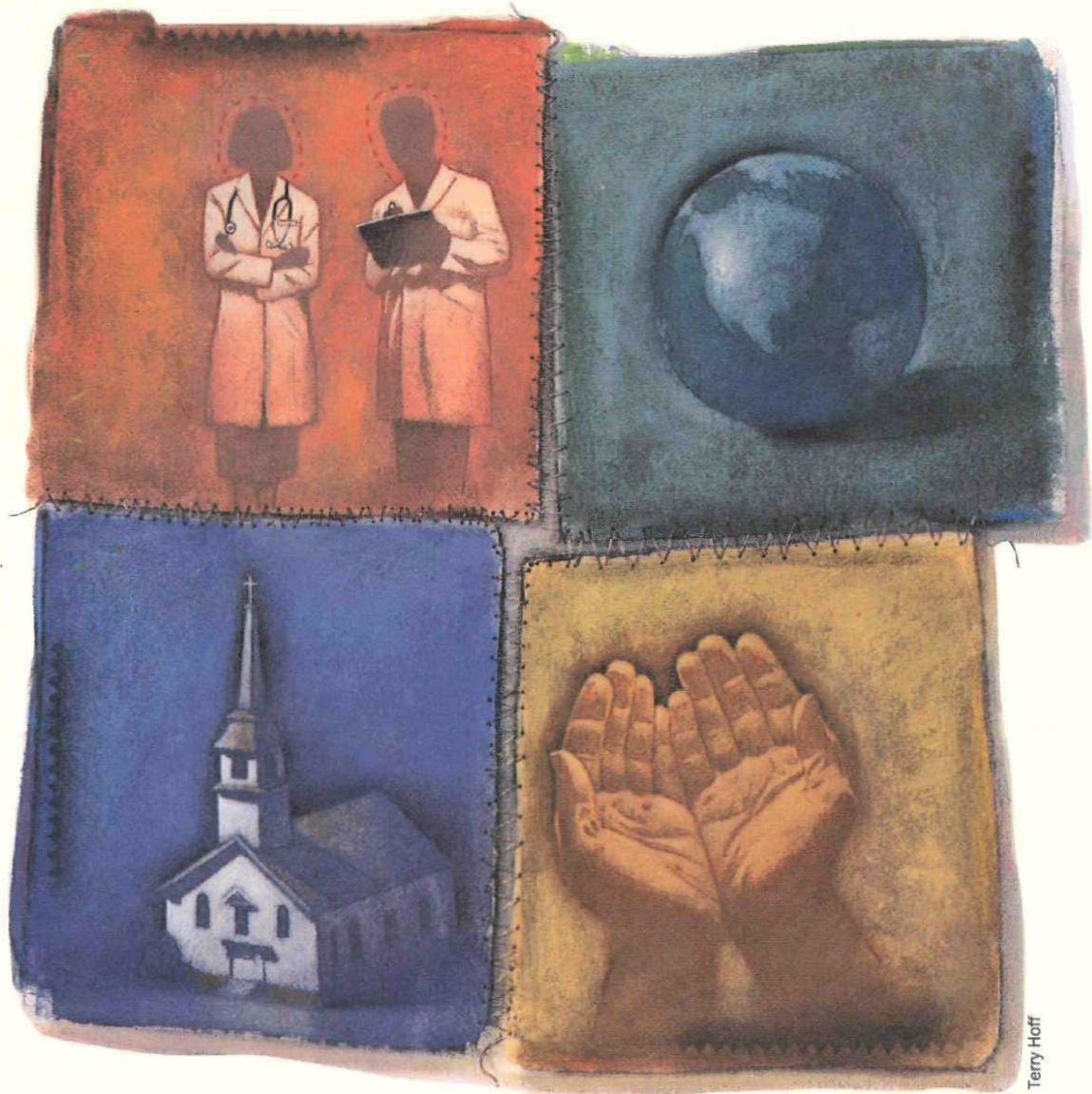


Identity and Institutions

Catholic Healthcare Providers Must Refashion Their Identity
As Actors and Advocates in the World

