Mission for This Moment

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According to the evangelist and physician Luke, Jesus articulated his mission when he was filled with the Holy Spirit after fasting in the desert for 40 days and enduring the temptation to forsake love for fame, fortune and power. His inaugural mission statement was a repetition of the prophet Isaiah's from another age:

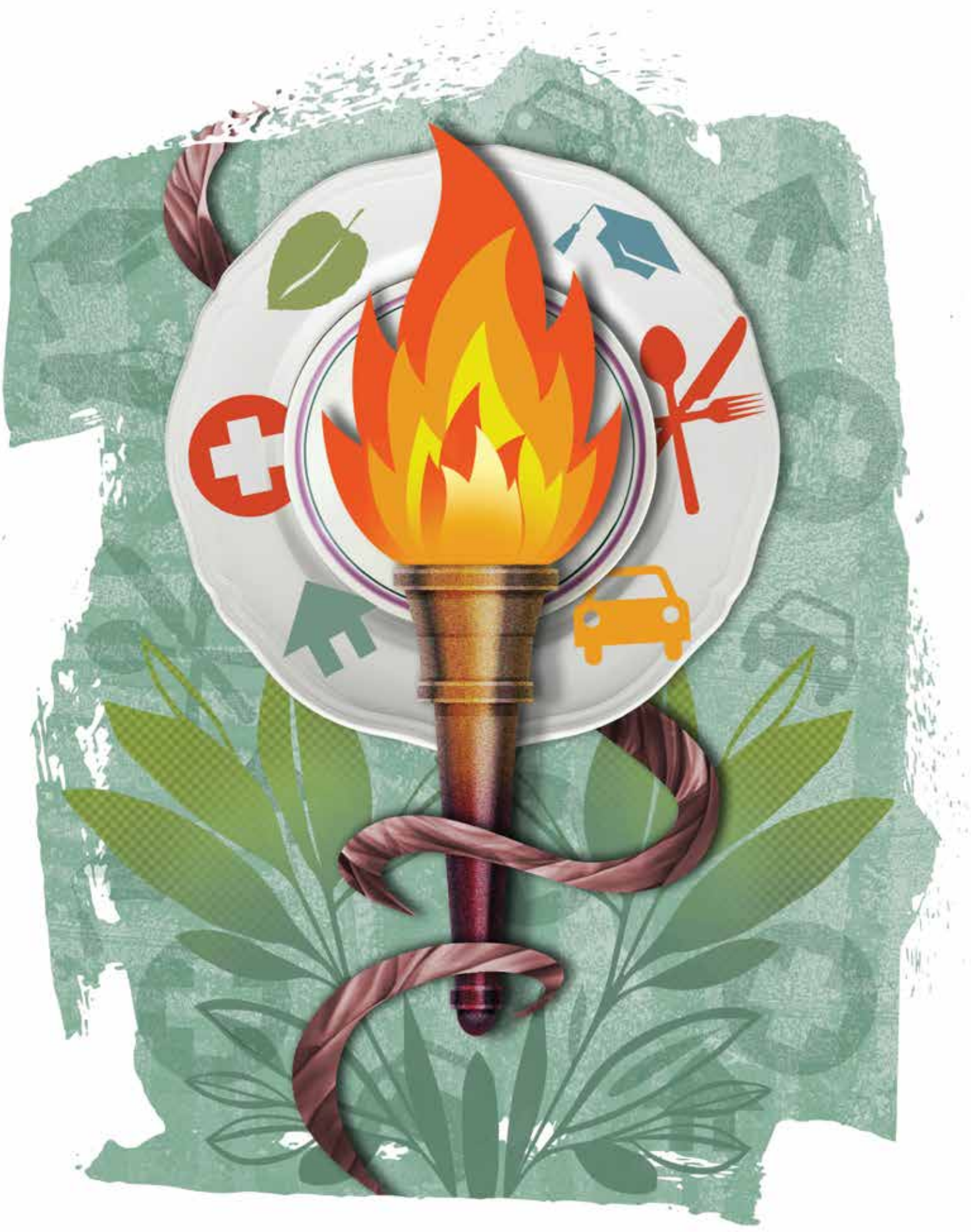
> "The Spirit of the Lord is upon me, because he has anointed me to bring glad tidings to the poor. He has sent me to proclaim liberty to captives and recovery of sight to the blind, to let the oppressed go free, and to proclaim a year acceptable to the Lord." (Luke 4:18-19)

