Unity Across Diversity: Catholic Identity and Physician Practices in Catholic Health Care

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Introduction

This essay emerged from theological reflections begun during a recent experience as a mission leader within a Catholic health system. Our local health system acquired a multi-specialty physician clinic in six locations across three counties in Arkansas. Among the varied business challenges that come with merging or integrating any new organization into an existing business model, e.g., human resources, financial accounting, software compatibility, etc., came the uniquely theological question of mission integration. On a specific day the business transaction was complete and these clinics became nominally Catholic. Accordingly, a plan was developed and put in place that included orientation and education, development of policies and procedures, purchasing art and sacred decorations to depict our Catholic heritage, and the discontinuation of ethically forbidden procedures such as surgical sterilization. Still, even as these efforts were underway, it was troubling that some fundamental conceptual questions were not being addressed, namely "What does it mean for a physician practice to be Christian/Catholic?"

Some might argue these questions have already been answered and that there exists a consensus in general terms within the Catholic health ministry around what constitutes "Catholic identity." Evidence for this would be found in statements such as the "Shared Statement of Identity for the Catholic Health Ministry" (Catholic Health Association 2008), the *Ethical and Religious Directives for Catholic Health Care Services* (United States Conference of Catholic Bishops 2009) and "Caritas in Communion: A Summary" (Catholic Health Association, 2013). In this view physicians, like any other employee, would need to conform to the existing standards of identity.

This approach seems less than adequate. First, while accord may exist within Catholic health care regarding questions of identity, this agreement is principally related to hospitals rather than physician practices. Even regarding hospitals, there is considerably less consensus on specific activities or outcomes around each category that comprise these shared statements. For example, community benefit practices and commitments to spiritual care of patients in Catholic hospitals vary widely among Catholic health systems. This ambiguity is even more evident in regards to integrated physician practices in a Catholic health system, e.g., should physician clinics provide pastoral care? Second, physicians do not view themselves as employees like any other. They

are highly educated, wealthy, and members of a powerful profession. Although physicians as individuals and as a profession have embraced the corporate practice of medicine, they are typically uneasy to abandon the locus of control over their practices to corporate structures (Starr 1982). Thus this diversity must be addressed in another manner.

Anyone familiar with the landscape of modern American health care is aware that the relationship between physicians and health systems has been changing. Hospitals are on a "buying spree" purchasing physician practices and employing physicians. The motivations for these purchases are multi-faceted from both the hospital and physician side. Not surprisingly, religious affiliation or congruity around ethical and theological worldviews is seldom articulated as a reason for physicians seeking partnership or employment with any particular hospital or health system. Given that Catholic hospitals and health systems are engaging in efforts to acquire physician practices or employ physicians in competition with their for-profit competitors serving in the same communities, it seems prudent to pause and reflect theologically on what it means for these physician practices to be Catholic.

These relatively new developments present both challenges and opportunities for religious orders and sponsoring entities of Catholic health systems. From the Cenobitic monasteries of the late Patristic period down through the middle of the twentieth century, religious orders cared for the sick and operated hospitals principally with the labor and leadership of the members of the order. These communities of women and men shared a common tradition and commitment to a Christian vision of health care interpreted through the particular charism of their founders and handed down through the formation of new members of the order. There was a certainty that an institution would be faithful to its roots because they operated in a sense as a "family business" (Grant and Vandeburg 1998). As the numbers of vowed religious declined, the day to day work of teaching, nursing, etc. transitioned to lay persons while the members of the sponsoring community took on a leadership role for "mission fulfillment, quality, critical components of operation…and culture as well" (Grant and Vandeburg 1998). This trend continued with the development of "mission" roles to oversee theological identity, set expectations for employees and develop leadership training and formation for those in administration and governance. In this model in the twentieth century into current times, physicians would collaborate with hospital leadership as members of the medical staff but, with a few exceptions, the medical staff was organized as an independent entity devoted to upholding professional standards around the practice of medicine within the hospital. Although physicians would be expected to adhere to the *Ethical and Religious Directives for Catholic Health Care Services*, this was characteristically understood as avoiding prohibited procedures in the area of reproductive ethics.

Certainly new partnerships can be an opportunity for Catholic health care to further its mission and influence the healing professions, but they can also pose serious challenges to Catholic health care "when partnerships are formed with those who do not share Catholic moral principles"(United

States Conference of Catholic Bishops 2009, 30). In the interest of expediency around "closing the deal" Catholic health systems might align with physician practices that do not share commitments vital to a faithful practice of medicine.

