WHAT'S PAST IS PROLOGUE

75 Years of Health Progress: Providing a Foundation for the Future

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The year was 1917. Michael F. Fallon, MD, surgeon-in-chief, St. Vincent's Hospital, Worcester, MA, was traveling home by train from a Catholic Hospital Association (CHA) convention. During the evening he met one of the sisters who had attended the convention. As the train chugged through the night, she told him about hospital life in the Pacific Northwest and some of the difficulties she faced in that isolated area.

Greg Couch

A few years later, when Fallon heard about a proposed journal for CHA, this anonymous sister came to mind. "My first thought was, what a boon this magazine will be to that sister away off in the Northwest, and to all other hospital sister nurses," he would write in the first issue of *Hospital Progress*, published May 1920.

Hospital Progress came into being to bring information to those sisters and the Catholic hospitals they operated throughout the United States. At the beginning of the decade they were already readying themselves for the standardization of their hospitals. *Hospital Progress* became a key instrument in communicating steps to take to meet these new standards. Later, the journal would begin to focus on virtually every healthcare issue that affected Catholic healthcare organizations in North America.

Throughout the decades its content, its style, and even its name would change. (In 1984 the journal became *Health Progress*, reflecting the association's earlier name change to the Catholic Health Association.) However, its mission, stated in Volume One, Number One, remained essentially steadfast: "to become the medium through which the best thought and practice in hospital service to the sick will be worked into the lives of those who are consecrated to this service."

To commemorate 75 years of *Hospital/Health Progress*, this article focuses on the healthcare trends that dominated the decades and how the journal has communicated them since 1920. Although the journal certainly covered other pertinent topics, what's striking is that many of these key themes—healthcare reform, Catholic identity, ethics—have recurred throughout the century and remain potent concerns today. "What's past is prologue," Shakespeare wrote. This history thus reminds us of the Catholic healthcare ministry's rich tradition and guides those in the ministry as they look toward the future.

75th Anniversary
Health Progress
Foundation FOR THE FUTURE

THE STANDARDIZATION MOVEMENT

"And now to the task we have undertaken," wrote Bernard McGrath, MD, secretary of CHA's executive committee, in the premiere issue of *Hospital Progress*. That task was the standardization of Catholic hospitals in the United States and Canada.

What was standardization? It meant that hospitals would have to meet American College of Surgeons' (ACS's) requirements that they be equipped, staffed, and organized to ensure adequate service to patients. The movement toward hospital standardization began in 1912 and would revolutionize healthcare by the end of the twenties.

From the beginning of the movement, Rev. Charles B. Moulinier, SJ, CHA's first president and a leader in moving Catholic hospitals toward standardization, worked closely with John G. Bowman, MD, ACS director.

The standardization movement got off to a sluggish start. In 1919 ACS officials examined 671 hospitals in the United States, but only 198 were able to meet the minimum requirements and make the list of standardized hospitals. "Now the time for a reckoning has come," wrote Fr. Moulinier in the August 1921 *Hospital Progress*. "I trust that any Catholic hospital that does not find itself on this printed list of minimum standard hospitals will immediately institute a court of inquiry, will not cease its endeavors, until an answer has been obtained to the question: 'Why am I not on the list?'"

In the early 1920s the number of hospitals that met the standards rose steadily. In 1920, 407 U.S. hospitals met the standards, and in 1921, 761 hospitals met the standards, according to a summary published in *Hospital Progress*.

The movement for standardization affected healthcare in the 1920s beyond anyone's expectations. It had a trickle-down effect, prompting a reevaluation of many areas in the healthcare field, from laboratory management to nursing to administration. Indeed, the 1920s were a sort of renaissance for healthcare. An excitement about education, research, and change permeates the pages of *Hospital Progress* during the decade.

Medical Ethics: The Roots of Catholic Healthcare

However the healthcare system has changed from the 1920s to the present, one concern has remained paramount to Catholic healthcare facilities: how to preserve Catholic values in a rapidly evolving healthcare system. The question then was, in the rush to establish uniform standards under a secular agency such as the ACS, would the unique principles that defined Catholic healthcare somehow be lost or diminished?

The pathology laboratory at St. Catherine's Hospital, Brooklyn, was no doubt one area affected by the 1920s' movement toward standardization.

In the 1920s most medicomoral problems revolved around obstetric/gynecologic issues. In one particularly controversial case, published in the July 1920 *Hospital Progress*, five physicians from the Marquette University School of Medicine resigned after a dispute with the university's president on the issue of choosing whether to save a mother or her unborn child in a life-threatening situation.

Confusion over similar cases compelled CHA to reaffirm its commitment to ethical standards that conformed to Catholic values. A series of "Ethical Chats" authored by Fr. Moulinier ran in early issues of *Hospital Progress*. Other contributors explored the history of medical ethics

1920
19th Amendment (women's suffrage) is passed.

1922
Mussolini takes power in Italy.

1924
George Gershwin writes *Rhapsody in Blue*.

1925
Scopes "monkey" trial takes place in Tennessee.

1926
Gertrude Ederle is first woman to swim English Channel.

and contemporary issues, especially problems related to organ removal or life-threatening surgery.

In 1921 CHA published its own set of minimum standards that not only conformed to ACS expectations but also established ethical standards for patient care. Periodically, these standards would need to be revised and expanded. Over the decades, *Hospital Progress* became an important forum for medical ethicists to explore dilemmas that healthcare providers face, from the earliest surgical issues to increasingly complex issues spurred by advances in medicine and technology.

Nursing: From Apprentice to Professional

Probably no other healthcare field blossomed as nursing did during the 1920s. Indeed, at the beginning of the decade the training of nurses was considered little more than an apprenticeship. By the end of the decade, nursing schools had raised their entrance requirements and were moving toward university affiliations.

"If we are to have the right kind of trained nurses, we must provide them with the right kind of training," wrote Fr. Moulinier in the June 1920 issue of *Hospital Progress*. "One of the great purposes of *Hospital Progress* will be to assist in providing ways and means for securing this training for those institutions."

Even as hospital administrators recognized the need to improve the quality of nursing education, a nursing shortage threatened to undermine this movement. After World War I, women were finding new opportunities to work at higher wages, under better conditions, and with shorter training periods, inducing many to shy away from nursing careers.

These rapid changes put enormous pressure on hospitals to care for ever-increasing patient case loads. Hospitals often overutilized student nurses for patient care. Hospital administrators even discussed lowering entrance requirements to nursing school and shortening the length of training in the rush to add to the nursing ranks.

However, in the spirit of the time, the commitment to quality prevailed. To achieve better training and nursing care, nurses became more tightly organized, forming the Committee on the Grading of Nursing Schools of the National League of Nursing Education (NLNE).

CHA heard from "not a few members of the medical profession . . . that too much education is not good for a nurse," according to an editorial by Fr. Moulinier. But since its first issues, *Hospital Progress* supported the evolution of nursing into a profession in its own right.

