AGENDA FOR THE STRONG AT HEART

Facing the Challenges Ahead Will Require Recommitment to our Right to Serve in a Manner Faithful to our Identity

BY FR. MICHAEL D. PLACE, STD

This article is a companion piece to my standard "Reflections" column, which appears on p. 6 of this issue of *Health Progress.* Whereas that column reflects on some aspects of our 275-year history as a healing ministry, this article engages some of the challenges we are currently encountering and will likely continue to experience over the next years. Those challenges will be considered in light of three concepts: social good, ecclesial ministry, and public actor.

SOCIAL GOOD

One of the more significant items found in the archives of the New Orleans Ursuline community is a letter from President Thomas Jefferson to Sr. Therese de St. Xavier Farjon, Superior, dated May 15, 1804. After the Louisiana Purchase the previous year, the Ursuline community had written the president; its members were concerned whether they would be able to continue their service after the treaty made New Orleans no longer part of a Catholic country. The president's reply remains one of the most significant commentaries on the role of religion in the still young country.

> I have received, holy sisters, the letter you have written me wherein you express anxiety for the property vested in your institution by the former governments of Louisiana. The principles of the constitution and government of the United States are a sure guarantee to you that it will be preserved to you sacred and inviolate, and that your institution will be permitted to govern itself according to its own voluntary rules, without interference from the civil authority. Whatever diversity or shade may appear in the religious opinions of our fellow citizens, the charitable objects of your institution cannot be indifferent to any; and its furtherance of the wholesome purposes of society by training up its younger members in the way they should go, cannot fail to ensure it the patronage of the government it is under. Be assured it will meet all the protection which my office can give it. I salute you, holy sisters, with friendship and respect.[1]

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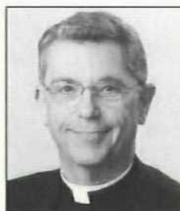

As comforting as the president's words were, even a casual student of history knows that there often has been a significant disparity between theory and practice vis-à-vis the Catholic experience. Nonetheless, over the centuries, an implicit understanding did develop about what might be called a distribution of social responsibilities within our nation. The provision of many social goods and services was left to private associations and religiously sponsored charitable services. The role of local and state government by and large was confined to what today would be considered a rather narrow definition of preserving public order. It was in this area of the charitable provision of social services that Catholic women and men religious served so many people. Although in many instances the recipients of these services were fellow Catholics, more often than not the services were explicitly requested by public or private officials as a solution to an existing social need. For example:

• In October 1861, the governor of Indiana, Oliver P. Morton, asked the Sisters of the Holy Cross to serve as nurses in Union hospitals. Within hours, a group of sisters was on its way from the sisters' home at St. Mary's Academy in Notre Dame, IN, to a military hospital in Paducah, KY. In the following months, additional groups of sisters were sent to manage hospitals in Mound City and Cairo, IL, where they served with distinction.[2]

• The Daughters of Charity of St. Vincent de Paul, whose convent is located in Emittsburg, MD, just 10 miles from Gettsyburg, PA, tended both Union and Confederate casualties of this most horrific battle. The sisters served for weeks in one of the fields, tending the wounded in tents until they could be moved.[3]

• During the New York City smallpox epidemic of 1875, people refused to go to the smallpox hospital on Blackwell's Island (now Roosevelt Island) because of conditions there. The city asked the Sisters of Charity at St. Vincent Hospital to take over the management of the smallpox hospital. Their impact was summarized in a report by the city government: "Since the change in management has been effected, the hospital has been steadily growing in popularity, and it is not at all unusual for us to be gratified with the sincere thanks of returned patients for the kindness and tender care which they received. . . ."[4]

• Mother Marianne of Molokai, a sister of St. Francis, traveled from Syracuse, NY, in 1883 to take over a hospital for lepers in Honolulu. From there she moved to Molokai Island, an isolated leper settlement, where she and her other Franciscan Sisters found 1,000 people suffering from leprosy and living in chaos and degradation. From 1889 until 1916, she turned Molokai into a model facility for addressing a public health problem that civil authorities had left primarily to voluntary efforts.[5]

Implicit in these requests and the generous responses were a cluster of assumptions about how society was to be ordered. In other words, concomitant with the American commitment to individual responsibility, there was a recognition that some situations call for collective or communal responsibility in addition to individual responsibility. At times that responsibility was best exercised by private religious/charitable entities of their own volition; at other times, by those entities at the request of or in an informal partnership with the government. In these instances, the role of government was to provide the "space" needed for these activities (e.g., exemption from taxation) or a degree of financial support.

