

Rising From The Ashes: Strategic Approaches for Reclaiming Healthcare and Research as a Culture of Innovative Care

Edward F. Gabriele

*National Center for Bioethics in Research and Health Care
Tuskegee University*

AUTHOR'S NOTE

This article summarizes and integrates original scholarship as prepared and developed for diverse international academic and professional academies and societies over the last several years. The opinions in this article are those of the author and do not represent the views of the institutions and agencies that he currently serves or has served in various capacities in his professional career. The author has no financial conflicts of interest.

ABSTRACT

In contemporary society, the fundamental nature of healthcare and healthcare-related research has come under particular scrutiny. While decidedly based upon human need and human care, a wide variety of historical developments often can collide not just with how these services are effected, but even more deeply as to their meaning in human culture. There is, therefore, a need for some form of leadership that can effectively deepen the primary nature of healthcare as human care and healthcare research as an essentially powerful source of innovation for the promotion and protection of The Good. Healthcare and research administrators have a unique and critically important leadership role in the ongoing expansion of every aspect of their institution's corporate life from organizational purpose, to policy and procedures, to programmatic and future development. This form of leadership is not hierarchical, but more deeply formative. It requires a sense of organizational vision and activity that respects the relational nature of the organization itself as well as the communities it serves. To achieve the greatest formative success, healthcare and research administrators must practice and engage in a form of leadership that moves and expands upon sound and substantive forms of ethical development and decision-making. This leadership is not just a professional practice. More deeply, it is a praxis—i.e., a form of action in reflection. It involves both reform and renewal in substantive and unforeseen ways. If such a praxis can begin to be effected in healthcare and healthcare-related leadership, perhaps a new age of truly trustful human and humane healthcare and research can arise from the ashes of cynicism that have recently singed the average citizen's understanding.

GENERAL INTRODUCTION

"You treat a disease, you win, you lose. You treat a person, I guarantee you, you'll win, no matter what the outcome."

Robin Williams (1951–2014) in his film, "Patch Adams"

In spring 2014, a major crisis developed in the healthcare system of the Veterans Administration. It is commonly known and has been a major subject of media attention. This crisis, wherein it was discovered that needy veterans lost time-sensitive care or even, so tragically, lost their lives over its absence, has resulted also in an impending review of the entire Military Health System.

One of the important aspects of the ensuing national discourse over this troubling scenario went beyond the irresponsible actions of individuals in the specific institutions involved. National discourse has begun to delve into what can be seen as problematic issues within the entire culture and dynamic of the institutions themselves as well as their parent organization.

Of particularly urgent importance is the implication that these cultural issues might have for the way in which healthcare and research are understood within human society both within the United States and

elsewhere across the globe. In an age of vast cultural dynamics related to the way in which the human experience is affected by siloed individualism, the business model of metrics of productivity and measurable outcomes, and the fast pace of information systems, these crises should be utilized as opportunities for critical reflection upon the implications for the ways in which we conceive and process the fundamental act of healthcare and healthcare-related research. Are they fundamentally businesses? Or are they truly human experiences that require sound business models that ensure sound and responsible care? Is research truly only about the money? Or is it an act of “genius becoming innovation” to secure and advance The Human Good?

To proceed in this discussion, the first step will be to explore these factors and suggest the re-imagination of healthcare and research as human and humane activities. To maintain and develop this fundamental definition or “personality” of healthcare and research requires the proactive and wise leadership of highly skilled and proficient leaders such as healthcare and research administrators. Therefore, the next stage of the discussion will explore the identity of the administrator as a relational leader impacting an agency’s purpose and principles, policies and procedures, and programs and pathways within four domains of human contingency. Such

leaders then must creatively and consistently be instruments or agents of reform and renewal who motivate their contingent partners while making use of five levels of decisional development that can enhance The Good as the foundation of healthcare and research as human care.

HEALTHCARE AND RESEARCH: A CULTURE IN A CAULDRON OF CRISIS

Whether for the public citizen or the professional, the understanding and practice of healthcare and healthcare-related research in our time is clearly in a state of motion. Certainly, this has been true for decades. However, particular strands and movements from other professions, whether scientific inquiries or business practices, are making an enormous impact on the practice of these services as well as their fundamental definition. In short, many see both healthcare and research as being in a state of crisis. Whether this has to do with the advent of information systems and individuals’ ability to monitor their own health from home, the reorganization of healthcare institutions as business franchises, healthcare as a personalized or privatized and siloed home practice, or the importance of research grants as a means to financial growth for universities, something has shifted and continues to shift understanding of these professions in contemporary culture. How can we capture

at least a core image of this nearly paradigmatic shift and its impact on contemporary living? I believe its primordial nature can be caught, at least nominally, through experience and story.