What is interesting here is the primacy of the poor in Jesus' understanding of his call and mission. Most, if not all, of his healing was focused on poor and marginalized people. But even before his concern for the poor was expressed that day, a plethora of Hebrew prophets before him used the treatment of the poor as the hermeneutical key for critiquing the moral state of society. Islam does the same. Therefore, all the children of Abraham can agree that people who suffer from poverty are of critical concern for God and, by extension, his children. For the Christian tradition, we see how care for the poor as a mission imperative becomes a magnet, a draw to the ministry.

> At that time, as the number of disciples continued to grow, the Hellenists complained against the Hebrews because their widows were being neglected in the daily distribution. So the Twelve called together the community of the disciples and said, "It is not right for us to neglect the word of God to serve at table. Brothers, select from among you seven reputable men, filled with the Spirit and wisdom, whom we shall appoint to this task, whereas we shall devote ourselves to prayer and to the ministry of the word." The proposal was acceptable to the whole community, so they chose Stephen, a man filled with faith and the Holy Spirit, also Philip, Prochorus, Nicanor, Timon, Parmenas and Nicholas of Antioch, a convert to Judaism. They presented these men to the apostles who prayed and laid hands on them. The word of God continued to spread, and the number of the disciples in Jerusalem increased greatly; even a large group of priests were becoming obedient to the faith. (Acts 6:1-7)

Note how this narrative in Acts of the Apostles reveals conflict and reconciliation. The Greeks and Hebrews were not getting along because of real or perceived unjust distribution of food for the poorest of the poor, the widows of gentiles who were not only deemed "unclean" but were also women who were without any property of their own, with no husbands or sons (property owners) to care for them. The Twelve Apostles heard the pleas of the marginalized and addressed the problem by welcoming wise men from those areas to serve their community's needs.

This was essentially an early workforce development program. And notice how the entire community, not just the poor Greeks but Jews and



Greeks of privilege, were also pleased. The whole community became happy when the poorest of the members were served. The Church then grew greatly, and many of the priests became obedient to the faith. The mission that Jesus articulated still has the power to heal, reconcile and transform today.

MISSION IN AN AGE OF 'OTHERING'

As a Black system ethicist working in Catholic health care, I have seen the pushback against the concepts of diversity, equity and inclusion (DEI). I will refrain from using the acronym DEI in this article because it loses its meaning as a three-letter lightning rod. A social media post once said that when the words "diversity, equity and inclusion" are used, they are more likely to raise the question in the other person's mind: "What am I fighting against, is it diversity, equity or inclusion?" Perhaps it is all three, but that is at least the basis for an honest discussion.

Clarity around terms and policies is critical. This became especially so when, in 2023, the U.S. Supreme Court ruled against the policy known as Affirmative Action, which some view as a quota system for admitting students, hiring personnel and selecting suppliers that violates the Equal Protection Clause in the U.S. Constitution.[1] The Court did not rule against diversity, equity or inclusion as principles. That means there is no such thing as "illegal diversity, equity and inclusion," which is evidenced by the fact that the White House continues to celebrate Black History Month in its own way.

But Catholic ministries are feeling dazed and confused because the word catholic means universal, which means that the Roman Catholic Church is global and welcomes everyone. Moreover, the Catholic Church and all its ministries are called to see the spark of the Divine in every man, woman and child, with no exceptions.

