From the Director...

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Summer is upon us, so I wish all our readers some time to rest from the hectic pace of the busy lives we lead in Catholic health care. This summer will be busier than usual at the Center for Health Care Ethics because we are moving locations. Last year, Saint Louis University purchased and renamed the former Incarnate Word hospital that is close to our University Hospital. The new name is the Salus Center (salus, as many of you know, is the latin word for health). So, we are moving from our current location in the School of Nursing to our new space in the Salus Center. We convey sincere gratitude to the School of Nursing for all the kind hospitality that we have received over the years. This relocation of the Center presents an excellent opportunity for us: we will have more space and we will be located beside several clinical departments and the School of Public Health. Naturally, lots of time, energy, and personnel will be involved in packing boxes, and settling into our new space. Fortunately, our PhD program in health care ethics is now fully enrolled so we will have lots of assistance from our doctoral students!

Our annual Institutes last Spring were very successful - we presented sessions on "Ethics Foundations" and on "Organizational Ethics". Let me take this opportunity to offer sincere gratitude to all the faculty who presented and to all those who participated in our week-long Institutes in May. It was wonderful to welcome so many new faces as well as to welcome back so many previous participants. Because of the anticipated relocation of the Center over summer and early Fall, we have decided to delay our next Institute until May 2002. When we have more specific plans for that Institute we will send you information accordingly.

Another very exciting development at the Center occurs this summer when our new member of faculty arrives. Marian McBay will be a Visiting Assistant Professor for next academic year. Marian's specialty in health care is research ethics, especially with regard to Institutional Review Boards and Ethics Committees. She also has expertise in Public Health ethics. As many of you know, compliance with regard to Institutional Review Boards is becoming increasingly neuralgic and worrisome. With this appointment, our Center plans to pursue a vigorous research agenda on research ethics, including the compliance issues that overshadow this arena. This appointment will enable the Center to work more closely than ever with our Health Sciences Institutional Review Board and our Ethics Committee. Also, Marian's expertise in Public Health ethics will help the Center continue to develop its research and teaching interests in this fast developing field. Marian begins her appointment on July 1 and we offer her the warmest welcome to our Center.

Finally, we have great news to announce about one of our faculty. Jim DuBois received tenure at the end of the academic year, so he is now an Associate Professor with tenure in the Department of Health Care Ethics. Ordinarily, the tenure-track process at our university takes 7 years. Jim has demonstrated his excellent scholarship by completing this process after only 4 years at the Center! Also, Jim began a 9 month research leave at the end of the Spring semester. He will be working on a new book in health care ethics. We wish him every success and enjoyment as he pursues his research and writing.

As usual, this issue of Health Care Ethics USA has three essays addressing ethics foundations, organizational ethics, and medical ethics. The first essay, on an exciting topic in medical ethics, is by James DuBois, PhD, DSc. Jim discusses the ethical debate surrounding the controversial issue of prenatal genetic testing and wrongful birth lawsuits. The second essay, on a much-discussed issue that addresses organizational ethics in health care, is by Griffin Trotter, MD, PhD, who is also a member of faculty at our Center. Griffin discusses a topic that has absorbed considerable media attention over the recent months - the ethical debate on AIDS in Africa with regard to patents and
intellectual property rights. The third essay, on a significant theme in foundational ethics in health care, is co-authored by two of our PhD students, Kevin E. Voss, M.Div., D.V.M. and Mark Repenshek, MA. The essay discusses relevant principles for physician leadership in the health care community. I hope you enjoy the essays and I look forward to receiving suggestions for topics that we might address in future essays.

Professor Gerard Magill, PhD  
Executive Director & Department Chair  
Center for Health Care Ethics
Prenatal testing for genetically transmitted health disorders has become commonplace in the United States. All pregnant women are offered genetic screening for certain common neurological disorders such as Down’s Syndrome and Trisomy 18. Screening is fairly non-invasive, requiring only that blood be drawn from the mother. Although screening has a fairly high rate of false positives (suggesting that there is a neurological disorder when there is in fact none), it has the advantages of being safe, minimally invasive, and inexpensive. Genetic testing typically involves drawing amniotic fluid. It poses some risk of miscarriage, but this risk is commonly thought to be outweighed when the mother falls into a high-risk group. High-risk groups include women over 35 years old or those with a family history of certain genetic disorders. These screening and testing practices have become routine even though, in most cases, we have no medical treatment for the disorders that we diagnose. A woman’s options are typically restricted to continuing the pregnancy or aborting the fetus.