In 2005, I had the privilege of working for the Commissioner of Health and Senior Services in the State of New Jersey. I was chosen by the department to design and direct a new program in human research ethics. When I was engaged in my initial orientation, I met with the Commissioner, Dr. Fred Jacobs, to obtain his direction for establishing this unique program. As historical coincidences would have it, we had been connected many years prior when he was a Navy physician/pulmonologist and I was a high school volunteer at Naval Hospital Philadelphia. During the course of our initial meeting, the Commissioner laid out his vision and recounted the various needs for forging the program. However, as our first meeting was coming to an end, he stopped me before I could leave his office. He said to me, "Dr. Gabriele, one final but critically important need. No matter what you design or establish or direct, whether in programs or policy, make sure one thing remains at the very core of everything you do. Always honor, respect, protect, and retrieve the human face of healthcare and research."

I was suspended in air. His words burned into me. Even the skin of my arms seemed to stand at attention as he

articulated what had always been, on a subconscious or subliminal level, what I had hoped would be the underlying premise to my entire academic and professional life. As I said, "Will do, sir," and then left his office, something even deeper occurred. Walking down the hallway to my office, two vivid and powerful memories flooded my mind.

Story holds the very stuff of our human nature and its meaning. More than just the recounting of tales or incidents, narrative is the living metaphor that absorbs, protects, promotes, deepens, and radiates the meanings and values that arise from human experience. In this particular moment after leaving the Commissioner's office, two stories came to mind. As I have come to appreciate in the ensuing years, each one seems to contain for me what I believe to be the ultimate definition of healthcare and healthcare-related research.

Story One: On healthcare. During that period when I was a high school volunteer, a group of my classmates and I, via our school's community service program, would visit Wounded Warriors returning from Vietnam. Sometimes we were even able to bring them to our homes for dinner. On one occasion I was asked to visit a newly arrived Marine. I walked into the ward and approached his bed. I stopped short and nearly lost my breath as I saw an image that I had never seen before. It is one I wish never to see again. He was lying in

his bed covered with shrapnel. It was everywhere, including all across his face. He gave me a hello as much as he was able to, given his stark and striking condition. I said hello back. As he began to say a few more words to me, I could not believe that my right arm moved and I lifted my hand toward his face almost without thinking. I was bent on touching the shrapnel. It was as if I were looking to touch something different. Just before I got to touch his face, the Marine grabbed my arm, pushed it away, raised his voice, and clearly brought me back into reality. "It hurts, kid. It hurts. You don't need to touch it. I'm not animal for you to stare at. And this ain't no zoo." I was deeply apologetic and almost came to tears. He realized what was going on and wiped the incident away. In fact, several weeks later he came with me to my parents' home for dinner. However, this incident was one of the most profound from which a fifteen-year-old could learn. I went to serve the needs of a wounded person, a patient. But in the end, he served my needs far more—especially my need to get beyond making other people into objects. He called my attention to the fact that he, a man who suffered for his country's defense, was hardly a victim because he was wounded. Rather, even lying on his bed covered in shrapnel, he continued to serve our nation's "defense" by serving the needs of a fifteen-year-old narcissist to get beyond himself and learn to live life on life's terms. In this

clear instance, this young Marine embodied in this moment healthcare and its completely human face. He was not a victim or just a survivor. His strength of character and his presence at the moment ensured that he would be a victor for the remainder of his life. He would use his wounds as a means of teaching others and bringing them into a deeper sense of what it means to be human and alive.

Story Two: On research. When we were in college, the university we attended required a certain number of credits in laboratory science. Science was never my strong suit. It struck fear in me as did no other subject save for mathematics. However, when I took biology for non-science majors, I was very fortunate to have a scientist-professor who energized every student with a love of the subject such that we enjoyed coming to class and never missed. The professor happened to be a Catholic priest and a member of a religious order. He was not pious in any regard. However, he brought a level of enjoyment and passion to each lecture that few of us had ever encountered in nearly any other class in which we were enrolled. It was not just that he made it interesting. He made each lecture something that stoked the imagination and brought into one's mind a sense of academic wonder. In the end, I wondered—as a future teacher myself—what aided this professor to become such a powerful educator who could make

students never want to miss his class? One day, several years later, a classmate from that course shared a story that seemed to give me an answer to my wonder. The story unfolded that this professor had at one time been a layperson who was married. His wife died very young from cancer. It was at that time that, after a sufficient period of loss and reflection, he decided to pursue his new current life's profession and continue his work as a research scientist. He wanted to devote himself to finding a cure for that which robbed him of his life's love. The story went that one night, very late, a laboratory technician was finishing up some work and walked by the professor's lab. He heard some banging on a table and what sounded like angry sobs. He stopped at the door that was cracked open a small amount. There he saw the professor, looking into a microscope, banging his fist on the lab bench and saying, "I can see it. I can see it. The answer is right in front of my eyes. But why can't I understand it and do something about it?" Clearly what the lab technician saw was a man of passion pursuing his goal to save people's lives through science and research. This was a man not seeking to obtain a grant, but seeking to protect and promote life and its abundance. And his passion was born of the most powerful force within him as it is in all of our lives—the power of pain.

