CONSUMING CARE:
CATHOLIC HEALTH CARE AND THE DANGERS OF COMMODIFYING A MINISTRY

THESIS

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ABSTRACT

This paper examines the impact consumerist healthcare is having on Catholic Health Ministries, particularly in the language that is adopted and integrated by its leadership into their organizational culture. It shows that while the broader consumerist culture has shaped healthcare in the United States, such an influence is notable in Catholic healthcare, which comprises a significant portion of the healthcare sector in the United States. It shows that while Catholic hospitals and systems proclaim themselves to be ministries rooted in the theological tradition and spirituality of the Catholic Church, they utilize language and have practices that are informed by consumer culture, which runs counter to said theological tradition. Thus, by adopting consumerist language and practices, Catholic health ministries risk losing their capacity to remain genuinely Catholic. By exploring this risk, this paper will offer a caution to Catholic health ministries and proposes that formation, as a deliberate exposure of leaders and team members within Catholic healthcare to Catholic theology, is a means by which Catholic healthcare ministries can cultivate a culture, rooted in the spirituality of their founding orders, that will preserve their missional identity as the healthcare sector becomes increasingly consumeristic.

DEDICATION

To my dad, Rafael Flores, and to the memory of my grandfather, Rafael Flores. Without your sacrifices, insights, encouragement, and example, I would not be the man I am today.

Siempre Para Adelante.

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TABLE OF CONTENTS

LIST OF FIGURES

Introduction

The Affordable Care Act (ACA), passed in 2010, sought, in part, to move the healthcare sector in the U.S. towards a system that prioritized value-based incentives over the dominant model of volume-based fee-for-service compensation models. Yet, today, while value-based models of care are dominant, the volume-based fee-for-service compensation model represents a sizeable percentage of reimbursement for health systems, hospitals, and physician practices nationwide. This is seen in reports that, as of 2022, the fee-for-service compensation model still accounts for over 40% of all reimbursements for hospitals, health systems, and physician practices (Bailey). The impact of a volume-centric approach to compensation is notable in that, as Windy Watt notes, such a model prioritizes "quantity over quality" within healthcare practices and is tied to physician burnout due to reduced time with patients and increased at-home work for physicians. The continuing prevalence of fee-for-service compensation, which ties the compensation received by hospitals and physicians to the "productivity" a high volume of services achieves, points to the ongoing influence of consumerism/consumer culture, in that volume-based compensation comes from a view of healthcare that relegates it as a commodity above all else.

While the reality that healthcare in America is consumeristic does not come to a surprise to anyone observing the trends and evolution of the healthcare sector over the past century, what should be surprising is the adoption of a consumerist approach to care within Catholic health ministries (CHMs). This is because CHMs exist with a foundational claim that they are ministries of the Catholic Church, and thus should be rooted in a particular theological anthropology.[1] Due to this vision of the human person, CHMs claim to operate primarily as relational service organizations and secondarily as businesses. Yet, as this thesis will show, by adopting consumerist

[1] While I am speaking of Catholicism's theological anthropology, such an understanding of human persons is not exclusive to this faith community.

language and practices, CHMs risk reducing the continuum of care into the transaction of commodities by embracing the language, and therefore the dualistic anthropology that consumerism flows from, thus causing their mission to become more focused on the margins they produce rather than the relational services they provide. Thus, this thesis will aim to show the impact the use of consumerist administrative language can have on the culture of CHMs as self-professed ministries, and the potential remedy formation offers.

To do so, I will begin by defining "ministry" and applying that definition to CHMs, utilizing modern literature regarding Catholic healthcare. Then, I will bring attention to the risk CHMs incur as they adopt consumerist language and practices by exploring the philosophical underpinning of consumerism, its practices, and the culture it produces, utilizing the work of Carl Trueman, Carter O. Snead, Nancy Tomes, and Vincent Miller. I will follow this with a demonstration of how CHMs have adopted the consumerist approach to care, particularly in the use of consumerist language by placing into dialogue the work of the previous scholars with the work of Edmund Pellegrino, Kathleen Popko, and other contemporary scholarship, which will offer insights into consumerism's impact on CHMs. I will then propose formation as a way for CHMs to remain true to their identity, using the work of Charlie Bouchard, Celeste Mueller, and other scholars working within CHMs in the United States. This last section will demonstrate how formation plays the role of ensuring that CHMs maintain an institutional fidelity to the Catholic theological tradition, as expressed in the spirituality of their founding religious orders, which develops an organizational culture that mitigates consumerism's impact. Given that this paper focuses on the impact language has on culture, many of the insights will be focused on the language and practices of leaders within CHMs, given that they are seen as those who will "build up the community and continue the tradition" (Shea, 31) of Catholic healthcare.

Catholic Health Care As Ministry

The use of the term "ministry" to describe Catholic Healthcare is relatively novel. Informal surveys of the relevant literature and ecclesial publications trace the use of the term ministry in describing what Catholic hospitals and health systems are to the 1980s. Of note the Pastoral Letter, *Health and Health Care*, published by the United States Conference of Catholic Bishops in 1982, primarily spoke of "formal health apostolate" (USCCB, 9-11) when speaking of CHMs. Yet, as the work of Catholic health systems and hospitals did on behalf of the religious Orders that sponsored them "became a more formal expression of the ministerial life of the Church" (Bouchard, 200), the term "ministry" began to be applied to *what* the organizations were in the eyes of the Catholic Church. Many scholars trace John Paul II's use of the term "healthcare ministry" in his 1987 address to Catholic Health Leaders in America and Canada as a moment that legitimized the use of the term for the Catholic Church as a whole.

The use of this term for Catholic healthcare organizations can be confusing in that, as Charlie Bouchard, O.P. notes, prior to the late 20th century the "idea of ministry was intrinsically associated with ordination, especially to the priesthood" (197). Yet, after the Second Vatican Council the "ministerial circle widened dramatically" (Bouchard, 198), as has been seen in the emergence of "lay ecclesial ministry" as a recognized reality within the Catholic Church (United States Conference of Catholic Bishops, 11). The definition of "ministry" that is generally utilized by many scholars focused on Catholic healthcare comes from Thomas O'Meara, O.P's work *Theology of Ministry*, where he states that ministry is "the public activity of a baptized follower of Jesus Christ, flowing from the Spirit's charism and an individual personality on behalf of a Christian community to proclaim, serve and realize the Kingdom of God" (150). Such a description of what ministry is reveals that CHMs are in fact ministries inasmuch as they are institutions that are actively seeking to live out the Gospel through charitable works, in a public

way, on behalf of the Catholic Church, and ultimately for the sake of the Kingdom of God. This reveals that CHMs can only claim to be ministries if their orientation is missional, that is to say, they can only be a ministries if their practices reflect them to be incarnating the commandment to "love your neighbor as yourself" (Mark 12:30-31), particularly by providing healthcare that is aware of and addresses the totality of the person as a body-soul composite (United States Conference of Catholic Bishops, 6). This last aspect of what makes CHMs ministries is particularly important, in that this comprehensive vision of the human person is what consumerism dismisses, due to its underpinning anthropology: expressive individualism.

The Anthropology of Autonomy Reigns Supreme

To understand how CHMs have and are adopting a consumerist approach to care, and how such an adoption poses a real risk to its organizational identities as "ministries", it is important to first comprehend the anthropology that undergirds consumerism itself. As such, in this first brief section, I will provide a summary of this "self-actualized" anthropology which sits at the core of consumer culture.

