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From the Director...

Our readers know that the Center for Health Care Ethics has partnerships with Ascension Health and with Catholic Health Initiatives to distribute this journal throughout their health systems. So it seems only proper to take this opportunity to offer tribute to Don Brennan who retired as CEO of Ascension Health at the end of the Fall semester.

We can all be grateful for the outstanding leadership that Don has shown during his years at the helm of the Daughters of Charity National Health System (DCNHS) and then at Ascension Health. On a daily basis we encounter the blustery sea of change in health care as the squalls of market forces and government regulations continue to pummel the sturdy but vulnerable vessel of our Catholic ministry. During such times of turbulence and uncertainty we need leaders with strong vision and deep conviction who know when to trim the sails and how to navigate the shoals. We have been blessed with such a leader as Don Brennan. He astutely recognized the opportunity to consolidate DCNHS by integrating the various regions into a more robust health system - a system that within a few years would be able to expand into an even more vibrant ministry by co-sponsoring Ascension Health with the Sisters of St. Joseph Health System. These have been transformative years requiring a sense of stewardship that truly integrated the fiscal, management, and operational needs of the system with the enhancement of Catholic mission, identity, and ethics in health care. Don's leadership boldly provided a collaborative vision to build a dynamic health system based on core values. His vision courageously fostered a new covenant of trust to serve our communities and patients based on ethical principles. And his sense of mission tenaciously inspired the ministry of Catholic health care to develop its role in society based on prudence and integrity. For his many gifts and dedicated service we are truly grateful for God's providence. We honor Don's leadership and wish him and his family continued success and happiness. And, of course, we wish every success for Doug French who has taken over the helm at Ascension Health, wishing him abundant blessings and organizational accomplishment.

How time flies! Looking ahead, already the Center is planning the Spring Institutes for 2001. In May we will offer two newly designed Institutes in health care ethics. Each Institute lasts for three days: the first Institute (May 7-9, 2001) considers the foundations for ethics in Catholic health care; and the second Institute (May 10-12, 2001) examines organizational ethics in Catholic health care. We have planned the two Institutes to run back-to-back to enable registrants to attend both if they desire, with an attractive price-break for those who register for both Institutes! We have a great roster of ethicists to lead the sessions, including the Center's personnel, ethicists from Catholic health systems and from the Catholic Health Association. The first Institute on Ethics Foundations for Catholic health care includes sessions on the recent revision of the Ethical and Religious Directives, sponsorship and mission, ethical principles, integrity and decision making, professional relationships, social justice, e-technology issues, and the work of ethics committees and consultations. The second Institute on Organizational Ethics in Catholic health care includes sessions on stewardship, professional leadership, developing organizational ethics committees, the health care work environment and human resources, care for the poor, managed care, unions, and applying the controversial principle of material cooperation to partnerships in Catholic health care. In this e-journal you will find an advert with the relevant contact and registration information.

As usual, this issue of Health Care Ethics USA has three essays addressing organizational ethics, medical ethics, and ethics foundations. The first essay deals with a crucial topic in organizational ethics: "Organizational Decision Making for Catholic Health Partnerships." This essay is the result of a research project coordinated by Sr. Marie Damian Glatt (former CEO and President of the Sisters of Charity of Leavenworth Health System) when she was a visiting scholar at the Center during the Fall semester. On her behalf, I thank the many leaders in Catholic health care who contributed wisdom and
time as they discussed various issues that led to this exciting and timely essay. And on behalf of everyone at the Center I extend sincere gratitude to Sr. Marie Damian for such gracious leadership during her visiting semester with us! The second essay deals with an emerging concern in medical ethics: "Electronic Medicine and the Medical Covenant." This essay is by Griffin Trotter, MD, PhD, who is one of the faculty at the Center - he explores many of the emerging concerns related to e-technology in health care. The third essay addresses one of the most important facets of ethics foundations in health care: "Catholic Social Teaching: From Principles to Practice." This essay is by Michael Panicola, PhD, the Manager for Ethics at SSM Health Care System in St. Louis - he provides a very helpful summary introduction to the Catholic tradition of social justice in health care. I hope you all enjoy the essays. Please do not hesitate to contact us with suggestions for future essays.