Reflection on that precedent has given rise to some helpful categories that allow us to organize and better understand this experience. The late Cardinal Joseph Bernardin discussed them in his 1995 address to the Harvard Business School Club of Chicago, entitled "Making the Case for Not-For-Profit Healthcare." He noted that our society has come to be divided into three zones or spheres: business, government, and voluntary (not-for-profit). One of the functions or purposes of the voluntary sphere is to provide what he called "social goods": "In other words, the purpose of not-for-profit organizations is to improve the human condition, that is, to advance important non-economic, non-regulatory functions that cannot as well be served by either the business corporation or government."[6]

He went on to argue that the provision of health care is one of those social goods most appropriately provided in the voluntary sector.

> So healthcare—like the family, education, and social services—is *special.* It is fundamentally different from most other goods because it is essential to human dignity and the character of our communities. It is...[in the words of Pope John Paul II] one of those "goods which by their nature are not and cannot be mere commodities." Given this special status, the primary end or essential purpose of medical care delivery should be a cured patient, a comforted patient, and a healthier community, *not* to earn a profit or a return on capital for shareholders.[7]

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History and theory support the critically important role Catholic health care and social services have played in our country. That role, however, has been significantly complicated by several factors.

Evolution of Health Care Delivery First, there has been significant qualitative evolution in the nature of health care delivery over the course of our nearly three-century presence to it in this country. It is clear that the early experience of providing basic nursing care while an illness ran its course, or palliative care and comfort to the dying, has been complemented by the ability to intervene and alter the course of an illness or eradicate it altogether. These developments were made possible by surgical procedures that depended on anesthesia and sterile environments; the discovery of antibiotics such as penicillin; vaccines that target the source of disease or illness; tools and technology facilitated, in part, by space exploration; and advances in

Is technology an end itself or a means to a higher end: enabling human dignity?

diagnostic techniques. These previous transformations are but a prologue to a new era of change being driven by the knowledge of genetics.

So although at its heart health care is a human reality involving art and touch, it also involves science and technology. And, as such, it is increasingly an interdependent rather than an independent reality. Its very complexity requires both greater expertise and financial resources.

Group Health Insurance Second, as the nature of health care changed and became more expensive, it made sense for groups of people to share the risk of the cost of medical treatment through the mechanism of insurance. Although health insurance coverage as a widespread employment benefit could be described as an accident of history,* it was also an expression of the concept of sharing responsibility for some social needs. (In fact, history has recorded that the Benedictine Sisters were among the first to implement the creative concept of health insurance as an additional source of income. They offered to cowboys in North Dakota and lumberjacks in Minnesota a ticket costing $1 to $5 that entitled the holder to care at one of their hospitals.)[8] As helpful as insurance was in providing increased access to health care, it did begin to change the "social landscape" of health care by introducing a third party to the previous two-party system of patient and provider.

Expanding the Formal Role of Government Although government had previously been present to health care, chiefly by sponsoring public health measures and biomedical research, its role changed significantly with the introduction of Medicare and Medicaid. These two programs were another response to the fact that we recognize health care is a social good, a good so essential that the well-being of society will be compromised if the aged (Medicare), the poor (Medicaid), or the young (State Children's Health Insurance Program) are systematically denied access to it. At the same time, the introduction of state and federal government as health care actors also significantly changed the landscape.

