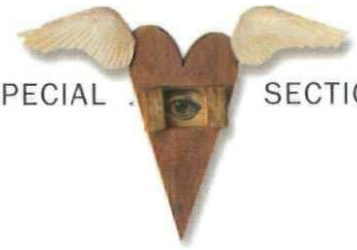


# CATHOLIC HEALTHCARE AND THE COMMON GOOD

*An Ancient Concept Can Bring the Transforming Power of Grace into the Public Healthcare Debate*

**BY REV. CHARLES E. BOUCHARD, OP, STD**

The notion of "common good" has remained constant through centuries of Catholic social teaching. Its roots lie in Greek and Roman philosophy, in which it was seen as the goal of political life—the good of the city—and entrusted to civic leaders. St. Augustine acknowledged that our earthly cities achieved a common good of a sort, but he stressed that only the heavenly city, the City of God, was truly worthy of that name. Later thinkers in the tradition of St. Thomas Aquinas saw the common good in three ways: as the good of any being, as the good of a political community, and, finally, as God's own self, to whom all creation tends.[1] Writing in light of the totalitarian horrors which preceded the Second World War, Thomist scholar Jacques Maritain emphasized that the common good could never violate basic human dignity: "It is the good human life of the multitude . . . their communion in good living. It is therefore common to the whole and to the parts. It flows back on the parts, and the parts must benefit from it."[2]

The *Catechism of the Catholic Church* summarized this tradition by describing the common good as "the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily." The catechism notes that the common good involves three essential elements: respect for the person, the social well-being and development of the group, and peace, which is the stability of a just order.[3]

Today, because health is clearly a good and healthcare is a need common to all, we frequently invoke the common good in the debate about the future of healthcare. Yet despite the centrality of this concept in our tradition it often remains an abstraction that is difficult to apply to the organization or management of healthcare. In addition, the rich spiritual and theological meaning of the common good is seldom seen as a resource in our attempts to redefine Catholic identity in healthcare.

## Cultural Challenges to the Notion of the Common Good

**Individualism and Pluralism** Robert Bellah, following Alexis de Toqueville's observations about the American character, has shown how Americans have clung to the same individualistic notion of citizenship that animated their revolutionary ancestors.[4] This view emphasizes personal freedom and self-determination, low taxes, and private initiative over government control. It has proved to be inhospitable ground for the notion of common good. This is particularly true in healthcare, which is rooted in a whole array of private goods:

> Physicians want to retain or restore autonomy of practice. Hospitals want market choices but protection from market discipline. Suppliers of medical devices and pharmaceuticals want the widest range of proprietary control in the development and marketing of products and drugs. Insurers want release from cost shifting and mandated benefits and freedom to exclude high-risk individuals. Patients and consumers of health insurance want the greatest range of coverage at the lowest cost and access to

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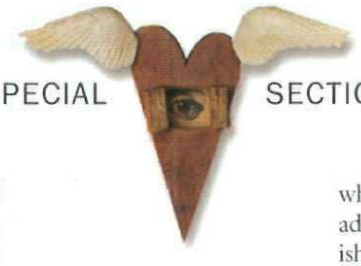


> the highest quality of medical care—without gatekeepers, waiting lists, or rationing of care. American taxpayers do not want to sacrifice the freedom represented by their disposable incomes, and many are reluctant to abandon unhealthy habits. In short . . . American health care is dominated by an individualism that asserts self- or group interest over the common good.[5]

In addition to all these incompatible needs, today we are rapidly adding high investor return to the equation. Achievement of the common good falls far down the line of priorities in the development and delivery of healthcare.

