JUSTICE IN AMERICAN HEALTH CARE: WHAT WE CAN LEARN FROM THE PHILOSOPHY AND OUTCOMES OF THE FAITHHEALTH MODEL

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LIST OF ABBREVIATIONS

1. ACOG – American College of Obstetrics and Gynecology
2. AIDS – Autoimmune Immune Deficiency Syndrome
3. ARHAP – African Religious Health Assets Program
4. CCCs – Congregational Care Coordinators
5. CE – Common era (AD, *Anno Domini)*
6. CHN – Congregational Health Network
7. ED – Emergency Department
8. HIV – Human Immune Deficiency Virus
9. LOS – Length of stay
10. MLH – Methodist Le Bonheur Health
11. NKJV – New King James Version
12. RHAs – Religious Health Assets
13. R/S – Religion and Spirituality
14. WFBH-LMC – Wake Forest Baptist Health-Lexington Medical Center
15. WFBMC – Wake Forest Baptist Medical Center

ABSTRACT

There has been an observed disconnect between the community of faith and the healthcare community, particularly since the mid twentieth century. From the beginning of Christ's ministry on earth, acts of healing were of similar importance to the proclamation of God's Kingdom on earth. By the early twentieth century, public health settled into the domain of civic duty reinforced by the notion of a moral high ground, the common good. The FaithHealth initiatives of South Africa, Memphis, Tenn., and Lexington, N.C., formulated and launched by Dr. Gary Gunderson, have provided the means whereby the faith-health partnership can be restored. Covenant relationships, between church congregations and major healthcare institutions, require specific obligations from each in order to care for congregants during times of illness and to provide preventive health maintenance during periods of wellness.

Specifically, this thesis considers various bioethical theories of justice for the purpose of determining which is the "better fit" alongside the FaithHealth model. As a result, the concept of justice in the provision of health care in the United States might be more achievable for the population's most vulnerable and underserved. The concepts of Congregational Health Networks (CHNs), covenant relationships, Gunderson's enumeration of "leading causes of life," and the process of "mapping" religious health assets (RHAs) are presented. Concluding consideration is given as to the potential role that the FaithHealth paradigm might contribute to the realization of a just system of health care in the United States and to the existing plight of health care worldwide.

INTRODUCTION

Having spent nearly thirty-five years devoted to the clinical practice of gynecology and obstetrics, I have observed a myriad of change, from all perspectives. Even the marked technological advances that have become reality during this period have done little to repair the disconnect between faith (religion) and health that began as far back as the Protestant Reformation of the sixteenth century. The brief ministry of Christ on earth chronicles the importance of His acts of healing as well as His final commission to His disciples: to heal the sick and to foretell of the approach of God's kingdom.[1]

It was my good fortune to be a part of the early discussions regarding FaithHealth initiatives in South Africa and in Memphis, Tennessee with their founder, Dr. Gary Gunderson. These early discussions considered whether such an endeavor might be successful in restoring some vitality and hope to a small Piedmont North Carolina town, bereft of industry and employment. My role has now been expanded to include, along with my clinical responsibilities, the position of medical director for FaithHealthNC. This opportunity will afford me an overview of the daily function of FaithHealthNC in order to evaluate its success/failure at providing equal access to health/health care for its constituents.

This thesis examines the FaithHealth model, as it posits a theory of justice relative to the provision of health care, that details a "bottom-up" approach. This method reverses the usual "top-down" approach which is employed most theory-driven justice models. In so doing, I use the common morality (common good) tradition as *prima facie*. As defined by

Beauchamp and Childress, "the common morality is applicable to all persons in all places, and we rightly judge all human conduct by its standards."[2] "This common morality is a product of human experience and history and is a universally shared product."[3] The FaithHealth paradigm is uniquely suited to this method since it incorporates social, economic and political entities into its "grassroots," community-driven model of a justice-based provision of health care to the most impoverished and underserved. By examining the core elements of FaithHealth, one can ascertain which established, theory-driven justice models are most congruent with FaithHealth's goals. Ultimately, it is my hope that the reader may realize how FaithHealth might initiate a justice-based reconnection between faith/religion and the public's health.

Bioethics more typically addresses health care primarily in terms of beneficence, rather than justice. I believe it is clear that FaithHealth initiatives succeed at beneficence; thus, an analysis viewed from the philosophical perspective and achieved outcomes of FaithHealth, in terms of beneficence is not a topic for this thesis.

In 2012 Dr. Gary Gunderson, Senior Vice President for Faith and Health at Memphis Le Bonheur Healthcare (MLH) in Memphis, Tennessee, accepted the position of Vice President of Faith and Health Ministries at Wake Forest Baptist Health, Winston-Salem, North Carolina, designated FaithHealthNC. Dr. Gunderson's Memphis initiative incorporated a covenant-based partnership between MLH, a large healthcare organization, and 512 church congregations. The CHN cements the covenant relationship between MLH and the individual church congregation by identifying and assimilating

existing healthcare assets in the community. The resultant outcome is "to create a seamless faith-driven community care system that leverages and integrates existing partners and assets to enhance the health and well-being of all."[4] James Cochrane, professor, Department of Religious Studies, and Senior Research Associate, School of Public Health and Family Medicine, University of Capetown, and co-author of *Religion and the Health of the Public*,[5] with Gary Gunderson, has previously written: "The hope is that the CHN model will continue to exemplify a 'just health system' that mediates between the necessary leadership or polity from above, and the experience and wisdom of those 'below,' taking into account the asymmetries of power that this equation represents."[6] Simply put, the CHN model achieves success by allowing "grassroots" leadership at the congregational level to maintain control of the process, not to be usurped by the unwieldiness of the large healthcare system's bureaucracy.

THE PROCEDURE OF THIS THESIS

This thesis explores whether or not Cochrane's statement, as stated above, can be substantiated. In essence does the FaithHealth model fulfill its mission to provide a justice-based provision of health care to those in need? I review and employ pertinent, established bioethical theories of justice to determine which is more consistent with the FaithHealth paradigm regarding the right to and delivery of health. This thesis describes the bases of the Memphis Model FaithHealth initiative and briefly reviews outcomes from its inception in 2007 to present. This thesis reviews the differences and similarities between the Memphis initiative and FaithHealthNC, the latter operational as of September 2013, and assesses NC data currently collated.

Finally, but not of least importance, I consider the possibility of extending the scope of the FaithHealth paradigm beyond its regional roots. It is of no surprise that Dr. Gunderson and his data analyst and coauthor, Dr. Theresa Cutts, have made numerous, recent trips to Washington to present the FaithHealth model and have published outcomes at the behest of the Department of Health and Human Services, just as the Affordable Care Act reaches full implementation this year, 2014. Having already produced significant health care benefits in the AIDS/HIV pandemic of sub-Saharan Africa as well as having demonstrated reproducible healthcare outcomes and substantial cost savings at MLH in metropolitan Memphis, implementation of the FaithHealth paradigm into the Affordable Care Act at some level could result in improved outcomes and cost containment nationally.

HYPOTHESIS TO BE TESTED

By design, Wake Forest Baptist Health enters into a covenant with a local church congregation (or perhaps small business) by which they agree to work together in order to help congregants/patients, enrolled in the CHN. The emphasis upon covenant, rather than contract, refers to the special biblical relationship God enjoined between Himself and the children of Israel. It is also an attempt to reconnect twenty-first century health care and the healing ministry of Christ, commissioning his disciples to be healers. The role of the CHN, then, is to assist enrollees in making connections to ease their path at all levels of care: before going to the hospital, while being cared for as an in or out patient, and after discharge, for follow-up, sustaining care. For Gunderson this means that people facing illness "come to the right door, at the right time, ready to be treated and not alone."[7]

Granting these practical considerations it remains to be proved whether the FaithHealth initiatives ongoing in Memphis and NC fulfill their mission of improved access to an acceptable standard of care, cost effectively, not only access to health care as the need arises but also the continued maintenance of the public's health. The continued maintenance of the public's health requires more than equal resource distribution, merely distributive justice. The ultimate test as to whether FaithHealth and its CHN model fulfill the bioethical criteria for justice must address, for example, Power's and Faden's so-called "core dimensions of well-being." Their premise is that social justice requires human well-being characterized by six core dimensions: health, personal security, reasoning, respect, attachment, and self-determination. Maintenance of health or cure of illness represents only a single dimension; justice personifies the achievement of the state of well-being not just the health to pursue it.[8]

In order to evaluate how FaithHealth dovetails into an accepted bioethical framework, I test it against the basic bioethical principle of justice, paying particular attention to a standard of justice relative to health care. This extends the definition of justice to include not just allopathic interventional provisions of health care, but considers FaithHealth's success at achieving social justice and a state of well-being for any class having been denied access to health care. I then compare FaithHealth to those specific justice theories with which it appears to be most closely associated: Rawlsian egalitarianism, specifically the difference principle and fair opportunity rule, as well as Singer's all-encompassing notion of utilitarian beneficence.

Peter Singer proposes a theory of utilitarian beneficence but sets a limit on sacrifice. "We ought to donate time and resources until we reach a level at which, by giving more, we would sacrifice something of comparable moral importance."[9] Some of his more recent writings have been less concerned with enumerating obligations of beneficence and more directed toward identifying social conditions that will motivate others to obligatory social activism,[10] mainstays of the FaithHealth initiatives.

More recent theories appearing early in the twenty-first century have cast light from a different angle on justice in bioethics, theories having direct corollaries within the FaithHealth initiatives. These theories include capabilities theory pioneered by Sen and Nassbaum,[11] well-being theories based on certain core dimensions, eloquently described in *Social Justice* by Powers and Faden,[12] and national healthcare policy – the right to health care, a "decent minimum" for health care/health.[13] As a means of concluding comparison, FaithHealth is examined for similarities and differences between global health policy, the moral norms irrespective of political boundaries and statist theory where governments engage in establishing law and policy affecting available opportunities and consumption of economics resources.[14]

SUMMARY

Having completed a comprehensive look at the conceptual framework of FaithHealth detailed in Chapter 1, I address the empiric data available for the Memphis model since 2007 and the accumulated start-up data from FaithHealthNC, as of September 2013. To reiterate, the purpose of this thesis is to determine whether the quest for achieving some

degree of justice in the traditional delivery of health care in America can be augmented by the current FaithHealth model. Beyond these considerations this thesis intends to provide the reader with a general assessment of the program's success thus far. It is a foregone conclusion that the status of health/health care within American borders continues to deteriorate, fueled by unemployment, lack of affordable health insurance, and a progressively aging, albeit long-lived population. FaithHealth initiatives, like those implemented by Gary Gunderson, might provide some insights for the survival of the national healthcare system; however, the clock is ticking.

