LOOKING BACKWARD TO MOVE FORWARD

Writing Your System's Racial Autobiography

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In 2015, Georgetown University confessed a painful secret: the Maryland Jesuit Province had sold 272 enslaved Blacks in 1838 to secure the struggling university's future.[1] Almost two decades earlier, three congregations of religious women in Kentucky that had enslaved Black people — the Sisters of Charity of Nazareth, the Sisters of Loretto and the Dominican Sisters of St. Catharine — began a similar journey to acknowledge and atone for their past. And in 2016, the Leadership Conference of Women Religious (LCWR) adopted a resolution to "examine the root causes of injustice, particularly racism, and our own complicity as congregations," a resolution that garnered little action at the congregation level until reignited by the murder of George Floyd in 2020.[2]

But what of Catholic health care? Have U.S. Catholic hospitals and health systems reckoned with their complicity during a racist past, a history they share with local communities and their founding orders of religious women? Have they discerned how this history permeates the structure and challenges of 21st-century health care, particularly racial disparities in health care delivery and health outcomes? Correspondingly, has the Catholic academy researched the tensive relationship between race and Catholic health care in the U.S.?

The answer to these questions is largely "no." While the literature on race and Catholic religious congregations in the U.S. is now growing,[3] to date there have been very few scholarly studies of race and Catholic health care.[4] Moreover, the stories told at new employee orientations and in senior leadership formation programs omit the troubling legacy of their organizations around race.

In this article, we challenge Catholic health care systems to again follow in the pioneering work of the sisters and examine their institutions' racial past. A critical first step in anti-racist training asks individuals to write their own racial autobiography. Here we explore the analogous practice of writing "institutional" racial autobiographies. To do this, we review a pilot project conducted in Spring 2021 by student researchers in Loyola University Chicago's Doctorate in Healthcare Mission Leadership program. These students — all mission leaders in Catholic health care — were asked to research and write a "system racial autobiography."

From these studies, four key themes emerged: 1) a profound silence on issues of race and racism; 2) how our collective racial history informs our present health care challenges; 3) the role of individual leaders in advocating anti-racism or sustaining racism; and 4) the persistence of "white spaces" — environments in which Black people are typically absent, not expected or marginalized — in health care systems and communities. We outline here the imperative steps involved in this examination, beginning with discussing the practice of creating a racial autobiography and the methodological guidance provided to the students. We then outline the recurrent themes and

findings from this study and their implications, followed by recommendations for writing our systems' racial autobiographies — the first step toward developing anti-racist practices in health care organizations.

RECKONING AND RECONCILIATION

Many current initiatives in Catholic health care focus on the vital issue of addressing racial disparities in health outcomes. While these forward-looking initiatives are crucial for redressing the legacy of racism in the U.S., anti-racist training emphasizes that it is equally crucial to look backwards. As previously mentioned, a key step toward developing anti-racist practices is the creation of a racial autobiography — an honest accounting of one's history, assumptions, actions and omissions that weaves together both the darkness and light of one's own involvement in U.S. racism.[5] Ibram X. Kendi's landmark book, *How To Be an Antiracist*, is his own extended racial autobiography, each chapter exploring his inadvertent complicity in various forms of racism endemic to the U.S.[6]

The sisters' recent work transmutes this practice from an individual activity, modeling a practice of writing institutional racial autobiographies. As of August 2021, at least 30 congregations of women religious had begun such a process.[7] As theologian and former Adrian Dominican M. Shawn Copeland notes, such work is necessary for dismantling organizational and institutional racism, for only by "really understand[ing] what happened in the past, you can identify your previous behaviors and try to correct them."[8] Margaret Susan Thompson, a professor of history at Syracuse University and an associate of the Sisters, Servants of the Immaculate Heart of Mary, who studies Catholic sisters and race in the United States, likewise notes: "The same way the United States cannot address institutionalized racism if it will not recognize the history that created it, Catholic sisters will not be able to build relationships with Black communities if they will not acknowledge how they have hurt them. ... They have to deal with their own histories to deal with the present."[9]

Thompson's insight is crucial for Catholic health care. The COVID-19 pandemic has made clear that communities of color often do not trust local health care providers, even Catholic hospitals.[10] It is commonplace to point to events like the Tuskegee Syphilis Study — an American medical research project that earned infamy for its unethical experimentation on Black male patients in the rural South — as a reason for that mistrust. But in reality, its source lies much closer to home as a result of decades-long experiences endured by people and communities of color with their local hospitals and providers, occurrences that still continue today.

