GUIDANCE FOR A FAILING SYSTEM

Catholic Social Teachings Provide the Needed Principles

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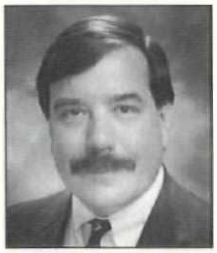

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In each issue of *Health Progress* in 1995, the journal's 75th anniversary logo highlights an article of particular significance to the Catholic health ministry.

The numerous changes affecting the healthcare ministry raise questions about the organization and delivery of its services; the communal aspects of these services; the financing of services across the delivery spectrum; the nature and structure of professional-patient relationships; and the ethical principles that have traditionally been used to address conflicts between these various goods. Healthcare analysts and consultants say these changes represent a paradigm shift. Ethicists and others concerned with the ethical aspects of these changes ask whether they can be adequately addressed through "principleism"—that is, reliance on the four major ethical principles nonmaleficence, beneficence, autonomy, and justice.

There is nothing particularly religious about these questions. Other community-based, not-for-profit delivery systems are experiencing the same difficulties and constraints—the same identity crisis and search for meaning—that religiously based healthcare is facing. How are these changes affecting the focus of our ministry, the way we deliver services, and our ability to be a player in the healthcare community of the future? What should we be about? Should we, as Rev. Richard A. McCormick and Charles Dougherty have asked, even continue to *be* Catholic healthcare providers?[1]

Or should we be doing something else? Should we perhaps sell our healthcare assets and work instead in other areas of Church ministry, areas where segments of society are underserved and our services may be needed more?

This article makes an important assumption that could be argued in another setting: that there *is* a place for religiously based, Catholic, institutional healthcare in America today. Indeed, America would be worse off without it. More important, the Catholic Church would be worse off without it. Although there are many other ways in which the Church carries out its healing ministry, the Church would experience a definite loss if it were to abandon the formal and institutional structures of healthcare.

The question then is: If the Church is to continue this ministry, what are the implications for the structure of its involvement? How does the institution envision its participation, and how

Summary Catholic healthcare has traditionally relied on four major ethical principles—nonmaleficence, beneficence, autonomy, and justice—to address conflicts between various goods. However, all healthcare now finds itself facing great changes. "Principleism" is too limited to guide the Church's health ministry through the current crisis.

But the Church possesses a body of social justice teachings that may provide healthcare with the necessary guidance. Eight inseparable but distinct themes are found in the social teachings: human dignity, human solidarity, the option for the poor, the common good, human rights, social justice, stewardship, and liberation.

The eight themes are here applied to five critical healthcare issues: the patient-physician relationship, the right to choose, healthcare as a communal good, rationing and limits, and work and its implications.

The Church's social teachings may provide us with a basis for a structural reexamination of healthcare—including Catholic healthcare. In that analysis, we may find that Catholic healthcare has developed practices and standards that are at odds with its own teachings. Such an analysis will be painful, but it must be done.

will it respond to the ethical challenges before it?

This article explores these questions primarily from a moral-theological perspective, by first examining one foundational approach—namely, the social justice teachings of the Church. In exploring these teachings, one wants to discover, whenever possible, the guiding principles that can shed light on how Catholic healthcare should be organized in the future, on how it might critique countervailing proposals, and on how it can transcend the limits of so-called principleism.[2]

The Social Justice Tradition

This article is too short to include an in-depth analysis of the Church's social justice tradition and the documents that constitute it.[3] Here I highlight eight inseparable but distinct themes that have been developed since the time of Pope Leo XIII. After that I examine the implications these eight themes might pose for five different areas of healthcare.

Human Dignity The Church affirms the fundamental dignity of each person. An individual is to be respected as one made in the image and likeness of God and is to be valued for himself or herself.