Carl Trueman notes that modern culture is defined by the triumph of the self-actualized individual, which is the product of the *poiesis* way of thinking about the world. This *poiesis* view "sees the world as so much raw material out of which meaning, and purpose can be created by the individual" (Trueman, 39). This differs from a mimetic worldview, that understands the world as having a particular order and meaning, and that compels persons to discover their place within such an order. In his work Trueman argues that the shift towards *poiesis* is a modern one, which places individuals as the primary source of creating meaning, that is to say, *poiesis* thinking means that we believe that our being is not *given* but rather is *claimed*. Yet, Trueman demonstrates that while we seek to actuate a self-determined way of being, this way of being is an irony of modern culture. We seek to create our own selves but do so by conforming to what has been modeled to us. In the case of a consumer culture, autonomy is what is being modeled through common modes of consumption.[2] Ultimately, in the assessment of several scholars (Trueman, Snead, and Miller to note a few) there has been a movement away from a teleological view of the human person to an unanchored understanding of personhood. This view asserts that since our identity is not given but claimed, then we are ultimately free to express what we are,

[2] In the case of healthcare, while CHMs seeks to be different, it falls into the consumerist trap of imitating its competitors for the sake of capturing market share in the name of widening its ministerial reach.

and in fact must do so if we truly want to be respected. Trueman posits that in our current day "self-creation is a routine part of our social imaginary" (Trueman, 42), and points to works of scholars such as Rieff and Taylor to label this self-creation as "expressive individualism." Trueman demonstrates that expressive individualism is the modern secular philosophical anthropology underpinning the "psychological man" Rieff and Taylor speak of, and that directs how persons act. This means that expressive individualism is, as Snead notes, a dualistic vision of the human person that functions by "privileging the mind while subordinating the body in defining the person."

In Snead's thought, expressive individualism is the anthropology of postmodern times, in which the unanchored, "automized self" is the "fundamental unit of human reality" that is defined "by its capacity to choose a future pathway that is revealed by the investigation of its own inner depths of sentiment" (Snead). Such a vision of the person is necessarily dualistic in that it prioritizes cognitive abilities as the prime measure of what denotes one to be a human person and by doing so places the body as a secondary, manipulatable element the person (*primarily* the mind) can use to express their place in society.

Thus, this dualistic anthropology asserts that we are what we *choose* to be, and from this belief flows a culture in which societal activity is focused on facilitating modes by which persons can pursue the "commitments that facilitate the overarching goal of pursuing their own, original, unique, and freely chosen quest for meaning" (Snead).

What is interesting is that in tracing the triumph of expressive individualism in American society, Trueman makes mention of consumerism as the culture that facilitates the sort of self-creation expressive individualism actuates, and as such demonstrates that the theoretical root of consumer culture is the dualistic anthropology of expressive individualism.

The Practice of Consumption

Consumerism can be best understood as a culture that "constructs every person as the author of his or her own identity," which is "expressed aesthetically through the consumption and display of commodities" (Miller, 29). That is to say, consumerism, as a culture, cultivates the mentality that people should assert their sense of meaning and place within society via acts of "conspicuous consumption" (Veblen, 20). Such a culture is marked by shared practices, and as such this section will focus on explaining how consumerism functions as a *practice*, using the work of William Cavanaugh and Vincent Miller. This, in turn, will facilitate the exploration of how the practice of consumption reveals it as a dominant culture in our society.

For consumerism to be a culture, it must be marked by the shared experiences, rituals, and symbols of a population. That is, the culture of consumption is revealed by the shared practices that people participate in. We can think of the process many have gone through to buy a new cell phone as an example of a unifying consumerist practice, which for the sake of this example, will be a new iPhone 15. The process of purchasing a new iPhone can be broken down by the five-stage consumer buying process used broadly in marketing. This process follows the path seen in **Figure 1** created by Comegys and colleagues (338):

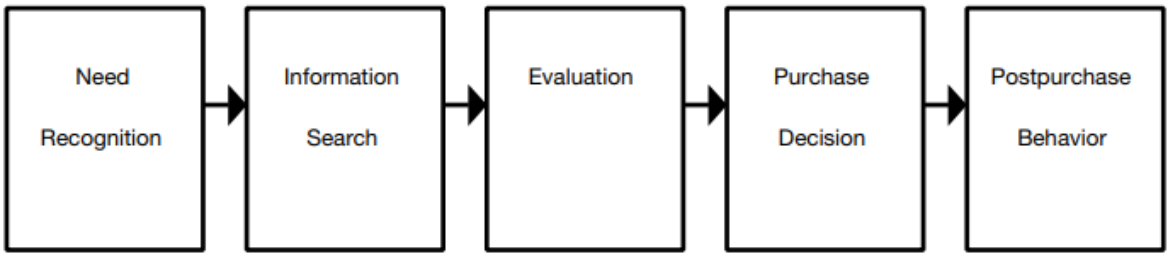

Figure 1: Five stage buying decision process model

The process of buying a new iPhone begins with what is termed as the "needs recognition step." This is when "the buyer senses a difference between their actual state and a state they desire. This need can be triggered by either an internal…or external… stimuli" (Comegys et all, 337). When it comes to buying a new iPhone we can imagine how the decision to purchase a new one may occur simply due to the old phone no longer working. However, many times the need for recognition is mediated by a form of advertising or implicit societal pressure to own the newest phone model which acts as a symbol of belonging to society. As Knight notes, upwards of 38% of phone purchasers acquired a new phone to stay up to date with the latest trend.

After the need recognition step, we have what is called the "information search" step of the process "where the consumer uses different channels to gather information about available products" (Comegys et all, 337). According to Comegys and colleagues, this is done via different sources of information with commercial sources being the most impactful. When purchasing a new cell phone, we can think of the sources we have. Media pressure and promotion of the newest model of cell phone is evident, and when our peers also purchase the new cellphone, we are likely to proceed with purchasing even if our current cell phone is not broken. This part of the consumer buying process is followed by evaluation alternatives, which entails the minimum cutoffs a person may consider for an alternative to the preferred. In the case of buying a new cell phone, if the primarily desired phone is an Apple iPhone X with Titanium casing, one may entertain purchasing the same model iPhone not with titanium casing, or even an Android if the iPhone expense is too prohibited. As Comegys and colleagues note, brand value is of incredible importance in that what it communicates to people will translate into the evaluative value a person places of the iPhone they choose to purchase. What follows is the purchase decision, as a person commits to buying the phone, and then the post-purchase behavior such as satisfaction, increase or decrease in brand loyalty due to product quality, and so on. Once the purchase of a

phone is completed, current statistics show that this process will begin again in 2.67 for approximately 44% of American consumers (Knight). What is worth exploring is what this process does for the person's sense of self. Buying the new iPhone is not just the purchasing of a product that serves a utilitarian purpose, but is also the acquiring of a status symbol, as evidenced by the polling that shows that more than ⅓ of people purchasing a new phone do so to keep up with what is new. If this is the case then, the purchasing process reveals that consumerism is a culture united by shared practices (the regular process of buying a new phone), symbols (the phone model, the brands, etc.), and rituals (lines at stores on the first day a new iPhone is released) that unite society by reinforcing the fundamental premise of expressive individualism: that we can, and should, create our own identity through what we conspicuously consume. This last portion merits thorough unpacking to show how consumption is more than the five-step process and is truly a culture that informs how people interact with each other and how they understand themselves.

The Culture of Consumption

The unifying practices of consumption reveal Consumerism to be a culture. That is to say, consumerism is, as Gerald Arbuckle states, a "pattern of shared meanings and values, embodied in a network of symbols, myths, and rituals, created by a particular group as it struggles to adjust to life's challenges and educating its members about what is considered to be the orderly way to think, feel, and behave" (4). This section will focus on unpacking the nature of the consumer culture, so that consumerist healthcare can be properly understood.

