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## How Does the Healthcare Professional Determine the Breadth and Depth of Healthcare to Provide to Patients?: The Personal Exploration of a Future Healthcare Professional

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**How Does the Healthcare Professional Determine the Breadth and Depth of Healthcare to Provide to Patients?: The Personal Exploration of a Future Healthcare Professional**

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Honors 490

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## **Introduction: Purpose of the Paper**

Today's workers in the medical field may have one of numerous roles. From house keepers, nurse aides, EMTs, nurses, physical therapists, physicians and more, each profession requires different technical skills and knowledge. However, when asked what they do for work, they may all answer that they provide healthcare. But what exactly is 'healthcare?' And how does each medical professional determine the level of 'healthcare' they should provide patients? Before answering this question, we first need to define the term 'healthcare', as well as discuss some of the set boundaries and conditions the healthcare professional must navigate within when determining the breadth and depth of care to provide to patients.

So, what is 'healthcare?' When defining what healthcare is, we must first understand that the definition of any word or concept is, to an extent, built within the framework of a society's construction of the term and dependent upon its community's values and perceptions of reality (Pellegrino et al., 2000, p. 78). Meaning, what 'healthcare' or any other term is to one culture or group of people may differ from another society's definition and understanding. For example, what the definition and meaning of 'God' holds for a Muslim, Hindu, Buddhist, Christian or Atheist will differ based on each group's values and perceptions of reality.

That is not to say that a definition of healthcare independent of society's influences does not exist, or that there is no absolute reality, some essential end intrinsic to healthcare that if captured in words, would be its truest definition. Rather, as described by Robert Veatch:

A realist account of social construction holds that although there is one reality out there to be described, human capacities for observation and human language permit an unlimited number of correct partial descriptions (as well as many clearly incorrect descriptions that conflict with reality). Each culture may emphasize different aspects of

the reality being described and use concepts available to that culture to attempt to convey the account of the reality being described. (Pellegrino et al. (2000, p. 80)

All of this is to say that the definitions and reasonings in this paper are very much colored by the author's values and perceptions of reality, and the answers sought here are first and foremost motivated by the author's desire to determine what their role as a future medical professional may require of them.

That is not to say that objectivity will be completely abandoned in this paper, and therefore whatever is contained within will not be useful or should be dismissed. I make no claim that the answers derived here perfectly capture any underlying reality or the full scope of the different aspects relating to the question of: how does each medical professional determine the level of 'healthcare' they should provide patients? I acknowledge that the answers arrived at, and points discussed in this paper draw from my own viewpoint, values, and understanding within the society I live. Therefore, they do not encompass all perspectives or points of discussion that could be covered when discussing the role of healthcare professionals in providing healthcare to patients.

However, within the limited scope of this paper, I hope that the answers formulated here will capture at least a partial description of reality. Additionally, through my exploration of the role of healthcare professionals in determining the level of healthcare to provide to patients, I hope to arrive at an answer that will help direct me in my future role as a medical professional, and help others still outside the medical profession, to better understand the complexities of the healthcare professional-patient relationship.

## Section 1: Defining Healthcare

So let us begin with the task of defining healthcare, before attempting to analyze factors which influence the healthcare professionals' provision of healthcare. According to the Merriam Webster dictionary, healthcare is defined as “efforts made to maintain or restore physical, mental, or emotional well-being, especially by trained and licensed professionals” (“Definition of Health Care,” 2023). Within this definition, it seems that anyone making an effort to restore or maintain the health (physical, mental, or emotional well-being) of an individual is engaging in healthcare, or rather, care for health. The healthcare professional is then one who is especially trained or licensed to care for the health of patients. However, this definition is by no means exhaustive, and parts certainly are ambiguous. Is the health of an individual limited to physical, mental, and emotional wellbeing? What is contained within the phrasing of ‘efforts made’, and how does the healthcare professional determine the depth and breadth of these efforts to ‘care’?

To help answer these questions, it is wise to turn to those who have greater medical experience than I, as well as those who have already devoted great thought to answering these questions. Two of these respected authorities are Edmund D. Pellegrino, M.D., and Robert Veatch.

Dr. Pellegrino is a deeply and widely regarded role model, whose interests ranged from bioethics to education, who helped formulate the role of humanities in medical education, in addition to receiving the first Lifetime Achievement Award from the newly constituted American Society of Bioethics and Humanities. As described in Pellegrino et al. (2000, p. 75), his thoughts on various perspectives have proved invaluable in helping form the field of bioethics and our understanding today of the healer's role.

Robert M. Veatch, who came after Pellegrino to the field of medical ethics and held him in high esteem, has restructured some of Pellegrino's views, in addition to trying to develop them further (Pellegrino et al., 2000, p. 75).

As described by Robert Veatch, Edmund Pellegrino's own definition of healthcare was considered vague in some respects:

Consider Pellegrino's formulation: the end of medicine is to meet the needs of the individual patient - that is, to cure, care, help, and heal. Each of these terms is terribly ambiguous. In fact, they are so ambiguous that a physician might have almost no idea what is called for from the bare terms standing by themselves. (Pellegrino et al., 2000, p. 82)

In the end of Veatch's analysis of social construction and Pellegrino's beliefs on the ends of medicine, he concludes:

It seems that Pellegrino should be saying that it is impossible to know the norms, ends, and morality for the practice of medicine until one turns to standards external to medicine, to one's religious or philosophical system of belief and value. (Pellegrino et al., 2000, p. 84)

I take this to mean that what is encompassed in 'health' and interpreted from 'efforts made' will therefore again be different for each individual and shaped by one's worldview. Whether the definitions and meanings derived from one's core beliefs are actually a reflection of reality is a different matter. However, the fact remains, a worldview is required to clarify ambiguous terms' meanings:

To know what counts as medicine, one has to know what counts as curing, caring, and so forth-but to know these things, one must move beyond medical knowledge and medicine.

One must move to some integrated worldview that includes within it an understanding of the ends of life. (Pellegrino et al., 2000, p. 83)

Personally, I hold to a Christian belief system, so according to Veatch's analysis, this is the standard external to medicine I should turn to in order to clarify any ambiguous terms when seeking to ascribe meaning and value to 'health,' and 'efforts made'.

## **Health**

Many experts and theorists of bioethics have provided a range of definitions of what is encompassed within the term 'health'. For example, G. Kevin Donovan (G. Kevin Donovan, M.D., M.A., assumed the directorship of the Center for Clinical Bioethics in 2012, succeeding his mentor, Dr. Edmund Pellegrino (*Georgetown University Faculty Directory*, n.d.)) paints a picture of what is encompassed by the term 'health' through describing his ideal of healing for the patient:

The patient wants healing-but healing means more than a physical cure. The state of illness also inflicts psychological, social, and even spiritual challenges to the ill individual. To heal is to become whole again and to return as far as possible to what one considers a normal life. Ideally, healing involves a cure, but when a cure is not possible, it still involves restoring function, maintaining function, or, at the very least, regaining the sense of balance and the integration of meaning and living. (Pellegrino et al., 2000, p. 16)

This definition uses the phrasing 'to become whole again' and lists the physical, psychological, social, and spiritual as areas the healthcare professional might encounter when seeking to provide healthcare to the patient.

Other definitions of health may only focus on the physical needs of the patient as the area of concern of the healthcare professional. Still others may include more than the physical as considerations the healthcare professional needs to be aware of when seeking to treat patients, but place the greatest emphasis on the physical, or weigh certain aspects of what they determine is included in the term 'health' over others.

For example, a healthcare professional may choose to focus on administering a vaccine to a child, as it has to do with the physical, but fail to address the mother's worry about the risks of vaccination. While these considerations may extend beyond the physical, and even beyond the immediate patient, the impact they can have on the child could be significant. If the healthcare professional fails to address the concerns of the mother, should she leave and her child experience a reaction (or what the mother perceives as a reaction), she may not decide to continue with vaccines in the future.