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Truth — an honest accounting of our own history — is a critical first step for rebuilding trust. As we have seen globally over the past three decades, it is also the critical first step in reconciliation — a practice rooted in Catholic liturgical identity.[11] As Sacred Heart Sr. Maria Cimperman states: "Reconciliation is both a choice and a grace. It's different from forgiveness. I may forgive you but never again speak to you. But reconciliation is building a new relationship."[12]

Catholic health care, as a ministry of the Church, is called to the work of reconciliation, which is inextricably interwoven with Jesus' healing ministry. A first step in reconciliation is the practice of confession, where we recognize and tell the truths about our past for the purposes of "metanoia," or conversion and to chart a new way forward in the community.

METHOD TO CONDUCTING RESEARCH

To pilot this work in Catholic health care, in Spring 2021, 13 health care mission leadership students enrolled in Loyola University Chicago's doctoral "Theology, Race, and Catholic Healthcare" course

were asked to research and write a racial autobiography for their health system.[13] The student researchers represented nine Catholic health care systems, ranging in size from a stand-alone hospital to six of the 10 largest Catholic health care systems in the U.S.[14] Quickly discovering that writing a racial autobiography of their system would be an extraordinary undertaking, most focused on one or two hospitals within their system. As such, the studies focused on 18 hospitals across the following regions in the country: the East Coast (1), South (1), Midwest (12) and West Coast (4). Overall, the historical period studied spanned from the mid-1880s to 1970.

The research conducted included the following questions:

- What is the history of your system around race?
- Do you have any archives?
- Can the archivist help you find resources that illuminate the work of the sisters or others around issues of race?
- What difficult racial issues has your system had to address?

To compile these system racial autobiographies, student researchers drew on a variety of sources: Community Health Needs Assessments (CHNAs), health care system and diocesan archives, oral history interviews, local newspapers and official histories of religious orders and health care systems.[13]

FINDINGS

1. A Culture of Silence

A first overriding theme from these studies was that of silence. Silence shaped these projects in three ways. First, the historical records of the systems studied largely evaded or hid questions of race and racism in Catholic health care. Most of the student researchers found few or no references to race in their systems' historical materials, one student referring to this finding as "a deafening silence." Another student stated that "much of what is 'not said' resounds more loudly" through the documentation than what was said. The most noteworthy results: almost no references to Black patients or employees; no information in the records about race; no founding stories that talked about race; no mention of people of color in the 150-year official histories; and little or no mention of race in past or recent CHNAs. Students particularly commented on the absence of Black people in archival photos. The rare references to race generally occurred only in conjunction with a good work performed in the community.[15]

The research also revealed contemporary silence. Emails sent — even to some archivists — received no response. Some student researchers discovered that people in their system were not willing to discuss race, that it was considered a "taboo" topic. As one student noted: "There is a culture here that does not permit discussions of race." In addition, some systems seemed wary of unearthing any historical evidence that would potentially cast a shadow on the sisters.

At the same time, however, a number of student researchers discovered that their hospitals and systems had engaged in laudatory actions around race that were not revealed in the historical record. Certainly, these records highlighted key moments of Catholic health care leadership around race — such as the founding of the first Catholic hospital for Black patients and the founding of the first integrated health care facility in the South. But equally, students unearthed additional positive stories that were largely excluded from official narratives; for example, efforts as early as the 1910s to integrate previously segregated facilities or the hiring of a Black physician in the 1950s.

