Bridging Two Solitudes

Two Faces of the Same Ministry

By GORDON SELF, DMin

"Behind every 'no' in the difficult task of discerning between good and evil, there shines a great 'yes' to the recognition of the dignity and inalienable value of every single and unique human being called into existence."
— Congregation for the Doctrine of the Faith[1]

Canada often is described as a "country of two solitudes," divided culturally between English-speaking and French-speaking people, owing to our formation as a nation forged between two colonial powers. This historic tension is something we Canadians know and identify, but it is a reality that also has required learning to build bridges over our diversities.

Bridging solitudes could equally describe the way the Catholic health care ministry unites around a common identity, mission and brand in serving diverse communities of the poor and marginalized, while at the same time managing its internal diversities. By internal diversities I don't mean ethnic or cultural differences — I mean differences between work groups, departments, job classifications and people in our workplaces. The inclusiveness rooted in Catholic identity recognizes, respects and celebrates human differences both in the population the ministry serves and within the ministry itself. You could say that the public face of the ministry is one solitude, and the private face is another.

I am old enough to remember when health care aides were simply called orderlies. I was one myself during the early 1980s while working my way through university. Those years began my journey in Catholic health care. The formation experience of cleaning people who had soiled their beds, or shrouding bodies to take to the morgue, or keeping close watch over those at risk of suicide, shaped my identity as a Catholic health care executive today. My orderly job and the chaplaincy clinical work that followed are as much part of my DNA as is my formation in moral theology, ethics and managerial leadership. And rightly so, for as a person takes on successive leadership roles, it is easy to forget about the realities of providing care and service and why we have to remain intentional about whom we serve.

But the same ministry called to serve the poor, marginalized or suffering — our patients and the residents in our facilities — also is a ministry shaped by daily interactions among the people with whom we work. Over the years I have attended funerals for staff or their families; I have walked into hospital rooms to visit ailing colleagues. I remember one of my own staff ministering to me in the hospital when my father-in-law died. And I will never forget earlier this year, when I was sick, feeling extremely unsure and vulnerable, and undergoing invasive tests. How touched I was by the compassion and care my colleagues provided me.

CATHOLIC IDENTITY

Such is the palpable human bond and power of our ministry's culture that cannot be underestimated. It also defines Catholic identity. If we were a health care system that focused on the patient or resident, as we all must do, but exploited or overlooked our colleagues, staff, physicians and volunteers in the process — that would be a diminishment of Catholic identity.

Long after integration through mergers and partnerships, we must continue to find ways to be inclusive, not only in terms of care for our facilities' patients and residents, but also with our staff, our personnel, our vendors and our community partners, lest we risk marginalizing the people we work with. To be sure, the success of our Catholic health care ministry depends upon them.

Catholic health care has devoted much attention to questions of identity and how we communicate in words and actions what it is that defines us. However, in recent years, external debates about aspects of our public face — that is, about provision of reproductive products, emergency contraception, assisted death and the associated concerns regarding conscience rights — have disproportionately focused attention on only one part of what defines our identity.

In Canada, for example, our Supreme Court has declared invalid the Criminal Code prohibition against assisted suicide and voluntary euthanasia. This will have huge impact on Catholic and other faith-based providers. There are absolute moral thresholds regarding what we won't or will never do — and these must be respected.

The Catholic health care community is working hard to influence Canadian legislative and regulatory frameworks being developed in response to the Supreme Court ruling. To preserve Catholic identity will require carving out legally available services beginning as early as February 2016 to ensure that our employed staff, medical practitioners and our institutions themselves are not mandated to cooperate in an activity deemed immoral and a violation of conscience rights and religious freedoms.

Significant issues such as this will arise regarding the provision or refusal of services and bring into focus fundamental questions of identity that demand our entire attention. There can be no ambivalence about Catholic identity when it comes to the termination of life.

However, despite media and interest-group attention to sensational issues such as assisted suicide, as we face now in Canada, it is critically important that the ministry not lose sight of what we *do*, rather than let ourselves be defined by what we *don't do*. It is for this reason that we keep focusing on shining "a great 'yes' to the recognition of the dignity and inalienable value of every single and unique human being called into existence."