What I am trying to get at is that while a healthcare professional might correctly focus on the physical health of their patients, I believe excluding other considerations from the term 'health' would be to the detriment of the patient, and not an accurate reflection of reality:

In the real world of judging, the attempt to focus on only one evaluation area and exclude others is neither entirely possible or entirely desirable... even if it were possible to make a measurement really within one particular evaluative area, the result would be disconnected not only from the world in which we must live in to which the ethical question of how we ought to act must ultimately address itself, but also from the essential features of the problem itself. (Pellegrino et al., 2000, p. 212)

While utilizing reason, and relying on objective data and facts to make a decision of action to treat the physical needs of a patient, may be valuable (Pellegrino et al., 2000, p. 211) and the



highest ideal for some (Pellegrino et al., 2000, p. 216), the reality is that human beings (both the medical professional and the patient, whatever their religious convictions or lack thereof) are more than purely physical beings affected only by reason (Pellegrino et al., 2000, p. 212). So, to attempt to help the patient become ‘whole again,’ I believe one must necessarily treat more than the physical (Pellegrino et al., 2000, p. 212).

While the term ‘whole again’ is very vague and still remains ambiguous, thinking about what one might consider a whole individual to be, I believe a definition of ‘health’ needs to be ambiguous. If healing seeks to make an individual whole again and restore or maintain what one considers normal life, then it needs to be broad if it is to try and encompass the human experience of life and what is considered a life of meaning. Therefore, I would define health as: the state or condition of an individual (physical, psychological, spiritual, emotional, social, etc.), which includes all aspects that affect an individual's ability to function and maintain what the individual considers to be a normal life of meaning.

This may complicate things, as the healthcare professional and patient may have different views of what a life of meaning, and therefore health, and the efforts or care required of the healthcare professional, on behalf of their patient, entails. That is not to say that a healthcare professional should seek to be all things to all people. There are certainly other considerations and limits on the healthcare professional's ability to provide healing to the health of a patient. Although one's religious views (or lack thereof) will most certainly inform what meaning one gives to any term, what is practically included under the healthcare professionals’ purview in terms of a patient's health, I posit would and should also be informed by other considerations. In part, I claim these considerations include established boundaries and conditions the healthcare professional works within.

## **Section 2: Factors Determining the Aspects of a Patient's Health that the Healthcare Professional May Access**

So how may the healthcare professional determine what is under their purview in terms of a patient's health? The healthcare professional can to an extent answer this question by practically examining how established boundaries, and conditions, help inform the limits of a patient's health that the healthcare professional may access within their role as a healthcare professional. To clarify, by aspects of a patient's health, I am referring to the areas contributing to their sense of wholeness, that the healthcare professional may access and provide care for.

### **Boundaries**

To begin, let us examine some boundaries that help determine the aspects of a patient's health that the healthcare professional is responsible for and may access. These boundaries include, but are by no means limited to, scope of practice, scope of experience, and the healthcare professional-patient relationship.

### ***Scope of Practice***

When determining what aspects of a patient's health the healthcare professional may ethically access and be responsible for, “Additional moral direction for health professionals and scientists comes through the public policy process, which includes regulations and guidelines promulgated by governmental bodies” (Johns, 2022, p. 9). As discussed by Fremgen (2019, p. 64), one such guideline, as determined by governmental bodies, is the scope of practice of a healthcare professional. Scope of practice is important for every healthcare professional to understand and work within, as it is the definition given by each state of the activities the healthcare professional is allowed to legally perform as indicated in their licensure, certification, and/or training. This is significant, as it is illegal to access aspects of a patient's health outside

one's scope of practice. To do so may also put the patient's health at risk, as it exceeds the bounds of what the healthcare professional has received appropriate training for (Fremgen, 2019, p. 64).

For example, a medical assistant's (MA) scope of practice in Washington state includes duties delegated by, and under the supervision of, a health care practitioner (*Chapter 18.360 RCW: MEDICAL ASSISTANTS*, n.d.). These duties mainly consist of tasks such as:

Measuring and recording vital signs; administering subcutaneous, intradermal, or intramuscular injections; venipuncture; educating and providing instructions to the patients; removing sutures from minor cuts; wound dressing; disinfecting treatment sites; preparing patients for examination; administering medications and administrative tasks (like billing, booking appointments, checkouts, insurance, routine follow-ups, etc.).

(*Chapter 18.360 RCW: MEDICAL ASSISTANTS*, n.d.)

This means that if an MA in Washington state tried to prescribe medications, they would be accessing aspects of a patient's health outside their scope of practice, and therefore be performing an illegal action that they may be held liable for.

In addition to prevention of liability, it is important not to exceed one's scope of practice in order to protect a patient's health. For example, an MA prescribing medication puts the patient's health at risk, as it exceeds the bounds of what they have received appropriate training for. This could lead to the MA mistakenly prescribing a harmful medication or failing to give proper instructions on its use, resulting in harm to the patient. This harm caused by the MA exceeding their scope is significant, as it would tempt the violation of non-maleficence (do no harm), one of the key principles of healthcare (Beauchamp & Childress, 2019, p. 155).

Therefore, for the protection of both healthcare professionals and patients, respecting the boundaries defined by the legal scope of practice of each healthcare profession is a critically

important way for the healthcare professional to determine what aspects of a patient's health they can safely access and are responsible for.

### *Scope of Experience*

Just as the healthcare professional should not perform duties outside their scope of practice, for many of the same reasons, they should not practice outside the scope of their experience. 'Experience' can have several meanings, but here I am referencing experience in terms of the skills and reasoning acquired from experiential learning (Pellegrino et al., 2000, p. 55). Experiential learning requires both an event and reflection of said event. Meaning, for experiential learning to occur, the healthcare professional must both undergo an event, and reflect upon that event and themselves with learning intent (Johns, 2022, p. 6).

If experiential learning only occurs due to reflection on past actions and events, then whatever past actions and events the healthcare professional has undergone necessarily determines their scope of experience. This scope of experience can then be used to inform the healthcare professional of what actions they can reasonably and safely take to care for the patient's health.

For example, a physician who has performed appendectomies (surgical removal of the appendix) several dozen times successfully can reasonably determine (provided there are no unusual circumstances), that it is well within their scope of experience to perform the same procedure again on a patient safely. However, if a physician has never performed the surgery before, then their performing the surgery presents a higher risk to the patient's health than if they had greater experience. This higher risk may then suggest the physician should not perform the procedure. However, failure to perform the surgery due to inexperience also risks the patient's health. While inexperienced action may cause harm, so may inaction.

This presents a bit of a quandary. If experience guides a healthcare professional's current actions but can only be gained by necessarily undergoing an action or event for the first time, then to create one's scope of experience is to also necessarily risk stepping outside of it. So then how does the healthcare professional determine when and how far they should expand their scope of experience?

For one, while the scope of experience of a healthcare professional may not always be clearly defined or rigid, its boundaries may not exceed those of scope of practice. Meaning, when developing one's scope of experience, the healthcare professional cannot step farther than their scope of practice, as this would invite legal consequences and compromise patient safety.

Secondly, the question of when the healthcare professional should seek to expand their scope of experience is not so easily answered with, 'they should never do so' (one could even make the claim of the impossibility of never gaining new experiences). While it may be tempting to say that the healthcare professional should always remain within their current scope of experience to prevent any possibility of harm, to step outside of one's experience does not always unnecessarily risk a patient's health. In fact, it is necessary to incur some risk to become an experienced healthcare professional:

No physician starts out knowing how to do a new procedure. From the early days as a medical student, each must start from the bottom of the learning curve for customary procedures, and all physicians must start over when new techniques are introduced into the practice. (Pellegrino et al., 2000, p. 21)

However, to seek to expand one's experience without regard to how this inexperience may risk harm would be akin to a person who does not know how to swim, attempting to rescue someone who is drowning (Pellegrino et al., 2000, p. 44). To attempt a procedure outside one's scope of

experience, without any caution, would be an endeavor with a high likelihood of failure and harm to everyone involved. However, one should also consider that if the healthcare professional does not learn to swim, they will never become an expert swimmer. Why be concerned with becoming a more experienced healthcare professional? Because without expansion of the experience of healthcare professionals, healthcare professionals would be limited in their usefulness to their patients.