Religious Commitments and the Practice of Medicine

The reality that few physicians are motivated to integrate or seek employment with a Catholic provider primarily based on its faith commitments should not be under emphasized. Although some Catholic health systems pre-screen physicians for "values alignment" prior to employment (Crawford 2011), the majority seek alignment after the deal is completed. In this author's experience with such negotiations, conflicts that might arise between the culture of the clinic and the culture of the Catholic institution are frequently minimized. These phenomena should not be surprising. As ethicist H. Tristram Engelhardt has observed: "In a liberal cosmopolitan culture, sectarian religious commitments go against the grain" (Englehardt, 2001, 154). Thus, there are strong cultural factors that contribute to minimizing the particular religious commitments of a Catholic institution. Physicians who had previously been independent or just coming out of training might rightly be concerned with how religious commitments might interfere with their practice of medicine or their ability to earn a competitive salary. Of course, up-front minimization of the particular norms of a Catholic institution can lead to problems. Engelhardt puts the question succinctly: "How can a corporate ethos be established, if a large proportion of the staff and employees are not even nominally Roman Catholic? On the other hand, if the staff and employees are not enculturated into a Christian ethos, the institution will be a Christian health care institution in name only, or perhaps at best in terms of a few prohibitions, which will appear as external constraints over against the actual life of the institution" (Englehardt 2001, 152). This brings us to the crux of the issue: if physicians and clinics are not going to explicitly confess the same Christian identity of their parent in what way are they Christian?

A thorough examination of the impact of Christianity upon the practice of medicine is beyond the scope of this brief essay but in my studies I have found no scriptural or traditional mandate that physicians practicing within a Catholic physician practice must practice the science of medicine any differently than their secular counterparts save for a few prohibitions which are central to the culture of life. Through the centuries, faithful Christians have utilized the science of medicine (rudimentary as it may have been in earlier times) to relieve suffering. Thus, we acknowledge that although the church continued to utilize physicians in providing care down through the centuries, the "relation between medicine, a secular enterprise, and spiritual healing is at best unclear" (Love 2008, 235). Although "sharing in the healing ministry of Jesus" is a common element in mission statements of Catholic health systems, specifics around this remain vague especially in regards to the practice of medicine (O'Rourke 2001).

Three Possibilities for the Catholic Physician Practice

One possibility is the concept of a "Christian" physician. Christian or Catholic physicians are typically defined through their personal virtues, i.e., their concern and faithfulness to their patients, their care for the poor and their continued attentiveness to prohibitions, e.g., abortions, sterilizations, etc. Pellegrino and Thomasma when describing a Christian physician portray her as "an amalgam of the ethical commitments to the sick by Hippocratic physicians, the divine revelations of Jewish and Christian Scripture, the tradition of healing as an apostolate for all Christians and a coterminous commitment to scientific competence" (Pellegrino and Thomasma 1996, 48). In this view to be a Christian physician is similar to being a Christian carpenter, plumber, baker etc. The skills of one's craft are essentially the same, but how one practices the craft is informed by the distinct nature of the Christian community.

Certainly Catholic health care should welcome such Christian physicians, but simultaneously acknowledge that we live in a diverse world with a plurality of religious and moral beliefs both among physicians and patients. From a practical standpoint, when a typical physician practice integrates into a Catholic health system, there will be a diversity of gender, age, religious affiliations and belief systems among the physicians. This diversity poses a challenge and opportunity. Integrating only Christian physicians would severely impede the possibility of an institutional response to the needs of the sick.

Therefore a second possible response to the challenge is what I would call the "formed physician," i.e., the development of physician formation programs similar to those devised for lay leaders in governance and administration to transmit core teachings regarding the tenets of Catholic health care, encourage individual spiritual growth and delineate and inculcate the behaviors required for those who would serve within the ministry (Yanofchick 2011). This approach seems to have a great deal of merit and indeed has been a dominant force in mission integration programs in hospitals for the past several years. In these approaches, the founding stories of the healing ministry of Jesus are retold and re-imagined in ways that bring new energy and insight to the ministry. The gaps between the current reality and the visions of the founders serve as a catalyst for action and allow new members of the ministry to see their place in the ongoing narrative of the organization (Arbuckle 2013). In regards to physician formation, there are preliminary reports of success throughout the ministry, where physicians have deepened their own understanding of the healing profession and better connected with the healing ministry of Jesus and the charism of the health system's founders (Doyle, 2014). These formation approaches value diversity, but do expect new members to embrace and adopt the identity of the parent organization and accept the founding stories as a motivation for action.

