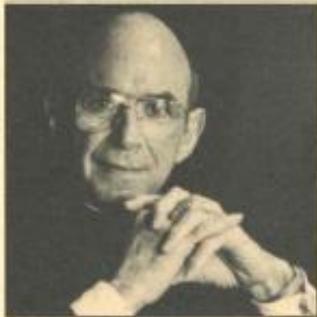


# A SIGN *of* HOPE

*A Pastoral Letter  
on Healthcare by*

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During my entire ministry as a bishop, especially during the past two years, I have invested considerable time and energy on issues related to Catholic healthcare. When healthcare reform became part of the public policy debate last year, I made several contributions to that discussion pointing out, for example, the importance of the not-for-profit status of Catholic healthcare institutions. In all of my efforts I have expressed my appreciation for the past and current dedication to, and service in, the ministry of Catholic healthcare by the religious women and men who sponsor this ministry and the dedicated laymen and women who collaborate with them.

Several months ago, I decided to write this pastoral reflection on Catholic healthcare to bring together several of my concerns and to give some direction to healthcare ministry in the Archdiocese of Chicago. However, before I was able to begin the project, I was diagnosed with pancreatic cancer. After surgery at Loyola University Medical Center in Maywood, Illinois, and a brief period of recuperation, I underwent nearly six weeks of radiation therapy and chemotherapy.

Now I return to this project not only as a bishop with an abiding interest in, and commitment to, Catholic healthcare, but also as a cancer patient who has benefited greatly from this competent, compassionate care in the model of Jesus the healer.

When I entered the Loyola University Medical Center last June, my life had been turned completely upside down by the totally unexpected news that what I had been experiencing as a healthy body was, in fact, housing a dangerous, aggressive cancer. The time since the diagnosis, surgery, and postoperative radiation and chemotherapy has led me into a new dimension of my life long journey of faith.

I have experienced in a very personal way the chaos that serious illness brings into one's life. I have had to let go of many things that had brought me a sense of security and satisfaction in order to find the healing that only faith in the Lord can bring.

Initially, I felt as though floodwaters were threatening to overwhelm me. For the first time in my life I truly had to look death in the face. In one brief moment, all my personal dreams and pastoral plans for the future had to be put on hold. Everything in my personal life and pastoral ministry had to be re-evaluated from a new perspective. My initial experience was of disorientation, isolation, a feeling of not being "at home" anymore.

Instead of being immobilized by the news of the cancer, however, I began to prepare myself for surgery and postoperative care. I discussed my condition with family and friends. I prayed as I have never prayed before that I would have the courage and grace to face whatever lay ahead. I determined that I would offer whatever suffering I might endure for the Church, particularly the Archdiocese of Chicago. Blessedly, a peace of mind and heart and soul quietly flooded through my entire being, a kind of peace I had never known before. And I came to believe in a new way that the Lord would walk with me through this journey of illness that would take me from a former way of life into a new manner of living.

Nevertheless, during my convalescence I found the nights to be especially long, a time for various fears to surface. I sometimes found myself weeping, something I seldom did before. And I came to realize how much of what consumes our daily life truly is trivial and insignificant. In these dark moments, besides my faith and trust in the Lord, I was constantly bolstered by the awareness that thousands of people were praying for me throughout the Archdiocese and, indeed, the world. I have been graced by an outpouring of affection and support that has allowed me to experience ecclesial life as a "community of hope" in a very intimate way.

I have also felt a special solidarity with others facing life-threatening illness. I have talked and prayed with other cancer patients who were waiting in the same room for radiation or chemotherapy. I have been contacted by hundreds of people seeking my advice and prayers on behalf of family or friends suffering a serious illness, often cancer.

This experience of the past four months plays an important role in shaping this pastoral reflection on Catholic healthcare. I have reason to believe that my reflections on my illness as well as on the state and future of Catholic healthcare will help and interest others who are struggling either with illness itself or with the delivery of healthcare services in a rapidly changing social, economic, and political environment.

In this statement I will first reflect on my recent experience of both illness and Catholic healthcare in the light of Scripture. Then I will share some of the key concepts that I have articulated in recent years regarding Catholic healthcare – especially my attempt to define more clearly what is distinctive about Christian healthcare ministry. Finally, I will outline some directions for the future of Catholic healthcare in the Archdiocese.

## I. A Bishop's Reflection

With people of all faiths throughout every age, Christians value physical and emotional life and health. We value all human life as a gift from God and, therefore, stand as ready stewards to respond to the reality of sickness in the world. We do so as individuals when we expend personal resources to prevent illness and find the best, affordable medical care available when we or someone we love becomes ill. We also do so as a Catholic community when we establish a variety of healthcare services, especially for the poor and most vulnerable in our society. Indeed, Catholics as a group are the largest provider of healthcare under single sponsorship in the United States today. Catholic healthcare continues Jesus' healing ministry and reflects a consistent ethic of life, which requires of us a commitment to preserve, protect, and promote the physical health and well-being of all people.

