

Pursuing Excellence in Health Care

using fourth-century wisdom to transform modern medicine

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ABSTRACT Despite growing interest in addressing health disparities in the US and around the world, excellence in US health care is largely defined by research dollars, innovation, and perceived prestige. This essay reimagines “excellence” in health care by exploring two different models that center care for the poor and vulnerable: the ancient example of the first hospital, founded by St. Basil of Caesarea in the fourth century, and the contemporary witness of Paul Farmer’s liberation theology–inspired work of accompaniment. This renewed vision invites both social and personal transformation, offering health-care

institutions and practitioners new ways of naming and pursuing excellence in academic medicine and surgery.

Significant social and health disparities in the US and around the world put the excellence of modern medicine in question. There is a deep tension between the poor suffering from lack of access to basic needs, including health care, while medical centers erect expensive buildings for elective procedures and research (Bourgeois et al. 2017; Nuila 2023). For the ambitious clinician, excellence is often associated with successful outcomes for the wealthy, as marked by proxies such as research dollars, specialized care, and *US News & World Report* rankings. Yet all is not well: new cancer diagnoses result in staggering rates of financial catastrophe, and life expectancy in the U.S. drops while maternal mortality continues to climb (Fleszar et al. 2023; Gilligan et al. 2018).

We are not the first society whose mainstream vision of medical excellence is incapable of meeting the challenges of such disparities. In the ancient Mediterranean world, marginalized persons—often lower-class noncitizens—did not register in the Greco-Roman social hierarchy. Professional health care was reserved for people of financial means and high status who enjoyed access to quality food and sanitary living conditions often inaccessible to those on the margins of society.

That world experienced a moral revolution. Might our world be ripe for one as well? In this article we trace how such a revolution took form in the fourth and fifth centuries CE, how a similar event happened in the late 20th century, and how these historical examples can shape our current conceptions of medical excellence.

Ancient Health Care and Moral Transformation

In the ancient Mediterranean world, the medical care patients received was tied to their wealth, which often depended on family connections. If someone fell ill and required care their household could not give, they might seek popular and religious healing, including herbs and plants, magical amulets and incantations, and dream remedies at the temple of Asclepius (Rhee 2022). And people fell ill quite often.

Urban population density was many times higher than rates in modern cities, and those settings coupled with social turmoil and lack of sanitation led to frequent episodes of famine and disease (Risse 1999; Stark 1996).

Only people with sufficient financial means could expect trained medical care. Their families would call a physician, who would come to the home and offer diagnoses, treatments, and a regimen of care (Risse 1999). The Hippocratic Oath may have committed physicians to moral conduct within this arrangement, but it did not morally obligate them to care for anyone who could not pay (Edelstein 1967). Furthermore, there was no specific place with clinicians where people could be taken if they fell ill. If someone was sick, isolated from familial support, and without wealth, there was little to no hope of receiving trained care.

Such an approach to health care was bound up in the social imaginary of the ancient Mediterranean. Following Charles Taylor (2004), a “social imaginary” refers to “the ways people imagine their social existence, how they fit together with others, how things go on between with them and their fellows, the expectations that are normally met, and the deeper normative notions and images that underlie these expectations” (23). Within the Greco-Roman social imaginary, the distinction between citizens and noncitizens was a fundamental divide. Citizens were primarily an urban group—sharing a common etymological link to *civic*, *city*, *civilized*, and so on—whose first loyalty was to their local city, which itself was bound up in the constellation of cities that made up the Roman empire. Their reality was defined over and against the largely rural and politically disempowered noncitizens located primarily outside of the cities. As scholar of late antiquity Peter Brown (2002) notes, “There was never a time, in the ancient Mediterranean, when an extensive grew mass of human persons did not pile up to press against the firm but narrow self-image of the classical city” (10). Wealthy Roman elites provided significant public support to the citizens within the city walls—thought of as a gift to the city itself—and civic glory was promulgated through extensive public building campaigns and monuments.