Summation of chapter contents follows. Chapter 1 outlines the philosophical/historical perspective of faith/religion and health associations, details the disconnect between the two as public focus shifted from clerical to secular, and presents Dr. Gunderson's FaithHealth initiative as a method for realignment. Chapter 2 defines the concept of CHNs and the importance of covenant relationships, a part of all FaithHealth initiatives. Representative outcomes in Memphis from 2007-2013 are presented in this chapter as well. Chapter 3 presents the concept of Dr. Gunderson's "leading causes of life" as a foundational imperative for the FaithHealth model. It details the process of "mapping" RHAs, specifically as was accomplished for FaithHealthNC, and presents outcomes data for the NC initiative's first eight months. Chapter 4 presents a review of theories of justice and focuses upon the fulfillment of the justice principle, relative to the provision and maintenance of health care/public health. Chapter 5 considers which traditional justice-based theories, enumerated in Chapter 4, are most congruent with the FaithHealth paradigm. Here I consider clinical economic prerequisites and realized gains for

FaithHealth thus far. I also consider Gunderson and Cochrane's critique of public health's dependence on the umbrella of polity and economy under which health care operates. A final appraisal is presented as to whether FaithHealth provides a "quick fix" or "sustainable cure" to healthcare justice in America. FaithHealth's primary outcome succeeds in providing traditional, allopathic medical care to the most vulnerable and underserved. Its secondary outcome enables a potential reconnect between faith and the public's health by means of CHNs. This reconnect can then extend community health beyond circumstantial wellness to the ultimate state of well-being, an implicit goal of the human condition.

CHAPTER 1

> "At the dawn of the twentieth century the Western world amalgamated the ideas of civic duty and public health. Conquering disease was viewed as a collective enterprise for the common good!"[1]
>
> Garrett

> "But science does not apply itself; groups of people have to decide to do so and how are those many faceted decisions made? How can we seek the health of the public when there is no public to be healthy?"[2]
>
> Gunderson & Cochrane

Religion/faith and health are congruent in that they are found interlaced between each other both within individuals and within community life worlds the world over. This congruency emerges from the fact that religion and health are social realities, woven from a common thread, originating at the level of the individual, winding itself to global polity and then back again to the individual. Faith and the public's health not only represent individual disciplines or fields of practice but also extend to the well-being of people and populations. In order to assess the success of the current FaithHealth initiatives (Memphis and NC) at achieving a measure of justice in the provision of health care, I examine the societal stimulus for faith-health to be aligned.

PHILOSOPHICAL AND HISTORICAL BACKGROUND

The connection between religion and the public's health can be found in all the major religions, extant world-wide. Using Christianity as an example, one may trace

faith/health's historical roots and spread of Christianity during the first three centuries CE. Christ's ministry, as chronicled in the New Testament, emphasized that His acts of healing were equally as important to His proclamation of the coming of God's Kingdom and His relationship to man. We recall His commission to His disciples: to tell of the approach of the Kingdom of Heaven and to heal the sick (Luke 9, vv. 10-11 NKJV).[3] However, the birth of the reformed Christian tradition of the sixteenth century marked the beginning of a schism between religion and health, fueled by technological, industrial advancement and a growing societal skepticism of established religion, i.e., the Catholic Church. This impending separation, however, would not be complete for yet another four hundred and fifty years, or well into the twentieth century.

Even as late as the early twentieth century, Christian churches viewed hospitals and healing practitioners as a natural extension of their healing ministry. In its formative years, public health viewed its role as a societal understanding of health; human suffering was linked to specific determinants of health. Gilson observed that "if social, political, and economic life was integral to understanding population health, then conversely, population health also exposed the nature of such systems!"[4] The connective bands between religion and health were becoming strained; the notion of common or just good came to inspire and to propel the wheels of public health. The dawning of the Industrial Revolution of the late nineteenth century provided the "final death knell" of the religion/health connection, as the focus shifted to the autonomous individual whose choices were fueled by self-interest. This schism between religion and the public's health is replaced by the notion of societal health emanating from a common, just good. Garrett

writes: “At the dawn of the twentieth century the Western world fused the ideas of civic duty and public health. Conquering disease was viewed as a collective enterprise for the common good.”[5] The current crises in global public health, Ebola virus outbreak, an extant, preventable communicable disease in Sub-Saharan Africa, even resurgence of childhood disease in the U.S. by non-vaccine compliant parents, exemplifies “how specific growth-oriented policies have not only failed to improve living standards and health outcomes among the poor, but also have inflicted additional suffering on disenfranchised and vulnerable populations.”[6]

Positive joint outcomes could still be found to dot the historical landscape as late as the 1800’s. A physician, Dr. John Snow, traced a pattern of cholera deaths in nineteenth century London. He identified a single contaminated water source which led to a successful intervention, eradicating the endemic outbreak and reversing current scientific wisdom regarding the spread of communicable disease. This monumental success was aided by a local parish curate, the Reverend Henry Whitehead. Owing to his intimate knowledge of his parishioners’ lifestyles and daily habits, as well as their undisputed trust in him, Whitehead could understand their patterns of water acquisition and provide insights (under Snow’s guidance) as to how cholera was spread.[7] A monumental public health success resulted from the partnering of faith and health to eradicate a cholera outbreak in nineteenth century England. In his foreword to Gunderson and Cochrane’s *Religion and the Health of the Public*, James Cowan, Dean of the Rollins School of Public Health at Emory, notes this as an example of an effective faith/health partnership, but points out “we have lacked a conceptual map to help public health and religious

leaders understand their common values and shared intelligence that should respectively serve their communities." He concludes: "the authors offer an overarching paradigm … new ideas forming an integrated map against which we all – religious and health leaders – may test our combined actions and ourselves."[8]

EXISTING PARADIGM

Before defining the elements of Gunderson and Cochrane's paradigm shift to reconnect faith/religion and the public's health and subsequently to determine whether FaithHealth provides just health care, we must first establish where we are in the existing faith/health paradigm. Although fueled by skepticism, distrust, and personal egocentricity, the seeming disconnect between religion and health is more ideological than reality-based. Religion and health are congruent in both the lives of individuals and the life worlds of communities worldwide. Following the Industrial Revolution and into the twentieth century, the development of modern technologically advanced societies required no clerical component. European economies offered some empirical evidence that secularization, not religion, spurred industrialization, urbanization and democratization.[9] Religion would be relegated to a personal concern having little influence in the evolving secularization of Western cultures. Communities of faith have not disappeared from the societal landscape as a result of technologic advance. However, the increasing heterogeneity of globalization and the need to stabilize diverse populations does require a separation between church and state in order to ensure equal justice and lack of discrimination.

Along similar lines of thought, if the notion of religion is relegated to a more individual status, so too might be the association between religion and health. Herein lies the interest in associating health outcomes with certain religious practices including prayer, liturgy and "laying on of hands." Harold G. Koenig, a Duke psychiatrist, has spent a career researching the association between religious practice and positive health outcomes, e.g., speed of recovery, healthier immune systems and decreased mortality.[10] His research and that of others is detailed in Chapter 2. Finally, the existing model of faith and health must consider instances in which harm has resulted in the pursuit of health, both individual and public, under the guise of religion. Rejection of proven therapies to combat HIV infection, the opposition of Jehovah's Witness congregants to the infusion of human blood products in life-saving situations and the admonition of Pentecostal clergy that faith alone can heal, all contribute to the breakdown of sustainable physician-patient partnerships and to the dissolution of trust. For the sake of the public's health, enlightened religious thinkers, irrespective of their traditions, must advance to a higher level that allows evidence-based science to continue on its quest for better cures, decreased morbidity and mortality, and heightened life expectancy.

PARADIGM SHIFT: FAITH/HEALTH: THE NEED TO RECONNECT

Having enumerated some antecedents to the faith/health disconnect, it is appropriate to present a paradigm of faith/health coalescence, aptly presented by Drs. Gary Gunderson and James Cochrane in their recent book, *Religion and the Health of the Public*. The interface between religion and health extends beyond the individual to societal, community issues – the social determinants of health. The aforementioned Snow-

Whitehead collaboration in nineteenth century London exemplifies a faith/health initiative achieving sustainable health for the public. The concept of RHAs is essential as a means of identifying "a kind of endogenous resource that may be leveraged for dealing with health cures as a part of public health policy and practice."[11] Rather than enumerating that which is lacking in a community's healthcare resources, it is necessary to identify existing resources to facilitate better health, both tangible and intangible. Tangible assets include hospitals, clinics, health care providers, pharmacies, non-profit funding agencies, community care groups, chaplain services, traditional and non-traditional healers, and hospice. Intangible assets, derived from the common good, include prayer, rituals, health-seeking behavior, self-motivation, regular church attendance, caregiver and patient relationships, commitment, voluntarism, faith and love.