Commodification of Health Care Not surprisingly, but somewhat ironically, even as a consensus about the social nature of health care as exemplified by the expansion of private and government-sponsored insurance grew, the focus of that delivery in the U.S. social scene began to shift. Although one could argue over the reasons for the shift (economic forces or shifting social/political philosophy, such as "Reaganomics"), the fact is that the delivery of health care has taken on a more commercial character. This is true both in the growing investor-owned sector and in the voluntary sector, which has too often responded to economic pressures by adopting practices associated with investor-owned organizations. Increasingly, though somewhat uncomfortably, health care is treated as a commodity—albeit a distinctive commodity—that can be the source of monetary gain.

As we look to the next 25 years and the 300th anniversary of Catholic health and social services in the United States, what is the significance of these forces, in particular for the health care ministry? Allow me to address them one at a time.

Growing Capacity Although our history has some rather significant examples to the contrary, the Catholic imagination is not afraid of science or technology. Both can be examples of divinely given creativity to humankind:

> So God made man like his maker. Like God did God make man; man and maid did He make them. And God blessed them and told them, "multiply and fill the earth and subdue it; you are master of the fish and birds and all the animals." (Gn 1:27-29)

In fact, high tech and "high touch" are not fundamentally incompatible. What is at issue is *setting priorities*. Is technology an end in itself or a means to a higher end: enabling human dignity? Although we do not have many equivalent models to assist us, there is no reason we cannot embrace the increasing complexity of health care as an opportunity to aggressively model the complementary contributions of faith and knowledge, art and science, touch and technology.

Outside Actors Just as challenging as the increasing complexity of health care is the presence of many third parties, such as private insurance payers, in their various forms. Their many and often inconsistent rules and cost-control efforts present a daunting challenge to both patients and health care providers. We can ask, however, whether the difficulties they bring are more symptomatic than causal. In itself there is nothing wrong with managing costs to bring about efficiency or seeking to bring outcomes and expenditures into a reasonable relationship. Indeed, a central tenet of Catholic health care values is the prudent stewardship of resources. Without cost containment, Cardinal Bernardin noted, "We cannot make health care

*In response to World War II controls on wages but not on benefits, many employers gave health insurance benefits instead of wage increases.

affordable" nor can we "avoid dangerous pressures toward the kind of rationing that raises fundamental ethical and equity questions."[9]

Is not the real problem the expectation that the system should be able to provide for *any* treatment or *any* drug available, no matter how effective or how expensive? Rather than engaging in a discussion of what we can reasonably expect to be covered by insurance, as a nation we act as if everything is available to everyone and then seek to manage this impossibility by limiting access for the person insured, by curtailing what is paid to those who provide services, or both.

Our ethical tradition has both the depth and the breadth needed to help our nation enter into a conversation about how to best resolve these tensions. As part of this national conversation and eventual shared moral consensus, Cardinal Bernardin said, "It is proper for society to establish limits on what it can reasonably provide in one area of the commonweal so that it can address other legitimate responsibilities to the community. But in establishing such limits, the inalienable life and dignity of every person, in particular the vulnerable, must be protected."[10]

Presence of Government Clearly the formal presence of state and federal government as payers and regulators of health care is a mixed blessing. Without their presence, far more than the current 40 million Americans would be marginalized from health care. Our common life as a nation would be less healthy, and the financial and psychological burdens on the elderly and the poor would be much greater. The absence, however, of a coherent public policy that ensures access to basic health care services to all, and provides adequate payments for persons covered by government insurance, leaves us and others in health care in a nearly impossible situation. We are expected to provide an essential social service in an increasingly costly environment, yet the government and some private insurers are unwilling to pay the full cost of the services we provide their beneficiaries. We who serve Catholic health care are obligated by mission, and in some cases by law, to serve those in need regardless of their ability to pay; yet society has so far been unwilling to commit itself to universal health care coverage. Consequently, our ministry finds itself compelled both by mission imperative and financial necessity to become a more assertive actor in the public sphere. The challenge is to do this in a way that is consistent with our identity and consequently differentiated from what can appear to be the narrow self-interests of special interest groups.

