Table Talk

Complex Questions Engage Leaders Forum

EDITOR'S NOTE: In 2011, CHA initiated "Tomorrow's Leaders," a program to honor outstanding young leaders in Catholic health care and to encourage them to continue their careers in the ministry. At the 2011 Catholic Health Assembly in Atlanta, the charter class of eight honorees was recognized during the annual awards banquet. They participated in a pre-Assembly Tomorrow's Leaders Forum designed as a formational experience for all participants.

This is the first of two parts edited from a transcript of the forum, recorded June 4 in Atlanta. The second part will be published in the Nov.-Dec., 2011, *Health Progress*. The forum opened with a brief lecture by Rev. J. Bryan Hehir, M.Div., Th.D., of Harvard University, on the role of institutions and individuals vis-à-vis Catholic tradition. Participants then discussed questions Fr. Hehir posed.

Fr. Hehir: The content of your work is the reason you are being honored this day. But I want to think a little bit about the context in which you work, and that brings me to thoughts about institutions and the significance of institutions in both the church and the society. I chose as a topic, or theme, the relationship of institutions, individuals and leadership.

The most important Catholic theologian in the United States in the 20th century was a man named John Courtney Murray, an American Jesuit who had enormous impact on the life of the Cath-

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olic Church. He always used to say Catholicism is an idea, but it's more than an idea. Catholicism is a public, visible, institutional presence. The theological grounding for that idea is a very fundamental truth in Catholicism: that God works through the human. We call it the "incarnational principle." That means not only human persons [but also] though human institutions, which do multiple things. They provide a sense of continuity, a sense of tradition and a kind of persistent witness in a changing wider context. They allow you to take basic values and project them into the wider society — [in our case to] take the religious moral values of the Catholic tradition and project them into a highly pluralistic, very complicated setting, which is the United States. Your work is both irreplaceable [and] complemented by the way those institutions take your work and project it into the wider society.

Institutions, as I've said, connote persistence, continuity and stability in the world of change. But as in personal life, sometimes our best assets become liabilities. And so the problem with institutions is that their very sense of stability can breed complacency. Institutions can get stuck, fail to relate what is unchangeable in their tradition to what needs to be changed because of new developments, new settings. So we have to watch the balance ... Institutions must be balanced by individual initiative, individual creativity, individual contributions.

[Receiving the tradition for individuals] means hearing, absorbing, analyzing and refashioning. The task of individuals is to go beyond

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what the tradition has always done, to add to what has always been done things that you see someone else hasn't seen before you, things that you hear that an earlier generation might have been tone- deaf to. So the task of reception is what we call, theologically, development of doctrine, the idea that we grow.

What we celebrate here today is that you've made choices about where you're going to work, how you're going to serve, where you're going to stand. Secondly, you've sought excellence. One of the things Aristotle taught the church was that excellence is a value that is inherently not only good but, we think, holy. And thirdly, you've been able to distinguish, I think, a job, a profession, and a vocation — a sense of "I've been called to something." If people are going to inherit the tradition, further the institution, maintain both persistence and creativity, they have to be people capable of doing the job, meeting the standards of the profession and interpreting the meaning of their work in terms of vocation.

Today, what this gathering does is to acknowledge a mutual investment — Catholic health care's investment in you, and your investment in us. So it would be an enormous loss not to talk about leadership and its potential. I think the components of leadership are three: an intellectual, conceptual component, a moral character dimension and an inspirational, catalytic dimension. A basic capacity for leadership is the ability to illuminate complexity for others, to not only see the horizon, but to also describe the road map — how we're going to get from here to there. That's the beginning part of leadership, I think.

The second part of leadership is the moral dimension of leadership: character. We have had some leaders who weren't big on moral character, and we've had a few people who were really big on moral character who failed as leaders. So I don't want to oversimplify. But I do think that when one is thinking about what leadership requires, one better think about the moral dimension, because knowledge without wisdom can lack direction, purpose and a sense of limits, as well as of possibilities. When you step beyond knowledge to power, which is essential for leadership, power without moral restraint can be destructive.

