until very recently, virtually all nonpaired, solid organs for transplantation have been obtained

When is it ethically and legally permissible to remove organs for transplantation?

from people who have been declared dead according to neurologic criteria. This pool of donors, however, has proven grossly insufficient to meet the increasing demands for organs. As transplantation technology advances, the gap between the supply of organs and the demand for organs enlarges. This growing need has led some transplantation centers to reconsider the nearly thirty-year-long practice of obtaining organs only from those patients who have been declared brain-dead.

In 1992, the University of Pittsburgh Medical Center (UPMC) adopted a policy that expanded the pool of potential organ donors to include patients for whom a decision had been made to withdraw life-sustaining medical treatment and who subsequently were declared dead according to cardiac criteria (DeVita and Snyder 1993). The policy, titled "Care of Terminally Ill Patients Who May Become Organ Donors after Death Following the Removal of Life Support," allows patients or their surrogates to forgo life-sustaining treatment and to elect to donate organs after their death. In cases in which death is expected immediately after the withdrawal of life support, the withdrawal can occur in the operating room; after two minutes of cardiac asystole (no heartbeat) or ventricular fibrillation (an erratic heart rhythm that produces no pulse), the organs will be surgically removed. This practice preserves the organs in a way that could not be accomplished if the patient were allowed to die and later transferred to the operating room for the removal of organs.

(continued on page 4)

(continued from page 3)

Similar policies have been adopted or are being considered elsewhere. Such policies have reopened the debate about when it is ethically and legally permissible to remove organs for transplantation. This debate is chronicled by the Working Group on Ethical, Psychosocial, and Public Policy Implications of Procuring Organs from Non-Heart-Beating Cadaver Donors in two publications. First, an article written by two of the working group members, Stuart Youngner and Robert Arnold (1993), and published in *JAMA* provides a succinct overview of the primary ethical, psychosocial, and public policy questions that arise in the debate about obtaining organs from non-heart-beating donors. Second, the June 1993 issue of the *Kennedy Institute of Ethics Journal* (KIEJ) provides several excellent papers by members of the working group which examine the host of ethical, legal, and public policy issues that surfaced in their deliberations. These works are "must-reads" for professionals involved in organ procurement, for members of ethics committees who may be considering a similar policy, or for clinicians who are caring for patients like John Maxwell.

Stuart Youngner and Robert Arnold discuss five primary ethical questions in non-heart-beating organ donation: Does this practice require a new or revised definition of death? Does the withdrawal of life support and immediate removal of organs constitute a "hastening" of death? Will potential organ donors receive less than optimal care? Is there a way adequately to protect patients from potential conflicts of interest on the part of their care providers? Is organ retrieval from non-heart-beating cadaver donors wise public policy? Each question is important to the development of ethically sound policies. Drs. Youngner and Arnold conclude that the practice supported by the UPMC policy "offers the promise of saving more lives and allowing more Americans to fulfill their wish to 'make a gift of life,'" but they urge caution in developing policies (p. 2773).

While Youngner and Arnold provide a middle-of-the-road conclusion, their article does not wholly reflect the broad range of opinions expressed in the above-cited issue of the *KIEJ*. David Cole, Tom Tomlinson, and Joanne Lynn each wrestle with the question, Are these patients really dead? The prohibition against taking nonduplicate organs from living persons has been—and remains—foundational to transplantation ethics. The Pittsburgh protocol recognizes that death has occurred after two minutes of asystole or ventricular fibrillation. Each author explores whether such patients are dead according to currently accepted definitions of death. Interestingly, Cole argues that these patients are not legally dead because of the statutory definitions requiring that the condition be "irreversible" but that they meet commonly accepted notions of death and are, therefore, dead. The legal requirement is flawed, Cole maintains, because it is inconsistent with "ordinary concepts" of human death. These "ordinary" notions rely on the criterion of the "loss of capacity for auto-resuscitation" but do not exclude the possibility that death could be reversed by means of "extraordinary therapeutic procedures."