BY REV. J. BRYAN HEHIR, ThD



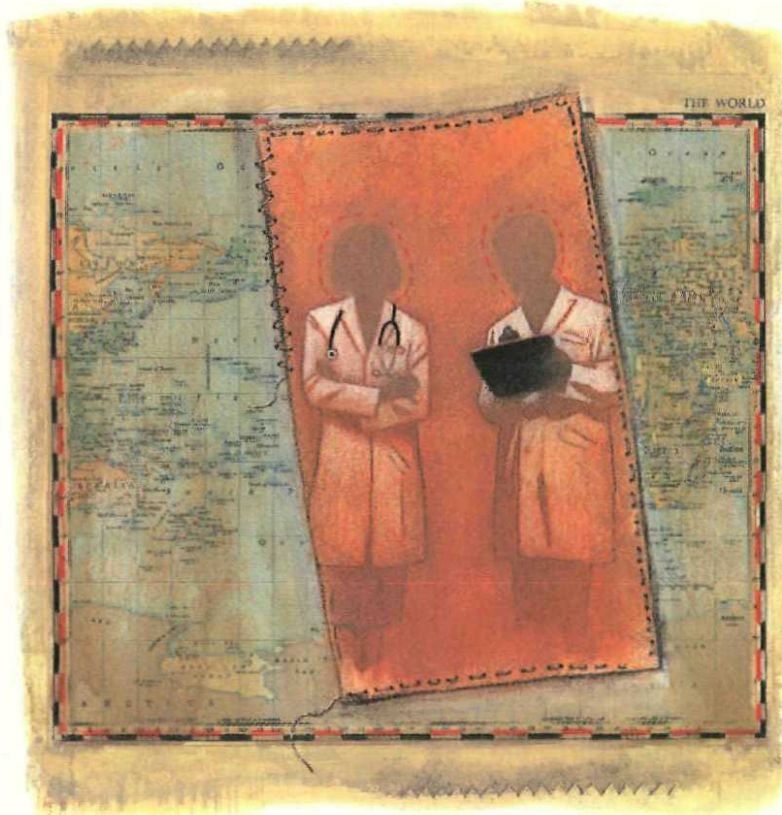
Terry Hoff

The fashioning of one's identity in an ecclesial institution like the Catholic Health Association is a theological task, but one that must be carried out in the context of the rational demands, the secular setting, the pluralistic context, and the scientific requirements of the world of healthcare. If we do not have a religiously grounded, theologically articulated understanding of who we are and what we are, we will lose our way in this complex context. At the same time, if we specify our identity but we cannot meet the standards of a rational, secular, pluralistic world, then our identity will not be effective.

CATHOLIC IDENTITY AND INSTITUTIONS

In discussing the need to "reclaim our identity," I begin with one fear. One way to understand that subject would be to say that somehow we had, purely and simply, lost our identity. I think that judgment would be too harsh, indeed inaccurate. My premise, rather, is that the identity of a complex community and institution must be continually rewoven and renewed. Identity must be maintained over time; time brings changing circumstances, conditions, and challenges; therefore, while identity has an essential element of continuity to it, it must also include a dynamic of development leading to a deeper understanding and

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expanding sense of what our identity is. Identity must be refashioned in light of questions that come to us precisely from the rational, secular, pluralistic context in which we function.

Catholic healthcare shares the task of developing its sense of identity with other Catholic social institutions. In these different settings we see a fundamental question about how to preserve identity and still participate effectively in the society of which we are a part.

The Catholic Church is institutional by instinct and by nature. We often think of the institution as a force that hinders, burdens, or creates obstacles. A contrasting perspective emerges from my professional colleagues, social scientists, and political scientists—most of them not Christian, hardly any of them Catholic—who see the institutional structure of Catholicism as a major asset in a society like

ours. These people, whose lifework is to examine which institutions carry the potential for public influence, see the structure of Catholic institutions as a great gift to the world we live in.