These stories convey a clear image of healthcare and research as cultural

phenomena that definitely serve the human person and the human condition. Yet in the last decades, images and language have developed that convey something seemingly far different. One principle of linguistics is that "language talks." In other words, the language we use conveys values and assumptions, especially those that are subliminal or subconscious. That makes them extremely powerful. Not so very long ago, it was noticed that the common term for one seeking healthcare was "patient." Certainly that vocabulary remains. However, many times today patients are also referred to as clients or customers. Sometimes healthcare establishments are spoken of as "customer service agencies or customer service desks." In one extreme example, one individual noted that patients in one organization were referred to in a training session as "generators of relative value units and metrics of productivity to be entered into electronic medical record systems." And in a recent popular article, one professional proposed that healthcare agencies and clinics should model themselves on successful fast food or restaurant chains so that medical customers can be served quickly in order to make room for the next in line. What can be made of all this? What is being "talked" within these language constructs, amalgams, and images?

It is absolutely clear that any organization or institution must have in

place solid, effective structural systems that can maintain and ensure the ongoing services that are promised. Whether it be in education, business, healthcare, or any other entity, sound structural systems must be put in place especially to be cost-effective in these financially strained times.

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Healthcare and research must have such sound and effective systems in place. However, to change the fundamental nature of healthcare and research such that they are businesses first before they are human services is another story entirely. In fact, to do so is to place the proverbial cart before the horse.

Based upon these images, it seems obvious that there are cauldronic shifts and contests in the understanding of healthcare and research in contemporary society. For the future of healthcare and research to be balanced between their fundamental nature and their effective professional practice, there is a need to understand their primordial definition as well as detail the creative leadership needed for their evolving benefit to individuals and to society in general. Let us take time, then, to

reflect upon the nature of healthcare and research as they seem to be appreciated historically as well as ontologically. In this way, the first steps for creative reform and renewal of healthcare and research can be understood and acted upon for their future development and ongoing benefit to the human condition.

HEALTHCARE AND RESEARCH: PHENOMENOLOGICAL REFLECTIONS

Scholars in the healthcare humanities, especially academic theologians such as Charles Gusmer, remind us that to understand human health, healthcare, and even their related research disciplines requires a thoughtful, even provocative, understanding of the phenomenology of human illness. Sickness is part of the human experience. Death is as well. Due to their inherently obvious ultimate impact on the human person and human culture, a large number of powerful energies affect in diverse ways our understanding of these areas that touch each person's life. In some ways, modern society with its various emphases and concerns leads us to deny the existence or impact of sickness and death. Media and cosmetology can reveal an attempt on the part of society to push sickness and death to the periphery of our awareness. We act sometimes as if we will live forever and that youth will never leave us. In some cases, we make distinctions among various diseases that reflect curious

systems of values. For example, we may say that a person *has* a particular disease such as diabetes, but another person *is* a schizophrenic.

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Yet scholars remind us that underneath the various facets of human health as well as any individual disease or health problem, the experience is the same as that of the human person in general, namely holistic or systemic. Health and sickness are broad and expansive phenomena that integrate and touch the physical, the mental, the emotional, the spiritual, and the metaphysical. This last category refers to the meaning we attach to life itself. Regarding sickness, the experience of illness is one of alienation. Sickness separates us from others, from our work world, our relationships, from our regular sense of who we are as persons. The result, as Elizabeth Kubler-Ross has taught us, can be denial, fear, depression, or anger and rage. The reality of human illness affects one's system of values and beliefs, whether those be associated with a tradition of religious faith or not. Whatever the case may be, disease touches the entire human person and affects us far deeper than just the skin or surface. It

is not just a physical phenomenon that we hope to assuage with a pharmaceutical or a change of behavior. Sickness is not just something that is done to us. It affects not just what we do. It affects who we are. It affects and impacts our total being. And to this already complex reality is the fact that each of us is a member of unique cultures or social groups, each with their own diverse personality and internal systems of existence.

With this sense of sickness and disease as a type of background, what might be an effective and powerful image for us to begin in our day a re-appreciation for the nature of healthcare itself and its related research activities?

In Western civilization, a particularly powerful image arises from history. During the medieval period, oftentimes the sick would journey to or be brought outside a particular village to the local monastery or convent. Monasteries and convents in this period of time were the places where education and what we call the professions were often safeguarded after the fall of the Roman Empire and as the new nation-states were emerging. Along with the universities, religious houses were places of learning and culture. They preserved what might otherwise have been lost or forsaken in a time of political and cultural tumult. In addition, monasteries and convents were places of safety for travelers. They also were the places where monks, friars, canons, and

nuns would cultivate herbs and develop procedures to treat their own sick members and others in the monastic infirmary. When the sick or their families would knock on the door of the religious house, the porter would open the gate and welcome them into the service of the local members who would provide them with care. If one might engage in a metaphorical image, it is as if when the knock occurred, the porter opened the door and extended religious garb to bear them inside to healing. The sick were welcomed into an experience of being covered with care.