This essay will explore the ethical issues that arise from genetic testing and screening as they pertain to Catholic health care providers (both individuals and corporations). It will focus above all on the tension that arises as Catholic health care providers try to provide prenatal care according to acceptable medical standards (to promote patient well-being and to avoid wrongful birth lawsuits) while being faithful to their ethical principles, which prohibit intentionally taking human life.

Principles

Three principles are of particular relevance in establishing a sensible policy for prenatal testing and genetic counseling.

First, while we need not prolong life using extraordinary or disproportionate means, we cannot kill. For example, an anencephalic newborn need not be given aggressive medical treatment to prolong life as long as possible; but it is not permissible to kill the newborn either to end suffering or to enable another good (such as donation of the newborn's vital organs). This principle pertains to all human beings across the continuum from conception to a natural death. With the exception of Oregon's laws permitting assisted suicide in special circumstances, this ethical norm is sanctioned by law in all 50 states insofar as it pertains to born human beings. Since Roe vs. Wade it has not been consistently applied to pre-born human beings.

Second, patients are entitled to reasonable information about health problems and treatment options because information is indispensable to enabling patient self-determination. This norm is also the law of the land, though the amount of information that must be provided depends on the standard of care, which is established by professional societies and common practice. Wrongful birth lawsuits involve allegations that a patient's right to information was not respected (e.g., through inadequate prenatal testing or counseling), thus interfering with the patient's right to decide freely whether to continue or terminate a pregnancy, which in turn caused harm to the patient (typically financial harm due to medical bills incurred caring for a handicapped newborn). This legal environment, created by wrongful birth lawsuits, brings us to the third principle.

The principle of material cooperation becomes operative whenever the question of cooperating with proscribed behavior arises. The principle of material cooperation allows us to cooperate with proscribed behavior as long as certain necessary conditions are met. One such condition requires that we not intend the proscribed behavior, but rather only some good that comes from our cooperation with the behavior. Thus, we not only cannot perform a proscribed action, but we must always ask whether there is sufficient "distance" from such actions to make clear that our intention is not to perform or enable these actions.

Discussion
Our discussion will be guided by a few key questions that arise for physicians, genetic counselors and hospital administrators in establishing practice guidelines for prenatal testing and counseling.

1. Are There Legitimate Reasons to Test When No Treatment Is Available?
A study of nearly 27,000 amniocenteses conducted in the Southeastern US found that of the 168 cases in which Down's syndrome was detected, 92% of the pregnancies were terminated.1 This suggests that the purpose of prenatal genetic testing is frequently to enable parents to make an informed decision whether or not to continue a pregnancy. Prenatal genetic testing has also been understood by some as a means of promoting public health by selectively aborting fetuses with genetic health anomalies, thus eliminating the anomaly from the gene pool.2

Nevertheless, even within our current legal and medical environment, prenatal genetic testing can be morally acceptable to Catholic health care. Among the legitimate reasons for prenatal testing are the following:

- to diagnose disorders that can be treated or that require special management of a pregnancy
- to help parents to prepare for the birth of a child with special needs
- to put parents' minds at ease
- to satisfy a physician's legal requirement to provide patients with information

While genetic testing may involve the risk of cooperating with proscribed behavior, it is not only morally neutral in itself, but may be good when it promotes these diverse interests of the fetus, parents, and health care providers.3

2. How and to What Extent Should Physicians Test?
As mentioned above, genetic tests such as amniocentesis have benefits and risks that are different from those of genetic screening. Amniocentesis is more reliable than screening, but also more costly and invasive, presenting some risk of miscarriage. It is commonly said that the risk of miscarriage is outweighed when the mother is in a high-risk group, that is, when the rate of the genetic anomaly is higher than the rate of miscarriage due to amniocentesis. This rationale may be found wanting by those who refuse to consider terminating a pregnancy. Yet, the decision whether to recommend or offer genetic testing has become one of those issues of medical practice that is determined by the practice guidelines of professional societies rather than the judgment of individual physicians. This fact provides the basis for wrongful birth lawsuits: were it not standard practice to provide genetic testing in certain circumstances, it would be difficult to establish that a physician failed his or her duty. Thus, in effect, the main ethical issues facing physicians arise from three sources: obtaining informed consent for genetic screening and testing; cooperating with parents who intend to terminate pregnancy should they find a genetic anomaly; and providing or referring patients to genetic counseling when they receive the results of genetic testing.

