HEALTH MINISTRY AND COMMUNITY

Catholic Health Care Needs a New Emphasis on Its Communitarian Roots

BY JOHN GLASER, STD, & KEVIN BUCK

The diminishing presence of "the sisters" is a phenomenon that no one in Catholic health care could miss. But something else is vanishing along with the sisters, and it is something we could easily miss—community ministry. It is not just that our ministry will have fewer sisters in the future; there will be less and less community in our ministry unless we carefully and consciously do something about it.

We, the authors of this article, intend to examine some aspects of the importance of, and endangerment to, community in Catholic health care. Our thesis is briefly this: Whereas U.S. culture is fundamentally individualistic, Catholic health ministry is essentially communitarian; the powerful presence of community inherited from religious congregations can only be sustained with clear focus and hard work.

Individualism and Health Care

U.S. health care is a mirror of American culture, and American culture is a culture of individuals. Our deepest affections, our spontaneous assumptions, our philosophical and political building blocks, all find their magnetic north in the ideal of the individual.

The roots of this fixation reach back to the beginning of our nation, whose founders were steeped in philosophers such as John Locke. The best-known early chronicler of our individualism is probably Alexis de Tocqueville, who described the American spirit trenchantly as one tending to a self-understanding that owes "nothing to any man; [Americans] expect nothing from any man; they acquire the habit of always considering themselves as standing alone and they are apt to imagine that their whole destiny is in their own hands. Thus, not only does commercial democracy make every man forget his ancestors, but it hides his descendants and separates his contemporaries from him; it throws him back forever on himself alone and threatens in the end to confine him entirely within the solitude of his own heart."[1]

This individualism can be seen in the subculture of medicine. Even when medicine focuses on ethics, it tends to do so in a way that focuses narrowly on issues affecting the welfare of the individual, rather than that of the community. Bioethics, for example, has spent three decades emphasizing and advocating individual patient autonomy. George Annas, a pioneer in U.S. bioethics, put it succinctly: "The core legal and ethical principle that underlies all human interaction in medicine is autonomy."[2] As two medical sociologists have noted, this cultural myopia is "a widespread characteristic of the field of bioethics, one that generally manifests itself in the form of systematic inattention to the social and cultural sources and implications of its own thought."[3]

The culture of the individual is present in psychotherapy as well. The founding theory of modern therapy, psychoanalysis, was focused on the individual. Even after the advent of family systems theory in the 1960s, the majority of therapists continued to work primarily with individuals. One of the authors of this article, a clinician and graduate professor who has been associated for more than

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12 years with the Marriage and Family Therapists program at Pepperdine University, Malibu, CA, has often heard other clinicians and students say that working with individuals is more attractive to them than working with groups, because it is less complex and therefore easier to manage. The fact that assessment and testing instruments are developed for individuals, and not for groups, also reveals psychology's bias for the individual.

Because organizational psychology had its origins in the larger conceptual world of individual psychology, it tends to focus on the individual, too. The authors know of many excellent instruments for the assessment and measurement of the strength and growth of individuals, but we have been challenged in our search for corresponding instruments for defining and measuring the strengths of teams. We are familiar with no instrument that specifically addresses the assessment of communities of leadership.

Catholic Ministry: Essentially Community Ministry

Catholic tradition paints a picture of striking contrast. A pointed expression of Catholic communitarianism appears in the U.S. bishops' pastoral statement on the economy: "Human dignity can be realized and protected only in community. . . . The Christian vision of economic life . . . asks, 'Does economic life enhance or threaten our life together as a community?'"[4]

The ultimate source of the Catholic Church's view of community life is, of course, the mystery of the Trinity. We, in our being and doing, are the likeness of God—not persons in isolated individuality, but being-in-relationships. Community is thus not what happens when individuals come together; it is the very condition for the possibility of individuals. Community is the easily forgotten—even in Catholic theology—essential element of human dignity: individual-in-community. As with the Trinity, we are distinct but not separate.

Secular philosophers, too, have noted how even our individual, physical being reflects our community nature: In our navels, we manifest our relationship to past generations; in our genitals, we manifest our bondedness to future generations. One of the scriptural images that best captures the communal nature of reality is, of course, 1 Corinthians: "Just as a human body, though it is made up of many parts, is a single unit because all of these parts, though many, make one body, so it is with Christ. In the one Spirit we were all baptized, Jews as well as Greeks, slaves as well as citizens, and one Spirit was given to us all to drink. . . . Now you together are Christ's body; but each of you is a different part of it" (1 Cor 12:12-13, 27).