Interestingly enough, the verb “to cover” comes from the Latin verb, *palliare*. As readily seen, the Latin *palliare* is the root of our current vocabulary associated with palliative medicine. In fact, the experience of healthcare as a response to human sickness is the experience of covering one with care. Healthcare in general, therefore, can be understood as an act of palliation. Palliation is not just about a response to chronic illness. It also is not just about preparing someone for imminent death. Palliation is at the very heart of what healthcare is as a response to human illness. It is a response to the alienation that the human animal experiences in the face of sickness and the inevitability of one’s death. All of healthcare is palliative. It is an act of palliation. Healthcare itself is fundamentally about the experience of covering with care those who bear the

woundedness of human suffering. And when human society does not honor and promote healthcare itself as an act of palliation, of covering with care, society wounds healthcare and inflicts a disease of alienation upon it as well. A curious contradiction.

Healthcare requires the very best of scientific, medical, and pharmaceutical achievements. There is no question about that. In addition, healthcare also requires the very finest structures and business practices to ensure responsibility and the greatest success for those who are in need. However, underneath these non-negotiable aspects of healthcare activity, there must always be present the deeper definition of healthcare itself. In fact, that deeper definition, namely healthcare as a palliative experience, must imbue every single individual aspect of the activities and structures of healthcare and healthcare/medical organizations and structures. If not, the very definition of healthcare and its importance mutate into something less than what is needed.

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What then of healthcare-related research? How can research be understood with the palliative nature of healthcare? From the outset, it must be underscored firmly that healthcare requires the very finest of scientific investigations and investigations into human nature that can result in the most productive and meaningful innovations to promote human health, prevent disease, and procure curatives for the suffering that individuals suffer and endure. This cannot be emphasized enough. Healthcare itself is a multifaceted and interdisciplinary complexus. To be most effective in covering others with care, the finest research is essential. But how do we understand the nature of healthcare-related research? How can its importance be captured and best appreciated?

To understand research and its critical importance for healthcare, it is important to delve beneath the scientific, social and humanistic disciplines and appreciate research and its place within the human condition and the corporate human personality. Three images assist this understanding of research and its place within human experience.

First, from the time of birth, the human animal is launched into a world of exploration. Ancient mythologies, perhaps unknowingly, captured an extremely important part of the human personality when picturing the ancients as being cast

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out of a sacred place and made to wander into the wide vistas of the unexplored earth. Indeed, like them, human persons enter life imbued with a sense of curiosity, a desire to know and to discover. We reach beyond the morass of colors and sounds that flood our senses to discover what is around us. Even the most elemental psychology is correct that our reaching is done, at least in part, to increase pleasure and to reduce pain. But of particular importance is the fact that we are born into and enter the world as *homo curiosus*. We live in curiosity and reach beyond ourselves that we might come to know the unknowable and discover. This is the first stage of how we might understand ourselves as knowing beings.

Second, when the human animal journeys in exploration, discoveries are abundant. There is a certain reaching out to grasp what is present and begin to understand it. In some cases it may be possible for the person, whether an

individual or a corporate whole, to touch and toy with what has recently come into one's sphere of experience. Much as we see in young children, discovery leads to a sense of play. The person advances from being *homo curiosus* to being *homo ludens*, namely one who is in the act of playing. Another way of understanding this is that the person or community begins to engage in testing. Discovery leads to experimentation. One begins to test out the parameters of what one has discovered. This is the second stage of the human being journeying along the pilgrim path of knowing.

Third, and finally, once the human person has engaged in discovery and experimentation, something occurs whether realized or not. The discovery of new realities and the testing that occurs inevitably lead to some form of interpretive knowledge or even wisdom. Sometimes the experience is painful, such as when a child grasps to feel the flame on a candle. At other times it can be filled with joy, as when one's invitation to become a new friend is welcomed. Regardless of the result, the pathways of discovery and experimentation lead us to newness. In this understanding, we finally become *homo hermeneuticus*. We are creatures of continuing interpretation. Just as the mythical god Hermes was a trickster who subverted the assumptions of those to whom he delivered the messages of the gods, the human person and each

human community is ever on a pathway of having one's identity, life, mission, and activities in the never-ending act of re-interpretation and change. No human person has a corner on the truth. As philosophers of old and modern psychology teach us, we know everything only by analogy. We are analogical beings. We are always in the act of re-learning again and again.

These three important aspects of human life are the ultimate bases from which human invention and progress are born. This is as true for healthcare as it is with any other form of human development and professional life. Hence, research is part of the fundamental character of healthcare itself. Innovation and invention are essential to cure and care. In this context, research is integrated within healthcare as the experience of palliation.