Finally, leadership requires inspirational catalytic dimensions — the ability to spark within others personal commitment, engagement — a quest, again, for excellence. The ability to lead requires both the ability to listen, to exemplify in one's life and then to mentor, so that what has been meaningful to a good leader becomes the model for the life of others. So today, you have shown characteristics to bring you to this table. And you're young enough for us to hope that you'll stay with us a long time and that you will continue to bring the potential for leadership in all its dimensions to a work that is clearly worthy of doing ... the work of Catholic health care.

And now my job is to get you talking. I thought I'd ask two questions. You can answer both or either one. The first is: In your experience so far, what do you think is the largest, most significant question for health care in the United States? And secondly, what do you think is the largest, most important question for Catholic health care?

Who wants to take it?

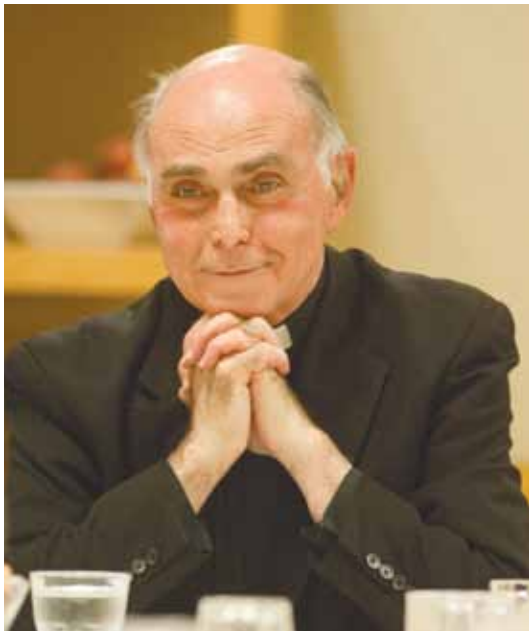
Stephanie Manson: [Although] it's sort of obvious ... I feel the sustainability of the health care model is probably the most significant question. And the ability to come up with some sort of reform package that either can be implemented or is easy enough to understand — that we can implement or that is in itself sustainable for us. So

I think, one, how do you redefine the rules? And then once they're redefined, how do we learn to live within them? ... [For instance] we continue to fund and basically underwrite mental health. It's something that's very important to our mission in ministry. It's important to the sisters. And so we've continued to do it because ... we have other services that allow us to do that. And so once the playing field is leveled, I worry a lot about our ability to continue to provide those mission-oriented services that are so important and fundamental to what we do and to be able to be sustainable.

Anthony Tersigni: For me the big question for health care in the United States is what is it that we want to accomplish for every man, woman and child? We don't have a health care policy. We have a health care *financing* policy. We've cobbled together over the last 70 years a number of models from other developed countries, a number of financing mechanisms, but we've never stepped back and said as a society what is it that we want. To me, it's very simplistic from the standpoint of form follows function. ... And the one thing I applaud President Obama [for] is — regardless of whether you like the legislation or you don't like the legislation — for the first time, at least in my career, it is front and center on the nation's agenda, health care. And there's a great opportunity for us as Catholic leaders to help develop that agenda as we move through it.

Fr. Hehir: So do you think within the Catholic system there is any clearer sense about how form follows function than in the wider American system?

Tersigni: Our view of the patient is different. The patient is holistic, body, mind and spirit, and I think that's what differentiates [us]. But I can tell you our system [Ascension Health] is as fragmented as any system around this table or any not-for-profit system, any for-profit system, any government system. For Catholic health care, the challenge is how do we continue to be in solidarity with the poor, taking care of the poor and vulnerable, and have a sustainable ministry at the same time? Intuitively, I believe we should be able to figure out how to do that. We haven't come up with the answer yet, but it would seem to me that there's got to be a way for us to have a sustainable ministry and continue to take care of the communities that we traditionally take care of — inner-city communities and the smaller rural areas.



