RENEWING THE SACRAMENTAL

There Are Practical Steps Catholic Health Care Facilities Can Take to Emphasize Their Religious Roots

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Identity and mission are central concerns of every Catholic health system. Although there are many ways to approach these concepts, "sacramentality" is an essential constituent. A sacramental way of life lies at the very roots of the faith. "No theological principle or focus is more characteristic of Catholicism or more central to its identity than the principle of *sacramentality,*" according to theologian Fr. Richard McBrien.[1]

My purpose here is to suggest strategies to enhance Catholic sacramental identity through ritual, art and design, personal presence, and visible witness.

Although American Catholics readily remember the old Baltimore Catechism definition ("an outward sign instituted by Christ to give grace"), the church today understands sacrament more personally. Grace is a relationship between the human person and God. Grace is the gift of divine life itself, the gift of friendship with God, as the *Catechism of the Catholic Church* puts it (paras. 1,468 and 1,997). Thus understood, grace is an essential part of the wholeness and healing of body, spirit, and relationships essential to health care.

Catholic sacramental identity grows from the Incarnation. The man, Jesus, who is at the same time God the Son, reveals the transcendent God as a Father of love and compassion. One way to say this is that Jesus is the sacrament of God. Jesus is the perceptible sign of God's love, the embodiment of God's compassionate grace. Because he has ascended to his Father, Jesus commissions the church to be the visible sign, the sacrament, of his salvation. Persons, actions, and objects of the church, therefore, are sacramental when they signify the presence of God's grace. This picture of the world is the heart of sacramentality, an insight as necessary for health care as for other dimensions of Catholic life.[2]

Because God took on human flesh, the divine can become present in physical things; matter touches spirit. "The sacraments are perceptible signs (words and actions) accessible to our human nature. By the actions of Christ and the power of the Holy Spirit they make present efficaciously the grace they signify" (*Catechism,* para.1,084). Catholic theology does not limit the scope of sacramentality to the seven sacraments; it recognizes many "sacramentals" (medals, statues, prayers, and holy cards) that extend the sacramental perspective into the routines of daily life. There is, moreover, a sacramentality that "blesses and enhances what the world, through God's grace, already has"; for example, the healing arts.[3] Therefore, if the church is to be fully sacramental, its health care (and other) institutions are to be places where patients, employees, physicians, and visitors experience God's grace—places of personal encounter with God.

SYMPTOMS OF LOSS, SYMPTOMS OF HOPE

"Payment arrangements must be made in advance." If this is the first sign visible in a physician's office or an emergency room, what does it communicate? When the material environment emphasizes finances, it erects a barrier between the person and the experience of grace. Of course, employees must be paid; supplies cost money; capital improvements cannot wait indefinitely. Nevertheless, when an experienced nurse of my acquaintance, who is now working in a for-profit specialty hospital, describes leaving her previous job in a Catholic hospital "because the first item on the agenda of any meeting was cost saving instead of patient care," there is a danger to Catholic identity.

Modern medicine itself is another barrier to signs of grace. Health care today is often "high tech, not

high touch." It is more difficult to experience God's grace in a machine than in the warmth of a doctor's voice or a nurse's hand. As important as medical invention is for the healing mission, the current prominent idea of infinite medical progress subtly undermines Catholic identity. Medical progress points toward success in this world, rather than toward God. When trust is placed in the latest pharmaceutical or the latest medical device, hope in the divine becomes obscure. Moreover, some medical "progress" (embryonic stem cell research, in vitro fertilization, contraceptive devices) conflicts with Catholic teaching.

Yet there are grounds for hope. Technologically advanced Catholic hospitals are also leaders in personal forms of health care, such as hospice services, pain management, health promotion, and disease prevention.[4] Catholic health care leaders define mission as healing, service to the poor, advocacy for justice, and respect for human dignity. These mission commitments do not exist only in frames on hospital walls. They permeate the culture of Catholic institutions. Every day, doctors, nurses, and technicians place the good of patients ahead of reimbursement. Every day, medical vans visit those without insurance in homeless shelters, poor rural communities, and church parking lots. Yet, a richer sacramental identity is possible.

Ritual

There are a number of ways Catholic health care organizations might renew their sacramental dimension. Ritual is one. Rituals communicate and embody meaning. Take a simple example: two alternative rituals for arriving home from work. (1) I enter the door, go to my study to unpack my briefcase, check the mail, and turn on the computer. Then I head for the family room where I greet my wife. (2) I enter the door, go to the family room, and greet my wife. We talk for awhile, and then have a glass of wine and dinner. Later, I go to the study, unpack my briefcase, check the mail, and turn on the computer.

Rituals are not limited to church settings; they evolve naturally in all areas of life. Medicine is full of them: taking vital signs, narrating the history, admitting patients to the hospital, and discharging them. Standard ways of doing things evolve; and they communicate a—sometimes intended, sometimes unintended—meaning. Rituals can be profound (those surrounding death) or ordinary (tooth brushing). Leaders can plan rituals, or they can allow rituals to evolve without direction or purpose. Rituals directly shape the character of the people involved (worshipers, for example), but they affect others indirectly (the way parishioners interact with fellow citizens after Mass, for example).