How do we do this as Catholic Christians? What is the distinctively Christian vocation in caring for those who are ill? What do we need to do when, as Christians, we care for those who are ill?

### A Promise of Life in the Midst of Chaos

Let us begin this reflection on the Christian vocation of helping the sick and the suffering by asking, "What is God doing in the world?" We begin to find an answer in the very first chapter of Genesis. The first creation narrative was written at a time of great turmoil in the history of the Hebrew people. The nation had been attacked by the Babylonians; their temple, the center of their life as a community, was destroyed; and many of the people were forced to leave their homes to live in exile. Against this background the narrative speaks of God as doing more than creating life in the world. In fact, in its emphasis that God looked at creation and "saw that it was good," we are reminded that God gives order, meaning, and purpose to the chaos that at times surrounds or invades our lives.

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It should be noted, however, that the biblical narratives do not portray God as conquering and doing away with chaos. Genesis does not describe a cosmic battle in which order triumphs over chaos once and for all. Instead, chaos itself is ordered through God's creative activity. But chaos continues to exist. It is a part of life. At times, it can seem to get the upper hand and overcome the order, purpose, and sense of meaning in our lives. But God's creative work is ongoing. God continues to order the chaos we encounter, making it possible for us to live our lives under his protection.

This is an important lesson for us who live in a world where disease and tragedy can shake the foundations of our faith, of our very being. In its own way, illness is a kind of human exile, a feeling of not being "at home," of being cut off from our former way of life. Depending on the seriousness of the illness and our own resources, we may be separated from our homes, our family or loved ones, our source of income or sustenance. Some are abandoned in their illness by those who are unable or unwilling to care for them. At times, family and friends feel abandoned by the sick person on whom they had depended, or by others who do not share the care of the sick person.

People who are ill sometimes speak of being attacked and ravaged by a disease that slowly but inexorably conquers them. They may even speak of their own body betraying them, as they begin to lose control of simple

bodily functions, or become weaker, fraailer, and more dependent on others. Illness can bring people to question if God has punished or abandoned them. Recently, a 13-year-old girl who has cancer

asked her parents, "I go to church every Sunday, and many of my classmates don't. Why do I have cancer, and they don't?"

We begin to ask: How can we live with Alzheimer's disease, cancer, heart disease, a disability, or an HIV-related disease? A life of illness or disability may seem to be, for the ones who are ill and/or for those who care for them, virtually impossible to live. And in this desperation some seek a solution in euthanasia or assisted suicide. The question that believers and non-believers alike have often faced is: How can I continue to live like this?

None of this is new. Believers through the ages have faced the desperation that sometimes accompanies the chaos of illness and suffering. The many laments in the Book of Psalms give eloquent expression to this pain, panic, and desperation. However, the laments also express a firm belief in the power of God to make it possible for us to live our lives despite the chaos. The first chapter of Genesis lays the foundation for this comforting reminder that God's creative activity includes the promise that we are able to live our lives, even in the face of the chaos of illness and death. God's promise of life is the basis for Christian hope.

## Hope and the Christian Life

Why does God make such a promise? Because God loves us. And how do we know of this love? St. Paul tells us that we can see God's love for us in the suffering, death, and resurrection of Jesus. "God proves his love for us in that while we were still sinners Christ died for us" (Rm. 5:8).

As the apostle also says, we are called to trust that neither death nor life, angels nor principalities, nothing already in existence and nothing still to come can separate us from that love that

comes to us in Christ Jesus (Rm. 8:38-39). This event of God's love, revealed to us in Christ Jesus, is the basis for our hope in the midst of life with all its health and sickness, joy and suffering, birth and death. Trusting in God's love from which we can never be separated, we are confident that it is always possible to continue with life despite the chaos we encounter along our pilgrim journey. This, St. Paul tells us, is our hope (Rm. 8:25).

*"Let me be clear what I mean by 'hope'. It is not a hope for something.... The hope of which I speak is an attitude about life and living...."*

Let me be clear what I mean by "hope." It is not a hope for something. It is not the expectation that something will happen. Although some people hope for a physical cure, not everyone does. Often people believe that a cure is not possible, or they are too tired to hope to be restored to their former state of health. But, even when a cure is not to be expected, one can still hope. The hope of which I speak is an attitude about life and living in God's loving care. Hope, rooted in our trust of God's love for us in Christ, gives us strength and confidence; it comforts us with the knowledge that, whatever is happening to us, we are loved by God through Christ. So, we need not grieve or despair in the same way as those

who do not share in this hope (I Th. 4:13-18). Illness need not break us. Even if we remain ill, even if we are to die prematurely, we can still be courageous and confident of God's enduring love for us (2 Cor. 5:6-10).

Some might think that the primary reason for our hope in time of sickness is the fact that Jesus physically cured in his ministry. It is true that Jesus did cure people of their illness, and it is certainly appropriate for us to hope and pray for cures. However, as Christians, we recognize that Jesus does more than offer a physical cure. More central to his mission is the strengthening of people's faith so that they may live as a people of hope. This is the fuller meaning of Jesus' healing miracles. In the miracle accounts, the central point is not so much that someone is cured, but, rather, that his/her relationship with God is restored and/or deepened through their trust in Jesus' love. It is people's faith in Jesus' love for them that saves them from the despair that can overwhelm people when they encounter chaos in their lives. Jesus helps us see that he is someone we can trust in the midst of chaos, someone through whom we can be filled with hope for the future. If we trust in Jesus' love for us, all life, even a life of sickness or disability, is worthwhile.

