

Bishop Urges Dialogue For Stronger Church

By BISHOP GERALD F. KICANAS, D.D.

Editor's Note: Bishop Gerald F. Kicanas of Tucson, Ariz., delivered a keynote address at a joint meeting of CHA's System Mission Leadership Forum and Sponsorship Institute, held Jan. 18-19, 2012, in Albuquerque, N.M. The full text of his address appears below.

On May 7, 1870, seven Sisters of St. Joseph of Carondelet set out from San Diego by covered wagon. With their driver, they were on their way to Tucson, more than 300 miles away. Srs. Emerentia, Ambrosia, Euphrasia, Monica, Hyacinth, Maximus and Martha, putting their trust in St. Joseph, braved what Sr. Maximus called the "Abomination of Desolation" — barren desert, steep mountain trails, howling wolves, the threat of attack — and even lonely cowboys!

Listen to what Sr. Monica wrote in her diary:

We sang all the time, and imagined St. Joseph in our company, protecting us, as he did the Infant Jesus and his Blessed Mother, through the Egyptian desert; thus we felt no fear. At midnight we reached a ranch. We would not have refused some refreshment, but for us there was none. We lay down in the corner of the stable and rested until 4 o'clock a.m.

We resumed our journey until 9:30 a.m., when we came to a ranch. The proprietor showed us great kindness; we were at once accommodated with water to wash, refreshment we sorely needed, as we had not washed since we left San Diego. You may imagine our condition after our weary trip. One of the Sisters wore low shoes, her feet and ankles were very painful; and it was with difficulty that she removed her stockings, as they stuck to the flesh with the blood which had congealed there. After getting them off, she found 22 bleeding sores, produced by the cactus plant, with which the desert abounds. She advises all the Sisters coming to Arizona, to be sure to protect themselves with very high boots, in order

to avoid the like disaster. At 6 o'clock p.m., we resumed our journey, and traveled until 3 o'clock next morning.

Along the way, the sisters found themselves having to reject invitations from cowboys to become their wives. Life-threatening danger, including a flash flood in which they nearly drowned, seemed to lurk at every turn. Despite the terror and fatigue of their journey, the sisters remained cheerful and full of courage.

When they neared Tucson, four priests on horseback came to meet them. The fathers dismounted from their steeds and ran to greet the sisters. Accompanied by the priests, the sisters approached the city at night. It seemed every soul in Tucson — some 3,000 people — awaited them, some discharging firearms and others carrying lighted torches. Balls of combustible matter were thrown to light the way. Sr. Euphrasia made the sign of the cross at each explosion. The residents were so delighted to welcome them. Bells in the city rang wildly and Bishop Jean Baptiste Salpointe stood by the door of their newly prepared convent, grateful that they had arrived safely.

The seven sisters had been recruited by Bishop Salpointe to start a school in Tucson, but not long after their arrival, he asked them to take on the



Bishop Gerald F. Kicanas (at right) chats with Daniel O'Brien, vice president of ethics and church relations, Ascension Health, at CHA's January, 2012, meeting in Albuquerque, N.M.

responsibility for a crucial ministry. The Southern Pacific Railroad was laying tracks through Southern Arizona. It was dangerous, sometimes deadly, work. Railroad executives prevailed upon the bishop and the Catholic Church to start a hospital where injured workers could be treated. The sisters set up a simple, 12-bed structure to begin their hospital. St. Mary's Hospital still serves in the name of Christ today in our Tucson community.

The history of Catholic hospitals in our nation reflects many such profiles of courage. This history is the story of religious communities braving personal hardship and great sacrifice to engage in a mission of helping and healing. We ought never to forget from whence we have come.

That history still enlivens and encourages us today. Sr. Carol Keehan, DC, president and chief executive officer of the Catholic Health Association, through her visionary leadership, calls and challenges you — the Catholic hospital sponsors, executives and mission leaders in Catholic health care — to preserve and augment the rich legacy of Catholic health care that we have inherited. Yours is a noble calling, a vocation in which the church takes pride.