The Catholic healthcare ministry, as the largest not-for-profit healthcare system in the United States, is joined by the largest social service agency in the country (Catholic Charities) and the largest private educational system in the country. Size never proved anything, but there is something to presence. If one seeks to influence, shape, direct, heal, elevate, and enrich a complex industrial democracy, it cannot be done simply by the integrity of individual witness. It is done by institutions that lay hands on life at the critical points where life can be injured or fostered, where people are born and die, where they learn and teach, where they are cured and healed, and where they are assisted when in trouble.

In a large, complex democracy like ours, institutions ultimately always make a difference for good or for ill. None of that eliminates the irreducible need for indi-



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vidual moral responsibility. None of it takes away from the value of personal witness, heroic as it often is. But in the context of the 1990s—where we have, on the one hand, exploding social problems and, on the other hand, declining public resources and maybe declining public will to address them—the pervasive presence of institutions like ours becomes all the more critical to a society like ours.

I would not be misunderstood. I share no common ground with the proposition that our country's governmental structure has no responsibility to the poor and needy. That idea has neither moral foundation nor religious validity. The fact is that local and national governments must face the necessity of weaving public-private partnerships at the seams of society where people must learn, must be cured, must be healed, and must be supported. Because we have pervasive institutional presence, this challenge confronts us as an opportunity.

We stand institutionally at strategic places in this society. When the questions come up—What are we going to do about children? What are we going to do about AIDS? What are we going to do about the fabric of the family? What are we going to do about the future intellectual health of this country?—we are already there. The question is how we understand who we are at those strategic intersections, and how we marshal limited resources, often under institutional pressures placed on us by society, in an effective witness. That is the task which faces Catholic social institutions as a whole.

The challenge is clear, but we do not pay enough attention to this question strategically. We ought to convene a well-chosen, representative body of Catholics who can think systematically about our strategic presence. The potential exists for a "Catholic summit meeting" that would cut across healthcare, social service, and education and look at where we stand in this society and in service of the Gospel. Because we have specialized functions, complicated lives, and busy schedules, we may miss the possibility of coming together for reflective assessment of where we stand in the country, what we have to say, and what we might do across the Catholic social spectrum.

THE IDENTITY OF CATHOLIC HEALTHCARE

In its journey toward reclaiming its identity, Catholic healthcare stands at a third stage of development. The three stages are the immigrant model, the Vatican II model, and the model that is being catalyzed today by

the conditions of the 1990s.

The Immigrant Model The immigrant model of healthcare, like that of Catholic education and Catholic social service, was a product of both ecclesial impulse and social necessity. Catholic healthcare, rooted in the middle of the nineteenth century and developing through the first 60 years of the twentieth century, was driven by an ecclesial impulse to heal, to teach, and to serve, and by a social impulse to serve specifically the needs of the Catholic community. We feared that this community would not be well instructed in a total vision of life or well cared for if we did not create our own institutions. Thus from the mid-nineteenth to the mid-twentieth centuries, the immigrant model focused on the Catholic community.

The Vatican II Model The Vatican II model is a product of ecclesial initiative; it arises from the Church's conciliar vision to take the essential tasks rooted in the Gospel—teaching, healing, and social service—and to think about them in terms of a Church at the service of society as a whole.

It is possible to trace in all our institutions over the past 30 years a definable trend toward serving a much broader constituency and thinking about ourselves as specifically Catholic in identity and broadly catholic in scope. The necessities of the immigrant model tended to exhaust care and ministry almost totally within the Catholic community. But the Vatican II model was a conscious choice to move beyond the bounds of the ecclesial community to demonstrate what it meant when we said the Church should be a sacrament of unity in the world.

The Catalyst of Social Forces

The Vatican II model still drives our conception of ministry and identity, as it ought to. But the catalyst of the 1990s is rooted not so much in ecclesial initiative as in the imperatives and the challenges posed by social forces. These forces are not unique to Catholic healthcare, but the Catholic health ministry must

face them along with everyone else. The forces, a product of events that are both beneficial and threatening, come together to create the context for ministry.