## Healthcare as a Ministry of Hope

In light of all this, I will now share several basic convictions about the ministry of healthcare.

As Christians, our hope relies on the fact that God's love for us in Christ Jesus is permanent and unchanging. Trusting that we are so loved, we face life, with all its sorrows and joy, with hope. However, it is not enough that we be comforted in our affliction. St. Paul tells us that our own consolation enables us to bring comfort to others in their need:

Blessed be the God and Father of our Lord Jesus Christ, the Father of mercies and the God of all consolation. He comforts us in all our affliction and thus enables us to comfort those who are in any trouble, with the same consolation we have received from him. (cf. 2 Cor. 1:3-4)

As Christians, we are called, indeed empowered, to comfort others in the midst of their suffering by giving them a reason to hope. We are called to help

them experience God's enduring love for them. This is what makes Christian healthcare truly distinctive. We are to do for one another what Jesus did: comfort others by inspiring in them hope and confidence in life. As God's ongoing, creative activity in the world and the love of Christ make it possible for us to continue to live despite the chaos of illness, so too our work in the world must also give hope to those for whom we care. Our distinctive vocation in Christian healthcare is not so much to heal better or more efficiently than anyone else; it is to bring comfort to people by giving them an experience that will strengthen their confidence in life. The ultimate goal of our care is to give to those who are ill, through our care, a reason to hope.

Our witness to hope is increasingly important in today's commercialized healthcare environment. There are strong economic pressures to pursue income at the expense of the patient and, in fact, to reduce the patient to a commodity. In this context one of the ways in which we witness to Christian hope is through fidelity to our charitable mission within the healthcare industry. Our primary service to those who come to us cannot be for sale. We can sell pharmaceuticals and surgical services, it is true, but these are secondary. Our distinctiveness cannot be turned into a commodity and sold. The moment we shift our motive to one of profit, we will, in fact, undermine our primary mission. Few will find hope in God's love for them if others make a profit from such care.

More importantly, we must recognize the absolute necessity of being present as a community to others in their need if they are to gain confidence in life. Human life is not meant to be lived in isolation. To be fully human, we must live in community. It is very important that a person who is ill have others with whom to communicate. Those who are ill can experience God's enduring love for them through the loving care and concern of the Christian healthcare community. We also serve as a community of conscience for the rest of healthcare.

We are also to give people an experience of God's enduring love for them through a nonjudgmental approach to illness. We do not make a theological or moral distinction between health and sickness. We do not,

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as Jesus did not, suggest that illness is a punishment for sin (Jn. 9:2-7). Our nonjudgmental welcome of the person who is ill, like Jesus' nonjudgmental welcome of the Samaritan leper (Lk. 17:11-19), gives people an experience of hope by delivering them from the isolation or abandonment that the sick fear most. A judgmental attitude toward illness and disability cuts people off from community and erodes or even destroys hope. Our hospitality saves people from such isolation. Like Jesus, we strive through our hospitality to give people the strength, comfort, and consolation of hope.

We seek to do more than merely cure a physical illness. Like Jesus, we heal the whole person. We care for people in such a way, that, whether or not we can physically cure their illness, they find strength and comfort in knowing God's abiding love for them, despite their experience of chaos.

To illustrate this point more fully, let us reflect briefly on two biblical accounts of illness: that of Job in the Old Testament and that of a paralytic in the Gospel of Mark. The contrast of the roles played by the sick persons' friends in these two accounts gives us a powerful insight into the kind of approach we Christians are called to take toward those who are ill.

You will recall that, as the Book of Job opens, Job is faced with several disasters, including the loss of his livelihood, his children, and his health. As a man of great suffering, he is in need of comfort and hope, but he does

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abandoned by those who ought to have offered him comfort and hope. At the end of the book, after God has spoken to him, Job acquires hope sufficient enough to continue living, but his suffering, his experience of chaos, remains a deep mystery to him.

The approach of Job's friends stands in stark contrast with that of the friends of the paralytic (Mk. 2:1-12). While Jesus is teaching in Capernaum, so many people come to hear him that there is no room for anyone else in the house. Then a paralytic, carried by four friends, arrives.

Unable to get in through the door, they climb to the roof, make a hole in it, and lower the paralytic down before Jesus. We know from the context of the story that the paralytic is seeking forgiveness for sin. But unlike Job's friends, the paralytic's friends do not accuse him before Jesus. Far from abandoning him in his illness or suggesting that he was in some way responsible for his plight, these four devote themselves to caring for their friend. They save him from isolation, and their friendship gives him a reason to have hope, even in the midst of his paralysis.