Commodification Of all the challenges, commodification troubles me the most. I do not believe it is an exaggeration to say that not-for-profit acute care delivery is one of the last bastions of the institutional dimension of voluntary sector health care. For example, a large percentage of long-term care facilities are investor owned, Blue Cross/Blue Shield plans are increasingly "going public," and publicly traded hospital firms such as HCA and Tenet are here to stay. But even as these forces of commodification grow, there also is disquiet heard that suggests an increasing realization that health care delivery is not the same as widget making. In the midst of what might seem to be an insurmountable momentum, perhaps our challenge is to remain steadfastly prophetic in our belief that as a social good, the promise of health care, is fundamental to human dignity. As suggested by the respected management expert Peter Drucker, not-for-profits understand this as part of their role in improving the human condition.[11] Our organizations do this by:

- Taking a leadership role in our communities
- Responding to the needs of the poor and vulnerable and urging others to do so as well
- Identifying unmet needs and working with others to meet those needs
- Advocating, both locally and nationally, just and equitable health care policies that will lead to improved health for all
- Attending to the future of health care by preparing practitioners and leading the way in clinical and health delivery research

In doing this we are being faithful to a vision of not-for-profit health care in which the service that is an essential dimension of health care delivery is both a means and our ultimate goal. This is unlike investor-owned health care, for which service is a means to its ultimate end of financial return to owners or shareholders.

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Ecclesial Ministry

Much has already been written about the challenges we face as a ministry: evolving new forms of sponsorship; ensuring necessary leadership in the areas of sponsorship, governance, and management; and sustaining and enhancing ecclesial relationships. In light of the considerations touched on so far, I would like to make note of what perhaps is an even more significant challenge: whether the ministry of healing and contemporary institutional health care delivery are compatible.

We all know that what we are about is carrying forward the mission of Jesus Christ and the church. It is in response to that mission that we are constituted as a ministry of the church.

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Mission and ministry are the *what* and *why* of who we are. There is an essential element to what we are about that transcends time and ultimately is eschatological in nature: witnessing to the radical healing that is found in the coming of the kingdom. The *how* of that ministry is the contemporary modality of institutional health care delivery along the continuum of care as experienced in our country. In a sense, these current modalities become the form of mission/ministry or, to put it differently, the outward sign used to communicate/mediate the inner mystery of Christ's healing presence. The question we face is whether it is possible that the forces I described earlier could converge in a "perfect storm" scenario, with the result that contemporary institutional health care delivery would not be an apt sign or an appropriate "how" for carrying on the what/why of mission/ministry. Although I personally believe the storm has yet to occur, humility requires that we not ignore the possibility. Our current efforts at defining our identity and benchmarking our commitments will provide us with helpful reference points for what should be a process of continuous reflection. Unlike some who have already concluded that a radical incompatibility already exists, I believe that by embracing the question with candor and creativity, we can ensure the continuing presence of an institutional expression of the healing ministry.

Public Actor

In the first part of this article, I reflected on our role as the provider of social goods. I noted that from the earliest times (the Ursuline Sisters came at the request of the French governor of Louisiana), while providing these services in what has come to be known as the voluntary sector, we have been in a variety of relationships with local, state, and federal government. While serving our own, we have also participated with others in addressing critical social needs, often partnering with the public sector in formal and informal ways. Contrary to the positions of some contemporary adversaries, this partnership involved at least an implicit accommodation in that the terms of the partnership honored our right to serve in a manner faithful to our identity.

Two realities have called that historic partnership into question. First, as noted above, the terms of the partnership have changed, with the public sector becoming a significant source of health care financing (Medicare/Medicaid) and not just a somewhat distant partner. Although we are only reimbursed (and at times, inadequately) for services rendered, clearly we are in a new relationship when 40 to 60 percent of a hospital's or long-term care facility's revenues come from government sources. Second, because of Roe *v.* Wade, our national public policy has placed into the arena of health-related services access to abortion services. In other words, within the sphere of the social good of access to health care, an activity we consider inimical to the common good—the taking of the innocent life of the unborn—now exists as a so-called right. The convergence of these two realties has not unexpectedly resulted in a call by those who advocate this so-called right that all who receive government reimbursement provide access to abortion and other "reproductive services."