So, to completely stay within one's scope of experience would also prevent the gain of skills and reasoning necessary for the care of a patient's health (Pellegrino et al., 2000, p. 55). However, to expand scope of experience without regard to scope of practice and other considerations would also be going too far. So how does the healthcare professional determine whether they can safely and should expand their scope of experience? Furthermore, how does the healthcare professional use such a movable boundary as scope of experience, as a guideline for what aspects of a patient's health they can access? To know whether aspects of a patient's health are beyond their scope of experience, or beyond the safe expansion of their scope of experience, the healthcare professional must use the process of reflection necessary to experiential learning (Johns, 2022, p. 6).

There are many ways to think of reflection and how one may practice it. However, the highest and most critical form of reflection a healthcare professional can attain uses an ontological approach of *being* reflective (concerned with 'who I am' rather than 'what I do') (Johns, 2022, p. 6). This is different from the simpler and perhaps more commonly thought of epistemological approach of *doing* reflection (to use it as a tool or device), involving looking back on an experience after the event with learning intent. The key distinction between the two

involves the additional reflection on self within the context of the event, regarding what you were trying to achieve:

Hence reflection can be viewed as a mirror to see images or impressions of self thrown back in the context of the particular situation. It is thinking deeply about the way the practitioner responded and reasons for that response in light of what they were trying to achieve. (Johns, 2022, p. 3)

Why be concerned with this distinction involving reflection on self? Because in order to think about the way one does things, one must necessarily involve themselves, who are to think about things in the first place (Johns, 2022, p. 6). The healthcare professional cannot determine whether they should intentionally expand their scope of experience, if they do not have a goal they are trying to achieve and are not aware of where they themselves stand regarding that goal.

For example, if it is the goal of the healthcare professional to restore a patient's health through a certain action, and upon reflection, they determine based on past experience that the next step they wish to take is achievable, and towards their goal, then through using reflection they have reflected on past events and their own vision as to whether and how they should proceed:

Reflexivity is the practitioner 'looking back' to plot their transformation towards realizing their vision of desirable practice. Such transformation is evidenced through a chain of experiences whereby one link of the chain leaves a thread that is picked up and developed by the next link. (Johns, 2022, p. 16)

Past experience through reflection informs the healthcare professional whether their desire to take certain actions outside their scope of past experience is towards their goals of desirable practice. Granted, each healthcare professional's goals of desirable practice will differ, if only

because their differing standards external to medicine (worldview) will ascribe varying meanings and value to anything not clearly defined. For example, a healthcare professional may determine not to learn or use a new technique outside their scope of experience (such as abortion), because doing so goes against their standards external to medicine and their vision of practice (Fremgen, 2019, p. 281).

That is not to say that it is only the healthcare professionals' vision of desirable practice realized through reflection, that is the only factor which guides them in their actions and whether they expand their scope of experience or take a certain action. The healthcare professional must also consider the needs and vision of their patient if they are to practice medicine ethically (Beauchamp & Childress, 2019, p. 182):

The idea of person-centered practice is loaded with cultural significance for both the person and the healthcare practitioner. It demands a working with approach that is culturally aware, sensitive, and safe. (Fremgen, 2019, p. 9)

This vision that a patient holds regarding their health, and the boundaries they set within the healthcare professional-patient relationship, is another guiding force regarding what aspects of and actions on behalf of a patient's vision of their health that the healthcare professional may take.

### ***Healthcare Professional-Patient Relationship***

There are many considerations in the healthcare professional-patient relationship, which may affect what aspects of a patient's health the healthcare professional may access, too many to cover in this paper. However, to understand the patient's power in setting boundaries regarding the aspects of their health healthcare professionals can access, one should understand the basics of a key principle of medicine, that of patient autonomy (Beauchamp & Childress, 2019, p. 13).



Respect for autonomy is a pivotal moral principle in medicine and is a norm of respecting and supporting a patient's autonomous decisions (Beauchamp & Childress, 2019, p. 13).

Essentially, autonomy refers to the individual's ability to act freely in accordance with a self chosen plan, or ability of self rule or self governance (Beauchamp & Childress, 2019, p. 99).

This self chosen plan, regarding the vision that a patient has of their health, is something that, if it became a contest between differing visions of the healthcare professional and patient, would subsume the healthcare professional's vision of the patient's health (Pellegrino et al., 2000, p. 16).

This is due to several preexisting factors inherent to the healthcare professional-patient relationship, which places greater responsibility on the ethical healthcare professional, to put the patients' needs above their own:

We must first acknowledge that the normal relationship is not balanced, and it is this inherent imbalance that places additional obligations on the position, legally and morally... This healing relationship must balance self-interest against self-effacement, and the balance must tilt in favor of the patient. (Pellegrino et al., 2000, p. 18)

This inherent imbalance in the relationship is primarily caused by the vulnerability which results from the patient's illness, in addition to the greater technical medical knowledge of the healthcare professional (Pellegrino et al., 2000, p. 18). These imbalances require a response from the healthcare professional and create and place moral obligations on the healthcare professional to give primacy to the patient (Pellegrino et al., 2000, p. 16, 18). Meaning, ultimately, the patient has the final say whether to proceed with certain treatments or allow the healthcare professional access to aspects of their health (Beauchamp & Childress, 2019, p. 113):

For example, if the physician recommends a certain treatment out of various options, the patient may choose none of the treatments, may choose a treatment other than what the physician

primarily recommends, or in fact may choose another physician. The only exception to a patient's right of autonomy is when a court of law deems the patient incompetent to make decisions on their own behalf and to provide for their own needs and protection (Fremgen, 2019, pp. 99, 182).

In cases where the patient is deemed incompetent, the healthcare professional relies on the designated healthcare power of attorney (HPOA) (Fremgen, 2019, p. 108). The HPOA is an agent or proxy designated by the patient to act on their behalf regarding their health (Fremgen, 2019, p. 108). The HPOA then relies on their personal knowledge of the patient or the patient's advance directive (written living will) to make decisions on behalf of the patient if they become incompetent (Fremgen, 2019, p. 321). In these ways, even when a patient is deemed incompetent, the patient's autonomy and vision for their health are followed as closely as possible through the substituted healthcare professional-HPOA relationship (Fremgen, 2019, p. 321). Although the healthcare professional may act as a steward for the patient's health using their own vision of best practice, ultimately the patient's right of autonomy will hold the greatest weight due to the virtuous healthcare professional seeking the good of the patient even at the expense of their personal preferences (Pellegrino et al., 2000, p. 20).

That is not to say that the healthcare professional is a complete servant to all of the patient's wishes, or that all responsibility for the patient's health is placed upon the patient. While the patient cannot be forced to act (unless in certain circumstances where the patient's competence or ability to make certain decisions is in question (Fremgen, 2019, p. 182)), and so does hold some responsibility to follow the healthcare professional's recommendations for treatment (Pellegrino et al., 2000, p. 19), neither can they be completely independent of the healthcare professional's guidance. Without the complicity of healthcare professionals, the

patient cannot receive treatment for good or for ill (Pellegrino et al., 2000, p. 18). Ultimately, the healthcare professional holds responsibility for the patient's health and to profess their vision for it, while also holding a moral responsibility to work as best as possible with the patient towards their vision of health:

Medical decision-making is not simply technical; it must encompass moral components as well. A scientifically correct diagnosis or choice of therapy must be aligned with decisions made for the patient's good. This good is not self-evident; it is subject to definition and negotiation by the patient. (Pellegrino et al., 2000, p. 18)

Ideally, it is not just the healthcare professional who is always submitting to the patient's vision of health. The best outcome occurs when the healthcare professional's authority and the patient's autonomy are compatible, and the vision of the patient's health is shared and worked toward by both the healthcare professional and the patient (Beauchamp & Childress, 2019, p. 104).