Jesus sees the man lowered before him, but takes particular note of those who lowered him. We are familiar with Jesus' words to other individuals who are ill: "your faith has saved you." In this text, however, we read that Jesus saw the four friends' faith (Mk. 2:5). He commends their faith, not the paralytic's. The four friends believe in God's enduring love for them revealed in Jesus, and they find their hope and comfort in him. It is this deep faith and comfort that enables them to console the paralytic, remaining with him as a reason for him to hope. This is the heart of Christian healthcare: caring for people in such a way that they have hope.

Although illness brings chaos and undermines hope in life, we seek to comfort those who are ill, whether or not they can be physically cured. We do so by being a sign of hope so that others might live and die in hope. In this we find the Christian vocation that makes our healthcare truly distinctive. It is the reason we are present to believers and nonbelievers alike.

## II. A Bishop's Ministry

One of the benefits of reflection is that it allows us to see reality in a new, fresh way. Although the object of our reflection stays the same, our understanding is deepened or enhanced. Speaking of the Catholic healthcare ministry as a sign of hope enriches an already fruitful ministry. It also serves as a source of motivation and inspiration, especially when we seem to be "losing control" of the ministry. Likewise, it is a powerful standard against which we continually evaluate all that we do.

As we know, however, the health ministry is situated in an environment that is evolving rapidly as a result of technological change and institutional forces. Today, healthcare delivery is no longer centered in the free-standing, acute care hospital. There are several reasons for this. Increasingly,

healthcare is focused not only on curing illness but also on preventing illness and building “wellness.” Similarly, healthcare is no longer focused solely on the patient but also attends to the overall health of the community. Further, the provision of healthcare is understood as an integrated process that involves many in the community: physicians, nurses, social workers,

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therapists, ambulatory care sites, physical therapy and rehabilitation centers, long-term care facilities, hospice programs, home nursing, local parishes, chaplains, pastoral care ministers, and individuals as well as the more traditional, community-based, acute care hospital.

Concurrent with these more “philosophical” changes, healthcare has experienced many external challenges. Over the years changes in the administration of federal entitlements (such as Medicare and Medicaid) and the concerns of those who purchase healthcare insurance have sought to constrain the escalating cost of providing healthcare. These realities precipitated a discussion at the national level about the possibility of systemic reform of the provision and financing of healthcare in the United States.

As followers of the Lord Jesus and as citizens of this nation, the U.S. Catholic bishops participated in that debate and articulated several principles that should guide healthcare reform. I personally participated in the discussion through my address at the National Press Club in Washington, DC, in March 1994, where I highlighted several key concepts. The points I made then remain relevant today, even though the context has changed somewhat. (See *Appendix A*.)

The same forces, and others, that precipitated the national debate unfortunately were insufficient to overcome the resistance that emerged from many sources. Although the systemic reform that I and many others advocated has not been realized, the debate did require us as a Catholic community to step back and reflect on why and how we continue the Lord’s healing ministry as a sign of hope. Assisted by the many significant contributions of the Catholic Health Association (CHA), as well as by the efforts of the many religious congregations that sponsor Catholic healthcare and countless individuals in the ministry, we have renewed our dedication to Catholic healthcare. I certainly have done so.

In the context of these national and ecclesial movements I developed a Protocol to inform and guide the making of important decisions by Catholic healthcare institutions in the Archdiocese of Chicago. Central to that Protocol (issued in August 1994) is my belief that healthcare is a ministry of the entire community of faith, the Church. Indeed, it is an essential ministry. Therefore, each healthcare institution or system should see itself as part of the whole Church, sensitive to the needs of Catholic healthcare and the other institutions within the Archdiocese. So, it is very important that we have both a vision and the strategies necessary to ensure that this essential ministry:

- Is available throughout the Archdiocese and especially to the poor and marginalized, women and children, the aged and the disabled
- Adapts to changing conditions so that it can provide quality and cost-efficient care
- Is carried on in such manner that the decisions of the individual Catholic healthcare institutions contribute to the well-being of the entire ministry and not bring undue harm to other Catholic institutions
- Is faithful to our beliefs and values when entering into relations with other than Catholic organizations.

The last point is included because, in the future, healthcare will increasingly be provided in the context of what is often described as “integrated delivery.” As a result, Catholic healthcare will find it necessary to enter into relationships with organizations, systems, and businesses that may share some but not all of our values. Of itself this is not bad. The Second Vatican Council taught us about the goodness that can be found in secular culture as well as about our responsibility to be present to culture and society as a leaven of transformation. In fact our mutual collaboration with other people of good will could help us bring about national healthcare reform.

*“[It] is my belief that healthcare is a ministry of the entire community of faith, the Church. Indeed, it is an essential ministry.”*

However, as we seek to realize the above goals, two obstacles stand in our way. One is *internal*, and the other is *external*.

Let me begin with the *internal*. The strength of Catholic health ministry has been grounded in the charisms of the many religious communities that have carried on the Lord's healing ministry. In a way, diversity of background, heritage, and religious sensitivities were the energizing forces that made possible the establishment of Catholic healthcare ministry across this nation in response to unique needs, whether they were ethnic, geographic, or other. Today, however, that historical diversity at times seems to get in the way of the future.