This bishop holds the highest regard for you and all you do to carry on the healing ministry of Jesus Christ, the ministry so central to His mission among us. You bring Christ's presence into a world of pain and suffering. It is a privilege and honor for me to reflect with you today on how Catholic hospitals and bishops can more inten-

sively collaborate in the work of the Good Samaritan. Our Holy Father, Pope Benedict XVI, holds the Good Samaritan up to us as the exemplar of one who has a heart that sees where love is needed and, when he sees where love is needed, responds.

I have been blessed to witness the heart that sees where love is needed — the heart of your Catholic Health Association. As chair of the board of directors of Catholic Relief Services, I am grateful for your generous support and commitment to rebuild St. Francis Hospital in Port-au-Prince, Haiti, that was obliterated by the devastating earthquake of 2010. Amid the rubble a new hospital is taking form today, thanks to your generosity and your conviction that we are all one family in Christ.

My hope is that these days of your gathering will provide an occasion for effective dialogue and fruitful collaboration as sponsors, mission leaders and bishops in which we come to see one another as people of good will who are motivated to do good in the name of Jesus Christ.

In my presentation today, I first will reflect on the core qualities of Catholic health care that define who you are: Catholic identity; fidelity to the founding charisms of your institution; regard for human life; ethical integrity; care for the poor; commitment to the littlest and weakest among us; compassion; and a deep desire to serve.

I then will share some thoughts about the indispensable value and absolute necessity today of dialogue between Catholic health care leaders

themselves and certainly with bishops as well. That dialogue should be characterized not by distrust, competitiveness and uncivil discourse, but by honesty, speaking the truth with love and the recognition of others' competencies.

This is the dialogue that will lead to common, united, collaborative efforts as bishops and Catholic health care professionals to uphold the right of conscience and religious liberty under challenge in our day. It matters much today that we commit ourselves to work together, to pull together, to pull in the same direction.

BISHOP GERALD F. KICANAS, D.D. **Tucson, Ariz.**

Bishop Gerald F. Kicanas, D.D., was installed on March 7, 2003, as bishop of Tucson, Ariz., after serving as coadjutor of the Tucson diocese for a year and a half and, before that, as auxiliary bishop of the Archdiocese of Chicago.

He is chair of the board of directors of Catholic Relief Services and former vice president of the United States Conference of Catholic Bishops. He serves on numerous USCCB committees, including the administrative committee, the budget and finance committee and the communications committee, as well as the subcommittee on Africa.

Over the years, Bishop Kicanas has directed the Catholic chaplaincy program of the Cook County, Ill., juvenile temporary detention center in Chicago and worked as a caseworker for Catholic Charities. He also has worked in personnel and human resources development, leadership and human growth and conflict management as a trainer, facilitator and lecturer.

A native of Chicago, he is a former rector of Mundelein Seminary at the University of St. Mary of the Lake, Mundelein, Ill. He has also served as a lecturer in community and organizational development and in clinical psychology at Loyola University, Chicago.

He earned a doctoral degree in educational psychology and a master of education degree in guidance and counseling from Loyola University. He holds a licentiate in sacred theology from St. Mary of the Lake Seminary.

Bishop Kicanas was the recipient in 2008 of the Cardinal Joseph Bernardin Award and has been awarded two honorary doctorates: an honorary doctorate in humanities from Lewis University (2010) and an honorary doctor of laws degree from the University of Notre Dame (2011).

CORE INGREDIENTS OF CATHOLIC HEALTH CARE

CATHOLIC IDENTITY

All that you are and all that you do should flow from your faith. Your work reflects your discipleship, imitating Jesus Christ. You bring his presence into the world. You witness and stand for God's abundant, unconditional love for those suffering. Catholic is not only a word in your hospital's name and on your business cards; it is who you are and what you strive to be.

Today, some question the Catholic identity of our colleges and universities, of our hospitals and of our charitable institutions. I think this questioning is often misplaced and unfair. Most often, I sense a deep pride among you for being Catholic. You value being Catholic. Faith imbues all you do.

I have seen in Tucson a real effort by our hospital boards and administrators and mission leaders to keep Catholic at the center of what is done, even when criticized or rejected for being Catholic.