2. The Impact of America's Historical Events

A second overarching theme is that, despite their religious mission, Catholic health care systems are not set apart from the larger history of racism in America. Student researchers noted the plethora of religious orders that founded hospitals near the end of the 19th century, when the United States was swept up in tremendous socioeconomic, political and cultural reform known as the Progressive Era (1896-1916). Yet Progressivism did not materially improve the lives of most Blacks; indeed, Progressive Era "reform" often was virulently anti-Black and segregationist. Northern urban areas where hundreds of thousands of Black Southerners fled

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in search of economic opportunity during the Great Migration became racially charged, volatile environments.[16] Therefore, students narrated the histories of their local hospitals relative to these broader social movements.

In one finding, a student described how white residents of his particular Midwestern city responded with fear, anger and violence to Blacks who had migrated to the city during the 1910s seeking equality and economic advancement. In September 1919, a bloody race riot unfolded after white residents attempted to burn down the county courthouse in order to terrorize and lynch an imprisoned Black man who was jailed for allegedly raping a white woman. After his body was burned and hanged from a lamppost downtown, thousands of white citizens subsequently rioted in the city and threatened to scorch and loot the city's "Black Belt." To restore order, federal troops quelled the violence and enforced segregation in the city.[17] This event marked the beginning of redlining as well as the rise of the local branch of the Ku Klux Klan. For decades afterward, Black residents faced traumatic racist violence, housing restrictions, inequities in educational and economic attainment and limited access to health care.

While this particular city's race riot might seem like an extreme example, the structural racism it illuminated reverberated throughout other students' narratives of injustice and missed opportunities for Catholic health care systems to serve those most in need. The student researching his city's disturbing past wondered why Catholic system leaders in the present have not deliberately named their local Black community as a population in need of targeted health care initiatives. Noting that "racism" was not one of the named CHNA determinants of health, he argued that given "its long history of segregation in our city and its current disparities in health, the Black community is, in fact, a particular 'vulnerable' community." Despite decades of collaborative Catholic health initiatives and significant community benefit funding, Black residents still face persistent challenges in obtaining equitable health care that have defied standard solutions.

3. Racist or Anti-racist Leadership

A third theme that emerged was the significance of racist or anti-racist leadership in shaping patient access to care and influencing the inclusion of non-white clinical staff in Catholic hospitals. More than one student researcher mentioned the importance of diocesan leadership

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in creating a racist or anti-racist climate. As one example, Cardinal John Joseph Glennon, who served as St. Louis archbishop from 1903 to 1946, was a segregationist. He acknowledged in 1927 that Black residents in the city were "expecting and demanding equal rights in the churches, eliminating the color line altogether." This was "impractical," according to then-Archbishop Glennon, because "St. Louis is by tradition a Southern city" and many of his prominent supporters were white Southerners.[18] In contrast to Archbishop Glennon was his successor, Archbishop Joseph Ritter. After the 1954 *Brown v. Board of Education* decision, which ruled racial segregation in public schools as unconstitutional, Archbishop Ritter ordered hospitals in the archdiocese to review their policies and proceed with desegregation for patients and to accept qualified practitioners of all races.[19]

Sister leadership likewise advanced racism or pioneered anti-racism. At a Midwest hospital, a sister and hospital administrator was hailed by the area's Black newspaper as "a foe of Jim Crow" during her six-year tenure. This attention resulted from her role in changing racist policies that had prevented Black patients from being admitted to her hospital and appointing the first Black physician in 1948. Elsewhere, the archives highlight how changes in system leadership were the catalyst for reform. In 1911, a new Mother Superior initiated the desegregation of a San Francisco hospital rebuilt after the 1906 earthquake. Without fanfare, she decided that patients would be categorized and admitted to floors based on their illness, not by race. "This was the sisters' way of combating the inherent racism in segregation," noted a person with knowledge of the history interviewed for the student's project.

Finally, not all examples are from past eras during which Jim Crow discrimination thrived. One student researcher documented that in 2021, the directors of a particular hospital opted not to diversify its board to include a Black member. Despite claims that fighting racism and working for health equity were top priorities, mem-

bers concluded that the prestige of the board would be undermined by adding a Black associate with the objective of diversifying the board.