What do I mean? The various forces that are propelling change in what is often called the healthcare "industry" are requiring greater collaboration;

***"It would be a tragedy if we did not have the courage to move beyond the past and have the creativity to address the future."***

increased collaboration from a position of strength. They would want to ensure:

1. That there would always be "space" for their religiously based "product" in the "evolving market," and
2. That, insofar as possible, they would have the ability to influence the community and others in a positive manner.

And it would seem this would also be the desire of institutions whose "product" is the healing comfort and hope of Jesus.

Often, however, this does not seem to have been the case. The diversity of the past seems to be an impediment to developing the type of collaboration on a local, regional, or national level that will allow us to adapt, as needed, to current trends in order to ensure our ongoing presence as well as our ability to influence the national culture of healthcare delivery. Indeed, at times it has been easier for religious-sponsored institutions to join with nondenominational entities than with other Catholic institutions.

As a bishop, I have responded to this obstacle in several ways. On the local level; I have been committed to the development of a network of Catholic healthcare institutions that will meet the goals and objectives I have mentioned. At the national level, I have encouraged my brother bishops and Catholic healthcare leaders to take the steps necessary to prepare for the future. It would be a tragedy if we did not have the courage to move beyond the past and have the creativity to address the future. I hope that:

- Religious congregations will continue to deepen their trust of one another as they ask themselves how they can ensure the future of the entire ministry as well as the future of their own respective institutions;
- Local boards, medical staffs, administration, and employees will enhance appropriate institutional or financial self-interest with a more "Catholic" perspective responsive to local, regional, and national health ministry;
- Diocesan bishops will experience "collegiality" in a new way as integration and consolidation challenge the divisions or isolation sometimes caused by diocesan boundaries.

Now to the second, *external* obstacle. We are experiencing a troubling trend in our nation: viewing healthcare primarily as a business commodity. The most evident manifestation of this is the movement to transform healthcare delivery from a not-for-profit to an investor-owned status. I reflected on these concerns in an address to The Harvard Business School Club of Chicago on January 12, 1995. (See **Appendix B**.) In quite strong terms I urged that all involved in the Catholic health ministry join with others to ensure the continued viability of not-for-profit healthcare in our nation.

The primary focus of that address, however, was on the status of healthcare delivery, whether it be sectarian or non-sectarian in nature. While I remain convinced that the reasons outlined in that address apply in a special way to Catholic healthcare, serious questions have recently been raised within the Catholic community about the compatibility of the Catholic healthcare ministry and investor-owned enterprises.

Because of these questions and other forces, we must carefully identify again that which makes the Catholic healthcare ministry truly distinctive and which organizational structures best preserve and nurture that distinctiveness. As a person of faith, I believe this time of challenge is a “happy fault” that will give us the opportunity to understand better the healthcare ministry as a sign of hope. As the Jewish theologian, David Hartman, reminded our group during my recent pilgrimage to Israel, when we confront another who is different from ourselves, we can better discover our particularity, our distinctiveness.

Overcoming these obstacles will not be easy. While confronting the demands of the changing reality of healthcare, we continually will have to ask ourselves two questions:

- 1. Can we make a successful transition to the new way of doing the “business” of healthcare?**
- 2. Does this new way lend itself to our Catholic mission and values, especially our being a sign of hope? Most secular providers, including the not-for-profits, have to address only the first question.**

As we strive to answer these general questions, we Catholics will also face some more specific questions:

- As the focus of healthcare moves from acute care to the organized practice of medicine within integrated delivery networks, how can we become “sponsors” of this form of healthcare?
- How can we sponsor HMOs, or own vehicles for providing insurance or other forms of securing adequate access to healthcare services?
- Can we ever sponsor investor-owned organizations?
- Can we work closely with or engage in joint ventures with investor-owned organizations or organizations whose mission and value base are possibly not compatible with our religiously based tradition?

In light of my earlier reflection, I suggest that, as we work to answer these questions, we do so keeping in mind that our ministry is distinctive because it is a sign of hope.

In what follows I cannot address all of these issues. They will have to be answered collaboratively by all who are involved in healthcare ministry. To that end I am encouraged that Catholic healthcare leaders are coming together at this crossroads for healthcare and fully support the “New Covenant” initiative sponsored by the National Coalition on Catholic Health Care Ministry, the Catholic Health Association, and Consolidated Catholic Health Care.

### **III. A Bishop’s Proposals**

In anticipation of that process I now will offer some pastoral guidance on several matters pertaining to the Catholic healthcare ministry. I will speak as a bishop who, with his brother bishops, is responsible for addressing moral and ethical issues that confront us as a nation as well as for engaging those pastoral concerns that are common to the life of the Church in the United States. In this larger context I will also speak as pastor of this local church about the healthcare ministry in the Archdiocese of Chicago.