The experience of the Catholic health ministry with physician integration is still in its infancy and so it is probably premature to judge formation programs, but this author is not yet convinced that existing formation programs can be easily replicated in the clinic

due to the strong culture differences between the culture of a physician clinic and that of a hospital or health system. As noted previously, physicians do not view themselves as employees like any other. In many health systems, including my home health system, the physician population reflects greater diversity than the mostly homogenous central Arkansas population. Our employed physician group reflects great diversity in age, gender, country of origin, religion, education, language, etc. With the growth in the divide between hospital-based physicians and clinic-based physicians, many of our employed physicians seldom interact with hospital staff or leadership and have little formal connection to the broader health system ministry. As hospital admissions decline and physician practices become a more identifiable part of the Catholic health ministry, it seems imperative that we clarify how these entities will truly be Catholic in a culture of greater diversity and plurality. I would like to pose for discussion an approach I will call (following communitarian philosopher Charles Taylor) "unity across diversity" which is anchored in an understanding of Catholic identity as rooted in the practice of care for the sick.

The work of Alisdair MacIntyre has provided a convincing argument that we can never achieve widespread consensus on matters of morality, including medical morality in our modern world. All that remains of past consensus are "fragments" of moral language that are no longer anchored in a coherent moral tradition (MacIntyre 1981). Some view these phenomena with extreme pessimism and call on Christian practitioners to set themselves apart from the wider cultural medical establishment. Engelhardt, for example, views the current state of Christian bioethics as in disarray in attempting to placate a secular culture. He sees this as directly traceable to efforts in the 13th century to translate the theological norms of the church into a moral language comprehensible to anyone in the natural law tradition. He views these efforts at using the natural law as ultimately fruitless:

> As our intractable secular moral pluralism demonstrates, a common sense of morality, or even a common sense of the secularly morally reasonable, does not exist for the secular culture beyond its rejection of a fully transcendent God Who determines the nature of the good, the right, and the virtuous (including the content of bioethics). (Engelhardt 2011, 67).

Engelhardt sees the current hostility of secular culture to religion as returning the church to its pre-Constantine status as an embattled minority. He views this as an opportunity for the church to reclaim a more robust confessional theocentric view of morality, medicine and health care as anchored in the truth of the triune God.

Unlike Engelhardt, we look not to conflict but to areas of agreement as a possible clue to building working relationships. There is a growing scientific literature on a biological basis for some types of moral behavior. Thus the near universal accord against killing of innocents, torture and incest may have a neurobiological source. In this view, much of moral discourse is simply rational

interpretation of "unconscious moral intuitions and behaviors" (Gazzaniga 2008).

Within bioethics there is also a strain that claims most ethical reasoning is *post hoc.* For example, one of the "founding myths" of bioethics is the nature of discourse that led to the drafting of the Belmont Report, created by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Using an inductive approach, the commissioners came to widespread agreement around particular cases. It was when they attempted to justify why they agreed that they ran into obstacles:

> The one thing individual commissioners could not agree on was why they agreed. Instead of securely established universal principles…giving the intellectual grounding for particular judgments about specific kinds of cases, it was the other way around. The *locus of* certitude in the commissioners' discussions…lay in a shared perception of what was specifically at stake in particular kinds of human situations (Jonsen and Toulmin 1988, 16-19).

In an international consensus, Charles Taylor has observed that widespread agreement can be achieved on the existence of human rights (as in the Universal Declaration on Human Rights) as long as we set aside the theoretical discussion of the foundation of those rights (C. Taylor 1996).

For Catholics this consensus is not surprising. Like Engelhardt, we look to the natural law tradition, but not as the source of our troubles but as a sign that a solution is possible. The natural law tradition has many strains and facets but in a simple sense it teaches that there is order and purpose in the world and that by examining this order and purpose we can determine which choices and activities lead to human flourishing and which impede it. It further argues that these actions can be discovered through the use of practical reason by reflecting upon the nature of humans. For the Christian, this order is discovered because nature reflects the design of the creator. A scriptural basis is found in Paul's Letter to the Romans:

> Indeed, when Gentiles, who do not have the law, do by nature things required by the law, they are a law for themselves, even though they do not have the law. [15] They show that the requirements of the law are written on their hearts, their consciences also bearing witness, and their thoughts sometimes accusing them and at other times even defending them (Romans 2:14-15).

The philosophical roots of the natural law are found in the teleology of Aristotelian ethics and further developed by St. Augustine and St. Ambrose and reach their zenith in the thought of St. Thomas Aquinas. Aquinas came to demarcate a three-tiered set of human goods including life itself, education of offspring, life in society, friendship, marriage, etc. Humans have natural inclination to seek these goods (Aquinas *Summa Theologica* I-II, 94, 2-6). Our point here however is not to defend or justify natural law reasoning nor to translate the claims of Christian faith into

neutral concepts, but instead to point the tradition as justification for a common morality or moral intuitions that can be fostered and nurtured even with persons whose avowed belief systems may be significantly different from our Christian/Catholic worldview.