Once a community's RHAs have been identified, they become part of the infrastructure for a CHN. It has long been recognized that church congregations form a social infrastructure for their congregants. Not surprisingly, the social infrastructure of congregations has been shown by Gunderson to provide social interventions to support health and healing.[12] The concept of CHNs has become the focus of Gunderson's public health perspective as it evolved with his Interfaith Health Program at Emory University and continued with his initiative with James Cochrane in forming the African Religious Health Asset Program (ARHAP) in order to leverage existing assets of tribal groups to combat the scourge of HIV/AIDS. For Gunderson, enumeration of RHAs and the formation of CHN creates a national intersection between faith and health. Beyond mere individual health, this intersection extends to include communities and arenas in which

people congregate and the social narrative that emerges. The South African Sesotho term *bophelo*, or well-being, denotes ecology of human relations epitomizing human connectivity to the highest degree. Not surprisingly, *bophelo* has a connotation that embodies the full ecology of faith/health in Lesotho mountain villages. This is of a special significance as it refers to AIDS epidemic in South Africa where the affected individual is inseparable from family, community, nation, land or creation.[13]

In summary, Gunderson's paradigm for a workable faith/health initiative connects a large health care entity providing the bulk of health care over a geographic area, with a CHN comprised of independent church congregations. A covenant agreement is established between the health care provider and individual congregations. Parishioners are afforded the option of becoming plan participants at no cost, and the congregation enlists volunteer members to assist their fellow congregants when a need for medical care surfaces, e.g., navigating through the tribulations of admission; inpatient care; education about needed lifestyle changes; and access to and administration of medications at discharge. The healthcare organization assumes all financial responsibility for plan administration. The congregational volunteers continue to monitor their participants subsequent to discharge to insure that follow-up appointments are kept, medications filled and refilled as necessary, and continue to monitor healthy lifestyles changes with regard to disease prevention. The covenant affiliated congregations have now reconnected with a large health care provider in an environment of trust and transparency to provide a continuum of care, especially for those with chronic disease morbidities who require the lion's share of healthcare expenditure. The health care entity recoups its investment through a

reduction in emergency room visits, generally uninsured and not monetarily recoupable. Dr. Gunderson has succinctly stated the bedrock of the Faith/Health Initiative: “To ensure that people facing illness come to the right door, at the right time, ready to be treated and not alone.”[14]

In the next two chapters, I expand upon the FaithHealth paradigm, as briefly introduced in this chapter, as it became a functioning healthcare initiative, first in Memphis, Tennessee and then in Lexington, North Carolina.

CHAPTER 2

FAITHHEALTH MEMPHIS

CONGREGATIONAL HEALTH NETWORK

The CHN concept traces its design roots to Gary Gunderson's think tank, Interfaith Health Program, at Emory University's Carter Center beginning in 1991. It was expanded by his collaborative work with James Cochrane in South Africa in the establishment of the ARHAP. This program, founded to address the HIV/AIDS epidemic in Africa, sought to identify and to leverage existing health assets. Gunderson and Cochrane, through previous decades of work in public health, realized that "religion in its deepest foundation and public health in its genesis are not just about specific intellectual disciplines or fields of practice, but, ultimately, about the health of the whole and health for all, the well-being of people and populations."[1] The CHN represents a junction between faith and health, not just the current condition of any one person, but a larger journey, "a journey of communities and of its bodies in which people congregate, as well as the social narrative that describes them in time and place."[2]

When Gunderson moved from Atlanta to Memphis in 2005 to affiliate with MLH, he recognized Memphis' existing needs with its range of health disparities and generally poor health status, e.g., substandard infant and maternal health, chronic disease processes, community violence, high stress levels and ongoing end of life issues. The concept of CHN, based upon RHAs, the covenanted relationships between a large health care organization (MLH) primarily providing indigent care for the corridors of poverty and violence, and congregational communities where patient-centered care originated,

became applicable. Thus was formed a connective network of patient centered care, moving from congregation into the hospital, then back to the congregational community for ongoing maintenance.[3] The CHN provides the connecting link between the hospital (disease-based entity) and the covenanted congregations (health care entities) to create permanent caring pathways to support its members.

The basic premise of CHN rests upon a church congregation's social organization. Gunderson recognized as far back as 1997 that organized congregations inherently provided social elements and elements of connectivity that supported the healing process and thereafter, maintenance of health.[4] Harold Koenig, referenced in Chapter 1, has spent his academic career at Duke University investigating the impact of religion/spirituality (R/S) upon both mental and physical health outcomes. A concise, yet comprehensive, review was published in 2012 which included only data-based quantitative research published in peer-reviewed journals.[5] I posit three statistically significant associations which have a linear relationship. A review of 16 studies examining the association between R/S and clinical outcomes following recovery from cardiac surgery (open heart, bypass) showed positive outcomes in 69% by meta-analysis. Included in this analysis was a quantitative assay of inflammatory markers, e.g., C-reactive protein and fibrinogen, predictive of individuals at high risk for coronary artery disease, which also showed a positive correlation (reduced event risk associated with higher R/S index).[6] Looking at immune function, whose parameters reflect disease prevention and health maintenance, 14 studies of highest statistical quality reported a 71% significantly positive association rate of immune function, in response to a R/S intervention.[7] As a primary end point,

reduction in mortality data is perhaps the most "telling" statistic. Considering 63 methodologically rigorous cohort studies, 75% found R/S affiliation as a positive predictor of longevity.[8] Frequency of church attendance correlated with serial increase in survival up to 37%, which is on a par achieved by cholesterol-lowering "statin" drugs and cardiac rehabilitation following myocardial infarct.[9] Studies by Idler as recently as 2008 substantiate Gunderson's premise by showing that mortality is reduced by being a member of a church congregation alone, when all other demographic factors are controlled and there is no ongoing connection with a healthcare system.[10]

The role of a large healthcare institution, working in concert with covenanted congregations and their volunteers, provides a method of change so that access to care is no longer dependent upon costly, inefficient, "turn-stile" care found in frequent, fragmented trips to emergency rooms. By combining the strengths of both entities, healthcare institutions and congregations, the CHN members believe that better individual health outcomes will be achieved and maintained while vital community wide social networks will be formed. The CHN takes advantage of established community/congregational resources by identifying and mapping out RHAs, which are considered in detail in the following chapter, FaithHealthNC. Throughout the entire process, from planning, to structural formation of congregational networks, to servicing and follow-up of health interventions, the CHN strives to maintain an open, transparent relationship with congregational pastors and leaders.

The ultimate reward of such a transparent, shared association is the resultant trust that emerges and empowers the affiliation. As previously noted in the Introduction and Chapter 1 of this thesis, the evolving disconnect between health and religion through the ages has been characterized by the dissolution of trust between the two that once epitomized the nascent rise of Christianity. Gunderson's primary motive for establishing his FaithHealth initiative has been not only to improve health care to the impoverished, but to recreate a new paradigm that works by reconnecting a community of faith and the public health that then becomes self-sustaining.

Elements of distrust are prevalent today in impoverished inner cities and industry-deprived smaller communities, where traditionally large healthcare systems have fostered distrust and sometimes fear in the communities they serve geographically. Gunderson recognized from the beginning of the Memphis initiative that total transparency in communication and respect for community leadership would be essential in order to maintain a progressive relationship between the CHN and its linked healthcare organization. Because of his African experience, he knew that ARHAP's principles of focusing on assets, honoring and respecting indigenous leadership abilities, and promoting partnership rather than colonial, governmental strategies alone were essential to the design and growth of CHN.[11] This concept is at odds with most senior level hospital leaders' notion of "taking over the leadership reins" and not recognizing community assets for their inherent value. It becomes easy to see why such medical center "top-down" programs are destined to be unsuccessful, can further widen the disconnect between religion and health, and, by one author's observation, prompt

participants to become "clients," which "guts the essence of what makes grassroots care most viable."[12] McKnight, in summary, states: "The invisible message of the interaction between professional and client is, you will be better because I know better. Through the propagation of belief in authoritative expertise, professionals cut through the fabric of community and sow clienthood where citizenship once grew."[13]

The functioning structure of the CHN connects *congregational navigators*, employed by MLH, to partner with volunteer health liaisons from within the congregations who will orchestrate the "healthcare journey" of its enrolled congregants. Community-based care giving is integrated with traditional, encounter-based clinical care, with most patient education occurring outside the hospital setting. Immediate post-hospitalization issues center on access to medications, good nutrition, healthy recuperative environment, transportation to follow-up appointments and a suitable physical activity regimen. Maintenance of well-being and preventive health issues focus upon healthy life-style habits, including maintenance of ideal body weight, nutrition and regular daily exercise, as well as community-based strategies for illness prevention. Such strategies include smoking cessation seminars, weight loss seminars for the obese, diabetic teaching seminars for nutritional guidelines, and hospital sponsored screening kiosks for detection of undiagnosed hypertension and type II diabetes at community events and festivals.

The guiding premise for the CHN system, as a community-based intervention, is that it can show positive empiric outcomes both in terms of more cost effective solutions for acute illness and more cost accountable methods of preventive health maintenance when

outcomes are matched in observational studies against outcomes for non-CHN members. I briefly address those known outcomes at the close of this chapter. A community domain focuses on a specific geographic region, established by church congregations, to provide a better paradigm for health care, not dependent upon a large healthcare organization as the dominant partner and recognizing non-healthcare volunteers as equal partners. Finally, a concept of *blended* intelligences is introduced. Local pastoral strengths and educative growth are enhanced by MLH staff, ARHAP, and partners in centers of excellence in faith and health based upon current global best practices.[14] This integrated model thus incorporates existing social networks and ministries in the community in order to yield individual outcomes, large scale network-building, community care giving, and future research that will have an impact on the health status and health outcomes of the broader community.[15]

COVENANT RELATIONSHIP

In ecclesiastical terms, "a covenant entails a solemn agreement between the members of a church to act together in harmony with the precepts of the gospel; the conditional promises made to man by God, as revealed in Scripture."[16] This is the biblical definition of the word, covenant, as stated in the Random House Dictionary of the English Language. Relative to the FaithHealth initiatives, it is important to understand Gunderson's emphasis upon a covenant relationship and the commitments to be made between healthcare organizations (MLH and WFBH-LMC) and local congregations joining the CHNs. The covenant relationship represents a special, individual agreement between an enrolling congregation, its leaders and pastor, and the funding healthcare

organization. It is meant to be representative of the covenant between God and the children of Israel as His chosen people. This document is more than a contract because it details specific commitments agreed upon by all signatories and is the product of a design team, composed of community pastors, Dr. Gunderson and colleagues at Emory and in South Africa and senior leadership at MLH, as a prelude to the Memphis initiative. All individual FaithHealth initiatives, e.g., NC in Lexington, have their own term specific covenants. The individual covenants allow pastors to recruit their members with the premise that CHNs are composed of neighbors serving in their own neighborhoods as defined by the bounds of the congregation.