Women Religious: The Core of Catholic Healthcare

A glance through early issues of *Hospital Progress* reveals women religious as the dominant force in Catholic hospitals throughout the United States and Canada. Photo after photo of convention meetings portrays sisters from numerous orders. In fact, in 1921 Fr. Moulinier estimated that 90 percent of the 674 hospitals in the United States and Canada were sponsored by congregations of women religious.

"There is a spirit, a soul, an atmosphere, an ideal of service in the Sisters' hospitals which they create and maintain and give their lives' best efforts to foster," said Fr. Moulinier in the September 1921 *Hospital Progress*.

Yet a large percentage of these sisters had no advanced education. The standardization movement and the formation of CHA opened new doors for them. From the outset Fr. Moulinier encouraged hospital sisters to take advantage of new educational avenues.

These nurse graduates from Good Samaritan Hospital, Zanesville, OH, were entering a healthcare field that blossomed like no other during the 1920s.

Problems in the nursing profession, such as the nursing shortage, often made it difficult for nursing sisters to leave their hospitals to pursue an education. In 1922 between 15,000 and 20,000 sisters worked in U.S. and Canadian hospitals. It was not enough.

CHA was quick to address the pressing necessity for more sisters. It formed a Committee on Vocations, and in the September 1922 *Hospital Progress*, Fr. Moulinier defined the "two great needs" of CHA members: more sisters in each hospital and more training for all of the technical work of the hospital.

1927
Lindbergh flies the Atlantic.

1928
Herbert Hoover defeats Al Smith for president.

1928
Alexander Fleming, MD, discovers penicillin.

1929
First Blue Cross plan is established

1929
Wall Street crashes.

A New Deal For Healthcare

If the 1920s were characterized by a striving idealism, the 1930s were marked by a dogged pragmatism, a general matter-of-factness. Indeed, healthcare workers who were caught up in the breathtaking changes of the 1920s must have wondered if all their achievements had been for naught.

Shortly after the collapse of the stock market in October 1929, articles on medical costs and economics began to dominate the contents of *Hospital Progress*, suplementing the earlier zeal for education, research, and training.

The Depression: Cutting Costs and Calculating Losses

How did the Depression affect hospitals? Foremost, it shifted attention from quality to cost containment. Hospital administrators watched with alarm as their occupancy rates dropped. In an August 1931 *Hospital Progress* article Sr. M. Robert, RN, reported an average 40 percent reduction in occupancy from 1930 to 1931 in the hospitals she evaluated. Simultaneously, hospitals were having problems in collections and in making interest payments. Many found their purchasing power reduced and were forced to cut back seemingly indispensable services.

Why did occupancy drop? Not because the number of people who needed hospital treatment had decreased, according to Sr. Robert. Illnesses were not declining but were, in many cases, simply ignored or lightly treated because people could not afford to pay doctor and hospital bills. "Were it not for the various forms of charitable work . . . how many of the very poor would come under a doctor's notice except in very severe cases of illness?" she asked.

At the beginning of the decade, CHA's Committee on the Cost of Medical Care was in the midst of a five-year research effort to evaluate healthcare costs. The December 1932 *Hospital Progress* published the committee's recommendations, including that medical services should be offered by groups of physicians organized in association with a hospital, public health services should be extended, and the cost of medical care should be covered on a group-payment basis through either insurance or taxation.

Throughout the economic travails of the 1930s, CHA President Rev. Alphonse M. Schwitalla, SJ, called on CHA members to exercise a self-sacrificing love. "What the Catholic heart feels in the midst of all this, what faith can do to offset the stresses of the economic world perhaps no one will dare full to define," he wrote in the January 1932 *Hospital Progress*. "It is only the heart that knows and is able to translate that knowledge into practice, the relative values of time and eternity, of wealth and poverty, of sickness and good health, that can see throughout the mists and fogs and can appreciate the brightness of the light beyond."

A major concern throughout the thirties was how to raise the standards for nursing education.

Americans began to see a "light beyond" in 1933, when President Franklin D. Roosevelt's New Deal was launched. Catholic hospitals looked at federal and state legislation with initial hope and then concern about where the voluntary hospital fit into the new direction the country was taking. And attention shifted to what Fr. Schwitalla described as a "shadow coming over the horizon": rising healthcare costs. But even Fr. Schwitalla could not have guessed how large a shadow this issue would eventually cast over healthcare.

1931
Empire State Building opens in New York City.

1932
Franklin D. Roosevelt is elected president.

1933
Hitler is named German chancellor.

1934
Dionne quintuplets born in Canada.

1935
Social Security Act is passed.

Continuing Struggles for the Nursing Profession

Throughout the 1930s, undaunted by the economic setbacks of the Depression, nurses pressed for continued nursing school reform. Articles in *Hospital Progress* called for nursing schools to separate from hospitals and affiliate with universities so that the standards for a nursing degree could be raised and education—not the hospital's labor needs—could become the primary focus of nursing education.

The dominant concern in nursing in the 1930s was the ongoing debate about grading nursing schools. In 1931 a rumor spread that the Committee on the Grading of Nursing Schools, established by the NLNE in the 1920, was planning to publish a list of 100 nursing schools that met its standards, only one of which was Catholic. The August 1931 *Hospital Progress* printed excerpts from the *American Journal of Nursing*, capturing the mood of the nursing sisters: "The Sisters were perturbed and anxious, for a rumor had spread among them that their schools were being discriminated against by the Committee on Grading of Nursing Schools."

Concerned about the need to maintain the Catholic viewpoint in nursing education, at the 1930 annual convention CHA members voted to organize what became CHA's Council on Nursing Education. In 1934 the council began to inspect and evaluate Catholic nursing schools and, in 1938, to accredit them, despite "great trepidation on the part of the Sisters regarding the advisability of forming our own accrediting agency within the Catholic Hospital Association," noted Sr. Mary Henrietta, SSM, in the December 1938 *Hospital Progress*. These efforts would stall during the war years, however, and by 1946 the council decided to abandon its accrediting activities.

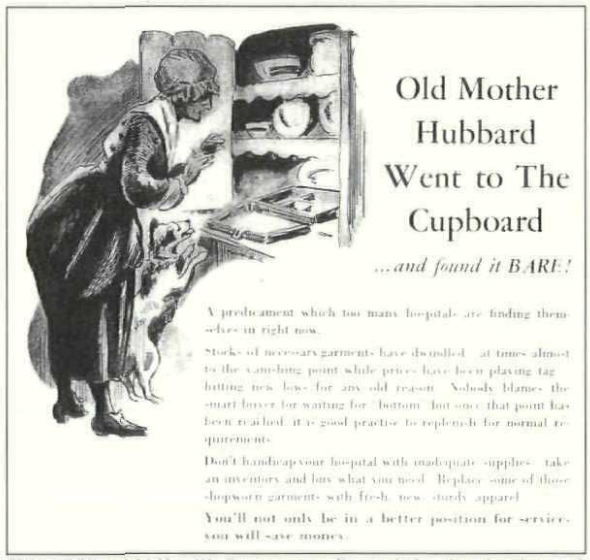
CHA Steps into the Political Arena

"Private community effort is not contradictory in principle to government effort. . . . All of these are needed to make up the partnership upon which our nation is founded. The scope of voluntary action cannot be limited because the very desire to help the less fortunate is a basic and spontaneous human urge that knows no boundary lines. It is an urge that advances civilization. I like to think it is a national characteristic," President Roosevelt declared early in his presidency, as later quoted in *Hospital Progress*.