Gerard Magill, Ph.D.
Organizational Decision Making for Catholic Health Care Partnerships

Institutional partnerships are becoming increasingly necessary for the Catholic ministry because of competitive pressures in the current market-driven environment of U.S. health care. The variety of these partnerships is expanding. For example, there are mergers between Catholic systems or hospitals or between Catholic and other community hospitals; there are arrangements between Catholic systems/hospitals and community hospitals, including lease arrangements; there are agreements between non-for-profit Catholic systems/hospitals and for-profit hospitals; there are partnerships between multiple providers, such as between a Catholic hospital, a specialist group like cardiology, and/or a for-profit developer or provider.

The development of these partnerships raises many complex issues that often entail decisions in giving up control for influence. Hence, there is an increasing need for appropriate decision making at a variety of levels, including the sponsors, the corporate board, and the relevant communities. This essay considers some crucial aspects of organizational decision making for such partnerships in Catholic health care. The essay discusses principles and challenges that have enabled Catholic health care to achieve significant accomplishments in recent partnerships with other organizations. These principles, challenges, and accomplishments were identified by prominent leaders in Catholic health care during a series on telephone interviews that discussed their approach to organizational decision making for Catholic health care partnerships. So the essay conveys in narrative form the practical wisdom of many current leaders in the Catholic ministry.

Principles

There are several general principles that can provide ethical guidance for sponsors and management in Catholic health care as they seek compelling reasons for mergers and partnerships.

First, we should foster the ministry of Catholic health care in our pluralistic society. This entails bringing our ministry to some communities or strengthening our ministry as an established presence in other communities so that we can have an impact upon the delivery of care. Because fostering our ministry in society must ensure compatibility between our mission and values and those of our potential partners, the local board chairs have a significant responsibility to encourage and facilitate appropriate conversation and discourse among the relevant stakeholders.

Second, Catholic health care should steward its resources to maintain or to enhance the influence of our ministry in society. Stewardship, then, can require Catholic health care to be a leading provider of health care in specific communities, or to be a catalyst for creating a stronger or more efficient health system, perhaps by sharing power or by fostering relations with physician practices. In other words, stewardship necessarily involves a strategic perspective for our ministry and society together.

Third, to continue the ministry of Catholic health care there is no option but to compete in an increasingly competitive marketplace where health care is driven more and more by business, economics, and financial strength. Hence, there are pressures to develop productive partnerships by offering revenue-producing services that create increased market presence. But significant trade-offs need to be considered when planning revenue-producing services. For example, pressures to close non-productive cardiology programs (because there is no longer a need for them at other area hospitals) can affect a hospital's financial viability.

The fourth principle that should provide ethical guidance for sponsors and management in Catholic health care is the obligation to provide health care services to the poor. This principle is actually more complicated that it may seem because it urges us to form controversial types of partnerships that are indispensable to continuing services to the poor. A common example is when a Catholic system assumes a lease management arrangement with a community hospital that is threatened with closure because of market pressures. Of course, the problem that arises here is the trade-off between
maintaining services to the poor while having to cooperate with the community hospital's provision of services (such as direct sterilization) that are proscribed by Catholic teaching. What is abundantly clear is that if we do not enter such arrangements the poor will not be served - care for the poor must play a crucial role in our ethical evaluation of such partnership arrangements.

Discussion

Hence, Catholic health care and its sponsors are faced with many difficult challenges as we seek to navigate our way through the hostile and competitive terrain where weaker institutions can be threatened by failure. The many challenges that require careful attention include the following.

Perhaps the most significant challenge deals with clarifying the mission and identity of our Catholic ministry in the intensely competitive environment of health care today. There is little doubt that serving the growing numbers of uninsured and underinsured in our nation will play a crucial role in this regard. As we focus upon our mission of the healing ministry in circumstances of partnerships with other organizations, there is a multiplicity of overlapping concerns that we need to address.

