

# OUR DEFINED SOCIAL PURPOSE

## Catholic Hospitals Have Organic Relationships with Communities

BY SR. LYNN MARIE WELBIG, PBVM, Ph.D., JCL



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**T**he current political environment continues to challenge the tax-exempt status of not-for-profit health care organizations.

This can certainly be frustrating, especially as we in Catholic health care often feel like we're being put on the defensive. But despite the inherent challenges, an opportunity exists to reengage ourselves with the call that brought us into the healing ministry in the first place.

Like those who serve the church directly, those serving Catholic health care practice and witness charity and justice, and we do it by immersing ourselves in the fray of community life. Our ministry to the healing of the community is rooted in the Gospel; is animated by our sharing in the redemptive ministry of Jesus; and, therefore, has a prophetic dimension. We frequently compare the fabric of our communities with the fabric of Jesus' healing ministry. This practical application of theology is a more holistic analysis of the benefit we bring to communities; a benefit that is deeply embedded in the ministry of Catholic health care.

Catholic hospitals were born within a social and moral context. As a result, those people serving the ministry might situate their *raison d'être* within the frame of stewardship, which is one of their corporate values. An organization said to practice good stewardship is commonly understood to be one that employs its material resources justly and responsibly. It is easy to slide into the notion that the Catholic health ministry's right to exist is justified if the dollar value of goods and services rendered to its communities is equal to some monetary measure such as tax exemption. Hanging on tightly to the idea of stewardship helps one resist such a slide.

### THE ORGANIC ASPECT OF NOT-FOR-PROFITS

Our ministry's medical centers and health systems are organizations that have emerged within the social fabric of particular geographic regions and

communities. These organizations are publicly structured within state and church, holding some form of personhood status. As such, they operate according to established policies and standards, as well as by the work of their staffs. Being generative institutions with a defined social purpose that directly affects the common good of their communities and regions, these organizations have an organic quality.

They also have institutional power and wealth that have coalesced as these corporate persons have evolved into organizations of even larger size and scope. As a result of their collective power, they often supplant the autonomy of individual providers, a fact that raises questions about the organizations' social consciousness and general sensitivity to public need. But we know better.

### SOURCE OF MISSION

Catholic health care organizations were born out of their communities' grave need, often out of a sense of desperation. Most were created by groups of religious women, not by the federal or state governments. Having been called into being by particular communities, those organizations were—and remain—accountable to those communities. In each case, the community's members comprise the organization's basic group of stakeholders.

The Catholic Church has what is known as a *theology of praxis*. This praxis theology might be called a "practical" theology because, in it, Jesus' call to advance the reign of God is given human, practical and contemporary dimensions. The praxis theology concerns healing in the here and now, just as Jesus healed in the then and there. The church's mission is primarily to sanctify the family of God, which is the ultimate advancing of God's reign. The practical theology of the church includes teaching and forming of conscience, as well as works of justice and charity. The work of Catholic health care institutions—whose calling

into service has come from a needy community to a canonical person (usually a community of women religious)—is a ministry of the church, permeated by the Spirit of God with a character consonant with Gospel values.

Those serving the ministry must always remember that, while our mission is a work of charity and justice of the Catholic Church, it is summoned into being by communities in need. This fact should always frame our purposes and ongoing decisions.

### **STEWARDSHIP AND THE THEOLOGY OF PRAXIS**

Stewardship is the way the ministry shepherds its material, human, political and spiritual resources in order to create and sustain healthy, well-ordered communities that foster the human dignity of all their members. Stewardship has two aspects: internal and external.

**Internal Stewardship** — High-quality patient care, concern for patient rights, transparency, clinical and economic integrity, and hospitality toward those who need care—these are absolute values in Catholic health care organizations. Such organizations recognize the distinction between medical technologies, which are curative, and the equally important ministry of healing, which brings hope. We who serve the ministry often express these two dimensions in the phrase “attending to body, mind and spirit.”

Because our stakeholders include our employees, their work schedules, financial remuneration, and benefits should stand up to principles of justice. The work environment should reflect a respect for the dignity of each person, and it should be structured in a way that provides space for the human spirit to grow and develop. When working conditions do not encourage flourishing of the human spirit, the mission to heal is compromised. The spirit of the workplace should include mutuality, listening and Gospel-centered behavior demonstrating that the organization is God-sent and Spirit-driven, not manager owned.

Of course, good stewardship includes the responsible, accountable distribution and use of material resources. Budgets, strategic plans, benchmarking protocols, health plans and annual reports—all these are moral documents as well as administrative ones. Under good stewardship, marketing is honest and responsible. An organization that practices such stewardship is trusted by both individual stakeholders and the community at large.

**External Stewardship** — An organization that practices good stewardship extends that principle

into its community. It has been estimated that clinical care accounts for only 10 percent of a community's health. Other factors include employment, education, housing and the environment. This fact suggests the ministry should also closely examine the ways it stewards our resources outside its organizations' walls. Although the core mission of the health care institution remains the wise application of resources within the walls, the communities that called Catholic-based organizations into being in the first place remain the primary stakeholders. Analyzing stewardship more holistically should take place.