Informed consent should be obtained before performing either genetic screening or amniocentesis. Two extremes must be avoided. On the one hand, women should not be coerced into genetic testing through harassment, by telling them that such testing is "routine and something we just need to get out of the way," by playing on fears, or by exaggerating treatment options should a genetic anomaly be detected. On the other hand, women should not be bullied into declining genetic testing by downplaying the risks of a genetic anomaly, by insisting that the only reason for genetic testing is to enable a decision to abort, or by exaggerating the risks of testing. There are legitimate reasons why a woman might either request or decline genetic testing, and these reasons need to be respected.

Physicians need to bare in mind that genetic testing itself is morally neutral, and that it is offered to patients only because there are legitimate human interests that can be promoted through genetic testing. But what should a physician do when confronted with parents who openly declare that they are undergoing genetic testing precisely in order to determine whether or not to abort the fetus? This presents us with a classic case of mediate material cooperation: the physician would not be performing an abortion, nor sharing the intention to abort the fetus, but would be enabling the abortion in some indirect manner. In dealing with such cases, we must first ask how "distant" the act of doing genetic testing is from the act of performing an abortion. It is clearly more intimate than performing a pregnancy test (without which some early abortions might not occur), but much less intimate than assisting in the abortion procedure. Whether or not an act is "sufficiently" distant is affected in part by the necessity of performing the act, and the risk of causing scandal. Offering genetic testing is arguably no longer optional for health care facilities that provide prenatal services, and the risk of
wrongful birth lawsuits provides a serious reason to offer these services uniformly. The risk of scandal is mitigated by the facts that genetic testing itself is neutral, that there are legitimate reasons for providing the service to patients, and that Catholic hospitals do not provide or financially benefit from abortion services. These facts make it plausible to argue that physicians may routinely provide genetic testing.

3. How Should Women With Anomalous Pregnancies Be Counseled?
Perhaps the thorniest issues in genetic testing arise when the results of testing indicate a genetic anomaly. Genetic counselors in Catholic health care may feel stuck between a rock and a hard place. On the one hand, they may not recommend an abortion because this would involve sharing the intention to abort (formal cooperation), and they must refrain from presenting it as merely one among several legitimate options. On the other hand, given common practice and the recommendations of some professional societies, they are obliged to present a woman with adequate information not only on the nature of the diagnosed genetic disorder but also on options. Fortunately, the prevailing model for genetic counseling is "non-directional." This means that neither pro-choice nor pro-life counselors should ever recommend an abortion. (Providing a more "directional," pro-life form of counseling might be well within the realm of what is professionally and legally acceptable on two conditions: 1) that the nature of this counseling is fully disclosed to patients before they enter into the relationship, and 2) that an option for "non-directional" counseling is provided either by the hospital or by referral.)

Conclusion
Our current laws regarding reproductive technologies and prenatal health care emphasize a woman's rights to health care and to reproductive choice. One author speculates that these rights may some day be balanced by fetal rights to privacy and confidentiality. Just as parents can currently claim to be harmed by a lack of information about a fetus, born human beings may some day claim harm from the information gathered on them in utero. Genetic information gathered about persons in the womb may have consequences for their future ability to seek employment or to obtain adequate health and life insurance; thus it is conceivable that the gathering of this information could become the material of future allegations of damage. Such cases would be no more outrageous than the wrongful life suits that have been brought forth in some states on behalf of children who were allegedly harmed by being carried to term.

In the meantime, and in the face of recent successes in reading the human genome, we are left wondering which genetic traits will be considered legitimate targets for testing. It is currently against the professional norms of genetic counselors to test for the sex of the fetus with the aim of enabling selective abortion (despite the prevalence of the rhetoric of not imposing values and of enabling reproductive autonomy). Being male or being female is rightly not treated as a genetic disorder, regardless of the views of parents. Will variations in IQ, weight, height, skin color, and temperament continue to be viewed as acceptable, or will they someday be counted as variations that parents have a right to control, or at least to accept or reject? Genetic testing is legitimate in principle, and may become even more useful as new technologies are developed that allow for the treatment of genetic disorders in utero. But before we reach that point, we will likely be presented with new issues that are thornier than those we currently face. The challenge, of course, will remain the same: to provide the best patient care that we can in an ethically acceptable manner. To this end, those in health care need to be at the forefront of policy debates on these issues.