The stewardship of religious sponsors, especially as we undertake the revision of *The Ethical and Religious Directives*, is needed possibly more than ever before. One aspect of this leadership deals with the significance of reserved rights within our secular society. Undoubtedly, the primary focus of the leadership and responsibility of our sponsors is to steward Catholic health care both with regard to the continuation of the healing ministry of Christ and with regard to maintaining a healthy revenue base in a tough market environment. The competitive nature of this environment, whether we partner with investor owned health care or otherwise, requires our sponsors to foster a ministry that successfully navigates the difficult arena of legal compliance, with Medicare fraud and abuse being an obvious example.

Also, ascertaining the mission compatibility of potential partners, such as for-profit organizations, is crucially important. This compatibility is indispensable if we are to enhance our relations of trust with the communities we serve; but the mutuality of organizational culture in our remarkably diverse nation must respect our partners in a manner that underscores commonalities rather than differences - this is particularly obvious when we discuss the values of *The Ethical and Religious Directives* with other than Catholic partners.

Moreover, the distribution of power between partners needs to be determined in a manner that ultimately assures the continued influence of the ministry. Often this distribution means a shift from power, whereby the Catholic partner has over-riding authority, to influence when the Catholic partner needs to accept being in the minority if it is to continue its ministry in a particular community. In situations of a minority voice, the Catholic partner can enhance its long-term influence by shrewdly attending to critical items in the partnership contract, such as: determining an appropriate governance structure, perhaps requiring super majority rule for major decisions and sometimes requiring the involvement of the entire system; ensuring there is appropriate management support and involvement, especially with regard to effective communication processes in the new organization. Of course, recognizing the complexity of institutional partnerships also requires a level of responsibly "letting go" so that loyalty to an original sponsor does not drain energy or detract the focus from the mission of the new organization.

In response to these challenges, Catholic health care has achieved significant accomplishments that offer hope for its future ministry.

First, Catholic health care has shown that it can establish partnerships that enhance the ministry, even in difficult organizational circumstances. Success stories demonstrate the importance of making bold decisions that combine sound governance and management structures with effective responses to community needs. One of the most important ingredients for success seems to be the creation of a trust-based reciprocity between the religious sponsors and governance and also between the local and corporate boards. Local accountability, support, and relationship building cannot be underestimated, including the need to keep local church representatives (such as the Catholic Bishop) well informed. Not surprisingly, such good relations often require making practical arrangements regarding some clinical, financial, and governance issues about controversial services to honor the requirements of *The Ethical and Religious Directives*.

Second, Catholic health care has shown that it can be a prudent steward of fiscal resources.
Successful organizations in the Catholic ministry have demonstrated prudent stewardship not only by addressing standardization and quality processes but also by improving cost efficiencies, services, and financial performance - sometimes demonstrating that the Catholic institution can be the provider of choice while also serving the poor in particular locations. Of course, economies of scale, reducing duplication, appropriate financial goals, and integrated planning and management, etc contribute to successful stewardship. But successes in these arenas need to provide a synergy that leads to increased satisfaction among employees, clinicians, patients, and communities while maintaining our service to the poor.

Finally, Catholic health care has shown that enhancing the ministry and fiscal stewardship can go hand in hand with a commitment in justice to its employees. Often, partnerships enable Catholic institutions to become influential participants with an increased market share, as occurs when they join large health systems - occasionally becoming the first or second preferred provider in a community. Such circumstances offer opportunities for the Catholic partner to ensure its commitment to justice enhances the working conditions and benefits of a larger population of employees than hitherto. When this occurs Catholic health care gives witness to its mission-influence upon society, even when it may have forfeited majority power or control in the new partnership.

**Conclusion**

If Catholic health care is to continue its ministry in our pluralistic society partnerships with other organizations are becoming increasingly necessary. But these partnerships raise many ethical issues that need guidance for the organizational decision making that is required. Several principles provide basic guidance for such partnership decisions. To foster its ministry, Catholic health needs to assure its continuation in our society. We need to steward the resources of Catholic health care if we are to compete effectively. And care for the poor must remain as a prominent focus of our ministry.

