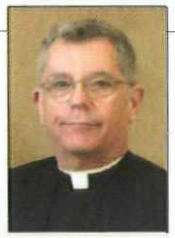
BY FR. MICHAEL D. PLACE, STD

Preparing for Four Challenges Ahead



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Editor's Note: *What follow are excerpts from remarks Fr. Place submitted prior to his departure.*

As has often been the case, I am beginning these reflections while on an airplane. What is different is that this will be my final column for *Health Progress.* My first column appeared in the March-April 1998 issue and was entitled "Toward a Common Vision for the Catholic Health Ministry." Since then, there have been 43 columns, covering a diverse range of topics. Although I did not always appreciate the pressure of deadlines, I have enjoyed the opportunity to step back on a regular basis and reflect on issues facing the ministry. I am deeply appreciative to my colleagues, who work to make *Health Progress* the successful journal that it is, for their patience and careful editing.

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Obviously, the occasion of leave taking is an opportunity for a great deal of reflection. Not surprisingly, it has proven difficult to sort through the myriad thoughts that have crossed my mind in order to prepare these reflections. Almost in desperation, I finally decided to take a look at my inaugural remarks at the 1998 Catholic Health Assembly in New Orleans to see if they might stimulate an approach. Thankfully, they did.

The title of those remarks was "The Faces of a Community in Ministry: Passionate, Determined, and Responsible." After seven years of service to CHA, I find that title to be as true today as it was then. Catholic health care is not an "it" but an "us," a pilgrim people who by our words and our actions make present, make real, the healing touch of Jesus. Catholic health care is the faces of those who serve and the faces of those who are served—"faces that, when viewed through the eyes of faith, reveal to us the face of God."[1]

As a passionate, determined, and responsible community, we continue to build on the incredible accomplishments of those who have gone before us. Working together to support and strengthen the ministry, we have focused more intently on understanding and integrating our Catholic identity as a ministry into all that we do; we have attended to the reality of sponsorship theologically and structurally; we have responded to the complex theological issues associated with the principle of cooperation and pursued theological reflection on such issues as the provision of nutrition and hydration and the emerging opportunities and challenges of genomics; we have intensified our advocacy efforts, with particular attention to the morally unacceptable reality of millions of uninsured and underinsured, and, at the same time, sought to protect our freedom to serve in a manner consistent with our faith. In so many ways, we have been about both service and transformation by building partnerships that allow us to do more together than we could separately.

But we continue to face many challenges. In 1998 I identified four of our many challenges. Not surprisingly, although much has been accomplished, the challenges remain. In what follows, I will offer some current observations on those challenges.

Strengthening Ministry Identity

In my 1998 assembly remarks, I suggested that a quotation from the theologian Raimon Panikkar could be of assistance as we thought about our Catholic identity. Panikkar noted that "a Christian is one who both confesses oneself to be such and as such is accepted by other people." In recent years, we have spent a great deal of time and energy on what it is that we "confess" as

Catholic health care. We have a statement of identity and core commitments as a ministry gathered and engaged. Individual systems and institutions have clarified their core values and commitments. In so many ways, we are quite clear about what we confess.

I have suggested that we can distinguish between the "how" and the "why" of Catholic health care. Our "why," our mission, is the call, the vocation to carry on the healing ministry of Jesus. Our "why" is distinguished by a sense of transcendence. Our "how" is the contemporary practice of medicine and health care delivery, with all of its complexity along the entire continuum of care. Could it be that the questions or suspiciousness we experience from theological and public-policy spheres are not about what we profess or confess but about how that confession is incarnated, enfleshed, made real in the clinical and business dimensions of the ministry?

In thinking about that question, I am reminded of a recent conversation with a diocesan bishop, a friend of Catholic health care. While speaking of his regard for the ministry, he also mused about whether it really could be distinguished from other health care delivery in the United States. After posing the question, he went on to note that the same could be asked about many of the structures and functions of a diocese. Without being critical, and admitting that he himself had no easy answers, the bishop said he thought it was important that we engage the question. He said that he sometimes encourages such reflection among diocesan leaders by asking, "What would you do differently if Jesus had not been born?"

I found this to be a fascinating question, one that has not left my mind. What would we in Catholic health care do differently if Jesus had not been born? This is a more effective way of asking whether the "why" of Catholic health care makes any difference in the "how" of what we do every day. Cardinal Joseph Bernardin was struggling with that question when he proposed, in *A Sign of Hope,* that "our distinctive vocation in Christian healthcare is not so much to heal better or more efficiently than anyone else; it is to bring comfort to people by giving them an experience that will strengthen their confidence in life."[2]

Challenging as it is to consider what bringing such comfort would mean in the clinical setting, it might, for Catholic health care, be even more challenging to consider what bringing comfort means with regard to our institutions' role as "public actors" or corporate citizens.