This is not to encourage a naïve hope that the existence of moral intuitions or a common morality will lead to a moral nation or world. Indeed there is ample evidence for pessimism. Pluralism is not an excuse for relativism or "a kind of Will Rogers pluralism: one where theologians have never met a position they didn't like." (Tracy 1981) Instead we can see the need for a communitarian ethic built on service. The early church's response to poverty and suffering was rooted in the concept of *imago Dei* and this concept, operative in Judaic thought, developed and was transformed by the activity of agape love in the early Church. As time went on the concept of *philanthropia,* which heretofore had not been characterized by private charity or caring for the indigent, was transformed by the early church. This is again possible with the active support of Catholic health care.

Thus against Engelhardt's call to retreat to some pre-Constantine ecclesiology we turn hopefully to a theology for a physician practice built upon practices anchored in a common morality. While not rejecting the primacy of faith, we are more optimistic than Engelhardt regarding the future of Christian health care, arguing that moral pluralism is not an excuse for isolationism. Taking seriously the charge of the Second Vatican Council in the Pastoral Constitution of Church in the Modern World (*Gaudium et Spes*) we acknowledge the interdependence of all persons and the needs for institutions and groups to work together for the benefit of humanity. The church must be in the world, at the service of persons and in dialogue with the world (Hehir 2008, 21). This is the church as faithful individuals, but also the church collective, the institutional church. As Bryan Hehir argues in a discussion of the Catholic health ministry, the Catholic Church is "institutional by instinct and by nature. We often think of the institution as a force that hinders, burdens, or creates obstacles," but he goes on to describe how the complexity of our world demands institutional responses as well as committed personal lives (Hehir 2008, 18).

Our society and our institutions are growing in diversity. Within these institutional lives we find the diversity already described. Communitarian Charles Taylor has argued that human diversity is part of how we are made in the image of the Triune God (C. Taylor 1999). Truly acknowledging this diversity and recognizing it as a part of God's plan is therefore fully "Catholic" and transforms the Gospel mandate to "go and make disciples of all nations (Mathew 28:18) from a unity-through-identity understanding to a unity-across-difference understanding (C. Taylor 1999). Thus, we do not have to make physicians (or any co-workers for that matter) into "Christian" physicians or close approximations to the same through formation programs in order to be faithful to our Christian identity. We do have to ensure that our actions as Christian health care are always faithful to a Gospel rooted in *agape* love. As Michael Himes notes in describing the centrality of service in the Christian faith, "We cannot experience God unless we love

our brothers and sisters and we cannot love our brothers and sisters without experiencing God" (Himes 1995, 55). This is an optimistic note which we would like to build upon.

To "share in the healing ministry of Jesus" must be understood more broadly as practices imitative and illustrative of gospel care and compassion as lived by Jesus Christ and understood by the early church in the term *agape* love. The Epistle of James continues to be instructive:

> What good is it, my brothers, if someone says he has faith but does not have works? Can that faith save him? If a brother or sister has nothing to wear and has no food for the day, and one of you says to them, "Go in peace, keep warm, and eat well," but you do not give them the necessities of the body, what good is it? So also faith of itself, if it does not have works, is dead. Indeed someone might say, "You have faith and I have works." Demonstrate your faith to me without works, and I will demonstrate my faith to you from my works (James 2:14-18).

The Epistle articulates an essential truth in moral epistemology: we do not believe certain things about God, the world, our neighbors, derive universal moral principles and then live according to those principles. Instead we form our beliefs, abstractions, principles from the language and practices that form our lives. Imitating God's mercy, forgiving enemies, giving freely to others, praying etc., can have profound implications on relationships and social practices (Cahill, "The Bible and Christian Moral Principles" 1996, 8).

In our developing relationships with physicians we must engage in dialogue around the practices that can unite us across our ideological differences. Without doubt, there will be practices that the Catholic health system will demand of any physician who wishes to become a part of the ministry including the defense of innocent life, compassion and a willingness to serve the poor. Apart from these essentials there will be a need for dialogue. Certainly, the church does not come empty handed, but neither does it come with all the answers. In faith we believe that in serving the sick and the poor we encounter Christ and this encounter cannot help but be transformative. We remain optimistic that we can come to agreement on what we should do without agreement on why we should do it. We must remain committed to this openness because of the nature of the problems we face and the mandate we have received to care for our neighbors in distress compels us to be open to the Spirit in new ways.

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