Health facilities have dozens of rituals that subtly communicate messages to employees, patients, and visitors. Most of the time management and staff are not consciously aware of such rituals, but the rituals suffuse the institution nonetheless. Think about the words and actions that surround direct medical care: the choreography of the operating room, the physical examination, or the movements and gestures in the imaging center. Think about the rituals of hospital routine: shift changes, announcements, record dictation. Think about the rituals of staff and management meetings, celebrations of employee arrivals and departures.

Most often we work with rituals already embedded in our institutions, striving to shape them more closely to mission and identity. However, some can be consciously designed. A Catholic hospital in the southwestern part of the country broadcasts a short prayer service by mission leaders at fixed times each day. Hospitals (Catholic and other-than-Catholic) have begun to "script" regular interactions. For example, a mandatory question on leaving a patient's room: "What else can I do for you now?" A Catholic hospital system on the East Coast suggests scripts for its senior managers for their regular rounds. These scripts embody core values. One CEO, for example, after asking of a harried nursing supervisor the scripted question, "Is there anything else I can do to help you do your job?" was surprised by the answer: "Yes, you can feed Mrs. Smith in Room 326." The hour that CEO spent feeding an elderly and demented patient communicated mission more effectively than any number of pronouncements from on high. That hour was the result of a rounds ritual devised by the CEO's system.

Mission leaders might well spend a couple of weeks simply observing ritual interactions throughout their facilities, taking inventory, and discerning meaning. What do the interactions communicate? Do the rituals affirm positive Catholic identity? Do they detract from mission? Do these rituals distance staff from patients and family, or do they bridge distance? Do they assert control by staff over patients or by one part of the staff over others? Do they communicate hope or indifference?

The answers to these questions and the responses to these answers by mission leaders and senior management can begin a sacramental renewal of Catholic health care.

Art and Design

With its "smells and bells," Catholicism understands that environment communicates meaning. Statutes and sculptures, crucifixes and posters, tapestries and mosaics can be profoundly therapeutic for spirit and body, as recent research doc-

uments.[5] It does not matter whether the visual elements of a health facility are relatively spare or relatively ornate; what matters is that they are designed to be healing, expressive of identity, and beautiful.

Lobbies and waiting rooms in Catholic facilities typically feature art and design to fulfill these purposes. However, even these locations are too often sterile and visually unappealing. Patient rooms typically have a cross or crucifix, but often little else. Admitting and discharge offices, corridors, recovery rooms, and intensive care units (ICUs) vary widely in their visual detail. Some facilities devote a good deal of attention to them; others equip them with nothing beyond the functional elements necessary for administrative or medical efficiency.

One major problem today is that areas that once welcomed patients and visitors often are no longer the customary places of entrance. Because hospital expansions have added emergency rooms (ERs), clinics, and parking garages, patients and visitors now enter from many directions into different parts of the facility. The old lobby, once the visual center of the hospital, now may be off the beaten path. The new entrances may be cramped, disorienting, and devoid of religious symbols.

It does not have to be this way. For example, the bridge from the garage of a Catholic hospital in a major eastern city leads directly to a spacious lobby with large and prominent tapestries communicating the history of its founding congregation in that city. This hospital designed a creative solution to the prominence of the parking garage.

What about the garage itself? What does it communicate? Does it welcome visitors and patients, or is it merely utilitarian? My own university, faced with the need to construct its first parking garage, spent extra money to make it (astonishingly) both attractive and compatible with the surrounding architecture. The only Spanish Renaissance parking garage I have ever seen, it communicates visually the identity of our university as fully as do the academic buildings.

Presence and Touch

People, not things, communicate sacramentality best. Even ritual, although always embodied in persons, is by its nature general. The ritual is the same no matter who participates. Presence and touch, however, are always particular and personal. The secular world today realizes the importance of presence. Wal-Mart has its "greeters" in every store.

Presence and touch communicate the care of one particular person for another particular person. They speak of God's presence and the assurance of grace. Consider the CEO story above from this perspective. A letter to *Commonweal* magazine testified eloquently to the sacrament of presence. According to the letter's writer, a recent *Commonweal* article

> reminded me of the special care I received at Saint Francis Hospital in Roslyn, New York. Here are two examples. . . .
>
> I was checking in at dawn for surgery when a Brother John greeted me: "How about this: Here's an Old Roman going to pray for an Episcopalian being operated on by a Jewish surgeon." I replied, "Here I would hope we are all one." Brother John said, "Of course we are," and I went upstairs with a lighter heart. . . . Another year, I was lying in a corridor waiting for an angiogram, and feeling twitchy. A young nurse walked past, then turned and started to talk. "You'll get in soon," she said. "The process isn't as bad as some may have told you. . . . You live in Port Washington? That's a nice town." This sustained me through a time when I needed help. The nurse did not have to take time for me. She gave more than duty called for."[6]

The machinery of modern health care threatens to relegate personal presence to the margins. In the physical examination, the CAT scan too often replaces the stethoscope and the physician's diagnostic (and healing) touch. Intravenous equipment, tubes, and electronic monitors restrict movement and communication. Medical facilities, therefore, must work especially hard to ensure personal presence and physical interaction.