However, the current moment has ushered us into an age of "othering." This can also be understood using the fuller meaning of the word apocalypse, which is an unveiling. Othering is the process of using real or perceived differences to distinguish in-group from out-group members, the worthy from the unworthy, the clean from the unclean, the Black from the white. I say unveiling because, since the founding of America, othering has been a driving force. It receded during brief periods of our collective history, but now it is clearly manifest. How do we use the mission of Jesus to meet the moment of today as Catholic health care ministries?

BLESSING THE POOR BLESSES ALL

Structural or concentrated poverty is defined as when 30% or more of people residing in a census tract live at or below the federal poverty level. Structural poverty is harmful to health regardless of race or ethnicity. In fact, researchers found that the incidence of coronary heart disease is 2.5 times higher for Blacks and three times higher for whites who live in structural poverty compared to those who do not.[2] Low birth rate, which is a risk factor for infant mortality, is also associated with structural poverty.[3] A consistent ethic of life requires that Catholic health care be attentive to contexts where people who are made in the image and likeness of God are languishing. Directive 3 of Part One of the *Ethical and Religious Directives for Catholic Health Care Services* states:

> In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn ... racial minorities; immigrants and refugees.[4]

When communities are redeveloped to include mixed-use, mixed-income, more than adequate, affordable housing and walkable and/or transit-oriented development that supports the lives, livelihoods and dignity of residents, what is currently called social determinants or drivers of health are ameliorated and health outcomes improve, even when personal income does not.[5] A 2015 report found that roughly 8% of whites, 25% of Blacks and about 17% of Hispanics lived in structural poverty.[6]

People living in structural poverty have greater difficulty accessing primary and sometimes emergency care, behavioral health, nutritious food, quality education, meaningful employment, public transportation and services that enhance the quality of life. For this reason, the Church calls these communities of structural poverty "intrinsically evil" because they put lives at risk.[7] Moreover, such contexts make it easy for infectious diseases to develop and spread from people

whose immune systems are compromised due to the chronic stress of structural poverty to others within and outside of those communities. Thus, care for the poor is care for everyone. Like the community in Jerusalem, the whole community is satisfied and healthy when the poor in their midst are supported and healthy.

As noted earlier, to continue the mission of Christ, the apostles recognized the importance of dealing with economic circumstances when they appointed the seven men filled with the Spirit of love and wisdom to address this need. Catholic health care can continue this apostolic work by addressing structural poverty. On any given day, a hospital may have several job openings, and many of these positions may require entry-level skills. Residents living in structural poverty can be recruited into these positions, and greater experience and additional education and training may lead them to more skilled roles. Roles like medical assistant and certified nursing assistant can be transformational to people living in structural poverty because health care, particularly nursing, is one of the top industries for potentially moving people from poverty to the middle class.[8]

Students in these communities should be exposed to health care careers and opportunities as early as elementary school. Failing to address community economics collaboratively with other stakeholders while providing health care is tantamount to treating sepsis with vitamins. While vitamins are generally important to health, they do not treat the root cause of the illness, and therefore, vitamins alone will not help the patient get healthy and stay healthy.

Finally, if Catholic health care can move people from structural poverty to employment, the financial strain on health systems serving these populations is reduced due to higher reimbursement from commercial insurance. Residents of communities of structural poverty are typically uninsured, underinsured or on Medicaid, which is perennially threatened by state and federal governments.

When this population is large enough, the hospital may become at risk for insolvency due to an adverse payor mix. The typical response is to close the hospital in these communities, but this approach does a disservice to mission and the health of all Americans because poor people go unserved, diseases worsen and spread, and health care costs rise for everyone. Therefore, we are called to remember what my previous executive vice president for mission integration at Trinity Health, Sr. Mary Ann Dillon, RSM, used to say: "We are a ministry that happens to be a business, not a business that happens to be a ministry."

MOBILIZING MISSION FOR THIS MOMENT?

The Church's social teaching tells us that dignity and the common good are the two great pillars that hold up the edifice of society. Along with solidarity and the preferential option for the poor, ministries can create health systems and communities where all people can thrive, especially the poor. There is no law against caring for the poor, and it has been our mission from the start. It worked for Jesus as our founder, and it can still work for Catholic health care today.

