# Does Catholic Sponsorship Matter?

## *Social Science Is Beginning to Reveal Differences between the Ministry and Other Forms of Care*

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Rapid changes in the American health care system, familiar to all readers of this journal, have placed extraordinary pressure on the mission and identity of Catholic health care.[1] Mergers and acquisitions blur the distinctive identities of the component institutions, and managed care contracts pressure the financial bottom line, threatening uncompensated or poorly compensated services. As the memberships of the religious congregations that founded and directed Catholic health care decline, the challenge of transmitting charism and mission to new lay leadership is daunting.[2]

These pressures are particularly acute for large, established institutions, such as Catholic hospitals. The difficulties and uncertainties in meeting these challenges stimulate such questions as "Why should the church remain in health care?" or, less dramatically, "Why continue to operate hospitals, instead of directing efforts toward smaller, more mission-intense institutions?" As health care and the church change, why continue commitment to ministries that may no longer be appropriate extensions of the social justice mission? Perhaps human and material resources may be better used in other areas.

Leaders of Catholic health care, responding to such questions, often refer to the superiority of not-for-profit over for-profit health care. Because Catholic institutions are an integral part of the larger framework of not-for-profit organizations in the United States, abandoning this mission would, these leaders say, weaken quality of care and leave marginal populations more vulnerable. Moreover, they continue, Catholic health care is distinct even within the nonprofit sector. If Catholic health care were to shutter its hospitals and other institutions, essential services for the poor, immigrants, the frail elderly, and other vulnerable groups would be severely compromised.

Leaders of Catholic health care could respond to these questions in other, equally serious ways, however. They could point out the differences between Catholic and other-than-Catholic organizations in such areas as, for example, care of the dying; pain management; uncompensated services; and provision of services to socially stigmatized groups, including people with chemical substance dependencies, people with HIV and AIDS, mentally or physically handicapped persons, and illegal immigrants. Stories of ministry to such groups regularly appear in *Health Progress*, *Catholic Health World*, and the annual reports of many Catholic health care organizations. Mission and vision statements routinely describe such services and their unique role in Catholic-sponsored institutions.

Of course, stories like these may represent only isolated instances; mission and vision statements may lead only a paper existence, never influencing daily operations. Then, too, Catholic institutions may not differ significantly from other health care organizations in the services they provide to marginal and vulnerable populations. Without evidence, the argument that Catholic health care is somehow unique is no more than a hypothesis.

Social scientists specialize in testing such hypotheses. It ought to be possible, by examining the medical and social science literature, to determine whether the claims of Catholic health care are supported by the evidence. Unfortunately, the available evidence is limited. Even so, we hope in this article to do three things:

- Consider some theoretical reasons why Catholic health care might be distinctive
- Examine studies of health care institutions (most of them conducted by one or the other of the authors) to see whether Catholic and other-

than-Catholic institutions differ in important ways

- Offer some conclusions for Catholic health care leaders, social scientists, and government policymakers

> Catholic organizations have become leaders in the provision of end-of-life care.

### Theoretical Differences

An examination of both Catholic theology and Catholic institutional life suggests reasons why Catholic health care should be strongly inclined to provide, for example, end-of-life (EOL) and palliative services.

Catholic doctrine regarding the end of life includes clear strictures against suicide, euthanasia, and (by implication) physician-assisted suicide. At the same time, this theology offers a variety of subtle moral distinctions that permit physicians to forgo (or, if begun, to cease) "extraordinary" medical treatment. These strictures and distinctions are, moreover, set out in the church's *Ethical and Religious Directives for Catholic Health Care Services*, a document designed to provide direction to its health care institutions.[3] Few other-than-Catholic health care organizations have such guidance for their EOL and palliative services.