**The terms nurses use to describe death—
"brain dead, dead-dead, living dead,
newly dead, and nearly dead"—
illustrate the confusion that surrounds
non-heart-beating cadaver organ donation.**

Tomlinson agrees with Cole's conclusions, but not with his reasoning. For Tomlinson, irreversibility of death does not necessarily mean that resuscitation is impossible. Although resuscitation of these donors may be possible at some point past two minutes after withdrawal of life support, "medical means for reversing . . . cardiopulmonary arrest are no longer ethically significant possibilities [and would be an] ethically objectionable [violation of the donor's wishes]" (p. 162). Therefore, these patients are irreversibly dead because it would be unethical to undertake resuscitative measures.

By contrast, Joanne Lynn raises significant concerns about the requirement that only two minutes elapse before a declaration of death is made. The determination of death, states Lynn, can occur only after "a period of increasing probability that the person is dead" (p. 168). Although Lynn does not propose a specific period of time, she expresses concern that two minutes may be insufficient in some cases and that the current policy "might allow taking organs from persons who are not dead" (p. 177).

Articles in the same *KIEJ* issue by Byers Shaw, Joel Frader, and James

Burdick examine what appears to be an inevitable conflict of interests. Each author notes that particularly in transplant centers the pressure for organs may influence those who care for terminally ill or severely brain-injured patients. When a patient awaiting an organ may be only a few feet away from the patient who is a potential organ donor, the tension may be overwhelming to caregivers. Separating the clinicians who care for the potential organ donor prior to death from the transplant team and from the clinicians who care for the recipient may seem sufficient, but the reality of clinical life makes such separations artificial at best. The solution, according to Shaw, is to enlist the help of arbitrators in each potential non-heart-beating cadaver donor case. Frader and Burdick suggest that, in order to avoid these inevitable tensions, such protocols be implemented only at institutions that do not have transplant programs. Each author believes that procedural safeguards can be implemented that will protect both those patients who need organs and those dying patients who may provide them.

Perhaps the most provocative piece in the collection is Renée Fox's "An Ignoble Form of Cannibalism." Fox describes the Pittsburgh policy as "border[ing] on ghoulishness," neither "medically acceptable" nor "morally permissible" (p. 232). Such protocols, claims Fox, are based upon the false (or at best unsubstantiated) premise that transplantation is an "unconditionally good way of sustaining lives; [and] that the more organs proffered, procured, and transplanted, the better" (p. 232). She criticizes the policy for "subject[ing] patient/donors to inhumane and irreverent deaths, increas[ing] the suffering of their families, and expos[ing] the nursing and medical personnel involved to new forms of emotional and existential strain" (p. 234). Fox proposes a reexamination of the ethical integrity of transplantation technology.

Companion pieces by John Robertson and Arthur Caplan examine the public policy implications of allowing procurement of organs from non-heart-beating cadavers and question whether such practices might further erode the public trust in the medical profes-

sions.¹ Robertson favors a trial period during which perceptions of patients, families, caregivers, and the public are analyzed. Caplan encourages widespread professional and public dialogue before sweeping changes in practice are implemented.

The articles highlighted here are but a representative sampling of the thoughtful papers compiled in this issue of the *Kennedy Institute of Ethics Journal*. The entire issue is an indispensable resource for the clinician and scholar alike.