Yet in our modern time, we are very well aware of the pressures of mass production, cost-effectiveness, and the goal of societal pressures to measure success based upon quantitatatives. Perhaps because of the relative ease of understanding coupled with contemporary society's being enamored with lightning speed and metrics, too often the human and humane dimensions of the definition of healthcare and healthcare-related research can be lost. Their meaning can be questioned. The awarding of grants is important not necessarily because of what might be

discovered to increase the quality of life, but because of the financial increase that such an award can bring to an institution or to a person's tenure on a faculty. Unfortunately, it is too easy in our present day to fall into the trap that it is only "all about the money." All of this can result unfortunately in the perpetuation of a tragedy that Western philosophers such as Nicolas Berdyaev defined as "moral objectification", where the human subject becomes an object, a thing, another form of data whose humanness itself can be denigrated if not entirely lost.

What then can be done?

Realizing that healthcare and research as human and humane services need to be balanced with the sound and obvious need for good organizational practices, what is needed are leaders who can maintain this balance and who can advance that through each complex aspect of the healthcare system, its activities, and its related research dimensions. What is needed are leaders of palliation who have the technical skills, requisite knowledge, and sense of formative wisdom that can steer all of these critically important dimensions along a pathway of successful and substantive human service. Such persons include those who are healthcare and research administrators.

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THE PALLIATIVE LEADERSHIP OF HEALTHCARE AND RESEARCH ADMINISTRATORS: AGENTS OF REFORM AND RENEWAL

The roles of healthcare administrators and research administrators have been extraordinarily diverse and developed upon unique pathways for different lengths of time in social history. Over the last half-century or more, these roles have grown exponentially and developed in ways that perhaps would seem unforeseen. In the social imagination and from certain historical perspectives, it is obvious that both of these professional groups concentrated upon the operational management and daily tactical maneuvers of healthcare institutions and research organizations. In the world of healthcare research, many times these unique roles were combined or at least conducted in tandem. Maintaining organizational structure and smooth daily operations, including the financial and regulatory, have always been and always will be

unquestionably essential. However, in these last decades the role and services of both healthcare and healthcare-related research administrators have advanced far beyond the securing of daily operations and tactical requirements. In point of fact, those who lead in administration and management are finding themselves today being called upon to become centrally involved in the strategic development of their organizations, including the formative evolution of the institution's character or being. Such a call is a call to leadership in *ethos*, noting well that *ethos* is defined as the fundamental character of a person or institution. Such involvement catapults the healthcare or research administrator into what could be categorized, in simple vocabulary, as four general processes of institutional strategic development. They are:

1. Promoting the best;
2. Preventing the worst;
3. Correcting and ameliorating the problematic; and
4. Assisting with evolving opportunities.

Ultimately, to become caught up in these four strategic processes means that the healthcare or research administrator is not just about the "doing" of one's duties for one's institution, but also about becoming caught up in the "being" of the organization, its mission and its services. To do so means that the administrator has to discover effective and meaningful ways of

professional service. The question arises as to how one does this best?

The Practice of Presence and Insight

Human beings are ordered too often toward the ordinary alone. Part of the ordinary in professional life is the daily performance of expected duties and work obligations. Yet instinctively, the human animal knows that it is much more than just a performer of the expected. In fact, one of the most powerful forces that the human person has is the power of presence. In healthcare in particular, though also true of other human amalgams, learning to be present is invaluable. To assist the person suffering from disease and from the primordial experience of alienation, it is important to learn to be present to someone's pain. To assist one's family, one must learn to be present to those with whom one shares life and home. To advance the work of one's profession and institutional affiliation, one must learn to be present to the processes and goals of the organization. Healthcare administrators and research administrators, to effectively contribute to the life of their organizations in proactively strategic ways, necessarily must be catapulted into the service of the institution in three constitutive areas: purpose and principles; policies and procedures; and programs and pathways of developmental opportunity. These areas of presence inevitably raise important critical questions for the healthcare or research

administrator.

Do I realize the purpose of the organization? How did it originate and evolve? What is its mission today? How is that mission perceived? What does the organization say are its guiding principles for its purpose and its daily work? From the behavior of the organization, what principles are manifest? Are they the same as those indicated by the organization itself? How can I add to the evolving purpose and principles of the organization and its mission? Am I aware of the organization's basic policies and procedures? Do these reflect the philosophy and purpose of the organization? Are changes or new developments needed? How are such policies carried out in tactical procedures? Are tactical procedures consistent with the overarching strategic policies of the organization? What is the state of the organization's current programs? Are they sufficient for the mission of the organization to others? Do they add to the internal life of the organization and its personnel? Are new programs needed? What of new opportunities that may be on the horizon? Is the organization open to such new pathways? How am I able to assist the organization in seeing, approaching, and welcoming new opportunities, especially those that are unprecedented despite any possible discomforts with potential change? How might I be able to assist?