Moreover, the collaborative institutional environment of Catholic health care facilitates the adoption and diffusion of new measures promoting Catholic identity. For example, in 1995 the Catholic Health Association (CHA) and five Catholic health care systems launched Supportive Care of the Dying: A Coalition for Compassionate Care "to develop and test innovative projects and to provide support to member organizations as they initiate systematic change in the care of persons affected by life-threatening illness."[4] CHA's benchmarking program, called "Living Our Promises, Acting on Faith," will provide Catholic health care with a system for measuring the effectiveness of their EOL care and pain-management programs.[5]

U.S. health care has generally been slow to adopt hospice and other EOL services, primarily because contemporary medicine remains committed to aggressive curative treatment.[6] But Catholic organizations—because of institutional guidance from their founding congregations, the *Ethical and Religious Directives*, and mission and vision statements—have become leaders in the provision of care to the dying.

### Empirical Differences

A variety of theological, philosophical, and anecdotal sources describe what the Catholic health ministry calls "Catholic identity." However, measurement of this identity is more difficult. Only a few researchers have conducted empirical studies attempting to define and measure the ways Catholic health care might differ from other varieties.

One approach to this problem involves deriving a sense of Catholic identity from the mission statements of Catholic health care organizations. "Social justice," "universal right to health care," "respect for the dignity of all people," and "provision of compassionate care" are themes commonly found in such statements. Having selected one of these themes, the researcher could specify the way an organization might carry it out. For example, what does it mean to provide "compassionate care" services? What are such services? Does one organization provide them in a manner different from other organizations? If (to take another theme) health care is viewed as a "universal right," and if all who receive it are to be treated with respect and dignity, does it not follow that Catholic identity would include providing services to socially stigmatized groups—for example, people suffering from HIV/AIDS, chemical dependency, or epilepsy?

In the 1990s, some social scientists began to investigate and analyze the provision of these services. A. J. LeBlanc and R. E. Hurley found, for example, that public hospitals were then shouldering the burden for most HIV/AIDS treatment.[7] However, a later study—conducted by Kenneth R. White, a coauthor of the present article, LeBlanc, and S. D. Roggenkamp—showed that by 1997, although public hospitals were more likely to offer HIV-AIDS services than private ones, Catholic hospitals were more likely to offer them than their investor-owned counterparts.[8]

In 1993 White conducted a study comparing private, metropolitan hospitals across the nation in terms of *stewardship of resources, social justice*, and *compassionate care*.[9] According to this study, Catholic, other not-for-profit, and investor-owned organizations revealed few significant dif-

ferences in their stewardship of resources (measured as return on assets, profit margin, and operating expense per discharge). As for social justice (access to services for all income groups), Catholic and other not-for-profit organizations ranked about equally, but Catholic facilities again provided far more access than investor-owned ones. Finally, Catholic hospitals provided more compassionate care services (e.g., care for people with HIV/AIDS, addictions, or other problems) than either investor-owned or other not-for-profit organizations. A study by White and J. W. Begun found that the provision of such services by Catholic hospitals was strongly influenced by their mission statements and hence by the larger healing ministry of the Catholic Church.[10]

A 1998 study by White, Clarke E. Cochran, and U. B. Patel of hospital EOL services across the nation, revealed that Catholic hospitals began earlier than many others to provide palliative care, hospice, and pain management services.[11] The study also indicated that Catholic hospitals continue to provide proportionally more of these services than other types of hospitals.

## Some Fundamental Questions

Catholic health care operates in a complex medical, business, political, and religious environment. Catholic sponsors are accountable to the church for carrying out Jesus' healing mission. At the same time, however, the health care organizations these groups sponsor must operate according to such secular medical and business criteria as effectiveness, efficiency, and compliance with various regulatory bodies. These two sets of requirements, representing different cultural "environments," are likely to collide on occasion.[12] As organizational sociologists know, competing environmental pressures spur organizations to change, sometimes radically. The big question for Catholic sponsors is whether their health care organizations are *distinct enough* from others to warrant continuation of a church-sponsored health ministry, especially one that takes the form of hospital-based acute-care services.[13]

Environmental pressures toward organizational conformity are intense. The need to have the latest and best medical equipment and treatments, the difficulty of finding money to pay higher salaries to nurses and other health professionals, and slow growth in reimbursement rates in both government and private insurance—factors such as these push all hospitals toward the same organizational models and toward the reduction of money-losing services. Responding to these pressures, Catholic hospitals sometimes begin to look like their secular counterparts.