Roosevelt had summed up what Fr. Schwitalla thought should be the relationship between voluntary and governmental agencies: a partnership. Yet more than a few healthcare providers saw government assistance as intrusive and economically unsound. "We all became hopeful that the government would not become more seriously involved in what we consider an economic mistake through duplication of hospital facilities [building of federally funded Veteran's Hospitals]," said Edward H. Cary, MD, in remarks made to CHA's 1932 annual convention, later published in *Hospital Progress*.

In 1934 the American, Catholic, and Protestant Hospitals Associations formed a coalition called the Joint Committee of the National Hospital Associations. Their common goal: to influence federal and state legislation that could affect the voluntary hospital system. One of the most interesting pieces of legislation, certainly the most alarming for the Joint Committee, was the National Health Act of 1939 (S. 1620), introduced in the U.S. Senate to institute national healthcare reform. Unfortunately, it virtually excluded the participation of not-for-profit hospitals.

For Fr. Schwitalla, the proposed bill was a cruel disappointment, especially after Roosevelt's encouraging statements at the beginning of the decade. "The Act leaves no doubt in one's mind but that the care of the nation's health and sickness is to be entrusted more and more to government agencies," he wrote in the April 1939 *Hospital Progress*. This piece of legislation would ultimately be defeated in the 1940s. But the issue of national healthcare policy would recur again and again until CHA took the lead in the 1980s and began its own formulation of healthcare reform.



This 1932 ad in* Health Progress *reflected the deprivations of the Depression.

1936
Edward VIII abdicates the throne to marry Wallis Simpson.

1936
Boulder Dam is completed.

1937
Amelia Earhart disappears in the Pacific.

1939
Sen. Robert Wagner, D-NY, introduces a national health insurance bill, which fails to pass.

1939
Germany invades Poland; WW II begins.

ADVERSITY TO PROSPERITY

Only the people who lived through the early 1940s can precisely describe the fear and uncertainty they felt. In the December 1940 *Hospital Progress* Fr. Schwitalla wrote about world events and their impact:

> The nations, both those at war and those on the edge of war, are preparing. Preparing for what? Those at war say for a new world order; those preparing for war say for the conservation of a world order. . . . All through our talk there is that horrible nightmare and that unthinkable fear that all the nations are thinking of something that is not Christianity—a culture based on material success, a civilization based on force and coercion; a new order based on might and overwhelming power. It is the dreadful enigma of the future that sharpens the agony of today; the uncertainty of what is to come that blackens the darkness of the Now.

How did the upheaval of the 1940s affect Catholic healthcare? In the January 1947 *Hospital Progress*, Fr. Schwitalla expressed hope in the power of healing: "A new era, a renaissance seems to be dawning for the hospital as a place in which men atone for the crimes of mankind by progressive success in alleviating the sufferings and torments, the anxieties and the anguish of men."

World War II: Setbacks and Opportunities

For the physicians, nurses, and missionaries abroad, healthcare took on a horrific reality during World War II.

"It is frightening here in Wuhan," wrote a Sister of Charity of Cincinnati from her missionary post in central China, published in the August 1942 *Hospital Progress*. "Everyday terrible air raids. The City Provincial Hospital was hit and Doctor Liu and six nurses buried alive. Gruesome sights! One person was so shot up that none of our men had the heart to put him in the coffin when he died. Sister Alban and Sister James finally attended to it. Sister Alban stood on the coffin lid while Sister James nailed it down."

On the homefront, Catholic hospitals faced an unsettling situation. At CHA's 29th Annual Convention and Second Wartime Conference, reported in the May 1944 *Hospital Progress*, Fr. Schwitalla pointed to Catholic hospitals' progressive physical deterioration, obsolete equipment, and food and personnel shortages as a consequence of the austerity imposed on civilians.

In spite of these obstacles, Fr. Schwitalla was able to see what he called the "blessing of the War" for hospitals. During the war, relations between hospitals and the federal government improved. Both joined in cooperative agreements to provide healthcare. "There has resulted a practical, though perhaps a temporary, solution of the relationships between public and private institutions, and we hear less of rivalry between the two groups," said Fr. Schwitalla in his address to the 29th Annual Convention.

Diagnosis and Treatment for a Nation's Healthcare

In 1944 a U.S. Senate subcommittee headed by Claude Pepper, D-FL, startled the country with its evaluation of U.S. Selective Service statistics. Of 22 million registrants, aged 18 to 37, as many as 4.1 million were regarded as physically or mentally unfit for military service.

"A shocked nation is interested in remedying this situation," said Fr. Schwitalla in the March 1945 *Hospital Progress*. "What part the hospitals can play in the rehabilitation of these rejectees, where the responsibility should be placed for remedial procedures and what the sources of funds should be for effecting a betterment of these conditions are all matters of discussion and controversy."

How to bring better healthcare to U.S. citizens, particularly in rural areas lacking facilities and physicians, continued to be the focus of legislative

1940
John Steinbeck receives Pulitzer Prize in fiction for *The Grapes of Wrath.*

1941
Japanese bomb Pearl Harbor.

1943
Congress adopts the Emergency Maternal and Infant Care Act to provide medical benefits for dependents of low-income servicemen.

1944
Allied forces begin the invasion of France in WWII—D-Day.

1945
U.S. drops atom bomb on Hiroshima, Nagasaki.

debates throughout the 1940s and subsequent decades. Legislation such as the Lanham Act of 1941 provided funds for hospitals, while programs set by the Works Progress Administration trained hospital attendants and auxiliary personnel.

The most important piece of legislation was passed in 1946 when Congress enacted the Hospital Survey and Construction Act, or what came to be known as Hill-Burton. The act provided an initial expenditure of more than $1 billion of combined federal, state, and local funds over a five-year period for hospital construction. The government hoped that stimulating hospital construction in rural areas would improve healthcare.

"Hill-Burton is a substantial step in the development of a national health program to distribute all the benefits of medical science more adequately among all our citizens," said Thomas Parran, MD, U.S. surgeon general, in the July 1947 *Hospital Progress.*

Throughout the 1940s, legislation to improve and reform the nation's healthcare system was proposed. At least three times President Harry S Truman in his State of the Nation addresses asked Congress to enact legislation in favor of a compulsory health program. The December 1945 issue of *Hospital Progress* quoted Truman: "Millions of our citizens do not have a full measure of opportunity to achieve and enjoy good health. Millions do not have protection or security against the economic effects of sickness."