The reader should not, however, miss a related article by Zane Robinson Wolf that appeared in the December 1994 issue of *AORN Journal*, the journal of the Association of Operating Room Nurses. Wolf studied the responses of nurses who provided care to non-heart-beating cadavers during the process of patient preparation and procurement of organs. Their stories provide the needed slap in the face to those of us who attempt to consider these difficult issues without ever participating in the care of these patients or in the procedures performed on them. Their emotions, ranging from acceptance to horror, underscore the complexity of this issue. Many nurses in this study found it emotionally difficult to care for patients who came under the non-heart-beating cadaver organ donor protocol. Perioperative nurses viewed the practice as "aggravating already difficult situations," and one nurse was quoted as saying "If I wanted to kill people, I wouldn't have gone into nursing" (p. 974). Much of the emotional difficulty surrounded the distinction between the "brain dead patients whose bodies remained as living shells" and "sentient, functioning patients" who were to be taken off of life-support equipment so that their organs could be removed. Wolf cites the plethora of terms nurses used to describe death—"brain dead, dead-dead, living dead, newly dead, and nearly dead"—as illustrations of the confusion that surrounds non-heart-beating cadaver organ donation.

While protocols like that adopted by the University of Pittsburgh Medical Center raise a host of ethical questions and are unlikely alone to solve the organ shortage, patients like John Maxwell aren't going away, either. Intensive work at personal, professional,

institutional, and societal levels will be required before widely accepted policies can be adopted. The sources discussed herein provide a solid foundation for that work. □

NOTE

1. This is not an unfounded fear, as an article in the 14 June 1995 *Chicago Tribune* illustrates; see Cindy Schreuder, "Demand for organ transplants puts medicine under microscope: Doctors are redrawing line between life and death."

REFERENCES

- Burdick, James F. 1993. "Potential Conflicts of Interest Generated by the Use of Non-Heart-Beating Cadavers." *KIEJ* 3, no. 2 (June): 199-202.
- Caplan, Arthur L. 1993. "The Telltale Heart: Public Policy and the Utilization of Non-Heart-Beating Donors." *KIEJ* 3, no. 2 (June): 251-62.
- Cole, David. 1993. "Statutory Definitions of Death and the Management of Terminally Ill Patients Who May Become Organ Donors after Death." *KIEJ* 3, no. 2 (June): 145-55.
- DeVita, Michael A., and James V. Snyder. 1993. "Development of the University of Pittsburgh Medical Center Policy for the Care of Terminally Ill Patients Who May Become Organ Donors after Death Following the Removal of Life Support." *KIEJ* 3, no. 2 (June): 131-43.
- Fox, Renée C. 1993. "An Ignoble Form of Cannibalism: Reflections on the Pittsburgh Protocol for Procuring Organs from Non-Heart-Beating Cadavers." *KIEJ* 3, no. 2 (June): 231-39.
- Frader, Joel. 1993. "Non-Heart-Beating Organ Donation: Personal and Institutional Conflicts of Interest." *KIEJ* 3, no. 2 (June): 189-98.
- Lynn, Joanne. 1993. "Are the Patients Who Become Organ Donors under the Pittsburgh Protocol for 'Non-Heart-Beating Donors' Really Dead?" *KIEJ* 3, no. 2 (June): 167-78.
- Robertson, John A. 1993. "Policy Issues in a Non-Heart-Beating Donor Protocol." *KIEJ* 3, no. 2 (June): 241-50.
- Shaw, Byers W., Jr. 1993. "Conflict of Interest in the Procurement of Organs from Cadavers Following Withdrawal of Life Support." *KIEJ* 3, no. 2 (June): 179-87.
- Tomlinson, Tom. 1993. "The Irreversibility of Death: Reply to Cole." *KIEJ* 3, no. 2 (June): 157-65.

Christ and Customers (continued from page 1)

medically ill advised and would squander expensive resources. Controversial—and costly—cases in which distraught family members insist on treatments judged futile or nonbeneficial by physicians highlight the practical problems created by this version of needs-as-claims. Clearly, not all wants are needs, and not all needs may claim equal priority.

While such objections to customer thinking must be taken seriously, customer focus should not be summarily dismissed. Even if its origin lies in the world of business and the profit motive, customer focus has borne valuable fruit in the form of more dignified and respectful treatment of persons—a value that health care and the church have always claimed as one of their own.