Ultimately, such questions and the

entire posture of "presence" invariably lead one to the experience of insight. As many scholars have pointed out, including distinguished theologians such as Bernard Lonergan, insight is never easy but can never be dismissed. To effect the greatest depth to one's professional life and therefore to the institution and persons one serves, entering into the never-ending process of insight is unavoidable. In the world of healthcare and healthcare-related research, where the lives of the suffering and the quality of life of all are at stake, the administrator must be committed to the processes of insight for ongoing betterment and quality development of the institution's life such that the lives of those served may be protected and promoted. Yet there is an important dimension to being instruments of being, service, and insight. That dimension is the call to engage in one's work not just as an individual but as a relational person, a member of a number of intersecting, inter-relational domains

Integration among Organizational Domains

Literature teaches us that no one of us is an island. Western history and philosophy clearly attest to the importance of the individual; however, the individual does not live as an isolated personality. We do not live in silos separate from one another. Nor, despite evolutionary common sense, are we destined or ordered toward a sense of competition that predicates us necessarily

toward defensive postures with one another. Quite the contrary—evidence even from the casual observation of infants shows that the human animal is ordered toward otherness and to the contact that we enjoy in what we call relationships. The human person is, by nature, relational. As such, professional life and professional leadership are likewise relational. As discussed previously, human sickness impacts in serious and even destructive ways the relational being of the person. In sickness, we experience alienation and separation—even from the ways in which we conceive ourselves. Therefore, healthcare and healthcare-related research have as one of their aims the restoration and healing of the sense of otherness and connectivity that is essential to the human experience. Within this context, it is then relatively sensible to consider that the leadership of healthcare and research administrators must avoid the problem of power that arises from a concentration on the hierarchical. This leadership must be relational. By the very nature of healthcare and healthcare research, the practice of leadership as a relationship phenomenon is consistent with the wider being of the profession and services to which this practice belongs.

What then are the relations among which such leadership is practice? There seem to be four vital domains in which healthcare and research administration is

served. Of particular note is the fact that all four are essentially interconnected.

The first domain is that of the self. As many of us mature, we become more aware of the complexities of our personalities. The mental health and social sciences rightly call our attention to our multicomplex natures. Inevitably, the human animal is like an amalgam of various personal aspects that requires that we develop a relationship with all of our respective dimensions. In leadership, whether healthcare and research or otherwise, there is a need to know oneself. This is a truism from the ancients onward. If the practice of leadership is to be as effective as possible, and if healthcare and its research components are truly to be about healing, especially of alienation, etc., then authentic leadership in the same necessarily must include and nearly always begins within the self. It is from that domain that one advances into the second domain, namely the domain of relating with others.

Just as the individual leader must learn to relate to the self as multidimensional, so the leader must learn to relate to others in the workplace in precisely the same fashion. The complexity in this is obvious. Yet there is no way in which the leader can escape the inescapable reality of it all. In addition, being leaders in healthcare and healthcare-related research requires that one adopt the courage to enter into what is many times the volatile mix of daily professional

relations among peers, supervisors, executives, and staff. It requires a sense of presence that is dedicated, wise, and also courageous.

As efforts in this relational domain advance, the leader then invariably enters into a third domain, namely the relational nature of the institution itself. Each institution, though comprised of individual persons, also is like a person. It has its own personality, history and evolution, a being and a doing, relationships with other peer institutions, its competitors, and a future. Like the individual person, these aspects are multidimensional and require a type of careful presence that can weave in and out of daily experiences.

As one learns to negotiate these pathways and their interactions with one's own self and one's peers, one is called into yet a fourth domain, namely the community of persons that the institution serves. Ultimately, this is the domain of healthcare and healthcare research that holds the most logical significance. As discussed previously, healthcare is primordially human care. It is about the care of those who come to us in need. In the world of research, the investigator and the research organization look to advance the Human Good, to save lives, and to advance the quality of life. Hence, administration leaders in healthcare and research must learn to know the communities and persons that they serve. And in that learning, they

must become intimately aware of how different each community is. Each community is like an individual person. It has its own personality, its own dynamics, its own sense of self, its own lifestyle, its own level of knowledge, and its own desires. Healthcare and research leaders, through careful and respectful means, must learn to be present to the persons and communities that their organizations serve. They do so by careful and non-judgmental listening, by a sensitivity to the unarticulated truths that these others convey as much in behavior as well as in words, and by the courage to convey such knowledge back within the institution so that the needs of others can be served more effectively and with great benefit.

Yet the question can next be asked—when one enters into these inter-related domains of relationship, is there a process that assists the development and success of leadership?