#### **Social Issues**

I was deeply disappointed by our inability as a nation to move forward with systemic reform of our nation’s delivery of healthcare. While now is not the time to attribute blame, I am troubled that our constitutional process for decision making seems increasingly incapable of addressing fundamental issues. We have become a nation of “sound bites” and “special interests.” More recently, we have also become ever more comfortable with an “ethic of punishment,” which seeks to replace an ethic of personal and social responsibility.

As persons of faith, we believe that these trends require that we become more and more involved as voices of conscience within the political process. In a very special way we must become more adept at challenging the “what-am-I-going-to-get-out-of-this” mentality. We can do this by sharing some Catholic insights. First, we must share with others our Catholic vision of the

human person as someone who is ultimately grounded in community. The vision of human solidarity of which I spoke earlier is the best antidote to a sense of alienation and isolation that ironically often expresses itself in an exaggerated attention to personal needs and desires.

Second, while encouraging the movement toward a greater sense of personal accountability and personal responsibility, we must share with others our convictions about the need for compassion, the existence of the common good, and the responsibility of society and government to promote the common good. An unbalanced attention to personal responsibility can become the excuse for neglecting our social responsibilities. While we can never condone or endorse personal irresponsibility, such irresponsibility does not destroy a person's innate dignity or our social obligations to ensure that all citizens are able to realize their basic human rights.

A third Catholic insight – one that is more difficult for some to accept – is our responsibility toward the poor. Our Catholic tradition tells us that those who are poor or marginalized have the first claim on us, as individuals and as a society. While this expectation is grounded in a deep faith conviction, it also flows from a Catholic understanding of social justice. This philosophy of society says that the state has two responsibilities. Many agree with the first, that government should do nothing to impede or violate fundamental human rights. In regard to the second responsibility, that government is to create those conditions necessary to realize those rights, people of goodwill may disagree on how to define such rights and are even more likely to argue over how one describes those conditions. Such a debate and discussion are healthy for a nation.

However, it seems to me that today the real debate, especially in the current discussion about welfare reform, is about whether to affirm or deny the second responsibility. In fact, in certain quarters I sense a meanspiritedness that, under the guise of encouraging responsible living, is, in fact, judging the poor and the marginalized as a class or social group who are responsible for their situation. The logical conclusion of this judgment is that society need do nothing. And because we are now in the realm of so-called "personal failure," some have concluded that the not-for-profit sector of society, and in particular religious institutions, and not the government, should care for the needs of such people. After all, it is argued, it is religion that helps people to achieve a moral conversion.

In addition, while it is true that much of what presently exists as welfare programs can and should be improved, our efforts at reform cannot ignore the reasons why current programs or entitlements were created in the first place. Over the last half-century,

we have come to recognize certain human and social needs, which, as a nation, we could not ignore. In effect, we concluded that in these areas the demands of the common good required action. Attempts to eliminate inefficiency and ineffectiveness must be carefully evaluated to ensure that, intentionally or unintentionally, they do not result in our walking away from these communal and social responsibilities.

*"...I sense a meanspiritedness that, under the guise of encouraging responsible living, is, in fact, judging the poor and the marginalized as a class or social group who are responsible for their situation."*

Obviously, we must do all in our power to ensure a proper ethical foundation for public policy in this and other aspects of our common life.

I make note of all this in a pastoral reflection on the ministry of healthcare for two reasons. First, the decisions the federal and state governments make on welfare reform will have an immense impact on the provision of Catholic healthcare. Because we consider the provision of healthcare as a social good, we are present where others will not go. That presence, however, has been assisted in recent years by state and federal entitlements. If that assistance is eliminated or significantly reduced, many people, especially the vulnerable, will not be served. In particular, many of our "disproportionate share" hospitals (those that serve a large number of patients who have no insurance or personal means of paying for healthcare) will find it extremely difficult to continue. While we will do all we can to preclude such closings, the suggestion that religious organizations should be able to replace government dollars with charitable dollars is, at best, naive. It is not realistic to assume that parishes, churches, and synagogues will be able to offset through their charitable activity the withdrawal of government support.

Second, if such regrettable decisions are made, we will have to find new ways of meeting the healthcare needs of those who are being abandoned by society. The poor, who will come to us because of a governmental retreat, must become the occasion for a new creativity on our part. While our presence will be different, we must still be there for those in need. How we

achieve such solidarity will require the involvement of the entire community of faith.

## Catholic Healthcare

I now would like to address my sisters and brothers who exercise positions of leadership in the healthcare ministry. We are at a turning point, at a critically important moment. While some have concluded that this is “the beginning of the end” of Catholic healthcare as we have known it, it can be a time of “refounding.” Previously I noted some of the changes that would help this “refounding” to occur: developing greater trust and more effective collaboration among religious congregations, moving beyond institutional self-interest that excludes the common good of Catholic healthcare, and entering into a new sense of episcopal collegiality.