Businesses that thoroughly implement customer-focus ideas and methods display a heightened sensitivity to persons and their distinctive needs. Initial efforts to infuse a customer-focus mentality into health care organizations have shown similar results in an arena where patient complaints about service and entrenched attitudes are legion.

To be sure, customer talk is not the native tongue of the health

care and church communities, nor should it become the preferred language of either. Both communities can—and do—raise significant objections to the customer-focus approach and language. Such language has overtones of greed, disguised self-interest, and a reduction of relationships to transactions. But can customer terminology be employed selectively as a complement to such terms as *patient*, *congregant*, or *parishioner* and the approaches they imply?

As theologian Allen Verhey has noted, the church's formative story is that of the "covenanted community," not that of the marketplace (Verhey 1994:77). To deny normative status to customer-focused thinking need not, however, deny a legitimate if limited place to customer focus as a *tool*.

One may of course still object that it is not possible to serve God and mammon, that a customer mind-set inevitably evokes the greed and competitiveness of the business world. In this regard an analogy from the ministry of the apostle Paul may be apropos. In his letter to the Philippians, Paul alleges that some who evangelize are in fact competitively motivated by "envy and rivalry," "selfish ambition,"

(continued on page 6)

(continued from page 5)

and a desire to cause Paul pain through their success. Paul concludes, however, that what really matters is "that Christ is proclaimed in every way, whether out of false motives or true" (Philippians 1:18 New Revised Standard Version).

Following Paul's lead, perhaps we can judge customer focus not primarily by its roots but rather by its fruits. Ironically, current experience in health care suggests that the customer-focus approach, for all its suspect origins and questionable motivations, has had greater success in humanizing the care of persons than previous attempts by health care professionals and churches presumably driven by purer motives and higher ideals.

When hospitalized people were simply patients, for example, they were usually at the mercy of routines that served the convenience of physicians, other staff members, and institutional departments. If a patient voiced frustration about such routines, the typical response was that things "had to" be done "this way." When, in some hospitals, "patients" became "customers" and their in-depth feedback was actively solicited and taken seriously, old and seemingly intractable ways of doing things became amenable to change.

Indeed, it is not clear that the customer-focus mentality is wholly foreign to the Christian tradition. It may be that even God "caters" to customers on occasion. When, after the flight from Egypt, the Israelites complained of the lack of bread and meat, God responded by providing quails for the evening meal and manna for breakfast the next morning (Exodus 16). God also used the occasion to press another agenda (testing and molding Israel's faith), but the fact remains that God heard the complaint and responded with dispatch to the need expressed.

More broadly, at the heart of Christian theology is the theme of divine condescension, God's accommodation to the needs of human creatures. God's righteousness is demonstrated not by an unyielding requirement that humans accommodate to God's law—even when they have agreed to do so—but rather by God's own willingness to accommodate to human need by assuming our flesh and experiencing human neediness from the inside.

Of course God is not exclusively in the needs-meeting business. On Mount Carmel, God responded to Elijah's lament by giving him new marching orders and largely dismissing his complaint (1 Kings 19:13–18). In the Gospels, Jesus laid down the law, albeit in love, to a wealthy seeker (Mark 10:17–22). Nevertheless the existence of contrary motifs in the biblical witness neither detracts from the gracious responses of God and Jesus to many human needs nor invalidates appeals to scriptural themes akin to customer focus.

A business-style emphasis on "meeting customer needs" may seem a far cry from God's response to our deepest human needs. Even so, customer focus has the dual virtue of recognizing that persons are significantly defined by their needs and seeking to understand those needs from the customer's point of view. As a tool, customer focus may be of service in various efforts to address human needs, including the kinds of needs that the church and church-related health care have traditionally sought to meet.