Consumerism, as a culture, functions as "a way of pursuing meaning and identity, and connecting with other people" (Cavanaugh, 243) via conspicuous consumption. In other words, consumerism is a way society unites and educates its members in normative behavior through a common vision of the person (the anthropology of expressive individualism), practices, and symbols. Such an understanding of consumerism is expanded by Vincent Miller in his work, *Consuming Religion*, which explores how consumerism is a "manifestation of the broad enactment of the modern values of autonomous self-determination and secularization" (Miller, 17). This manifestation of autonomy and secularization is found in how those who participate in consumerism attain meaning through the acquiring of material goods, which is followed with display of the goods purchased. Both actions, the acquisition and display of the goods purchased then function in tandem as a, if not *the*, way people assert their sense of self to those around them for the sake of cultivating connections with the people they seek to impress. We can think of the impulse to wear a new article of clothing repeatedly after purchasing it, how it makes us feel both unique and yet a part of the community as an example of how consumerism is experienced. Yet, what is of note is also how the use of that article of clothing tends to steadily decrease the longer we have it, to the point that some of our clothing is given away, not because it rips a seam, but rather because it no longer communicates what we want it to "say" about us. This is

because, in a consumer culture, what matters is not the thing that I am buying and consuming; what matters is what *this* object currently says about *me* now. Miller names this the "commodity logic" (Miller, 37), which is a way of thinking that causes us to approach our valuation of things, experiences, and relationships through a "calculus of maximum returns" and an "exchange of emotional commodities" which ultimately reduces persons to objects by ingraining within societal thinking a "commodity abstraction" regarding everything and everyone as primarily things to be consumed. Such logic is, in Miller's assessment, "our cultural default, the form in which we are most likely to cast our deliberations" (Miller, 37). This commodity logic is rooted in the anthropology of expressive individualism and has created a particular vision of the human person in consumer societies which merits further exploration.

Consumerism's vision of the human person, being an outcrop of expressive individualism, can be understood as having three aspects. First, consumerism is a culture that prioritizes the individual, in that it is the individual whims and desires of persons that are stoked by the use of advertising that asserts that buying X product will make a person stand out in the crowd and simultaneously belong and be welcomed by the very same group. As Miller posits, all commodities that are sold in a consumer culture are framed around offering "solutions to the inadequacies of the self" (Miller, 44). Second, because consumerism is focused on allowing persons to assert and affirm their identity through acts of consumption, consumerism views persons through a materialistic lens. By this I mean that consumerism, being focused on the attaining and consumption of goods, has a vision of the human person that is abstracted from a transcendent, metaphysical view. In consumerism the *telos* of a person is the temporal affirmation of their sense of self. This is because, as a fruit of expressive individualism, consumerism reduces persons to thinking things, which cannot exist with truly meaningful relationships given that there is no transcendent essence or goal that unites persons as a

community. This leads to the third aspect of a consumerist vision of the human person: that they are ultimately commodities. As "atomized, unencumbered, inward-directed" (Snead) selves, without a transcendent purpose of meaning, consumerism reduces persons to become "the fundamental commodity" (Miller, 44), which like all commodities are meant to be interacted with through modes of transaction.

Ultimately, what has been shown in unpacking what consumerism is, and what its vision of the human person entails, is that this culture has tremendous impacts on how people view and interact with things and each other. As Miller and Cavanaugh note, consumerism causes us to become detached from the implicit value of objects and people, and in turn replaces the valuation of everyone with a calculus of personal benefit tied to how this thing or this person (which is ultimately a thinking thing) helps me to assert my sense of self. Simply put, this "detachment" as Miller names it, or "dissociation" as Vincent does, has a broader impact on the capacity of active members of a consumer culture to cultivate authentic relationships in that consumerism produces nothing more than "an isolated monad, tragically longing for wholeness promised in its fiction of self-sufficiency" (Miller, 111) by reducing all relationships to commodities whose worth is found in the value placed by the individuals in the transaction of relationality.

Given the realities of consumer culture, there should be concern for the impact the adoption of this culture has on healthcare. As such, the next sections will seek to explore the rise of consumerist healthcare, its benefits, and the negative impacts it is having on healthcare in America.

The Rise and Impact of Consumer Healthcare

Nancy Tomes' work *The Remaking of the American Patient* gives a historical overview of healthcare consumerism in America, along with the positive and negative impacts consumerism has had on the American healthcare sector. She traces the rise of consumer healthcare back to the early 1900's, and demonstrates how the rise of "consumer medicine," as she labels it, reveals both its positive and negative impacts. To understand the historical progression of consumer healthcare, Tomes first offers a definition that reveals two forms of consumer healthcare.

Nancy Tomes defines medical consumerism (interchangeable with "consumer healthcare") as a form of medicine that transforms the experience of a person seeking to receive care for a particular ailment in America in the same way that they have approached the buying of a car or a home. That is to say, medical consumerism/consumerist healthcare is a continuum of care marked by a "supermarket touch" (Tomes, 331) that empowers the patient to shop for the sort of care that they want, even if they may not medically need it. This approach to care has tremendous implications for how the whole healthcare system operates, and yet not all of that impact is bad. As Tomes notes, this is because medical consumerism has two distinct modes, with one having a generally positive impact on healthcare delivery in America, and the other reducing it to a commodity.

Tomes defines "critical medical consumerism" (5) as an approach to care that views healthcare in the light of consumerism more broadly and posits that it can improve how healthcare is delivered. This is because critical medical consumerism seeks to actuate the core values of the patient's rights to: safety, being fully informed, having ample choices, and being given a voice in the care continuum. Adherence to these values focuses the healthcare sector on respecting the patient-consumer's right to choose the care that is preferred, convenient, and

affordable to them based on transparent and clear information being made available. This, quite frankly, is not bad in that it is a realization that the patient acts as a consumer, and as such should be afforded certain rights. Tomes points to another mode of consumer healthcare that has taken hold of America's healthcare sector, and which has had, and is having, much more detrimental effects.

"Cultural medical consumerism," as Tomes names it (10), is the embracing of the broader consumerist mentality American culture has when it comes to the care continuum. Such an embrace has developed over time and merits a discussion to be properly understood.

In Tomes' assessment, America's embrace of healthcare consumerism was a transition from paternalism to a patient-consumer oriented sector, in that consumerist medicine arose as a reaction to paternalism, which highlighted and focused on the sacredness of the patient-physician relationship, but it led to the patient experiencing care as a subservient to the physician's gaze. In Tomes assessment, the 1960s' pushback against paternalism was about the patients' rights, and as such was rooted in the desire to humanize a hyper-medicalized care experience. This was achieved by the push, both popular and legislative, for healthcare entities across the continuum to practice greater transparency and the empowerment of patients as *consumers*. She points to the development of the Patients; Bill of Rights as a noteworthy point in the adoption of consumer healthcare, when she quotes Willard Gaylin, who asserted that: "It is not for the hospital community to outline the rights it will offer, but rather for the patient consumer to delineate and then demands those rights to which he feels entitled" (Gaylin, 22).

This demonstrates a concerted shift in how healthcare was being approached. Rather than accepting the delivery of care as something determined by physicians, the 1960s and 70s saw a movement towards empowering the patient, now being termed as a "consumer," to hold the power to increasingly determine what was or what was not the appropriate mode of care for

them. This move was not one to transform healthcare into a strictly consumerist experience, as Tomes notes that the community health movement of this time sought to “advance the medical rights of poor and underserved groups” (263), and sought to do so by utilizing the term “consumer” as a means to shift the power dynamics in the physician and patient relationship, which they had termed to be authoritarian. This was seen in how the Patient Bill of Rights was originally written with language that imitated consumer rights language that President Kennedy used in his speeches regarding consumer protections. This use of language, paired with robust advocacy efforts, led to the push for policy to be adopted that enshrined the rights of the patients as consumers in tangible ways. Tomes points to the move in the 1970s to buff up consumer protection regarding healthcare as evidence of the push towards and adoption of a consumer mentality regarding healthcare.

