

ARE WE PART OF THE PROBLEM
OR PART OF THE SOLUTION?

Clergy Sexual Abuse and Catholic Health Care

FR. CHARLES BOUCHARD, OP, STD

The Pennsylvania grand jury’s August 2018 report on sexual abuse by clergy has exposed anew the church’s failure. The exhaustive report documents decades of misconduct and cover-up, names some specific offenders, conceals the names of others and describes in painful detail how hundreds of lives were ruined in the state of Pennsylvania.

The Supreme Court of Pennsylvania next is considering whether to lift the redactions and make all names public. Arguments in that matter began in late September, and lawyers for some of the accused priests already have filed documents raising questions about errors in the report and lack of due process for their clients. Still, the Pennsylvania report paints a tragic picture, and we know there have been a similar number of sexual abuse cases in other states’ and internationally. What was originally thought to be a U.S. Catholic Church problem now is being seen as a worldwide social problem.

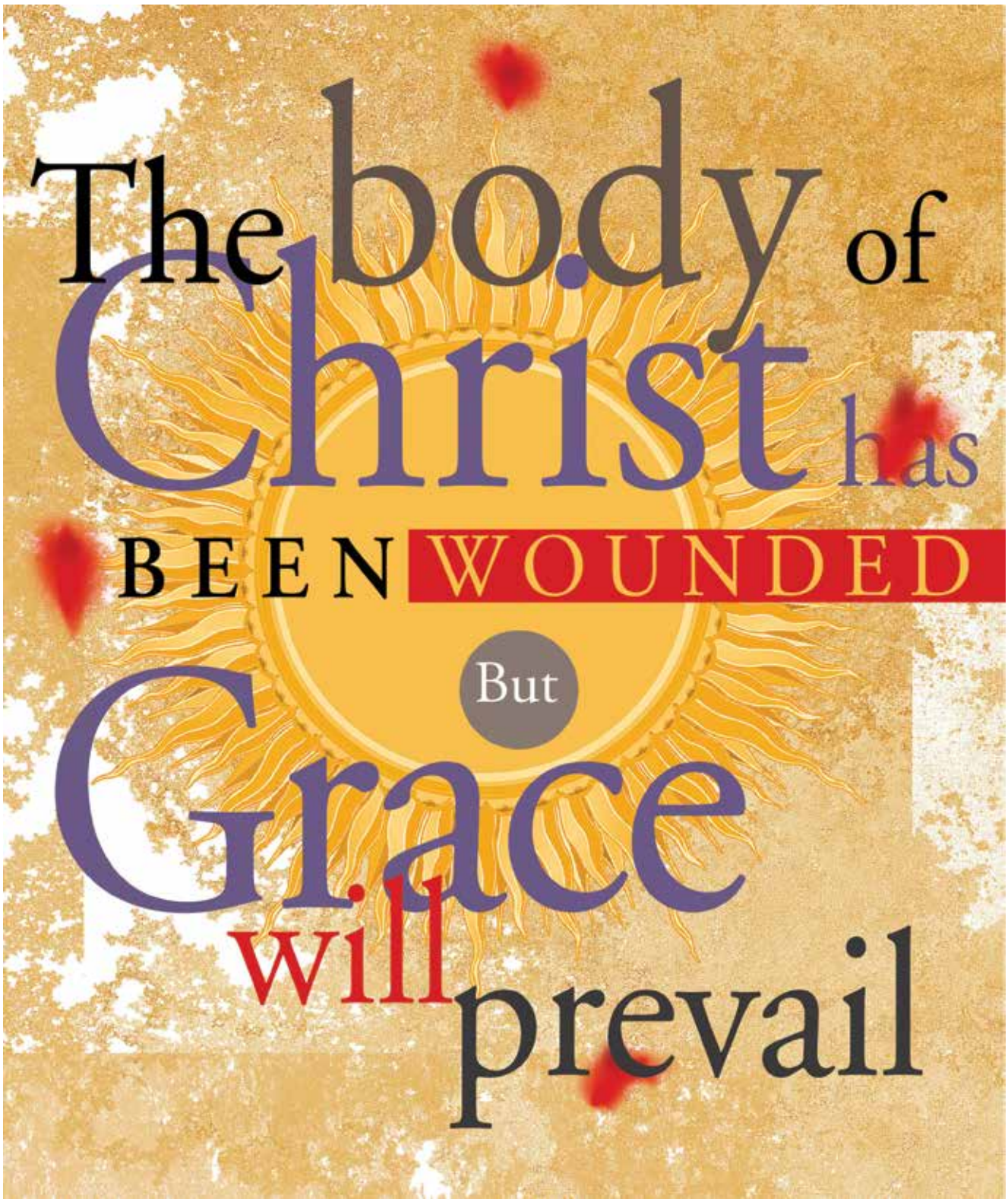
We in health care have our own scandals to worry about — those that arise from malpractice and substandard care, financial mismanagement, discrimination or neglect of those on the margins. It would be convenient for all of us in Catholic health care (and for me as a priest) to distance ourselves from these misconduct scandals either because of most sexual abuse in the church took place long ago, because this scandal has nothing to do with health care, or “Who needs another problem?” But in many ways, that is not possible. We already are involved, if not implicated, in the church’s failure.