**Affluence and Political Apathy** Affluence and the false security it provides are further obstacles to the common good. They can lull most of us into feeling that the rest of us will be just fine, and that government and political life are more intrusive than helpful. *Harper's* editor Lewis Lapham has noted with dismay the growing disenchantment with politics in America. The general ineffectiveness of our political system today, coupled with unprecedented economic prosperity, has led many to believe that government and political life are not really necessary any longer. He cites remarks by *New York Post* columnist James K. Glassman, who noted that Americans are "really happy," and probably do not need to be interested in politics. Mr. Glassman elaborated: "We have reached an era . . . in which we can turn our attention from politics and war and toward art, in the broadest sense of the word, which includes not just porcelain, but philanthropy, aesthetics, religion and family. As the century draws to a close, we seem to be witnessing the death of politics and the rise of something else. Call it the art of living."

Lapham says this affluence and the corresponding indifference to politics have appeared before. They caused "an oligarchy that might once have aspired to an ideal of wisdom or virtue" to acquire instead what Aristotle called 'the mentality of the prosperous fool'—a man or class so bewildered by their faith in money that they therefore imagine that there is nothing that it cannot buy."[6] This view of government and political life contrasts sharply with the descriptions of the common good taken from the Catholic tradition.

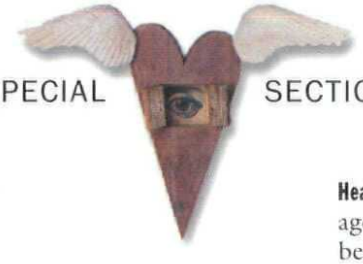
This idea that the best government is the least government is rooted in a view of the human person that stresses freedom and autonomy above all else. Theologically, this view depends on seeing government as a result of the fall and as a punishment for sin. If that is true, then indeed, the less of it the better.[7] However, the Catholic view is more sanguine. In a rather arcane question, Aquinas asks whether there would have been political life in paradise, before the Fall. If government were a punishment for sin, we would expect him to reply in the negative, but he does not: "Someone has dominion [that is, exercises political power] over another . . . when he is directing him to his own good or to the common good. As such, domination . . . would have existed in the state of innocence . . . because we are naturally social, and [even] in innocence we would have lived in social groups. The social life of many is not possible unless someone presides who can *direct the group toward the common good.*"[8]

This means that, theologically, we do not view government, nor presumably a common good toward which it can direct us, as necessary evils nor as infringements on human freedom. As persons with a communal, transcendental end, this drive toward union is inherent, and the political means to achieve it are a blessing rather than a curse. Government and political life exist not to limit human freedom, but to help facilitate distribution of goods, with a view to creating a peaceful, interdependent society. In our own day, Aquinas might well have asked whether, in a state of innocence, there would have been managed care!

**Affluence and the security it provides are further obstacles to the common good.**

**Moral Agnosticism** Philosophically, the biggest obstacle to a theory of the common good is epistemological: Is there "a good" to be known, and, even if there is, who can know it? There is a strong strain of moral agnosticism which denies that we can know what our own good is. Michael Novak notes:

> It is not so easy, either, to come to know the common good of free persons. There are three reasons for this. *First*, even in trying to determine one's own economic good, in the full context of one's own political, moral and cultural goals—one often feels confusion and uncertainty. Should one buy this house? Take this position? Accept this contract? All such decisions are made in ignorance of the future. Not all the relevant contingencies can be known. . . . It follows that it is no easier to know the economic good even of one's best friends and nearest neighbors. . . . *Second*, each of us is necessarily ignorant about the economic good of those in trades . . . and circumstances of which we have no experience. *Third*, the economic good of an entire nation, on a high level of abstraction from particular persons or groups, may be easy enough to sketch in a "wish list": low inflation, low unemployment, steady growth, [etc.]. Yet the scholarly discipline designed to investigate the



> tradeoffs among these . . . goods has won the historical sobriquet of the "dismal science". . . . The phrase "common good" sounds simple and neat. But upon inspection this good turns out to consist of many goods . . . not only not in natural harmony, but often in direct conflict. . . . Thus, even if we were to accept the ideal of the common good, we would still be operating in considerable darkness and uncertainty.