In this teaching, an individual is seen as embodied spirit—body and soul linked together in a person acting in the world, responding to God, loving both self and neighbor. One should not spiritualize human existence—treat people as if their physical lives were less important than spiritual goals. By the same token, one should avoid vitalism—a fascination with the purely physical aspects of human affairs. In all things this unity, this complementarity of the human person, must be respected.

Human Solidarity No person is an isolated being but is, rather, by nature fundamentally social. The fullness of human expression is found in the communal dimensions of human life. Primary among these is that smallest of social units, the one in which life is begun and nurtured—the family. In some writings this unit is idealized: Mom and Dad working and living in harmony, the children obedient to their parents. Though these idealized notions are frequently contradicted by reality, the family remains one of the social units most important for human fulfillment.

One grows up and leaves the family to experience life in larger communal groups. These include the neighborhood, the congregation, the community of co-workers, and the many other groups one passes through because of one's social, leisure, and cultural experiences."

"Solidarity" describes the chief characteristic of such groups, whether they be familial, local, national, or geopolitical. Because we are essentially one in the family of God's creation, we are to look after one another. And the face of the "other," stranger and lover, calls one to a relationship that is fundamentally characterized by justice. Our solidarity with one another calls us to care for and do justice to those in need. Solidarity also raises questions about those "limited" social resources that the well-off so frequently cite when they are confronted by the needs of the poor.

The Option for the Poor The Church's social justice teachings posit a preferential option for the poor, suggesting that they have a particular claim on justice. "The poor," in these teachings, are those who are economically disadvantaged and hence suffer oppression and powerlessness. There is no "victim blaming" in the preferential option for the poor. On the other hand, the Church, in its concern for the common good, does require that the poor share responsibility for overcoming the devastating and evil effects of poverty.

Many Church organizations—for example, Catholic Charities, the St. Vincent DePaul Society, Catholic healthcare institutions—have provided genuine service to the poor. But tensions can arise between the struggle against poverty (which is often systemically rooted) and the demands of charity (which, while helpful to the poor, is unlikely by itself to overcome the causes of poverty).

The Common Good The Church is also committed

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Kari Alberg

to the common good, a concept denoting not simply a sum of particular goods but, rather, the conditions of communal life in which human beings thrive. Included in the common good are economic, political, social, and cultural structures. In recent years the Church has used this concept to discuss the increasingly heavy impact of transnational political and economic structures.

Decisions should be made at the level where they will have the greatest impact.

Human Rights Affirming as it does the fundamental dignity of each person, the Church believes that each has certain political and economic rights. The political rights include those found in many national constitutions and the Charter of the United Nations, such as rights of free speech, political involvement, and emigration and immigration. More important, the Church's social teachings say human beings also have rights to food, shelter, work, education, leisure, the possibility of acquiring private property, the exercise of religious beliefs, and—according to *Health and Health Care*, the U.S. bishops' pastoral letter of 1981—a certain level of healthcare services.[4]

Catholic institutions influence the exercise of these rights. Because of their role in the larger social nexus, such institutions inevitably affect—either positively or negatively—the pursuit of justice, expressions of solidarity, and respect for the dignity of individuals.

Social Justice: Political Participation, Subsidiarity, and Economics From *political participation* individuals derive a sense that they are helping make those decisions which will most strongly affect their dignity and liberty. Government and institutions, which have the power to either increase or reduce this sense of citizen participation, should examine their activities in light of the common good.

The principle of *subsidiarity* says, on the other hand, that such decisions should be made not in the general interest but, whenever possible, at the local level—by those individuals who will be most seriously affected by the decisions and who will therefore know intimately which choice is best for them. Subsidiarity does not require that every decision be made at the lowest level of a polity or institution; there are roles for governments, trustees, and managers. The point is that decisions should be made at the level where they will have the greatest impact.

Economic justice requires that all individuals share available resources in an equitable fashion. This involves every level of human society: communal, institutional, national, international. And it is not limited to the sharing of resources. The concept of economic justice also involves questions about the nature of work and the workplace, such as whether individual workers are allowed to realize to the fullest extent possible their human and communal desires. Economic justice requires that concerns about ownership, management powers, and profitability be subordinated to concerns about the meaning of work and just wages for workers.

