Health in Need of Healing: Church History as a Road Map for Future Evangelization in Medicine

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James O. Breen, MD¹

Abstract

Western medicine developed as an expression of Christian charity and played a large role in the growth of the early church. Despite its original foundation in Christian moral principles, modern medicine has deviated from its origins. The principles of human dignity, solidarity, and subsidiarity have been subjugated to a materialist and transactional construct that forms the basis of the contemporary medical delivery and financing systems. The dehumanization of both healthcare practitioners and patients by the partnership of governmental and corporate entities, and the use of health care as a political instrument, has debased the original mission of the medical profession and represents an affront to the principles of Catholic social teaching (CST). This essay explores the ways in which the US medical delivery and financing systems violate the principles of CST by means seldom recognized due to the inurement of the public and medical professionals. By examining the prevailing healthcare model through the lens of CST, the author illustrates the ways in which CST principles are systematically violated. This analysis serves as the foundation of a Catholic response to the question of how faithful Christians might live out their calls to holiness through the exercise of their professional vocations. A vision of an invigorated model of medicine as vocation, along with illustrative examples, is presented. By exemplifying the principles of human dignity, solidarity and subsidiarity in health care, Christians can seize a golden opportunity for evangelization by rearticulating the historical spiritual mission of Western medicine.

Keywords

Catholic identity in health care, Catholic social teaching, Healthcare access, Healthcare financing, Healthcare reform, Medical practice and the Christian worldview

When one considers how polarized and contentious the topic of health care has become in the United States today, it may seem almost unfathomable that the development of medicine in the West grew out of early Christians' practice of charity in the relief of suffering, extended to all, and was a contributor to the rapid growth of the early Church. The performance of corporal works of mercy by Christian healers—animated by their belief in the intrinsic worth of each person as created in the image of God—distinguished Christian ethics from those of the medicine men of the classical Greco-Roman world. Christians' practical expression of concern for the poor and infirm, irrespective of religion, tongue, or class,

transformed the concept of the physician from that of a craftsman concerned primarily with the practice of his trade to a compassionate healer responding to a call to personal charity. Over time, this concept of

¹ Florida State University College of Medicine, Fort Myers, FL, USA

Corresponding Author:

James O. Breen, MD, Florida State University College of Medicine, 2780 Cleveland Ave, Suite 709, Fort Myers, FL 33901, USA.
Email: james.o.breen@gmail.com

Christian duty to care for the poor and sick led to the foundation of the earliest hospitals in the Fourth Century, which were unlike any institutions that preceded them because of their offer of aid to all in need regardless of class or social status (Fengren 2009, 124).

While the Greek and Roman classical world established institutions dedicated to caring for the sick, they lacked essential characteristics associated with modern-day hospitals. The Roman Empire's *valetudinaria* offered convalescent care solely to slaves and some military men and did not include the services of trained secular physicians. *Asklepieia*, or shrines to the Roman god of medicine Asklepios, were often sought out by the sick, despite their absence of nursing care or daily rations. Healing was thought to occur during the sick person's slumber, during which time he would receive an order from the medicine god in a dream, instructing him in a remedy or perhaps healing him immediately when he awoke. The *iatreia*, physician offices and operatories, have been postulated as the precursors of modern hospitals, because they were the places where physicians would practice their art and included areas for patients to recover after medical interventions. However, as a matter of custom, ancient *iatreia* did not offer room and board to patients. The exceptional case of the physician and holy man Sampson, who offered food and lodging to his patients in his home as an expression of his Christian faith, highlights the distinction between Sampson's practices and the customary treatment in the *iatreia* of the ancient world (Miller 1997, 37–43). In the Eastern Christian world of the Fourth Century, the care of the sick was considered among the highest expressions of Christian *agape*, offering lodging and sustenance along with the care of physicians studied in Hellenic medicine. Under the guidance of such early Church fathers as Basil of Caesarea, Gregory of Nazianz, and John Chrysostom, Christian communities extended their philanthropic care of the sick to all, with special attention to the poor, as an expression of their love of Christ and of neighbor (Miller 1997, 50–62).