Novak goes on to say that even though, because of this ignorance, it is impossible to "*intend* the common good," or "take it by frontal assault," it could be *achieved* by persons with freedom and dignity, "by an indirect, less paternalistic route."[9]

This kind of liberalism stresses human freedom and independent choice of individual goods. It creates, at best, a "thin theory of the good" that values noninterference and privacy rights over cooperation in a common project. However, as Daniel Callahan notes, it is important to remember that this approach can also limit freedom by creating its own culture:

> If we think of medical developments as simply putting difficult but discrete moral choices before us—how best to use this or that technology, whether to turn off this respirator—we have already failed to see the presence of a still deeper question, [e.g.]: first, to what extent has the culture engendered by medicine already constrained our choice (forcing us, for instance, to consider the use of a respirator whether we want such a choice or not); and second, what kind of a culture will we be engendering by the pattern of private decisions that eventually emerges from the need to make decisions. Those individual decisions, in short, sooner or later create a culture.[10]

## Can We Retrieve the Common Good as an Operative Principle in Catholic Healthcare?

Despite these cultural and theoretical difficulties, the public nature of healthcare demands that we find ways to make it more than a private good or a series of individual choices. Since the notion of the common good is also a spiritual concept rooted in the belief that our common good is God's own self, Catholic healthcare providers must find new ways to link the social and human good of healthcare with its spiritual and sacramental goods. This involves development of new, participatory management styles, redefinition of patient and physician autonomy, and increased awareness of the sacramental nature of healthcare.

**Managers must learn to create healthcare organizations that operate as organic units and maximize employee participation in achievement of the common good through mission education.**

**Healthcare Management and Participation** Not very long ago the healthcare relationship was a private one between the physician and the patient. Today, medical care "has moved from being a privately paid, individual good of marginal value to the status of a largely public-supported individual and social good of great benefit."[11] The patient and physician are just two players in a whole panoply of providers and support personnel whose interests are not always complementary. Managers must learn not only to maintain a strong bottom line, but to create healthcare facilities and systems that operate as organic units and maximize employee participation in achievement of the common good through mission education.

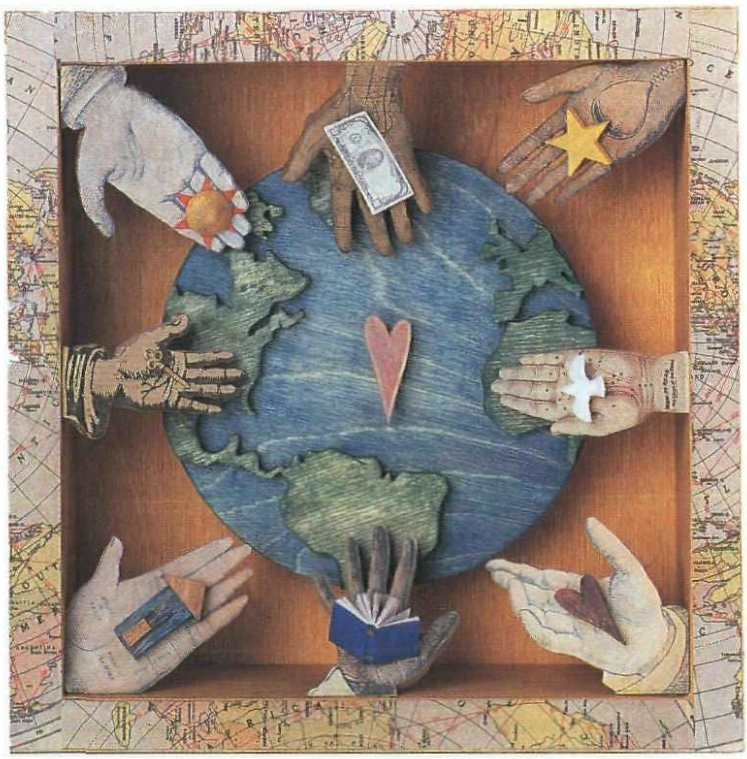
This education should be rooted in the notion of subsidiarity, where authority and competence to act are not merely delegated from above, but are elicited from employees' talents and commitment at a level appropriate to their skills. We are trying to make our employees part of something bigger than themselves. Ezekiel Emmanuel calls this "something" a "higher level of freedom [where they] develop the capacity to understand the views of others and to make decisions not against them, but with them . . . [enabling them] to transcend contingent, individual existence by becoming part of an enduring community."[12]