The Process of Decisional Development

Over the past decade or more, highly significant research has been accomplished in the area of ethical decision-making. As in the scholarship of Elizabeth Holmes and Sarah Hope Lincoln, including those whose research they studied, the stages of ethical decision-making are highly illuminative and important for building upon such activities as the process of leadership development. In the preceding pages, the

complexities of leadership in healthcare and research administration have been made obvious. Within the universal of healthcare and its related research activities as being fundamentally about human care, what practical steps should one take for the practice of effective and ordered presence with the relational domains of professional work on behalf of human healing? When confronted with a particular task, a need, or an evolving new opportunity, the following five steps may prove useful. They are based generally upon the Holmes/Lincoln research as well as other sources of sound experience.

1. *Awareness*: First and foremost, the healthcare or research administrator must be completely aware of the task or need or opportunity at hand. Whether the situation is positive or negative, urgent or more long term, the question arises about one's complete awareness of the current situation.
2. *Assessment*: Second, regarding the situation and one's awareness, what are the relevant factors and variables surrounding the same? How conscious is one to the situation, its widest contextual configuration, and the value (or lack thereof) attached to the situation by various persons and constituencies? What is its importance as well as short- as well as long-term impact?
3. *Proposed Options*: What options does the situation or opportunity present?

What pathways can be taken to deal with the same? What are the relative prices and consequences of each option, including if the decision is not to decide?

4. *Decisional Choice*: What choice is recommended as best? What choice has been made?
5. *Evaluation*: After the choice has been made, what steps are being taken to evaluate the results? From an evaluation of the results, how can one assess the aforesaid decisional developmental process? From what has been experienced, what has been learned for the future?

These are practical and useful steps for insightful decisional development in leadership and management for healthcare and research administrators. However, there remains one final aspect to consider. All decisions, whether in the face of positive developments or corrective needs, ultimately lead to some form of change. Yet change, like any other aspect of human life, is not simplistic or unilateral. Change itself is a complex process. As those called in so many ways both strategic and tactical to be leaders, healthcare and research administrators are, to use the popular term, agents of change. But to what end? What might be a general way to understand the results of one's change agency in the healthcare and healthcare-related research arenas?

The Call to be Agents of Reform and Renewal

Scholars in social and cultural history attest to the realities of reform and renewal as being at the heart of historical development. Many, if not all, are very well aware of the impact of reforming movements in nations and institutions. Yet many others are also aware of the equally extraordinary power of renewal. Are reform and renewal the same? Actually, they are not. They are related but they are not equivocal terms or realities.

As experts demonstrated, reforms are movements that change aspects of life that already exist. Reform is an actual “re-forming” of already existing constituents or parts. To use the term more broadly, the experience of a reformation is something that the human animal and human society engages readily and nearly daily. It is a rearrangement. At times, it is also very powerful. As historians point out, the experience of the Reformation in 16th-century Europe was explosive. It was a time in which national, religious, and social consciousness was altered. Political affiliations were broken and re-aligned. The very way that human beings and their national communities defined themselves was rearranged. However, the European mentality effectively stayed the same. The constitutive “parts” of being European and even in belonging to certain traditions were not altered. Reform was a reconfiguration of

existing parts. Change was powerful indeed in this example, but it was reform, not necessarily renewal.

Thomas Kuhn, in *The Structure of a Scientific Revolution*, addressed what is meant by renewal. When he talked about scientific discoveries of immense impact, such as those from Galileo, he demonstrated that such discoveries did not just change variables in society. Rather, such discoveries altered social self-consciousness with an unprecedented flash of newness. Such discoveries brought about what he called “paradigm shifts” in the total ways that human beings think, act, live, and even “be.” Discoveries like those from Galileo created a complete and unprecedented shift even in the assumptions and self-preconceptions that human beings have about life. Such discoveries continue to occur and affect human existence in history. These are the processes of another form of change, namely that of renewal. Renewal occurs not when constitutive elements are rearranged. Renewal occurs when something truly radically new bursts upon the scene and creates unprecedented catapults of activity at the very *radix* (root) of the human experience. That is what makes renewal so radical—or, to build upon the Latin image, so “radix-al.”

In our day and age, healthcare and healthcare-related research are standing at a crossroads. Imbued by the power of the Industrial Revolution, the pursuit of

business practices and their relatively easy quantitative measurables as the normative ruler of success, and the swiftness of an Information Age that can make the speed of data more important than the incalculable depth of wisdom, the human nature of healthcare and its related research activities has been affected seriously and with wide and deep consequences. As stated previously, there is no question that both healthcare and healthcare-related research demand sound and effective business management. Human sickness needs swift and effective action that involves the best resources in the best manner possible. To provide for others effectively means that the resources for such provision must be directed and overseen with care and due regard for all. That too is wisdom. However, to replace or alter the fundamental experience of healthcare as human care, even subconsciously, is to tamper with its very definition, meaning, and value. Hence, while preserving the very best of management in carrying out the healthcare and research mission, there is a need to develop and promote those in our midst who can call us to reform and renewal when we lose sight of our primordial identity and mission.