If meeting customer needs recalls significant themes in the Christian tradition, customer-focus approaches to those needs have their own scriptural parallels. One strategy of the customer-focus approach is to *listen* to the customer, indeed, to "saturate your company with the voice of the customer" (Whiteley 1991:15). Through interviews, focus groups, and surveys, an organization can develop an

in-depth, indeed empathic, understanding of customers' experience and thereby respond more effectively to their needs.

Jesus "had compassion" for the crowds who came to see him when he discerned that they were "harassed and helpless, like sheep without a shepherd" (Matthew 9:36 NRSV). By paying empathic attention to his "customers"—truly listening to them—Jesus was able to identify and meet their deepest needs. He understood them better than they understood themselves—an aim of "listening to customers" in Richard Whiteley's "customer driven company" (1991). Today health care organizations and professionals are rediscovering that such listening works: patients and families who feel truly "heard" express gratitude—and often surprise—along with a desire to return to the same provider in the future.

The organization that listens attentively to its customers is also in a position to follow another customer-focus maxim: "*Anticipate customer needs.*" By listening to customers, it can prepare itself to meet future needs. In the midst of his healing activity, Jesus alertly anticipated the crowd's need for food on their long journey home and saw to it, despite his disciples' demurs, that the need was met (Mark 8:1–4).

Even in business relationships, customers who experience an empathic anticipation of their needs feel cared for. They discover an unexpected hospitality that transcends the financial basis of the business being transacted. How much more, especially in church-related health care and in the church itself, should "cus-

tomers" be able to report similar experiences of surprising hospitality? How often, by contrast, do patients in hospitals or parishioners in churches feel misunderstood, unheard, or "taken for granted"?

Indeed, the latter question highlights a most significant *ethical* impact of renewed customer thinking, both in the corporate sector and elsewhere: the potential of a customer focus to restructure power relationships and thereby increase justice. To view people as customers is to recognize that they have freedom of choice and can indeed take their business elsewhere. Thus, customer focus (especially when coupled with customer self-awareness) can serve to *empower* the person-customer and create a more equal—and just—footing in the relationship in which care or service occurs.

In health care, the rise of patient autonomy as an ethical priority has coincided with physicians' and hospitals' recognition that old, paternalistic, or institution-centered ways of treating patients alienate these customers—some of whom do change providers. Customer language can reinforce this move away from paternalism on the part of providers. *Patient* suggests one who suffers whatever befalls him or her, one who is done to. *Customer* suggests one who has power, both the power to say "no" and the power to go elsewhere. A customer is not required to suffer whatever a physician or an institutional system chooses to offer—let alone dictate.

Some question the use of customer language because it appears to deny the distinctive nature of the physician-patient relationship. In law this relationship is often described as a "fiduciary" one; that is, the fiduciary's knowledge and power are to be used in the best interest of the recipient of services. Lacking the fiduciary's specialized knowledge, the service recipient is often deemed incapable of evaluating the fiduciary's performance of this responsibility (Rodwin 1995). If this assumption—one held by many physicians—is granted in medical care, patients, understood as customers, are really at the mercy of the physician-fiduciary's beneficence and trustworthiness. The most suitable customer maxim in that case might be "let the buyer beware."

How much can the church— and its affiliated health care organizations— adopt the market's ideas and methods and still remain faithful to Christ?

Moreover, only a few legal structures actually exist which enforce or otherwise support physician accountability (Rodwin 1995). In their absence, the question of how to secure such accountability arises. A careful application of customer-focus methods to physician-patient relationships might fill part of the accountability gap through direct feedback from patients. Studies show that, far from being irrelevant to an assessment of treatment effectiveness, patients' relational experience of the physician's care and competence during treatment correlates significantly with the extent to which they experience healing (Press, Ganey, and Malone 1991).

In the church, to advocate viewing persons as customers is to court the presumed dangers of the consumer mentality among those laity who equate their expectations with needs. Here, however, the church's tradition may serve both to correct and to augment the customer approach and its understanding of needs. For it is one thing to listen to those customers who are adept advocates of their own religious needs; it is quite another to extend the notion of customers to include—and even favor—those who lack the assertiveness, articulateness, or clout of skilled consumers.