We are involved because we are Catholic, and

many people make no distinction between us and the lives of our parishes. They see Catholicism as a monolithic institution and aren’t interested in fine distinctions. This perception affects us in other ways as well. I believe groups that target Catholic health care for alleged inadequate care for women are doing so in part because of general antipathy toward the bishops and the church. Some journalists have suggested that everything in health care was fine when the sisters were in charge, and that it was only when “the bishops started getting more involved” after the U.S. Supreme Court’s *Roe v. Wade* decision in 1973 that problems started.² I disagree with that assessment, but sometimes perception is the reality.

We are involved because we are a ministry. Like parishes and priests, we are authorized by and accountable to church authorities, and ultimately, to the Gospel. A failure of integrity in one member of the church diminishes all of us.

We are involved because we treat victims of sexual abuse — not just those victimized by priests, but those abused by spouses, parents, relatives, teachers, coaches and others.³ The scandal in the athletic department at Pennsylvania State University was shocking because of its extent, but also because it involved the same kind of miscon-



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duct, willful blindness and cover-up that occurred in the Catholic Church. The only difference is that *it wasn't the church.*

In the past, many institutions simply overlooked the signs or avoided exposing an abusive parent or spouse who was an upstanding citizen. Such attitudes were part of the culture at a time when we couldn't even speak openly about alcoholism, let alone sexual abuse. We saw addiction and abuse as moral failures rather than as illnesses or crimes. We see them today through a very different lens. We know they are not just moral failures, and we know we can intervene. There is a significant body of literature on how health care providers, especially primary care physicians, should learn to recognize signs of abuse and do something about it.⁴ Even if they do, however, we must ask whether our fragmented and underfunded behavioral health system is equipped to provide effective treatment. We also should bear in mind that although most victims of childhood sexual abuse are girls, the vast majority of abusers are men.⁵ This suggests there is a serious issue for research in men's behavioral health.

Finally, we are implicated if we work alongside an abuser. Sexual abuse by health care providers is not as well documented as abuse by clergy, but it exists. There is the highly publicized case of Larry Nassar, who spent decades — and earned renown — as a sports physician working with gymnasts. He held positions on the faculty at Michigan State University where he also was a team physician, and he was appointed national medical coordinator for USA Gymnastics, traveling with the U.S. athletes to the Olympics. Allegations about his behavior surfaced from time to time, but neither the university nor other trainers and coaches took action against him. In 2014, Michigan State cleared him of any wrongdoing three months after a graduate made a sexual assault complaint.

In 2016, a newspaper printed results of a lengthy investigation into USA Gymnastics and how it handled sexual abuse complaints. Women began to come forward publicly with accusations against Nassar, and he has since been convicted of state and federal crimes that will keep him imprisoned for the rest of his life.