2. One author has observed that this eugenic "public health" attitude may contradict the first secular purpose of testing insofar as it restricts a woman's choice to carry a pregnancy to term by placing her under significant, even if subtle, pressure to abort. See Abby Lippman, "Prenatal Genetic Testing and Screening: Constructing Needs and Reinforcing Inequities" in Dan Beauchamp & Bonnie Steinbock, New Ethics for the Public's Health, (New York: Oxford University Press, 1999) pp. 353-365.
3. This view is supported in part IV of the National Conference of Catholic Bishop's, Ethical and Religious Directives for Catholic Health Care Services, (Washington, D.C.: United States Catholic Conference, Inc.).
4. The guidelines of the American College of Medical Genetics can be found at: http://www.faseb.org/genetics/acmg/

James M. DuBois, Ph.D., D.Sc.

**Suggested Readings**


**Questions for Discussion**

1. What criteria should guide us in deciding which genetic traits should become the target of testing and screening efforts?
2. When should a health care provider risk legal liability rather than compromise ideals?
3. How should genetic counseling in a Catholic health care facility differ from secular genetic counseling?
**AIDS and Property Rights in Africa**

For such a grave matter, the international AIDS epidemic is surprisingly rife with silliness. In South Africa, President Thabo Mbeki insists that "AIDS is simply a disease of poverty, not an infection with the HIV virus." Somehow he fails to grasp or explain the effectiveness of anti-viral medications - which do little to alleviate poverty - or the fact that Yemen, a much poorer country than South Africa, has an HIV seroprevalence rate of 0.01% (compared with about 20% in South Africa). In Sub-Saharan Africa (SSA), the richer countries - Botswana and South Africa - have the most AIDS. Though poverty may be a crucial factor in its transmission, AIDS is not "simply" about poverty.

Meanwhile, AIDS activists, incensed by failure to provide medications and supplies for HIV victims in SSA and other economically deprived regions, seem determined to hamstring industries that develop AIDS treatments. Pharmaceutical offices are picketed and vandalized. Scathing criticisms issue from leaders of activist groups such as Doctors Without Borders, Oxfam, ACT UP, and the Treatment Action Campaign. Most importantly, patent rights are challenged and, in some jurisdictions, repudiated. At Yale University, students helped pressure Bristol-Myers Squibb Co. into relinquishing its patent on an AIDS drug. At the University of Minnesota, students expressed outrage that the University earns money from partial ownership of an AIDS drug patent. One graduate student at UM reports: "We are furious at the university's complicity in the denial of access to life-saving medication to poor people across the world." I suppose fury about complicity (i.e., earning money) overwhelmed any feelings of gratitude about helping to develop the treatment. Of course, in blaming Universities and the pharmaceutical industry for the crisis in Africa, these activists send a clear message. If you want to earn money - do it by some other means than by developing medical treatments for AIDS.

In what follows, I will refrain from analyzing the odd logic which holds that the motive to earn a living is morally immiscible with the motive to provide important goods and services. Instead, I will zero in on HIV drug patents and ask how they help or hinder the fight against AIDS in Sub-Saharan Africa. My thesis is that patent laws are useful and that attempts to portray international patent law as a culprit in the spread of AIDS are inaccurate and misguided.

**Principles**

Patent rights are a species of property right, justified by a number of moral, political and practical considerations. According to John Locke, we acquire a right to the products of our labor. Of course, since most productions are based on cooperation between many parties, and because effective production frequently depends on available capital, this notion becomes rather complex and contentious in contemporary societies. Patents are recognized, for the most part, because we believe that human beings deserve to reap benefits from innovations that beget useful or pleasing goods and services. Creation, research and technological innovation, then, are viewed as forms of labor that generate specific property rights.