Components of the covenant generally include pastoral input in designing care pathways, which follow enrolled congregants from the community into the hospital system for care when needed and then back into their communities, both for continued short term care and to provide oversight for preventive health care. These pastoral design teams have identified five care elements: prevention, education, treatment (outpatient), intervention (inpatient) and aftercare.[17] Pastors, as congregational leaders, agree to follow personal lifestyle examples of healthy living and to partner faith and health in their personal lives. They supplement their pulpit messages with admonitions toward healthy living and continually evaluate the success of CHN strategies in their own congregations. Ultimately, the pastoral design team looks beyond their individual congregations in order to keep the community's FaithHealth initiative on track as to measurable outcomes from other covenanted congregations.

Fiscal gain by the funding hospital results from a reduction in overall length of stay (LOS) for CHN patients, reduced costs accrued specifically by CHN enrollees since they may be triaged to specific levels of care, reduced numbers of Emergency Department (ED) encounters for non-emergent conditions, and a marked reduction in hospital readmission rates for CHN participants. From the patient perspective, shorter hospital stay and early discharge into the care of a committed group of neighbors reduces the feeling of being alone or outright abandonment. This results in the realization of an improved quality of life and well-being, which has been shown to reduce the incidence of re-hospitalization and to improve health outcomes.[18] Less measurable, although significant, gains realized by the funding hospital facility include shorter stays for patients with protracted illnesses, as attending physicians might opt for earlier discharges, knowing that a community caregiver, CHN, is in place and dependable. Difficult placement issues for discharge planners could be assisted by CHNs working in concert with aftercare facilities. Many other bidirectional benefits of the CHN model have yet to be identified, but the potential seems limitless given the disarray of our current healthcare system.

REPRESENTATIVE OUTCOMES 2007-2013

Early outcomes data (inclusive of the first 25 months of CHN operations) tracked 493 CHN members through the MLH system beginning in October 2007. The Memphis initiative successfully identified RHAs that then could integrate community care giving (CHN) and traditional health care (MLH), founded upon trust and communicative transparency, to produce improved outcomes with cost savings to the funding institution.

Cost analyses in that 25 month period showed that CHN members, as compared to non-members, accrued a savings of approximately $8700 per admission for similar ICD-9 diagnosis codes and resulted in approximately 4 million dollars in savings for MLH over the same period.[19] When that data were released there were approximately 200 participating congregations. The number grew to 430 congregations by 2011, and through 2012, 512 congregations comprised the CHN (current outcome figures inclusive of 2012).[20] The levels of inpatient care provided by MLH is similar as shown by similar lengths of stay, adjusted for diagnosis, regardless of CHN membership; however, members have the advantage of post discharge community caregivers, the CHN liaison volunteers. This advantage is reflected by a 39% prolongation in time until readmission by CHN members.[21]

MLH showed a statistically significant reduction in cumulative charges per hospital stay for ICD-9 specific diagnoses including congestive heart failure, septicemia, stroke, and type II diabetes mellitus. Prior to establishing the initial 25 month CHN data base, MLH's total charges per patient admission were 41% greater than for CHN enrollees at the 25th month of operation.[22]

I have previously noted a significant prolongation in time interval to readmission for CHN enrollees for all causes. This followed similar patterns of all-cause mortality rates (adjusted odds ratio = 0.78, p = 0.04), i.e., gross mortality rate 2.63% non-member vs. 1.32% CHN member.[23] There was a 40% increase in time until readmission for patients with congestive heart failure but this did not reach statistical significance. CHN members

were significantly more likely to be discharged to home health care than their non-enrolled congregational peers, and they were more likely to be discharged to hospice care for end of life care than the general population.[24]

The FaithHealth Memphis initiative has become Gunderson's prototype in the U.S., showing that the HIV/AIDS-inspired ARHAP program in Sub-Saharan Africa can be configured into the CHN where communities of faith/health leverage existing health assets and become equal partners toward the provision and maintenance of a community's health.[25] By placing leadership into the hands of a dynamic minority pastor, rather than allowing the health care organization to assume the leadership role, the message to the community was that "such a network must reflect the 'face' and 'intelligence' of the area or the city to extend a 'just health system.'"[26] Keys to success include establishing, nurturing, and maintaining trust and transparency between congregations and community healthcare organizations, which previously had little incentive to share financial data with their consumers. In fact, early on, senior accounting officers at MLH had little hope that this initiative would be financially beneficial or result in positive health outcomes. Empiric outcomes data from the first 25 months of operation supplied the undeniable "numbers," and they were beyond all expectations. More importantly, hospital "navigators," working in concert with local pastors and congregational volunteers, successfully alleviated some of the insecurity and fear of the unknown that generally accompanies hospitalization.

In the next chapter, I address an entirely different, smaller community that found itself suddenly bereft of its major industry, which had supplied the lion's share of employment and healthcare benefits for the majority of the twentieth century. Could a bedrock community of faith find elements of hope in its own faith/health initiative, FaithHealth NC?

CHAPTER 3

FAITHHEALTH NC

Upon assuming the position of Senior Vice President of Faith and Health Ministries for Wake Forest Baptist Medical Center (WFBMC) in July 2012, Gary Gunderson came to Lexington, N.C., for an "exploratory meeting" with a primary care physician, the head of pastoral care at Wake Forest Baptist Health-Lexington Medical Center (WFBH-LMC), and a senior pastor from a mainline community church. Although he had yet to meet his colleagues in the Department of Social Sciences and Health Policy, the seeds of his next FaithHealth initiative, FaithHealthNC, were being sown. Gary Gunderson inspires others with an unassuming demeanor fueled only by the octane of empiric data and outcomes harvested from ARHAP and the Memphis initiative. The community, approaching a population of 19,000, had lost its industrial base, furniture manufacturing, leaving double-digit unemployment, loss of healthcare benefits, and a preexisting functional illiteracy rate of roughly thirty percent. Clearly, there had been little positive expectation over recent years for this bedrock community of faith until the announcement that North Carolina's first FaithHealth initiative would launch in Lexington. From Gunderson's initial encounter, within a ten month window of time, FaithHealthNC launched in September 2013, structured along the Faith Health Memphis paradigm with sixteen covenanted congregations on board.

A brief schema of FaithHealthNC shows its similarities to the Memphis initiative although the communities are vastly different, in both healthcare needs and identifiable existing assets. FaithHealthNC is an active partnership between congregational

communities of faith and WFBMC and WFBH-LMC with the mission to provide for indigent medical care and ultimately to improve upon the public's health. Trust and transparency cement the partnership. A signed covenant between WFBH-LMC and each enrolling church congregation links the partnership, which combines the caring strength of the congregation, the clinical acumen of the medical center, and identifiable community resources, all directed to forwarding the shared mission of healing. Local clergy and their congregants enlist unpaid, volunteer congregational care coordinators (CCCs), who act as facilitators when one of their covenanted members presents to the hospital for care, maintain a helping presence during hospitalization, and continue to provide aftercare through home visits post discharge as well as help to supply transportation needs. The churches also agree to provide programs on wellness and disease prevention.

WFBH-LMC hires the health care "navigator" who is the direct link to ensure that members' needs are met during hospitalization. The navigator is also the hospital's representative during congregational recruitment. WFBH-LMC provides equally for the medical needs of all its occupants, regardless of their FaithHealth status; however, FaithHealth signatories have the added benefit of their CCCs, both during hospitalization and subsequent post discharge recovery. WFBH-LMC provides the training for the CCCs during the start-up phase and continues to provide educational programs to covenanted congregations regarding disease-specific topics (diagnosis and treatment), preventive screening, and the maintenance of wellness. As a token of appreciation for their role in formation and maintenance of CHNs, partnering clergy in FaithHealthNC receive

discounts on Wake Forest Baptist Health bills (Lexington and Winston-Salem) for themselves and their families, free CareNet counseling services up to a pre-determined number of sessions, free Center for Congregational Health services (coaching consultation and educational events up to a predetermined number), waived tuition for a basic unit of Clinical Pastoral Education, clergy wellness events and programs, and free parking at WFBMC. Finally, of critical importance, WFBMC is responsible for funding and implementing community asset mapping to identify and to connect enrollees as well as the whole community to existing health-related resources, which will be outlined in detail, later in this chapter.

LEADING CAUSES OF LIFE

Before I consider community RHAs identified for FaithHealthNC, and the initiative's progress over its first operational eight months, I must describe an essential element of Dr. Gunderson's new paradigm, vital to the "reconnect" of religion and the public's health. This new way of thinking is outlined in his book, *Leading Causes of Life*.[1] It is particularly relevant to the conditions found in Lexington, N.C., as this community, long dependent upon a single industry for its lifeblood and well-being, found itself searching for survival in an environment now with a "dying" infrastructure, bereft of "life-giving" energy.

Death is an assured endpoint for all of us; the business of health care commits large expenditures of time and resources to merely postpone this eventuality. Would it not be more resourceful to identify those elements Dr. Gunderson describes as the "leading

causes of life" in order to construct an initiative that can reconstruct the bridge between faith (religion) and health? Gunderson writes: "I have chased death around the world … but I wasn't searching for death … I was looking for life and writing about how life prevails in the midst of death-dealing circumstances."[2] Gunderson and Cochrane, in their book *Religion and the Health of the Public*, further refine the life-sustaining concept: "Life dissipates energy to be sure, but it also adapts and transforms in unpredictable patterns that are remarkable, if not beautiful in their emergence."[3] One might logically conclude that the search for influential contributions to well-being will lead to vitality and life, not shrouded by death. Their five "leading causes of life" are briefly outlined here, as they provide the essence for the attainment of community health, regardless of where the seeds of the FaithHealth initiative are sown.