For example a cooperative agreement between Carondelet/Ascension Health and a community hospital in our diocese was challenged recently by Merger Watch and other groups, and even some doctors, because they believed that the Catholic affiliation would reduce the range of procedures the community hospital had been offering. Some outrageous misstatements of Catholic teaching were spread by the Hemlock Society and other groups. Carondelet stood firm, insisting that the *Ethical and Religious Directives* based on our Catholic faith be respected. The board of directors of the community hospital reluctantly and regretfully withdrew from the agreement.

We have seen in Louisville, Ky., the rejection by Gov. Steve Beshear of including the University of Louisville Hospital in the merger of three hospital systems. While many reasons were given, clearly one roadblock was the potential influence of Catholic teaching on University Hospital, particularly regarding procedures that are euphemistically called "reproductive health care." The Catholic hospitals and the archbishop were in close dialogue about proceeding with the merger without compromising the church's moral and ethical positions.

I believe that in both instances when the merger was rejected that opportunities for improved health care for the community were lost.

"Fight and flight" is a sad reality for Catholic health care these days in our country. We fight the

good fight, opposing abortion, contraception and immoral uses of biotechnology. But in the face of intractable government action and misleading advocacy by special-interest groups, we are forced into flight, into leaving the ministry of care. This is a tragic loss.

Today, the original sponsors of Catholic hospitals are few in number. Laity more and more are the leadership of our Catholic hospitals. This is a great blessing. But this means that if we are to maintain a strong Catholic identity and to be faithful to the founding charism of the ministry, the new leadership, indeed, all in the institution need to learn, be taught and be immersed in the charism of the founding religious community and of the church's teaching. This begins with hiring interviews that highlight the Catholic ethos of the institution and continues with regular guidance and dialogue with personnel on what it means to be Catholic.

Strong Catholic identity means choosing mission leaders who are respected and well-regarded and who can shape the organization so that faith is the foundation of all that happens in the organization. These mission leaders need to be well grounded in the church's doctrine and steeped in her moral teaching.

Being Catholic means that the pastoral care department will not be just an afterthought, but that its mission and service permeate the institution and are a vehicle for the core value of the institution. Under financial pressure, Catholic hospitals do not dismantle pastoral care, for it is at the heart of what we do for those suffering.

REGARD FOR HUMAN LIFE

Your responsibility as Catholic health care leaders is to energize and infuse your institutions with a commitment to preserve, protect and foster human life as God's precious gift. Our institutions stand for the dignity of life. When someone enters our doors, they ought to know — from the receptionist who greets them at the entrance to the aide pushing a patient cart to the attending doctor to the staff person in the cashier booth — that they are respected and valued, viewed as children of God. They should experience that this institution and all who are part of it are centered on promoting and restoring the wholeness of life. This is a place where Christ's compassion for the man born blind, the paralytic, the woman with hemorrhage, still lives and where the suffering are cared for.

Characteristic of Christ's ministry was that the blind regain sight, the lame walk, lepers are cleansed, the deaf hear, the dead are raised and the poor have the Good News proclaimed to them. Healing sickness of all forms is of the essence of his ministry and that of his church.

ETHICAL INTEGRITY

You do what you do with ethical integrity. We embrace and hold to a Catholic moral vision that Cardinal Joseph Bernardin referred to as "a con-

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sistent ethic of life." Our embrace and hold on this vision is more necessary than ever in a culture that involves multiple threats to the sacredness of life. The church is not a political party, nor should it be co-opted by partisan politics. The church teaches from a moral perspective flowing from what it means to be human, created in the image of God. The church upholds the dignity of all human life from conception to natural death.

You embrace the *Ethical and Religious Directives* not as begrudged restrictions or roadblocks, but as foundational statements of the values that hold up what we believe, what we respect, what is ethically permissible. These directives lay out what anyone coming to our institutions can expect from us and what they cannot demand. These directives are about the values to be promoted in our Catholic institutions of healing, values that reflect insights regarding the human person that flow from what it means to be human.

Medicine today has seen revolutionary breakthroughs from genetics and reproduction to the technologies to prolong life. It seems we are able to do almost anything technologically in manipulating and managing life. Our advocacy for the sanctity and dignity of human life means that we are compelled to question not only what we *can* do, but what morally and ethically we *should* do.