4. Catholic Health Care as a "White Space"

A fourth predominant theme uncovered was the way in which Catholic health care has maintained itself as a "white space" and contributed to the construction of these environments within local communities. Sociologist Elijah Anderson defines a "white space" as one in which cultural assumptions "reinforce a normative sensibility in settings in which black people are typically absent, not expected, or marginalized when present. ... While white people usually avoid black space, black people are required to navigate the white space as a condition of their existence."[20] Historically, segregation was an explicit approach to creating white and Black spaces. Catholic health care participated in and often perpetuated such segregation, both directly and indirectly, in at least three ways.

First, for nearly a century after the arrival of the sisters in the U.S., Catholic hospitals participated in established segregationist practices of U.S. culture. While the sisters may have cared for Black patients, as Susan Karina Dickey narrates in a 2005 *American Catholic Studies* article, the care they offered was largely segregated, either within their hospitals or by sponsoring different institutions for Black patients.[21] Many systems relinquished segregation only reluctantly, following the 1964 Civil Rights Act.

Second, most Catholic health institutions were not welcoming to Black nurses or physicians. While many religious congregations sponsored schools of nursing, the student researchers noted that few Black students were admitted prior to 1949.

Third, although many sisters founded their original hospitals in the poor and often Black parts of their communities, most of the students documented how their systems had participated in "white flight," routinely moving their hospitals to wealthy, white and often suburban locations. Many of the pioneering hospitals or infirmaries for Black patients were eventually closed or demolished after the 1960s. Almost every student told of a hospital "located in what became the poorest zip code in the state," that ultimately closed. Researchers also noted a pattern in language surrounding the reasons for these closures: the system was "forced" to leave the neighborhood, was "driven out" or "had no choice" to leave because of finances and then reopened in suburban locations. The trend across systems, however, was clear: Catholic health care systems closed historically Black hospitals and thereby served fewer Black patients, rendering many Black communities — in the apt phrase of one student — "medical deserts." As another observed, there could be no doubt that racism was an impetus for this pattern.

Unfortunately, students heard examples of Catholic health care institutions continuing to perform largely as white spaces today. One Black mission leader noted: "Not one of my presentations [that I had given on the sisters' or health system's history] included any information about race and the racial history of any of our hospitals." The historical research is prompting students to question what is absent from what they learn about these institutions, and why it's important.

WRITING A SYSTEM'S RACIAL AUTOBIOGRAPHY

After the murder of George Floyd in 2020 and the global uprising against racial injustice, many in Catholic health care felt called to join the fight. To address these issues, CHA launched the We Are Called initiative in 2021 to urge members to confront racism by achieving health equity.[22] To date, many Catholic health care systems have signed the pledge, issued system-wide statements and have taken system-level steps to begin addressing diversity, equity, inclusion and belonging (DEIB).

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Yet history reminds us that white enthusiasm around racial justice often quickly loses momentum. And, as we have seen over the past year, the backlash against anti-racist efforts by some in the Catholic church — from misrepresentations of critical race theory, to the refusal to support the Black Lives Matter (BLM) movement and more — infuses Catholic health care systems as well. Student researchers reported a disconnect between system-level rhetoric and commit-

ments and what is happening on the ground in local hospitals. They perceive, too often, through the hospitals they observed, a tacit permission for employees to push back against DEI, BLM and other initiatives designed to make people of color feel a sense of belonging — efforts that seek to deconstruct Catholic health care as a white space which might make some white employees feel uncomfortable.

In light of our current context and the findings of our student researchers, we offer seven recommendations for systems that are open to beginning the process of writing their own racial autobiographies.

First, publicly embarking on a system racial autobiography is a critically important first step. Doing so will enable Catholic health care systems to advance health equity by honestly confessing complicity in decades of racial injustice while illuminating positive historical moments. Importantly, it signals recognition that structural racism is a social determinant of health. Creating meaningful change requires knowledge and insights from the past and learning what role the system has played in that history. Systems will not be able to move the needle on external outcomes and social determinants of health if we do not recognize and acknowledge the racism that is embedded in our institutions historically and currently.

Second, who should do this work for the organization? One of our takeaways from this pilot project is that the researchers should not be mission leaders — nor should it be someone internal to the system. Not only might such a standing create a conflict of interest, but the work calls for the skills, knowledge and abilities of professional historians. Catholic health care systems committed to the work of dismantling racism and advancing health equity should retain academic historians — particularly those who have begun the work of studying the racial history of U.S. Catholic institutions — as independent researchers via their DEIB budgets.