Rev. J. Bryan Hehir

Sr. Doris Gottemoeller: I'll weigh in on the second question, on the challenge for Catholic health care, and I think it is what it means to be Catholic — what that Catholic identity means, particularly in an increasingly multi-faith context where our leaders are not [always] of the Catholic faith. In many cases, our associates, our employees and those who come to us for care are not. If a community in which we exist is not Catholic or predominantly Catholic, what does it mean to be Catholic? How do we quantify that, describe it, identify it, validate it? And as we move into the new world of health care reform, where increasingly we' re going to be collaborating and partnering with other providers — as we should — how much of that can we do without diluting the Catholic identity?

Fr. Hehir: So how do you feel about our resources in defining what it means to be Catholic in that context you talked about? Do you see consensus higher than polarization, or polarization threatening consensus?

Sr. Gottemoeller: I see confusion.

John Paul Slosar: I think the sustainability piece is hugely important, and I agree with what Stephanie and Tony said, but I think we need to be looking beyond that. And so to me, the question is

what kind of organizations ought Catholic health care institutions and systems to become in order to foster and promote sufficiently robust understanding of the common good in solidarity? In an economic market which requires our sustainability but that is hallmarked by competition, and in a social morality in which the common good is often looked upon as communism, — what kind of leadership is required for that? Is there something greater than just having a set of virtuous individual leaders that's required for a virtuous institution able to promote a prophetic understanding of the common good, if you will?

Fr. Hehir: Now, do you think the biggest threat we face is the kind of institutions we may become? Or is it the ability we have to share our values with others and with the wider health care system within which we need to function?

Slosar: I think it's contingent upon the ability to share our values in light of the need to remain sustainable.

Mark Repenshek: To the first question, I think the biggest challenge is this idea of rights and privileges. We haven't as a society settled on a question of is the model like education or is there a different model? And is health care a right or a privilege? I know that's going to be probably the question that goes down in infamy as unsettled in a pluralistic society. But that leads to my answer for the second question. I think across the board, in terms of the models of church, our failure is not having a prophetic answer to that question.

Fr. Hehir: Now tell me a little bit more about the different implications [around] health care as a right versus a privilege. If those two roads fork, what happens down each side of the road?

Repenshek: Socially, they could end up with the same thing. They could end up in a delivery system that is based upon an agreed-upon procedural process without answering the underlying question. But from a Catholic health care standpoint, if we do the same thing, we've lost the very foundation upon which we're grounded. And that's a tragedy.

Brian Yanofchick: The answer to the question "Is it a right or a privilege?" is going to guide what kind of policy we have down the road. [Under] the policy we have now, I think the financial thing is based on the fact that it's not a right. That if we can pay for it, fine. If we can't pay for it, oh well. But if we begin as a society to look at it as a right, that changes everything in terms of finding the will to make things work.

Fr. Hehir: Let's say they do. Let's say that this idea that it's a right is accepted. In the Catholic tradition, rights and duties are correlated. If health care is a right, who has the duty to fulfill the right? How will we answer that one?

Fahid Tahir: We have a sense of identity within Catholic health care, one formed over a much longer time than the [current] debate. And so can we start demonstrating that we define the access part? But we haven't defined the delivery part. We know that the delivery system is fragmented. We know that everyone is trying to reform our delivery avenues. Can we get ahead of the development of the better delivery system in a way that's tied back to our identity? And through that, influence the national picture?

Fr. Hehir: So you're back to this question of organization and values. OK. But neither you nor anybody else can get away from, "If health care is a right, who has the duty?"

Sr. Carol Keehan, DC

Mollie Bresnahan: Those that have the almighty dollars, unfortunately. My question is, how can we sustain mission-oriented services that you speak of while collaborating with other resources that we may have to, be forced to, with health care reform? How do we provide services to those that have a myriad of problems — mental health, social and medical — and look at the issue of quality of care and accessibility of care?