CARE FOR THE POOR

From the founding of Catholic hospitals, your institutions have been known to be available to the poor. Cardinal Bernardin says of Catholic hospitals, "Social justice and health care cannot be

separated. [Being Catholic]... is not just having a cross in the room or a chaplain in the halls. One of the earmarks of Catholic health care has been the care of the sick poor.”

You have long advocated courageously for universal access for health care for all as a basic human right that is grounded in the sanctity of human life. You have spoken up for the unborn, for the undocumented, who some feel today ought to have no rights, as if they are less than human. You care deeply for the uninsured and underinsured. Fostering the community’s betterment is at the core of your mission. That is your real bottom line.

In [Cardinal Bernardin’s] “Spanning the Barriers: Catholic Health Care in a World of Need,” you are reminded that you ask a different set of questions from “What is the bottom line?” You ask,

It is the responsibility of bishops to teach, but how a bishop teaches makes all the difference. Open and honest dialogue can resolve differences and confusions and make it possible for the Gospel to be proclaimed and embraced.

“What is best for the person served? What is best for the community? How can the organization ensure a prudent use of resources for the whole?”

Given the limits of our resources and the government encroachment on our freedom of conscience, might we need to consider developing alternative health care strategies rather than attempting to offer care for all? For example, we might reach out with spiritual and pastoral care in all health care situations and institutions but provide material care to particular groups such as immigrants, those unable to obtain health care by other means, the homeless, those who are victims of abuse and of pandemics such as HIV. We would not be managers and greatly dependent on insurance and government monies, but, rather, using our limited resources for these specific, often neglected populations.

COMPASSION

Let me tell you about a man. He’s tall, towering and tender. He has a terrific smile and a loud

laugh. If he were here in Albuquerque, you could hear him laugh all the way to Tucson. His name is Jean Vanier, founder of the L’Arche communities worldwide. To me, Vanier epitomizes what Catholic health care looks like.

Several years ago, Vanier gave a Faith and Sharing retreat at Mundelein, Ill., where I was serving. He had originally been asked by a bishop in Canada to give a priest retreat for that bishop’s diocese. Vanier said, “No,” but indicated that if the bishop invited to the retreat his priests, religious and laity, those with disabilities and those not, he would do the retreat. The bishop agreed, and the first Faith and Sharing retreat was held.

At the Mundelein retreat, Carol was there, 32 years of age, cerebral palsied since birth. She sat in a wheel chair, thin as a rail, her head back, her

tongue hanging out, uttering unintelligible sounds. I thought that most of us who saw her felt as I did. I felt sorry for Carol. When Vanier came over to her, he did not say a word. Carol saw him and smiled and laughed and shook all over. She knew that to him she was not just a handicapped girl to be pitied, but a beloved daughter of God, precious in God’s eyes.

Vanier exudes compassion. He is remarkable in his attentiveness and care for those not always valued. He is Catholic to the core. Who he is and

what he does stem from his faith in Jesus Christ. His faith moves him into action and underlies the love he has for others. These are qualities that are defining characteristics of what we should be about in Catholic health care. Aware of our mission, knowing what we stand for, aware of our calling, we can then enter into dialogue.

THE INDISPENSABLE VALUE OF DIALOGUE

CHRIST IN DIALOGUE

Let us look first at Christ, our exemplar, as he engaged in dialogue, especially in some powerful instances in John’s Gospel. The Lord engaged Nicodemus and the Samaritan woman. One encounter took place at night, the other at noon. Nicodemus was learned, probably one of the Sanhedrin; the Samaritan woman, an ordinary woman with her share of problems. Nicodemus came to Jesus, but it was Jesus who came to the Samaritan woman.

It took a lot for Nicodemus the Pharisee to seek out Jesus, but he risked talking to Jesus and calling him a teacher at least on par with himself.

It was amazing, considering the culture of that time, that Jesus, a Jew, opened a conversation with a Samaritan woman, an enemy who was ritually unclean, and asked her for a drink. She had something to give, as did he.

Dialogue in these instances took place respectfully, with mutuality and at some risk.