Throughout the centuries, wise women and men arise in our midst. They call us to remember and to be re-membered in the core of what it means to be human. On some days, such a call is to rearrange the

pieces around us. On other days, their call is to a newness of experience and professional life that may be deeply uncomfortable, perhaps even viewed by some as heretical. However, reform and renewal can never be avoided. As healthcare and research administrators, if we wish to be true and authentic to that which we profess as a service of excellence, then we also must accept the price. On some days, that may be the applause for inventing a new and profoundly imaginative program of service. On other days, it may be the offer of a glass of hemlock. In either regard, the call is the same—the call to be Agents of Change and Instruments of Reform and Renewal—and to serve best those who come to us for care for the sake of the Greatest Good.

CONCLUSION: AND YET WE RISE AGAIN

In 2014, national attention was captured by the grave situations that arose in the Veterans Affairs Health Care System. The media regularly filled our minds and eyes with initial developments in which individuals did not receive care they needed and deserved, or that this and related developments were having dire consequences for them and their families. National reports and congressional hearings brought to our attention a complex series of incidents. The reactions to these were deep, diverse, and often divisive. On the one hand, there was the naturally expected and

disbelief. How could a abandon those who had defended us and to whom we had pledged and promised our care? How could this happen? What could possibly motivate such abandonment? On the other hand, there was apathy or denial. Such is always the possibility when facing tragedy. The human animal can be so overwhelmed by experience that the person simply shuts down and refuses to accept tragedies. Both of these reactions are understandable. However, they are not the only major reactions. In fact, to deal effectively with the tragedy of non-care and its result into a type of cultural or social dis-ease, a third reaction is needed and is emerging.

Interestingly, reports of problematic issues in the VA health system were first revealed from a place called "Phoenix." This might strike one as a deep and abidingly powerful curiosity. Ancient mythologies of many cultures have sustained the powerful image of the phoenix bird. In this tale, a creature of amazing beauty and power over time builds for itself a nest that is then enflamed while the phoenix is in it. The phoenix dies in the flames it has created. Yet from the ashes that are left behind a young chick emerges and a new phoenix bird arises and lives again for another long period of history. A regular cycle of life, death, and rebirth is captured in this story whose tale of rebirth or resurrection has influenced the human mind and consciousness since the dawn of

civilization.

What is required is the rebuilding or rebirthing of the entire culture of healthcare and healthcare-related research into something new and unforeseen.

In a certain respect the image of the phoenix and its rebirth captures a third reactionary option in the face of the problems recently evidenced. News stories from 2014 conveyed in a certain respect that healthcare and the public's trust of it have become enflamed. In some cases, our anger has brought about cynicism, perhaps even despair. But perhaps we are called to something deeper, something more powerful, something that in the words of Augustine of Hippo is ".....ever ancient yet ever new." From the issues and problems we have recently experienced, perhaps there is a call within our cultures and societies to allow a new form of healthcare and healthcare research to emerge from the ashes. Perhaps it is time to call for systems and services that are truly patient-centered and ordered toward the Greatest Good, namely our call to protect one another from disease and to promote among us all truly what is total, human health. Such a call, however, cannot be answered only by reforming systems and rearranging management practices. What is required here is also a complete renewal of what we

mean by healthcare as human care, as well as research defined as genius becoming innovation for the Common Good. What is required is the rebuilding or rebirthing of the entire culture of healthcare and healthcare-related research into something new and unforeseen. While seeking to establish a culture of total transparency and accountability, the culture that emerges must have as its first dedication the call to serve others before the self. To initiate and energize for the long run such a comprehensive culture of care that is built on solid reform and proactive renewal,

there is a need to raise up leaders who themselves are not afraid to be enflamed. They do not fear the flames because they know that what they do is done for the best of those who come to their communities for healing and care and a better quality of life. This may be the outstanding and life-giving service of healthcare and research administrators who strive, even at risk to themselves, to build communities of health serving those who come to them in need and seeking the very best of what it means to be fully human and fully alive.

We can and will rise again.

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ABOUT THE AUTHOR

Edward Gabriele from 2013-2014 was Professor and Director of Special Projects for the National Center for Bioethics in Research and Health Care at Tuskegee University. Previously, he was Special Assistant for Ethics and Professional Integrity to the US Navy Surgeon General, directing ethics in healthcare, research, organizational systems, and ethics education and formation. In addition to his current appointment, he is Distinguished Professor in the Graduate School of Nursing at the Uniformed Services University of the Health Sciences, and Professor in Clinician Education at Georgetown University Medical Center. He is also Director of the Annual Ethics Education Series previously held at the Smithsonian. An international expert in healthcare humanities, human research and research ethics, he has served in research administration for over two decades. He is former Editor of the *Journal of Research Administration*, and Founder/Editor of *the Journal of Healthcare, Science and the Humanities*.