This participation is at the heart of the notion of the common good. The catechism stresses the importance of participation by "each according to his position and role, in the promotion of the common good" and notes that responsibility extends not only to personal and family life but to public life, and even to "a continually renewed conversion of the social partners" (nn. 1913-1916). Kenneth Himes summarizes this tradition by noting that "the common good is the term used by the Catholic tradition to convey this sense that human well-being is achieved through experiences of solidarity, a life lived with and for others."[13]

**Corporate Management and the Common Good** Originally, "business ethics" meant codes of conduct that reflected usual business practices. More recently it has come to mean thoughtful deliberation about how corporations ought to conduct themselves, especially internally. But the definition is expanding even further to include ways in which a corporation might conduct itself responsibly and effectively as a public moral agent that has a major role in shaping the society around it.[14] The emerging field of organizational ethics asks what it means to consider corporations as moral agents, and this question becomes even more pressing if political life is diminished or dysfunctional, as it is in the United States in 1999. Corporations have unprecedented economic and cultural power in our society. Healthcare corporations arguably have

even more. Not only do they collect and disburse hundreds of millions of dollars per day, but their product, healthcare, is at the very heart of what it means to be human. David Hollenbach notes:

> Managers must be careful to recognize when they are functioning in their traditional roles and when they are functioning as representatives or stewards for a group of economic and human assets that are part of the nation's economic and social potential. Executives must develop a broad view of the national interest and then be sure that their companies' positions are consistent. An international view and an educated perspective on major national issues are important to their effectiveness in their new role.[15]



**Redefining Autonomy: The Patient as Citizen** We have made great strides in patient autonomy in the past 20 years. The notion of informed consent has evolved to include living wills, durable powers of attorney, and the Patient Self-Determination Act. The downside of this evolution is that it sometimes reinforces patients' view of themselves as totally autonomous agents, consumers who have a wide variety of healthcare products to choose from. But, as Daniel Callahan notes, we must be aware of the social nature of medicine and the constraints it places on our demands: "The social constraint on the self means that its demand for health and its desire to avoid death do not impose ruinous burdens on others, whether family members or the public. The provision of healthcare is increasingly a communal task. We are medically and economically interdependent. We need, therefore, a picture of the self that is compatible with that mutual dependence."[16]

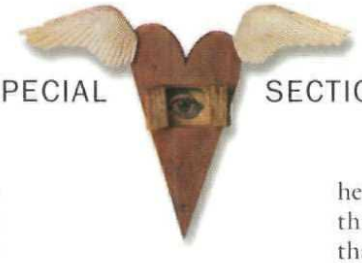
A number of other authors have highlighted this communal duty as well. Marion Danis and Larry Churchill have proposed that by returning to the ancient, political roots of the notion of the common good, we can see the patient as "citizen" rather than as consumer, and hence as part of something larger than his or her own medical needs:

> The moral, social and communitarian side of citizenship emphasizes common purposes and shared vulnerabilities. This latter understanding of citizenship identifies the self as essentially social, as constituted by civic relationships. . . . Our reliance on the concept of citizenship is intended to evoke a sense of belonging to something larger than self, or particular individual relationships. Citizens are persons who perceive allegiances as extending beyond self-interest. . . . The citizen is not only a patient with rights, but a citizen with duties. . . . The right to make healthcare decisions should not be seen as an absolute without a context, but as bounded by the limited resources of society and the competing rights of others.[17]

This reminds us that any valid theory of rights presupposes a corresponding obligation or responsibility on someone else's part. "The idea of patient as citizen," Danis and Churchill continue, "can help to bring these responsibilities to the foreground. . . . The patient as citizen has *rights*, but also *duties* to make judicious and proportionate choices."