Stewardship The Church's social teachings about stewardship require both individuals and institutions to recognize that all goods, property, and assets have a social mortgage. The resources of the earth are to be shared and respected by everyone. It is through the appropriate use of these resources that we are co-creators with God. No single person or group of people is entitled to reserve significant social resources solely for themselves.

Liberation The Church has in recent years developed certain teachings around the social-theological theme of liberation. This principle describes as unacceptable those social, political, and economic structures which benefit some while oppressing others. Such structures must be changed so that both individuals and communities can realize their full potential. The liberation principle raises significant questions about healthcare in particular: For example, why shouldn't a society provide at least limited healthcare services to each of its members?

Applying the Teachings

These eight social justice themes are not the whole of the Catholic Church's social teachings. They are, however, particularly relevant to the healthcare debate going on in our country today. Although these teachings and principles might be applied to many areas, I would like to address five specific healthcare issues that I regard as critical.

The Patient-Physician Relationship

In discussions of healthcare ethics and changing healthcare roles, nothing has been considered more sacred than the relationship between a patient and his or her physician. According to this philosophy, patient and physician stand in a particular relationship that is marked by solidarity, confidentiality, trust, and fiduciary obligations. The physician is obliged to:

- Furnish the patient with information necessary for his or her medical care
- Be the patient's advocate; fight for his or her interests regardless of personal costs
- Shield the patient from institutional and insurance claims that, in the physician's eyes, result in poor care

This relationship should not be compromised by financial incentives offered to physicians to withhold treatment. One problem with healthcare reform is that it impinges on the patient-physician relationship by (1) possibly requiring the patient to change physicians from time to time, and (2) requiring the physician to assume such roles as gatekeeper for a health maintenance organization (HMO) or rationer of care in certain insurance programs.

If Catholic social teachings are applied to the changing healthcare paradigm, two aspects of that teaching seem to conflict. On one hand, an individual's dignity and right of access to healthcare services depend on protection of the patient-physician relationship. On the other hand, the relationship is never experienced in a vacuum. Any particular relationship between a patient and a physician is immediately tied to numerous other relationships, including those involving family, employer, insurance cohorts, and society at large.

Because of the fundamentally communal nature of human life, patient-physician relationships are never exclusive. This fact causes endless tension. How are we to balance, for instance, the physician's perception of what is in the best interest of the patient (sometimes known as beneficence) with the patient's freedom to make his or her own choices (usually known as autonomy)? Recent examples of this tension—including the well-publicized stories of Helga Wanglie, Baby K, and others—abound. The tension demands resolution, even though resources are limited.

Although the following principles are at best sketchy, they may at least provide a jumping-off point for a discussion of this issue:

- The relationship between a patient and a physician is not primarily an economic one. It is characterized more by the patient's need for healthcare than by the physician's need for compensation.
- Certain decisions must be made about the limits of a patient-physician relationship. These may be made by small social units—by the relevant members of an HMO, for example—or they may also need to be made at the governmental level. Governmental participation may be necessary to facilitate significant steps in this process, including care of the poor.
- All healthcare choices are circumscribed by limits. The ultimate limit is death, but anyone covered by private insurance or an entitlement program also faces limits. In the future, individuals may be restricted in the amount of care they are allowed to purchase, even out of pocket, especially if such purchases deplete the resources available to all.

Issues of Choice

The exercise of choice is one of the fundamental values found in most healthcare reform proposals.[5] Patients should be able to choose which physicians, hospitals, and HMOs they use. Physicians should be able to choose which patients they treat, where they practice, and what their subspecialty is. Leaders of institutions should be able to choose where their facilities are geographically located and which services they provide. And the list goes on.

