

Charism and Community: Catholic women religious and the corporate commitment to healthcare

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There are three elements I want to draw out for you from the title of this presentation. I want to talk about a legal incorporation, as the coming together of a group of not-for-profit hospitals, but I also want you to consider corporate in the broader sense of *corpus*, the body of Christ, in the sense of how Catholic women religious care for the social body.

The distinguishing character that motivates that care has to do with *charism*, by which I mean that particular religious attitude and orientation that flows from the tradition of their foundress, the history of their religious ministry that drives their mission to care for the poor and the sick. I want to emphasize the relation of that mission to Catholic social teachings, but I also want to distinguish healthcare ministry from the magisterium, the male hierarchy of US bishops in the Roman Catholic Church. I want to highlight how this work is related to the Church proper, but very different, because this difference is an important consideration in the goals of these meetings here today.

Part of that *charism* is the way that Catholic women religious constitute *community*. To care for the social body, by providing services to those who are poor and those who are sick. The constitution of *community* leads sisters and their organizations to look beyond direct healthcare provision to address their role as corporate citizen, as advocate for civil society that is fundamental to understanding their commitment to healthcare.

Why is this important? It is the scope and the story of Catholic healthcare ministry that is easily overshadowed by the largely reactionary discourse on abortion in this country. Understand me. That issue *can* be a significant dialogue as it can engage the substance of rights and protections, and the value of human dignity and self-determination. But it so easily slides into a

polarized and facile debate that eclipses the work and long-term commitment to social justice in health and social services that some Catholic organizations represent.

I am an academic, not an activist or advocate. I am here today a medical anthropologist who studies the ethics and social values within healthcare and medicine as they play out in diverse and pluralistic settings. My work is about the ethico-moral formations that constitute “identity”, and the role of the public and private, collective and individual spheres that such values formations engage. My contribution to the discourse of this convocation today is a piece of the story of Catholic women religious and their hospitals, one that I hope will add some texture and depth, a different perspective to the very legitimate concerns raised by our convenors about the prospects, promise and pitfalls inherent in the federal funding of faith-based organizations that make up the social welfare safety net in the United States.

Field of Research:

As many of you may know, Roman Catholic organizations together constitute the single largest provider of health and social services outside of the federal government. Last year, 774,000 Catholic hospital employees cared for more than 85 million patients last year in 63 healthcare systems, in 683 individual hospitals (619 are Catholic facilities, 64 are non-Catholic members of Catholic systems) and over 300 long-term care and other facilities.²

I completed fifteen months of fieldwork this winter, capping off a six-year engagement with administrators who operate hospital and clinic facilities, design and implement policy within a large Catholic hospital network in the western US. My comments today center on the women religious (meaning Sisters) and former women religious involved in the system as the board of governors, as senior system and facility management, as well their lay colleagues who partner with them to manage a \$4 billion network of acute care hospitals. This network is

recognized for its unique collaborative origin in the affiliation of several different orders of women religious that brought their healthcare ministries together in the early 1980s, as well as for a corporate acquisition strategy that brought more than 20 secular community hospital partners into this Catholic system over the last decade.

Mission: Ethics and Politics

In the corporate endeavor of the sisters who sponsor the operations of this non-profit network, Catholic ethical meaning is articulated then sustained against and within the moral limitations of US liberal healthcare. Driven by a preferential option for the poor, orthopraxy in this hospital organization asserts that a faith that does justice address root causes and advocate societal reform, as well as provide acute care services for which the hospitals, of course, demand adequate reimbursement.

Understand that providing healthcare as a not-for-profit service in the United States *is* a political act. The US Conference of Bishops rescinded a statement in its political platform calling for single payor health insurance for all US residents following the failure of the Clinton administration's efforts at national healthcare reform. But the sisters on the board of governors in the system I study have retained their public stance calling for universal access and single payor health insurance, as have other organizations of women religious. Theorist Jürgen Habermas argued that the “penetration of forms of economic and administrative rationality into areas of action that resist being converted over to the media of money and power” impoverish collective cultural life (Habermas 1987, p.330). For Catholic ministry, healthcare is one such area of action. Catholic social teachings insist on healthcare as a social good, and health as a universal right. Catholic hospitals stand as points of ethical resistance to the penetration of economic rationality.