In American society, healthcare is a product of our science and our technology, and it is an overwhelmingly positive asset and a success story. But technology has produced a certain style of healthcare, a certain logic in the economy of healthcare, and a certain set of demands and possibilities that require wise social policy to ensure the system accomplishes both useful human purposes and valid moral purposes.

In the midst of this highly complicated social and technical environment, we have just been through the

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sixth try for systemic healthcare reform in the United States. The attempts go back to 1910 and continue through the most recent debate in the U.S. Congress; each time, we seem not quite to make it.

The recent healthcare struggle was the most consequential social policy debate we have faced since the New Deal. It was precisely because the New Deal did not address the healthcare question, and the Fair Deal tried but failed, that in the 1990s we were back again to our discussion of whether healthcare is a right, who has responsibility for it, and how we shall fund it.

By anyone's assessment, the sixth try at systemic reform clearly came to a dead end. Now we still stand in need of reform, but few initiatives for systemic reform are being proposed. Enormous *change* is going on, but one ought not to equate *change* with *reform*. Indeed, a movement is under foot in which powerful market forces seem to be the only forces at work. We are still without comprehensive healthcare coverage, and the one victory from the fifth try at comprehensive reform in medical care—the Medicare and Medicaid programs of the 1960s—is now under threat. These clearly not perfect but useful programs may be rolled back also.

As we look at the debate that surrounds not just healthcare, but also social policy, it is important to see that the argument now being launched raises the most fundamental moral questions, as well as technical and secular questions. Anyone who listened to the recent debate about

tax reform in the U.S. Congress found people on both sides saying they spoke in the name of moral values. Anyone can claim to speak for moral values, but that claim is the beginning of an argument, not the end of it.

We need to understand what is at stake in the debate that follows the collapse of the healthcare reform efforts of the 1990s. It involves first defining precisely the state's moral responsibility in society. This is a different question from what the state's empirical capabilities are. That is an entirely legitimate question, but in Catholic terms, it is never the only question. The moral responsibility of the governing authority of a society, in Catholic terms, carries a positive responsibility. That question is now up for grabs: What is the content, scope, and extent of the state's moral responsibility?

A second question is: What is society's responsibility for the poor and the vulnerable? The option for the poor may be possible only as a product of a religious vision, but even without this vision one could say that any secular society has moral responsibility for the poor and the vulnerable. We have no settled view on that in the United States today.

Third, what is the moral role of the market? The market clearly has an empirical role in social policy. But

the first pope to highlight the value of the market—John Paul II—immediately followed his commendation with a discussion of the *moral limits* of the market. If healthcare reform is to be driven *only* by the market, we clearly will not reach even minimal moral standards.

Finally, what is the connection between healthcare and the common good? Can you sustain the common good without a minimal level of healthcare for each person in society? Precisely because health is an irreducible human need, it never can be defined purely as a commodity; it is also a social obligation for the morally good society.

MINISTRY WITHIN A CONTEXT

The complexity of the Catholic healthcare struggle is that it is committed to be a ministry, but it must be a ministry within a context. The context is shaped by the market, which in turn fits within a broader political and economic structure. Thus the Catholic healthcare ministry is both an actor in the system and an advocate for those least able to protect themselves. When we try to be both an actor and an advocate—when we try to represent effective, efficient action as well as the vision and

voice of the prophets—we have defined a role filled with tensions. Actors must survive; but actors who fulfill a ministry cannot survive at any cost. The question of identity brings together both the place we hold in the system and who we think we are as we hold that place.

Reclaiming our identity is a process of development, of reflective evolution in our understanding of ourselves, faced with the demands of healthcare in late twentieth-century America. Defining one's identity as a ministry roots it in both ecclesial and moral soil.