The beneficent relationship, grounded in trust, allows for negotiation and rests on the concept of treating the whole person, including the patient's needs and values *as defined by the patient*. This concept avoids paternalism by combining a principle of beneficence with respect for the patient's autonomy. *Beneficence-in-trust* means that physicians and patients hold in trust the goal of acting in the best interests of one another in the relationship. (Pellegrino et al., 2000, p. 20)

In this way, patient autonomy and the healthcare professionals' obligation to respect this autonomy, in addition to each one's best interests, guide the actions and aspects of a patient's health the healthcare professional seeks to access.

## **Conditions**

While there are boundaries that guide the different aspects of a patient's health that the healthcare professional can access, there are also conditions that predetermine whether the healthcare professional *can* access, or *responsibly can* access aspects of the patient's health. By responsibly, I am referring to the healthcare professional accessing aspects of a patient's health, only if they have predetermined that doing so under current conditions will provide the greatest available benefit and least harm possible to the patient's health. Such conditions which predetermine the healthcare professionals' ability to access or responsibly access aspects of a patient's health involve both patient circumstances and the resources of the healthcare professionals.

### ***Patient Circumstances***

To begin, let us first discuss conditions that predetermine whether the healthcare professional *can* access aspects of a patient's health. For, we must first understand factors which deny even the option of access, before discussing whether aspects of a patient's health can be responsibly accessed by the healthcare professional. Such conditions which deny the possibility of access to a patient's health are patient circumstances. Although there are many other patient circumstances which prevent healthcare access, some examples are patient insurance coverage, and access to healthcare professionals.

Insurance coverage is a significant factor in patients able to afford needed healthcare services and medications as about 1 in 10 people in the United States don't have health insurance or a primary care provider, preventing various aspects of their health from being provided care (*Health Care Access and Quality - Healthy People 2030 | Health.gov*, n.d.). Without the necessary financial support, patients may not allow the healthcare professional access to aspects

of their health if they know they are unable to afford treatment. Health insurance as a barrier to healthcare access is significant, as it can lead to harm to an individual's health that could have been prevented. For example, if an individual injures and cuts themselves while working on a home project, knowing it will not be covered by insurance, they opt to try and care for the wound themselves. As a result, they develop an infection and suffer more severe consequences to their health than if they had access to professional medical care.

Another significant barrier to the healthcare professional accessing aspects of a patient's health is the patient's inability to access the healthcare professional themselves. For example, if the patient lives too far from the healthcare professional, this may prevent patient access to care (*Health Care Access and Quality - Healthy People 2030 | Health.gov*, n.d.). Another barrier could be patient circumstances regarding reliable transportation, and whether they can afford to commute to health services to seek treatment (*Health Care Access and Quality - Healthy People 2030 | Health.gov*, n.d.). Regardless of the barrier, it is such patient circumstances, which prevent the healthcare professional from accessing aspects of the patient's health.

In addition to considering the patient's circumstances when discussing what aspects of the patient's health the healthcare professional can access, we must also consider the resources of the healthcare professional, as a single sided examination in the healthcare professional-patient relationship would be complete (Pellegrino et al., 2000, p. 22).

### ***Healthcare Professionals Resources***

While patient circumstances may prevent the healthcare professional from accessing various aspects of a patient's health, resources within the healthcare professional's work environment limit the healthcare professional's ability to *responsibly* access aspects of a patient's health. Why the healthcare professional must be concerned with responsibly accessing aspects of

a patient's health has many ethical considerations, but also legal consequences should avoidable harm come to the patient when providing care for their health (Fremgen, 2019, p. 37). For this reason, the healthcare professional must carefully examine professional resources and look carefully at all alternatives in treatment before accessing aspects of a patient's health (Fremgen, 2019, p. 21). Such resources, which may limit the healthcare professionals' responsible access to a patient's health (although there are other considerations outside this paper), include availability of supplies, number and diversity of other staff, and the healthcare professionals' own reserves of time and ability.

Depending on the healthcare facility, its type and number of supplies will differ. Such supplies might include bandages; suturing materials, medications, medical equipment such as X-ray machines, MRI's, etc. The reason why the supplies at hand might limit what aspects of a patient's health the healthcare professional can access is much like how an artist cannot fill in a canvas if they lack the brushes to do so. They might know what they desire to paint, or what aspects of a patient's health should be accessed to provide care. However, without the supplies to provide the needed care, those aspects of the patient's health cannot be responsibly accessed. The healthcare professional could proceed without certain supplies, and like an artist attempting to use their hands instead of the preferred brush, they may do the best they can. However, the quality of the painting and therefore the care would be diminished. Therefore, to provide the best quality of care possible to the patient, the healthcare professional should not access aspects of the patient's health they are not responsibly equipped to treat.

One thing that struck me in the course of my job shadowing a physician assistant (what I hope to eventually work as) was this phrase they used, "Medicine is an art, there are many ways to paint" (original origination unknown). So please bear with me if I continue with the artist

analogy. Much like how supplies limit what aspects of a patient's health the healthcare professional can access, so does the number and diversity of staff of the healthcare professional's work environment. The staff and coworkers with whom the healthcare professional works may be likened to the palette of colors with which the painting of the patient's health can be filled in. When there is not enough staff on hand, the healthcare professional is limited to a smaller amount of paint, and as a result, the patient may receive incomplete care. Therefore, due to the limited number of staff, should the healthcare professional attempt to access areas of the patient's health they are not equipped to handle, the patient may come to harm and fall through the cracks unable to be reached in the canvas of their health.

For example, if a patient requires the attention of two nurses to help turn them to prevent bedsores, but only one nurse is available because the facility is understaffed and the other nurse is busy, then the available nurse cannot turn the patient safely (NurseGrid, 2022). Should the nurse access this aspect of the patient's health on their own, they risk injuring the patient or themselves. Should the nurse wait, the patient's health is being neglected in the meantime due to the limited number of staff (NurseGrid, 2022).

Not only is the number of staff important, but also the diversity of staff employed. By diversity, I mean the variety of healthcare professionals of different specialties who care for different aspects of the patient's health. To care successfully for a patient's health, in most cases, requires a team interdisciplinary approach. When there is a lack of healthcare professionals who are trained to care for the patient in different ways, it is like having limited colors with which to paint. The patient will be unable to receive needed care in certain aspects of their health, and as a result, their sense of wholeness will be diminished to a less vibrant, incomplete painting.

For example, if a patient requires surgery, but only has the care of the surgeon, who will prep them for surgery? Who will administer the anesthetic? Who will monitor their vital signs during the procedure? Who will assist the surgeon during the surgery? Who will care for the patient during their recovery? In other words, the physician is only one part of the medical team, all healthcare professionals have an important function. While it is possible to work with a limited diversity of medical staff, to do so may result in gaps of care for the patient's health.

Finally, the most important resource that determines the quality of healthcare a patient receives is the healthcare professional themselves. For much the same reason that the artist is critical to the production of art, the healthcare professional is critical to the provision of care. Later, we will discuss how the healthcare professional may determine the efforts they should take in terms of care on behalf of their patients' health. However, before we can discuss how the healthcare professional determines what breadth and depth of care to provide, we must also consider that the healthcare professional is a finite resource and cannot be used inexhaustibly.