Third, systems, as well as dioceses and religious orders, also need to document their histories and make sources available, and encourage open collaboration with historians. Many of the student researchers discovered that their system had no archivist and limited access to historical materials. Systems must ensure that evidence such as oral histories, newspaper accounts, pertinent correspondence and photographs are preserved, maintained and accessible. Significantly, students who attempted to access diocesan and religious orders' archives often were met with a lack of cooperation and missing documentation.

Fourth, we must ask: Have we left segregationist practices behind? While Catholic hospitals no longer have segregated wards, there are still "minority-serving hospitals" that are often staffed almost exclusively by white health care workers due to only 4.8% of physicians and 10% of nurses nationally being African American.[23] In November 2020, researchers from Stanford and Duke University found that the staggering disparities in COVID-19 mortality were explained in part by "site of care" rather than by race or ethnicity, leading to questions about the ways in which "minority-serving hospitals" are resourced.[24] At the same time, health care systems continue to close hospitals in communities of color, reinforcing geographies of Black and white spaces with language of "having no choice."

The historical record makes clear that meaningful change requires courageous leadership. Today, the sisters are leading anti-racist efforts in their communities and ministries.

Fifth, a central component of mission formation programs across the U.S. are celebratory stories of Catholic health care systems. But what do these stories reveal about the relationship between Catholic health care and the endemic U.S. racism in which Catholic health care emerged? What do they leave out? How and where should those who work in Catholic health care incorporate this more realistic history into their formation programs?

Sixth, the historical record makes clear that meaningful change requires courageous leadership. Today, the sisters are leading anti-racist efforts in their communities and ministries. Can their legacy health care systems follow? It will take real leadership at the system and diocesan levels, committed to dismantling racism in the church, health care and society to make this happen.

Finally, such leadership will also provide a powerful witness and model for employees to do this work on an individual level. It will help counter the contemporary silence, taboo and fear care-

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— SR. JAYNE HELMLINGER

givers and employees still harbor today regarding talking about race. Many white associates do not want to say or do the wrong thing; however, they do not know where to start, so the silence continues. But, as Sr. Jayne Helmlinger, a Sister of St. Joseph of Orange, California, notes: “You can’t [dismantle] organizational and institutional racism without doing the personal work.”[25] To dismantle institutional racism and advance health equity will require both organizations and their individual associates to begin this process of self-examination. As she noted in her August 2020 presidential address to the LCWR: “This part of God’s vision is infinitely clear to me: We have work to do, sisters, in our complicity in enabling the insidiousness of racism to flourish within and around us. I cannot be, live or lead authentically if I’m not willing to do the inner work required in naming and eradicating the racism that dwells within.”[26]

Addressing racism and racial injustice — a 400-year problem — is not going to happen overnight or in a financial cycle. Truth and integrity are at the heart of mission. And if Catholic health care is going to effectively meet the goals of the We Are Called pledge, a necessary first step will be to reckon with its racial past. As Sr. Cimperman notes: “These are sacred conversations we’re being called to. This is going to take my lifetime. This is going to take generations.” Sr. Helmlinger concurs: “It’s painful work,” she said, “but it’s very gratifying work.”[27]

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QUESTIONS FOR DISCUSSION

Authors M. Therese Lysaught and Sheri Bartlett Browne describe how Loyola University Chicago doctoral students in a mission leadership program wrote institutional racial autobiographies last year, and what they learned from the process about how those working in U.S. Catholic health care may benefit from a better understanding of racism, both from the past and that still persists.

1. Has your health care system done any work to explore its history? Would a racial autobiography be helpful for your facility or system? How so?

2. What concerns do you have about a biography like this? Do you think people are afraid to honestly explore history? Why? What might the benefits of a racial autobiography be? How might it ultimately help patients and communities?

3. What work has your system or site done to "get its own house in order"? To examine the prejudice, unconscious biases or economic inequities that may affect health care? What are the places where you're doing good work to reduce health inequities?

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