It is interesting that the final document of Vatican II, "The Pastoral Constitution on the Church in the World" (1965), discusses the Church's identity and ministry in terms of the Church *in* the world—not the Church *and* the world, never the Church *apart* from the world, nor simply *over against* the world. The Church is to locate itself precisely in the context from which the challenges to our ministry arise. It wants to be tested because being tested means living in the midst of the fabric and fiber of life where real decisions are being made. And so the framework for the ongoing process of reflection on our specific identity is set: Be in the world.

Second, the anchor of our presence in the world is radically human. It is the service of the human person, the service of human dignity. In the language of Vatican II, the Church is to stand as the transcendent sign of the dignity of each human person. To quote Pope John Paul in *Redemptor Hominis* (1979): "The

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person is the way for the ministry of the Church." Our identity is tested by how our ministry contributes to human dignity and human rights.

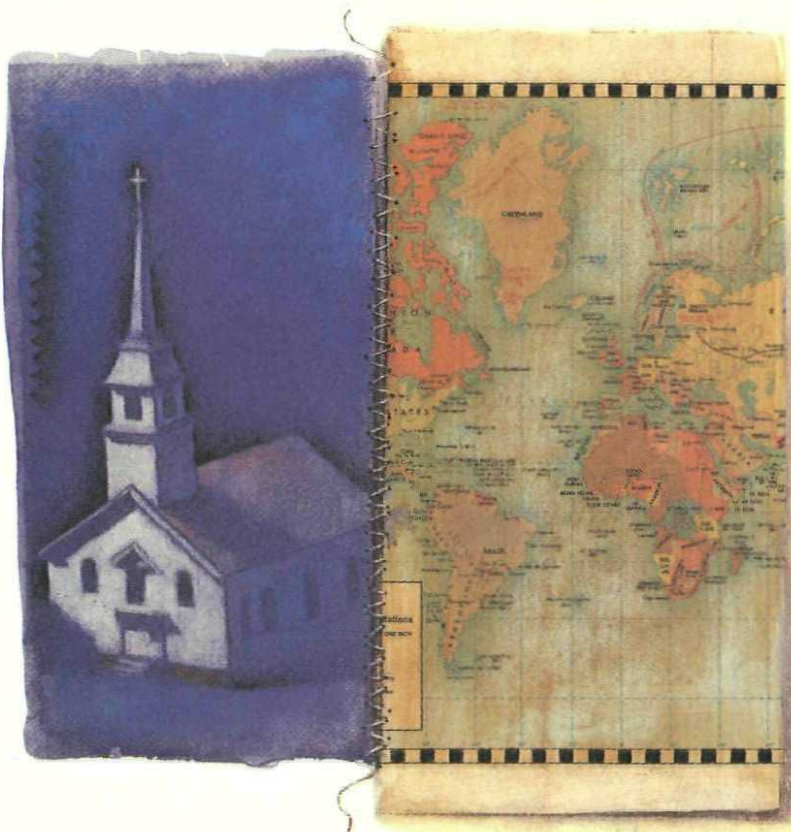
Third, we are to be in the world by dialogue with the world. The Council says this is how the Church shows its love for the world—by being willing to be in dialogue about all the issues that touch the human person.

This role raises the critical notion of what our *posture* ought to be as institutions strategically located in society. The posture of Vatican II is what I would call "confident modesty." It is a Church that believes it has something to learn from the world and something to teach the world. It is a ministry of both collaboration and criticism, for we are never to be simply of the world. In the world as we know it, there is much to criticize. But it is also a ministry in which we seek to find common ground where the dignity of the person can be served.

You are faced now with choices, from social policy to institutional identity, that raise the questions of how much one can collaborate, where one must draw the line, and what criteria one should apply. These eminently tactical choices are never purely tactical. They are rooted in the idea that the Church willingly locates itself in the world, striving to make the right choices about maintaining our identity, but not preserving our identity by taking ourselves out of the flow of human history.

The result of the Council's vision—in the world, for the person, in dialogue with the world—is a Church that is more open to the secular, is universal in its conception of service, and defines itself as a servant. This was the ecclesial initiative which spawned the second stage of Catholic healthcare identity. It moved us purposely out into the wider community, defined the ministry precisely as service, and kept it universal in focus. Moreover, this legacy of Vatican II gives us the criteria to assess the changes we face in the 1990s. But times

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have changed and the tension may be greater today in the Church-world relationship.