As we apply these basic principles in different circumstances, Catholic health care has to address significant challenges. Religious sponsors have to face the challenge of stewarding the ministry of Catholic health care in the sense of assuring the continuation of Christ's healing ministry via prudent fiscal stewardship. This entails a shrewd discernment of the mission compatibility among potential partners and the subsequent distribution of power that may require the Catholic partner to forfeit its previous power for effective but minority influence in a larger organization.

Fortunately, there has been sufficient success for Catholic health care to offer hope for a vibrant, future ministry in our pluralistic society. We have fostered a multiplicity of partnerships that have enhanced the ministry, even in very complicated circumstances. Also, Catholic health care has shown that it can provide the prudent stewardship that will assure its presence in a competitive environment. And as our ministry has faced its many challenges it has been able to pursue a dedicated commitment to social justice.

Organizational decision making for Catholic health care partnerships can rely on the above principles to face ever new challenges and to seek even greater accomplishments. Catholic health care will need to continue its scrutiny of potential partnerships to ascertain if they will care for the poor, serve the local community, and enhance Christ's healing ministry. Moreover, Catholic health care can provide leadership for a paradigm shift from competition to collaboration in health care, such as occurs when the Catholic ministry forfeits previous power for effective influence in a larger organization. And as Catholic health care seeks to be guided by the Church, there will be an increased need for education and honest dialogue among the stakeholders, including bishops, sponsors, governance, management, and providers. When partnerships in Catholic health care fail or founder, often it is because of differing expectations and vocabularies among these stakeholders, requiring further education and deeper understanding. By writing this essay that reports the wisdom and experience of many current leaders in Catholic health care partnerships, we hope to contribute to this shared process of organizational decision making.
Suggested Readings


Questions for Discussion

1. What challenges do you consider Catholic health care must face in the next few years?
2. What ethical principles can you identify that may address these challenges in our pluralistic society?
3. What are some of the recent accomplishments of Catholic health care that can provide a bridge to our future ministry?
Suppose it is the year 2010. Joey and Maria Davidson have recently retired and moved to Phoenix, where they play tennis, sip Manhattans and thank the Lord that 65 years of Wisconsin winters are behind them. After nine months of relative bliss, Joey develops a persistent cough and reluctantly visits the local internist. Chest x-ray and CT reveal a mass in the upper lobe of Joey's left lung. He is referred to the top oncologist in Phoenix. But Joey's son James is an oncologist back in Wisconsin. Instead of scheduling an appointment with the local specialist, Joey sits down at the computer, inserts his MedSmart data card and forwards everything (including the chest CT) to James. That afternoon, James reviews the information and calls his father with bad news. The nodule is probably malignant. James recommends that Joey get in touch with Dr. Hilda Johnson at Research Medical Center in Los Angeles. Dr. Johnson is an esteemed colleague who is doing ground breaking research in lung cancer. Never one to dally, Joey hangs up the phone and starts typing on his personal computer. He consults Research Medical Center's Web site and obtains a secure email connection with Dr. Johnson, mailing a query and attaching his MedSmart data. Dr. Johnson operates a thriving online service. One of her oncology fellows is assigned to round-the-clock computer detail, ensuring a rapid turnaround to Joey's inquiry. A visit to Los Angeles is quickly arranged, where lung biopsy shows small cell carcinoma. After consulting online with son James and his old internist in Madison, Joey agrees to enter one of Dr. Johnson's clinical trials. Just one week after growing impatient with his nagging cough, Joey is fighting for his life in a strange city, receiving a promising but unproved remedy from the world's foremost lung cancer researcher.

Joey's story, or something very close to it, is possible today. In the future, it may be commonplace. Several major research centers (such as the Cleveland Clinic and MD Anderson Cancer Center) use sophisticated Web sites to attract clientele globally. Patient data is transferred through intranets and extranets, as well as the Internet. Kaiser Permanente has developed an online service that allows patients to email their physicians, maintain personal health records, schedule appointments, order medication refills, obtain customized health information and participate in online support groups. However, studies show that there is far more demand for online health services than willingness or ability to provide them. Success in the increasingly competitive healthcare industry will probably depend on meeting this growing demand. One possible strategy is the Virtual Managed Care Organization (VMCO) envisioned by Farrokh Alemi. The VMCO is a technology-based clinic that manages patients on the Internet. In a VMCO, face-to-face patient-physician encounters are kept to a minimum. Physicians are expected to forestall problems by monitoring patient medication use (through online compliance data), checking clinical parameters (such as glucose values and blood pressures) obtained by patients or by mobile nursing units, and offering timely online advice. Alemi thinks that VM COS can thrive by drastically reducing brick-and-mortar expenses and by offering highly customized services for specially targeted chronic illnesses.