If this view were to prevail, it would call into question our historical relationship within our nation's social compact in which we have been able to contribute to the fulfillment of social goods on which there is broad agreement while remaining true to our core values. I believe that such an eventuality can be avoided, but it will require an honest dialogue in the context of the fundamental principles of the American experiment that recognizes the centrality of accommodation and mutual respect to the success of our society. In the long run, our ability to heal the tear in the social fabric that has resulted from Roe *v.* Wade may be critical to the continuing our healing mission through the institutional forms we know today. Consequently, we must recommit ourselves to working for a consistent ethic of life that is grounded in the inviolable dignity of human life from conception to natural death as both a moral imperative for our country and an ethical vision that sustains our very identity. Even if in the short term Roe *v.* Wade is not overturned, we must effectively defeat the pro-choice campaign to eliminate Catholic health care and other social services as a partner in the provision of health care. To avoid this confrontation is to guarantee our opponents success and deprive countless communities of the compassionate care that is unique to our ministry.

As we celebrate the richness of a history whose origin and destiny is the Lord Jesus, the Alpha and the Omega, we have many opportunities facing us:

- Navigating the growing complexity of health care as an art and a science
- Serving as an active partner in public discourse about the proper allocation of health care resources across the continuum of care and the adoption of coherent national policy that guarantees access to all and just payment for all providers

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• Witnessing to the distinctive character of health care as a social good

• Confronting honestly the tensions arising from being an institutional ministry in today's health care environment

• Preserving our very freedom to serve

I am optimistic that those who gather to celebrate our 300th anniversary in 2027 will be able to recount the stories of how, with God's grace, we turned these opportunities into successes just as those who came before us shaped and sustained not only their destiny, but ours and that of those who will follow us. □

NOTES

1. Letter from Thomas Jefferson to Sr. Marie Therese Farjon of St. Xavier, May 15, 1804, courtesy The Ursulines of New Orleans.
2. Suzy Farren, *A Call to Care: The Women Who Built Catholic Healthcare in America*, The Catholic Health Association of the United States, St. Louis, 1996, p. 9.
3. Farren, pp. 16-19.
4. Farren, p. 23.
5. Farren, pp. 97-103.
6. Joseph Cardinal Bernardin, "Making the Case for Not-for-Profit Healthcare," in *Celebrating the Ministry of Healing: Joseph Cardinal Bernardin's Reflections of Healthcare*, The Catholic Health Association of the United States, St. Louis, 1999, p. 89.
7. Bernardin, "Making the Case for Not-for-Profit Healthcare," pp. 87-88.
8. Bernardin, "Making the Case for Not-for-Profit Healthcare," pp. 139-140.
9. Joseph Cardinal Bernardin, "The Consistent Ethic of Life and Healthcare Reform," in *Celebrating the Ministry of Healing: Joseph Cardinal Bernardin's Reflections of Healthcare*, The Catholic Health Association of the United States, St. Louis, 1999, p. 78.
10. Bernardin, "The Consistent Ethic of Life and Healthcare Reform," p. 79.
11. Peter F. Drucker, *Managing the Non-Profit Organization: Practices and Principles*, Harper Collins, New York City, 1990, p. xiv.

CHRISTIANS AND THE GENOME PROJECT

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medicine—in which "death shall be no more, neither shall there be mourning, nor crying, nor pain anymore" (Rv 21:4).

Meanwhile, physicians, nurses, and researchers can continue their work unburdened by messianic expectations, in carefree response to God's grace and in confident hope of God's future. The Bible offers no ethical code for the practice of genetic medicine. It does offer wisdom, but this wisdom will require discernment. As Christians oriented by Scripture—rather than by the Baconian and other "projects" I have described here—we must exercise discernment concerning the human genome. □