One of the most important areas where these duties come into play is the duty to rethink what appropriate medical care is as we age. Callahan has urged us to think about age as a factor in decisions about medical care, and has advanced the notion of "biographical age," a point at which our natural lives, while not over, nor even threatened, have largely drawn to a close, at least in terms of what we will accomplish in the future. This is the point when the quality of care should shift from acute intervention to preparation for death. He writes:

> There are large and growing numbers of elderly who are not imminently dying but



> who are feeble and declining, for whom curative medicine has little to offer. For many, old age is a reason in itself to think about medical care in a different way, whether in forgoing its life-saving powers when death is clearly imminent, or in forgoing its use even when death may be distant, but life has become a blight rather than a blessing.[18]

This view need not be morbid nor harshly utilitarian. It is really rooted in an eschatological view of the person in which physical life, marvelous though it is, is not the final purpose for which God created us. Our common good is ultimately to be one with God in whom we have our beginning.

Another way of seeing this is to understand healthcare as a "commons," much like large fields in the middle of colonial towns that were maintained and utilized by all the citizenry. Nancy Jecker and Albert Jonsen propose that, like the commons, healthcare (1) depends on contributions from society; (2) benefits society; (3) has a finite carrying capacity; and (4) is a vital and important good to members of society.[19] Principles of Catholic social justice can help us educate patients, staff, and sponsors about ways in which healthcare is a public good that is held in trust and stewarded responsibly.

Physicians, too, need to see themselves as citizen-participants in achieving the common good. It has not been customary, but is it possible for us to imagine that physicians can begin to make decisions about patient care based not just on benefits and burdens for this particular patient, but for the patient citizenry as a whole? As Danis and Churchill note, referring to the code of the American Medical Association, "the idea of citizenship as a source of medical obligations is not new. What is new is our contention that citizenship should play a different and a larger role than in the past. . . . If resources are acknowledged to be scarce, both physicians and patients have a responsibility for helping to shape policies for fair allocation at the societal level and for participating self-consciously in enacting those policies humanely at the level of individual patient care."[20]

Underneath it all, this requires that we help our patients and staff cultivate what Bruce Jennings calls "the virtue of solidarity." "Framing health reform as a problem of distributive justice inevitably leads to conceptualizing healthcare itself as a 'commodity' [and] obscures the tradition . . . where physicians are not simply providers and patients are not simply consumers. . . . It also leads us to think about health and illness as conditions that happen to individuals one at a time." Can Catholic healthcare move from seeing healthcare reform as merely a serial distribution of things, but rather as "education in virtue [so that] human individuals are not primarily consumers or private appropriators of things that have instrumental value; they are interdependent beings who are in need of mutual assistance and who, if properly motivated, possess the power to offer it to others in turn?"[21]

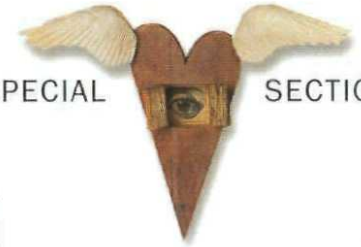
**We might view healthcare as a "commons," like those large fields in colonial towns that were maintained and utilized by all the citizenry.**

### Theology, Spirituality, and Catholic Identity

The common good is, as I have shown, a secular idea used originally to describe the role of secular government. But, at least since Augustine, it has also been a theological concept that must shape the Church and its institutions. For much of the past 20 years, discussions about Catholic identity have focused on proscribed procedures, so that Catholic healthcare facilities are often defined more by what they do not do than by their positive goals and values. This has caused us to neglect the theological roots of what "Catholic" means. If Catholic healthcare wants to root its mission in this theological notion of the common good, it must be clear about its theological basis. There are three primary theological elements to the notion of the common good: that we are created "into the image of God"; that our human community, and the common good itself, have an eschatological and supernatural dimension; and that healthcare is sacramental.