Principles

Whether or not Alemi has accurately predicted the details, major Internet-based changes in the management of chronic disease are almost certain. The patient-physician relationship will be altered - which leads to the fundamental question of this essay: Will Web-based alterations in clinical medicine affect physicians' fundamental ethical commitments? If we change the manner and means of contact between patients and physicians, must or should we change the ethical paradigm through which we interpret their relationship? Many physicians and medical ethicists endorse a covenant model to describe the moral basis for patient-physician relationships. Will Web-induced consumerism render the medical covenant obsolete?

Covenants and Contracts

The medical covenant, like any covenant, is the ideal of a moral community. Unlike contracts, which
are exchange agreements between mutually disinterested parties, covenants require persons to care for one another. To fulfill the terms of a contract, one needs only to carry out specific obligations stated therein. Covenantal obligations, on the other hand, are too broad to be spelled out in detail. They require a kind of transformation in the covenanter. Proponents of a medical covenant believe that clinicians' devotion to healing should trump their desire for profit or for other rewards external to the practice of medicine. Though little has been written on the matter, a genuine covenant also requires the commitment of lay persons who are potential patients. Responsibility for shaping, supporting and enhancing the health care system falls on every citizen who partakes of the medical covenant.

I defend the covenant model because I believe it is most conducive to human flourishing. It is better for patients, because they get physicians who are committed to helping and serving -- even when service demands uncomfortable discussions, extra hours or a willingness to defend patient interests against intrusions and injustice. The covenant model is also better for physicians, offering an integrated life with rewards not experienced outside the select circle of dedicated healers. For the covenant physician, medicine is honorable and intrinsically rewarding. For the contract physician, medicine is merely a means of earning a living.

Discussion

Covenants and Customers

These arguments may not apply so neatly if traditional clinical medicine gives way to e-health. Changes that occur in scenarios like Joey Davidson's pose apparent threats the notion of a medical covenant. First, mobility between doctors and between medical centers is greatly enhanced, while personal contact is decreased. Compared to the price of health care, transportation is not expensive, and online sources make it possible for folks like Joey to shop for the best providers. In contemporary medicine, mobility is constrained by restrictive insurance arrangements, but these barriers will lessen as health systems are horizontally integrated and insurers respond to market pressures. If switching doctors or hospitals is so easy, one traditional element of the medical covenant - the conviction that patient-physician relationships are intrinsically valuable - is clearly threatened. Renowned physician Francis Peabody claimed that the bond between patient and physician is "the greatest satisfaction of the practice of medicine." What happens to this bond when face-to-face contact is drastically reduced and patients change doctors at the drop of a hat?

Second, patients such as Joey exhibit very high levels of self-reliance. Part of the justification for the covenant model is the observation that sick persons are vulnerable, not only due to their illness, but also because of their relative ignorance. But Joey doesn't seem so vulnerable. He is savvy about obtaining medical information and - like the growing proportion of patients with chronic illnesses or wellness concerns - he has his wits. Unlike the passive, loyal patient of Peabody's day, Joey comes across more like a business customer. And business begets contracts, services and profits - not covenants.

The New Covenant

On the other hand, the medical covenant may be flexible enough to accommodate these new developments. Covenants are about communities. Perhaps we can forge new forms of communal alliance between providers and patients. If so, the first step may be to recognize that the differences between Web communities and real-world alliances such as the traditional patient-physician relationship are based on technical details, not fundamental values. The September 2000 issue of Fast Company - a prominent journal of the new economy - contains an interview with Web leader Cynthia Typaldos. Typaldos dramatically underscores the moral similarities between Web-based and conventional communities. She says that Web communities form around shared purposes and that meaningful participation requires a stable identity, mutual trust, shared history and, most of all, commitment. Interestingly, these are virtually the same elements that philosopher Josiah Royce identified in the late nineteenth century as the generic characteristics of any community.