In the history of the United States, the Catholic Church has long been the largest custodian of not-for-profit healthcare facilities, established by religious orders with a mission to care for the sick, often under tremendous hardship. Originally led and staffed by religious sisters and brothers in service of others through Christian charity, the latter half of the twentieth century challenged Catholic hospitals with changes in the economic landscape that increased the financial and organizational pressures on their sense of mission. Over this period, hospitals

that had been managed and led by religious sisters were forced to relinquish oversight to business-oriented secular leadership in order to contend with rising economic and regulatory complexities, many of which originated with the advent of the Medicare and Medicaid payer programs in the mid-1960s (Wall 2014, 24).

Looking back at the origins of Western medicine more than a millennium-and-a-half after the founding of the first hospitals, medical care in the United States appears to have wandered far from its original mission. In perhaps the most fundamental example, the primacy of the human person that inspired the early Christian healers has been eclipsed by the designs of a massive bureaucracy that has subjugated the nation's health and nearly one-fifth of its economy. Indeed, as the political and financial clout of the financiers of healthcare has increased, so has the use of medical care as a cudgel for political control. The development of the current state of affairs over several generations has led to resignation and learned helplessness among both the public and healthcare professionals regarding the excessive cost and inefficiencies of the bloated US healthcare system.

Ironically, the impersonal and commodified state of contemporary American medicine may represent an unparalleled opportunity for a renaissance of evangelization among committed Christians. An examination of the infrastructure of the modern-day healthcare system exposes a false understanding of the concepts of human dignity, solidarity, and true freedom which contravenes the principles of Catholic social teaching (CST) beyond the life issues and human sexuality. The articulation of these failings points toward a contemporary Christian response to the needs for physical, mental, and spiritual healing and serves as a catalyst for Christians in medicine to use professional vocation as a tool for evangelization.

For many generations, Americans have been entrenched in a national debate over the organization of a healthcare system that simultaneously presents itself as a safeguard of individual autonomy and as a societal safety net. While the country has grappled across this ideological divide, our medical care has been decidedly occupied by nonmedical managers from the halls of business and government who are unencumbered by the tenets of the Hippocratic Oath. This is evidenced by the staggering rate of growth of healthcare administrators, rising over 3200 percent between 1975 and 2010 compared with a rate of growth among physicians that was comparable to that of the US population (Borders 2015). Now

thoroughly commoditized at the hands of private insurers and as a benefit of public assistance programs, medicine's primary function has diverged far from its putative purpose of restoring health and well-being and alleviating suffering. Accounting for expenditures of \$3.5 trillion and more than 18 percent of the nation's gross domestic product (Abutaleb 2018), public financing of healthcare continues to rise alongside the political influence of payment and practice regulation, taking on a profound social and moral dimension. Much of this political control is exerted by assertion of a false dichotomy pitting the concept of healthcare as a guarantee of government against the duty to protect the invisible hand of an unfettered insurance market. A consequence of the reliance on big government and big business for access to health services is that care becomes dehumanized, less effectual, and less accessible. In this way, our national debate conflates acquisition of health insurance with access to medical care, in effect surrendering the control of access to even the most basic medical services to those who regulate the availability of health insurance (McKalip 2016).

A look back at the past 130 years in Church history reveals stark parallels between the current forces animating American healthcare and the dehumanizing global conditions of the Industrial Revolution that prompted Pope Leo XIII (1891) to issue his papal encyclical *Rerum Novarum* (Leo XIII 1891), considered the contemporary foundation of CST. At a time when robber barons were prompting a social transformation that assaulted the rights of workers, the articulation of a coherent Catholic position defending the dignity of the human person, the rights of the poor, and the principle of private property over Marxist class struggle served to promote the concept of the common good in social issues.