Much evidence has accumulated to indicate that jurisdictions recognizing and protecting property rights - including patent rights - do better economically than jurisdictions in which property is insecure or not recognized. In Africa, this correlation seems especially prominent. Indeed, 40% of the wealth of African residents is deposited outside that continent. Some Africans are not even assured of owning their own bodies. The International Labour Organization estimates that 80 million African children are engaged in forced labor. On average, 9% of the Gross Domestic Product of African nations is gleaned from foreign aid, yet aid is limited by the perception that it will be misappropriated by property-hungry tyrants.

Consistent with Africa's poor record on property rights, South Africa recently passed legislation that threatens international patents. The South African law ostensibly represents an effort to increase the availability of AIDS drugs to HIV-positive persons in that country. It condones two practices. The first
practice, compulsory licensing, occurs when a government allows production of a patented product or use of a patented process without the consent of the patent owner. The second, parallel (gray-market) importing, has been misunderstood. According to the World Trade Organization, this practice occurs when products made in accordance with patent laws are imported into another country without the approval of the patent owner. The practice does not include production without patent-owner consent (as per Cipla and Hetero, two pharmaceutical knockoff corporations located in India). Contrary to popular misconceptions, compulsory licensing and parallel importing are both approved under emergency conditions in the TRIPS (Trade-Related Aspects of Intellectual Property Rights) agreement. South Africa, however, seeks to institutionalize these practices in a way that allegedly violates TRIPS. When pharmaceutical corporations challenged the law in court, they experienced a barrage of negative publicity and protest.

Discussion

Despite the commotion in Johannesburg, parallel importing and compulsory licensing have not produced AIDS medication for HIV patients in Africa. Following their legal triumph over pharmaceutical companies, South African officials conceded there are no plans for importing or producing AIDS knockoffs. Cipla announced cheap knockoffs in February 2001, but so far there are no takers. Indeed, even before Cipla's high profile offer, Uganda and some other African countries had deals to buy cheaper drugs from legitimate manufacturers. Since then, many drug companies have offered AIDS cocktails at prices equivalent to or below the cost of production (and below Cipla's price). Yet, despite the availability of inexpensive drugs, Africans afflicted with HIV infection go largely untreated. Why?

Some analysts point out that even when prices come short of production costs, AIDS drugs are too expensive. Zerit, for instance, now sells at $54 per patient-year in Africa (versus $3,589 in the U.S. and Europe). For poor Africans (who typically live on about $200-$300 per year) this price is steep at best. When Zerit is combined with other discounted agents into an effective HIV cocktail, the price exceeds $300 - well beyond the reach of most Africans.

But expense is not the crux. More important by far is the lack of a health care infrastructure. Tuberculosis drugs, for instance, cost only about $5 per year in Africa, yet as many as 15% of TB patients in Africa are unable to sustain a six-month course of treatment. Some people move frequently, looking for work or food. Others avoid medical clinics because they do not want employers to know they are sick, or because they do not trust scientific medicine. The dropout rate for HIV treatment would inevitably be much higher. These regimens are far more complicated than TB regimens, and they must be continued indefinitely. Further, HIV patients are apt to sell their medications on the black market, which diverts them back to Europe. When treatment is interrupted or discontinued, resistant viral strains emerge.

Even if patients are determined to stay on medications once they begin, conditions are not favorable for delivering the medications. Consider Uganda - a poor country that has been unusually successful at stemming the tide of HIV infection. In Uganda there is one doctor for every 23,000 people (compared to one per 1,000 in industrialized countries), one nurse for every 2,332 people and one hospital for every 200,000 people. In such a spread-out, rural environment, these numbers represent a virtual absence of health care infrastructure.

Hence, given current circumstances it is questionable whether HIV medications - even free ones - could have a beneficial impact in African populations. If it is to seriously address AIDS, Africa needs more doctors and nurses, more hospitals, better education and transportation, and, above all, it needs economic and social stability. These objectives are more viable in countries that respect property rights - including patent rights. By threatening patents, we deplete incentives for research and development of AIDS solutions. Likewise, local innovation and economic development are discouraged wherever property rights are tenuous.