As discussed by Pellegrino et al. (2000, p. 45), as a practical matter, the healthcare professional only has two hands and limited time. It is impossible for the healthcare professional to treat anybody and everybody in medical need (Pellegrino et al., 2000, p. 45). For example, if the healthcare professional has several patients to care for at a time, then division of the attention and ability of the healthcare professional will be required. Apart from patient load, there are many other considerations which could affect the personal resources of healthcare professionals. Therefore, before the healthcare professional accesses some aspect of the patient's health, they must weigh whether they have the personal resources to successfully complete the needed tasks involved in care.



However, “When we understand that the doctor-patient relationship involves more than a single individual as the patient, the relationship becomes not only more complex, but more open to including others in the decision-making process” (Pellegrino et al., 2000, p. 17). Although the personal time and ability of the healthcare professional may direct what aspects of a patient's health can be responsibly accessed, the resources of other healthcare professionals who are part of the medical team should also be included in the decision making process.

In summary, although the healthcare professional *may* be able to access aspects of a patient's health to provide care for, whether they can successfully care for the patient's health with available resources determines whether the healthcare professional *should* access aspects of a patient's health.

### **Section 3: Establishing the Appropriate Efforts or Care that a Healthcare Professional Should Provide.**

Thus far in this paper, we have discussed what aspects of a patient's health the healthcare professional may access when taking into account established boundaries, and conditions the healthcare professional works within. However, within these considerations, how far should the healthcare professional go in terms of care, or ‘efforts made’, on behalf of a patient's health? When discussing how far the healthcare professional should go in terms of care, we may think of it in terms of breadth (variety of actions that a healthcare professional may perform on behalf of a patient's health) and depth (how effective versus efficient the healthcare professional is when performing actions on behalf of a patient's health). So, how does the healthcare professional determine the breadth and depth of care to provide to patients?

I posit that the breadth and depth of care that the healthcare professional should provide to patients can be determined from expectations. Expectation has to do with the belief that

someone will or should achieve something (“Definition of Expectation,” 2023), and expectations for what breadth and depth of care the healthcare professional should provide to patients may come from many sources. Although there are other considerations, I believe the expectations of the healthcare professional's employer, patients, profession, and worldview inform the breadth and depth of care that the healthcare professional provides.

However, before seeking to answer what breadth and depth of care the healthcare professional *should* provide for a patient's health, we will first seek to determine what breadth and depth of care the healthcare professional *must* provide. In other words, what is the minimum of care that is required of the healthcare professional, and how can this required breadth and depth of care be determined? I claim this minimum breadth and depth of care can be determined from the legally enforceable expectations of the healthcare professional's employer, patients, and profession.

### **Legally Enforceable Expectations of the Employer**

To begin, let us explore the minimum breadth of care that the healthcare professional must provide, as determined by the expectations of the healthcare professional's employer. We have already gone over scope of practice in section 2, and how governmental bodies determine what are the acceptable actions that the healthcare professional may perform when caring for a patient's health (Fremgen, 2019, p. 64). Out of these acceptable actions, what variety of tasks a healthcare professional is required to perform in their job is subject to the expectations of their employer as defined within their employment contract:

It is imperative that employees understand and practice within the guidelines of their profession. However, the physician/employer also has a responsibility to instruct

members of the healthcare team to perform activities that are within their respective scope of practice. (Fremgen, 2019, p. 64)

An employment contract uses the expectations of the employer to define the terms of employment for the healthcare professional (*Employment Contract: What Is It? Important Terms to Include*, n.d.). This employment contract can be implied, oral or written, but regardless of the format, the contract describes the responsibilities of the job and various actions that the healthcare professional legally must perform to remain employed (*Employment Contract: What Is It? Important Terms to Include*, n.d.). An example list of tasks defined in an employment contract as provided by (U.S. Legal Forms, Inc., n.d.) that a MA must fulfill in the course of their job includes:

The *Employees* duties consist of filing, making and canceling patient appointments, obtaining the names and phone numbers of physicians who make referrals to *Employers* clinic, ordering medical records of patients from other health care providers, scheduling medical tests for patients, answering the phone, checking patients in and out, and such other office activities of the *Employer* as assigned by the office manager and subject to the direction and control of the officers and board of directors of the *Employer*. (U.S. Legal Forms, Inc., n.d.)

These expectations of the employer then inform the legally required minimum breadth of care that the healthcare professional must provide in order to remain employed. Additionally, the expectations of the employer also inform how effectively or what legally minimum depth of care the healthcare professional must provide to patients.

Minimum depth of care is important to discuss, as determining what tasks one is legally required to perform does not necessarily answer how effectively one must perform such tasks.

Simply doing tasks may be efficient (completing a job), but not necessarily effective (completing a job right) (Fremgen, 2019, p. 178). For example, if it is part of an MA's employment contract that they must answer the office phone, this does not answer in what manner they are to answer the phone or for what purpose. If the MA answers the phone in an angry manner, they have completed the task, but they likely have not done so in a way that is pleasing to their employer. So, any ambiguity in how effectively or legally one must perform a task can also be informed by the employer's expectations as defined within the employment contract. For example:

The *Employee* shall perform all her duties in a manner satisfactory to the officers and board of directors. The *Employee* shall obey all policy, rules, and orders of the *Employer* set by the officers and board of directors. (U.S. Legal Forms, Inc., n.d.)

Therefore, the role of the employer in informing the required depth of care to provide to patients is significant, as how effectively the healthcare professional is legally required to complete tasks is subject to the expectations (satisfaction, policies, rules, and orders) of the employer (U.S. Legal Forms, Inc., n.d.) and whether the healthcare professional meets those expectations determines whether they retain employment. (U.S. Legal Forms, Inc., n.d.). In this way, whenever a task is to be completed, the legally required minimum depths of care in that task are informed by the expectations of the healthcare professionals' employer.

### **Legally Enforceable Expectations of the Patient**

Another key factor informing the required breadth and depth of care to provide to patients, are the expectations of the patients themselves. As previously discussed in section 2, due to the patient's right to autonomy in the healthcare professional-patient relationship, the healthcare professional cannot legally make any efforts on behalf of the patient's health without their consent (excluding the incompetent patient). Therefore, the healthcare professional-patient

relationship is key in navigating the mutual act of healing (Pellegrino et al., 2000, p. 227), as it is in working with the patient that identification and expression of their expectations can occur (Pellegrino et al., 2000, p. 52), and consent can be given for what aspects of their health they wish to undergo available treatment (Pellegrino et al., 2000, p. 227). Therefore, the patient's autonomy and expectations within the healthcare professional-patient relationship, are critically important in informing the healthcare professional of the breadth and depth of care legally available to them to provide to the patient.

However, expectations of the patient do not just inform what breadth and depth of care the healthcare professional *can* legally provide, but what breadth and depth of care they *must* provide in order to maintain the healthcare professional-patient relationship. Should the healthcare professional not listen to the patient's expectations regarding what breadth and depth of care they must provide, it is then legally within the patient's rights to terminate the healthcare professional-patient relationship and seek treatment elsewhere (Fremgen, 2019, p. 41). This is significant, as although profit may not be the primary motivation for many healthcare professionals when providing care, without patients the healthcare professional ultimately has no livelihood.

That is not to say whenever the patient says 'jump' that the healthcare professional should say 'how high'" under threat of the patient terminating the relationship. Although there are certain qualifications that must be met to avoid a charge of abandonment of the patient, the healthcare professional (primarily physicians) also legally has the right to terminate the healthcare professional-patient relationship (Fremgen, 2019, p. 41). Therefore, although the patient's expectations should be considered and used by the healthcare professional to guide what minimum breadth and depth of care they must provide, patient expectations are not the sole

driving force behind decisions of care. Another factor informing the required breadth and depth of care to provide are the expectations of the profession that the healthcare professional works within.