The first cause, coherence, allows us to make sense of our lives and gives order to entropy. Random, unanticipated events make us feel as if our lives are becoming unglued. Unplanned hospital admissions, characterized by fear of the unknown and heightened vulnerability, represent such an occurrence. Coherence affords us "a way of seeing and trusting connections across which life might flow via those who hold one up until one is healed."[4]

Connection is the second cause. The human spirit feeds upon the social connections formed in complex societies or communities. They exist in all arenas: the home, the workplace, community centers, church congregations, wherever we come together as an escape from our momentary places of solitude. In Chapter 1, I introduced the South

African Sesotho term, *bophelo*, directly translated as well-being. But I observed that its territorial connotation includes the full scope of faith/health in smaller village communities. It is the way in which these mountain villages speak of the health of the whole body, "a person inseparable from a family, which is inseparable from a community, which is inseparable from 'the people,' who are inseparable from the land and creation."[5] This term represents perhaps the highest level of social community since "any separation is a fissure in the life of every facet of the whole.[6]

Agency, a third cause, is a human capacity to perform. Agency is an action but it becomes a gift when aligned with a calling; agency goes beyond mere activity.[7] Agency requires leadership to transform connection and coherence into observable outcomes of a community or societal endeavor. Agency is self-sustaining, generating a viable, adaptable community with reinforced coherence and connection, ultimately sustaining an aura of hope for the future.

Blessing, a fourth cause, requires its companion causes to achieve its goal of change and renewed affirmation. Blessing demonstrates its interconnectivity since it is not self-bestowed; we must ask others to bestow their blessing upon us. "Blessing is a dual consciousness extending before and after us. This consciousness results in gratitude and responsibility that is life giving, life sustaining."[8]

Hope, a final leading cause, fuels our life quest and brings us together. As with a microscope, it allows us to view a large panorama of community aspirations and goals at

a lower magnification; then by switching to a higher power, we view our own personal domain of expectations. Having briefly touched upon the five leading causes of life, it is fitting to sum up as Dr. Gunderson aptly states: "Hope to connections, connections to agency, agency to coherence, which illuminates blessing. It looks like life is finding a way."[9] Just as all five leading causes of life had been identified in South Africa (ARHAP) and Memphis (the Memphis Model), so too in Lexington, as FaithHealthNC became a reality. Their discovery required only a change in refractive index to look beyond death and dismantling to a clearer image of life's restoration. "The leading causes of life model looks at the scale of human communities seen within the horizon of generations; it sees the wholeness and not the pieces, the passages and the journey."[10]

MAPPING RELIGIOUS HEALTH ASSETS

The concept of identification and mapping of RHAs was developed in sub-Saharan Africa by Gunderson and Cochrane as part of their initiative to combat the public health epidemic of AIDS/HIV. A detailed description of RHAs was previously enumerated in Chapter 1. Davidson County, of which Lexington is the county seat, is a geographically large county with a population of approximately 165,000, possessing historically deep communal roots and strong faith-based alliances. RHA identification was accomplished during the year 2014 by establishing two workshops, separately composed by representative "health seekers" and "health providers."[12] The "health seekers," 40 workshop participants, represented county residents who had received both needs for daily living, e.g., food, clothing, and shelter, and healthcare services from Crisis Ministry of Davidson County, Davidson County Medical Ministries, Salvation Army of Davidson

County, and other United Way-sponsored agencies. Of this group, 80% were unemployed and lived below poverty levels.

The "health provider" workshop, numbering 25, represented 21 different health and social service organizations within the county, including those mentioned above, as well as Carolina Cancer Services, Davidson County Health Department, Pastor's Pantry, and WFBH-LMC among others. In all, 80 entities were identified as established RHAs, with 24 being named by both groups. The most commonly cited entities by both groups included WFBH-LMC, Davidson County Health Department, Crisis Ministry of Davidson County and Davidson Medical Ministries. "Healthcare seekers" placed high emphasis on available medical facilities and service ministries as sources of food, shelter and episodic health care for themselves and family. Both "seekers" and "providers" noted the role played by both individual and combined church congregations, especially regarding urgent community needs. Factors identified as contributors to health included service ministries, hospitals, and relative accessibility to health care. Factors identified as negatively affecting health included lack of access to mental health services, lack of access to existing healthcare facilities, and social services bureaucracy. The "providers" noted that the county's economic downturn over the past quarter of a century has had a forceful negative impact upon the general health of the county as well as suggesting, along the lines of Powers and Faden's "well-being theory" of social justice, that the equilibrium of general well-being is as yet far from being restored in the county.

Regarding the convergence of faith and health, the "seekers" placed emphasis upon "having faith in God that you will get better," "faith in yourself to get better," confidence in your doctor, and the hospital's reputation where you are being treated. With county unemployment still hovering at double-digit thresholds, having had low single digit figures for the post-war twentieth century, "seekers" respondents identified lack of employer-subsidized health insurance as pivotal as to their inability to access care outside of the ED or to afford prescribed medications even if seen. A sense of defeatist resignation came to characterize "seeker" attitudes upon viewing this bleak landscape. The mere idea of launching FaithHealthNC in this community came as a small Godsend for all that had been lost. Not only available, cost-effective healthcare access but also life-style education to promote health maintenance inspired "health seeking" participants to see the positive outcomes that FaithHealthNC might contribute to themselves and to their families. Those in attendance as facilitators noted not only a heightened level of energy but a reduced level of momentary anxiety that these revelations inspired. Inclement weather canceled the summation meeting of "health providers," but the process of mapping RHAs in Davidson County identified substantial, existing resources and provided rays of hope from the perspective of both "health seekers" and "health providers."

EARLY OUTCOMES

Cumulative data for FaithHealthNC is now just available for the first eight months since its September 2013 inception.[13] As noted above, RHA mapping was just completed in January 2014. Eighteen individuals had 57 admissions inclusive of 2012 through the first eight months that FaithHealthNC was up and running (through April 2014). Mean patient

age was 59.8 years. Given the small community size and only eight months of active data collection, thirty-four percent (6 of 18) of those surveyed had end stage osteoarthritis of knee/hip joints, and admissions represented secondary traumatic events, inclusive of fractures, all leading up to joint replacements. This also accounted for the fact that eleven of eighteen consumers tallied charges greater than $20,000 over such a short period of time (inclusive of the admission for final joint replacement). Eight of eighteen consumers tallied four or more visits during the study period.

Following the FaithHealth start up in September 2013, there was a longer interval between admissions for those who ultimately became affiliated with a covenanted church congregation following hospital release, but participant numbers were insufficient to reach statistical significance. In addition, the success of the FaithHealthNC "navigator" of WFBH-LMC was reflected by the fact that only 22% of FaithHealthNC-eligible consumers were allied with a church congregation upon hospital admission, whereas 89% of those eligible at discharge were aligned with a participating FaithHealthNC congregation for continued functional and psychological support.

Significant financial gain has yet to be accrued by WFBH-LMC. But FaithHealthNC has provided WFBH-LMC with an identity of trust in the community, particularly among minority churches. It is not unreasonable to assume that 25 month data, as previously presented for the Memphis initiative, will be equally telling, although cumulative savings achieved should be proportional to community size and success in enrolling participating, covenanted churches.

Finally, there have been exploratory discussions that the FaithHealthNC model might be extended to incorporate small businesses to serve, in addition to church congregations, as health network providers. This would extend the model to a secular base, beyond its established clerical base. In so doing, this would reach a larger portion of the community's underserved population with no church affiliation. As a result, the FaithHealthNC initiative would further extend its reach and achieve an even greater degree of justice relative to the community's healthcare needs. It is too early to tell whether these discussions will be fruitful, but the possibility exists, nonetheless.

CHAPTER 4

REVIEW OF BIOETHICAL PRINCIPLES/THEORIES CONSISTENT WITH THE PRINCIPLE OF JUSTICE

Of all bedrock principles of bioethics, e.g., beneficence, non-maleficence, autonomy, and justice, justice is the most elusive to nail down. Distributive justice connotes a fair, equitable, suitable distribution of benefits and burdens reflecting the norms of social cooperation.[1] But the justice model entwined in the FaithHealth paradigm is more about basic societal rights to well-being founded upon a common morality, e.g., equal opportunity, right to a "decent minimum" of health care, regardless of race, gender or economic status. Comparatively, one can see the shortcomings of distributive justice relative to an all-encompassing justice theory to which FaithHealth aspires.

Traditional theories of justice provide a foundation upon which I can establish justice principles referable to health care. In this review I consider three traditional justice theories, utilitarian, libertarian and egalitarian, and two more recent, twentieth century theories, capability and well-being, which present a more clearly defined connection to maintenance of the public's health, linked directly to outcomes. It is important to remember that, in discussing the first three theories, I am addressing basic theoretical principles to which I later compare to FaithHealth model's core philosophy. This assists the reader to determine which justice theories are substantiated by FaithHealth.

Utilitarian theories of justice, grounded in the principle of utility, maximize positive value over that which is of limited or no value. All benefits from a utilitarian perspective

improve welfare, but results are difficult to quantify. If conditions of social utility (welfare) are subject to change, so too might the range of protected rights change.