In a similarly extreme example, Richard Strauss, who died in 2005, has been accused

of sexually molesting hundreds of male wrestlers and other athletes and students during his approximately 20-year career at Ohio State University as a faculty member and physician in the athletic department, clinic and student health services. The allegations began to surface more than a decade after Strauss had retired and moved to California, where he took his own life. In 2018, Ohio State hired a law firm to investigate the accusations and pledged to make the findings public.

These examples involving physicians are not unique.⁶ They also point to troubling, critical questions regarding colleagues and workplaces: Who knew or should have known about the abuse, and who looked the other way or covered it up? We have to ask ourselves if we are able to recognize the behavior patterns of a colleague that might suggest inappropriate conduct.⁷ Are we able to raise our concerns with supervisors or licensing boards? Are we able to refer them to law enforcement? Whether sexual abuse or harassment takes place in church, in the office, at a university or in the family home, it is always the result of a failed or dysfunctional system that sees and knows and even enables, but is unwilling to act. Organizations are human creations. They often have noble purposes and mission statements, but too often the stated mission hides a tacit agree-

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ment to protect insiders. We see this in virtually every profession. It is right to stick with our colleagues and protect them, to a point. But in the church, inappropriate loyalty has disastrous consequences.⁸ We can avoid this in our ministries and set an example for others.

The systemic nature of sexual abuse is an aspect of organizational ethics. Some thinkers, like Michael Rozier, SJ, PhD, want to bring systems theory into public health so that “the ethical frameworks we propose should not only help resolve specific dilemmas (which we are good at) but also be applicable to the routine work of public health.”⁹ This means going beyond the discrete

ethical dilemmas to the social and organizational factors that give rise to them in the first place.

The idea of “structures of sin” or “social sin” was the basis of liberation theology, a movement in the 1960s that started in Latin America and attempted to address the systemic factors that led to oppression, poverty and a diminished experience of God’s grace.

According to Rozier, “By structures [these theologians] meant ‘the combination of institutions and practical devices which people find already existing or which they create, on the national and international level, which orientate or organize economic, social and political life.’”¹⁰ The theologians recognized that social structures can do great good, but that they also can become corrupt and cause great harm. Their efforts are based on the same dynamics that are leading us to explore socioeconomic diversity as a cause of disparities in health and in health care outcomes.

Rozier goes a step further to suggest that if there are structures of sin that perpetuate injustice, there also can be “structures of virtue,” ways of organizing our human capital that are rooted in honesty, transparency, compassion, and yes, chastity. Public health practitioners, he says, should not be concerned just with redressing existing wrongs, but also with creating “new structures that have a positive influence in the lives of individuals and communities.”¹¹ [We see this challenge most clearly in our efforts to move from fee-for-service care to population health and more equitable distribution of health care resources.

Rozier points out that these structures “do not accidentally come into being...they do not fall out of the sky but are built up over time, reproduced and changed by actors. The moral character of the individuals who reproduce and change it plays a determinative role in the structure itself.”¹²

This is the purpose of our formation programs. They are designed not just to impart knowledge, but to shape spiritual awareness and character, individually and organizationally. If Catholic health care is distinguished by anything, it should be the fact that we have formed virtuous persons who create structures of virtue. This is what made Catholic health care great. Our founders were mostly women who were recognized figures of strength, courage and holiness. Their

virtue shaped the institutions they created. If our ministries are structures of virtue, they will affect not only patient care, but the communities around us. They will strengthen the common good and the quality of our social life together. They also will allow our ministries to be a sacramental presence, making God’s grace visible and effective in the world. A system that tolerates sexual abuse, substandard care or disrespect for human dignity doesn’t have much sacramental potential.

There is a glimmer of good news. Since 2002, when the U.S. bishops approved the Dallas Charter for the Protection of Children, new allegations of abuse have dropped precipitously, to an average of about six per year nationally. This is six too

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many, but the drop shows that the new protocols have been very effective.