These seem so self-evident that one immediately begins to wonder why it appears so difficult for them to be realized. I offer one possible explanation for this difficulty: Catholic healthcare has become more of a business than a ministry. As healthcare has become increasingly expensive, quite complex,

*“I noted some of the changes that would help this ‘refounding’ to occur: developing greater trust and more effective collaboration among religious congregations, moving beyond institutional self-interest that excludes the common good of Catholic healthcare, and entering into a new sense of episcopal collegiality.”*

revitalize the “Catholic imagination” of healthcare that sustained and challenged those who went before us? Unless we attend to this spiritual and formation vision, we will not be able to experience the rebirth we all desire. Economic, technological, systemic, and medical realities are not enemies. Rather, it is also to them that we bring our ministry of Christian hope.

## The Archdiocese

Now I will address the Church in Cook and Lake counties, Illinois, and indicate some directions we need to pursue as a local church. In order to realize them, we must work together as one family of faith.

First, I challenge the parishes of the Archdiocese to become more vigorously engaged in forming people and communities of hope. As Jesus himself lived and taught, it is in the midst of the Christian community that God’s word of hope is proclaimed and people of hope are formed and nourished. The parish is a vital place for education and formation, for bringing the resources of our faith to bear on how we interpret and respond to the experiences of aging, illness, and dying in the local community. Historically, the parish community has responded to the spiritual needs of its sick and elderly. The parish needs to reclaim its sacred responsibility by calling forth and training leaders and groups to provide a powerful witness of God’s care for those suffering sickness or struggling with the process of aging. Our unique vocation in healthcare will not be fully achieved unless it is rooted first in our parish communities, and our parish communities, in turn, collaborate more effectively with other ecclesial institutions, such as Catholic Charities.

Second, I encourage Catholics to take advantage of Catholic healthcare. In saying this, I realize that often the first decision people make is about which physician they will consider “their doctor.” They then go to the hospital at which their doctor serves or one that is most convenient geographically. For others, the choice is more restrictive, depending on the type of healthcare coverage or plan that is offered by their employer. Nevertheless, I encourage individuals and employers to consider and support Catholic healthcare systems and institutions. I say this not out of an outdated sectarianism but because of a profound belief that Catholic healthcare can and should provide an environment of faith-filled hope in face of the chaos that accompanies serious illness. Catholic healthcare envisions working in partnership with parishes and others to develop healthy communities. And a vibrant Catholic healthcare will have the resources necessary to carry on our ministry to those in need. I strongly encourage pastoral leaders in our parishes and agencies to add their own encouragement.

Third, we must ensure that the vision of the Catholic healthcare ministry outlined in my meditation is truly present in our Catholic healthcare institutions. To achieve this end, I ask the Catholic Health Alliance of Metropolitan Chicago (CHAMC) to develop a joint committee representing sponsors and management as well as representatives of the Archdiocese. The task of this committee, using work already done by the Catholic Health Association and others, will be to propose ways to identify and implement standards for evaluating the Catholic character of our healthcare institutions and programs. I do not envision these standards as punitive. Rather they will raise up the best of who we already are in order to ensure that what we proclaim is what we provide. They will complement the necessary movement within Catholic healthcare to ensure the existence of high-quality, cost-effective, community-based services by guaranteeing that our services are also value-based.

Fourth, because the leadership of our Catholic healthcare institutions is more and more the responsibility of dedicated laypersons, we need to ensure the ongoing theological and spiritual formation of all levels of healthcare leadership in the Archdiocese. While primary responsibility for such formation belongs to the particular institution, we need to explore how we can ensure that this is done effectively. I therefore ask that CHAMC, in conjunction with the Center for Development in Ministry, research what is currently available, including the resources of the Catholic Health Association, and how this formation can be enhanced.

Fifth, I have a direct responsibility for overseeing the pastoral or spiritual care of patients in Catholic healthcare institutions. I know that our healthcare facilities are committed to providing this important service and that they see it as essential to their identity. I am asking that the Archdiocesan Office for Health Affairs bring together representatives of pastoral care departments in our facilities, along with skilled pastoral

practitioners whom I will appoint, to review the issues confronting the provision of effective spiritual care and to make appropriate recommendations

*"...we need to ensure the ongoing theological and spiritual formation of all levels of healthcare leadership...."*

for its ongoing transformation. Such care must attend to the manner in which physical, emotional, and spiritual needs intersect in a person whose life is lived in the environment of family and friends, as well as business, social, and other relationships. Consequently, this spiritual care,

while respecting the conscience and privacy of those it serves, must be better integrated with parish pastoral services. In this way it can become an effective catalyst for healthcare being a ministry of hope to all it touches.

Sixth, I again express my support for the creation of an effective archdiocesan Catholic healthcare network. While such a network is but a first step in what I hope will be a process of increased collaboration, it is a very important step. I commend those who have already decided to participate. Unfortunately, at this time, not all of our Catholic acute care institutions have decided to participate in the network. I will continue my discussions with those institutions with three goals in mind: achieving effective collaboration within the Catholic ministry; avoiding actions that will bring unjustified harm to others who share in the Catholic ministry; and preserving Catholic integrity and identity.

Seventh, because our healthcare ministry continues Jesus' healing work, the Archdiocese will initiate discussions with other institutions and systems in the Chicagoland area that also carry on the Christian mission of healthcare. Our commitment to developing effective avenues of ecumenical cooperation, as well as the common needs we share as faith-based organizations, requires such dialogue. This is particularly true of the Episcopal and Lutheran communities with whom we have entered into covenantal relationships.