A compulsory health program was an issue that would not go away. But the country had just come through a war that threatened the very ideals of freedom and individuality. Anything that smacked of too much federal involvement in healthcare was perceived as a move toward socialized medicine.

At CHA's 1944 convention, Rev. Alphonse M. Schwitalla, SJ, pointed to both the pressures and the "blessing" of the war.

Fr. Schwitalla described CHA's stand on the delicate balance being sought by the voluntary hospital system and the federal government. "In Catholic thinking, government should have a minimal rather than a maximal effect," he said in the June 1947 issue of *Hospital Progress.* "Hence, too, government will be ready to assist those who cannot be responsible for themselves or who lack means to exercise that responsibility. . . . The measure of a man's need only will be the measure of the government's subsidy and such a subsidy will leave untouched and unimpaired the self-respect of the individual." This concern for human dignity would be carried forward into the 1990s, when CHA's proposal for healthcare reform referred to this as a foundational value.

Ethics for a Contemporary Society

In the March 1949 issue of *Hospital Progress* Rev. Lawrence E. Skelly posed a fundamental question to readers: "Certainly if there should be one distinguishing mark of a Catholic hospital, it should be its code of ethics—else why do we exist?"

Indeed, a Catholic code continued to be the cornerstone of Catholic hospitals throughout the 1940s. Although CHA had published a surgical code in 1921, advances in science coupled with social confusion and uncertainty following World War II had made that code outdated. In the 1940s the need for a revised code of medical ethics became imperative.

Rev. Gerald Kelly, SJ, had been addressing medical ethics questions in a regular *Hospital Progress* column titled "Medico-Moral Problems" throughout the 1940s. Through his efforts, CHA published the *Ethical and Religious Directives for Catholic Hospitals* in 1949. The new code was broader than its predecessor, addressing issues such as x-ray treatments, artificial insemination, and birth control information. It also advised care givers on the religious care of patients, such as baptism and preparation for death.

The critical issue that arose from the 1949 revision was whether it meant the Church was shifting its position on these ethical problems. Fr. Kelly stressed that the Church's underlying teaching remained untouched. "Such a code cannot be static," he said in the July 1948 *Hospital Progress.* "It must grow as the progress of medical science opens up new problems and sheds new light on old ones. *This does not mean that moral principles change.* It simply means that the applications of such principles can multiply, that principles not yet expressed in a code might have to be added, and even that old principles may admit of more accurate formulation."

1946

Frances Xavier Cabrini, foundress of the Missionary Sisters of the Sacred Heart, is first American citizen canonized.

1946

President Harry S Truman calls for compulsory national health insurance.

1946

Hill-Burton passes, providing funds for hospital construction.

1947

Jackie Robinson becomes first African-American major league baseball player.

1948

Israel is founded.

The Evolution Of Specialties

During the 1950s medicine evolved at a breathtaking pace. Rapid advances in science and medicine created the need for specialization. Increasingly, care givers were under pressure to provide expert care in a rapidly changing healthcare system.

First Glimpse of the Graying of America

By the early 1950s the healthcare community was waking up to a new crisis: the plight of its elderly. In the January 1952 *Hospital Progress* Mother M. Hilary, CSC, cited alarming statistics: 177 cases of chronic illness were reported per 1,000 population in the United States. Although chronic illness was documented in all age groups, at that time 59 percent of adults aged 65 and older suffered from chronic illness.

Sisters at the 1950 CHA convention observe a demonstration on the latest developments in x-ray technology.

In her article Mother Hilary pointed out the need for more facilities and services for a growing aging population with chronic or long-term illnesses. "The census bureau forecasts that by 1990 13.1 per cent of all the inhabitants of this country will fall in this age period," she said. "This means there will be approximately 20,000,000 people over 65 years of age. Using the above figure of 59 percent having chronic illness, this would mean approximately 12,000,000 cases of chronic disease in this one category—adults over 65."

According to a June 1954 *Hospital Progress* report on a national conference on the Care of the Long-Term Patient, problems in treatment for the chronically ill stemmed from medical advances that increased life expectancy. A September 1955 *Hospital Progress* editorial sounded the call for a solution:

> We have not realized fully that certain types of chronic illness demand continuing hospital care; the fact that an illness is prolonged does not necessarily mean that the patient is less ill or less in need of intensive medical and nursing attention. The demoralizing effects of long-term illness and its consequent burden on the patient and his family should concern us in a special way.

Psychiatry as a Medical Specialty

In the 1950s advances in psychotherapy and in drug treatment, with the development of new drugs such as Thorazine and reserpin, gave new credibility to psychiatric medicine. With this recognition came the realization that treatment for mental illness could or should take place in general hospitals instead of separate asylums that had traditionally housed the mentally ill.

"One-half of 1,000 general hospitals surveyed in the United States never admitted a known psychiatric patient," Frank H. Ayd, Jr., MD, wrote in the October 1955 *Hospital Progress*. One-sixth gave some treatment in mild cases, and one-third admitted such patients for emergency treatment or diagnosis only, he wrote.

"This is regrettable, for it need not be," Ayd continued. "Even without a special psychiatric unit, experience has shown that not only neurotics but even psychotics can be adequately treated in a general hospital without disturbing either the other

1950
Richard Rodgers, Oscar Hammerstein II, and Joshua Logan receive the Pulitzer Prize in drama for *South Pacific*.

1950
Korean War begins.

1951
Color TV introduced in U.S.

1952
Joint Commission on the Accreditation of Hospitals is established.

1954
McCarthy hearings held.

At a 1958 CHA program for directors of nursing services, most attendees were sister-nurses, but lay professionals—whose numbers were on the rise—were also present.

patients or the hospital routine."

Hospital Progress took its editorial stand on mental illness in March 1955: "In the past the majority of our general hospitals did nothing in this field except refer mental cases as quickly as possible to a special institution. This was custom and the accepted pattern. . . . General hospitals, especially those which aspire to function as health centers in a community, should set up psychiatric divisions wherever possible."

Women Religious: A New Formation

For the sister-nurse the postwar period presented a particular dilemma. Juxtaposed between a rapidly changing healthcare system and the more protected, obedient life of her order, she struggled to fit into a rapidly advancing, increasingly specialized healthcare delivery system.

In the mid-1950s the sister formation movement was organized to focus on ways to better train sisters and to promote mutual help in securing such training. Sr. Mary Emil, IHM, chairperson of the National Sister Formation Committee, described what she foresaw as the "sister of tomorrow" in an article for the September 1956 *Hospital Progress*. "She will be high-powered in many ways," Sr. Emil said. "She must have deep spirituality, an intense prayer life issuing in a radiance of self-forgetting charity. She must achieve this in spite of activity, work, distractions and without long and uninterrupted hours of contemplation. She must be an informed, interesting, cultured person with a high degree of social ability. She must be this in spite of the demands on the one hand of her life of prayer, and on the other of her professional duties."