Sr. Carol Keehan: I want to respond to the question, "If it's a right, whose duty is it to provide it?" In everything else — we have a right to education, we have a right to police protection — you know, it's the government. And it doesn't mean they have to provide it, but they have to assure its availability. The truth of the matter is we don't have a health policy in this country that everybody agrees to. We in Catholic health care live with this fragmented financing, trying to make the fragmented financing work with our philosophy that everybody does deserve care. And that's where all the kinds of questions that you all are raising come up. How do you live in a fragmented, underfinanced, undercapitalized national system for health provision and do what the church tells us, what our Catholic teaching, what the Gospels tell us, are a basic right of people? It comes down to the title of one of the documents of the [Second] Vatican Council, "The Church in the Modern World." How does the church want to do health care? How does the church want to live in a pluralistic society? How does the church want to minister to people who don't share all their values? Minister with people? I would tell you that is something we certainly don't have consensus on in the church.

Imran Chaudhry: I just want to add a little bit more on the quality of care. One of the things in an organization you'll see is the dashboard around financials: How are we doing financially, and did we hit our bottom line? But I think the whole concept of quality of care, it's new. I mean, is 90 percent good enough? What about that other 10 percent of patients who come to our doors who did not get the quality of care, which is where we spend a lot of money because that leads to re-admission, and to all those other things — an opportunity, a privilege, that could be given to others [but] taken by somebody who came through our doors earlier but did not receive [effective] care? If you have all of those measures [demonstrating] how we're doing financially, why do we not have indicators available on how well we are providing care to those that come for care to our organization?

Fr. Hehir: But Stephanie and Mollie have said we've got these mission-oriented services, and we put them in the larger context of how we're going to finance them. So, in a sense, they're pushing on a certain kind of quality, aren't they? That we've got certain things that Stephanie called non-negotiable? Is that the way it really happens in the board meeting? I'll be interested to hear.

Chaudhry: I think it ties to what Stephanie was saying about sustainability, which I think, as we talk about it, comes down to quality. It's all about providing the best care to every patient and family every time. But are we really sustaining those models and working on those? And do we have those policies and procedures in place in our organizations, which is, I think, the challenge for health care and Catholic health care? Do we have the system? Do we have the right metrics?

Robert Stanek: As I listen to the conversation — and my heavens, I can hear every one of the issues — but when you really reflect on the current environment, I can't think of another time in at least the 30-plus years that I've been associated with health care that we have had such an opportunity to make a difference. I think we have to stand back and grasp that for a moment, both as health care providers as well as Catholic health care providers, because, in fact, there is new legislation. Yes, it's being challenged. Yes, there are going to be all kinds of issues associated with it. But I think it's people like those around the room who talk about things like mission, about things like quality, about how to provide access for persons. And if we really reflect on the health care legislation, the opportunity to grasp that is truly there. And I guess for me, the real issue, whether it's related to health care or Catholic health care, is how do we really position the environment in a way that the Catholic ministry can be truly meaningful and, frankly, have the ministry act like the system that you just described?

Fr. Hehir: If this is the best chance for us to make a difference, what are the component elements of that insight? In other words, why is it different now than it has been? What do we have to grasp to do it?

Stanek: We have a framework of health reform,

and it isn't clear; it's as clear as mud. There is no true health policy. Much of what was passed still has a health financing component to it. However, there are aspects that speak about access for so many more Americans. If it shakes out the way it has been envisioned, there are aspects that reward quality of service. There are aspects that speak about outcomes. There are aspects that speak about health prevention. There's funding for health. I mean, there are all of those things that are in that legislation that, albeit not formed, albeit certainly not funded, the fact remains at least the framework for the dialogue and the discussion is there.

Sr. Melissa Camardo: The most central questions for me are also about identity. I think we need all of these questions, but what we do, I think, has to flow from who we are. And as I was thinking about your big question, the question that came to me was a Scriptural one, "Who do you say that I am?" Even in my own ministry, the further that I get pulled away from that central question, that personal relationship with God that allows me to be receptive ... We won't know who we are [unless we have] that ongoing developmental understanding of who God is. The Catholic identity pieces, I think, cannot be disconnected from a much more intimate connection to who God is for us, for who we say God is, than I think we're willing to risk right now.