But choice is not the only value, and it sometimes clashes with others. Obviously some balance must be achieved among competing values. In the United States this balancing is usually left to the market. But, to the extent that U.S. healthcare is regulated by market forces, some patients will not be able to use the physician or institution they wish; and some physicians will not be able to practice the specialty they wish, or practice it in the location they wish.

This is the rub. As long as market forces are employed to balance values in healthcare, choice will be dictated by those forces, not by patients and professionals. If, on the other hand, market forces were disregarded, choice would have to be exercised by some government agency, either state, regional, or federal. Neither option is entirely acceptable in the current political climate. The first is too ineffective and expensive, and the second is seen as a restriction of American freedoms.

A more careful analysis of these problems, in light of the Church's social teachings, could provide us with a powerful critique of the current distribution of U.S. healthcare services and the value of choice. Such a critique might have radical implications not only for patients and professionals but also for institutions, including Catholic institutions. After all, there is no guarantee that Catholic institutions would survive a

critique that is both rational and ethical. Here are some rudimentary principles:

- Because one must have health to realize other values, healthcare services are not goods like other market commodities.
- Choice must be structured in a way to serve the common good.
- Government intervention may be necessary to ensure healthcare for the poor.

Healthcare as a Communal Good

The current healthcare crisis demonstrates what happens to certain members of the community when they lose access to a variety of healthcare services. The Church's social teachings say the crisis must be addressed in its communal context, which has three aspects: delivery, finance, and services beyond the medical model.

Healthcare Delivery In Catholic healthcare the delivery model has changed from women religious caring for the destitute and dying to complex organizations providing a sophisticated range of curative, chronic care, and palliative services. But the current healthcare crisis and the social teachings of the Church may combine to challenge the relevance of both these models. Some care is likely to be delivered at sites other than hospitals and clinics. And some is likely to be delivered by different kinds of professionals—persons who are not necessarily physicians, nurses, or registered therapists, for example.

Such changes will be necessary if the common good is to be realized; if justice is to be served; if stewardship of resources is to continue; and if patients are to feel liberated in the contexts of their own communities, rather than oppressed by a large medical complex. This vision calls for a reevaluation of the traditional delivery structure, but not, in my opinion, for abandonment of it.

Financing Healthcare Closely related to the question of delivery structures is that of finances. The U.S. government currently provides more than 50 percent of the money spent annually on healthcare. Most of the remainder is controlled by major payers, particularly private employers. Both the government and employers, contending that they can no longer afford the current system, plan to reduce the number of healthcare dollars they spend.

The question for the Catholic health ministry is: How should principles concerning economic justice and subsidiarity, combined with those concerning the appropriate role of government, be applied to financing healthcare? First, these principles make it clear that government participation is not "evil." They tell us, second, that neither patients nor professionals can behave as if they have unlimited choices with no connection to the larger world.

A principled look at healthcare might produce other conclusions, such as the following:

- Expenditures for healthcare services should constitute only a reasonable fraction of the cost of doing business. If, therefore, the market continues to drive prices blindly upward, society could legitimately cap expenditures at some point. Finding the appropriate point is, of course, the problem.
- Government should provide overarching support for those left outside the healthcare marketplace—especially since private healthcare coverage is so closely linked to employment, and our society has apparently decided that a certain level of unemployment must be tolerated for the free market system to work well.
- The stewardship of resources principle is not limited to acute care. Americans have gotten into the habit of applying the medical model of care to a wide range of social problems (drug abuse, for example). But hospitals cannot solve these dilemmas. At some point we must begin discussing personal, corporate, and social responsibility for health status.

If, as Catholic social teachings hold, each person has innate dignity, it follows that each also has responsibilities, including responsibility for his or her own health. This does not mean that sick people should be punished for their failure to care for themselves adequately. But neither does it mean that society must satisfy unlimited claims by people regardless of their behavior.