Increasing contact with lay healthcare professionals also played a part in the sisters' reevaluation of how to meet contemporary demands. Laypersons were playing a larger role in Catholic hospitals as a result of economic conditions. "For better or worse, in their own institutions—hospitals, schools of nursing, clinics—nursing sisters are by far outnumbered by lay nurses," said Sr. Madeleine Clemence, OP, in the November 1962 *Hospital Progress*. "In hospitals, a ratio of one sister to 20, 30, or even more, lay nurses is the rule rather than the exception and in many instances, these lay nurses occupy key positions."

One of the movement's concerns was to ensure that Catholic sisters would be as fully prepared as possible to be on equal footing with their lay colleagues. "Personal and religious formation stand in the same relationship as matter and form," Sr. Clemence wrote. "The professional activities are informed by the religious consecration, and the two are co-principles of the being that the nursing sister ought to become."

This ad for "Psycho-Security Screens" from May 1955 reflects hospitals' increasing treatment of patients with mental illness.

1954
Brown v. Board of Education decision says school segregation unconstitutional.

1954
Jonas Salk develops a vaccine against poliomyelitis.

1955
Montgomery bus strike begins, led by Martin Luther King, Jr.

1955
James Dean stars in *Rebel Without a Cause*.

1957
Soviets launch Sputnik, first space satellite.

THE NEW FRONTIER OF MEDICINE

"Yesterday's tomorrow has become today," said Barbara Callahan in her September 1966 *Hospital Progress* article, "New Era in Medical Instrumentation." Callahan, a public relations counsel and regular contributor to the magazine during the 1960s, was referring to the space-age technological advances that affected medical diagnosis and treatment; however, she pinpointed the crux of the issue that dominated healthcare in the 1960s.

Suddenly the future was here: Medicine had evolved to more science than art, and a very specialized science at that. Physicians' focus of treatment had shifted from the office and home visits to the hospital. They were using new and powerful drugs and treatments that required considerable expertise to administer. And in 1965 Congress enacted Medicare and Medicaid, establishing unprecedented government involvement in healthcare.

Reflecting the general mood of the country, most of the decade represented a period of excitement and hope for the potential quality of healthcare. But by the end of the decade, hope had turned to concern as healthcare costs mounted and a disproportionate number of Americans still lacked access to high-quality care, a number that continued to increase in the decades ahead.

VATICAN II: A PAINFUL REDEFINITION

After Pope John XXIII announced that he was convening an ecumenical council, seeds for reform were planted, eventually resulting in changes that would prompt apostolic groups to reappraise their commitments. Catholic healthcare facilities were no exception.

"The general principles the Church adopts for its own renewal as a Christian community would be useful for making Catholic hospitals not more efficient as institutions but more Christian as communities," said Rev. John M. Comey, SJ, in an analysis of Vatican II's impact, published in the June 1971 *Hospital Progress.*

Principles stressed by the Second Vatican Council, held between 1962 and 1965, challenged traditional concepts of leadership. The principles of coresponsibility, collegiality, and subsidiarity rejected the image of the Church as a pyramid with the laity at the base and the hierarchy at the peak. As subcommunities within the Church, Catholic hospitals began to reevaluate authority within their organizations. For bishops, women religious, and priests, the old dividing lines of authority began to blur. And a painful redefinition began.

"This is a tremendous challenge to our Catholic hospitals," said Fr. Comey in the same article. "Will they accept this principle of renewal and restructure their complex interpersonal relationships?"

CHA's executive director from 1947 to 1968, Rev. John J. Flanagan, SJ, was prescient about the far-reaching effects of Vatican II.

In a March 1966 *Hospital Progress* article on the apostolate, Rev. John J. Flanagan, SJ, CHA executive director, predicted Vatican II would lead to some new patterns in healthcare. One major change would be a new role for some religious sponsors, who would retain ownership and policy-making responsibility but "will utilize religious in direct service to patients and in

1962
Pope John XXIII convenes the Second Vatican Council.

1963
JFK is assassinated.

1964
Civil Rights Law passed (public accommodations).

1964
Beatles make first U.S. tour.

1965
Lyndon Johnson sends U.S. combat troops to South Vietnam; war escalates.

purely spiritual roles and will be obliged to place administration in the hands of seculars."

Fr. Flanagan also called for Catholic hospitals to "plan more carefully with other Catholic hospitals and with diocesan officials to avoid unnecessary competition and costly duplication." He continued: "We must study our ownership and our management to determine if these are oriented to apostolic health service or if they have become too much centered on buildings and management as ends rather than as means for Christian service to people."

Fr. Flanagan's speculations about the future proved accurate over the decades that followed, as the effects of Vatican II led many religious to give up work in institutions in favor of more direct service to the poor; lay leaders assumed an ever-increasing presence in hospital management; healthcare providers increased their collaborative efforts; and the hospital's mission moved into the community, decreasing its emphasis on the institution per se.

A Wealth of Legislation

President Lyndon Johnson's first special message to Congress on January 13, 1965, focused exclusively on health, as reported in the February 1965 *Hospital Progress* by George E. Reed. "Our first concern must be to assure that the advance of medical knowledge leaves none behind," said Johnson. "We can, and we must, strive now to assure the availability of and accessibility to the best health care for all Americans regardless of age or geography or economic status."

Indeed, during the 1960s Congress enacted a wealth of healthcare legislation, most importantly Medicare in 1965 (and later that year, Medicaid). These key acts were described in a September 1965 *Hospital Progress* article by Barbara Callahan as the "biggest extension of government welfare benefits since the Depression years of the 1930s." Their passage, she said, signalled the end of a long fight by the American Medical Association and conservative members of Congress who feared a giant step toward socialism.

Medicare provided government-financed medical care for the aged, higher Social Security benefits—and more liberal rules for disbursing them—and a higher payroll tax for financing most of the $6.5 billion program, according to Callahan.

Other laws passed during the 1960s, described in the same issue, also affected healthcare:

- The Older Americans Act of 1965 provided assistance in the development of healthcare and social programs to help older people and established the Administration on Aging within the Department of Health, Education and Welfare.
- The Community Mental Health Centers Act of 1963 appropriated $150 million in federal financial aid to states for the construction of comprehensive community mental health centers.
- The Nurse Training Act of 1964 appropriated $283 million over a five-year period for construction of nursing schools, project grants, and loans to student nurses.
- The Health Professions Educational Assistance Act of 1963 authorized grants to schools of medicine, dentistry, and osteopathy for scholarships to needy students and for construction of teaching facilities throughout the nation.

When President Johnson signed the Medicare legislation in 1965, he brought Harry S Truman and his wife, Bess, to Washington for the ceremony, honoring Truman's work for healthcare reform in the forties.