Fostering Ministry Leadership

The second challenge I noted at the 1998 assembly was ministry leadership for the future. Clearly, a great deal has been accomplished in this area, and the level of intentional activity in the leadership arena is growing. Distinguishing between being a leader within the ministry and a "ministry leader" has proved to be of some help in clarifying what is required for us to have effective and dynamic leaders who will have "fire in the belly" and vision in the mind similar to the fire and vision of those who came before us and entrusted this ministry to us.

"What would we do differently if Jesus had not been born?"

That being said, the challenges before us are daunting. The ecclesial context in which the ministry is situated is as complex as any in our history in the United States. Those we serve, and those with whom we serve, reflect an incredible diversity of cultures, beliefs, and attitudes—a diversity that stretches the understanding of pluralism. Our society—from which, of course, potential leaders come, and which influences those potential leaders every day—celebrates the primacy of the individual over the common good and refuses to accept the reality of normative truth or moral absolutes. The church clearly celebrates different values.

In such an environment, it seems to me, it is critically important that we continue our search for what it will take to ensure that we have within our institutions a "thick" culture that clearly provides an alternative perspective on life and meaning, as well as leaders who can form, shape, and nurture that culture. As we know, culture is much more than rules and statements. Culture is the expression of an organization's most deeply held beliefs and values. It is expressed most profoundly in that which is unspoken and presupposed. Culture is a shared affective sense of the way things ought to be. And the "thicker" the cul-

ture, the more unspoken it is, the more it is second nature.

Even though it is largely unspoken, culture needs to be celebrated and nurtured. Such celebration and nurturing is best accomplished through the medium of the symbolic and the imaginative. In many ways, the world of institutional culture is the world of social imagination. And it is in that world that we find what we might describe as our problem or our opportunity. In so many ways, the world of health care is a world of science and business. We are quite comfortable speaking of "measurable" outcomes and "value-added" results—which are hardly the "stuff" of social space or collective imagination.

Culture is much more than rules and statements.

Another important component of culture is that which provides part of the context and framework for decision making and, in our case, for *ethical* decision making. In the shared values and beliefs of a culture are found the principles and categories that form the basis for discerning what is right and what is wrong. Culture also is the bearer of a collective wisdom that is accumulated as a result of previous decision making. In addition, culture provides support and encouragement for the development and maintenance of a community of ethical discourse. All three of these realities—principles and categories, collective wisdom, and a community of discourse—are essential if leaders and organizations are to be able to act in a manner consistent with our beliefs.

According to this perspective, it would follow that the successful ministry leader would have to be comfortable developing a culture—grounded in the beliefs and teachings of the church—that sustained all three of these realities.

Consequently, I would propose that, in thinking about the future of ministry leadership, it will be critically important that we consider how we can ensure that our leaders and our culture are more than adequate to meet the challenges we face.

Reinforcing Ministry Structures

The third challenge I identified in 1998 was strengthening the structures that support the ministry. Again, so much has been accomplished by so many. In many ways we now have a new generation of systems (e.g., Ascension Health, Bon Secours Health System, and others) that have become so critically important to, and in some ways distinctive to, Catholic health care. We also are in more mature relationships with Catholic Charities USA and other parts of ecclesial life. "Ministering Together" (formally known as *New Covenant*) has developed as a "movement" that continues to encourage opportunities for greater collaboration with and among church ministries.

As regards structures, there clearly remains a great deal of interest in and attention paid to the future of sponsorship. While sponsorship is more than a structure (it is a relationship), it is expressed, in part, in and through structures. Currently, the ministry is blessed to have a variety of approaches to the way those structures can be constructed and maintained. And there is every reason to believe that this will remain the case for the foreseeable future.

As we know, governance and sponsorship are essentially related. In fact, in some settings, the same people exercise both responsibilities. It would seem that there are possibilities for future reflection on how best to structure governance as sponsorship evolves.

Emphasizing Health Care as a Social Good

The final challenge I commented on had to do with how we as a nation understand health care. From the Catholic perspective, access to health care is a fundamental human right that is also a social good that should be rendered on the basis of need, rather than on the ability to pay. This perspective has been the motivation for our continuing attention to the issue of the uninsured and underinsured. Although the intensity of our efforts has varied because of the evolving political landscape, our passion has never lessened. In fact, "inside the beltway" the Catholic health ministry is known for its ongoing commitment to this issue, as well as for its commitment to the other needs of the poor. On numerous occasions, I have been told that we are a good partner on these and other issues because we do not shift our perspective according to our political calculations. We are a respected and trusted partner in

the complex—and at times messy—process of developing public policy and law.

As you know, your board has decided that we need to intensify our efforts with regard to the uninsured, paying particular attention to how we might contribute to the development of a social movement that could result in a change in public policy. Clearly, this is a new venue for Catholic health care. There is much that we must learn about why our country has tolerated what we consider to be morally unacceptable. Similarly, we need to learn from other social movements in the United States and elsewhere about successful and unsuccessful practices. Finally, in light of what we learn, we will have to develop a cohesive strategy for individual and collective activity.