Tomes uses the rise of medical advertising as an example of how consumerist practices have been adopted by the healthcare sector in America, particularly through federal policy. She notes that in the 1970s, “political leaders…were impressed by the need to placate a riled up generation of unhappy patient-consumers" (Tomes, 291) and this was achieved through the passage of multiple laws in the 1970s and 80s, such as the HMO act in 1973, which “signaled new political resolve to make physicians, hospitals, and insurance companies more accountable for the cost and quality of their services” (Tomes, 293). This policy move was paired with the strengthening of professional service review organizations (PSROs) to act as watchdog entities for healthcare organization’s approach to care, and the increased oversight role the FDA took during this time. This also came with an increase in oversight authority for the FTC regarding medical marketing, which in turn brought about tighter criteria for what were acceptable means of advertising new medicines, and interestingly occurred parallel to the FTC challenging the American Medical Association’s “ban on physician advertising” (Tomes, 295). In the FTC’s

view, which aligned with consumer advocates, the lack of physician advertising deprived the patient-consumers of valuable information regarding the care available to them. And, as Tomes notes, the FTC agreed with the advocates that "like buyers of any good or service, prospective patients deserved the right to know more about medical care" (Tomes, 296), which would most effectively occur via telemarketing. The FDA's and FTC's regulatory moves demonstrate attempts at empowering the patient-consumer's rights through transparency, with the former insisting robust and study-backed transparency, and the latter compelling physicians to be transparent about their services through marketing. The judicial system agreed with the logic of both regulations, and the Legislative Branch of the American Government reinforced it through the adoption of policies that affirmed the right of the patient to be informed.

According to Tomes, such policy and regulatory moves led to the death of the "passive patient" in that since health information was now a priority, the country was flooded with different means by which the patient-consumer could be informed of the different avenues of care available to them. This new patient-consumer was encouraged to prioritize their individual choice and opinions of care, and to shop for the doctor that would provide said care. Tomes notes that this was the era when "doctor-shopping, doctor-switching, reliance on other consumers' evaluations, asking for second opinions, and requesting copies of one's medical records...had been recast as the reasonable actions of mature adults." (Tomes, 303).

This must all be noted as a manifestation of critical medical consumerism, which seeks to frame the approach to healthcare as consumer-centric. While the adoption of consumerist language in healthcare was meant to illicit practices such as transparency of information to the patient, a regulation of cost, and an increase in the quality of care and resources, what came with it was the adoption of the cultural aspects of consumerism. This cultural consumerism ultimately turned the patients, the *patiens* (those who suffer), into the consumers, the *consumere* of care,

those who “use up, eat” and ultimately “waste” the resources of care. As such, after exploring the historical development of consumer healthcare it is necessary to unpack the good and bad impacts it has had, the latter of which will then reveal the risk the adoption of cultural consumerism poses to CHMs.

Modern Manifestations of Consumer Healthcare: The Good and the Bad

The good that came from consumer healthcare can be understood as flowing from the general acceptance of critical consumerism. This acceptance has led to efforts such as the Triple Aim that enshrines providing measurable quality, ease in care access, and transparency of services as universal goals across the American healthcare sector. This enshrinement has led to an increase in a greater care quality of care for Americans due to the increased standards of care healthcare organizations must abide by. The voice of the patient has also become a pivotal indicator of the quality for hospitals and clinics (think of the Joint Commission standards met by Patient and Family Advisory Councils, or the role PressGaney Surveys play in guiding health system operations) and the growing amount of policy and regulatory measures around care price transparency are evidence of the good impacts critical consumerism has had on healthcare in America. That being said, given that the adoption of critical consumerism has occurred in tandem with the adoption of cultural consumerism tendencies, the negative impacts of such an adoption - which are robust - must be examined.

To quote Tomes' assessment of the negative impacts of consumerism healthcare, the adoption of it *carte blanche* caused "medicine's traditional *ethos* to "do no harm" to be "recast in the language of consumer culture" (Tomes, 390). Such a recasting of the *why* of healthcare led to several negative impacts on care, as is seen in the move to volume-based reimbursement that has dominated healthcare in the U.S. The volume-based, or "fee-for-service", compensation model caused hospitals and physicians to pursue increased patient volumes and test order which, in the clinical setting, led to less time with each patient. In Tomes' assessment, this decrease in time had in turn caused 50% of American patients surveyed to hold that "their doctor visits were too short to allow them to fully understand the treatment being recommended" (Tomes, 402). Such an impact to the patient-physician relationship is a byproduct of the fee-for-service/volume

compensation model in that the physician incentive structures have shifted to equating value with volume. This has also caused an increase in the number of specialists a patient-consumer sees, in that the strained primary care physician, strapped for time, now refers patients out to multiple specialists who individually coordinate an aspect of the care provided, and may not see the whole picture. This reveals that consumerist healthcare, in its push to increase the "value" of care provided, has led to a reimbursement model that deprioritizes physician-patient relationships for the sake of patient volume, and thus, the patients experience less coordinated care.

Another interesting negative impact consumer healthcare has had is that related to the increase in healthcare information people have, in that as Tomes and others note, more access to health and care option information does not mean a more informed and empowered patient population. This is noted particularly by Visser and colleagues in their article "Unequal Consumers: Consumerist Healthcare Technologies and their Creation of New Inequalities," where they explain the inequities caused by the growing adoption of communication technologies that are inaccessible by some people. They examine how healthcare communication technologies, such as ParkinsonNet, in seeking be a bridge between the patient and their healthcare providers, actually place the "responsibility for care provision onto the patient" (Visser et all) by placing the onus on the patient to ask a question regarding her condition directly to a specialist, and not ask the question to their primary care physician. This, as Visser and colleagues note, "fits neatly in consumerism that centralizes individual needs and celebrates the importance of asking for specific forms of care, whole also being made responsible for this" (Visser et al) in that communications technologies, by seeking to empower the rights and capacities of patients as consumers, makes them the most responsible party for their care. At face value this may seem good, but underlying the use of this technology there is an assumption of a "universal individual" that has equal capacity to access and use the technology provided, which

is simply not the case. Their study of personal online health communities and technologies reveals an assumption in consumerism that all people with access to consumer products have equal access and capacities to utilize such technology, which is not the case. This has revealed a negative impact of consumerist healthcare: providing "consumers" with more access to health information assumes that they all possess an equal "ability and desire to express their individual needs," which does not lead to a more informed and empowered patient population. This is because while new technologies are designed to be "open access and catering to individual needs" they cause the:

> [P]roduction of new inequalities, by not allowing access to a diverse group of patients. Rather than increasing the involvement of all patients, the technology actually ends up widening the gap between diverse groups of patients, without providing the space to acknowledge and address these new inequalities. (Vissier et all)

This gives credence to Tomes' caution that consumerist healthcare has led to increased suspicion of healthcare as an industry, particularly as the processes and technologies that are meant to increase quality, transparency, and access at times impede it.

While the two previous impacts are notable, the broadest and most impactful negative impact consumerist healthcare has had on American healthcare is the commodification of the care continuum that has made healthcare into a transaction, not a relational act. Tomes uses the criticisms levied against the first walk-in clinics as evidence of such an impact, when she quotes Dr. Donald Trunkey who observed that such clinics offers "convenience for the physician, convenience for the patient," yet eliminates "the longstanding personal, human relationship a physician should have with a patient" (Tomes, 321). Such forms of care, because they treat healthcare as commodity that should be delivered efficaciously and speedily, have the outcome of causing the experience of healthcare to be equivalent to that of buying a cup of coffee: convenient, good, and cheap. Yet, the care of our bodies is not equivalent to the purchasing of a

latte, and to treat it as such cannot lead to the sorts of overarchingly better health outcomes the consumerist healthcare seeks to actuate.