On the other hand, society—including the private corporations that are such a large part of it—*is* responsible for some of the causes of sickness. These include environmental and ground pollution, the destruction of waterways and healthy drinking water, lead paint on the walls of government-subsidized homes, the overall neglect of communal infrastructure, and the lack of meaningful educational opportunities in poor communities. The point here is not to enumerate all the sources of disease but, rather, to argue that if health status has a communal dimension, the medical model is too narrow for it. Healthcare must also have a communal dimension. Government and business may be justified in cutting the number of dollars they spend on healthcare, narrowly considered—but only if those dollars are used to promote good health in the broader areas of individual and communal life.

Rationing and Limits

Debate continues about whether healthcare rationing—the deliberate denial of certain beneficial services to some or all people—is necessary. Many contend that if administrative, legal, and

medical waste were cut from the current healthcare system, there would be enough funds to provide all reasonable services to all who needed them. Others argue that even if waste were eliminated, the remaining funds would still be insufficient to care for all. This latter position seems most logical, since more sophisticated medical technologies and extended life spans will always engender new healthcare problems.[6]

Once again, the Church's social teaching may provide some guidance:

- Rationing must be governed by concern for the common good, and therefore must be done only after all have been given access to a minimal level of care.
- Rationing schemes cannot be the work solely of those who are economically advantaged and already have access to care.
- In the Catholic perspective, based on beliefs about the death and resurrection of Jesus Christ, death is not a final defeat. Nor is the application of all available resources to stave off death respectful of human dignity.

It may not be possible for a religiously based dogmatic truth about death and afterlife to affect healthcare service delivery in general. But this truth should certainly have an impact on Catholic institutions as they address questions about rationing and limits.

Work and Its Implications

In general, healthcare reform has come to suggest layoffs, "restructuring" of services, "reengineering" of activities, and the other buzzwords that signify lost jobs for members of all healthcare professions. Catholic institutions are not immune to these processes. Many institutional leaders are agonizing over such layoffs—which break what many workers saw as a commitment to lifelong employment. But Catholic healthcare simply cannot afford to keep all of its current employees, especially as care-giving settings change. Institutional leaders know they are recreating a work force for today, for the year 2000, and for the changes to come in the century ahead.

Adjustments in the workplace are a fundamental responsibility of sponsors, trustees, and senior managers. It is good that, in making these decisions, leaders can rely on the firm guidance of the Church's social teachings. Work is one of the fundamental social questions, if not *the* social question, to paraphrase Pope John Paul II.

> When making workplace adjustments, leaders can rely on the guidance of the Church's social teachings.

Under principled workplace reconfiguration, a company may not simply eliminate its highest- or lowest-paid employees. In fact, although payroll is usually the biggest operating expense, a company should spread cuts across all areas of its budget; employees should not bear the entire burden. The following guidelines should be considered:

- Organizations must recognize the importance of the dignity of the worker and assign it a higher priority than productivity and profits.
- As workplaces are reconfigured, their owners should have a fundamental concern for those workers most in need of employment. Training programs, outplacement services, and financial resources must be made available to the lowest-paid workers, not just senior managers.
- An organization should clearly explain to its workers the economic rationale behind workplace reconfiguration. It should also explain the principles it intends to follow in making that reconfiguration—and then stick to those principles.
- Employers should provide workers with opportunities for reeducation to keep their job or obtain a new one—and employees should take advantage of these opportunities.

A Failing System

The current healthcare system is failing, on all levels. It fails in its delivery aspect. It fails in its care of those who are impoverished. It fails as an employer. It fails in its resolution of professional conflicts. It fails in its ethical analysis, especially when that analysis is reduced to the principles of beneficence, nonmaleficence, patient autonomy, and justice.