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As we saw in the Acts of the Apostles, a commitment to the poor is a magnet and recipe for growth, as well as the catalyst for reconciliation. If Luke were on earth today, I would like to think that, as a physician, he would write of us in the Acts of the Health Apostolates that all patients, residents, community members and employees — whether white, Black, Hispanic, Asian, female, male, citizen, immigrant, refugee, heterosexual, homosexual, nonbinary, transgendered, rich or poor — were all well cared for and pleased.

By living our collective vocation to continue the healing mission of Jesus Christ, especially for the poor, we can be the seeds of transformation and reconciliation. When we recognize that mission is catalyzed by chaos and crisis, we should not be discouraged. The late Pope Francis declared 2025 as the Jubilee Year of Hope, so let ministries respond to his call to be pilgrims of hope. We are called to mission for this moment.

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NOTES

1. "Students for Fair Admissions, Inc. v. President and Fellows of Harvard College," Supreme Court of the United States, 2023, https://www.supremecourt.gov/opinions/22pdf/20-1199_hgdj.pdf.
2. Dr. Ana V. Diez Roux et al., "Neighborhood of Residence and Incidence of Coronary Heart Disease," *The New England Journal of Medicine* 345, no. 2 (2001): 99-106, https://doi.org/10.1056/NEJM200107123450205.
3. Judy Beal, "Race, Ethnicity, Concentrated Poverty, and Low Birth Weight Disparities," *MCN, The American Journal of Maternal Child Nursing* 34, no. 2 (2009): https://doi.org/10.1097/01.NMC.0000347315.05648.68.
4. *Ethical and Religious Directives for Catholic Health Care Services: Sixth Edition* (Washington, DC: United States Conference of Catholic Bishops, 2018), 9.
5. Lisa Sanbonmatsu et al., "The Long-Term Effects of Moving to Opportunity on Adult Health and Economic Self-Sufficiency," *Cityscape: A Journal of Policy Development and Research* 14, no. 2 (2012): 109-36.
6. Paul Jargowsky, "Architecture of Segregation," The Century Foundation, August 7, 2015, https://tcf.org/content/report/architecture-of-segregation/.
7. Second Vatican Council, "*Gaudium et Spes*," section 27, https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_cons_19651207_gaudium-et-spes_en.html.
8. Marla Nelson and Laura Wolf-Powers, "Chains and Ladders: Exploring the Opportunities for Workforce Development and Poverty Reduction in the Hospital Sector," *Economic Development Quarterly* 24, no. 1 (2010): 33-44.

QUESTIONS FOR DISCUSSION

Author and ethicist Cory D. Mitchell asks us to contemplate what mission means in this moment. When it can feel like news cycles pass so rapidly, it's challenging to hang onto any one piece of information or focus long enough to work for change. He makes the point that Catholic teaching is resoundingly clear on caring for those most in need.

1. Do you know how much poverty exists in the area served by your health care facility or facilities? Why might it be important to know this information in your work?

2. Think for a moment about your preconceived notions about other people. Are there occasions when you reach a hasty conclusion or lose patience with patients? What are some techniques that may allow you to recognize and overcome these concerns?

3. What training, resources or support might your system offer to better educate about differences in the populations you serve, how people respond to health care matters based on culture or life experience, and how to best communicate across differences?

4. As you read Directive 3 from the *Ethical and Religious Directives for Catholic Health Care Services*,[1] what is your ministry doing to address the needs of those living at the margins who are particularly vulnerable to discrimination, such as those experiencing poverty, the uninsured and underinsured, children, racial minorities, immigrants and refugees?

NOTE

1. "Ethical and Religious Directives," Catholic Health Association of the United States, https://www.chausa.org/focus-areas/ethics/ethical-and-religious-directives.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, Summer 2025, Vol. 106, No. 3