In the century-and-a-quarter since Leo XIII issued his encyclical, the Church has repeatedly spoken in defense of human dignity, the principles of subsidiarity and solidarity, and the dignity of work. The dignity of the human person affirms that the preservation of the inherent worth of all human beings is the measure of all economic and social institutions. As John Paul II (1981) states in *Centesimus Annus*, "God has imprinted his own image and likeness on man (cf. Gen 1:26), conferring upon him an incomparable dignity. . . . In effect, beyond the rights which man acquires by his own work, there exist rights which do not correspond to any work he performs, but which flow from his essential dignity as a person." The principle of subsidiarity, highlighted by Pope Pius XI (1931) in *Quadragesimo anno* among other encyclicals, holds that social concerns

of civil society are best addressed at the most immediate and local level possible, while Pope Benedict XVI's appeal to solidarity calls us to work toward a society that advances the common good of all members of the human family in justice and charity, with particular attention to the most vulnerable. He goes on to describe the intimate relationship between these two pillars of CST:

"The principle of subsidiarity must remain closely linked to the principle of solidarity and vice versa, since the former without the latter gives way to social privatism, while the latter without the former gives way to paternalist social assistance that is demeaning to those in need" (Benedict XVI 2009).

Addressing the role of work as an expression of man's collaboration with God, Pope St. John Paul II affirms the dignity of all human labor when he asserts that work is a means of participation in God's creation, and that the economic system must exist in the service of workers and their families. "[I]n the final analysis it is always man who is *the purpose of the work*, whatever work it is that is done by man—even if the common scale of values rates it as the merest 'service', as the most monotonous even the most alienating work." (John Paul II 1981). Viewed through the lens of CST, the rise of the medical welfare state and the healthcare industry it supports, accounting for nearly 20 percent of the nation's gross domestic product (Conover 2017), represents a profound loss of respect for the dignity of the human person. This results from an impoverished societal understanding of the goal and purpose of the medical profession, which exists to relieve human suffering and restore individuals to wholeness in body, mind, and spirit. Neglect of this purpose permits social engineers to replace humanistic values with utilitarian concerns in the misguided emphasis on efficiency, cost containment, and quantifiable clinical metrics over the inherently relational aspects of medical practice. The societal transformation of medicine from a time-honored profession to an agent of government welfare programs and insurance conglomerates supporting a multi trillion-dollar healthcare industry has subjugated the therapeutic relationship in the name of efficiency by stripping doctors and patients of their uniquely individual characteristics. As healthcare corporations grow ever larger and more depersonalized, the tools used to effect this transformation are the same models that MBAs have been applying to such industries as

automobile manufacturing and guest services at theme parks. The language of health care's administrative handlers is that of Lean, Six Sigma Black Belts, hospital service lines, and "healthcare as experience" *a la* Toyota, Cheesecake Factory (Gawande 2012), and Disney (Cision PR Newswire 2011). In negating medicine's personal dimension and focusing exclusively on the transactional, today's appointed healthcare experts have advocated for the commodification of both patients and healthcare professionals, treating both as interchangeable pieces in the production line, a position that damages the dignity of the human person in as highly an intimate human exchange as the care of the sick (Widmer 2016).

Perhaps the most debated healthcare policy issue in the era of the Affordable Care Act is the expansion of federal and state programs for the poor. While many advocates of state Medicaid expansion claim their position represents a visible form of solidarity with the least among us, the entrapment in cycles of dependency and the limited care access that results from this federal-state partnership makes Medicaid a healthcare "scarlet letter" for the poor and a subtle offense against genuine solidarity with the disenfranchised. The putative intent of Medicaid to serve as a limited safety net for the poor and disabled when it was created in 1965 has morphed into a means to increase access to state-sponsored health care. This has resulted in a massive increase in both the number and proportion of Americans enrolled in the program, with the number of covered lives ballooning from 23 million (9 percent of the US population) in 1990 to 72 million (24 percent) in 2016 (Edwards 2018). The strident support for an increase in the Medicaid rolls—and the expansion of federal control over a state-administered program that now eclipses Medicare as the nation's largest health insurance program (Dodd 2016)—paints a false dichotomy between an exercise in aid to those in need and a callous and volitional withholding of care to the most vulnerable (Ollove 2019). Many advocates for an increased role for the State in healthcare financing and access base their position on the belief that private associations are incapable of meeting such a large social need, a charge which Esolen denounces thusly:

