THE SOCIETY FOR SPIRITUALITY, THEOLOGY & HEALTH

The Duke Center for Spirituality, Theology and Health
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Thank you very much for this opportunity. I am pleased to participate in this first annual meeting of the Society for Spirituality, Theology and Health. It has brought together scholars and practitioners from across the US and around the world – it has even brought Duke and UNC together!

For the past 30-plus years of my career, I have been an observer and commentator on health issues in American society. I have been privileged to do this from a variety of vantage points – in government, the private sector and the academy – alternating between positions that gave me a broad societal focus and others that gave me a more narrow medical care focus.

Please excuse the personal references – but I want to tell you my story, and describe how my work in medicine, public health and health policy have been intertwined with concerns related to spirituality and health.

I am not an expert in the field of spirituality and health – but many of you are. What I am going to do is tell you some stories, that together will explain my perspective on this important topic.

I was raised in a family that valued and emphasized matters of faith and morality, and I attended a church-related junior college for my first two years after leaving home. I went on to graduate from The University of Alabama, majoring in chemistry and minoring in mathematics.

After my formal training in medicine at The University of Alabama in Birmingham, I pursued a residency in pediatrics at the University of

Colorado Medical Center. During my time there I became interested in medical ethics, and I spent an elective month at the Kennedy Institute for Bioethics at Georgetown University. I devoted most of my attention to the issue then know as "defective newborns," the ethical, moral, and medical issues related to the care of children born with severe disabilities.

My first job following my residency was directing the local public health department in Birmingham, Alabama, my home town. I had been drawn to public health because of my desire for a leadership opportunity and for serving the underserved. The agency I headed operated a network of neighborhood health centers, with a strong indigent care mission. In addition to my role as director of the agency, I worked in one of the facilities – seeing pediatric patients – a half a day a week. This gave me a chance to see firsthand the challenges of safety net institutions.

After five years in local public health, I went to Washington, DC, as a White House Fellow, having applied and been selected for this one year program. But I had a series of other opportunities – for continued service on the White House staff, then to lead the Health Care Financing Administration (with responsibility for the federal Medicare and Medicaid programs) and then back to the White House at a higher level.

In each of these positions I worked on many different issues – but most especially I was involved in working out the complex interplay of the ever increasing cost of these public health care financing programs, with trying to extend access to health care for more Americans, and to improve the quality and safety of health care services.

But there were many other issues as well. I worked with then-Surgeon General Everett Koop on the development of guidelines for the care of disabled newborns – an outgrowth of the celebrated "Baby Doe" case. My earlier time at Georgetown was very helpful for this.

My one year in Washington was actually eight – and then I went to Atlanta, to head the US Centers for Disease Control. Given my earlier work in public health, there was much of this work that was familiar to me. In an effort to solidify CDC's role as the Nation's prevention agency, we formally added "and Prevention" to the agency's name. During my time there, I worked on many issues – including AIDS and

HIV. One of the most poignant days of my tenure was going to south Florida to meet with a brave young lady named Kimberly Bergalis, who was dying of AIDS. Our epidemiologists suspected that she was infected while being cared for by a dentist who was HIV-positive. Her case led to the creation of guidelines for HIV-infected health care workers.

As CDC director, I had the opportunity to travel to many parts of the world, to consult with leaders there and to celebrate CDC's leadership internationally. Whether in Africa, China, Latin America or Geneva, CDC was and is a hugely important force for improving global health and understanding.

I left the CDC in mid-1993, and joined Prudential HealthCare. I led the medical management and the public policy efforts of this very large health insurance company. I worked on deepening and extending our ability to give the best of quality and effective health care services to our members. One of the areas of my responsibility was overseeing the determination of which services we would pay for – and which not. I still remember quite clearly talking personally with a lady who had terminal cancer – and telling her that we would not pay for an unproven, experimental treatment. She died not long afterwards – and the treatment was later shown not to be efficacious – but it still was very difficulty to handle.

In 1997, I was given the wonderful opportunity to come to Chapel Hill, to be dean of the UNC School of Public Health. Leading this prestigious institution for six-plus years was a great privilege, and I had many satisfying experiences. Perhaps chief among them was the launching of two interdisciplinary activities – the UNC Program on Health Outcomes, to foster quality and patient safety research and related activities, and the UNC Program on Ethnicity, Culture and Health Outcomes (the ECHO Program) to pursue work on health disparities.

About four years ago I was given the remarkable task of leading the UNC Health Care System and being dean of the UNC School of Medicine. These intertwined roles have been interesting and challenging – especially as we have sought to grow our national leadership and prominence, while deepening our service to the state of North Carolina, particularly to those indigent citizens of our state who

have no other place to go for their health care needs. Through two broad initiatives – "Assuring Access" and "Commitment to Caring" – we have labored to improve how we serve others. These efforts have not been without controversy – but we are making great progress, I believe.

Throughout these activities, I have come to understand, ever more clearly, that "health" is a much broader agenda than just clinical interaction – and it extends in many directions to meet the needs of individuals and populations.

This annual meeting, and the Society, seeks to add the focus of spiritual and theological issues to considerations of "human flourishing."

It makes sense to do so – as spirituality and religion are major parts of our individual and community lives. It would be arbitrary and foolish to try to exclude spirituality / religion from our efforts to understand human health and well-being.

My own faith compels me to do this because of my conviction that, as Blaise Pascal said, "there is a God shaped vacuum in the heart of every man which cannot be filled by any created thing, but only by God."

But regardless of whether one comes at this issue based on a personal faith conviction, it is objectively true that matters of spirituality and religion are very important to many, many people around us. We do no one a favor if we try to pretend this is not so.