To treat disease, to care for the poor and the sick, is to make a statement about social reform, and thus to stake out moral ground, making claims on the nature of the good. We can see healthcare as an ethical practice to be a “synthetic object” a construction having personal, social, medical and particularly, political significance (Good 1994, p.167). Simply put, operating clinics and hospitals brings Catholic-ness into being; fostering an organization that cares for the sick and the poor makes explicit a particular religious identity. A political ontology of Catholicity is made manifest as action extends the moral into the political, thus the translation of a private belief into a public claim.

As part of a larger American institutional tradition, Catholic healthcare ministry assumes a broad definition of health for individuals by building on a relational theology of human nature that positions man within the collective. Mobilized by the spirit of *communitás* rather than *societas*,³ the women religious in the network I study understand the mission of their hospitals to encompass social justice concerns that subsequently determine ecological obligations and a sense of corporate citizenship that drives aggressive advocacy and reform throughout the healthcare industry.

These values and ethical stances are clearly central to Roman Catholic identity but they also affirm common secular American civic culture. But in a healthcare organization led by women religious, where organizational development is explicitly committed to a legacy of core values – dignity, justice, collaboration, excellence – corporate culture can be noticeably different even from within mainstream America.

For example, last autumn I spent several weeks at a secular community hospital within this Catholic hospital network. One day I observed a senior staff meeting during a discussion of a system-wide charity policy that was being promulgated from the network’s headquarters. A

long-time director of admitting had introduced the policy and sought input on where public signs and explanations should be posted. At one point in the meeting, I overheard a new employee, a Clinical Nurse Specialist who had just joined this rural hospital, but had served the previous thirteen years in the United States Airforce, comment aloud as she shared the document with a colleague. I heard the new CNS say, “I don’t know if you noticed, but look at the text, it says ‘provided without regard to race, ethnicity, religion or national origin.’ I have my own opinions on that,” she said, “but it means you *don’t* have to be a US citizen to receive charity care.” The room sat in a shocked silence, and after an awkward pause, conversation resumed discussing where in the Emergency Department to hang the signs.

Among senior staff implementing hospital or service area-wide policy, it is clear that the sister-sponsors dictate, through the board of directors, that the network provide healthcare as a service, *not* as a right of national membership. I am not moralizing; I present this exchange to illustrate the contrast between the organizational ethics at work here. “Organizational ethics asks whether the individual conduct fostered and reinforced by such factors [as culture, policies and procedures], is morally right and whether the individual character being shaped by such factors is morally good, given the environmental conditions within which an organization exists and operates” (Heller 2001, p. 135). As ethicist Jan Heller points out, this applies as much for the individual agent as for the collective moral agent that is the organization in which individuals work. The CNS had recently come from an institution operating within a moral framework premised on national identity, the Armed Forces Joint Services. The Catholic sister sponsors are speaking from within a moral framework that seeks to promote a more universal, “catholic” if you will, collective. Each illustrate that the practice of healthcare in the US is premised on moral assumptions that underpin ethical stances.

However, Catholic healthcare ministry has nothing to do with evangelism or religious conversion. While Catholic social teachings and the particular charism of a sponsoring congregation informed by this particular history of collaboration do underpin the identity and the mission of the hospital network I study, but it is common values of human dignity and community that motivate partnerships with other non-profit agencies, local state and county government.

In fact, this hospital network mobilizes the Catholic principle of subsidiarity to advocate for the most localized level of ministry, promoting local priorities and local control. Many studies in healthcare and non-profit sector research suggests that Catholic hospitals are indistinguishable from their secular peers in the provision of healthcare services (Desai, Young et al. 1999; Keeler, Melnick et al. 1999; Duggan 2000; Vita and Sacher 2001). The possible points of difference lie in what I perceive as the Catholic understanding of health and community, and the consequent scope of initiatives related to community benefit (Buchmueller and Feldstein 1996; Schlesinger, Gray et al. 1996; Montoya 1998; Kane and Wubbenhorst 2000; Nicholson, Pauly et al. 2000).

Values in Operation: Scope of Community

The facilities of the network I study provide direct healthcare services like any other hospital. But the network asserts a broader understanding of its role in creating healthy communities. For example, the network runs a community grants program to fund local non-profit organizations that extend the concept of health beyond medical care to social services, low-income housing or job training. Every year, some forty member-hospitals contribute 0.05% of their total expenses from the previous fiscal year. Seventy percent of that fund is earmarked for proposals from community organizations in each hospital service area for projects tied to the

health priorities already identified by the state-mandated regional needs assessment. Twenty percent of that fund is allocated to proposals responding to an annual system-wide focus, such as domestic violence intervention. The remainder supports an endowment to boost community grants in following years. In the years 1997-2000, the community grants program distributed \$6.26 million to 372 different community non-profits throughout the hospitals' service areas.