As a successor to biblical communities exhorted to care for the poor, the widow, and the stranger, the church should count among its customers those who are in the minority or at the margin. Depending on the congregation, such customers may include the elderly, singles, mothers of young children, and individuals and families struggling with mental illness, grief, abuse, or job loss—not to mention members of ethnically, racially, and economically disfranchised minorities. Churches might even identify members of these groups as “preferred customers” in their congregations. Congregations that recognize such preferred customers and their needs as a priority could serve as a model for faith-based health care systems.

One might argue that members of marginalized groups do not fit the customer definition precisely because, in their disfranchisement, they are unlikely to leave their congregational home or to have financial resources that would be missed if they did so. In this respect they resemble the nonpaying customers of health care who are often seen only as a drain on resources.

If a church ignores these customers, however, it violates biblical mandates regarding justice and mutual love. It may also be that those who speak softly and complain seldom need especially to be invited into full customer participation. Whiteley notes that many business customers have complaints but few express them. They find voicing complaints difficult, feel pushy or awkward about speaking up, or simply feel that complaining “won’t do any good” (Whiteley 1991:48). The church—or the health care provider—that takes the trouble to encourage its dissatisfied customers to speak will probably hear more criticisms but may, paradoxically, attract greater loyalty in the process.

Whatever its drawbacks, the customer-focus approach has much to commend it, both to the church and to its affiliated health care organizations. It offers terminology, attitudes, maxims, and methods that can help organizations to carry out their mission more faithfully and, indeed, more justly and lovingly.

Even a qualified recommendation of customer-focus language and approaches will still be greeted with suspicion in some quarters, both in the church and in health care. In health care it is widely feared—not without reason—that the encroachments of the managed-care market will create intolerable conflicts of loyalty and interest for

physicians and provider organizations. Customer talk may appear to be just another unwelcome example of this encroachment.

The church, historically, has always harbored fears that the seductions of culture will undermine the purity of its faith. Today many Christians fear the seemingly irresistible and often subtle attractions of secular market forces. How much can the church—and its affiliated health care organizations—adopt the market's ideas and methods and still remain faithful to Christ? Might not such borrowing create H. Richard Niebuhr's “Christ of culture,” a Christ tailored to the needs of the market culture—and a *church* of culture as well (Niebuhr 1951)?

Such a fear is healthy if it leads the church continually to evaluate its use of cultural tools, including customer focus, in light of its core commitments and Niebuhr's own call to follow a Christ who *transforms* culture. At the same time, it is good to recall that the church has always borrowed from culture, and has often been sustained, even renewed, by such borrowing. Nevertheless, the aversion to bringing the business culture's ideas and practices into the church can be deep-seated.

If customer-focus ideas can serve the cause of justice, love, and healing, dare we object too loudly to their cultural and conceptual family tree?

This aversion may be not only moral but aesthetic—and prejudicial. To some, concepts drawn from business smack of all that is morally objectionable in market capitalism. This perspective conveniently ignores the fact that all our endeavors, both in health care and in the church, take place in the context of one economic system or another. We do not keep

our hands clean simply by pretending that money does not pass through them.

Business-derived concepts may also, by virtue of their source, be deemed shallow and simplistic. They may fall prey to a professional, ecclesiastical, or theological conceit that, a priori, finds little to be learned from such a source. One may wonder, however, whether this disdain conceals an underlying fear: that we in the church or in health care might learn something valuable from this “unworthy” source—and be forced to acknowledge that we need to change.

Humility is, in fact, a condition—and a product—of genuinely adopting customer-focus ideas and methods. When listening to customers helps organizations learn how their customers actually perceive them, it promotes a salutary humility. “To see ourselves as others see us . . . is to have a moral experience,” as H. Richard Niebuhr puts it (1941:84–85).