Libertarian theory espouses individual rights to social and economic gain, involving fair procedures as a justice standard. Such theory dates back to the writings of John Locke, the renowned seventeenth century English empiricist. He espoused the concept of just and natural rights to liberty: comprising general duties all members of society owe to one another, and when necessary to enforce individual liberty rights by coercive power.[2] With regard to justice theory, libertarian thinking focuses not upon public entitlement or basic health needs but rather upon the evolution of fair and equitable procedures within the constraints of common law and order. Robert Nozick, twentieth century libertarian philosopher and Lockean contemporary heir apparent, posits a theory of justice affirming individual rights to monetary gain in a free market, not liable to governmental redistribution on the basis of public entitlement or utility.[3] In essence, this philosophy militates against governmental taxation of the wealthy at a rate higher than those less wealthy in order to fund indigent entitlements, e.g., unemployment and welfare compensation. Nozick, typical of classic libertarian thinking, defines justice on the basis of empirically just, fair procedures, irrespective of outcomes or equitable distribution of resources. He argues that in the absence of agreed-upon welfare entitlements one cannot use the principle of justice to justify claims for health care.[4]

H. Tristram Englehardt notes that there will always be competing views of distributive justice. “Such views are rooted in the various content-full moral philosophical

understandings of the proper use of resources or in a religion or traditional moral vision."[5] Englehardt, a Christian libertarian philosopher, has written extensively with regard to whether inequality in health should be considered unfair or unfortunate. "The natural lottery creates inequalities and places individuals at a disadvantage without creating a straightforward secular moral obligation on the part of others to aid those in need… In such cases there will be neither fairness nor unfairness, but simply good and bad fortune."[6] This leads him to conclude that "the imposition of a single-tier, all-encompassing health care system is morally unjustifiable … a basic human secular moral right to health care does not exist-not even to a 'decent minimum' of health care … such rights must be created."[7]

Libertarian theory, as described, allows for any distribution of goods or resources, inclusive of provisions of public health or healthcare per se, but only if the populace freely chooses to do so. "A just society protects rights of property and liberty, allowing all persons the freedom to improve their circumstances and protect their health on their own initiative. Healthcare is not a right, the ideal system of health insurance privatized, and charitable care institutions are nonprofit and untaxed."[8] There must exist individual freedom of consent in order to provide a just allocation of resources for health care for the beneficence of those less fortunate.[9] Libertarian theory thus appears remote from any justice theory that is congruent with FaithHealth. FaithHealth, as a religion/health partnership, is not about public choices for distribution or protection of individual property rights. For FaithHealth, access to health care is that which is just-not merely what its members agree should be done.

Egalitarian theory evokes equal access to tangible goods in life, valued by competent individuals. Englehardt interprets egalitarian theory to be based upon "a goals-based justice in pursuit of the achievement of the good for individuals in diverse communities … The goal of just healthcare allocation is realized through the particular understanding of morality and fairness, not predicated upon joint agreement of individuals to parcel out resources.[10] Egalitarian theory has closely evolved along the chronological timeline of Christianity's emergence and growth of the established church, since it espouses similar precepts: humans must be treated as equals regardless of class or wealth, because they are created as such and possess equal moral status.

John Rawls is perhaps most representative of egalitarian philosophers of the twentieth century, and his *magnum opus, A Theory of Justice* (1971), is regarded as a seminal work in moral philosophy since the end of World War II. As a starting premise, now dubbed Rawlsian, he wrote that "the most reasonable principles of justice are those everyone would accept and agree to from a fair position."[11] On justice, he writes "what justifies a conception of justice is not its being true to an order antecedent and given to us, but its congruence with our deeper understanding of ourselves and our aspirations."[12] This statement aligns him with the basic theory of Immanuel Kant. Kant believed the moral worth of one's actions depends upon the moral acceptability of the maxim, or general rule of conduct, upon which one is acting.[13]

Rawls espoused two principles which he felt would be acceptable to all reasonable persons: 1) each individual should be given a maximum amount of basic liberty, equal in measure to the liberty conferred on others, and 2) promulgation of social inequalities is

permissible if they fulfill two conditions. These two conditions have given rise to interpretation and to assimilation into health policy, as justice based, by students of Rawlsian thinking. First, the difference principle allows that inequalities of social primary goods, e.g., income, rights, and opportunities are permissible, but must be of benefit to the least well-off. Second, "the rule of fair equality of opportunity" requires that social offices and positions be available to all.[14] The second condition has been expanded to become the so-called "fair opportunity rule" by Norman Daniels and others and becomes the foundation for a justice based healthcare system, with characteristics shared by Gunderson's FaithHealth initiatives. Daniels believes that, owing to the uniqueness of healthcare needs, the concept of fair opportunity is central to the distributive justice theory as it relates to equitable access to care. Social institutions implementing healthcare distribution should be aligned to allow each person to receive a fair share of the opportunities present in that society. "Allocations of health care resources, then, should be structured to ensure justice through fair equality of opportunity."[15] Daniels further refines his concept of fair opportunity as he envisions a societal obligation to eliminate barriers preventing access to fair equality of opportunity. His thinking goes beyond international health care as he views disease/disability as "undeserved restrictions on persons' opportunities to realize basic goals."[16] "Healthcare is needed to achieve, maintain, or restore adequate or 'species-typical' levels of functioning so that individuals can realize basic goals."[17]

Daniels has essentially translated basic tenets of Rawlsian egalitarianism, which never pursued health policy implications, into a viable concept that governs allocations of healthcare resources to ensure justice, based upon Rawls' difference principle and fair

equality of opportunity. Far reaching implications now arise with regard to distributive justice and access to an acceptable level of health care, regardless of wealth or social status. Individuals, not responsible for their disabilities, should receive benefits to ameliorate unfortunate consequences of "nature's health lottery" in order not just to receive episodic, allopathic care, but also to experience a climate of well-being. It is these *capability* and *well-being* theories of the twenty-first century, to which I now turn my attention.

CRITERIA FOR THE FULFILLMENT OF THE PRINCIPLE OF JUSTICE AS IT RELATES TO THE PROVISION OF HEALTHCARE AND MAINTENANCE OF THE PUBLIC'S HEALTH

Contemporary bioethical theorists have extended the focus of justice, in bioethical terms, to abilities and opportunities requisite to achieving a state of well-being as well as to those elements that define well-being, not just cure of disease. Many of these interpretations of justice, relative to the acquisition of health, may be seen as logical extensions of Rawlsian egalitarianism, although Rawls' justice-based theories do not espouse outcomes. Capability theories may be shown to have originated in part from Aristotle's theory of moral excellence, suggesting that moral character and moral achievement result from functions of self-cultivation and aspiration.[18] Amartya Sen and Martha Nussbaum introduced a concept that the quality of persons' lives is contingent upon what they are able to achieve and a life well lived represented by the maintenance of a group of *core capabilities*.

They are:

1) being able to live a normal life, without premature death or loss of capacitance;
2) maintaining good bodily health;

3) to move about without physical threat, to have free sexual/reproductive choice;
4) to be able to use one's senses, imagination and thought;
5) to be able to make emotional attachments without fear of reprisal;
6) to be able to use practical reason to assess that which is morally good;
7) to be able to live in the company of one's peers with humility and self-respect;
8) to have an awareness and respect for nature's other inhabitants, plant and animal;
9) to be able to enjoy oneself in recreational endeavors;
10) to have control over the environment in which we live.[19]

Sen and Nussbaum further develop this core capability theory to the degree that each element is a minimal essential for human life. Nussbaum posits that "all ten of these plural and diverse ends are minimum requirements of justice and that society sometimes must equip persons with capabilities, including provision of the resources necessary for living appropriately such as food, education, nondiscriminatory initiatives and health care … putting persons in circumstances or conditions in which they are enabled to set their own goals and live as they choose."[20] Clearly, this is a far reaching theory of justice, "extending justice to all world citizens … by providing the necessary conditions for a decently just society."[21] The Sen-Nussbaum *core capabilities* theory will be readdressed in our later consideration of justice, as evidenced in Gunderson's FaithHealth initiative.

As a final recent expansion of justice theory I focus on the achievement of well-being as a deserved societal end point. In capability theory and its expansion of traditional theories of justice, Sen and Nussbaum focused upon the means toward achieving well-being.

Madison Powers and Ruth Faden have taken the criterion a step further. In their seminal work, *Social Justice*, Powers and Faden "contend that it is impossible to make a progress in our understanding of the demands of justice *within* medical care without looking *outside* of medical care to public health and to the other determinants of inequalities in health and indeed without situating an analysis of justice and health policy in the wider social and political context."[22] They identify six core dimensions of well-being, "an account of those things characteristically present within a decent life, whatever a person's particular life plans and personal commitments: health, personal security, reasoning, respect, attachment and self-determination."[23]

In contrast to Sen and Nussbaum, Powers and Faden focus not upon the means of achieving social justice (inclusive of health/health care) but of its final attainment. They view the international crisis of global injustice as one of inequality, "inequalities that contribute to systemic patterns of disadvantage are the ones that matter most. These inequalities, as well as those that represent a lack of sufficiency in one or more dimensions of well-being, that are the primary object for our remedial account of justice."[24] With regard to their dimensions of well-being, health, its acquisition and maintenance, depends equally upon the maintenance of its five supporting dimensions lest there be a domino effect in which the underpinnings of the state of well-being are lost. In a poignant summation regarding the justice-based right to health, they write, "the human right to health generates a duty to ensure that the social conditions necessary to achieve a sufficient level of health are in place. Any society that fails to ensure for its members the conditions necessary to achieve a sufficient level of health is an unjust

society that in our view has violated a basic human right."[25] They view world poverty as the major determinant in defining health deficits, and social justice can only succeed by eliminating poverty's role in the initiation and perpetuation of poor health.[26] World poverty represents the existential blockade to the "core dimensions of well-being" of which health is a single component. Implicitly rooted in Rawlsian egalitarian tradition, Powers and Faden have clearly expanded their definition of social justice to the global stage and require solutions far greater than global public health institutions can provide.[27]

A CLINICAL APPRAISAL

Before I consider the impact of existential forces that affect the FaithHealth model, as a clinician, I present a clinician's view of healthcare justice. Lawrence McCullough and Frank Chervenak have written extensively regarding ethics in the practice of obstetrics and gynecology and are frequently cited by ACOG when ethical dilemmas in clinical practice arise. In the chapter, "Preventing Conflict and Crisis in Clinical Practice" from *Ethics in Obstetrics and Gynecology*,[28] they provide insight into the ambiguity of distributive justice in a clinical setting. As a premise, they recognize that the quandary regarding management and distribution of healthcare resources must be reconciled by the ethical principle of justice: "we give each individual that individual's 'due' … understood in terms of fairness."[29] Unfortunately, there is no defined philosophical theory of justice acceptable to all rational people; however, fortunately, clinical decision-making does not require it. They introduce the concept of substantive and procedural principles of justice. Substantive principles of justice concern the *outcome* of the process of allocating health care resources, who will get what. For example, should antenatal care and/or universal access to assisted reproductive technologies be available to all women? "Procedural

principles of justice concern the *process* of decision making about the allocation of resources."[30] Such issues would include the federal and state decision-making processes that result in limits on Medicaid funding for the non-paying patient as well as the vagaries of Medicaid coverage per individual state mandates.