GOLD STAR

Recently, some of our executive and management staff gave one of our bishops a "sneak peek" of a new hospice unit, in anticipation of the formal grand opening and blessing later in the fall. As we showed him around the unit — it already was in operation, given the demand for hospice services in this community — I was mindful that there were only a few crucifixes in view, compared to other Covenant sites and program areas. The chaplain was nowhere to be seen — he happened to be ministering to a family when the bishop arrived. The nursing staff paused briefly for introductions, and they were respectful in greeting the bishop and delegation, but it was obvious they felt they must get back to their clinical duties.

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The bishop may have noticed the scarcity of crucifixes on the walls, but his comments showed he saw Catholic identity in real time, manifested in the staff's care and dedication in service of our dying residents. He cheerfully awarded us a "gold star," praising our ongoing commitment to palliative and end-of-life care for which the Covenant family of sites has been publicly and positively identified.

All of us in Catholic health care who provide palliative and hospice care get a "gold star." The work we do in care of vulnerable and marginalized people demonstrates Catholic identity in words and action. We all can hold our heads high

for our fidelity to the ministry and our consistent advocacy for those we serve.

This commitment is a hallmark of our collective identity. Our ministry has long embraced the call of Pope Francis to go out to the margins of society in response to our hurting brothers and sisters. And although there are fundamental threats to our Catholic identity in light of morally unacceptable services that are contrary to the *Ethical and Religious Directives for Catholic Health Care Services* in the United States or the *Health Ethics Guide* in Canada, we can be proud of the work we do each day in giving shape to Catholic identity with the range of services we do provide, and provide very well.

SAYING YES

How will we respond if a patient or resident in our facilities happens to request assisted suicide? Certainly we know what we won't do, but where shines the "great yes" that we are called to utter in response to that person, who, in a moment of desperation and vulnerability, may feel there is no way out of their suffering but to end their life?

It takes moral imagination to stay engaged with the person crying out and to find a way forward. It seems to me that Catholic identity is also about defining our response, finding the "yes," so we neither abandon conscience rights or moral boundaries, nor do we abandon that person in his or her suffering. That ability to navigate and bridge such potential conflicts and find ways to say "yes" is as much about Catholic identity as the nonnegotiable boundaries we will not cross.

We need to be equally vigilant in bridging other potential solitudes to advance our mission and further the ministry of Catholic health care, *together*. As I reflect on the sisters who founded Catholic health care in Canada and the United States, I am reminded that their ministry was never one-directional. They gave their love and attention in saying "yes" to the entire community. Their vision of ministry was not limited to the people they served, but also with whom they served. In fact, in some instances, the very person they cared for and restored to health later became the hospital cook, or medical resident, or financial benefactor. And I dare say you could never find a more engaged and committed employee than the person whom Sister rescued from the street and gave a second chance. Long before employee engagement programs or just culture policies, the sisters intuitively knew their ministry was twofold. All people need to be lifted up in their dignity.

There always has been a robust vision among the sisters about lifting up and restoring people and being Christ's presence to both fellow staff and to patients. They forged a spirit of community within the walls of the buildings they founded, so the ministries they founded never really were simply institutions. They were, rather, healing communities. The staff member who was hurting, or battered, or financially vulnerable, was as equally the sisters' concern as the dying, or abused, or indigent patient in their care. Like Canadian flight attendants who help continually bridge differences in the country of "two solitudes" with preflight instructions repeated in both French and English, the sisters announced their message of Christ's healing love in languages that could be understood by both.

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TWO SOLITUDES

Many spiritual writers have written about the risks of living a divided life. The Pontifical Council for Justice and Peace's reflection on the vocation of a business leader warns of this same fragmented existence, an existence composed of two solitudes in which one part of our lives is publicly proclaimed at the diminishment of another part of our being.[2] It is a sobering message for those of us who are responsible for the business or the ministry of Catholic health care. As we continuously integrate programs and services across the organization and right-size staff, we need to ensure we also remain integrated in our vision of creating a healing community: a community that embraces the people we serve, as well as the people we work with. A community that only together, in respect-

ful harmony, fully expresses Catholic identity.