From 2011 to 2015, I served as superior of my religious community, which numbers 150. We had no allegations of inappropriate behavior with minors occurring during those years. To be sure, no one can know how many past offenses eventually will emerge, any more than we can know how many incidents will never come to light. But we can know, in detail, that some fundamental circumstances have changed. We handle selection and formation of priesthood candidates differently than we did in the past. We require more time with candidates (including multiple weekend visits to our communities). We are especially vigilant about patterns of behavior that suggest inability to form peer relationships (which we learned too late was often an indicator of a tendency toward inappropriate relationships with youth), sociopathic tendencies or exaggerated piety and asceticism which can be a way to hide or compensate for inappropriate behavior. We see celibacy not just as *not having sex*, but rather an attitude of respect for self and others, and as a different kind of generativity that does not include

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procreation and expresses itself in joyful service. In short, we are placing far more emphasis on human formation so that we start with a solid, integrated candidate. We are required to have regular training, and our compliance is tracked by two different organizations.

Allegations are handled differently too. Any substantive allegation results in immediate suspension from ministry. The diocesan bishop or major superior presents the case to a lay review board, but he is not allowed to participate in their deliberation. They determine whether the allegation is credible and what the next steps should be.

WHAT SHOULD CATHOLIC HEALTH CARE DO?

So for Catholic health care, what are our options? We could hide, pretending we have nothing to do with these other ministries of the church. At least in the public perception, we already are implicated, so this would be difficult. We could distance ourselves by reducing our connection with bishops and the local church, and maybe even changing sponsorship structures to reduce our juridical accountability to the church. I have already had someone ask me if our Catholic health systems should become “Catholic in spirit” and let go of our official ministry status.

That would be a mistake. As a ministry of the church, we have a responsibility to acknowledge the damage to our reputation and seize the opportunity to show that the church is about more than its failures. Catholic health care is a legitimate ministry in its own right, and even though we have been affected by association with the scandal, we must remember that the church and the transcendent values that motivate us are much larger. In the last 15 years we have been very intentionally deepening our Catholic identity and strengthening our own self-understanding as a ministry. We have formation programs at every level, and Cath-

olic health care has formed thousands of leaders who have gone through demanding programs so they can be credible and effective ministry leaders in the future.

In some places, Catholic health care is the most visible face of the church. Our formation programs and preparation of lay women and men to assume management, governance and sponsorship roles for health care as a ministry put us in a unique position to show the rest of the church what a non-clerical, transparent exercise of Gospel authority might look like. It could well be that our efforts are the key to renewal of the whole church.

The Catholic Church is not just the clergy and the bishops. It is all of us who have been baptized into the Body of Christ. The Body of Christ has been wounded, but grace will prevail. Let this unfortunate moment be an opportunity for our sponsors, board members and executives to ensure that we build new structures of virtue that will not only avoid such problems in the future but allow the healing light of the Gospel to shine forth even more brightly.

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NOTES

1. A 2002 study commissioned by the United States Conference of Catholic Bishops and conducted by the John Jay College of Criminal Justice in Manhattan indicated that some 11,000 allegations had been made against 4,392 priests in the United States. This number constituted approximately 4 percent of the priests who had served during the period 1950-2002, covered by the survey. This appears consistent with incidence of abuse found among other professionals. Of the abused, 81 percent were male, and 19 percent were female, 22 percent were younger than age 11, 51 percent were between the ages of 11 and 14, and 27 percent were between the ages of 15 and 17 years when first abused. Within the youngest age group, 64 percent of abused children were male, while within the older age groups, 85 percent were male. 2,411 of the priests had a single allegation made against them, while 149 priests had 10 or more allegations made against them.

A further analysis by the John Jay College found that, among clerics with a single accusation of abuse, the victims were more evenly divided between male and female and were more likely to be older. Abusers with

greater numbers of victims abused a higher proportion of boys. The report also identified some subsets of abusive behavior: pedophilia or preference for pre-adolescent children (96 priests) and homosexual ephophobia, preference for boys ages 15-19. (474 priests).