They continue their observation by suggesting two ways of addressing allocation of a fixed healthcare budget appropriation. Horizontal distribution of resources addresses universal access to some basic minimum of medical services, and different notions of substantive justice can lead to a variety of cost allocations for what might be considered "just health care." A second consideration regarding resource allocation is defined as vertical distribution of resources, the dollar amount that may be allocated to a specific patient, given the diagnosis, treatment plan and prognosis.[31] Regardless of limited resources, the states' specific medical practice acts hold the attending physician responsible to a standard of medical care commensurate with his peers and in keeping with the patient's stated expectations inasmuch as they are consistent with a successful outcome. "Limited resources are thus never an excusing condition for clinical judgment that does not take into account the social-role, subjective, and deliberative interests of a patient.[32] As such the physician retains a fiduciary role for the patient in dealings with all other parties, e.g., families, hospitals, custodial care facilities and third-party payers. The physician's clinical mandate is unassailable and is not governed by any concept of distributive justice. This rationale is a fitting link between the FaithHealth model and traditional, allopathic medicine. For McCullough and Chervenak, the physician assumes

responsibility for providing the care the patient requires. FaithHealth's role is to assure access to allopathic gateways regardless of race, gender or economic status.

In the concluding chapter I compare the theoretical concepts of justice, as presented, to determine those most closely aligned with the FaithHealth philosophy. By making such an analogy, one might entertain the idea that the FaithHealth model could be expanded beyond its community roots to provide justice-based health care on a national level. But does FaithHealth really progress toward achieving its goal of healthcare justice or is it a mere allopathic "band aid" which falls off before the "wound" is healed? And with respect to the patient, should he/she be considered to be a citizen or a consumer by systems impacting the provision of health care, e.g., government, existing economy, large healthcare organizations?

CHAPTER 5

> First premise: Suffering and death from lack of food, shelter, and medical care are bad.
>
> Second premise: If it is in our power to prevent something from happening, without sacrificing anything nearly as important, it is wrong not to do so.
>
> Third premise: By donating to aid agencies, you can prevent suffering and death from lack of food, shelter, and medical care, without sacrificing anything nearly as important.[1]
>
> Peter Singer

BEYOND ALLOCATION THEORY

Peter Singer's theory of utilitarian beneficence, as detailed in his recent book, *The Life You Can Save*, argues that the challenges before us are ethically obligatory: to give aid to those trapped in extreme poverty and to contribute our time and resources, individually, to that end.[2] Although many ethicists would consider this an ethical principle of beneficence, and rightfully so, I believe that Singer has identified a far reaching principle of justice, perhaps not of his own conscious intent. Herein lies the connection to Gary Gunderson's FaithHealth initiatives. Thus far, Gunderson has demonstrated that these initiatives can provide an organized structure which establishes the link between the caring strengths of faith-based community congregations and those who are suffering, usually made most vulnerable by circumstances of poverty. The financial collapse which fueled the Great Depression and the more recent downturns of 1986 and 2008 demonstrate that none of us are immune to temporary economic downturns, but recovery for most middle class Americans is likely. However, for some individuals and families,

nature's lottery, i.e., underserved economic shortfall, perpetuates economic unfairness. Distributive justice, as a concept, cannot support the rationale for providing a "decent minimum" of health care for all classes. It has become common knowledge that many recent personal bankruptcies have resulted from catastrophic illness.

Equal and fair distribution, even that of healthcare access, is assumed, *prima facie,* to be derived from the common good of a moral community. Libertarian theory allows that persons are entitled to equal liberties/freedoms as constitutional guarantees, as well as to the access to the tangible goods valued by all in their pursuit of happiness. But the extension of justice theory as it relates to health care must account for more than constitutional guarantees or purchasable assets. Health presupposes the attainment of a state of well-being; cure of disease is a mere "piece of the puzzle." Sen and Nussbaum, by means of their "capabilities theory," and Powers and Faden, via their "core dimensions of well-being," have provided us with a composite picture, bodily health being a part of the whole. The strength of the FaithHealth model, in its unique provision of health care, places an emphasis upon insuring that all have access, as a matter of justice, to the comprehensive journey: ready access to care, diagnosis and treatment within the healthcare system, support for continued recovery, and continued maintenance of well-being upon discharge.

TRADITIONAL THEORIES – ALIGNMENT WITH FAITHHEALTH

Now, I revisit the traditional theories of justice, calling upon material principles, as outlined in Chapter 4, and comparisons to the FaithHealth initiatives. Utilitarian theories,

follow the premise that rules of justice emanate from utility, which seeks to produce the maximal balance of positive value in order to improve welfare.[3] However, should conditions of social utility change, so too might change the availability of goods and services. It is apparent that utilitarian principles present potential moral problems as to the justification of rights, in particular, rights to health care. "Just as conditions of social utility can change, so the range of protected rights can change."[4] Although utility currently supports providing governmentally mandated health care to the poor and elderly, it might not be able to justify provision of a "decent minimum." The FaithHealth paradigm is not predicated upon agreed-upon mandates like welfare status or entitlement, and as such, has little correlation to the utilitarian model.

Libertarian thought espouses natural rights to social and economic gain, based upon Lockean principles of just and equal rights to liberty which incorporate concepts of morality and justice. This is not about entitlement but about the evolution of fair and equitable procedures through the just actions of individuals.[5] As noted previously, libertarian thought recognizes justice as having been achieved when all persons are allowed the freedom of improving their circumstance and achieving health on their own without governmental redistribution of resources that have been obtained through free market enterprise. Libertarian ideology does accommodate voluntary, charitable giving as long as one's rights to just procedures are neither forfeited nor federally limited. However, libertarian justice does not support a universal claim to health care since there exists no right to welfare. FaithHealth, although voluntary and not entitlement-based, views availability and procurement of basic health needs and wellness maintenance, as

the right all human beings, regardless of social class or wealth. Libertarian philosophy might circumstantially support the FaithHealth model but only with public consent. For FaithHealth, it would be difficult to reconcile the libertarian's emphasis upon just procedures, rather than just outcomes, i.e., right to health care.

Egalitarian principles, as presented, move into the arena upon which the mission of FaithHealth was conceptualized. Basic egalitarian theory promotes equal access to goods which have value to the public. As noted previously, this concept traces its lineage to the Aristotelian concept that equals should be treated equally, proceeds along Christian teachings to proclaim that all men are created equal, and as such, possess equal moral status, and incorporates Kant's "maxims." The justice doctrine underscoring the FaithHealth initiatives could be well characterized by John Rawls as he writes that "what justifies a conception of justice is not its being true to an order antecedent and given to us, but its congruence with our deeper understanding of ourselves and our aspirations."[6]

Of Rawls' principles, the difference principle and the fair equality of opportunity rule lend themselves to the FaithHealth paradigm. In keeping with the difference principle, FaithHealth provides "more" to the underserved poor than to the middle and upper classes since, at the end of the day, all are benefited. As originally stated, the fair equality rule required that "social offices and positions be open to all under circumstances of fair equality of opportunity."[7] The term, rephrased "the fair opportunity rule" by Norman Daniels and others, became a foundation for a justice-based health delivery system. As noted in Chapter 4, Daniels believes "fair opportunity" is central to a justice theory

providing equitable access to care. On a broader scale, he views disease/disability as restrictive in that they interfere with one's opportunity to realize basic goals. "Health care is needed to achieve, maintain, or restore adequate or 'species-typical' levels of functioning so that individuals can realize basic goals."[8]

This statement has far reaching implications with regard to both national and international healthcare policy. It is a key concept in the FaithHealth paradigm at the "grassroots" level: a concept of linking a large healthcare provider with local congregations in order to provide a ministry of ready access for those who are already poverty-stricken and vulnerable, and suffering from illness. FaithHealth, by means of organization centered upon CHNs and identification of RHAs, provides the means whereby local congregations can make the most of their natural and caring inclinations to serve the underserved. Daniels' focus upon "realization of basic goals" transitions us to twenty-first century justice models: Sen and Nussbaum's "core capabilities theories" and Powers and Faden's "core dimensions of well-being." Perhaps more than any other principle or theory of justice, these two concepts epitomize the heart and soul of Dr. Gunderson's FaithHealth paradigm.

Sen and Nussbaum's "core capabilities theory" focuses upon basic requirements requisite to *achieving* the state of well-being with health as an essential component. Powers and Faden advance the notion of social justice to the level of fulfillment of all of their "core dimensions," not merely the possibility/capability of such. This is in keeping with

Singer's mandate for the abolition of world poverty and Daniels' focus upon health care as essential to the realization of individual "basic goals."

Having revisited the theories of justice, detailed in Chapter 4, one might develop those concepts most closely aligned with the principles of the FaithHealth initiative. FaithHealth's strengths include open access to medical care, continuity of care both during and after the fact via CHNs, identification of extant RHAs in the community, focus upon life, not death, via "leading causes of life," and the establishment of a covenanted relationship between a major healthcare provider and community church congregations. As I have demonstrated, these characteristics of FaithHealth incorporate elements of justice theory, most closely aligned with Kant, Singer, Daniels' extrapolation of Rawlsian egalitarianism, Sen and Nussbaum, and Powers and Faden.

FAITHHEALTH – CLINICAL PERSPECTIVE

Before summarizing the initiatives' benefits for MLH and WFBH-LMC and looking to FaithHealth's future, I, as a clinician, will revisit McCullough and Chervenak's categorizations of justice in a clinical setting from Chapter 4. They clearly define substantive principles as to *outcome* and procedural principles as to *process* as a requisite to resource allocation.[9] They further distill their premise into what constitutes a basic minimum of medical services for all and what allocation limits should be placed on each individual medical event. Thus having defined certain elements of cost/resource accountability, at the end of the day, the physician-patient relationship is built upon trust and transparency. The patient must truly believe that the doctor is applying all of his/her acumen toward a successful outcome. "The clinician can and ought to be held to a

standard of reasonable advocacy on behalf of the patient."[10] From this clinical perspective, the FaithHealth model provides state-of-the-art care along the lines of currently accepted standards of care, without regard to cost, to all its enrollees. As a caveat for the supplemental, post hospitalization benefits and preventive maintenance provided by CHN's volunteers, one could not even begin to speculate as to a fair market value for the services provided and the donated time allocation.