**Creation "into the image of God"** In his *Summa Theologiae*, Aquinas talks about humans being created not in the image of God, as though we were reflections in a mirror, but "*into* the image of God" *(ad imaginem Dei)*. This implies that the moral life, far from being just conformity to a more or less arbitrary moral law, is really a dynamic movement into the image of a God who has revealed himself through scripture and human experience. Aquinas suggests clearly that God's plan for us is planted deeply within us, and that we can come to know this plan which God has for us and take intelligent steps to achieve it. This could blend well with liberal theories of morality, since it suggests that God has endowed each of us with an exquisite, unfettered freedom. However, we must also remember that we are called to achieve our goal and purpose *with one another* since "persons tend by nature to communion."[22] This natural tendency is not just accidental but is essential to what it means to be human. As Himes notes:

> To perfect oneself requires participation in community, for, in Catholic teaching, communal life provides the opportunity to gives oneself away to another and it is by so doing that a person becomes more fully



> realized. . . . "Justice as participation" is a way of summarizing the foundational theory which serves as the warrant for rights language in Catholic social teaching.[23]

**The Eschatological Nature of the Common Good** Wendy Mariner notes two reasons why Americans refuse to accept rationing: the absence of any limitation on healthcare, and the belief in vitalism, that "everyone is entitled to unlimited longevity and good health."[24] However, if we believe that persons have a supernatural destiny, and that we were created, as the Baltimore catechism used to say, "To know God, love God and serve God in *this world*, and to be happy with him *forever in the next*," then we must be willing to move away from a vitalistic position and to acknowledge, happily, that there are limits to healthcare.

If Catholic healthcare can be animated by the belief that our common good is, finally, God's own self, that to be one with God is the ultimate reason for which we were created, then the curative powers of healthcare can be seen in a relative sense. We will no longer need to grasp at every technological intervention. Both healthcare providers and patients will feel free to "let go" when the burden of a treatment has outweighed its potential benefits, if these benefits are viewed not only in the perspective of physical life, but relative to eternal life and union with God, which is our ultimate goal.

**Healthcare and Sacramentality** The single most characteristic feature of Catholic thought is the notion of sacramentality, described succinctly in the axiom "grace perfects nature." The Catholic view—foreign to most Protestant theology, which holds that grace and nature have been rendered incompatible or even hostile to one another by original sin—insists that human nature, even weakened by original sin, is still "good enough" to mediate grace. Whatever is naturally good is open to fulfillment or perfection by grace.

This is the source of our sacramental system, which takes ordinary good things and makes them "occasions of grace," and it is also the theological basis of healthcare. We undertake healthcare because it is an act of basic human compassion; but we also do it because we know that human actions—and these include healing—are sacramental. They are goods in themselves, but they also mediate God's grace. Not all doctors or nurses or even administrators must be Catholic, but, if they work in a Catholic hospital, they must be aware of our belief that healing touches us at both a social and spiritual level and bears the possibility of redemption. As Himes notes:

> The Church must bear witness to the Gospel in all aspects of human existence. No realm of our life is removed from the redemptive work of Christ. [To divide up] human existence into compartments, some labeled sacred and others profane, is fundamentally a misunderstanding of the power of religious belief to integrate and bind together the range of human experience. Catholic teaching affirms the divine presence in all reality, but maintains that such presence must be manifestly expressed.[25]

**At least since Augustine the common good has been a theological concept shaping the Church and its institutions.**

Thomas O'Meara takes this even further and emphasizes the importance of human instrumentality when he says that we can actually "cause grace":