The dialogue proceeded slowly, marked by misunderstanding that was only gradually clarified. The dialogue was a learning moment, a moment of conversion and change. Nicodemus and the Samaritan woman left the dialogue changed. They felt listened to, challenged and taught not by a one-way announcement but by discourse. The Lord would talk to anyone in search of truth.

Sometimes, I think we bishops can be content to simply state a position and expect others to embrace it. But Jesus invited his dialogue partners to see and embrace his teaching. He dealt with their misunderstandings and facilitated a real reception of his teaching. It is the responsibility of bishops to teach, but how a bishop teaches makes all the difference. Open and honest dialogue can resolve differences and confusions and make it possible for the Gospel to be proclaimed and embraced. Fidelity to the faith and acceptance of the truths of faith happens less today by sheer obedience than through dialogue that leads to understanding and personal conviction. Such understanding and conviction happen through engagement resulting from serious, respectful conversation.

After a day of dialogue with bishops and political leaders, Archbishop Timothy Dolan [of New York] indicated that “these political leaders asked that bishops be not only firm, clear and prophetic in our divine role as teachers but also to enlighten them, challenge them and engage them, rather than threaten them.” This was characteristic of Christ’s dialogues.

PAPAL TEACHING

Blessed John Paul II reflected on ecumenical and interfaith dialogue in his pastoral letter, *Ut Unum Sint*. In Note 31, he says that dialogue has become an outright necessity, one of the church’s priori-

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ties. If this is true for ecumenical and interfaith efforts, could it be any less important within the church itself? John Paul felt a deep concern, an urgent longing for Christian unity. In Note 2, he said, “We cannot remain divided. We must do all that we can to break down the walls of division and distrust, to overcome obstacles and prejudices which thwart the proclamation of the Gospel of salvation.” This happens, John Paul asserted, when we recognize the other as a partner. Reciprocity is required. Each side presupposes in the other a desire for reconciliation, for unity in truth.

Dialogue was to be a natural instrument for comparing differing points of view and examining those disagreements. That demands patience and courageous efforts, he reminded us.

Pope Benedict, in a May 2010 address in Belem, Lisbon, Portugal, said “The church must enter into dialogue with the world in which she lives. The church becomes word, she becomes message, she becomes dialogue (*Ecclesiam Suam*, n. 67). Dialogue without ambiguity and marked by respect for those taking part is a priority in the world and the church does not intend to withdraw from it.” Benedict looks toward tradition not as a static reality but a dynamic heritage. He mentioned that the Second Vatican Council was convened “to place the modern world in contact with the life-giving and perennial energies of the Gospel (Pope John XXIII, *Apostolic Constitution, Humanae Salutis*, 3). The Church considers her most important mission in today’s culture is to keep alive the search for truth.”

All of this must be characteristic in our dialogue within the church.

STRUCTURES FOR FAITHFUL DIALOGUE

In today’s culture, opportunities for dialogue

are often marginalized by polarization. Television and radio talk shows include the expectation that those participating will shout one another down. Some TV shows even encouraged people to go after one another physically. We need to turn down the decibel level of our disputes in society and in the church. Yet, it seems positions are hardening. People only read material or go to lectures or seek out websites that support their understanding. There is a lack of bridges within the church and among those who need to be in dialogue. Rather than taking the risk that Nicodemus, the Samaritan woman and Christ himself took, we resort to labeling one another as restorationists, conservatives or progressives.

Deborah Tannen in *The Argument Culture: Stopping America's War of Words*, (New York; Ballantine Books, 1999) describes our polarized and polarizing environment as “the argument cul-

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ture.” Argument “sells,” and so it has become our culture’s preferred way of engaging in public discourse. Such discourse limits creativity in dealing with issues because it limits issues to two sides, imposing two sides on all issues.

I believe that differences can be resolved and bonds strengthened by open and honest dialogue. Such dialogue, grounded on the Gospel, is critical between bishops and theologians, bishops and administrators of colleges and universities, bishops and the media and, of course, bishops and those in Catholic health care. We need to create structures by which this can happen. Too often today we stay in our own groups, talking to our own, but not to one another. Or we only engage one another in moments of crisis when it is hardest to dialogue.