We might take a tip from Wal-Mart. How about recruiting volunteers (or part-time employees) with the requisite interpersonal skills to simply be present (and not behind desks!) in such high-anxiety areas as ERs, ICU and cardiac care unit waiting rooms, and neonatal intensive care units? Most fitting would be retired religious women and retired physicians and nurses, who could offer not only presence and a comforting word but also reassurance and information about confusing and frightening medical procedures.

Visible Witness

The three forms of sacramentality I have mentioned are primarily internal, focused on the life and structures of the medical facility itself. Sacramentality, however, also looks outward; it represents the mission and identity of Catholic health care. In this representation, it connects with Catholic social teaching and the church's responsibility to be a transforming presence in

the community. Catholic health care must be a visible witness to the society that "here is healing; here is hope; here is a passion for justice." CHA's Fr. Michael D. Place, STD, refers to this aspect of sacramentality when he describes Catholic health care's lived faith as built and sustained by "its public icons and symbols."[7]

Sacramental witness links public and private life, often through individual heroic actions of health care workers that become public knowledge, or through institutional decisions (for example, refusal to perform certain procedures or decisions to keep open an unprofitable but crucial community service).

It is relatively easy to see how individual persons can embody sacramentality; institutions have a more difficult, but not impossible, task. Location is one clear way that institutions walk with the poor and neglected. The choice of a Catholic hospital to remain open in a medically underserved inner city instead of relocating to a more lucrative suburb is a clear case. Institutional commitment to its surrounding culture is another way; that commitment might be shown in, for example, the ease with which an illiterate, Spanish-speaking person can enter a hospital and find someone to talk to, someone who empathizes with her problem and attends to the ensemble of her financial, personal, medical, emotional, and spiritual needs.

Two engagements constitute sacramental witness. The first is with those social groups whose wounded humanity reveals the presence of Christ; for example, persons with AIDS, immigrants, the uninsured, residents of *colonias,* and the neglected aged. This recognition is vital for sacramental identity, for it establishes members of those groups not as victim groups (the temptation of the political left) or as irresponsible individuals (the temptation of the political right) but as *alter Christi* (other Christs). Such discernment calls forth personal caring and medical attention. Yet the fact that particular social groups tend repeatedly to have unmet needs prompts institutional creativity. This may take the form of residential centers for the mentally ill, clinics in the *colonias,* mobile primary care vans sent to visit immigrant neighborhoods, new religious communities committed to staffing new forms of elder care centers, and so forth.

The second engagement is advocacy that flows from this solidarity. First of all, the fact that particular groups, rather than simply random individuals, have unmet health care needs signifies a failure of the common good and, most likely, a violation of principles of justice and human dignity. Solidarity is the virtue of commitment to the common good. Therefore, Catholic institutions and activists will involve themselves in lobbying, opinion formation, and other forms of public activity to redress wrongs and to include all people fully in the life of the community. This will mean support for universal health insurance coverage, programs that provide continuity of care for the elderly, and public outreach to enroll all eligible people in Medicaid.

Both of these engagements make the church's witness visible in the community, witnessing the core principles and commitments of mission and identity.

Ask the Hard Questions

Catholic health care is sacramental. Catholic health care can be more sacramental. Sponsors, boards, and management must ask hard questions of their institutions. Are there standard medical or institutional rituals that distance and dehumanize patients and families (and staff)? What can we do to make our facilities more personal, more human?

In the area of the visual, there are many opportunities for making Catholic facilities more sacramental. Sponsors, boards, and management should tour their facilities, walking in the shoes of first-time patients and families. What do they see, hear, and smell? Do these sights and sounds draw them into a community of healing, or scare them away?

Finally, in the arena of visible witness, Catholic health care already does a great deal to identify unmet needs and promote social justice, but this identity is never complete. New needs, new marginal groups, and new challenges regularly emerge. Taking stock of the institution's visible witness to mission and identity is a ceaseless task. □

NOTES

1. Richard P. McBrien, *Catholicism,* rev. ed., HarperCollins, New York City, 1994, p. 1,196. Emphasis in original.
2. See Catholic Health Association, "The Dynamics of Catholic Identity in Healthcare: A Working Document," St. Louis, 1987.
3. Dennis M. Doyle, *Communion Ecclesiology,* Orbis Books, Maryknoll, NY, 2000, p. 22.
4. Clarke E. Cochran and Kenneth R. White, "Does Catholic Sponsorship Matter?" *Health Progress,* January-February 2002, pp. 14-16, 50.
5. Wayne Ruga, "A Healing Environment, by Design," *Modern Healthcare,* October 23, 2000, p. 24.
6. Loring W. Batten III, letter to the editor, *Commonweal,* April 21, 2000, p. 36.
7. Michael D. Place, "Faith and Public Policy" (the inaugural Cardinal Bernardin Lecture), Elmhurst College, Elmhurst, IL, October 26, 1998. See also Michael D. Place, "Elements of Theological Foundations of Sponsorship," *Health Progress,* November-December 2000, pp. 6-10.

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