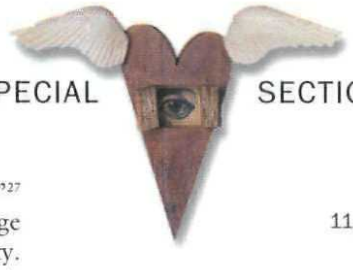
> We have seen that Aquinas so prized the activity of creatures that even in the realm of grace he permitted [us] within life, church and liturgy to make grace present. The ministries of priests and bishops, parents instructing their children, husbands and wives living amid the joys and difficulties of married life—ordinary people could be real causes of grace. Strictly speaking of course, only God could cause grace. . . . Nevertheless, in ways quite circumscribed, God allows and encourages creatures to act.[26]

Surely healthcare, which touches us at such a profound level of life, is also a "cause of grace." Would Catholic healthcare be different if we—and our employees—really believed that?

**Politics, Compromise and the Allocation of Healthcare** This sacramental understanding of reality affects how the Church "stands in the world," as well. Christians can, for example, adopt a separatist or sectarian approach in which they view the world as essentially evil and, like the Amish, withdraw from it into small communities to avoid contamination. They can also see religion as an essentially private matter that has no bearing in public life or public policy. Or they can try to replace public life with religion, creating a theocracy that aims at total moral purity.

The Catholic view, however, differs from all these. Rather than exhorting its members to withdraw from a sinful society, keep religion private, or replace civil government with a theocracy, the Catholic view urges us to seek common ground with those who do not share our views, while also trying to persuade them of the deeper values and goods which underlie our view of human life. We might describe this view as "persuasive collaboration."

The Catholic understanding of the relative compatibility of grace and human experience



leads us to look for the holy or to "name grace"[27] in the world around us, and also to acknowledge the need for compromise in a pluralistic society. It is this view that provides the theoretical basis for joint ventures and mergers with non-Catholic or non-faith-based healthcare institutions. We know that such cooperative arrangements may not fully express the truths and values of our faith, but we are willing to "tolerate" this compromise as a means toward the common good of high-quality healthcare. This view recognizes that if the common good is ultimately God's own self, it will never be fully realized here and now. Yet we must continue to strive for it. As good citizens, Catholic healthcare systems must gently but persistently bring our belief in community, eschatology, and the ultimate transforming power of grace into the public debate. □