By not being in dialogue, we can attribute the worst of intentions or motivations to the other.

By not being in dialogue, we lack relationships of trust, especially critical in times of conflict.

There will be conflict among us. Conflict is inevitable, but conflict can be effectively managed within a strong relationship built on trust. By being in dialogue, we can enrich one another. We need to talk to one another often and at length, especially about our differing perspectives and viewpoints.

The notion of “group think” proposed by Irving Janis in his book *Groupthink: Psychological Studies of Policy Decisions and Fiascoes*, (Boston: Cengage Learning, 1982) suggests that without a counter voice, a devil’s advocate, poor conclusions and decisions are more likely to result.

Sometimes today, it can appear that any attempt to engage a bishop about his way of thinking or his exercise of authority is interpreted as being disloyal. This is unfortunate in that on the way to a decision, a bishop needs to hear many voices. For sure, bishops are called to be authoritative teachers in the church, responsible for sound theological teaching. The bishops in union with the Holy Father assure that we stay faithful to what we have received from Jesus Christ. Clearly, the bishop has the right to speak for the church and to claim that such teaching is binding. Yet, the bishop must also be a listener, hearing the voice of the people in the practice of his ministry as shepherd of the local church. In this he models for his priests the importance of both teaching and listening.

There is a need to be deliberate and clear when proposing dialogue in the church. Consensus is not what defines church teaching. Searching for the common denominator is not the way to arrive at the full truth. The teaching authority of the bishop can be ignored or become compromised.

While this was not what Cardinal Bernardin intended in his 1996 statement, “Called to be Catholic: Church in a Time of Peril,” these concerns made some people hesitant about embracing the call for dialogue in order to confront the growing polarization in the church. That was unfortunate. Dialogue among the bishops with Cardinal Bernardin at the time the common ground initiative was proposed might have clarified any misunderstandings or misinterpretations, allowing the initiative to address the divisions within the very household of faith that are deep concerns and that still exist today.

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When he served as President of the U.S. Conference of Catholic Bishops, Cardinal Francis George, OMI, called for the formation of three task forces, each charged with considering the role of governance by the bishops in relationship to Catholic theologians, Catholic college and university presidents and Catholic media practitioners. One could certainly add Catholic health care professionals to the list.

The cardinal's concern was that those in the three groups have a significant role related to the church's mission, yet they do not always seem in sync with the teachings of the magisterium. How do bishops govern amid differing positions and viewpoints?

The task forces made an initial report, identifying concerns, but as yet no conclusions or directions have come forth.

Key to resolving the governance concerns is providing recurring occasions and regular structures where respectful, open and honest dialogue can take place. The characteristics of such dialogue between bishops and these groups of competent professionals would be respect for those participating, a willingness to listen and a readiness to learn.

I would suggest that of first importance would be opening lines of communication between the local bishop and the health care leaders in his diocese so as to build up trust. This ongoing, recurring dialogue can build bridges between partners that have a common concern that our Catholic institutions remain "Catholic."

Likewise it is incumbent that our bishops' conference, through its committees, organize ongoing, structured dialogues with theologians, university and college presidents, members of the

media and health care administrators and mission leaders. Those with differing viewpoints should be invited, not excluded. We can learn by hearing positions that we do not hold, positions that are counter to what we are saying.

In these ongoing dialogues, many neuralgic issues could be discussed in depth: the role of the bishop as one responsible to teach, to sanctify and to govern; how to draw upon the competence of those entrusted with a key portion of the church's mission; how we might value and appreciate the differing roles and responsibilities each group holds.

Such fruitful dialogues are already taking place. For example, within the conference of bishops, an *ad hoc* committee on health care issues was formed that still exists today. There were meetings and discussions between bishops, sponsors of Catholic hospitals, the Catholic Health Association and Catholic Charities. They collaboratively wrote *The Pastoral Role of the Diocesan Bishop in Catholic Health Care Ministry*.

In preparing for the writing of the bishops' document on lay ecclesial ministry, *Co-Workers in the Vineyard*, several gatherings between bishops and theologians took place. They were lively, engaging conversations that sought to identify and clarify a theology of lay ministry. As Cardinal

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Francis George said, "If we get the theology right, the rest of the document will flow."