Conclusion

The key to preserving the medical covenant is to carefully adapt its central premise to the opportunities and demands of Web-based medicine. The primary goal of medicine, according to the covenant model, is to benefit patients. According to the contract model it is to secure profits. As long as health care providers prioritize benefiting patients over maximizing profits, the medical covenant will
thrive. If patient loyalty and the longevity of patient-physician relationships are important, then new technology should be harnessed to facilitate these ends. Online technology will allow patients to remain in contact with established physicians even after out-of-town moves. A responsive and secure email correspondence program could enhance patient-physician loyalty while greatly improving patients’ quality of life. Tradeoffs will certainly be required. Physical proximity between patients and physicians is beneficial even in many circumstances where it is not essential. And it is essential in more situations than gurus of online medicine seem to think. How many patients will be misdiagnosed because they don't receive an adequate bedside diagnostic evaluation? This critical question must be addressed by any e-health initiative. Nevertheless, online medicine, insofar as it is based on fidelity to patient needs, need not be a serious threat to the medical covenant.


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Griffin Trotter, MD, PhD
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**Suggested Readings**

"E-Health: Managing the Revolution." A special issue of Frontiers of Health Services Management 17 (Fall 2000)


**Questions for Discussion**

1. One of the pitfalls of the technological revolution is the shift in workload. Though we are spending less time with charting, billing and accessing crucial information, we are spending considerably more time learning about new technologies and working out glitches in our technological systems. Hence, there is little evidence that new technologies are freeing clinicians to spend more time doing clinical medicine. Is this a problem? If so, how should it be addressed?

2. Health care seems to be experiencing a paradigm shift from a clinically-centered, bedside orientation to an educationally-centered, preventative health orientation. If this is so, should we transfer some of the tasks of health care to the school systems? Why or why not?
Catholic Social Teaching: From Principles to Practice

Catholic social teaching (CST) and the principles embodied within that teaching provide the broad framework for understanding how Catholic health care organizations should structure themselves and interact with their employees. Yet while the principles of CST are relatively clear, the implications of the principles are less transparent. In this essay, I will describe several principles within CST and highlight their implications for Catholic health care organizations, specifically focusing on how the principles shape and guide organizational structure and employee relations.

Principles

Four principles have been articulated within CST that have special relevance for the present study. The first principle is human dignity which holds that every human person is made in the image of God and thus is of inherent dignity and incalculable worth. This principle is the cornerstone of CST. The basic source of human dignity does not reside in a person's functional ability or social utility. Rather, God's love that encompasses all of humanity provides the basis for human worth and subsequently confers on every person an inalienable dignity.

The second principle is participation which maintains that every human person has a right and a corresponding responsibility to participate in society to the extent they are able, promoting at once themselves, their families, and the common good. This principle pertains especially to human work because it is in and through work that persons: enhance their dignity and become more truly and fully human; promote and protect their families; and contribute to the building up of society and participate in the unfolding of God's own creative design for humanity and the world.

The third principle is solidarity which claims that every human person is at once unique and historically/culturally conditioned but nevertheless part of one human family. This principle illuminates the deep connections among all persons, regardless of race, sex, age, national origin, religion, personal characteristics, and so on. It also points out that in a mysterious and profound way, individual persons are their sisters' and brothers' keepers in this interconnected and interdependent world. How a persons acts affects others and thus individual choices must promote the good of others and the common good.

The fourth principle is subsidiarity which contends that decisions should always reside with individual persons or groups at the lowest, most appropriate level. This principle limits the extent to which governments and organizations can usurp proper decisional authority by insisting that no higher level of organization should perform any function or make any decision “that can be handled efficiently and effectively at a lower level of organization by human persons who, individually or in groups, are closer to the problems and closer to the ground.”