Yet the mission and identity of Catholic health care call it to be different in important ways: to refuse to provide certain medical services that violate human dignity; to work for solidarity and social justice in employer-employee relations; and to insist on serving the health care needs of the community, whether doing so earns money or loses it. In addition, the growing need for long-term care, for supportive care of the dying, and for mental-illness and addiction treatment might lead Catholic health care away from the acute-care hospital into smaller, community-based settings. Social scientists cannot yet predict how these tensions and pressures will change Catholic health care or in what ways Catholic health care will continue to be distinctive.

To answer this question, researchers must study the data more closely than they have to date. Going beyond a mere enumeration of the various services Catholic organizations have adopted, researchers must examine the quality and outcomes of these services and patients' satisfaction with them. Pain management would be a good place to start. How satisfied are patients, family members, and providers with a particular pain-management program, for example? How successful is the program in facilitating healing? How successful is it in helping patients to cope with chronic illness? How successful is it in helping dying patients to maintain their dignity?

Incidentally, researchers should remember that the optimal setting for EOL care and other services central to the mission of Catholic health care is often *not* the hospital but rather the patient's home or an ambulatory clinic, hospice, or nursing home. The complete story of sponsorship and mission is not captured in hospital-based data. Especially in EOL cases, treatment should involve a seamless integration of in-hospital services with other services or home care. Catholic health care organizations often include many of these service components under a common organizational umbrella, with a common set of ethical and religious principles and a mission-integration mandate. Because they do, Catholic organizations may have an advantage over others. Researchers should investigate whether this potential advantage has been realized.

Research could also help answer other fundamental questions. For example, do patients experience Catholic health care differently than they do other types? Do the employees of Catholic organizations deliver care in unique ways? How do patient outcomes in Catholic health care differ from that resulting in other types? Catholic health care organizations need to know if EOL units are cost-effective, particularly whether they replace costly invasive treatment, or are simply

*Continued on page 50*

## MINISTRY LEADERSHIP

*Continued from page 12*

to believe in her own intuition is detailed in the narrative. She was still active in journalism when she died at age 84.

Graham's leadership qualities of humility, belief in her own intuition, personal and professional integrity, and trust and empowerment of employees made her one of America's most remarkable and accomplished women. Constantly struggling to improve and develop herself and her coworkers, including a son who ultimately succeeded her at the *Post*, she represents a model of self-development and personal growth. She struggled, as did Welch, with being "married to the job" and, like Welch, suffered the loss of relationships as a result.

Graham's sense of social responsibility, not personal ambition, guided her decisions with regard to publishing the truth. She approved the publishing of the Pentagon papers after a federal judge had prohibited the *New York Times* from continuing to publish them—a bold and daring move. During a contentious and sometimes violent strike, she managed to maintain daily publication almost without interruption.

These two autobiographies showcase extraordinary professional successes and failures that exemplify several of the core competencies for mission-centered leadership. Both public figures were devoted to the rigorous pursuit of excellence, a selfless passion for developing colleagues and coworkers, uncompromising personal and professional commitment to integrity, and a deep, abiding love of their professions—all hallmarks of Catholic health care leadership. Imagine the potential impact of combining these competencies with the power of spiritual grounding! □

### NOTES

1. Katharine Graham, *Personal History*, Alfred E. Knopf, New York, 1997.
2. Jack Welch and John A. Byrne, *Jack: Straight From the Gut*, Warner Books, New York, 2001.

## DOES CATHOLIC SPONSORSHIP MATTER?

*Continued from page 16*

added to such treatment at the end of care. Are uncompensated services equal in quality to compensated services? If not, how can they be made equal? Are the emotional and spiritual effects of chaplaincy services in Catholic health care more significant than those resulting from other types?