This moral world changed with the rise of Christianity. Drawing from its prophetic Jewish roots, Christianity saw social divisions through the lens of rich and poor, rather than citizen and noncitizen.

Poverty extended beyond material lack and began to refer to social belonging; “the poor” became a term that described all persons existing outside of the community. Further, Christian churches and individuals called the poor both “blessed” (in their scriptures) and the most deserving recipients of care (in their ethics). By naming these socially vulnerable people as “poor” rather than as “noncitizens,” early Christian churches folded them into a new moral world—a new social imaginary. “It was the ‘poor,’” Brown (2002) argues, “and not one’s fellow citizens, not even one’s dependents, who were now supposed to be the object of acts of public giving appropriate to a Christian world” (11). “Excellence” for elites thus became tied to how people acted towards the poor, including giving charitably, rather than to public beneficence for their city or fellow citizens (Brown 2002; Holman 2001). This expectation of social elites spread in the fourth century, as Christianity became legalized and then established as the Roman Empire’s official religion (Brown 2002).

In the early fifth century, the influential Christian bishop and theologian Augustine clarified this contrast between moral orders in his magnum opus, *The City of God*, written at the time of the fall of the Roman empire. Against those who blamed Christianity for the Roman Empire’s decline, he proclaimed the divine city as “most glorious,” setting it in contrast to the vainglory of the earthly city and its clearest representative, classical pre-Christian Rome. The earthly city was “that city which, when it seeks mastery, is itself mastered by the lust for mastery, even though all the nations serve it” (3); in contrast, the Christian community extolled humility and care for the marginalized.

The power of this new moral vision—and its corresponding contrast between the earthly city and the “City of God”—played out in the world of health care. In the fourth century, Cappadocia was considered the backwater of the Roman Empire. Located in what is now Turkey, it was situated where ancient trading routes crossed and horses were bred for imperial calvaries. It was there, far from the centers of power, that we can see Augustine’s alternative social imaginary taking a new institutional form.

The *Basileias* and Love for the Poor

For insight into this moral transformation, we look to fourth-century Christian bishops in Cappadocia:

Gregory of Nazianzus, Basil of Caesarea, and Gregory of Nyssa, along with Basil and Gregory of Nyssa's older sister and teacher Macrina. These leaders, known collectively as "the Cappadocians," played a pivotal role in remaking the social vision of health care and its core institutions. Inverting the values and vision of Rome, while using its infrastructure and wealth to grow, they were part of a counterculture that broke new ground conceptually and institutionally. In the Cappadocians' early sermons and writings, we can find a robust social imaginary that makes intelligible Basil's founding of the first hospital. As we also will see with Paul Farmer in the 20th century, the revolution in social imaginary took place via institutional innovation, personal transformation, and in prioritizing the wellbeing of the poor, leading to a new vision of excellent medicine.

We begin with institutional innovation. With the invitation "Go forth a little from this city and behold the new city," Gregory of Nazianzus contrasted the complex institution of care created by his friend, Basil, with the fading glory of Greco-Roman Caesarea ("On St. Basil the Great"). Basil's "new city" was a cluster of interrelated buildings focused on what we would now call social services: a hospital for the sick, an orphanage, a hospice for those with chronic diseases like leprosy, long-term dwellings for the poor and infirm, short-term accommodations for travelers, and other structures as well (Crislip 2005). In what became known after its founder as the *Basileias*, we see how a transforming social imaginary intersected with the world of health care. This "new city" is historically notable as the first hospital, defined by historian Andrew Crislip (2005) as an institution that shared a set of three basic features: "inpatient facilities, professional medical care, and charity" (102). Unlike medical facilities for slaves or soldiers (*valetudinaria*), the *Basileias* was open to all; unlike Greco-Roman religious healing temples devoted to Asclepius, it included trained medical practitioners. Until the *Basileias*, there was no institutionalized medical care available to everyone, especially the poor and sick.