### **Legally Enforceable Expectations of the Profession**

The expectations formed by the healthcare professional's profession, is also a key determinant of the minimum required breadth and depth of care the healthcare professional provides to patients. Such expectations formed within a profession are not something to be dismissed, as the care provided by healthcare professionals within a shared medical specialty and geographical region, informs the 'standard of care.'

Standard of care is the "ordinary skill and care that all medical practitioners... must use, as determined by their state licensure or certification and that a 'reasonable' person would use in a similar circumstance" (Fremgen, 2019, p. 59). How the 'reasonable' healthcare professional within a certain profession and geographical area must act, is determined by how a similarly trained healthcare professional would provide care under the same circumstances (Fremgen, 2019, p. 59). This standard of care is an important consideration, as if a healthcare professional fails to meet the standard of care, they can be held liable for negligence in their performance of a task (Fremgen, 2019, p. 59). So, in addition to required care being determined by the legally enforceable expectations of employer and patient, expectations of care formed within a medical profession also informs the breadth and depth care the healthcare professional must provide to patients.

An important thing to note, is that under standard of care, a healthcare professional is not called to act above what is required by law. There is nothing stopping the 'reasonable' healthcare professional in a certain specialty from only providing the minimum of care, so long as the

majority of their fellows also only do so. “The law does not require the (healthcare professional) to use extraordinary skill, only reasonable, ordinary care and skill” (Fremgen, 2019, p .59). This may then prompt the question, should healthcare professionals only seek to provide the minimum breadth and depths of care that is legally required of them?

If commitment to the completion of various tasks to a certain level of effectiveness under legal penalty was the only motivating force behind the provision of care to patients by healthcare professionals, healthcare itself would be relegated to a business relationship (Pellegrino et al., 2000, p. 19). That is not to say that a business model of healthcare is inherently wrong, as most recognize a need to reward work well done in a field that is difficult to quantify (Pellegrino et al., 2000, p. 247). However, should the breadth and depth of care in the healthcare professional-patient relationship, the “heart of medicine and the healing process” (Pellegrino et al., 2000, p. 17), be restricted to contractual obligations?

As determined by G. Kevin Donovan, a business relationship of only the minimum of care as defined by contractual obligations between patient and healthcare professional cannot be the ideal (Pellegrino et al., 2000, p. 19). Such a purely business relationship cannot be the ideal, as merely fulfilling a set of tasks as outlined by contract would limit the healthcare professional to services previously agreed upon in advance and would likely fail to meet all the patient's needs (Pellegrino et al., 2000, p. 19). Therefore, only performing the legally required minimum breadth and depth of care to patients cannot be sufficient to care for a patient's health (Pellegrino et al., 2000, p. 19). Additionally, only fulfilling legal requirements would ignore important moral considerations, as moral obligations are not necessarily discharged when healthcare professionals meet all relevant legal requirements (Beauchamp & Childress, 2019, p. 8).

According to Robert Veatch a virtuous healthcare professional does more than comply with the law of the land (Pellegrino et al., 2000, p. 20). So, if only fulfilling legally obligated expectations is not the ideal, fails to meet the needs of the patient, and is not how the virtuous healthcare professional *should* act, what other guidance in determining the breadth and depth of care to provide to patients can the healthcare professional turn to? Although there are certainly other considerations, I claim that the healthcare professional can receive further direction for what breadth and depth of care to provide to patients beyond the minimum, from moral expectations informed by their profession and worldview.

### **Moral Expectations from Profession**

Moral expectations from within a medical profession or medical specialty can often be found and summarized by the oath to be sworn by the healthcare professional upon completion of their training (West Liberty University, 2019). The original healthcare professional code of ethics, the Hippocratic Oath, dates to 400 b.c, as written by the Greek physician Hippocrates who is often referred to as the father of medicine (Fremgen, 2019, p. 258). The Hippocratic Oath's purpose was to remind those in medicine of the importance of their profession, the need to teach others, and the obligation to never knowingly harm a patient or divulge a confidence (Fremgen, 2019, p. 258). Today, many medical professions use ethical principles like those as stated in the Hippocratic Oath, to form the expectations of moral standards of conduct and care for those within a profession (Beauchamp & Childress, 2019, p. 7). For example, a Physician Assistants oath as determined by the American Association of Physician Assistants is the following:

I pledge to perform the following duties with honesty and dedication:

I will hold as my primary responsibility the health, safety, welfare, and dignity of all human beings.



I will uphold the tenets of patient autonomy, beneficence, non-maleficence, and justice.

I will recognize and promote the value of diversity.

I will treat equally all persons who seek my care.

I will hold in confidence the information shared in the course of practicing medicine.

I will assess my personal capabilities and limitations, striving always to improve my medical practice.

I will actively seek to expand my knowledge and skills, keeping abreast of advances in medicine.

I will work with other members of the health care team to provide compassionate and effective care of patients.

I will use my knowledge and experience to contribute to an improved community.

I will respect my professional relationship with the physician.

I will share and expand knowledge within the profession.

These duties are pledged with sincerity and upon my honor. (West Liberty University, 2019)

While such professional moral standards and expectations of conduct as defined within a profession are generally acknowledged by those who are serious about their moral responsibilities (Beauchamp & Childress, 2019, p. 7), all such listed expectations may not be strictly required or enforceable. Unless violating a professional expectation also violates a legal obligation, there is nothing demanding the healthcare professional provide beyond the minimum of care as implied by the profession's moral standards and code of ethics. Nothing, that is, aside from whatever value they place upon their 'honor' and personal convictions concerning care as derived from their worldview (Pellegrino et al., 2000, p. 20). Which brings us to our ultimate

question. “How does the medical morality embodied in these codes and oaths square with the values that are the ingredients of the students' and physicians' own sense of medical morality?” (Pellegrino et al., 2000, p. 32).

Morality embodied in these codes and oaths may inform a healthcare professional's sense of medical morality and their beliefs as to the breadth and depth of care they should provide to patients but knowing how one *should* act does ensure one *will* act in that way. So, what enforces provision of care beyond the minimum legal requirements? I claim that the healthcare professionals' provision of care beyond the minimum is determined by the healthcare professionals' values as derived from their worldview. In other words, although legal obligations mandate the breadth and depth of care a healthcare professional must provide to patients, care provided beyond the minimum is motivated and determined by the healthcare professionals' religious convictions.

### **Moral Expectations from Worldview**

In section 1, it was determined that one's worldview is based upon one's religious (or lack thereof) beliefs. These religious beliefs are what defines the healthcare professionals' values and expectations of provision of care to patients (Pellegrino et al., 2000, p. 84). According to this, when determining whether to provide beyond the minimum of care and what expectations to uphold, I must turn to my personal religious convictions. For me, this means examining my Christian faith for answers to the question of what breadth and depth of care I expect of myself to provide to patients.

Before we begin, I wish to clarify that what I am about to describe are my personal expectations of care informed from my personal understanding of my faith. I make no claim that the answer I arrive at is THE standard of care that all should seek to attain or follow. While I do

believe that the moral standards according to my faith are true and right (if it was, otherwise, I would be providing false testimony) they do not have the authority to bind other persons or communities, nor is my particular morality the authoritative moral voice for all other persons. Likely, anyone reading this paper will have a different answer to the question of breadth and depth of care, or perhaps different reasons behind a similar answer. It is not my intention in explaining my own thoughts to diminish the positions of others, or even claim the moral superiority of my position over others. I believe that other persons whose views differ from mine may also have morally acceptable and even praiseworthy beliefs. One final note. Although I write as an adherent to the Christian faith, I make no claims that my reflections are *the* theology or the *only* theology of the Christian faith. I write with only my personal understanding of my own faith, which is best described under the umbrella of the Christian religion. With this understanding, I will now describe what I believe to be the theory of care for myself as a future healthcare professional to provide.