Sr. Gottemoeller: I'd like to push back a little bit on Mark's dichotomy between health care as a right and a privilege. I gravitate toward, health care as a right. But I'm not at all confident that it's a right that's firmly established in Catholic social tradition. A right to well-being and the care of one's neighbor, perhaps. But a right to health care, a right to heart transplant, a right to a kidney transplant? A right to what? What, specifically, is [it in] health care that I have a right to, and what is my obligation? If I'm a lifelong smoker of three packs a day, I have a right to a lung transplant? So what is it that I have a right to? And what of the rest of the world? I mean, if this is the basic social right, then everybody in the world has it. And you couldn't even have this conversation in half of the world. So, you ask the question about duty. I think the duty is an individual one as well as it is a common duty.

Fr. Hehir: But with rights, we first affirm them, and then we have to figure out what their limits are. Everybody has a right to freedom of speech. No one has a right to yell fire in a crowded theater. The right to religious liberty can be limited if religious liberty fosters violence. That's the reason I asked the question about duty, and I'm going to move this to a different level.

Sr. Gottemoeller: And one more thing: the tremendous redundancy and duplication in

From left, John Paul Slosar, Ph.D.; Sr. Doris Gottemoeller, RSM, Ph.D., and Sr. Melissa Camardo, SCL.

health care. We talk about our struggle to take care of everybody and not to refuse anybody. But at the same time, sometimes we have to know that what we're offering is duplicated down the street. And I don't think we do much better than everybody else in dealing with that issue.

Angela Haggard: I think that gets back to the opportunity. I mean, I think if you look at health reform as asking us to redefine how we deliver care, and we've delivered care for many years as a very hospital-focused, hospital-centric kind of model ... And whether health reform is right or perfect or needs changing or what have you, it's still that opportunity to look at things differently, to do things differently. I think the biggest question is, do we have the resources? Do we have the intellect? Do we have the leaders that can really change how this ... I mean, it's like the Titanic. How do you move this big being that's been moving this way for so long ... do it completely differently? I think for Catholic health care, it gets back to I think what Mollie was saying about the partners. How do you change it — so that we avoid the duplication, avoid the redundancy — to a community-driven health system and have those partners that make sense for Catholic health care and are the right partners for us to move that vision forward?

Slosar: With regard to the question of "If it's a right then who has the duty?" we all have the duty in different ways. So there are different roles for individuals. As an individual, I have a duty to help ensure access to this right by engaging in responsible practices regarding my own individual health, not insisting on useless or expensive treatments at the end of life that don't have a proportionate benefit. I think as organizations and leaders in Catholic health care, we have the responsibility to make sure that those non-negotiables are in the boardroom. And I think that as society and government, we also have the duty to ensure that there's a reasonable financing mechanism available. So if we're not successful in taking advantage of the opportunity, I think it's because of that missing view, as Mark was saying.

Fr. Hehir: I'm going to give you a new question. Many of you have talked about vision, values, what's central to us, what the church wants for health care and what Catholic health care wants for health care. So if I am to take Sr. Doris's answer as a starting point, that we're in confusion, where does the discussion have to take place within the Catholic system to bring some clarity out of confusion about who we are and what we're supposed to do? Is CHA capable of that? If CHA is not capable of that by itself, where else does the discussion have to go? Are there voices that are complementary? Are there voices that are threatening? Are there voices that are adding to the confusion? Who has to discuss this question to get enough clarity to move forward?

Stephen Moore, M.D.: I really want to root it in the history of the women religious — to the comments about the dollars running everything we do. I've had actually the benefit of seeing the "Women in Spirit" exhibit on three occasions now. And in all of that exhibit, there was not a mention of anybody waiting for the government to pass a policy to care for the communities that they cared for. So I would say first that from a historical, women religious perspective as part of our Catholic identity and Catholic health care, there's a perspective associated with humility of service that we've lost track of.