Historically, the *Basileias* was established after a famine in the late fourth century, following Basil's appointment to bishop (Brown 2002; Ferngren 2009). Basil drew in part from a tradition of hospitality institutionalized in *xenodocheia*, guest houses where strangers (travelers, pilgrims, foreigners) were given a place to stay (Brown 2002; Crislip 2005). Formed by the witness of Abraham, Jesus, and

others, Christians believed hosting the stranger was an occasion to welcome God (Bretherton 2006; cf. Gen. 18:1–15, Matt. 25:31–46). The hospital became Christianity’s primary institutional expression of this commitment to hospitality. Through it, Basil also provided evidence to the imperial authorities that Christianity deserved its status within the Roman Empire (Brown 2002).

This institutional innovation was bound up with a call for personal transformation through acts of generosity, service, and hospitality. Raising money for famine response a few years before the founding of the Basileias, Basil preached a series of sermons imploring the rich to be generous to the poor: “Whoever has the ability to remedy the suffering of others, but chooses rather to withhold aid out of selfish motives, may properly be judged the equivalent of a murderer” (70). Basil charged those with power with ignoring the poor while building civic monuments in Caesarea. He sought to inculcate new habits of attention and action for the wealthy, seeking to “bring the sufferings of the poor to your attention, so that you might realize from what misery you are collecting riches for yourself” (85). Basil identified the poor with the story and claims of Jesus as recorded in Matthew 25:31–46, in which Jesus rhetorically identifies himself with “least of these” (the most vulnerable) and claims that whatever is done to them is just as equally done to him. Basil came from a wealthy family, and these sermons display his fundraising prowess. In response to Basil’s exhortations, the city’s elites shared their wealth to abate the hunger of the poor and, eventually, to fund the hospital and institutions that would care for them. Through these sermons, Basil rhetorically pushed for the transition from one social and moral order—“love for the city”—to another—“love for the poor” (Brown 2002, 5).

Gregory of Nazianzus further explored this connection between the poor and Jesus in his sermon “On the Love of the Poor.” For Gregory, love for the poor (*philoptochia*) unites the two most important commandments: love for God—who in Jesus identifies with the poor—and love for one’s neighbor as oneself. Love of the poor, therefore, displays at the highest level what love looks like in action. Gregory invited his listeners to see the poor—perhaps chronically ill, disfigured, excluded, and hidden—not only as fellow humans who deserved love and care, but even as the Divine hiding behind human eyes: “Let us visit Christ, let us heal Christ, let us feed Christ, let us clothe Christ, let us welcome Christ, let us honor

Christ . . . through the poor who are today downtrodden” (60). This vision of love for the poor as those bearing the presence of Jesus Christ, God made human, involved a reorientation towards service and hospitality: “do not walk past your brother; do not turn away from him as though he were an abomination, a blight, or anything else that one should avoid or repudiate. He is a part of you, even if he is bent down with misfortune” (70). The heart of Gregory’s moral posture is one of solidarity (“he is a part of you”) instead of pity, of proximity to suffering instead of distant control or “benevolence.”

The early Christian bishops we have discussed redefined social values (towards love, especially of the poor) and social vision (towards the poor, instead of the city). This transformed social imaginary was bound up with the growing social approval of Christianity in the fourth century, and together they enabled the creation of new institutions of care for all. The long-term effects of this transformation continue to reverberate to this day. Historical accounts of the rise of hospitals and modern medicine refer to the Basileais and this era as a critical moment of change (Crislip 2005; Ferngren 2009; Risse 1999). In addition, love of the poor and the idea of the hospital continue to be important internal criteria for judging the church itself: Pope Francis frequently drew from this moral vision when he spoke of the church aspiring to be a field hospital, close and intimate with the wounds of the world (Spadaro 2013). These institutional and personal transformations display a fundamental commitment to the wellbeing of the poor and vulnerable.