What can be seen from this assessment of the negative and positive impacts both forms of consumerism have had is that the modern American healthcare landscape is influenced, if not defined by consumerism, both critical and cultural. Several summative points may illuminate this. First, based on what has been discussed so far, we can see the credence to what Visser and colleagues mean when they state: "more and more, healthcare takes a product-like form that can be traded on a market, where healthcare professionals appear as service providers following patients' wishes, and patients as (empowered) consumers who make autonomous and individualized choices." Second, while critical consumerism seems good but this good cannot be separated from the issues caused by cultural consumerism in that they are two sides of the consumerist coin given that consumerism as a whole is driven by a vision of the human person that reduces people to nothing more than thinking things, and as such boils down their experience of medicine to that of a the purchase of a commodity. This is important to note in that consumerism necessarily reduces the human person to an intelligent animal, and thus adopts a vision of care that implicitly, if not explicitly, denies the existence of a spiritual dimension of persons, and thus of care. Visser and colleagues summarize this criticism when they comment on the tyrannical aspect of consumerism which "collapses the many complex roles that patients might play into a simplified role of an individualized consuming patient." (Visser, et al)

Thus, it is evident that cultural consumerism has and continues to shape modern healthcare into a business that offers health as a material *commodity* rather than a service, and CHMs are not immune from this influence. The next section will focus on how CHMs have adopted this cultural consumerist approach to care.

Catholic Health Ministries' Adoption of a Cultural Consumerist approach to Care

To demonstrate how CHMs are adopting a cultural consumerist approach to care, I will focus on the adoption of consumerist language, first by showcasing an example of its use by CHM leadership/administration, and then by expanding on what it reveals.

In January of 2022, Ascension Health, one of the largest healthcare systems in the United States, announced the creation and filling of a Senior Vice President (SVP) of Consumer Experience, or "Chief Experience Officer." In their press release, Ascension noted how the new SVP, Carol Campell previously worked as a consumer experience executive for Delta Airlines, and noted how her responsibility in this newly created role was to ensure "a consistent, exceptional experience for those we serve" which "is essential to living our [Ascension's] brand promise of listening to provide compassionate, personalized care" (Jensik). In an interview with *HealthLeaders* published in November, 2022, Carol Campbell spoke of how she thought of the role consumer experience plays in healthcare. She observed that:

> Our consumers are the core of "why we do what we do." The people and communities we serve are the reason for our focus on delivering a deeply personalized and frictionless experience that reinforces trust, while also providing moments of delight. When we deliver great experiences that bring people back, time and again, we build relationships that deliver value to those we serve, our associates, and our ministry. (Blackman)

What is seen by this example is that there is an acceptance and use of consumerist language in CHMs which at face value, may not appear bad as one can see how this approach to viewing persons interacting with healthcare as consumers is a manifestation of critical consumerism and the Triple Aim it produced. Yet, using the terms "consumer" and "brand" to refer to an organization that identifies explicitly as a ministry is of note and reveals, at the very least, that a language shift towards consumerism exists within CHMs. This should cause concern because such a shift in language may "erode in subtle ways the faith-based mission and values that undergird the Catholic health care ministry" (Popko et all). In other words, the move to speak of and view the *patiens* of CHMs as the *consumere* comes with the risk of accepting the

anthropology of expressive individualism that consumerism is founded on. An analogy may help to reveal the issue at hand.

If Fr. Joseph Donahue, the pastor at St. Anne Catholic Church paused after his homily, or perhaps after the Liturgy ended, to update the parish on how they are doing financially, or in regard to membership, not many in the pews would be surprised. But let us imagine that as he did so, he made it a point to thank each parishioner for being good "customers" or "consumers" of the services the parish provided and then proceeded to express how, due to their targeted mailing campaign and church renovations, St. Anne's "brand" had never been so strong. It can be easy to imagine that terming the parishioners as "customers" and "consumers" and the church as having a "brand" to be promoted would seem incongruent with what the church fundamentally is as a community of faith and as a ministry. In the same way, CHMs, such as Ascension, identify and operate as ministries of the Catholic Church. As such, intertwining consumer terms with promoting "the ministry" is problematic. As Kathleen Popko and her colleagues note, language is a means by which we "describe our relationships and work" (Popko et al), and as such, language not only expresses but shapes our perceptions about the world. This then means that the use of language over time shapes the ideas we have about fundamentals both at the personal and organizational level, and the language "ministries" use is no exception. A fair question to ask regarding this shift in language is "Why?" Why does it seem like CHMs are willingly adopting the language undergirded by an anthropology that runs counter to the theological anthropology Catholicism upholds? To answer this, it would be appropriate to point to Carol Campbell's interview, where she ties Ascension's focus on consumer experience with the desire to create experiences that provides them more customers (Blackman). Again, this is not a bad in and of itself, but the use of consumer language in articulating *why* Ascension seeks to do what it does reveals that capturing market share, and ensuring the survival of CHMs is the

priority. That is, Ascension's focus seems to be the increase of patient volume and market share, particularly through promoting their brand and the consumable goods they provide to their communities. This is a focus that Popko and colleagues note is a shift away from CHMs cultivating ways of becoming ministries "of healing, responding to the health care needs of people and communities" and towards ones primarily "promoting consumption" (Popko et all).

This shift in language reveals that CHMs are embracing a consumerist approach to healthcare through the adoption of consumer language, which in turn impacts how their practices align with their claim to be ministries seeking to "proclaim, serve and realize the Kingdom of God." As such, the embrace and use of consumerist healthcare language threatens CHMs' capacity to survive the modern age with their identity intact. This is because, as I have noted before, consumer language cannot be untangled from the anthropology that gave rise to consumerism, which Pellegrino expands on in this work on the matter.

Pellegrino highlights this paradigm shift towards a consumerist, market mentality in CHMs, and ties such a shift to a shift in the way we think about people, much like Snead does in his work. In his article, "Catholic Healthcare Ministry and Contemporary Culture: The Growing Divide," he notes that while CHMs and contemporary, secular, culture both "seek to relieve suffering and to improve the quality of life" (Pellegrino, 3) they do so while possessing vastly different understanding of personal dignity. Pellegrino argues that the anthropology of secular culture is materialistic, and embraces the "ideology of science," that comes with an abandonment of metaphysics and transcendent understanding of creation. Such a vision of human persons is parallel to what Snead speaks of when he notes the anthropology of expressive individualism that our culture is defined by, and reveals that the difference between CHMs and secular healthcare is found it the latter's associating consumption with human flourishing, whereas the latter sees communion as the means by which dignity is upheld, and thus flourishing is actuated. This

means that in secular healthcare the foundational vision of the human person is understood to come through self-actualization (rooted in the anthropology of expressive individualism) whereas in the Catholic view[3] of healthcare, human dignity and flourishing is actuated through an acceptance of a transcendent *telos*[4], and in acts of communion, both which lead to a provision of care for the "the physical, psychological, social, and spiritual dimensions of the human person" (United State Conference of Catholic Bishops, 10)

This all may seem like an aside, but what it reveals is that such an understanding of what human persons are, and what actuates their flourishing is revealed in the language used by organizations that are seeking to respect and help persons. Popko and colleague's chart below, in **Figure 2**, may demonstrate how this shift is occurring in CHMs, with the left column containing language that is more "mission/value" oriented and the right using consumerist terms.

Mission/values language	Consumerism language
Concept of the innate dignity of each person	Concept of person as consumer, a person who purchases goods or things for personal use; an economic model
Health care as relationship	Health care as transaction
Focus on caring for mind, body and spirit	Focus on quick service, price and convenience
Healing of the whole person	Attending to consumer's preference
Ministry of caring, a community of caring "A health care partner for life"	A commodity to sell A consumer-experience framework
Integrated, holistic approach to healing	Potential for episodic, fragmented care in seeking convenience, price

Figure 2 – Mission v. Consumerism Language Chart (Popko, et all)

This chart reveals the glaring difference language makes when speaking of what CHMs are *doing*. Where a mission/values articulation of what CHMs do is one focused on relationships, a consumerist articulation frames the actions of CHMs as transactional, given what the term

[3] Albeit, this view is not exclusive to Catholicism.
[4] The telos of CHMs is the same as the telos of all people: achieving holiness.

consumer means to the broader culture that uses it. As such, the use of terms like “consumer” or “brand” are monumental shifts for CHMs, in that consumerist language drives people and organizations to adopt hyper-individualistic perspectives, which run counter to the vision for human flourishing of Catholicism, which sees human fulfillment as being found in communion. Thus, if CHMs adopt consumerist language, in time they will adopt its practices, and if they adopt its practices, then they will embrace its anthropological roots, and thus lose their core identities as ministries of the Catholic Church.