Both bishops and theologians grew from their interaction. A deliberate decision was made to invite bishops and theologians who might view the questions and issues differently. That diversity was immensely helpful in formulating the theology of lay ministry that was the foundation of the document.

But such dialogues, as good and important as they are, happen far too infrequently and in an *ad hoc* manner, oftentimes with only a small group of representatives.

Developing these regular structures for dialogue would be an impetus for greater collaboration.

COLLABORATION BETWEEN BISHOPS AND CATHOLIC HEALTH CARE PROFESSIONALS

You are learning the importance of collaboration and partnerships in carrying on your mission. Today, Catholic hospitals realize that competitiveness weakens, while cooperation strengthens. I remember being in the Archdiocese of Chicago when efforts were made to bring Catholic hospitals in the Archdiocese together for conversation on how they might cooperate. It was like pulling teeth. Turf and self-interest mattered, even though such battles lead nowhere. It was like having to endure a symphony of solos.

Resistance to cooperation and collaboration is changing today partly because of financial reasons or for efficiency purposes, and simply because it makes more sense. Yet parochialism is still far too rampant today in the church, locally, regionally, nationally and even internationally. This is happening at a time when many in business realize the power and strength of collaboration. A lesson we still need to learn.

Creating connections, forming networks, building bridges are ways to get things done today.

My final encouragement is that we as bishops and you as health care professionals team up, work together collaboratively. We have a shared purpose. The challenges facing Catholic health care and the church are daunting, especially in a culture that does not share our Catholic values, values rooted in what it means to be human.

Specifically, today the church and health care face challenges to religious freedom and the right of conscience. Governmental regulations can place expectations on us that go against our conscience as Catholics. Government agencies' insistence that a health care institution receiving government funds must provide a full range of so-called "reproductive services" makes demands on us to which we cannot comply.

Advocacy on behalf of religious liberty is enhanced when all in the church stand together — the bishops' conference, the Catholic Health Association, Catholic Charities, Catholic Relief Services and other Catholic organizations, including our parishes. This has begun to happen in the recent efforts to respond to the Health and Human Services requirement to include contraceptive coverage in our Catholic institutions. We spoke together. We wrote together. We advocated together.

We need to formulate structures that bring us together for planning and strategizing in order to form a collaborative community in which our efforts are aligned. This demands ongoing dia-

logue and opportunities for bishops and health care professionals to discuss and work through differences that may exist. This takes time, but it would be time well spent.

CONCLUSION

I am blessed as a bishop to have Carondelet/Ascension Health in the Diocese of Tucson. Even though there have been many changes of administrators and mission leaders, each one made a point to stay in dialogue, to meet at least quarterly with me and, in times of difficulties, to be on the phone often with one another.

We discuss a wide range of issues, from compliance with the *Ethical and Religious Directives for Catholic Health Care Services* to planning and financial challenges of the network, to planning collaborative programs sponsored by the diocese and the network on a particular issue in Catholic health care offered to the larger community.

We stood together when they were challenged about partnering with a community hospital.

At times, the dialogue among us has been difficult. But it has always been respectful. We can be open and honest, trusting that the dialogue will get us to an agreed conclusion. And it has.

I feel sure they value the role of the bishop and that they respect me. I pray they feel my respect for their competence and commitment to being Catholic.

By their invitation, I have had the opportunity to speak to the leadership of Carondelet on the *Ethical and Religious Directives* and on Catholic identity.

My experience gives me confidence that the identity of "Catholic" matters to our Catholic hospitals and that ongoing dialogue can respect the role of the bishop while recognizing the expertise of those in the profession.

I hope one of the results of this gathering will be a realization of what makes us Catholic and a greater commitment to develop more opportunities for dialogue among bishops and health care professionals within dioceses and across the church in the United States.

Catholic health care came to this country at the invitation of bishops and through the sacrifice of so many women's religious communities who endured incredible hardship to answer the call to serve. Together we seek to uphold and further the work they began.

And like the seven Carondelet sisters, we rely on the Lord, and thus we feel no fear of what lies ahead.

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