Would nonhospital services perpetuate Catholic identity more effectively than those delivered in acute-care hospitals? To fully evaluate the contribution of Catholic health care services, researchers must answer these and other questions. We hope that social scientists in other fields will collaborate with other health care researchers to address them.

In the meantime, policy-makers who wish to promote new, socially desirable services—such as EOL or HIV/AIDS care—could use the studies summarized here to develop strategies enabling them to select the types of institutions in which such services might be best introduced. We cannot predict what those services should be because they will arise in response to changes in medicine and society. These new services may be uncompensated (as pain management is today) or unpopular (as HIV/AIDS care was a decade ago). In any case, policy-makers should now develop incentives, as needs for new services emerge, to encourage certain health care organizations to pioneer and test such services, and, if successful, to disseminate them among other settings. Research suggests that Catholic-sponsored organizations may be strategically positioned for these initiatives. □

### NOTES

1. C. E. Cochran, "Institutional Identity; Sacramental Potential: Catholic Healthcare at Century's End," *Christian Bioethics*, vol. 5, no. 1, pp. 26-43; see also C. E. Cochran, "Another Identity Crisis: Catholic Hospitals Face Hard Choices," *Commonweal*, February 25, 2000, pp. 12-16.
2. Michael D. Place, "Elements of Theological Foundations of Sponsorship," *Health Progress*, November-December 2000, pp. 6-10.
3. *Ethical and Religious Directives for Catholic Health Care Services*, 4th ed., *U.S. Conference of Catholic Bishops*, Washington, DC, 2001; see especially Part 5, "Issues in Care for the Dying," pp. 29-33.
4. Supportive Care of the Dying: A Coalition for Compassionate Care, which can be found at www.careofdying.org. The coalition currently has 13 members, including CHA and three of the nation's four largest Catholic systems.
5. *Living Our Promises, Acting on Faith: A National Program of Performance Improvement for the Catholic Health Ministry*, Catholic Health Association, 2000, St. Louis, pp. 13, 18-22.
6. C. K. Cassel, et al., "Perceptions of Barriers to High-Quality Palliative Care in Hospitals," *Health Affairs*, vol. 19, no. 5, pp. 166-172.
7. A. J. LeBlanc, "Undercompensated, Unpopular Services in Hospitals: The Case of HIV/AIDS," 1991, Pennsylvania State University, *Dissertation Abstracts International*; and A. J. LeBlanc and R. E. Hurley, "Adoption of HIV-Related Services Among Urban US Hospitals: 1988 and 1991," *Medical Care*, 1995, vol. 33, pp. 881-891.
8. K. R. White, S. D. Roggenkamp, and A. J. LeBlanc, "Urban U.S. Hospitals and the Mission to Provide HIV-Related Services: Changes in Correlates," *Journal of Healthcare Management*, forthcoming in 2002.
9. K. R. White, "Catholic Healthcare: Isomorphism or Differentiation?" 1996, Virginia Commonwealth University, *Dissertation Abstracts International*.
10. K. R. White and J. W. Begun, "How Does Catholic Hospital Sponsorship Affect Services Provided?" *Inquiry*, 1998/1999, vol. 35, pp. 398-407.
11. K. R. White, C. E. Cochran, U. B. Patel, "Hospital Provision of End-of-Life Services: Who, What, and Where?" *Medical Care*, forthcoming in January 2002.
12. See K. R. White, "When Institutional Environments Collide: Hospitals Sponsored by the Roman Catholic Church," in S. S. Mick and W. Wyttenbach, eds., *Innovations in Health Care Delivery*, 2nd ed., San Francisco, Jossey-Bass, forthcoming in 2002.
13. K. R. White, "Hospitals Sponsored by the Roman Catholic Church: Separate, Equal, and Distinct?" *Milbank Quarterly*, vol. 78, no. 2, pp. 213-239.