What is interesting though is that many, if not all, CHMs are not denying the Catholic Church’s theological anthropology. In interviews with Ascension executives, the words “relationship”, and “ministry” are paired with consumerist terms such as “brand” and “consumer experience.” This reveals that CHMs are mimicking language and practices that are consumeristic in ignorance, which may mean that they are just as ignorant of the risk posed by such an adoption of a cultural consumerist approach to care. This risk merits further analysis.

What is the Risk Posed by Consumer Healthcare?

Given that consumer culture is a product of secular anthropology that denies a transcendent reality, the risk CHMs are exposed to by adopting consumer language and practices is the secularization of ministry itself, which is a point spoken of previously. In becoming more consumeristic, and thus adopting the priorities of expressive individualism, CHMs run the risk of becoming subservient to the priority of such an anthropology: self-actualization, via psychological well-being. Such a risk comes with real harms to the ability of CHMs to remain authentically Catholic. Expanding on these harms will reveal the gravity of the risk

First, in adopting the priorities of expressive individualism, CHMs will experience the harm of losing any teleological grounding for their identity. Traditionally, the end of CHMs as ministries has been healing and accompanying the ill (the *patiens*) through their temporal ailments for the sake of actuating the Gospel call to love our neighbor. This is because CHMs as ministries historically ordered themselves towards the *telos* of the human person in mind, eternal life, and as such informed their practices within the "constraints of the divine law" as Pellegrino notes (3). But, in consumerist medicine, the *telos* of healthcare is the *telos* of all other industries: serving the desires of the customer as an atomized individual. This echoes Trueman's assertion that expressive individualism, as the predominant anthropology of our age, places the highest importance on society facilitating the psychological self-fulfillment its members, which as Lisanti and Lisanti note, "intersects with the expanded notion of health that now includes well-being along with the transformation of the value of respect for autonomy into merely autonomy" (Lisanti & Lisanti, 263). Such a move to prioritize personal autonomy due to a shift in *telos* comes with a shift in priorities, in that by making healthcare into a commodity, CHMs may negate any rights-claims society and the poor have to an equitable distribution of care, in that within a commodity logic, healthcare like any commodity it is provided first and foremost to those who can purchase it. As Pellegrino states, if healthcare is treated as a commodity, then:

> [T]here would be no duty of stewardship over medical knowledge which would require its use on behalf of those who need it but cannot pay for it. Nor can there be any valid moral claim by the sick on society for its allocation or distribution. (247)

As such, if CHMs adopt a cultural-consumerist healthcare, in time there will be questions about whether or not resources should be utilized to help those who cannot afford care, and if care is seen first as a commodity, then the allocation of resources to the less fortunate will be done at a bare-minimum for tax-status purposes, and not due to the mission-alignment such a choice upholds. Thus, the harm is the twisting of CHMs from servants of the Kingdom of God (what ministries *do*) via healthcare services, into operating as disease-addressing corporations with margins as priorities and crucifixes on their walls.

A second harm that adopting consumerist healthcare will bring on CHMs' identity comes in the dilution of its ethics. Expressive individualism, as a dualistic anthropology not tied to a transcendent sense of existence, is marked by moral pluralism and normative relativism.

This is because, with expressive individualism comes an understanding that moral norms are dependent upon the perceptions and desires of persons as individuals. As such, in consumerism good medical practice is dependent on an individual's desire, a willing provider that can meet it, and the legality of said mode of care. As Meulen notes, this is how "consumerism [has] turned the caring relationship between patients and healthcare professionals into a contractual relationship, which is defined in terms of rights and obligations." (Meulen, 89). This ethics is vastly different than that which is found in the *Ethical and Religious Directives*, which frames its ethical guidelines within a particular vision of the human person (a theological anthropology) that applies to all persons everywhere. If CHMs adopt consumerist ethics they will adopt an approach to care that envisions its actions purely in "economic terms related to their ability to purchase a product" (Popko et all) and not as ministries that help its members "pursue a special vocation to share in carrying forth God's life-giving and healing work." (USCCB, 10). Thus, the second harm a consumerist mentality would cause to CHMs is that the significant shift

in the ethics of CHMs by promoting an expressive individualistic vision of the human person, and thus a relativistic ethics.

These two harms reveal the gravity of the risk that adopting consumerist language and practices pose to CHMs: the loss of its identity as a Catholic ministry that possesses a particular theological anthropology through the warping of a transcendent mission-focused organization into a margin-driven secular business selling care. Such an erosion of CHMs' identity will lead to the end of CHMs as ministries in that through the adoption of a consumerist approach to care, CHMs will inevitably reduce the relationships they participate in into transactions and therefore all people to commodities, even if they are unaware of the change due to them utilizing language of ministry and relationality self-referentially.

There is a way forward and out of the adoption of such language and practice, and such a way is found in the intentional, and robust formation of those who work within and lead CHMs in the theological tradition of Catholicism, particularly the virtues. The next, and final section will explore how formation can be an, if not *the*, antidote to a consumerist approach to care for CHMs ministries.

The Way Forward: formation in CHMs

What is formation? Why is it important? How can integrating formation into all levels of a CHM help preserve its claim of being a ministry? These are the questions answered in this section. First, a definition of what formation is will be presented, which will be followed by explaining what exposing CHM leadership and personnel to the theological tradition and spirituality of Catholicism can do for the culture of a CHMs, particularly by highlighting how language integration and virtue cultivation can orient CHMs towards their *telos* as ministries. This will reveal that formation ultimately cultivates a culture within CHMs that counteracts the commodification caused by consumerism, therefore actuating CHMs' capacity to live up to their foundational Gospel call to see and treat all as neighbor (Luke 10:25-37).

Formation in CHMs is the programmatic integration of experiences, materials, and language that clarifies the *telos* of the ministry through the cultivation of a common spirituality. This clarification then orients participants towards actuating the sort of culture that honors the founding spirituality and theological tradition that undergirds Catholic healthcare. Formation occurs by exposing participants, particularly CHM leaders, to the spirituality of CHMs' founding orders, and the theological tradition that guides Catholic healthcare. This exposure in turn (and in time) aids CHM leaders and team members grow in virtue, and thus maintain the CHM's "organizational integrity as a ministry of the Church" (Mueller, 271).

That being said, formation programs within CHMs are historically novel attempts at replicating the "the formation that was traditionally provided to priests and religious" in methods that are "appropriate to [the] new expression of lay ecclesial ministry" (Bouchard, 205), and there does not yet exist a uniform methodology or approach to formation, albeit such work to articulate a uniform methodology is currently being done by organizations like the Catholic Health Association. Yet, while formation of CHM leaders and members is novel, it can still be understood to fall under a broader tradition of formation, which Henri Nouwen speaks of as

spiritual formation. Spirituality here can be understood as how an individual or a community of people understand their life in relation to who God is. That is to say, spirituality is the fundamental understanding of who God is, and who we are in relation to God. Spirituality, then, is the foundation for an identity, a worldview, both for persons and communities. This is because whatever we define as our "god" defines what we are and what we do. This is why Miller posits that consumerism is a quasi-spirituality, in that within consumer culture the act of consumption serves the purpose of affirming the "god" that is the atomized individual. On the other hand, the spirituality of CHMs is unique in that, as Paul Marceau states, it is:

> grounded neither in the collection of the individual personal beliefs systems represented in its workforce nor in universal human values but, rather, in the healing ministry of Jesus.