I have been formed and I practice out of the particularity of my Christian convictions and story. This is an example of how we are all formed by the tradition that has informed the filling of that "vacuum" in our own social and historical experiences. In my own case – as a Christian – I believe my work as a physician and public health leader is driven by my desire to show Christ's love – agape love – to those around me. Trying to make sure that my faith informs my secular vocation is a real challenge – as it is for each one of us. I readily acknowledge that others are formed and informed by their Jewish, Muslim or Hindu faith.

And I believe there are some additional challenges for those of us in academic health leadership positions concerning spirituality, theology and health.

First, there are substantial educational questions for schools of medicine, public health, nursing and the other health sciences. How should we incorporate a focus on these issues into our curricula – which are already crowded and stretched? And how do we explore these important issues with students in an interesting and effective manner, while doing so in a non-sectarian fashion?

And there are important research questions as well. To date, much of the funding for research in spirituality, theology and health has come from private sources – most notably here from the John Templeton Foundation. While such private funding has proven very worthwhile, it is in contrast to the fact that most health research funding in America comes from the National Institutes of Health.

An important question for the field is whether and how to interest the federal research establishment in pursuing a broad and sustained research program in this area – and how to make sure it is driven by the best of scientific inquiry, and not by a any one sectarian point of view.

In my current academic role, I see very clearly the need to build upon the research and education within the work of the Society in providing leadership in this field.

In addition to the research and teaching questions, there are significant health care delivery questions that we face as well. In my case, since I head a public safety-net institution, it is very clear that we have a mission to serve the people of our state. A sign in our lobby has long said that we are operated by and for the people of North Carolina. Balancing this thoroughgoing commitment with the other aspects of our work is a continuing challenge – made progressively more difficult by the growing problem of the uninsured in our society.

We daily struggle with how we can serve more – while being reminded all the time of the truth of the aphorism – "No margin, no mission."

My Christian faith informs my leadership of this large, public institution. I assume that my Jewish, Hindu or Muslim colleagues are similarly shaped by their traditions of formation.

But what does that really mean? What is the importance of our religious formation to the practical issues we face? In my case, what is the moral and theologically informed perspective within the Christian tradition and community on these health care issues?

I want to spend the balance of my time elaborating on this –

First, a few facts –

There are ~45 million Americans without health insurance, and many more with less-than-adequate health insurance. It is demonstrably true that un-insurance leads to diminished health care access, which leads to worse health outcomes and diminished health status.

Although it is often said that people in America without health insurance eventually do get care, their access is impaired in significant ways. This has long been debated nationally and at the state/local level, and is likely to be a major focus of this year's Presidential electoral debate.

And so I ask … What is the Christian ethical / moral perspective on health care reform?

Jesus healed the sick, and the Gospels are filled with admonitions to help the sick, the poor and others. The Epistles have similar admonitions, and we are told taught that agape love requires us to demonstrate "active good will." Thus we are to work to produce good for others.

It has often been asked -- is health care a "right"? And whether or not it is, what should we do to advance the health care and health of others? What would Jesus do?

Some would say that we ought to give away free care. Others would work for health care reform, in the state or national political processes.

There are several competing proposals for health care reform

- **Physicians for a National Health Plan are advocating a single payer system;**
- **Others are focusing on children and want to expand S-CHIP;**
- **And some seek to expand public providers – neighborhood health centers, rural health centers, etc.**
- **A target for many is to give tax credits for lower income individuals / families to purchase health insurance;**
- **And some, particularly conservatives are advocates for "Consumer driven health care – HSAs."**
- **What about the Obama plan? The Clinton plan? The McCain plan?**

To each of these questions, one can ask "What is the Christian perspective?"

There is a long and worthy tradition of people working for social change because of their own religious commitment.

This includes William Wilberforce and the anti-slavery movement in Britain in the 19th century, and the Social Gospel movement in the late 19th and early 20th centuries in this country and abroad.

The American Civil Rights movement, in the 1950s and 60s was animated by the deep faith commitment of many of its leaders and followers – most notably Rev. Martin Luther King, Jr.

And the anti-abortion movement in the U.S. has been driven by the Roman Catholics and conservative Protestants whose faith has led them to oppose Roe v. Wade. Indeed, the Religious Right as a political force is the latest example of the interrelationship of faith and social action.

So, what is the analogy for Health Care Reform?

Should Christian compassion take the "liberal" position and compel government to reform health care (or, insert, raise the minimum wage, ban sweatshops, stop global warming, etc.) – or – should

Christians take the "conservative" position and push the Wall Street Journal editorial page solutions (or, insert, promote home schooling, faith-based institutions, etc.)?

What is the right mix of government and market solutions? Each of us, as people of faith, or of no faith, has to grapple with these questions.

I do not have final answers to these questions, and I am sure that my current thoughts will not satisfy everyone.

These are issues that I have personally struggled with – and they are very much at the intersection of my faith and my vocation. I think there are some useful principles –

- **People of faith cannot stand on the sidelines**
- **We should work with our heads as well as with our hearts**
- **If this were easy, it would have been done a long time ago.**

I hope these reflections on spirituality, theology and health have demonstrated some of the challenges and possibilities that lie before us.

Whether confronting decisions about the care of very sick babies and others, or searching for the best ways to prevent the spread of HIV/AIDS, or seeking to provide health care to everyone, especially the uninsured, or examining the implications of these issues for those of us who try to lead academic health institutions – the interdisciplinary work that you and others are doing in these areas is very important. The varied disciplines represented here need each other to address these matters optimally.

Thank you for the opportunity to discuss these ideas with you, and thank you for the challenging and worthwhile work that you do.