1965
Medicare and Medicaid pass.

1967
Thurgood Marshall becomes first African-American U.S. Supreme Court justice.

1967
Christiaan Barnard, MD, conducts the first human heart transplant.

1967
Green Bay defeats Kansas City in Super Bowl I.

1969
U.S. astronauts walk on moon.

PUTTING A CAP ON COSTS

By the beginning of the 1970s, disillusionment with rising healthcare costs was mounting. According to Rep. James C. Corman, D-CA, in 1974, $104 billion, or 8 percent of the gross national product, was spent for health and medical care. "The total cost increase during the past eight years was more than $56.1 billion from $47.9 billion in fiscal year 1967," he said in the June 1975 *Hospital Progress*. "Thus the nation's total health bill has increased well over 100 percent in eight years."

How to address healthcare problems became the dilemma of the 1970s. The language of healthcare in the 1970s was very different from the New Frontier bravado of the 1960s. Terms like "HMOs" and "managed care" dominated debates. For the first time patients were referred to as consumers, and administrators of not-for-profit facilities started thinking about marketing strategies. Healthcare had shifted from an unquestionable ideal of medicine to the reality of an industry.

Ethics in the 1970s

In 1971 the National Conference of Catholic Bishops approved a newly revised *Ethical and Religious Directives for Catholic Health Facilities*—the first revision of the directives since 1954. In an October 1971 article for *Hospital Progress*, Abp. John F. Whealon of Hartford, CT, said:

> A legal code of conduct is necessary for all civilized nations; an ethical code is necessary for all hospitals. A Catholic hospital must have a code reflective of the moral values taught by the Catholic religion. Patently, this is among the first and basic requirements that make a Catholic hospital Catholic—more basic, seemingly, even than other considerations such as ownership, corporation membership, presence of religious, presence of priest-chaplains, etc.

The revised directives addressed contemporary medical issues such as organ transplantation from living donors and postmortem examinations. They also reflected post–Vatican II developments in sacramental theology and ecumenism.

As the directives were being revised, on January 22, 1973, the U.S. Supreme Court legalized abortion, the most controversial ethical issue of the century for Catholic healthcare. Since that landmark decision, Catholic healthcare providers have grappled with its ramifications. Throughout the 1970s, in news analyses and essays, *Hospital Progress* vigorously defended the Church's position opposing abortion, as well as Catholic hospitals' right to refuse to provide abortions.

"What we believe and what we do in the preservation and restoration of man's greatest gift from God—life itself—is under attack," wrote Sr. Mary Maurita Sengelaub, RSM, in the November 1973 *Hospital Progress*. Sr. Sengelaub, CHA's first woman president, called on Catholic sponsors to recommit their efforts to providing healthcare services while "striving for pro-life on all fronts."

Anti-abortion forces achieved a victory in 1973 when Congress passed the Church Amendment, which "insulated hospitals and health personnel from being required to participate in sterilization or abortion procedures," as George E. Reed wrote in the January 1974 *Hospital Progress*. The original amendment, along with subsequent court cases and a later extension of the amendment to Medicare and Medicaid, "evidences a continuing constitutional and judicial policy of recognizing the civil rights of individual health personnel and hospitals in this highly sensitive and controversial area," Reed wrote.

The Nursing Education Debate Continues

In the 1970s, challenges such as the changing roles of women, higher con-

1970
Students shot at Kent State, Jackson State.

1971
National Conference of Catholic Bishops issues revised *Ethical and Religious Directives for Catholic Health Facilities.*

1972
The Godfather wins Oscar for best film.

1973
U.S. Supreme Court rules on *Roe v. Wade*, legalizing abortion.

1974
Nixon resigns presidency in Watergate scandal.

sumer expectations, and educational changes—all were putting pressure on nurses.

By the end of the decade, the nursing profession was experiencing sharp dissension on the subject of nursing education. In 1965 the American Nursing Association (ANA) had published its first position paper on education for nurses, advocating that the baccalaureate degree be required for minimum entry into registered nursing practice, while the associate degree would be required for minimum entry into technical nursing practice. In 1978 the ANA reaffirmed this position and recommended that it become effective by 1985.

In the November 1979 *Hospital Progress*, Marilyn L. Dyer, RN, opposed the ANA proposal. "Diploma schools continue to provide nursing students with the greatest percentage of clinical experience in a hospital setting," she said. "The nursing profession needs to spend more time and energy making education relevant and accessible and less time 'labeling' nurses."

As the 1980s approached, changes in the form of cost containment would bring new pressures and challenges to a profession that was still seeking to establish its credentials and ultimately its place in the healthcare system.

Another Push for Healthcare Reform

In the early 1970s national health insurance re-emerged as a major social issue. Virtually every president since Franklin D. Roosevelt, with the possible exception of Dwight Eisenhower, had grappled with the issue of national health insurance and somehow been deterred from it. In the pre-Watergate, early 1970s, Richard Nixon was no exception. In 1971 at least six major proposals for national health insurance had been developed for consideration by the House Ways and Means Committee, and in August 1971 *Hospital Progress* summarized these proposals in an article by Lawrence Prybil.

The Nixon administration, as well as Sen. Edward Kennedy, D-MA, the American Medical Association, and the Health Insurance Association, each backed proposals, Prybil explained. The Kennedy proposal was the most comprehensive of all those before Congress, according to Prybil, because it would provide "virtually total health protection for all Americans and would overhaul the existing health enterprise." The Nixon plan encouraged the development of comprehensive prepaid group practice plans, or HMOs.

By May 1973, however, John K. Iglehart was to write in *Hospital Progress*: "The rhetoric which ran so thick in 1971-72 on the dire need to enact national health insurance legislation has slowed to a trickle this year." The debate lost steam, he said, because of the nation's tight budget situation and policymakers' lack of consensus on the problem, much less the solution.

In 1974, under pressure because of the Watergate scandal, the Nixon administration reintroduced its national health insurance plan. The momentum increased throughout 1974, as other bills joined the fray. The August 1974 *Hospital Progress* reported testimony on national health insurance by Sr. Sengelaub, then CHA's president, before the House Ways and Means Committee. She made a reasoned plea for a national health insurance system in which "preventive services, the needs of the elderly, medical services for the poor, long-term illnesses, and catastrophic illnesses are given the highest priority." But in the same issue Iglehart reported, "The prospect for any definitive action on national health insurance legislations this year grows dimmer as time runs short and Congress remains preoccupied with the possible impeachment of President Nixon."

On August 9, 1974, Nixon resigned the presidency. Although national health insurance was debated through the end of the decade, when President Jimmy Carter and Sen. Kennedy both had bills before Congress, the presidential elections, a lagging economy, and a lack of consensus among policymakers led to the eventual demise of the issue.

Sen. Edward Kennedy was a popular speaker at the 1971 CHA assembly. His comprehensive healthcare reform proposal—like others of the day—died in the wake of Watergate.

1974
The Kennedy-Mills national health insurance proposal fails in Congress (by one vote).

1974
Hawaii becomes the first state to mandate employer-provided health insurance.

1974
A New Jersey court allows Karen Ann Quinlan's parents to withdraw life support from their permanently comatose daughter.