**NOTES**

1. See Thomas Aquinas, *Summa Theologiae*, I-II, quest. 47, sect. 10: ". . . now the good of the whole universe is that which is apprehended by God, who is the maker and governor of all things: hence whatever he wills, he wills under the aspect of the common good. This is his own goodness, which is the good of the whole universe." I wish to thank Ann Garrido for her research assistance on this topic.
2. Jacques Maritain, "The Person and the Common Good," in Joseph Evans and Leo Ward, eds., *The Social and Political Philosophy of Jacques Maritain*, University of Notre Dame Press, Notre Dame, IN, 1955, p. 82.
3. *Catechism of the Catholic Church*, nn. 1907-1909.
4. Robert Bellah, et al., *Habits of the Heart: Individualism and Commitment in American Life*, University of California Press, Berkeley, CA, 1996.
5. Charles J. Dougherty, "Ethical Values in Health Care Reform," *JAMA*, vol. 268, 1992, p. 2411.
6. Lewis Lapham, "Coq au Vin," *Harper's*, March 1998, pp. 8-10.
7. Jeffrey Stout says, "The idea that liberal society lacks any shared conception of the good is false, but this doesn't mean that all is well. It could still be the case that politics, as the social practice of self-governance directed toward the common good, has begun to give way to merely bureaucratic management of competition for external goods." *Ethics after Babel*, Beacon Press, Boston, 1988, p. 291.
8. *Summa Theologiae*, I, quest. 96, sec. 4, "Whether man in the state of innocence would have held sway [held dominion, governed] over other men?"
9. Michael Novak, *Free Persons and the Common Good*, Madison Books, New York City, 1989, pp.87-89, p. 92. Ezekiel Emmanuel, MD, himself a communitarian thinker, acknowledges this difficulty and describes at least six concepts of "the good life" operative in decisions to terminate medical care for incompetent patients. See *The Ends of Human Life*, Harvard University Press, Cambridge, MA, 1991, pp. 78-82.
10. Daniel Callahan, "Bioethics: Private Choice and Common Good," *The Hastings Center Report*, May-June 1994, p. 31. See also Callahan, "When Self-Determination Runs Amok," *The Hastings Center Report*, March-April 1992, pp. 52-55.
11. Marion Danis and Larry R. Churchill, "Autonomy and the Common Weal," *The Hastings Center Report*, January-February 1991, p. 29.
12. Emmanuel, pp. 158-160.
13. Kenneth Himes, "Catholic Health Care: The Common Good, Public Responsibility and the Culture of Profit," *New Theology Review*, November 1997, pp. 22-28.
14. David Hollenbach, "The Common Good Revisited," *Theological Studies*, March 1989, p. 73, quoting Joseph Bower, notes that "corporate decision making not only influences the success of a company itself, but also bears on the well-being of larger, interdependent communities."
15. Hollenbach, p. 73.
16. Daniel Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death*, Simon and Schuster, New York City, 1993, pp. 122-3.
17. Danis and Churchill, p. 27. See also Churchill, "The Ethical Issues of Futility from a Community Perspective," *North Carolina Medical Journal*, September 1995, pp. 424-427: "We need to demonstrate that it is possible to break free from the grip of medical utopianism—the idea that medicine is more important than other social goods, that medical progress holds the key to human happiness." See also Leonard Weber, "The Patient as Citizen," *Health Progress*, June 1993, pp. 12-15.
18. Daniel Callahan, "Terminating Treatment: Age as a Standard," *The Hastings Center Report*, October-November 1987, pp. 21-25.
19. Nancy Jecker and Albert Jonsen, "Healthcare as a Commons," *Cambridge Quarterly of Healthcare Ethics*, 4, 1995, pp. 207-216.
20. Danis and Churchill, p. 29. For a negative appraisal of this approach, see Jerome P. Kassirer, "Managing Care: Should We Adopt a New Ethic?" *New England Journal of Medicine*, August 6, 1998, pp. 397-398. Kassirer notes with disapproval the fact that many healthcare plans are forcing physicians to "make caring for their entire group of patients a higher priority than caring for each individual patient."
21. Bruce Jennings, "Beyond Distributive Justice in Health Care," *The Hastings Center Report*, November-December 1996, pp. 14-15.
22. Maritain, *La personne et le bien commun*, Desclee de Brouwer, Paris, 1946, p. 47. Quoted by Hollenbach, who notes two reasons for this statement: "First, it is the result of the fact that the positive realization and fulfillment of personality is achieved only through knowledge and love of other persons . . . . Second, human beings are social for a negative reason as well. As finite and limited persons they have needs and deficiencies as well as positive capacities for friendship. They need other persons and the larger society in order to strive or even to exist at all" (p. 86).
23. Himes, p. 24.
24. Wendy K. Mariner, "Rationing Health Care and the Need for Credible Scarcity: Why Americans Can't Say No," *American Journal of Public Health*, October 1995, pp. 1439-1445.
25. Himes, p. 26.
26. Thomas O'Meara, *Thomas Aquinas Theologian*, University of Notre Dame Press, Notre Dame, IN, 1997, p. 146.
27. I am indebted to Mary Catherine Hilkert for this concept, found in her book, *Naming Grace: Preaching and the Sacramental Imagination*, Continuum Publishing, New York City, 1997.

> Surely healthcare, which touches us at such a profound level of life, is a "cause of grace."