Religious congregations made this being-in-community come alive as did no other part of the church. The religious community was the soil in which individual members had their roots and from which the life and nurturance of specific ministries came. Enormous amounts of thought and effort went into nurturing these communities. The vast majority of U.S. Catholic ministries would not exist today were it not for all the spiritual and material investment that has gone into building and nurturing religious communities.

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But just as, when visiting a forest, one often overlooks the forest floor that feeds the trees, so do we who prize Catholic health care tend to overlook this community-beneath-the-ministry—even as we admire the sisters and their work. Put another way, seven-eighths of the ministry is like the seven-eighths of an iceberg that floats beneath the surface of the ocean and is therefore beyond one's view.

This puts those who value the ministry in a potentially calamitous situation. The community source of the present ministry is diminishing—just as, though perhaps less visibly, the number of women religious is diminishing—and the ministry's leadership is being transferred to people who have achieved their success in an individualistic culture and industry. This situation is especially fraught with danger because the two cultural dimensions shaping the situation—the community dimension of the sisters, on one hand, and the individualism prized by Americans and their health care culture, on the other hand—are subtle but also enormously powerful.

These are the elements that give us, the authors, a sense of urgency concerning the community dimension of health care ministry. We want to call attention to the inadequately noticed disappearance of the nurturing soil of Catholic ministry—the community of ministry. We want to focus attention on the task of building a robust theology of community ministry among new leadership.

Practical Consequences

If the analytic sketch above is accurate, it raises some practical issues. The authors would like to offer some suggestions that outline the larger arc of the subject and some details of specific elements in this arc.

A Focus on Core Values The overall challenge may be described as follows: How do you take a dominant culture of individualism and modify and expand it to include a complement of community? The following thoughts are suggestive, not prescriptive. They are meant as "triggers" and "teasers" leading to further dialogue, not a detailed road map.

In our pursuit of a culture of communities, we can learn something from our ongoing, decades-

long evolution of "core values." Over the last 25 years, we have come to recognize what a foundational role core values play in an organization. Every institution has developed its version of such values. Catholic health care organizations have defined them in detail and made them part of their aesthetic and ethic. Core values have become the starting point of most major efforts—from individual evaluations, to workplace philosophy, to five-year strategic plans.

We who work in the ministry have developed detailed standards for the values; we have defined layered competencies that flow from the values; we have created metrics to measure performance against these values and attempt to tie them fairly and effectively to compensation; we construct continuous improvement programs to enhance our realization of these values. We have given them star treatment by identifying "heroes" and "champions" of these core values and celebrating them with maximum corporate kudos.

Community Is More Important than Values Integration Over the last three decades, Catholic health care has worked hard to identify and integrate core values into the key systems and structures of its institutional life. The results have been admirable and effective.

However, the authors believe that attending to the community nature of ministry is an even more fundamental component of ministry than values identification and integration, because it is the larger, more encompassing reality within which the values have their importance and meaning. But we also believe that the weight and centrality of the community nature of ministry have not been recognized and elaborated adequately. Indeed, our awareness of and sense of urgency concerning the community nature of the ministry is similar to our awareness of and sense of urgency about "the values" some 25 years ago.

Much of the values work actually can be seen as having community as an indirect and secondary theme. Perhaps our efforts are now best understood as making this implicit and secondary dimension—community of ministry—the broader and deeper context for understanding health care ministry.

Recognition of Community as Framework A first step in building a culture of community consists in recognizing that what was formerly implicit and marginal needs to be made explicit and central—the fact that the theological concept of community is the framework within which mission, values, vision, and goals have their coherence and integrity.

At the St. Joseph Health System's Center for Ministry Leadership, Orange, CA, we have experienced how difficult it is to go beyond the language of community—which we have incorporated into our thinking and discussion—to the consistent detailed understanding and application of the reality. We have engaged in lengthy dialogues about the concept, but these have produced more questions than answers.

Those of us who work at the center are aware of the problem. Sometimes, even when we intend to discuss leadership development in a communitarian context, we find ourselves relapsing into a "default setting"—focused, that is, on *individual* leadership development. The individualistic model is dominant even in the center's organizational culture. Balancing individual leaders with communities of leadership is difficult. Even when we know the destination, the journey of extricating ourselves from patterns of individualism involves traveling a long, dusty road.

Elaboration of Essentials of Community The next step, of course, is clarifying the essential components of a new community of ministry. For the sake of further discussion and development, the authors venture to offer the following rough definition:

> A community of ministry is one that so lives, loves, sacrifices, serves, and celebrates that other people, when encountering the community in a sustained and significant way (regardless of their religious belief), experience harmony with the deepest truths of their hearts: truths concerning human dignity, community, success, power, growth, sacrifice, love, suffering, debility, and death. Having experienced harmony between their heart's deepest resonances and this community's character, those people go from this encounter more healed; more whole; and more able to live, to love, to hope, and to die.