### **USING OUR POLITICAL CAPITAL**

Our institutions and staffs constitute an immense store of mission-driven political capital. Politics is not a bad word. Politics is about the processes and principles according to which we manage ourselves and our purposes as we live together in communities. Democracy is the philosophy that should drive our politics, and the Gospel should be the framework within which we engage in political activity.

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Our health care organizations are a complex of human, material, spiritual and political power. In rural and smaller urban communities, the local Catholic hospital and/or health system is usually one of the area's major service (and business) organizations—if not the major organization. In larger urban centers, our organizations also have a defined, widely recognized presence. Our network of providers and support systems includes people who are well-educated, experienced,

strategically positioned and politically active. Catholic hospitals and systems are potentially influential organizations.

**ATTENDING TO COMMUNITIES HOLISTICALLY**

In considering external (political) stewardship, one might ask: Who or what attends the body, mind and spirit of a community? As a generative social unit, a health care organization has the power and resourcefulness to be profoundly active in enhancing the health and dignity of the community and its members. The community is more than the place where the organization does its business. It is more than a location in which health care is delivered. The health care organiza-

tion and its community should together determine what serves the common good.

By virtue of its mission, resourcefulness and openness to the Spirit, a Catholic health care organization is positioned for a leadership role in caring for its community's life and health. Through participation in the various entities involved in community politics—for example, social-service agencies, service clubs, boards and committees, and community projects—a health care organization responds to the whole of its sacred entrustment. As staff members function in the community, they can be instrumental in identifying its life-support needs. ■

**'MIND, BODY AND SPIRIT': QUESTIONS TO CONSIDER**

When one considers organizational stewardship in relation to a community's body, certain questions occur, such as:

- Is access to health care treated as a basic right in this community?
- Is access to decent housing being measured? How about improvements to existing housing?
- Has the minimum-wage issue been broadened to include the notion of a living wage?
- Is the medical center aggressive in helping the community preserve and conserve air, water, and landscape quality?
- Are day care, elder care, and transportation services adequate, especially for the vulnerable?
- Is the tax system just and transparent? Whose interests does it serve?
- Is safety a concern relegated solely to the police department?
- Do public parks and places of recreation reflect human dignity and community hospitality?
- Does the local Catholic health care institution model responsible charitable giving, rather than self-serving philanthropy?

Other questions arise in consideration of a community's "mind." These include:

- Are the education and formation of children seen as the responsibility of every member of the community?
- Do community sports and recreation enhance or undermine the values of family life?
- Is adult learning a value? How can the availability and interest in it be measured and benchmarked?
- What value is placed on the arts and museums and on the legacy of the community's "founding stories?"
- Is there an insistence on transparency and integrity in governance structures and processes?
- Is there an insistence on socially responsible journalism and use of public media?
- Who participates in the formulation of policy and legislative agendas?

The following questions arise when one considers a community's "spirit":

- Does the economic climate serve the fabric of the community, or is the well-being of residents and local businesses sacrificed to predatory economics?
- Is health care delivery a business commodity driven solely by (and subject to) economic forces in the market place? Or does it have a principled human-services core?
- What is on the agenda of the local ministerial association and how extensive is its membership?
- Are prayer and references to faith and values respected in public forums?
- Does the community welcome newcomers and demonstrate a concern for its most vulnerable members?
- Is there an active concern for the health and preservation of marriage and family life?
- Is personal integrity a non-negotiable for all civic and religious leaders?
- Does the community exude a sense of inclusiveness and neighborliness?

## STEWARDSHIP

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## ETHICS

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### **Tools for Ethical Discernment**

John (Jack) W. Glaser, STD

The analysis of health care programs requires an inner organic structure and sequencing. This structure and sequencing is analogous to the law of human development—one cannot skip infancy and childhood and get right to adolescence. An adequate ethical process must be as concerned with the sequencing of analysis as it is with its substance. This point of starting at the foundation and moving upwards demands repeated emphasis.

There are three major dimensions of the guiding ethical paradigm. Dimension 1 is an articulated vision and priorities of health care. It is the foundation on which all else must be constructed, the source from which everything else will flow, the compass that will guide the rest of the journey.

Dimension 2 encompasses the systemic/structural implications of Dimension 1. This is the toughest, most extensive, and complex part of the ethical process. We clarify and specify the social infrastructure required to create the vision of health care elaborated in Dimension 1 and sustain it in the future.

Dimension 3 is concerned with policy and programs for U.S. health care. This is the pyramid's peak, the end point of the ethical process, not its beginning. Unfortunately, this organic sequencing has been recognized neither in the historical development of U.S. health care nor in most reform discussions. Leaders in the political, academic, church, health care and ministry realms tend to begin the discussion where it should end. They become fixated on plans and proposals without having done all the hard, foundational work that must precede it. The article proposes steps and a time-frame for organizations to begin practicing systemic ethical analysis of specific health care programs and proposals.



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