1975
Elizabeth Ann Seton, foundress of the Sisters of Charity in the United States, is canonized.

1978
In England, the first test-tube baby is born.

A Decade of Decision, Disaster

Healthcare in the 1980s was marked by enormous changes. Early in the decade healthcare was moving toward becoming a cost-contained, market-driven system. Free-market pricing, competition, and product lines became the buzzwords for the eighties.

To reflect its role in this volatile environment, in September 1984 *Hospital Progress* changed its name to *Health Progress*. The change was part of a communications strategy to keep CHA members apprised of a challenging healthcare environment. And it was consistent with the association's 1979 renaming (from Catholic Hospital Association to Catholic Health Association) to demonstrate its widening range of activities and constituencies, which had spread well beyond the traditional hospital setting.

In 1983 Edmund D. Pellegrino warned that the consequences of increased competition would be stricter governmental regulations.

As the decade progressed, the reality of a competitive, sometime ruthless, healthcare system was realized. Emily Friedman, a Chicago-based healthcare analyst, related this trend to what she called "Yuppie Ethics."

"Yuppie Ethics is the study of the values (or lack thereof) of the 76 million people born between 1946 and 1964," she wrote in the January-February 1989 *Health Progress*. "The first corollary of Yuppie Ethics is that what the poor and other vulnerable groups deserve varies directly with the amount of resources available. In other words, if I think that providing you with decent healthcare will deprive me of what I want, I will not let you have it," Friedman said. "This sort of self-absorption might be acceptable—marginally—when the resource in question is running shoes. It is not acceptable in healthcare."

Early in the 1980s Catholic healthcare providers found this situation untenable. In the February 1983 issue of the journal, Edmund D. Pellegrino, MD, expressed his concerns: "Healthcare is simply not like other commodities, but this lesson has to be learned over and over again." He added, "I predict, as a consequence of the abuses competition will foster, that public reaction will in a few years call for much stricter governmental regulations than we've ever had."

Healthcare and Government: The New Federalism

A major factor in the new direction of healthcare was the 1980 presidential election, which ushered in the era of "new federalism."

"Ronald Reagan, in a remarkably short period of time, has transformed the debate on social spending in the United States from a question of whether growth should be cut to how much trimming should occur," said John K. Iglehart in his January-February 1983 *Health Progress* column.

One of the most important and controversial measures implemented under the Reagan administration was the Medicare prospective payment system (PPS), which was intended to limit government healthcare expenditures. Hospitals no longer receive retrospective, cost-based reimbursement; instead, they are paid a fixed rate for each Medicare patient's treatment, based on the diagnosis-related group (DRG) into which the patient falls.

"Using DRGs for hospital reimbursement signals an important conceptual shift away from cost-based reimbursement, in which hospitals are financed for their activity regardless of efficiency, to a competitive prospective

1980
Mt. St. Helens erupts.

1981
AIDS is first reported in the United States.

1981
Sandra Day O'Connor becomes first woman U.S. Supreme Court justice.

1981
Congress passes the Omnibus Budget Reconciliation Act.

1981
U.S. bishops issue pastoral letter, *Health and Health Care*.

reimbursement service," wrote Michael J. Goran, MD, in the March 1981 *Hospital Progress.*

By the mid-1980s, concerns about the effects of the new federalism on the social fabric of the United States were being raised in *Health Progress.* "While the United States moves into an era of social Darwinism, . . . millions are left homeless, and millions more are left underinsured or without health insurance," wrote John K. Iglehart in the April 1986 issue.

In March 1989* Health Progress *excerpted* A Time to Be Old, a Time to Flourish—*CHA's call to action on behalf of the poor and frail elderly.

The Mission of Healthcare: Concern for the Marginalized

In 1986 CHA published its study of the underprivileged and healthcare in *No Room in the Marketplace.* A condensed version ran in the July-August 1986 *Health Progress*, with responses to it by healthcare leaders appearing in issues through the end of the year. "*No Room in the Marketplace* is a wonderful document, acutely attuned to the traditions of the Church and to contemporary political realities," Daniel Callahan wrote in the December 1986 *Health Progress.* "The authors are sensitive to the problem's social context, to the need for a renewed commitment to serve the poor, and, in particular, to the challenge of using specific responses to deal with present circumstances."

Two years later CHA published a study on the elderly and healthcare in *A Time to Be Old, a Time to Flourish.* Together, these two reports laid out the healthcare problems of those at risk and recommended action for CHA member organizations, government, and society to aid the medically indigent and the frail elderly.

"Unfortunately, the U.S. long-term care system does not do an especially good job of maintaining this balance [between informal and formal care] or of generally meeting the needs of the frail elderly," according to a condensed version of *A Time to Be Old, a Time to Flourish*, published in the March 1989 *Health Progress.* "In fact, it can best be described as a 'nonsystem': a set of expensive and uncoordinated programs and services that have evolved in an irregular and often patchwork manner."

The issues involved in providing a continuum of care, especially for the elderly, became an important focus of *Health Progress* in subsequent years.

To help Catholic providers plan and report community benefits, especially services to the poor, in 1989 CHA published the *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint.* "The Catholic healthcare ministry has a religious tradition of serving the poor and the needy. But today, as in the past, resource shortages constrain this tradition," wrote Julie Trocchio and Timothy Eckels in the June 1989 *Health Progress*—one of several *Health Progress* articles on the *Social Accountability Budget.* "Probably no issue is more painful for Catholic healthcare executives, trustees, and other leaders than the tension between mission and margin."

Multihospital Systems: The Sleeping Giant Awakens

Strength in numbers could be the way to describe the rationale behind the growth of multihospital systems in the 1980s. This approach to healthcare provision, based on the concept of a single corporate entity that owns or manages two or more healthcare facilities, was one more response to continued pressures to contain costs. "Finding ways to develop multi-institutional arrangements to achieve economy, quality, and access and to better utilize specialty services in primary markets is on literally every hospital's agenda," said Montague Brown, Paul R. Donnelly, and Michael Warner in a December 1980 article.

Indeed, 256 multi-institutional healthcare systems accounted for 32.1 percent of the nation's community hospitals, according to an April 1983 *Hospital Progress* article by William L. Dowling. Dowling noted in the article that these systems could improve access, comprehensiveness, and continuity of care while reducing duplication of healthcare service and improving quality of care.

1982

Vietnam Veterans Memorial is dedicated in Washington, DC.

1982

Congress passes the Tax Equity and Fiscal Responsibility Act.

1983

Congress passes legislation establishing Medicare's DRG-based prospective pricing system.

1986

First official observance of Martin Luther King Day.

1989

Berlin Wall comes down.