Far from the centers of power in the Roman Empire, then, we see a new vision of excellence supplanting the old. When these moves are made in the world of health care, success and excellence begin to be understood in new ways—excellent health care becomes defined by its ability to care for and dignify the poor and sick, as well as by the cultivation of institutions, practices, and virtues to pursue those commitments. In our contemporary context, what might it mean for our understanding of excellence in health care to be marked by a moral commitment to the marginalized? For a recent witness to this possibility, we turn to the work of Paul Farmer and Partners in Health.

Liberation Theology and Modern Health Care

Basil claimed that the rich ignored the plight of the poor in their community. If social elites were to experience a profound moral transformation, what might Basil have hoped to hear from them afterwards?

What state of mind would mark someone seriously considering Basil's concerns?

Imagine if someone had come up to Basil, saying:

Often if these individuals are privileged people like me, they understand that they have been implicated, whether directly or indirectly, in the creation or maintenance of this structural violence. They then feel indignation, but also humility and penitence . . . this posture—of penitence and indignation—is critical to effective social justice work.

While the phrases “structural violence” and “effective social justice work” might have been new to him—there is a real gap between his fourth-century world and our own—such concepts resonate with the moral vision offered in Basil's sermons. We can imagine that Basil might have been delighted with such a response from a listener.

The words, of course, are not from ancient Cappadocia, but come from the modern American physician Paul Farmer (2003, 140). Like Basil, Farmer insists on indignation in response to the disparities between rich and poor. Like Basil, Farmer innovated institutionally, working in a way that invited personal transformation and redefining medical excellence once again according to the criterion of the wellbeing of the poor. By attending to the witness of Farmer, we can see a modern moral response grounded within a transformed social imaginary committed to serving the sick and needy.

As a physician and anthropologist, the late Paul Farmer was committed to pursuing a “preferential option for the poor” in health care. Farmer was formed in this commitment by his Haitian coworkers and by liberation theologians like Gustavo Gutiérrez. Flowing in part from a 20th-century movement within the Catholic Church in Latin America—and eventually finding expression in other marginalized communities—liberation theology argues for a “preferential option for the poor,” that is, a form of life that takes seriously God's own special love for the poor, seeking to listen to, become friends with, and accompany the poor in a mutual pursuit of justice and liberation in explicit confrontation with the various forms of domination they face. *Option* in this formulation does not carry the sense of

“optional,” but rather, “to opt for.” God’s universal love, according to liberation theology, is necessarily preferential toward the poor, for whom the world lacks love. Liberation theology’s focus on God’s preferential love for the poor is one way to instantiate the virtue of *philoptochias*. While liberation theology’s “preferential option for the poor” includes more structural forms of analysis than we find in the fourth-century Cappadocians, both pursue institutional innovation and personal transformation to cultivate a new social imaginary committed to the wellbeing of the poor.

Farmer’s (2003) acute sensitivity to medicine and injustice in the global order led him to declare that the preferential option for the poor

offers both a challenge and an insight. It challenges doctors and other health providers to make an option—a choice—for the poor, to work on their behalf [while] the insight is, in a sense, an epidemiological one: most often, diseases themselves make a preferential option for the poor.

(140)

Farmer and Partners in Health (PIH) developed fruitful clinical programs in Haiti and elsewhere flowing out of their “O for the P,” as they colloquially referred to the preferential option for the poor. These commitments became expressed through Farmer and PIH’s moral and practical framework of “accompaniment” (Nicholson 2021; Johnson 2023; Nicholson et al 2024; Palazuelos et al 2018).

In one well-known example, two groups of rural impoverished tuberculosis patients were compared head to head, with the free-treatment group having a 50–57% cure rate and multiple deaths, as compared to the accompaniment-model group (daily clinical visits, financial support for food, donkey rental fees), which had a 100% cure rate (Farmer et al. 1991). Reflecting on this early study in a speech elaborating accompaniment as a model for policy, Farmer (2013, 236) explained, “We took to calling such complex wraparound services *accompaniment*. Community health workers were more than distributors of medicine and keepers of records; they were patients' *accompagneurs*.”