To flourish as a community of ministry, the community we have in mind would have qualities identified by the psychologist Carl Rogers as essential to personal spiritual growth: unconditional positive regard, empathic understanding, and congruence.[5] What do these terms mean?

- *Unconditional positive regard* This unconditional affirmation of the other person results from the experience of our individual and unique, but common, shared humanity. It is such a strong recognition that it becomes the frame for all other issues and exchanges. It is this deep affirmation that provides the unshakeable ground from which even powerfully divergent opinions and judgments can be directly and strongly expressed, explored, and brought to closure.
- *Empathic understanding* This is the ability to "walk a mile in another's shoes." It involves the suspension—not the abandonment—of one's own perspective long and deeply enough to enter into

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the experience and world of the other person.

• *Congruence* This occurs on two levels. First, it is the capacity to be increasingly aware of and intentional about one's own inner world of body/mind/spirit. The content and intensity of one's mental, visceral, and emotional movements are available to one's awareness with minimal delay or masking. Secondly, it is the ability to know when and to what extent these should be explicitly expressed in one's exchange with another person.

The authors' point in spelling out this Rogerian construct is not to suggest that these are the only or the essential relational qualities needed by a community of ministry (though a case could be made for including them in such a context), but, rather, that a culture of community will be guided by an explicit and detailed understanding of the qualities it strives to deepen.

Creating the Environment in Which These Elements Flourish

Next, each defined community characteristic would be further translated into processes, experiences, and tools that deepen them. Instruments would be developed that measure the elements' presence or absence; and such profiles would lead to continuous improvement programs.

An example can help. If we identify unconditional positive regard as an essential characteristic of the community, it follows, as night follows day, that we must value spending time together in order to encounter one another on that level of shared humanity that is the foundation of such regard. If a group is unwilling to spend adequate time together, it cannot develop the quality of unconditional positive regard and sense of community it needs to become a true community. The opportunity for co-creating relationships thrives within the sacred space of time. There is really no substitute for this.

Kevin Buck, one of the authors, has worked extensively with physicians in this regard. As an initial exercise, he invites each physician to tell his or her story to another in the room, explaining why he or she decided to dedicate life and energy to the healing ministry of medicine. While one physician speaks, the other tries to discern the deeper, universal themes under the individual story. After both partners have told their stories, they share with the group the themes and "veins of meaning" they have heard. Their hospitality toward each other in the present moment has allowed a powerful new story to emerge. The transformation of their community has begun.

In assessing this essential element, one looks at the frequency with which the group meets and the length of time it is willing to invest in being together. A group that recognizes and values growth in this regard will be willing to schedule such time; indeed, the group will make such sessions one of its "non-negotiables."

Processes and tools such as these can provide leaders with an explicit picture of the larger community of ministry—including executive teams, boards, middle managers, groups of employees, and medical staffs—revealing areas in which the community is robust and areas in which it needs attention. Such models and tools would provide the means for setting priorities and making continuous improvement.

> How do we define, create, and nurture the communities we need?

The Public Juridic Person as Community

It may be helpful to apply some of this reflection about community to a current and emerging issue: the formation of public juridic persons (PJPs), the lay entities that have begun to succeed congregations of women and men religious as sponsors of the church's health care organizations. It would be easy to approach the new church-community issue of the PJP with individualistic categories: What criteria, for example, should we have for inviting someone to be a member? What kind of education should individual members have? What kind of formation, beyond education, is necessary? These are all individually oriented queries. They are important.

But the deeper, more difficult questions concern the PJP as a community. Do we have a *taxonomy of community* with which we could examine the PJP? If we think of a continuum of community—with what might be called "communities of convenience" at one end and genuine communities at the other—where would PJPs fall? Clearly, they are not "mini" or "lite" versions of religious communities of old. But they are just as clearly not boards of trustees equipped with more power and a more thorough theological/canonical education than current boards. The authors do not see these as academic or rhetorical questions, but, rather, as essential entry points to future forms of ministry. How do we define, create, and nurture such communities? We believe that these are more fundamental questions about the PJP, in whose context questions about individuals can best be asked and answered.

If we were to summarize the PJP as a community question, we would ask: How shall we define and nurture communities of vision, commitment, and sacrifice that lie on the community continuum somewhere between boards of trustees and religious congregations and for which we currently have neither experience, language, nor—an especially important element—a juridic model?