### **The Ideal**

To begin, I would first like to explain what I believe is the ideal of care for the healthcare professional to provide, using whom I hold to be the ultimate example that the Christian healthcare professional should seek to reflect. The example I am referring to is the figure central to the Christian faith, that of Jesus Christ.

In the Christian faith, Jesus Christ is considered to be the Son of God and part of the Trinity (Father, Son, and Holy Spirit). In other words, Jesus is both God and human (*1 Timothy 3:16 (NIV)*, n.d.), therefore possessing the sinless nature of God. What the Bible (considered to be the Word of God and what the Christian should turn to in order to learn about the expectations of God) says about the nature of God is summed up in *1 John 4:8 (NIV)*, ... “God is love.” Why

considering the nature of God is important to my answering what breadth and depth of care to provide to patients, is because as a Christian, I am called to be Christlike (*1 John 2:6 (NIV)*, n.d.). To reflect Christ, is then to imitate His example of love and sacrifice for others:

Beloved, let us love one another, for love is from God, and whoever loves has been born of God and knows God. Anyone who does not love does not know God, because God is love. In this the love of God was made manifest among us, that God sent His only Son into the world, so that we might live through Him. In this is love, not that we have loved God but that He loved us and sent His Son to be the propitiation for our sins. Beloved, if God so loved us, we also ought to love one another. (*1 John 4:7-12 (NIV)*, n.d.)

According to this and other scripture, “there is no greater love than this: to lay down one's life for others” (*John 15:13 (NIV)*, n.d.). To follow Jesus's example, is then considered life's greatest fulfillment (Pellegrino et al., 2000, p. 254). That is not to say that every Christian is seeking to die on behalf of others. However, the faithful Christian should be seeking to live their life in sacrificial service to God and others, motivated out of love for Jesus’s sacrifice on the cross with his life for themselves (*1 John 3:16 (NIV)*, n.d.). Therefore, in whatever the Christian does in life, they are called to “work at it with all your heart, as working for the Lord” (*Colossians 3:23 (NIV)*, n.d.). Therefore, in seeking to be Christlike, the Christian of profound faith will reflect in his or her dispositions the very shape of that faith (Pellegrino et al., 2000, p. 252). The shape of that faith, as described, is the calling to serve and love God, through loving others in charity (love and personal sacrifice) (Pellegrino et al., 2000, p. 252).

Here I would like to turn to Edmund Pellegrino's analysis of how charity can shape moral choices of breadth and depth of care to patients in medicine, which I feel summarizes beautifully how Christian faith should reflect in the healthcare professional’s practice. Pellegrino argues that

charity will influence how the dominant principles in medical ethics are interpreted, the way the healthcare professional-patient relationship is construed, and the way certain concrete choices are made (Pellegrino et al., 2000, p. 252). A few key things that I would like to draw from his analysis include the following.

First, that the Christian healthcare professional is called to self effacement and sacrifice for others as a minimum moral obligation:

The Christian (healthcare professional) sees himself or herself as called to perfection, to imitate Jesus's healing, and this perspective, appeals to exigency, fiscal survival, self protection, and the canons of a competitive environment are morally feeble, even totally unacceptable. (Pellegrino et al., 2000, p. 252)

Therefore, when seeking to answer what breadth and depth of care to provide to patients, cost to self should not be a hindrance when providing care:

Secondly, a Christian healthcare professional possessing a charity based ethic will reject notions of healthcare as a commodity transaction and the healthcare professional as a businessperson (Pellegrino et al., 2000, p. 252). Meaning, the Christian healthcare professional rejects the notion of the healthcare professional-patient relationship being only a contract for services or primarily for profit (Pellegrino et al., 2000, p. 252).

Thirdly:

Faithful Christians will go beyond the strict calculus of duties and claims and exercise a 'preferential option' for the very persons whose moral claims on society are difficult to establish: the poor, the outcast, the sociopath, alcoholic, the non-compliant in the care of their own health. (Pellegrino et al., 2000, p. 252)

In other words, the faithful Christian healthcare professional should be unbiased when providing care to patients, without regarding societies or their own negative judgments of them (Pellegrino et al., 2000, p. 252). An example of these ideals in practice can be reflected in the parable of the good Samaritan as told by Jesus:

A man was going down from Jerusalem to Jericho when he was attacked by robbers. They stripped him of his clothes, beat him and went away, leaving him half dead. A priest happened to be going down the same road, and when he saw the man, he passed by on the other side. So too, a Levite, when he came to the place and saw him, passed by on the other side. But a Samaritan, as he traveled, came where the man was; and when he saw him, he took pity on him. He went to him and bandaged his wounds, pouring on oil and wine. Then he put the man on his own donkey, brought him to an inn and took care of him. The next day he took out two denarii and gave them to the innkeeper. 'Look after him,' he said, 'and when I return, I will reimburse you for any extra expense you may have'. (*Luke 10:25-37 (NIV)*, n.d.)

As described in Luke 10:25-37, the Samaritan (of a people despised by Jews and who despised Jews), cared for the Jewish man without regarding his personal biases, how his community viewed his patient, or the personal cost (monetarily or otherwise) to himself. Jesus himself tells the Christian through scripture to 'go and do likewise' (*Luke 10:25-37 (NIV)*, n.d.). Although unbiasedly following this example without regard for self is the ideal, when going and doing likewise, the Christian healthcare professional is not called to care for patients without regard for their personal responsibilities and obligations (Pellegrino et al., 2000, p. 252).

Edmund Pellegrino ended his analysis with this key consideration, that charity does not mean the healthcare should have a fanatical devotion to medicine that would exclude other

obligations to family, self, society, or country (Pellegrino et al., 2000, p. 252). Rather, charity disposes the healthcare professional to place these obligations in a morally defensible order (Pellegrino et al., 2000, p. 252). Therefore, when seeking to provide beyond the minimum care, the healthcare professional must do so according to a morally defensible order, in a way that does not neglect what one has determined to be one's primary responsibilities.

This morally defensible order may differ for each healthcare professional. However, biblically the Christian healthcare professional is called to serve God first, then others, then self (*Philippians 2:3 (NIV)*, n.d.). What is included in 'others' as discussed in 1 Timothy 5:8, would be ordered in terms of private responsibilities, putting family and other private relationships outside of medicine first, then those with whom there are no private obligations as secondary. For if the Christian "does not provide for their relatives, and especially for their own household, has denied the faith and is worse than an unbeliever" (*1 Timothy 5:8 (NIV)*, n.d.).

Therefore, for the Christian healthcare professional to place private obligations outside of medicine as their primary responsibility is not considered to be selfish or a moral failure of the ideal. In fact, to be a faithful Christian one is instructed to care for their household before caring for others (Pellegrino et al., 2000, p. 252). This order of service to God, private responsibilities to others, care for strangers/patients, then self, would then be the biblically morally defensible order of obligations. Not only is it morally defensible, but it is also practically necessary to devote attention to one's private life to be a more effective healthcare professional:

(Healthcare professionals) too must maintain a focus on their lives outside of medicine...

Anyone who neglects his or her family life, intellectual life, or physical and spiritual well-being cannot be an ideal physician. (Pellegrino et al., 2000, p. 22)

While to completely ignore private obligations to focus solely on one's patients, might at first seem the epitome of self sacrifice for those in medicine, in reality it would be depriving both family, friends, and patients, of a well balanced healthcare professional who is able to sustainably provide charitable care to others (Pellegrino et al., 2000, p. 22). Therefore, a balancing of obligations within and outside of medicine is necessary for the Christian healthcare professional to obtain in order to be an effective healthcare professional as well as to stay within their morally defensible order of obligations. So how does the healthcare professional determine how to balance their private and professional responsibilities in order to develop an amount of personal sacrifice that is supportable?