I am not saying that these principles are bad or destructive; they are simply too limited to help

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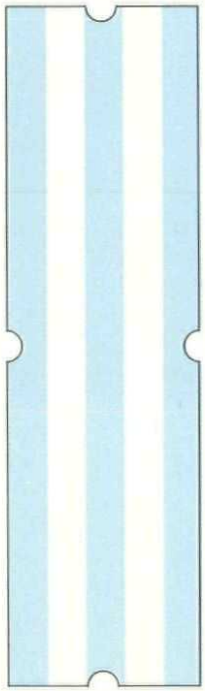

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us solve the current healthcare crisis. But Catholic social teachings may well provide the principles on which healthcare can be restructured for the years ahead.

We must remember, however, that an analysis of healthcare delivery based on Catholic social teachings will have as heavy an impact on *Catholic* healthcare as on non-Catholic forms. It is indeed possible that, in some circumstances, Catholic healthcare may have helped develop practices and standards that are at odds with its own teachings. That should not stop us from employing these teachings for a structural reexamination of Catholic healthcare. It will be painful, but it must be done. □

NOTES

1. Richard A. McCormick, "The Catholic Hospital Today: Mission Impossible?" *Origins*, March 16, 1995, pp. 648-653.
2. On principleism, see Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, Oxford University Press, New York City, 1983; see also E. DuBose, R. Hamel, and L. O'Connell, *A Matter of Principles? Ferment in U.S. Bioethics*, Trinity Press International, Valley Forge, PA, 1994.
3. See, for example, D. Hollenbach, *Claims and Conflict: Retrieving and Renewing the Catholic Human Rights Tradition*, Paulist Press, Mahwah, NJ, 1979; P. Henriot, E. DeBerri, and M. Schultheis, *Catholic Social Teaching: Our Best Kept Secret*, Orbis Books, New York City, 1985; and M. Schuck, *That They Be One: The Social Teaching of the Papal Encyclicals, 1740-1989*, Georgetown University Press, Washington, DC, 1991.
4. National Conference of Catholic Bishops, *Health and Health Care*, U.S. Catholic Conference, Washington, DC, 1981.
5. See, for example, D. Brock and N. Daniels, "Ethical Foundations of the Clinton Administration's Proposed Health Care System," *JAMA*, April 20, 1994, pp. 1189-1196.
6. Catholic Health Association, *With Justice for All? The Ethics of Healthcare Rationing*, St. Louis, 1991.

BEGINNING OF LIFE

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and further study, including inquiry into theological as well as clinical data and materials.

• Appropriate regard for the goods of marriage and family and respect for unborn human life require much more than mere adherence to the prescriptions and proscriptions expressed in Part 4. Although specific directives set the parameters for determining appropriate action on behalf of human good, they do not exempt decision makers from reasoned analysis and conscientious decision making.

• The nature of the material addressed in Part 4 should lead ethics committees in Catholic healthcare to educate themselves and ensure they understand the issues. Moreover, ethics committees should carry out ongoing educational activities to promote better understanding of the issues and help shape organizational policy and practice in ways that promote the goods and values in question. □

NOTES

1. Congregation for the Doctrine of the Faith, Instruction on *Respect for Human Life in Its Origin and On the Dignity of Procreation*, Ignatius Press, San Francisco, 1987, p. 12.
2. Pope John Paul II, "The Christian Family in the Modern World," in Austin Flannery, ed., *Vatican Council II: More Post Concilior Documents*, vol. 2, Costello Publishing, Northport, NY, 1982.
3. Congregation for the Doctrine of the Faith, p. 9.
4. See, for example, Leon Kass, *Toward a More Natural Science: Biology and Human Affairs*, Free Press, New York City, 1985; Paul Lauritzen, *Pursuing Parenthood: Ethical Issues in Assisted Reproduction*, Indiana University Press, Indianapolis, 1993; Rita Arditti, Renate Klein, and Shelley Minden, eds., *Test-Tube Women: What Future for Motherhood?* Pandora Press, London, 1984.
5. Sandra Carson and John Buster, "Ectopic Pregnancy," *New England Journal of Medicine*, vol. 329, no. 16, pp. 1,174-1,180.