I believe that, as a nation, we are in a vitally important conversation, the result of which could profoundly affect both how we proceed and the potential approaches to resolving the issue of the uninsured. A few years ago, I would have described the terms of that conversation as being about the *nature* of health care. For example, is health care a commodity or a social good? Is it best provided in society's business sector or in its voluntary sector?

Over the course of the last few years, the terms of the conversation have been expanded, I believe. Without becoming partisan, I would suggest that a phrase such as "ownership society" is a reflection of this deeper conversation. For example, some in our society are questioning the role of government vis-à-vis individual economic achievement. We are beginning to ask ourselves how much economic inequality a society can sustain. Ought not there be a role for the government in providing a safety net for those who, for whatever reason, are not able to gain access to basic social goods? How do we understand the concepts of *human solidarity* and *shared responsibility*? Are health insurance, unemployment insurance, and retirement plans necessary to the nation's welfare—or do they, instead, contribute to increased medical costs, greater unemployment, and reduced savings? When the focus is on health care, some participants in this conversation describe health savings accounts and catastrophic insurance coverage as opportunities to control the escalating cost of health care by encouraging individual responsibility, whereas others speak of the importance of maintaining a large enough pool of insured people in order to adequately spread the risk.

Because this conversation can easily become partisan, many people might choose not to become engaged in it. Similarly, because the terms of the conversation can sound so abstract and philosophical, other people might decide to "take a pass," especially when they know they must fight to maintain current federal and state reimbursement. From my perspective, it would be quite unfortunate if that were to happen, as understandable as it might be. I say this because, as a ministry, we are informed by the richness of the Catholic theological tradition, which has a very definite perspective on the meaning of human personhood as well as on the social order. In other words, we have both the analytical tools and an approach to social analysis that allow us to have a coherent perspective. We have the capacity to participate in public discourse in a way that can make a difference. Although our goal, in a pluralistic society, is not to oblige everyone to accept our perspective, we *can* insist that our perspective be part of the public discourse and that we be judged on the quality of our reasoning and not on our religious preference.

We need to learn from other social movements.

My concern is that if we do not exercise this right and aggressively participate in the public discourse, the resulting public policy and social conventions of our nation could become inimical to those about whom we care the most—the poor and the marginalized. Although we, as Catholic health care providers, bring a definite expertise to such discourse, we will need, if we are to be successful in the public square, to act in concert with other parts of the Catholic community in a way we have not done to date.

We have been living it for several centuries in the persons of the religious women and men who established this ministry and in the institutions they established. Like the ministry's founders, we are active in the public square because of who we are and what we believe, and without seeking to impose our beliefs on others. Whether on a Civil

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War battlefield, in a public hospital caring for victims of an epidemic, in a sanitarium for TB patients, or in a contemporary safety-net hospital, we have been a living incarnation of the role of institutional religion in the United States. Our challenge is to bring to the current debate the strength of that rich tradition in a way that identifies radical secularism—not Catholic health care or other Catholic ministries that serve in the public square—as the outsider.

Let me express my gratitude to the women and men who have been my colleagues on your CHA staff and to those who have served on your board.

As we think of the future, we will clearly need to pay a great deal of attention to the public square in regard to such "macro" issues as the uninsured, the philosophical underpinnings of public policy, and the role of religious institutions, as well as to "micro" issues such as government reimbursement and regulations. An overarching challenge will be to focus on the macro and the micro at the same time and with the same effectiveness. I am confident we can do both. And, in doing both, we will demonstrate something that we might not have done if Jesus had not been born.

Until We Meet Again

The plane is landing and so is my tenure in service to all of you. I hope these reflections and the others published over the years have been of some help to those who have read them. As great as the challenges might be, we have a confidence whose origin is the gift of the Holy Spirit who is always in our midst.

In closing, let me express my gratitude to the women and men who have been my colleagues on your CHA staff and to those who have served on your board. The successes of the past years are due to them, and I am deeply grateful. I also thank all of you who are the faces of Catholic health care. Thank you for your passion, your determination, and your sense of responsibility. In so many ways, they provided me the motivation to dream and work with and for you. Be assured of my continuing prayers. Though I do not know the specifics of my future ministry, I am confident it will include some presence to this great and vital ministry. So this is a time to say, not "Goodbye," but, rather, "God speed" until we meet again. ■

NOTES

1. Michael D. Place, "The Faces of a Community in Ministry: Passionate, Determined, Responsible," *Health Progress*, July-August 1998, p. 45.
2. Joseph Bernardin, *A Sign of Hope*, Office of Communications, Archdiocese of Chicago, 1995, p. 5.

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