I believe that developing a sustainable balancing of private and professional responsibilities is something that must be learned through experience and reflection on that experience (as discussed in section 2) when seeking to determine the appropriate amount of self sacrifice when caring for patients. So, if the ideal is to perfectly balance charitable care to others in a morally defensible order when determining what breadth and depth of care to provide to patients, one may ask if the ideal is even attainable?

### **Failure to Reach the Ideal**

In short, I do not believe it is. This is mainly due to two reasons, the fact of sin, and the inescapable emotionality of human beings.

The Christian healthcare professional is called to imitate the perfect sinless example of Jesus Christ (*3 John 1:11 (NIV)*, n.d.). However, sin is defined as anything against God, even a selfish thought is considered sin (*Mathew 5:28 (NIV)*, n.d.). According to scripture, "all have sinned and fall short of the glory of God" (*Romans 3:23 (NIV)*, n.d.). Therefore, to attempt to act sinlessly and perfectly imitate Christ's love for others, is an exercise against our sinful nature



(*Galatians 5:17 (NIV)*, n.d.). While the Christian has been given the Holy Spirit by God which possesses a perfect sinless nature, our original sinful nature still exists in our physical bodies (*Romans 8:3 (NIV)*, n.d.). These two natures fight against one another, and in the struggle the good intentions of the Christian may not always win:

For the flesh desires what is contrary to the Spirit, and the Spirit what is contrary to the flesh. They are in conflict with each other, so that you are not to do whatever you want.

(*Galatians 5:17 (NIV)*, n.d.)

In other words, the Christian healthcare professional may desire to imitate Christ when providing care. However, due to their inherently sinful nature they will fail, even though they desire otherwise:

For what I want to do I do not do, but what I hate I do... As it is, it is no longer I myself who do it, but it is sin living in me. For I know that good itself does not dwell in me, that is, in my sinful nature. For I have the desire to do what is good, but I cannot carry it out. For I do not do the good I want to do, but the evil I do not want to do—this I keep on doing. Now if I do what I do not want to do, it is no longer I who do it, but it is sin living in me that does it. (*Romans 7:15-20 (NIV)*, n.d.)

Although Christians are made sinless in the eyes of God and have the Holy Spirit to help them fight against sinning, while on earth in their physical sin filled bodies Christians do still commit sin (*Romans 7:15-20 (NIV)*, n.d.). It is only upon physical death and the loss of the Christians physical sinful flesh, that the Christian will be made completely perfect in action and thought in heaven (*Hebrews 10:14 (NIV)*, n.d.) (*Philippians 3:21 (NIV)*, n.d.). The Christian knowing this, realizes that attaining perfection like that of Jesus when caring for others is impossible. Even should one not subscribe to the Christian faith or a belief in humans having an inherently sinful

nature as a reason for why they would fail to maintain such an ideal, one may also look to the emotionality of human beings as another reason for failure.

In medical practice, judgments are also affected by the emotions that a particular situation or patient engenders (Pellegrino et al., 2000, p. 210). For example, the healthcare professional may fail to provide the same selfless level of care to a patient who is constantly rude and fails to follow medical advice (Pellegrino et al., 2000, p. 219). Conversely, the healthcare professional may give more personal attention and care to a sick patient who reminds them of a family member (Pellegrino et al., 2000, p. 219):

Physicians cannot escape past judgments and their consequences, and they cannot totally evade an emotional or aesthetic commitment of a particular diagnosis or treatment...

(Pellegrino et al., 2000, p. 212)

Due to inescapability of the healthcare professional being affected by emotion in their judgements of how to provide care (Pellegrino et al., 2000, p. 216), despite any of their best efforts otherwise, some patients and circumstances will alter how care is provided (Pellegrino et al., 2000, p. 212). So, whether because of one's sin nature, or emotionality, the Christian healthcare professional is doomed to fail to perfectly fulfill the ideal of care. So, why does the Christian healthcare professional strive for a knowingly unattainable ideal?

Why does anyone with a hero or celebrity they admire seek to emulate them? Do they follow their example expecting to become them? I would say realistically most follow an example seeking to become more like that which they hold in high esteem, not with the thought that they will become a perfect copy. To perfectly follow an ideal, would be like the ideal being set in front of a mirror (the mirror being an individual) and the ideal seeing itself perfectly reflected back. For the Christian who has accepted Jesus's sacrifice of himself on the cross for

their sin, when God steps in front of the mirror, he sees his Son Jesus perfectly reflected (2 *Corinthians 5:21 (NIV)*, n.d.). To God, the ideal is met on our behalf by the sacrifice and example of his son Jesus. However, as discussed in *Romans 7:15-20*, while Christians are made sinless in the eyes of God, Christians do still commit sin. God might honor the ideal as being met, however the Christian until parted from their physical body, will fail to perfectly reflect the ideal (*Romans 7:15-20 (NIV)*, n.d.). Much like how a dirty mirror will always fail to perfectly reflect an image, the Christian knowing their sinful state realizes the unattainability of meeting the ideal themselves (*Romans 3:23 (NIV)*, n.d.). Therefore, the Christian strives for Christ's example not to attain it, as it is unattainable and has already been met on their behalf, but out of their love for Jesus who attained the ideal for them by his sacrifice on the cross, seek to become more like him (*Philippians 1:6 (NIV)*, n.d.). The Christian healthcare professional seeks to reflect the charity of Jesus in care of others not with the goal of immediate perfection in action and thought, but of growth (2 *Peter 3:18 (NIV)*, n.d.). This striving for growth, is then the practical goal and application of the healthcare professional for whatever their ideal:

Our understanding of ethics, like our understanding of anything else, can never be complete. We hope to do less badly tomorrow what we did not do well today or do better tomorrow what we did reasonably well today. (Pellegrino et al., 2000, p. 218)

Whether the healthcare professional is Christian, Atheist, Buddhist, etc., whatever their beliefs which motivate care beyond the minimum, it is the healthcare professionals desire to improve care to patients' day by day which is part of the answer in determining care.

#### **Section 4: Conclusion and Reflection**

## **Conclusion**

In summary, what aspects of the patient's health the healthcare professional can provide care for is determined by boundaries and conditions the healthcare professional must work within. Within those considerations, the healthcare professional can determine the minimum of care from the legally enforced expectations of their employer, patients, and profession. When seeking to determine whether to provide beyond the minimum of care to patients, the healthcare professional may use the expectations of their profession and expectations from their religious beliefs (or lack of) for answers. Then, using experience and reflection to determine a supportable balance between private and professional responsibilities, the healthcare professional should then seek to come closer and closer to these expectations throughout their practice when providing care to patients.

## **Reflection**

When reflecting on my own journey in seeking to answer the question of care, I can begin to understand and appreciate how this research has shaped, affected, and changed my understanding of issues involved. I began this paper seeking to find clarity as I contemplated a career in healthcare, and to an extent I have. Before beginning my research for this paper, I had very little understanding of bioethics and law involved in healthcare. Although before beginning my research I had an idea of what might be the ideal of care based on my religious convictions, I knew that I couldn't only consider my ideal when seeking an answer, as I would be working within a framework of boundaries and with others of differing convictions. Having researched this paper, I now feel I better understand the legal and ethical frameworks within which I will be working, and how to better stay within these boundaries while respecting others when seeking to grow towards my ideal. I also am left with questions. Questions of how I will react within certain

situations, of what I will do when invariably confronted with some dilemma as a future healthcare professional. However, I feel I am better aware of some of these possible moral dilemmas as well as what the legally required responses are in many situations. I know some remaining questions I have will not be able to be answered in a thought paper. Some questions, I believe, simply cannot be answered unless utilizing those key ingredients of experience and reflection. Knowing this, I am looking forward to acquiring such as I continue to work toward a career as a healthcare professional.

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