Farmer (2013, 239) then went on to consider accompaniment’s theological origins, reminding his audience of the term’s Latin origins “*ad + cum + panis*, one way of saying breaking bread together,” an activity of hospitality with both religious and everyday importance. This resonance with the practice of

sharing a meal points to how both accompaniment and hospitality are marked by relations of mutuality (Bretherton 2006; Nicholson 2021). When formed through practices of accompaniment, agents are able to pursue policy work in ways that resist a purely technocratic frame. Accompaniment and “O for the P” are both medically and spiritually integrated with one another, articulating a way of moving through the world that is characterized by refusal to simply help the poor and then return to a “safe enclosure” at a “controllable, geographical distance—instead, one is challenged to become *proximate* to those at the margins in friendship and solidarity (Goizueta 1995, 199). After articulating the theological backdrop to practices of accompaniment, Farmer immediately goes on to describe Gustavo Gutiérrez’s “preferential option for the poor” as “a guiding principle of our work,” saying,

although everyone deserves decent medical care, those living in poverty receive the lion’s share of our attention. As any epidemiologist can tell you, diseases themselves make a grim and preferential choice to strike the poor. Our life’s work would be to accompany the destitute sick on a journey away from premature suffering and death (Farmer 2013, 239).

Farmer’s life and work is impossible to understand outside of these religious commitments, despite his occasional reticence to center them in his public work and the officially nonreligious nature of PIH (Block 2018; Farmer and Gutiérrez 2013; Johnson 2023). Susan Holman (2023) suggests Farmer belongs in a particular tradition of doctor-saints—the so-called “unmercenary” (*anagyroi*, or without-silver) healers whose lives serve as another challenge to our mercenary medical age of private equity and public neglect. Basil’s power and influence in the fourth century influenced wealthy donors to give away their money to build and sustain the Basileias; similarly, Farmer engaged in what Holman (2023) calls “savvy fiscal networking,” a tongue-in-cheek way to describe the entrepreneurial combination of badgering, friendship, and invitation that funded projects and transformed donors. Farmer pursued the “preferential option for the poor” and practices of accompaniment in incredibly difficult circumstances with the help of many patients, coworkers, donors, and friends, with the work now happening in many other countries and extending beyond his death in 2022.

To better understand the resonances between the Cappadocians’ focus on *philoptochias* and

Farmer and PIH’s “preferential option for the poor” and moral framework of accompaniment, it is instructive to return to the early days of Farmer’s clinical work in rural Haiti, where the tuberculosis accompaniment trial mentioned previously would eventually be run. Here we can see more clearly how Farmer’s institutional work resonates with Basil’s creation of the first hospital. In Haiti, Farmer was connected to the village of Cange through an Episcopal priest, Fr. Fritz Lafontant. Their medical-priestly combination is reminiscent of Basil’s own formation as a bishop who had previously trained in medicine, and their shared work centered around a clinic called Clinique Bon Sauveur (“Good Savior Clinic”). The clinic grew out of creative efforts for the common good, including Lafontant’s school project and newly built church, with a sister diocese in the US partnering for construction and financial support. Several other social service institutions developed alongside it: a vocational training program in construction, a teacher dormitory, bakery, laboratory, daycare and nutrition center, guesthouse, and small food production operations, in addition to the robust clinical programs that reached out from the clinic into far-flung villages. Farmer (1992) wrote this “efflorescence of new services drew many new families to the area.” Where there had been a dusty plateau and displaced people, “The community starts to become a livable home for these water refugees, and in the village a nucleus emerges: while there has been ‘no village center or ‘square,’ . . . the school-church-clinic complex may be taking on this function” (34–36). PIH’s innovation in 20th- and 21st-century Haiti calls to mind the fourth-century Basileias. They both became hubs for new community life, with their beginnings lodged in dignified and ambitious medical care for the poor.