2. Katie Hafner, "As Catholic Hospitals Expand, So Do Limits on Some Procedures," *New York Times*, Aug. 10, 2018. The quote is from Barbara Mann Wall, a professor of nursing at the University of Virginia.

3. The nonprofit organization Darkness to Light provides a wealth of information about child sexual abuse in general. They make it clear that the problem is not limited to the Catholic Church. See www.d2l.org/.

4. Kelly Colleen McDonald, "Child Abuse: Approach and Management," *American Family Physician* 75, no. 2 (Jan. 15, 2007): 221-28. See also: Carole Jenny and James E. Crawford-Jakubiak, "The Evaluation of Children in the Primary Care Setting When Sexual Abuse Is Suspected," *Pediatrics* 132, no. 2 (August 2013) e558-e567. Full report available at <http://pediatrics.aappublications.org/content/132/2/e558.full>.

5. The National Sexual Violence Resource Center said in 2011 that "96 percent of people who sexually abuse children are male." Child sexual abuse prevention: Overview. www.nsvrc.org/sites/default/files/Publications_NSVRC_Overview_Child-sexual-abuse-prevention_0.pdf.

6. A six-part series by the *Atlanta Journal-Constitution* in 2016 uncovered many cases of physician sexual abuse. One reporter discovered "about 70 cases clearly involving sexual misconduct. And in about two-thirds of those

cases, he was shocked to find, doctors either didn't lose their licenses or were reinstated after being sanctioned. That included doctors who had repeatedly crossed the line with patients." One section of the report was entitled "License to Betray: A Broken System Forgives Sexually Abusive Doctors in Every State." The report is a sobering picture of many of the same kinds of collusion and cover-up that existed in the church. See information about the *Doctors & Sex Abuse* series at http://doctors.ajc.com/about_this_investigation/.

7. There are many sources of indications of sexual abuse. One is from the U.S. Department of Justice, "Learn the Warning Signs: Recognizing Sexual Abuse," www.nspw.gov/en-us/education/recognizingsexualabuse.

8. Listen to the interview with Harvard Divinity School Professor Mark Jordan. He says that the abuse resulted in part from a military type of formation in which loyalty to authority was the only virtue, trumping even loyalty to those we serve. Available at www.npr.org/2018/08/16/639371736/what-allows-sex-abuse-to-proliferate-within-the-catholic-church.

9. Michael D. Rozier, "Structures of Virtue as a Framework for Public Health Ethics," *Public Health Ethics* 9, no. 1 (April 1, 2016): 37-45 at 37.

10. Rozier, 39, quoting Marciano Vidal, "Structural Sin: A New Category in Moral Theology?" in Raphael Gallagher and Brendan McConvery, eds., *History and Conscience: Studies in Honour of Father Sean O'Riordan, CSSR* (New York: Gill and Macmillan, 1989) 181- 98.

11. Rozier, 39.

12. Rozier, 39.

QUESTIONS FOR DISCUSSION

In his article "Sexual Abuse and Catholic Health Care," **Fr. Charles Bouchard, OP**, discusses the most recent scandals of clergy sexual abuse and how that affects the Catholic health ministry. He writes that "a failure of integrity in one member of the church diminishes all of us."

1. Fr. Bouchard describes how Catholic health care is sometimes the most visible ministry of the church. How can Catholic health care be part of the solution in helping those who are hurting because of the abuse that has occurred? How can it be a source of healing to those in the ministry who feel angry, sad and ashamed?

2. Does your workplace have a clear and consistent mechanism to report inappropriate or abusive behavior? How do you assure your patients, employees, volunteers and contracted workers that they can safely make a complaint or raise an issue?

3. Fr. Bouchard includes a discussion about corporate sin and corporate virtue. Can you think of any examples of organizational sin in your ministry? What examples can you give of your ministry demonstrating corporate virtue? How do both impact the ministry's identity and integrity within the community?

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