Conclusion

Moralistic rhetoric that convicts pharmaceutical companies and entrepreneurism for the failure of AIDS prevention and treatment in Sub-Saharan Africa is inaccurate and misguided. Africa currently experiences negative economic growth and needs more entrepreneurs.3 AIDS medications could be provided to Africa's 25 million HIV sufferers at a cost of $7.5 billion - but only if we build the requisite health care infrastructure. This sum could conceivably be reached through philanthropy (in the United
States alone, charitable donations currently exceed $20 billion per year. It is the infrastructure that poses the most serious obstacle. By preening for AIDS knockoffs and patent violations, we undermine important research, damage prospects for HIV victims, and divert attention from significant causes of human misery in Africa and elsewhere.


Griffin Trotter, MD, PhD

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Suggested Readings


Questions for Discussion

1. Is there a moral imperative to help less fortunate people who suffer from horrific diseases such as AIDS? Do such obligations extend to persons in different countries and continents? In Africa, where economic malaise is related historically to Western colonialism and other forms of exploitation, is the obligation greater? Are companies that develop AIDS medications more obligated than others to sacrifice economic benefits on behalf of HIV sufferers?

2. In Uganda, some measure of HIV containment has been achieved despite (or perhaps because of) the subversion of certain prominent Western public health strategies. For instance, Uganda's government stresses sexual monogamy while questioning the effectiveness of condom distribution programs. Are such measures justified? Will they be effective in the long term?
Principles for Physician Leadership in the Health Care Community

Hospital administrators, fellow physicians, and those involved in drafting health care policies need the unique input supplied by physician leaders. Unfortunately, many doctors are so wrapped up in the daily demands of practice and/or research that they find little time and energy to devote to broader community issues. Although medical practice typically deals with concerns and problems of individuals, a physician's responsibility to the community is also vitally important. The medical profession historically has recognized that obligation. For example, Principle VII of the American Medical Association Principles of Medical Ethics reads, "A physician shall recognize a responsibility to participate in activities contributing to an improved community." Certain aspects of this responsibility are even clearer for the Christian physician. This article discusses principles that frame the notion of Christian physician leadership, describes qualities of leaders applicable to different settings, and gives suggestions as to how physicians can be encouraged to take on leadership roles.

Principles

Stewardship
A steward is one who manages another's property, finances, or affairs. Stewards are always accountable to the owner. The Bible elevates stewardship to a fruit of faith and permeates it with spiritual meaning. Christians recognize that "the earth is the Lord's and everything in it, the world, and all who live in it" (Psalm 24:1). Even our own talents and abilities are temporarily in our charge, and we must give an account to God for their use (2 Corinthians 5:10). Physicians in particular are blessed with wonderful gifts such as high intelligence, a quality education, and a comparatively high income. But these earthly blessings carry a special burden: "From everyone who has been given much, much will be demanded; and from the one who has been entrusted with much, much more will be asked" (Luke 12:48). This burden should be born in mind especially by Christian physicians who feel called to service.

The call to service for Christian physicians can be based on three principles: a responsibility to others, a call to instill Christian values in a pluralistic society, and a mission to become a prophetic witness for justice and a powerful voice against injustice. As leaders, they access the traditional role of a steward by serving as instruments of God's grace to the communities they serve. Words like "responsibility," "call," and "prophetic witness" foster an environment in which self-reliance is not the central value. Physician leaders, as good stewards, are persons of hope for patients, families, and communities that encounter suffering.

Subsidiarity
The principle of subsidiarity affirms that nothing should be done at a higher level that cannot be done as well at a lower one. Subsidiarity has an innate dichotomy. On one hand, the role of larger organizations is to support, and not replace, smaller ones. Conversely, subsidiarity affirms that the supportive role of larger institutions is necessary for the community.

Although this principle has mainly come to light in the 20th century as a crucial norm of Catholic Social Teaching, subsidiarity was traditionally used to describe relationships between communities and individuals. It served to protect those who were most vulnerable. The traditional sense of the principle becomes a dynamic tool to articulate the proper role of the leader within the community. Physician leaders serve the organization and the greater good of society-always in the context of patients, colleagues, and localized communities.

Preferential Option for the Poor
Dorr voices wisdom in these words: "To make an option for the poor is to choose to disengage from serving the interests of the powerful and instead to take the side of those who are relatively powerless." This becomes acutely applicable for physicians, who are seen as empowered members of society, when serving the community. To show preference for the plight of the poor is a deep
individual and communal commitment. It is demonstrated with an experiential expression of human solidarity and political advocacy. Insofar as physician leaders make this choice, they will serve the community through a lens that defines their effectiveness by their ability to provide for those who are the most vulnerable and marginalized.