Echoing Jesus’s admonition in Matthew 25, Farmer, Lafontant, and countless others at PIH recognized how society overlooked the “least of these,” and their response represents an institutional commitment to a different moral order. This school-church-clinic complex—couched in networks of *accompagneurs* and supporters—nests care for the sick within the wider cultivation of communities of flourishing committed to solidarity and friendship with the poor. The work of practical solidarity and love for the poor also becomes a tool for moral analysis of the world. Here “progress” is not the criterion for making the world a better place. Care for the poor is. According to this social imaginary, medical

advances actually *increase* our moral culpability unless they are shared equitably. For Farmer, preferential love for the poor pushes even further than simple equity: “The notion of a preferential option for the poor challenges us by reframing the motto [that ‘the homeless poor are every bit as deserving of good medical care as the rest of us’]: the homeless poor are *more* deserving of good medical care than the rest of us” (155).

Farmer and PIH challenge fundamental assumptions about what truly marks excellence in modern health care via the criterion of the poor, just like Basil did centuries before. In this social imaginary, advances in health care are only fully realized as they serve the poor—the true condition of possibility for communion across boundaries, including healthy and sick, rich and poor.

Conclusion

In 2010, Mullan and colleagues published a provocative report that ranked medical schools via a “social mission” metric instead of the default *US News & World Report* ranking based on prestige, selectivity, and research funding. Without the promise of funding or the threat of enforcement, their report still managed to shape conversations about medicine’s standards of excellence by making abstract social commitments (like academic medical centers’ claims to care for community) into something concrete, allowing comparisons to be made across institutions. Since 2020, the Lown Institute has continued this kind of effort through their Hospitals Index for Social Responsibility (Saini et al. 2023). These challenges to the status quo do not deny the fruit of biomedical research. Instead, they raise important questions that are at the heart of the entire enterprise of health care and education: Who is this for? What does excellence look like? How does our commitment to health relate to our other commitments? What are we willing to sacrifice for the things we say we value? Do our stated values match our actions? Pursuing scientific excellence in health care isn’t enough; the effort to morally clarify our standards of excellence is a core task for those who care about health and suffering.

Returning to Paul Farmer’s example, he could have abdicated the ranks of academic medicine and spent his life entirely among the poor, but he instead returned often to central places of power and

prestige like Harvard's Brigham and Women's Hospital to care for patients, teach, and write. Farmer referred to the link between these seemingly disparate worlds as

“Harvard-Haiti” [which] is quite distinct from “Haiti,” . . . [for] I would not understand health disparities in Haiti if I hadn't gone to Harvard Medical School. I wouldn't understand what medical penury is and what a clinical desert is and why a clinical desert is always a bad place to be when sick or injured. (Powell 2018)

For Farmer, moving between places like Harvard and Haiti was a focusing, clarifying act. His moral vision was shaped in both places, and this movement between them helped him better grasp the depth of disparities that exist in the world, focusing and sharpening his work toward global health equity. It also caused him to find a life of solidarity to be “the good life,” despite its associated difficulties.

For Farmer—like Basil—immediately responding to those in need must be held together with the wider work of reinterpreting and reimagining the social order in light of a new conceptualization of excellence, one predicated on preferential work with and on behalf of the poor, marginalized, and minoritized of our world. Farmer and Basil also offer a lesson in how to deal with power: by using its very real benefits, truthfully critiquing its roots and violence, sharing its resources, and inviting the powerful to materially and personally participate in the transformation of the system they benefit from. PIH's main benefactor Tom White died having given all of his many millions away, and Basil's wealthy audiences opened their coffers to feed the poor and fund his new institution.

Basil and Farmer do not offer simplistic formulas for successfully “changing the world,” nor do they give easy leave to abandon success as defined within our roles in medicine. What they do witness to is an alternate social imaginary, one that transforms what we imagine good work and good lives to be. We need an imaginary that leads to both personal and institutional transformation, such that the work of loving the poor and building our common life together changes what we consider excellence to be. Just as Basil and Farmer did in their own contexts, we must discover what it might mean for us to index our notions of excellence to the poor. Like them, we may do so through practices of loving and accompanying the poor, and through submitting our actions and lives to judgment rendered in light of a preferential

option for the welfare of the poor.

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