Thus, the spirituality that CHMs are rooted in is the general understanding of the organization's relationship to God, as a ministry rooted in the healing ministry of Jesus Christ. Such an understanding of a common spirituality gives rise to a unique culture in that once an organization can speak of a clear *why* (as expressed in foundational theology and spirituality), it will then articulate it through a mission and then live it out through a common way of life (culture). Each founding religious order of a CHM had a spirituality that rooted their common life, and thus the culture of the CHM as a whole. Now, as the religious orders continue to transition the leading of CHMs primarily to the laity, the need to maintain and awareness an acceptance of the founding spirituality that differentiated CHMs from non-religious hospitals and health systems is paramount. This is because the cultivation of an awareness and appreciation of a spirituality leads to a culture that focuses CHMs on actuating the relational approach to the care continuum, in that if CHMs are ministries that proclaim, serve, and realize the Kingdom of God, then they should seek to imitate the healing work of Christ in their daily operations today as the religious orders historically did.

Actuating the healing ministry of Jesus Christ necessitates more than a generally accepted or promoted sense of purpose, it requires the development of means by which such an awareness of a common spirituality is developed it into a culture that lives it out. This is the work of formation programs, which ultimately seek to nourish CHM leadership and team members with "serious theology and spirituality" as Bouchard notes (205). An example may help to clarify this point.

In exploring the impact formation can have on CHMs, Mueller discussed how it occurs by creating programs in which participants can appreciate and integrate the fundamental concepts of: "the reign of God, the call to ministry, and the nature of the human person," as Mueller claims (272). Mueller admits that all three of these focal areas may seem too theologically complex and foreign to formation participants, especially those who are not Catholic, or religious at all. Yet, as she notes in her discussion of forming leaders in an awareness of the "reign of God," in connecting the concept of the reign of God to the *telos* of CHMs, the history of the CHMs, and its practical manifestation within operations, participants see themselves as active maintainers of the mission of CHMs, and as such become cultivators of a culture that seeks to enact the reign of God as a standard of operations (273-274). Mueller observes that at the very least, introducing the importance of the reign of God to the ministerial claim of a CHM, the leaders of the CHM learn a language that "is core to our Catholic identity" that then becomes "part of the vernacular for leadership and governance" (274). This reveals how formation can introduce a common language that, if integrated into practices, cultivates a general culture that is aware of the identity and mission all CHM members help to actuate through their work. It is this sort of programmatic integration of the language of mission that counteracts the impacts cultural consumerism has on CHMs. This is because whereas consumerism causes us to dissociate ourselves from the interconnectedness of all involved in

what is being commodified (in this case healthcare), formation seeks to answer the challenge of "preserving and even strengthening the Catholic identity of the [Healthcare] institutions and the spiritual quality of the services given" (John Paul II, 3) by rooting participants in the *telos* of CHMs, that is to say it's transcendent end as a *ministry* of the Catholic Church whose focus is on providing care for the whole person. Therefore, formation is an antidote to the depersonalization cultural consumeristic healthcare produces, in that formation programs highlight the relationality that defines CHMs' approach to care. To fully understand this, exploring three ways formation programs cultivate a culture rooted in Catholic theology and spirituality is needed.

First, formation programs stress that learning to steward the religious tradition within a consumer culture is paramount, and thus seek to expose participants to the "meta-story of CHMs" (Shea, 22-23), with the aim of helping them cultivate "an ever-clearer discovery of [their] vocation and the ever-greater willingness to live it so as to fulfill [their] mission" as John Paul II noted (58). Formation therefore roots participants in a broader narrative of CHMs as a ministry of the Catholic Church. We can think of Mueller's point regarding formation seeking to help participants understand and integrate the language and concepts of the reign of God, the call to ministry, and human dignity into CHM operations. Rooting participants' work in these theological concepts helps them to cultivate a deeper awareness that their work is not just part of a process of consumption, but is a vocation that exists within a particular community, is oriented towards a transcendent goal, and exists to affirm the value of life, the work they do, and the relationships that define the work itself.

Second, exposing formation participants to the meta-narrative of CHMs occurs through the integration of language of communion into a field that increasingly relies on corporate and consumeristic language (think of Popko and colleagues work here). Formation's utilization of value-language helps to mitigate the commodification of care consumerism causes, by

introducing and insisting that in CHMs words matter and inform the level of fidelity to the mission. Something as simple as forming participants in using the word "patient" versus "consumers" or "customers" can have cultural impacts in that the former reveals the patient-institution relationship to be one of service, whereas the latter reduce it to a transaction. Thus, formation's role in language-integration is a primary way it counteracts consumerism's impact on healthcare in that language, "has the power to influence and shape our values, attitudes, prejudices and behaviors" (Popko, et al) and thus forming people to use language rooted in an anthropology of transcendent dignity will cultivate a culture deeply aware of that dignity.

It may seem that such language integration is a means by which CHM's teach the *lingua franca* [5] of the organization to leaders and team members that ensures the *appearance* of ministry while continuing to practice consumerist healthcare. Here Mueller's work and testament helps to point to the reality that exposing participants to the theology and language of healthcare as a ministry can reframe how they think about what they do, and thus shape the organizational culture and practices. She quotes a CHM board member who participates in one of her board formation session, and who attested that prior to the formation program he "operated on [the] board on the principle that we must build our margin so that our mission could have impact" and after the formation session, realized that he was wrong, stating that "the mission exists with or without us. We are part of something much bigger. The mission has to come first" (Mueller, 274). This example reveals that while formation can become just another experience that is consumed by participants for the sake of working for a CHM, its potency to change the perspectives of participants in a way that drives the culture and operations of CHMs is real, particularly in how they utilize the language by which they speak of the ministry they serve in.

[5] This is also a recognition of the existence of "language games" that exist within CHMs, but in this sense such common language is needed given the role language plays in developing culture.

Third, the exposure of formation participants, particularly leaders, in the meta-narrative and language of CHMs can lead to the growth in personal virtue, which itself leads to development of a culture rooted in Catholic spirituality, and thus focused on ensuring a CHM is a ministry of communion. Formation in the virtue of humility, and its impact on organizational discernment and care may offer a proper example of what this means, given that it can be understood as the cornerstone of holiness in Catholic theology. [6]

Humility as a virtue is the appropriate *ordo amoris* as it relates to the self. Humility, as the ordered love of self, stands as a balanced self-perception between pride and self-deprecation, and thus causes "us to value our own worth appropriately while accepting our helplessness, fallibility, moral frailty... acknowledging our relative insignificance in the universe." (Jeffrey) Thus, it is an important, if not pivotal virtue for healthcare in that this appropriate sense of self "enables the openness, curiosity, and critical spirit necessary for learning anything well" (Wadell), that is to say, humility allows us to be open to right relationships in that we are not hung up in our own perceived worthlessness or magnanimity.

This virtue, as Wadell notes, can aid healthcare workers – from bedside to boardroom – to consciously and continually see patients first as persons, in that the "clarity of vision" humility causes us to see the patients "not as cases, but as guests." Humility then is paramount in that it roots healthcare leaders and workers in awareness of who they are, and what they have been called to do, and by doing so aids healthcare workers to love well, which mitigates the impacts consumerism has on healthcare as a whole. As Wadell notes:

[6] It is worth clarifying that I am speaking of virtue as Augustine would, understanding it to be the *ordo amoris*, that is to say the "rightly ordered love." (Agustine, XV, Chapter 22) This means that formation in all virtue, including humility, is the development of an awareness and integration of different ways of ordering our love for self, and others in such a way that we actuate the flourishing of all.