To the charge that "private charity" cannot possibly fulfill the role of the State in ameliorating the lives of those who suffer, we must answer again that that puts things exactly backward. In the first instance, the State has no wealth of its own to

administer but must confiscate its funds from the work of private citizens themselves. Second the State, by consuming the functions of truly social bodies that do work nearest to the people who participate in them, renders the people less and less able to unite to care for one another, and thus it helps to produce the pathologies it pretends to cure. (Esolen 1994, 111)

To this point, an unintended consequence of the expansion of Medicaid has been the erosion of the sense of ethical duty among physicians to provide care *gratis* or at a reduced rate for the indigent and uninsured. The growth of Medicaid and the accompanying reduction in physician autonomy has eroded this sense of professional responsibility by transferring the care of the poor to the welfare state, while at the same time adding cost and administrative burdens to physicians who care for its beneficiaries (Bryan 2014). This runs counter to CST, which declares that the call to solidarity is not an obligation that can be met by the state nor by our tax dollars. Pope Benedict XVI speaks to the expression of true solidarity in his encyclical *Caritas in Veritate*, saying,

Solidarity is first and foremost a sense of responsibility on the part of everyone with regard to everyone, and it cannot therefore be merely delegated to the State. While in the past it was possible to argue that justice had to come first and gratuitousness could follow afterwards, as a complement, today it is clear that without gratuitousness, there can be no justice in the first place. (Benedict XVI, 2009)

Widespread resignation to the dysfunction of American medicine has inured American Catholics to the ways the prevailing healthcare system works against CST principles. Rather than despairing at a myopic view of the state of things, it is heartening to recall that the foundation of modern medicine is found in Church history. A return to the principles that animated the birth of hospitals in the fourth century—combined with contemporary Catholic expressions of solidarity and subsidiarity within healthcare—can form the basis of an authentically Christian expression of the mission of medicine, which has been sullied by decades of governmental and corporate intrusion and cooption.

How can modern-day Catholics live a faithful call to witness in the morass of contemporary American healthcare? Combining a look back over two millennia of church history with an examination of

existing responses to medicine's troubles, we can articulate some basic principles inherent in such a witness:

1. A Catholic healthcare response puts human dignity at the center of its work without compromise.
2. It responds to the needs of the poorest of the poor and is offered and open to all, regardless of socioeconomic status, race, religion, or creed.
3. As a ministry, it is rooted in a local call to service within the community, in accordance with the principle of subsidiarity.
4. Because of its conviction to the Gospel, a truly medical witness remains independent of the influences of public or corporate payers which can hold sway over the way it carries out its mission of evangelization and healing.

Examples of contemporary Christian responses to the expropriation of medicine by outside forces include the emergence of cost-share ministries, spurred to growth as a faith-filled response to the governmental mandates of the Affordable Care Act and its attendant coverage requirements. These organizations, founded around the concept of medical mutual aid societies, pool resources of members to assist in the payment of one another's medical expenses. Because they do not use actuaries and thus are not insurance companies, Christian cost-shares depend upon negotiation with healthcare service providers to lower costs for their members and thus leverage the benefits of a market-based approach to healthcare. Members create solidarity with one another through the sharing of economic burdens and the mutual offering of petitions and prayer (Smith 2014).