Balance of Individual and Community

Our concern with community should not obscure the need for balance between individual and com-

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compassionate words and actions of Jesus toward the blind, lepers, and paralytics. Counselors find replenishment in the strength and tenderness of Jesus toward the possessed, the arrogant, and the disenfranchised. Sponsorship in the Catholic tradition provides that essential context of meaning for Catholic managed care as well. Those who work in this ministry find meaning in the Gospel values, tradition, and ethical construct of Catholic heritage.

For example, managed care ministers may be renewed by the parable of the loaves and fishes. In the light of this story, we may say that we experience the ministry of graced administration and management of resources, in which right relationship is achieved for the whole community, not only for individuals within it. The parable of the loaves and fishes shows us a specific kind of ministry. Jesus does not, in the parable, directly feed the hungry. He issues a challenge, the response to which brings forth riches from the community itself. Distributive justice, based on a balance of need and possession, allows all to be fed. Distributive justice is the administrative face of compassion.

Managed care ministry, at its heart, is about this kind of distributive justice. It is about the administration and promotion of resources for the healing of the whole community. It is about setting the challenging context in which individuals who possess more than others divest and share so that all may have an equal "some." Managed care ministry, as in all ministries of administration, is about keeping before us the difficult and essential question of distributive justice: To whom do things really belong? At its best, managed care ministry asks this question of itself, of the delivery side of health care, and of the corporate and civic communities that it influences.

Managed care ministry, framed and sustained by Catholic sponsorship, possesses the potential to effect systemic change through self-discipline, advocacy, and mutuality. It has an opportunity unparalleled in the history of Catholic health care. The emergence of the Catholic managed care ministry offers tremendous potential to exercise the precious gift of the Holy Spirit that reflects the mercy and justice of God for our times.

An Esmerelda for Managed Care

Like the more traditional provider-based model of health care, Catholic managed care cannot sustain a value-driven ministry without the sponsorship of the faith communities whose heritage, experience, and practice have shaped them to the mind and heart of Christ. Quasimodo sought stability in Esmerelda, the novel's beautiful heroine, who treated him kindly. He wanted her to recognize him for his true self, love him, change him, and thus free him. Although his expectations concerning her may have been inappropriate and naive, his recognition of his need for a life-sustaining relationship was accurate and well founded.

Managed care too needs its perfect Esmerelda—that construct of mutual truth, understanding, and motivation we call sponsorship for mission. Catholic managed care seeks equilibrium through the anchors sponsorship provides: faith, tradition, service, self-examination, and conversion.

In order for this relationship to achieve its potential for the sake of God's people, sponsors and systems must move beyond any perception of Catholic managed care as an ugly stepchild. They must work harder to understand its unique power for mission and ministry, to call its practitioners to the continuous examination of values-based practice, and to articulate the mission structures and supports that will effect its strengthening as an essential and valued health care ministry for today and for the future. □

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munity. Part of the wisdom of religious communities is that they both encouraged individual spiritual direction, on one hand, and practiced ongoing community formation, on the other. It will be essential for the ministry to create processes that hold us accountable for the interplay of both the community and the individual as we move forward during this time of transition.

The authors believe that the ministry's best efforts are still in front of it, and not in the past. Nostalgia of who we have been is vital in recounting our legacy. It is an integral part of telling our story. And, because of what we are called to do as communities of ministry, we must not rest on the accomplishments of the past. We are called as a community to be tireless in our efforts until all are one, as God is one. We are at a tipping point, where the choices to be made will be of critical importance.

In a culture fixated on the individual, an emphasis on community deserves to be the imperative of the moment. There is so much about community to be recognized, created, and realized. Perhaps, for the foreseeable future, the ministry should adapt a much-used slogan: "No community—no mission." □

NOTES

1. Alexis de Tocqueville, *Democracy in America*, Henry Steele Commager, ed., Oxford University Press, New York City, 1947, p. 312.
2. George Annas, "Life, Liberty, and Death," *Health Management Quarterly*, vol. 12, no. 1, 1990, p. 5.
3. R. Fox and J. Swazey, "Medical Morality Is Not Bioethics—Medical Ethics in China and the United States," in R. Fox, ed., *Essays in Medical Sociology*, Transaction Books, New Brunswick, NJ, 1998, p. 647.
4. National Conference of Catholic Bishops, *Economic Justice for All*, U.S. Catholic Conference, Washington, DC, 1987, p. 2.
5. Carl R. Rogers, *On Becoming a Person: A Therapist's View of Psychotherapy*, Houghton Mifflin, Boston, 1961.