> One of the potential hindrances to excellence in health care is to gradually lose sight of patients as unique human beings with distinctive needs, fears and concerns. The more bureaucratized and depersonalized medicine becomes — and perhaps the more technical — the more likely it is that the personal dimension of medicine will be lost. A love informed by humility resists this depersonalization by reminding us that the relationship between health care providers and their patients is, from first to last, a human encounter in which a person in need comes for help. That very encounter constitutes a moral call to affirm the dignity of the persons in need by acknowledging their presence and doing what one can to help them. (Wadell)

This reveals how helping leaders and team members within CHMs to grow in humility through formation mitigates what consumerism does to CHMs, in that by helping healthcare workers become more humble, a CHM can improve the patient experience by making it more relational, and thus more rooted in the reality that healthcare is a service and not a commodity. This is to say, in helping those who work in healthcare practice the virtue of humility, a CHM helps itself become more *hospitable*, and thus more aligned with the fundamental claim that it is a ministry.

Hospitality here can be understood as a virtue that comes from the *ordo amoris* of humility, in that the ordered love towards self necessarily leads to an ordered love of others, and this ordered love for others is what constitutes hospitality in practice. Cultivating the practice of hospitality then helps create a broader culture of hospitality, which is a collectively lived expression of the love of neighbor Christ called his followers to live by.[7] This genuine love of our neighbor (hospitality) sees and upholds the dignity of others not because of what they can provide us (as consumerism's commodification logic does), but simply because of what the neighbor is: a person with inherent dignity.

Such a practice of hospitality is pivotal to what it means to be a CHM, in that hospitality is the *praxis* of Christ's call to love one's neighbor as one loves themselves. Thus, the practice of hospitality by persons or institutions is done through tangible acts that Thomas Aquinas holds fulfills a "law of hospitality" set forth in the Epistles of St. Paul (Aquinas, 43-45) That is to say,

[7] Luke 10:25-37's Parable of the Good Samaritan offers a Scriptural root of the sort of ministerial work CHMs seeks to actuate.

practicing hospitality is a way a CHM lives out its identity as a ministry, in that it is through being hospitable to all in need that CHMs carry on Christ's mission on earth through works of caring and healing. An example of what these sorts of virtues look like in action may help clarify formation's role in cultivating virtue.

If Tau Health, a Catholic Regional Health System in a relatively impoverished State, was suddenly faced with the reality that due to the State's reimbursement-model for the uninsured and the high percentage of uninsured patient population of their Behavioral Health Unit (BHU), they would either need to close the BHU, or risk putting their entire System in peril of closure, then the Tau Health leadership team would call for a formal discernment process to be initiated.

In Catholic healthcare, formal discernment is a regularly occurring decision-making process by which CHM leaders (executives, board members, community leaders, etc) come together to prayerfully discuss the problem at hand, the relevant data, potential outcomes and solutions, and ultimately enact organizational prudence in the action(s) taken. As Scott Kelley and David Natais note, this form of decision making is unique to CHMs in that it "brings into being the mission of the organization" through a process of prayer, dialogue, and reflection. In the case of Tau Health, the leadership of the System set aside time to gather the data needed to discuss possible actions to be taken, as well as time to engage in a period of open dialogue, prayer, reflection, and consensus regarding a decision. Financial and population data are included to measure the impact of maintaining the BHU, or closing it, and mission-related imperatives would be highlighted to frame the decision made to be mission-centric, and not margin-focused. This would include the call for Tau Health to practice the sort of hospitality that Christ spoke of in the Parable of the Good Samaritan, which is seen as a foundational parable within Catholic Healthcare. Such a framing of the discussion around hospitality would in turn cause the leaders participating in the discernment process to practice humility, as they are

reminded by the session's facilitator that their role is not one of ownership of Tau Health, but of stewardship of a ministry that is ultimately "bigger than they are."

Sitting with the reality of what a discernment process entails, one can see how the only way that it can successfully occur regularly in CHMs is if the leaders participating in them are formed to understand and appreciate the theological tradition and spirituality that leads to such a practice. This formation would also have to cultivate a sense of community, and individual virtues so that the discernment could be cohesive and aimed towards the Common Good, not just the good for Tau Health. As Kelley and Nantais note, "[c]ommunities of trust are not formed on the basis of explicit rules and regulations, but out of a set of ethical habits and reciprocal moral obligations internalized by each of the community's members," that is to say, the sort of trust needed to do a formal discernment process is founded on the participants trusting that all, if not most, there possess the sorts of virtues oriented towards the *telos* of Tau Health as a CHM.

This example reveals that forming healthcare leaders and team members in humility is paramount, and leads to the cultivation of individual virtue, particularly of those who drive decisions within CHMs, and thus causes the rise of a broader culture of hospitality that genuinely reflects and lives out the claim that the CHM is a *ministry.* This is most evidently seen when CHMs enter formal discernment sessions that drive their strategy and orient the whole organization towards modes of service that will actuate the mission before it increases the margins. This in turn reveals that formation's fruit is the development of an organizational culture that orients CHMs towards their *telos* as ministries: the incarnation of the healing ministry of Jesus Christ in the present moment. Such a culture could be seen in a different approach to the Triple Aim's value-based compensation model, which I will discuss next.

Let's imagine that Tau Health chooses to adopt the Triple Aim, not as core organizational principles, but as means by which their core value of hospitality is actuated in a

modern, consumeristic, healthcare market. In this scenario, Tau Health is making the Triple Aim and value-based compensation – both of which are products of critical consumerism – into methods to achieve a greater end: actuating healthcare that highlights the dignity of each patient served. Tau Health can do this by framing means how they approach quality, cost, and accessibility under the transcendent value of hospitality. This approach to the Triple Aim gives a deeper meaning to the "value" provided to the patient, and thus prevents the risk posed by adopting a consumeristic approach to Triple Aim that equates the value of care with the dollars spent on it. In other words, Tau Health could adopt a value-based care compensation model and *elevate* it by utilizing the existing incentives and goals to become the community for patients to actuating a sort of comprehensive hospitality for the patients it serves.

We can think of Tau Health using the value-based care model to create teams of allied health professionals (social worker, community health worker, chaplain, etc.) to help address the broader issues a patient has, and which a primary care physician may not have the time to address. Such a model of care would be comprehensive and would prioritize approaching the patient first as a person with inherent value, and thus worthy of being accompanied holistically. Such a program would be the fruit of Tau Health's team members being empowered to believe that their role within the health ministry is not to increase the overall margin, but rather to live out a unique mission of healing. In this scenario it would be the role of Tau Health's formation department to cultivate these sorts of perspectives within Tau Health through exposure to the theological tradition that undergirds Tau Health's claims of being a ministry.

If Tau Health succeeded in approaching value-based compensation in such a way, not only would it thrive financially, but it would sustain its identity through the generation of a culture of hospitality, aimed at actuating a transcendent mission. This example demonstrates that through formation, CHMs can become prophetic ministries of communion in a culture of

consumption. Still, such an organizational character can only be cultivated if its members are formed in an awareness of the unique *telos* of CHMs, their mission, and the virtues that make it possible.

Conclusion

In this thesis my aim has been to bring attention to the risks incurred by CHMs if they continue to adopt and utilize consumerist language and practices. If such adoption continues, they run the risk of fully adopting the anthropology that undergirds consumerism: expressive individualism. Such an anthropology runs counter to the Catholic understanding of human personhood and flourishing, and thus its adoption – whether intentional or not – may cause CHMs to exist as Catholic in name only. Yet, such a risk is not absolute. As I have shown, formation offers an antidote to the detrimental effects of consumerism, in that through formation programs, CHMs can ensure that they remain rooted in the Catholic vision of human persons, their foundational spirituality, and thus their call to actuate relational care. Such a rooting occurs through the cultivation of personal virtue of members of a CHM, and thus produces a broader culture within CHMs: one that ensures that the ministry remains loyal to its mission, and in doing so incarnates the healing ministry of Christ in a society marked by commodification and disassociation.

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