A model for Christian medical ministry would depend on the development of independent Christian medical practices that are answerable to a call to charitable service rather than beholden to contracts with insurance or governmental programs. By rejecting economic dependence on exploitative, high-overhead insurance networks and onerous regulation inherent in governmental programs, practices would retain a level of autonomy that would allow them to provide services in accordance with Christian principles and to allocate resources in an authentic expression of Christian subsidiarity. Rather than depending on government or insurance contracts for operating funds, such practices would rely on the support of their patient-members and faith communities for their operations, elevating the communities'

participation in solidarity while also reducing overhead associated with the high cost of insurance contracting and regulatory compliance, offering services to all, including those who lack the means to make economic payment for services. Indeed, such practices already exist in the form of faith-based "Robin Hood" nonprofits such as St. Luke's Family Practice in Modesto, California, which combines a membership-based financial model with accessible medical services for the needy. This model relies on subsidization of care for poor agricultural workers by financially secure "benefactor-patients," whose membership fees make it economically feasible for the practice to offer a high standard of primary care services to all (Forester 2008). The faith-centered focus of practices such as St. Luke's, coupled with the reduced economic cost of providing care outside the prevailing third party-based system, would dovetail with the mission and market-based focus of Christian cost-shares as a shining example of Christian solidarity and subsidiarity. In the same way that Catholic hospitals do not offer their services only to Catholics, a faith-based healthcare ministry in the "Robin Hood" model would be open to serve all people who are drawn to its sense of service and mutual aid, even if they do not recognize by name the Catholic principles that undergird the model.

While the concept of Catholic subsidiarity seems most applicable to the low cost and broad reach of primary care medicine, examples have emerged of hospital and surgical care that reduce costs by eschewing contracts with commercial insurers and governmental payers. The Surgery Center of Oklahoma in Oklahoma City posts the prices of its surgical procedures—often over 50 percent less expensive than comparable procedures at conventional insurance-based hospitals—online, in the name of price transparency. This has attracted the interest of individuals without insurance or with high-deductible health plans as well as self-insured businesses who pay directly for employees' health expenses (Edwards 2017). Despite their lack of an outward confession of faith principles, these cash-based centers provide an example of the feasibility of expanding the scope of a faith-based subsidiarity model beyond the limits of primary care medicine.

The perennial state of crisis in American medicine, coupled with the systematic contravention of CST in the healthcare system, presents an invitation for the development of a true Christian witness through medicine. Building on the faith's rich history of service to all, coupled with modern-day expressions of solidarity and subsidiarity, there exists tremendous possibility for a renewed Christian

response to the US opportunistic healthcare matrix. Such an authentically Catholic medical enterprise would allow for adherence to the mission of ministry to all people, irrespective of their social or economic station. Through an economic model based on mutual aid without governmental or insurance contracting, a uniquely Catholic medical service would muster not only economic support but also spiritual solidarity from other Christians and people of goodwill who wish to support its mission. Lastly, in an age where corporate virtue-signaling raises the hackles of conscientious Christians who do not wish to be de facto accomplices to objectionable social and political stances, a truly Christian approach to medical care in the spirit of the early Church would be a welcome approach for many patients, patrons, and professionals, as well as a way to put solidarity and subsidiarity into action. Indeed, the large-scale emergence of such a medical ministry based on the principles of CST just may be the catalyst that spawns another wave of evangelization from the ruins of our contemporary healthcare system.

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ORCID iD

James O. Breen, MD <https://orcid.org/0000-0002-1222-3143>

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Biographical Note

James O. Breen, MD, received his doctor of medicine degree from Jefferson Medical College of Philadelphia, and completed his internship and residency in Family Medicine at Brown University. He has practiced family medicine in various clinical settings from rural and urban community health centers, multispecialty practices, solo independent practice, and academic medicine. He is passionate about considering how the practice of medicine can better exemplify the Christian virtues on which it was founded. He is a faculty physician in residency education and lives with his wife and two children in Fort Myers, Florida.