Discussion

In order to provide a context for this discussion we offer the following hypothetical situation. A new hospital joins a system. Flowing from the system's mission, a desire for physician leadership is necessary so that the hospital and physicians can transition smoothly to the new system leadership. However, animosity regarding re-application for privileges, poor staffing ratios, and lack of communication between administration and physicians all contribute to a "less than smooth transition." Rather than becoming discouraged, a physician within the hospital develops a mentoring program designed to seek out physician leaders who can mentor those granted new privileges. As a result, leadership abilities are no longer assumed in those hired into key positions where physician leadership is necessary. Rather, leadership ability is nurtured and fostered within the spirit of community relations and the calling of Christian physician leadership.

How physicians view their relationship to the community has a powerful impact on how they delineate their obligations. The ability to share responsibility between the community and the physician is a necessary obligation of the community in fostering the leadership of its physicians. Mahoney clearly realizes as well that the "sharing of responsibility injects dignity into the relationship…this indeed, may be the major role of the leader-to make self-worth and dignity possible in others." Looking more closely at leadership one notes its inherent social dynamic. That is to say, in order to lead one must have followers. A responsibility to serve the common good of the institution and the members involved is demanded of the effective leader. In sharing this role the leader motivates and cultivates an environment that participates in its social nature through shared resources.

This type of physician leadership is a response to a call involving: service to the community, a spirit of respect, advocacy for the marginalized, a concern for responsible stewardship, and a witness to faith. It is important to understand these concepts more clearly in order to live the mission of a physician leader. Mission's call is to serve the community by providing for those who are in need, as it is guided by hope and a need to be witnesses to the Christian faith. This service is to be provided within a spirit of respect by serving with compassion, being sensitive to vulnerability, and realizing that the patient is a member of a family and society. Leaders are called to be advocates on behalf of those who are marginalized and powerless because all are unique persons worthy of care. In this same breath we must be attentive to use resources wisely and responsibly, and be good stewards of the gifts granted to those who have by providing for those who have not. Living attentively to this mission, in solidarity, gives witness to our faith by providing a space for leadership in a community through an inculcation of Christian values in society and the greater medical community. Christian physician leaders can be important witnesses to the power of the Gospel of Jesus Christ.

It has been said by various authors that effective leaders model the way, encourage the heart, enable others to act, think about the future, align people to a shared goal, and are focused on producing change. All in positions of authority need assistance in becoming more effective leaders. As demonstrated by the system in our hypothetical situation, Christian health care communities can empower physicians to lead in the following ways:

- Actively seek the leadership of physicians because they have an intimate understanding of patient and physician needs.
- Work to initiate and develop effective communication among physician leaders and those with whom they interact.
- Include the physician as part of a shared vision. Recruit physicians for long-range planning and policy-making committees.
- Help to inspire physicians about the mission of the system/institution and that of Christian health care.
- Foster collegiality by assisting physicians to see themselves as part of a greater community and the greater good.

Conclusion
A nurturing environment often precipitates a "fleshing out" of good leaders. Therefore, it is important to establish boundaries as well as outline leadership characteristics specific to each environment. Notions of leadership are not easily defined, as leaders exhibit dynamic characteristics in each unique situation. However, there are overarching characteristics of leadership that are essential to all settings. We believe this grounding can be found at the roots of how our Christian identity frames that notion of leadership. As we discussed physician leadership in health care, we looked to the qualities found in principles of ethics in order to "re-plant" those essential roots in the solid foundations of Catholic Social Teaching and the Biblical tradition. This solid foundation then sprouts growth that can be lived out in the vital mission of being conduits of our Lord's healing care to the community.


Mark Repenshek, MA
Kevin E. Voss, M.Div., D.V.M.

Suggested Readings


Questions for Discussion

1. Can the physician's leadership role be seen as being outside the bounds of the physician-patient relationship? If so, what new boundaries need to be created?
2. What problems can arise within a health care facility when physician leadership is overemphasized (or taken out of the context of a community)?
3. What actions could Christian health care facilities take to inspire physicians to be good stewards of the gifts God has given them?