To move beyond the tyranny of the solitudes, we must be prepared to build bridges and transverse divides so our very existence as Catholic health care is not lost. We must be clearly intentional about giving proportionate attention to the entire healing community that is as central to Catholic health care and our very identity. If we are not vigorously intentional, and if we don't work hard to ensure a consistent ethic of life, as coined by the late Cardinal Joseph Bernardin, we risk losing our identity.

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Is this claim an overstatement? Is it nearly as important as other moral issues of our time, such as assisted suicide and voluntary euthanasia? In my assessment, Pope Francis seems to be calling the entire church to look within and not be overly focused on waging culture wars that give disproportionate attention to some ills and moral challenges in society. My understanding of Pope Francis is that he wants us to look within our own parishes, our public institutions and businesses, including Catholic health care workplaces, to address the messy issues that also threaten our identity.

BUILDING BRIDGES

This begins with a resetting of attitudes that is sometimes overlooked as a core element of our shared ministry. We must work together to bridge relationships when potential solitudes divide those who provide care and service from those who provide corporate support and administration. Recognizing that we all have a fiduciary responsibility for furthering Catholic health care, we must learn how to have true dialogue without demonizing one part of our ministry to another.

As I reflect on the bridge that must continually be built and strengthened to more powerfully unite us in our shared ministry, I go back to the "gold star" our bishop awarded us in celebration of our Catholic identity, even when all the crucifixes were not yet on the walls of our new hospice unit. I also harken back to the challenges facing Catholic health care regarding provincial- or state-mandated services that can erode our identity, or even our very existence in some jurisdictions. These external threats are significant, and we need to keep speaking out and advocating for justice.

We must be careful not to single out and give "gold stars" only to those who provide direct care and service. We also must say "yes" to our facility and maintenance staff who provide a warm and well-lit environment, or the housekeeping staff who save lives by their commitment to infection protection and control practices. And our occupational health and safety staff who make available influenza vaccination to keep staff safe, while also mitigating the spread of illness to vulnerable patients. And to recognize the contribution of our finance and human resources staff who ensure we have the dollars and people we need to run operations. And all the other back-office staff too numerous to mention, who may not always be the face of Catholic health care as our doctors and nurses are, but together make up the strong and agile body of the healing ministry.

If we give disproportionate attention to only one group of personnel at the expense, or even the disdain, of others, we undermine Catholic identity. That is unacceptable.

THRESHOLDS

Catholic health care can never cross the moral threshold that leads to termination of life. This is very clear and nonnegotiable.

But as we work to protect life by asserting Catholic identity in the face of morally unacceptable practices, do we also look within and critically examine the church's social teachings as to what we must do, also in the name of Catholic identity, to ensure our staff receive a just, living wage, or have a voice in decisions that impact them, or are supported when critical incidents befall them? We share a common humanity, thus our common shared concern that both the people in our hospitals and residential care beds be lifted

up in their dignity, as are the people who serve the sick and dying.

In Catholic health care, we are a microcosm of society. Leadership and consistent messaging must communicate that we are all important and that we cannot be successful in our ministry without working together. There are two aspects to the language of Catholic health care — care and community — and we need to speak and act from both rather than allow them to function as individual solitudes.

The sisters understood this. And I believe it is a message to heed when we talk about Catholic identity. We need to confront the social ills that lurk within our own institutions and our hearts and learn to communicate in languages that all of us, as pilgrims on our shared faith journey, can together hear, embrace and champion.

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NOTES

1. Congregation for the Doctrine of the Faith, *Instruction* Dignitas Personae *on Certain Bioethical Questions*, no. 37.
2. Pontifical Council for Justice and Peace, *The Vocation of the Business Leader,* 10-11. www.pcgp.it/dati/2012-05/04-999999/Vocation%20ENG2.pdf.

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