In Chapter 2, I presented empiric data on MLH's realized savings as calculated for the initial 25 months of the FaithHealth Memphis initiative. This data is significant only to demonstrate that MLH's initial and continuing capitalization of the initiative harvested a return, unexpected from the outset. It also demonstrated that FaithHealth could not only produce significant cost savings but also reduce the number and frequency of ED visits and significantly reduce short term mortality rates among its enrollees. Most importantly, the initiative is moving toward its implied goal of reconnecting faith/religion and the public health in an admittedly hostile environment. Elements of trust and transparency reappeared to link a violent, culturally diverse metropolitan area with its primary source of health care and provided an unexpected public relations coup for MLH.

FaithHealthNC is at a fledgling stage in its development. It is a markedly different environment from that of Memphis, and the initiative must be structured accordingly. The data, presented in Chapter 3, represents the initial eight months since inception and is too limited to yield statistical significance. What can be determined is that the principles of Gunderson's paradigm can be applicable to specific community needs and circumstances.

The concept of CHNs and "mapping" of RHAs has universal applications. Most importantly, FaithHealthNC is demonstrating that a community, having lost its industrial and financial base, can be brought together by a faith-health reconnect whereby caring, covenanted congregations along with the community's primary source for health care, WFBH-LMC, join together to restore health access in an environment of trust and hope. This emerging, positive outcome harkens back to Gunderson's "leading causes of life." "Hope to connections, connections to agency, agency to coherence, which illuminates blessing … looks like life is finding a way."[11] The catchphrase of FaithHealth NC, as encapsulated by Dr. Gunderson, could not be more appropriate: "To ensure that people facing illness come to the right door, at the right time, ready to be treated and not alone."[12]

Gunderson and Cochrane in Chapter 8, "The Challenge of Systems," in *Religion and the Health of the Public* consider the influence that government and the economy have upon the FaithHealth model.[13] Being able to achieve equality, measuring more than pure economic equality or simple political participation, is a good predictor of social-scale health.[14] It is also important to determine whether one is a citizen or a consumer (patient) of healthcare. "To be a citizen in a healthy political economy means to be a person, in multilevel relationships with other persons, who has access to and the use of the full range of capabilities that define what it means to be human.[15] This runs counter to the impression of large healthcare organizations that they serve consumers (patients), not citizens. RHAs, a primary FaithHealth component, require an awareness of citizenry in order for people to have a say in determining which clinical interventions are best for

them, how they should occur, and what changes might shift the social determinants of their health.[16]

Gunderson and Cochrane harken to their basic Kantian roots, i.e., human beings as ends in themselves rather than as a means to an end, when they contrast, within a healthcare system, the kinds of knowledge relevant to the instrumental purposes of science and governance and those relevant to citizenship and communicative ends.[17] It is of little wonder that such competing entities would confound the highest aims of public health or blur the visions of religious faiths. In summary, "as long as analyses focus narrowly on health and fail to address the systemic maldistribution of resources that feeds poverty and impacts negatively on the health populations, the deep structural impediments to 'health for all' will remain untouched."[18] And "if such analyses are cast primarily in the language of inputs and outcomes, while ignoring the agency of those people for whom health is intended, effectively turning them into passive recipients of care, then the communicative action necessary to altering their conditions will be undercut.[19]

Before my concluding remarks, one might entertain, from the discussion thus far, that FaithHealth merely applies "a band aid" on "the wound" of injustice in American health care. Harkening back to the leadership skills of the Reverend Dr. Martin Luther King, Jr., one appreciates the importance of the role that boundary leadership plays in the "bottom up" quest for justice in a complex, turbulent society. Gunderson and Cochrane define boundary leadership as "the practice of leadership in the boundary zone, where relationships are more fluid, dynamic, and itinerant."[20] "Boundary leaders participate in

the emergence of social wholes and know that no one step of that journey is definitive."[21] "Life in every sense is contingent, passing, dependent and in service to others, and to this boundary leadership surrenders itself … it is driven by hope."[22] Herein lies the connection with FaithHealth and the initiative's ultimate goal. "The paradigm of religious health assets finds its way into transformational practice mostly where people imaginatively exert their influence in malleable social spaces, histories, and hopes. The multiple interplay of ideas we have introduced are mental tools to bring out that dense complexity into view, tools that require boundary leaders."[23]

FaithHealth embodies the concept that "living well with and for others is the practical project that justice enables and that injustice undermines."[24] The "wounds" of injustice may sustain continued healing by directing efforts, resources, money, and institutional priorities into action. "It is precisely on these grounds that we work with the ideas of assets and agency, and the notion of the leading cause of life."[25]

In conclusion, this thesis has used the paradigm, based upon Dr. Gary Gunderson's FaithHealth initiatives in South Africa, Memphis, Tennessee and Lexington, North Carolina to critically assess whether the cause for justice in American health care might be advanced from the philosophy of FaithHealth and its measurable outcomes thus far. It is noteworthy that Dr. Gunderson has been solicited by both the U.S. Department of Health and Human Services and the World Health Organization to present this model and measurable outcomes. I believe FaithHealth has achieved its primary goals: assessment and provision of healthcare needs at the community level, by means of introduction and

application of CHNs and identification of existing resources through "mapping" of RHAs, and the ultimate establishment of trust between healthcare provider and consumer. Its experience in Memphis and Lexington demonstrate that the potential of reconnecting faith/religion and the public's health exists in the twenty-first century, but it can only succeed with the highest standards for justice, to which FaithHealth aspires. I believe there is a natural, logical expansion of the "grassroots" philosophy of the FaithHealth paradigm from the community initiative to a larger venue, e.g., national and even global. If such a model were to be implemented on a national or global scale, it would require that it not forsake its "grassroots," community-driven foundations. Clearly, governmental bureaucracy could negate its currently realized successes.

As Gunderson and Cochrane aptly conclude: "The practice of public health rests on a moral vision and not just a science or technology, and one significant criterion in determining whether or not a health system is just is whether it pays attention to what all health citizens find generative or life-giving, or what they experience as a threat or diminution-a critical indicator of respect for their knowledge and their capacity to survive or thrive."[26]

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RESIDENCY	North Carolina Memorial Hospital University of North Carolina, Chapel Hill, North Carolina Department of Obstetrics and Gynecology Chief Resident July 1978 – June 1979 North Carolina Memorial Hospital University of North Carolina, Chapel Hill, North Carolina Department of Obstetrics and Gynecology Assistant Resident July 1975 – June 1978
EDUCATION	University of North Carolina, School of Medicine Chapel Hill, North Carolina M.D. August 1971 – May 1975 Davidson College, Davidson North Carolina Bachelor of Science in Pre-Med August 1966 – June 1970 Thomasville Senior High School, Thomasville, North Carolina Graduate 1966; Valedictorian
RESEARCH	University of North Carolina, School of Medicine Chapel Hill, North Carolina Department of Obstetrics and Gynecology Research Assistant June 1974 – May 1975 University of North Carolina, Chapel Hill, North Carolina Carolina Population Center Research Associate September 1970 – August 1971
EMPLOYMENT	Wake Forest Baptist Health Lexington Gynecology 106 West Medical Park Drive Lexington, North Carolina 27292 Phone (336) 243-3034 2009 - Present

James F. Black, M.D., FACOG
106 West Medical Park Drive
Lexington, North Carolina, 27292
Phone (336) 243-3034
1988 - 2009

Lexington Clinic for Women
7 Medical Park Drive
Lexington, North Carolina, 27292
Phone (336) 243-2431
1981 – 1988

MEMBERSHIPS

Fellow, National Board of Medical Examiners
1976

American Board of Obstetrics and Gynecology
Board Certified
Dates Certified: 1981 Voluntary Recertification 1997

Fellow, American College of Obstetrics and Gynecology
Dates: 1982 - present

North Carolina Medical Association
Dates: 1975 - present

Fellow, American Society for Colposcopy and Cervical Pathology
Dates: 2007 - present

North American Menopause Society
Dates: 2000 – present

UNC School of Medicine, Alumni Board Region IV
2013 - present

HONORARIES

Alpha Omega Alpha
Alpha Epsilon Delta

LICENSURE

North Carolina Issued 1976

PRIVILEGES

Lexington Memorial Hospital
Lexington, North Carolina
Full/Active Clinical Staff 1982 to Present

COMMITTEES

Division of Perinatology, Chair 1982 – 1984; 1990-1992
Department of Surgery, Chair 2008 to present

Ethics Committee, Chair 2008 to present

MILITARY

USAR Commission – 1970 1985 Maj., MC., 1980
United States Darnall Army Community Hospital
Fort Hood, Texas
Staff Physician, Department Obstetrics & Gynecology
1979 – 1981
Army Commendation Medal 1981
Honorable Discharge 1985

CIVIC ORGANIZATIONS

Youth and Family Counseling Service, Lexington North Carolina
1982 Served as a Board Member

Lexington Area American Red Cross
1985 - Served as a Board Member

Member, First Presbyterian Church, Lexington, North Carolina
1982 - present
2008 - Appointed Deacon
2011 - Appointed Elder

Lexington Kiwanis Club
1985 to present 2009 - Served as a Board Member

PUBLICATIONS

Brenner, W.E., Edelman, D>A., Black, J.F., and Goldsmith, A.: Laparoscopic Sterilization with electrocautery, spring loaded clips, and silastic bands: technical problems and early complications, Fertility and Sterility 27:256, 1976

Dingfelder, J.R., Black, J.F. Brenner, W.E., Straurovsky, L.G., and Grubar, W.: Intra-amniotic administration of 15 (S) – 15 methyl PGF2 for the induction of mid-trimester abortion, American Journal of OB/Gyn., 125:821, 1976

Black, J.F., "Ultrasonography in gynecology and obstetrics," an instructional package, Dept. OB/Gyn, University of North Carolina School of Medicine, 1979

"Endometriosis" in Infertility A Practical Guide for the Physician. Health Sciences Consortium, 1981.