Secondly, this discussion has been framed around the institution. I just loved how you teed this up — what is the role of institutions, and then what is the role of the individuals, the people we've selected today to honor? And what is the role of leadership? And now, I'll go back to finance and probably reverse what I just said. Within my organization, Catholic Health Initiatives, and within Catholic health care and within Catholic social teaching, the way we treat our employees is a very religious, deep value. We spend over $385 million on their health care. ... And then we spend just in pure charity care, not adjustments to Medicaid or Medicare, but in pure charity care, another $275 million. So I challenge anybody who says we don't have any financial incentives to be able to ... create a health care environment ... that has the quality, has the prevention, has the mental health services, has all of these in a purposeful, understandable way that's supported by the teachings of the Catholic Church.

You know, we're caring for the poor at the top of a pyramid in a very expensive place. We're spending, in my organization, $275 million pretty much at the top. And there's maybe $30 or $40 million being spent on what we call mission services. And how do we begin a discussion around going down to the bottom of that pyramid? Beginning truly to serve those who do not have access to the services? . . .


Mark Repenshek

My last comment would really be around access. I would say be careful what we ask for. This is really around unintended consequences. The last major government access that took place, took place in the Johnson administration, in the food stamp program. We gave people access to food. And now the poor are the folks who are suffering the most with obesity. When we look at access, do we really want to give everybody access to what we currently have designed? What's our responsibility to design, within the purview of what we spend, a system that would be much more supportive, innovative, similar to what the women religious did?

Fr. Hehir: You have all raised a lot of questions. One is whether the circle of the conversation is Catholic, not meaning that everybody in it is a Catholic, but it is the Catholic conversation? Or whether it's impossible to have that conversation without wider conversations. If we are trying to have the conversation about who we are, who is crucial to that? Who is not in it but ought to be in it? In other words, who are the players around the table to answer this identity question?

Sandra Bruce: I think the important question in the Catholic health care ministry is really, who are we as Catholics? Kind of Sr. Doris's question, what does it mean to be Catholic? We struggle with it every day in trying to be viable in our communities and partnering with an FQHC, a federally qualified health clinic, which has to live by another set of rules that directly conflict with some of the things that are critically important to our Catholic identity. Yes, CHA could be a convener around what is it going to mean in terms of Catholic identity to do the things that we want to do, and this opportunity we have under health reform to bring more people under the tent. We can't do it all by ourselves at CHA. We have to have the bishops or someone at the table.

It's a huge issue because we are the safety nets in so many communities. And now we have an opportunity to be even a bigger safety net. I mean, what has been provided to us as opportunity with a redistribution of some of our assets is huge. But we've got to figure out the Catholic identity issue, and we can't do it alone. We need the church at the table with us in whatever constituency that is.

Tersigni: My view is just a little different. I don't think that CHA could convene the meeting. I think we ought to figure out a way to have a symposium where you would have CHA, representatives from USCCB [United States Conference of Catholic Bishops], and representatives from parishes around the country in the room ... and have a candid conversation about real life — about what it means to be a real-life Catholic in today's secular age. And to have a discussion about, "OK, how then does it inform what we keep calling our Catholic health ministry?"

Repenshek: And there are different models of church. We've got many models that aren't part of the conversation. You do raise questions about limits. Absolutely. But there are foundational principles where you ground that right — principles that really aren't up for a lot of debate. And so I'm going to add a piece related to the three components of leadership: the intellectual, moral and inspirational. It's the formative piece. I don't know how we're supposed to have a conversation bringing in all the different models of church if we have to back up so far, with all the different constituencies, to points that should be fundamental. Having to educate people on something as foundational as human dignity and how you draw certain rights from that, when they are debating with us as to whether or not, you know, health care reform is something that's necessary or needed or what the present construction looks like — it shouldn't be a debate in certain places. And if we're talking about the laity leading the church into its next era, if it doesn't have that formational aspect to leadership, we start moving all over the place.

Part 2 of the panel discussion will appear in the next issue of *Health Progress*.

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

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Reprinted from *Health Progress*, September-October 2011