Discussion

While the principles of human dignity, participation, solidarity, and subsidiarity have been considered separately, they are actually overlapping and intersecting. That is they work back-and-forth upon one another in shaping and guiding organizational structures and employee relations. The precise implications of these principles for Catholic health care organizations in terms of how they structure themselves and interact with their employees are widespread and can only be worked out in the context of the individual organization. This points to one of the strengths and limitations of principles, that is, they are normative guidelines that prompt action and generate response, but they must always be interpreted and applied in a particular setting involving unique circumstances. Notwithstanding the difficulty in formulating precise implications for Catholic health care organizations, some overarching implications can be delineated from these principles.

In light of the principles of human dignity and participation, the following implications can be drawn.
First, just wages and appropriate benefits such as affordable health insurance and vacation time are vital to the overall well-being of employees because they allow employees to increase their dignity, nurture and sustain their families, and participate in society. Catholic health care organizations are thus required to provide employees with just personal wages and appropriate benefits established in view of the contribution of the employee to the organization, the financial state of the organization, and the general and common good. Second, in addition to just wages and appropriate benefits, it is absolutely critical that employees are able to perform their daily tasks in healthy work environments free of unsafe conditions, abuse, and discrimination so they can increase their dignity and contribute to the building up of the organization through their own work. Catholic health care organizations are thus required to structure work environments in ways that enable employees to do their jobs safely and develop processes to respond to unjust behavior that contradicts the dignity of employees and impedes their active involvement in the organization. Third, education and training initiatives that help employees increase their skill sets are crucial in our technological world because they make it possible for employees to meet the demands of their jobs and respond to ever-changing work environments.

Catholic health care organizations are thus required to provide educational and training opportunities to employees so they are well equipped to fulfill their job responsibilities and are able to realize their full work potential and participate effectively in the life of the organization. Moreover, given the volatility in the health care industry and the elimination of the implied "lifelong employment contract" in the general work setting, education and training designed to improve skill sets is a vital safety net for health care employees in the event of downsizing or closure. In truth, enhanced skill sets is one of the only promises Catholic health care organizations can make to employees in terms of continued employment.

In light of the principles of solidarity and subsidiarity, the following implications can be drawn. First, involving employees in planning processes and decisions that directly affect their work is important so employees feel more connected to the organization as well as to other employees and recognize their legitimate decisional capacity in matters directly relating to their work. While top-down decision making is necessary to some extent in any organization, concrete decisions should be handled by knowledgeable employees who are closer to and more in tune with the actual issues. Catholic health care organizations are thus required to facilitate processes that allow employees to take part in decisions that have a direct impact on their work. Not only is this sound leadership, but it also encourages and empowers employees to take more ownership in the organization, unite with other employees, and cultivate their own gifts and talents. Second, adequate communication to employees regarding the cultural and strategic pathways of the organization and specific job requirements is an important element of the overall work relationship because it fosters commitment and accountability on the part of the employee. Catholic health care organizations are thus required to align employee activities with the mission and values as well as the performance initiatives of the organization. By doing this, employees will gain a better understanding of the nature of their own work and come to realize how their work combines with the work of others to fulfill the overall vision of the organization.

Conclusion

These are just some of the overarching implications that flow from the principles of human dignity, participation, solidarity, and subsidiarity. While this discussion of implications for organizational structure and employee relations may not be exhaustive, it does provide a framework for understanding some of the demands that these principles place on Catholic health care organizations. The principles of human dignity, participation, solidarity, and subsidiarity provide the backdrop against which Catholic organizations should be measured in terms of how they structure themselves and interact with their employees. If Catholic health care organizations are not able to meet the general and specific demands of these principles, then social justice requires that they change. This change, however, should always be effected with due consideration for all stakeholders (i.e., employees, management, the organization, patients/families, the community, and the common good), not just one set of stakeholders over the rest.

Michael Panicola, PhD
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Suggested Readings


Questions for Discussion

1. What role do the principles of human dignity, participation, solidarity, and subsidiarity play in the lives of Catholic health care organizations, particularly in terms of how they structure themselves and interact with their employees?
2. What ways do Catholic health care organizations "live" or "operationalize" these principles in their organizational structure and employee relations?