···The Early 1990s···

THE ERA OF HEALTHCARE REFORM

Healthcare reform has been on the political agenda repeatedly, but probably never as prominently as in the early 1990s. In the December 1989 *Health Progress*, John E. Curley, Jr., CHA's president and CEO, set the tone for the Catholic healthcare ministry in the 1990s: "Our country, which promotes healthcare as a right of all people, must develop a system that recognizes the millions of Americans who lack health insurance, the frail elderly who cannot afford home care, the pregnant women who need access to prenatal care," he wrote. "Our challenge for this century's last decade is to insist that providers and policymakers find the political will to forge a coherent, just healthcare system for all Americans."

In the June 1990 *Health Progress*, CHA outlined its principles for healthcare reform. First and foremost was a call for universal access to "healthcare services necessary for the development and maintenance of life." CHA's reform package also called for basic comprehensive benefits, shared responsibility between the private and public sector, and "the right of all parties to the free exercise of their ethical and religious beliefs." CHA's call for healthcare reform, particularly universal coverage, was rooted in Catholic values.

In 1992 CHA published its final proposal for healthcare reform, *Setting Relationships Right*. Sr. Bernice Coreil, DC, head of the task force that developed the proposal, explained in the March 1992 *Health Progress* that CHA's approach "recognizes the primacy of mission without diminishing the importance and legitimate needs of healthcare facilities." The proposal emphasized a client-centered *delivery* reform based on the creation of integrated delivery networks that link various types of providers to offer a wide array of services.

In the years following publication of CHA's proposal, association staff and members became increasingly involved in advocacy to make CHA's vision a reality. *Health Progress* ran frequent analyses of the situation—from ethical, operational, and political standpoints—and added a new section, "Reform Update." During the heat of the reform debate, in 1993 and 1994, these articles kept readers informed about the Washington scene, the advocacy activities of CHA and its members, and state reform efforts.

The Push for Integrated Delivery

As healthcare reform stalled on the national level, unprecedented pressures, such as inpatient market shrinkage, increased competition, and constrained payment rates, continued to push providers into collaborative arrangements. These integrated delivery activities sometimes involved Catholic and non-Catholic entities, creating new dilemmas and conflicts.

According to a national survey reported in the May 1991 *Health Progress*, approximately half of 500 hospital CEOs expected their institutions to be involved in a merger, acquisition, or divestiture within five years. "Although the reasons for these collaborations vary, most are deeply rooted in the desire to better serve constituents, develop critical mass, eliminate duplicative services, create economics of scale, and enhance survivability," wrote Jack A. Newman, Jr.

In the April 1994 issue of *Health Progress*, CHA published "How to Approach Catholic Identity in Changing Times," offering guidance on how to maintain Catholic identity in new forms of healthcare service. "The four essential expressions of Catholic identity—mission, sponsorship, holistic care, and ethics—must be deliberately provided for in the negotiating strategy when new healthcare relationships are being considered," CHA advised. "If they are not, you may unwittingly compromise or exclude Catholic presence and influence in the new relationship."

Leaders for the Ministry

But ensuring survival of the Catholic healthcare ministry will

1990
Healthcare spending represents 12.3 percent of the U.S. gross national product.

1990
Americans with Disabilities Act passes.

1992
More than 1.1 million votes are cast in favor of using a portrait of the "young Elvis" for a postage stamp.

1993
Branch Davidian standoff in Waco, TX.

1993
World Trade Center is bombed.

require more than business expertise. In 1993, with the establishment of the Center for Leadership Excellence, CHA increased its commitment to helping leaders in Catholic healthcare continue the mission of their institutions' founders. The June 1994 issue introduced the results of CHA's landmark study, identifying for the first time key competencies of outstanding leaders in Catholic healthcare.

Community Benefit: Watchword for the '90s

The push for cost containment throughout the early 1990s impelled Catholic healthcare providers to seek creative ways to serve their communities. A special section in the January-February 1994 *Health Progress* highlighted the importance of documenting and reporting community benefits, as well as specific outreach programs.

In this and subsequent issues, articles on community benefit provided solid evidence of the contributions of Catholic healthcare organizations. Another aspect of this—the imperative of Catholic providers to enhance the health and well-being of the communities they serve—was explored in the September 1993 issue of *Health Progress*. Articles focused on holistic care that heals the body, mind, and spirit and on cost-effective approaches to wellness.

In June 1994, *Health Progress* reported on testimony by Msgr. Charles J. Fahey before the U.S. Senate Finance Committee regarding the continued need for tax exemption for not-for-profit healthcare facilities. "Tax exemption, with its requirements for community benefit and prohibitions against private inurement and private benefit, is one safeguard against commercial values overtaking the professional and service orientation of individual not-for-profit facilities and the healthcare system as a whole," he said.

Ethics: New Questions

Medical ethics of the 1990s may well revolve around the philosophy of moral privatism. Patient autonomy—participation and self-determination in medical decisions—has become a key facet of medical ethical decision making. Healthcare providers are now faced with issues of euthanasia, physician-assisted suicide, and care of the dying in an ever more complex, technical healthcare environment.

Sr. Bernice Coreil, DC, provided CHA's vision of a reformed healthcare system during a 1993 meeting of the president's healthcare task force.

One of the most important medical cases of the century was decided on June 24, 1990, when the U.S. Supreme Court handed down its opinion in the case of Nancy Cruzan, supporting states' authority in the refusal of medical treatment. The ethical confusion surrounding this case was addressed in the October 1990 *Health Progress*.

"These dilemmas include uncertainty over when treatment can be refused, which treatments state legislatures should never allow to be refused, who can refuse treatment, and what written or oral statements (of a previously competent person) can constitute proof of his or her desire to refuse treatment," wrote Rev. Dennis Brodeur. "In fact, consensus on questions about death and dying will develop only from moral reflection and discourse among members of society, patients, and healthcare professionals."

Throughout the early 1990s, reflection on these issues remained a central focus for *Health Progress*. The centerpiece of CHA's end-of-life project, *Care of the Dying: A Catholic Perspective*, was excerpted from March through June 1993. "The way we care for the dying is influenced by the cultural, political, and clinical contexts in which we live, as well as by the theological, moral, and pastoral framework we endorse," the document begins.

Into the Future

Throughout the years, as *Health Progress* has provided information and guidance for those involved in the Catholic healthcare ministry, its one constant theme has been change.

Health Progress's July-August 1994 issue highlighted some of the concerns that will occupy CHA members—and hence the journal—in the years ahead: "increasing demands on leaders to shape their organizations' future and ensure continuation of the Catholic healing ministry; requirements for collaboration, often with organizations that differ in many respects, if not in the basic values held; and a growing call for attention to the health and well-being of communities."

As we move into the twenty-first century, *Health Progress* faces the same challenges as CHA members—to understand current realities and, more important, to draw out their implications for a future in which healthcare delivery will be dramatically different from what it is in 1994.

1993
Clinton administration unveils healthcare reform plan.

1994
Schindler's List wins Oscar for best film.

1994
A players' strike cancels the World Series for the first time since 1903.

1994
National Conference of Catholic Bishops approves revised *Ethical and Religious Directives for Catholic Health Care Services.*

1994
Control of both houses in Congress passes to Republicans.