Such a “moral experience” is, of course, not always welcome. Many in business (and, more recently, in health care) have learned, not without chagrin, that in-depth customer feedback punctures cherished assumptions about how an organization can best serve its publics. Moreover, “new occasions teach new duties”: inviting customer feedback creates an obligation to respond to what customers say they really want and need.

Upon first receiving customer feedback, health care professionals often report that they are moved to work harder at patient relationships and especially at listening to patients. Customer focus thereby heightens accountability, as customers learn that they may legitimately expect more than in the past.

But change is seldom accomplished without resistance. Even apparent good intentions can serve as a defense against change. “Almost everyone who works in health care is motivated by genuine humanitarian concern; almost everyone wants to believe, therefore, that problems must lie elsewhere” than in one's own caregiving. As a

(continued on page 8)

In this issue: Christ and Customers in Health Care and the Church

(continued from page 7)

result, providers have been "understandably reluctant to seek out information that might suggest otherwise," and, at least until recently, patients were "rarely" asked for their views on how to improve care (Gerteis et al. 1993:2, 6). Similarly, those in the church who already define themselves as "servants" may be reluctant to hear information suggesting that their efforts have been misdirected. The challenge, in customer-focus terms, is to "add value for customers"—value that meets real, felt customer needs.

Mark's Gospel portrays the resistance of the disciples to Jesus' version of customer focus. When Jesus voices concern for the hungry crowd, the disciples—no doubt wearied by other labors for the mission—reply that resources to meet the needs of "these people" (Mark 8:4 NRSV) simply aren't available. In another instance, the disciples realize that the crowds will soon be hungry, and they ask Jesus to send the crowds away to forage for food (6:35–36). The disciples do "anticipate customer needs"—and seek to avoid dealing with them! When Jesus suggests that *they* provide food, the disciples resist further; they cite not only a lack of funds but also the inconvenience of having to go shopping (6:37).

Jesus nonetheless keeps prodding his followers to add value for customers by finding creative ways to use their human and material resources and by trusting that the Spirit will both guide and provide. Jesus' challenge to the disciples is not unlike the challenge facing the church and its related health care organizations today: to reduce the discrepancy between what people actually "want and need" and the

services that we "can or will provide" (Gerteis et al. 1993:6).

In light of such a significant challenge, both to health care providers and to the church, any resource with known potential to help deserves a fair trial. Jesus told his followers how to test the legitimacy of those who claimed to be prophets: "You will know them by their fruits" (Matthew 7:16 NRSV). We should apply similar criteria to customer language and methods even as we make judicious use of them in health care and in the church. After all, if customer-focus ideas can serve the cause of justice, love, and healing, dare we object too loudly to their cultural and conceptual family tree? □

REFERENCES

- Bruss, Jon. 1995. Personal conversation, 31 October.
Gerteis, Margaret, et al. 1993. "What Patients Really Want." *Health Management Quarterly* 15, no. 3: 2–6.
Nash, Laura L. 1994. "Mallway to Heaven? Religious Choice among Baby Boomers." *Christian Century*, 5–12 January, 15–18.
Niebuhr, H. Richard. 1941. *The Meaning of Revelation*. New York: Macmillan.
———. 1951. *Christ and Culture*. New York: Harper and Row.
Press, Irwin, Rodney F. Ganey, and Mary P. Malone. 1991. "Satisfied Patients Can Spell Financial Well-Being." *Healthcare Financial Management* 45, no. 2: 34–42.
Rodwin, Marc A. 1995. "Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System." *American Journal of Law and Medicine* 21:241–57.
Verhey, Allen D. 1994. "The Health Security Act: Policy and Story." *Christian Century*, 26 January, 74–77.
Whiteley, Richard C. 1991. *The Customer Driven Company*. New York: Addison-Wesley.