INCREASING TENSIONS

Several years ago, at the beginning of the healthcare debate, the Church had three essential objectives: justice for each person, symbolized by universal coverage; bioethical concerns in terms of the basic minimum package of health-care benefits; and institutional pluralism, meaning that religiously based institutions would continue to contribute to society.

In the late 1990s, each of these objectives is much more difficult to achieve than it was in 1993. Precisely because of the failure of a debate about systemic reform, we are further away from the social justice criterion than before. We are in danger of dismantling a fabric of social service and protection for the most vulnerable,

which will make us a disgrace among industrialized nations. We face on the bioethical front intensification of the struggle from the beginning of life to the end. Finally, the question of institutional pluralism is not so much threatened by governmental regulation as it is by the logic of market forces and the role of very large private actors in that competition.

Pope John Paul II's encyclical of 1995, *Evangelium Vitae* ("The Gospel of Life"), moves us from focusing on identity as our place in society to how we engage a set of specific issues. It moves us from ecclesiology to moral argument.

The accent of John Paul II's text tends to fall on the increasing tension of being the Church in the world. There is no call here to leave the world, but simply to recognize the complexity of what we face. Indeed, the encyclical is best understood as a passionate call for defense of a specific moral vision. It is a passionate call

to defend the sacredness of life at the end of a murderous century, a century that has consumed 160 million lives in warfare alone. It is a cry of the heart, and I think the personal history of the pope is not irrelevant here. This is a person who has lived at the vortex of the major social traumas of this century: the rise of totalitarianism, the Holocaust, the Cold War, and the strange lack of peace that has followed the collapse of the Cold War. He casts the moral argument in cosmic categories, arguing that there is competition between a culture of life and a culture of death.

The pope's description of the threats to life can be divided into three categories, which bear upon the tests we face in the healthcare ministry today. The synthetic sweep of the letter addresses ancient, modern, and postmodern threats to life.

The ancient threats to life include hunger, poverty, famine, and genocide. They arise from our inhumanity to each other, and they have been with us a very long time. What is surprising is that they are still so very much with us at the end of this century, in Central Africa, Central Europe, and our own inner cities. Any healthcare ministry clearly must be committed to mitigating the ancient threats to life.

The modern threats to life are more complicated. They arise not from the worst that is within us, but often from the best. This paradox is central to the story of this century: that enormously significant human insights, inventions, and creativity have often produced choices we seem unable to make or to control. In American society, the world's laboratory, in the last 50 years we have split the atom, cracked the genetic code, pierced the veil of space, and extended life far beyond the expectation of any generation before us. Who would describe any of this as unfortunate, much less

evil? When we cracked the atom, we penetrated the center of the universe and unlocked its energy; who would not see in that the fulfillment of what we were called to do in Genesis?

But the modern threats to life arise out of the ambiguity that is in the best of us. We split the atom, created the nuclear age, and then struggled with the Cold War for half a century. We cracked the genetic code, and now face choices in which our scientific insights outpace our moral capacity to make judgments about preserving human dignity. We extend the life span of everyone and then find ourselves wondering whether we contribute to the dignity of the patient or erode it.

Healthcare is at the heart of the ambiguity of the modern threats to life. Once again, just as the Catholic style is never to leave the world to avoid its risks, the Catholic moral style is never to deny what was done or wish that it had not been done. When human intelligence reaches toward the truth, it is always a grace, but we are left with the task of bringing our moral vision to match our intellectual insight.

I believe that is what the pope describes as the postmodern challenges to life.

They are rooted not in what we do, but in how we think. The fear that runs through the encyclical is that we do not know how to think well about protecting human dignity and promoting human rights in a world framed by the ancient and modern threats to life.