Eighth, we must review our own archdiocesan and parochial ministries to those who experience permanent or transitory healthcare challenges, in particular, those who experience mental or emotional illness. Often these persons and those who care and support them have not felt the support and encouragement of their brothers and sisters in faith. I ask that the Office of Health Affairs review these efforts and make appropriate recommendations for consideration by the Archdiocesan Pastoral Council and Presbyteral Council. This review also should pay attention to the manner in which we provide for the spiritual and sacramental needs of those who are homebound or in other than Catholic institutions.

Finally, I ask that all those who share in the responsibility for carrying on Jesus' healing ministry join me in resisting efforts to make healthcare in our nation or our own ministry merely another commodity, simply another item to be sold.

## Personal Thoughts

Now, I will close with some personal thoughts.

As I said at the beginning of this pastoral reflection, I have recently experienced personally the chaos that accompanies illness. I have had to let go of some things that I thought brought me security in order to find the healing that only faith in the Lord can bring. I have been graced by an outpouring of affection and support that has allowed me to experience the Church as a community of solidarity and a sign of hope in a very intimate manner. I am grateful for this because it has strengthened my confidence, my hope that in Christ life can be lived, even with pancreatic cancer.

In the context of this new moment in my own pilgrimage I offer this pastoral reflection to the Church. May it be for all who encounter it an opportunity for personal reflection and rededication. May we always be a people "who comfort those who are in any need with the same consolation we have received" (2 Cor. 1:4) from the Lord.

*Joseph Cardinal Bernardin  
Feast of St. Luke  
October 18, 1995*

## APPENDIXES

## APPENDIX A

### Key Concepts of Address to National Press Club (March 1994)

1. In this current debate, a consistent ethic of life requires us to stand up for both the unserved and the unborn; to insist on the inclusion of real universal coverage and the exclusion of abortion coverage; to support efforts to restrain rising health costs; and to oppose the denial of, or retrenchment in, providing needed care to the poor and vulnerable.
2. We have been drawn into a discussion of fundamental values and social convictions. And these convictions find their origin in a vision of the human person as someone who is grounded in community, and in an understanding of society and government as being largely responsible for the realization of the common good.
3. Healthcare is an essential safeguard of human life and dignity, and there is an obligation for society to ensure that every person be able to realize this right.
4. The only way this obligation can be effectively met by society is for our nation to make universal healthcare coverage a reality. Universal access is not enough.
5. Universal coverage is not a vague promise or a rhetorical preamble to legislation, but requires practical means and sufficient investment to permit everyone to obtain decent healthcare on a regular basis.
6. If justice is a hallmark of our national community, then we must fulfill our obligations in justice to the poor and the unserved first and not last.
7. If real reform is to be achieved – that is, reform that will ensure quality and cost-effective care – then we must do what is necessary in order to ensure that our healthcare delivery system is person centered and has a community focus.

8. Our objective must be a healthy nation in which the mental and physical health of the individual is addressed through collaborative efforts at the local level. The poor, vulnerable, and uninsured persons cannot be denied needed care because the health system refuses to eliminate waste, duplication, and bureaucratic costs.
9. In light of these concerns, the nation must undertake a broad-based and inclusive consideration of how we will choose to allocate and share our healthcare dollars. We are stewards, not sole owners, of all our resources, human and material; thus, goods and services must be shared.
10. The U.S. Catholic bishops continue to insist that it would be a grave moral tragedy, a serious policy mistake, and a major political error to link healthcare reform to abortion.
11. Fundamentally, healthcare reform is a moral challenge – finding the values and vision to reshape a major part of national life to better protect the life and dignity of all.

## APPENDIX B

### Key Concepts\* of Address to The Harvard Business School Club of Chicago (January 1995)

1. The healthcare delivery system is rapidly commercializing itself, and, in the process, is abandoning core values that should always be at the heart of health care delivery.
2. Healthcare by its nature is not a mere commodity. It is fundamentally different from most goods and services.
3. The primary goals of medical care are wellness, a cured patient, and a healthier community – not to earn a profit or a return on capital for shareholders.
4. A not-for-profit structure is better aligned with these “noneconomic” ends and is more compatible with the essential purpose of healthcare.
5. There are four essential characteristics of healthcare delivery that are especially compatible with the not-for-profit structure but less likely to occur when healthcare decision making is driven predominantly by the need to produce a return-on-equity for shareholders: access to care for costly and hard-to-serve populations; medicine’s patient-first ethic; attention to community-wide needs; and volunteerism.
6. Each of us and our communities have much to lose if we allow unstructured market forces to continue to erode the necessary and valuable presence of not-for-profit healthcare organizations here in Chicago and throughout the nation.

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\* Excerpted from *Making the Case for Not-For-Profit Healthcare*. For a copy, call the Archdiocese of Chicago, 312-751-8233, or CHA, 314-253-3463.

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