NOTES

1. Walter Gilbert, "A Vision of the Grail," in Daniel Kevles and Leroy Hood, eds., *The Code of Codes*, Harvard University Press, Cambridge, MA, 1992, p. 96.
2. Gilbert is quoted in Jean Bethke Elshtain, *Who Are We?* Eerdmans, Grand Rapids, MI, 2000, p. 90.
3. Matt Ridley, *Genome*, HarperCollins, New York City, 1999, p. 145.
4. See Ted Peters, *Playing God? Genetic Determinism and Human Freedom*, Routledge, New York City, 1997, p. xiii.
5. Thomas Aquinas, *Commentary on Aristotle's "On the Soul,"* 1.3, cited in Hans Jonas, *The Phenomenon of Life: Toward a Philosophical Biology*, Dell, New York City, 1966, p. 188.
6. Francis Bacon, *The New Organon and Related Writings*, Bobbs-Merrill Co., Indianapolis, 1960, p. 8.
7. See Gerald McKenney, *To Relieve the Human Condition: Bioethics, Technology and the Body*, State University of New York Press, Albany, NY, 1997, p. 122.
8. Bacon, p. 15.
9. Jonas, p. 195.
10. Bacon, pp. 19, 29.
11. Mark J. Hanson, "Indulging Anxiety: Human Enhancement from a Protestant Perspective," *Christian Bioethics*, August 1999, p. 125.
12. See the treatment of "the liberal convention" in Hans Reinders, *The Future of the Disabled in Liberal Society: An Ethical Analysis*, University of Notre Dame Press, Notre Dame, IN, 2000, pp. 22-35.
13. Reinders, p. 65. See also pp. 77-78.
14. See Oliver O'Donovan, *Begotten or Made?* Oxford University Press, Oxford, England, 1984.
15. On the relation of parents to children, see Sondra Wheeler, "Contingency, Tragedy, and the Virtues of Parenting," in Ronald Cole-Turner, ed., *Beyond Cloning*, Trinity Press International, Harrisburg, PA, 2001, pp. 111-123.
16. See Julie Clague, "Genetic Knowledge as a Commodity: The Human Genome Project, Markets and Consumers," in Maureen Junker-Kenny and Lisa Sowle Cahill, eds., *The Ethics of Genetic Engineering*, SCM Press, London, 1998, pp. 3-12.
17. Robert Mullan Cook-Deegan, "Genome Mapping and Sequencing," in Warren Reich, ed., *Encyclopedia of Bioethics*, rev. ed., Macmillan, New York City, 1995, pp. 1,014-1,015. See also Karen Lebacqz, "Fair Shares: Is the Genome Project Just?" in Ted Peters, ed., *Genetics: Issues of Social Justice*, Pilgrim Press, Cleveland, 1998, pp. 82-107.
18. See Stephen Sherry, "The Incentive of Patents," in John F. Kilner, Rebecca D. Pentz, and Frank E. Young, eds., *Genetic Ethics*, Eerdmans, Grand Rapids, MI, 1997, pp. 113-123.
19. Francis Collins, "The Human Genome Project," in Kilner, Pentz, and Young, eds., *Genetic Ethics*, pp. 95.
20. See, for example, Francis Collins, "Medical and Societal Consequences of the Human Genome Project," *New England Journal of Medicine*, July 1, 1999, pp. 28: "Scientists wanted to map the human genetic terrain, knowing it would lead them to previously unimaginable insights, and from there to the common good."
21. This topic is much discussed, of course. Some see humans as "stewards," conserving and preserving God's Creation, while others see them as "cocreators," free to correct or "redeem" nature. See the discussion in James J. Walter, "Theological Issues in Genetics," *Theological Studies*, March 1999. Frankly, I do not think much is at stake in the name we give our vocation, as long as we set it in the context of the biblical story.
22. This point was made powerfully a quarter century ago by Bernard Haring in his *Ethics of Manipulation*, Seabury Press, New York City, 1975.
23. Haring, p. 50, suggested this as well.
24. See Mark J. Hanson, "Indulging Anxiety: Human Enhancement from a Protestant Perspective," *Christian Bioethics*, vol. 5, no. 2, pp. 121-138.
25. See the very celebratory survey of some genetic applications in Kenneth W. Culver, "A Christian Physician at the Crossroads of New Genetic Technologies and the Needs of Patients," in Cole-Turner, ed., *Beyond Cloning*, pp. 14-33.