A FRAMEWORK FOR IDENTITY

These challenges are at the heart of what we confront when we ask about Catholic identity. If we combine the basic structure of "The Pastoral Constitution" with the principal argument of "The Gospel of Life," key

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From this conviction flows the understanding that being human means accepting accountability, personally, professionally, institutionally, for the lives of others.



themes emerge that can provide the framework to address who we are and where we should stand today. Those themes are a commitment to sacredness, an understanding of stewardship, and a deep conviction about the social fabric of life.

A commitment to sacredness entails not only a philosophical statement that life is sacred, but the development of a personal attitude that is evident in the way we approach every human person who comes to be healed and cured; a development of a social attitude that radiates from institutions; and a development of a professional sense of awe when we stand in the face of the mystery of every human person, well or ill. This is not automatically cultivated in an age of much technology and great complexity.

A sense of stewardship involves maintaining a conviction that life is a gift and not simply a product. Such a conviction means that we stand in the face of a mystery that is larger than we are, that comes *to* us and will be taken *from* us. In the Catholic tradition such a conviction yields a posture personally, professionally, and institutionally that we are entrusted with life—we do not own it. Such a posture provides direction for methods of healthcare and sets definite limits that should not be transgressed.

This, too, is hard to sell in a culture like ours. For if we do not own our own life, what else escapes our grasp? But that is just the point: The principle of stewardship in Catholic thought guides our approach to economics, as well as to bioethics. For the goods of the earth are entrusted to us and, while we can legitimately claim we own some, how we use them is as much a

moral question as how we understand stewardship at the beginning and end of life in a medical setting.

The social fabric of life involves a conviction that we are bound together in a single destiny, that we are social by nature and not by choice. From this conviction flows the understanding that being human means accepting accountability, personally, professionally, institutionally, for the lives of others. This sense of social fabric is not a vague, nice-sounding theme. For example, if the euthanasia debate is viewed with the understanding that we are socially bound together, one gets a different perspective than if society is seen as a series of atomized individuals all in possession of their own lives and disconnected from each other in their choices.

This sketch is far from a finished product, but convictions about sacredness, stewardship, and the social fabric of life give us the kind of moral vision that allows us to be a Church *in* the world, *for* the person, and

capable of *dialogue* about the interaction of science, technology, and social policy.

INSTITUTIONAL CHOICES

Fashioning an identity always requires institutional strategy; that is, in the end we have to make choices and apply tactics in the face of challenges.

The first step in a strategy is to be aware of the value of institutional presence. Today, our institutional instinct is a social asset; in this society, institutions will not do everything, but they will fundamentally shape the quality and character of life. How we keep alive that institutional presence is an ecclesial theme, a social challenge, and a human necessity.

Second, strategy requires an integrated witness, that is, horizontal and vertical integration in the Church. Horizontal integration means that the multiple Catholic social institutions need to conceive of ministry in an integrated fashion; health, education, and social service should form an interlocking presence for the Church in American society. Strategic vision needs to be developed *across* the range of Catholic institutions in the United States. It is going to take multiple insights from the social sciences, from ethics, and from

ecclesiology to do this well, but we will never do it adequately by thinking about institutions separately. Vertical integration means that institutions like hospitals and health-care facilities can be related in the future to parishes, for example, in whole new ways. This is a leading edge of where we need to go in changing forms of healthcare.

Finally, we must hold together our un-

derstanding of identity and values, of viability and integrity. This imperative takes me back to the beginning of this address: Catholic institutions must survive, but with a distinctive posture and presence in society. It is clear that the logic of healthcare reform, whether it comes by systematic planning or purely by market forces, includes the reduction of the number of healthcare institutions. The maintenance of institutional presence becomes a strategic challenge, particularly where viability must be preserved within the ambit of ecclesial and moral integrity. A person without identity and integrity is a threat to himself or herself. But an institution that loses its moral compass and its sense of identity is a much larger threat to society.

The 1990s is no time for Catholic healthcare to lose its way. The stakes are too high and potentially too great: to make a difference for sacredness, stewardship, and the social fabric of this country. □

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