The Catholic principle of subsidiarity, of local control, is implemented from the very beginning when all local non-profits are invited to submit proposals. Then, in the proposal review process, where a team from each local hospital matches grant proposals to the needs assessments done in conjunction with community representatives. This means that local needs dictate where the grants go, not network leadership, but providers at the hospital level. In one urban community, for example, the local needs assessment identified the lack of social support for gay and lesbian senior citizens, and last year, a local 501(c)3 organization received a grant from the local Catholic hospital to extend services to that non-traditional population. In that geography, that population is part of what constitutes community. Further, the network actively promotes best practices and dialogues between community organizations by convening grantees regionally over the course of the year.

As a very large corporation, the network that I study also recognizes that its financial equity can be leveraged to extend the scope of mission even beyond cash grants. The network sponsors a Community Investment program that makes no- or low-interest loans to non-profit housing developers and similar community organizations. Since the hospital network was incorporated in the mid-eighties, it has lent over \$45 million, and further made guarantees totaling \$23 million. In FY 2002 alone, it made 9 new loans of \$4.8 million to create low-income housing in its service areas.

More traditional concerns for a religiously-sponsored organization in healthcare are the provision of spiritual care services and chaplaincy staffing. These emphases do not reflect an evangelical intent, but rather a broader understanding of health and well-being, and the potential for critical intervention in the time of crisis that illness represents in patient and family members' lives. These are secular values as well, reflected most significantly in the standards required by the industry's Joint Commission on Accreditation for Healthcare Organizations. In late 1998, JCAHO adopted standards for spiritual care, articulated in terms of patient rights, standards that are now part of the site team evaluation for all accredited hospitals throughout the nation.

The impetus for improving spiritual care grows when secular community hospitals that struggled as independent facilities join the Catholic network becoming part of an organization willing to commit the resources and management objectives necessary to strengthen those services as a fundamental part of patient care. In one situation I monitored, the expansion of spiritual care services was undertaken in the secular community facility by consciously selecting an interfaith chaplaincy team of a Buddhist, a rabbi, and ministers from two different Protestant denominations precisely to anticipate and defuse the anxiety that Catholic affiliation meant conversion for a hospital with a strongly secular community identity.

Faith-based Bias: History and Society

Many government and secular community non-profits also claim to build community capacity and leverage social capital in the interest of the under-served. But when faith-based organizations make the same claims, they are often met with suspicion about, for example, the "Catholic" way of doing things. Such presumptions conflate magisterial dictates of doctrine and moral theology with the complexity of actual lived experience of modern Catholics, namely the ministries of Catholic women religious in the world. It is important to recognize where our social history as a country predisposes us to perpetuate unexamined social bias that may underlie the

wariness with which we approach the federal funding of faith-based organizations that provide social services.

Human beings are sense-making creatures. We create complex social worlds in which it is easy to forget that identity is a multi-valent and textured phenomenon. In order to function, we all reduce that complexity to categories and labels. I want to draw attention to our reliance on stereotypes of “Catholic” or even the idea of what it means more broadly to be “religious” or “faith-based.” We can easily overlook how the diffuse Protestant culture of the US public, and more importantly, our elected government, gets hung up on its perceptions of what Catholic connotes, namely – to be blunt – “popery.” I remind you – not that long ago – of the *national* consternation at the prospect of JFK becoming the first Catholic to be elected to the office of President. More recently, similar anxiety arose at the possibility of appointing a Catholic priest as chaplain to the US Congress in 2001.

In the network I study, the Catholic hospitals belong to the congregations of women religious who founded them, operated them and now govern them as a non-profit corporation. The twenty some-odd secular community hospitals that are part of the network, including a district facility, report to a central fiduciary board of directors. Individual affiliation agreements provide for local community boards with substantial responsibilities and oversight, particularly over medical staff. However, for their operations, this not-for-profit network is not directly accountable to the Roman Catholic Church – a determining factor in *Bradford v. Robert* (1899) wherein the Supreme Court upheld a federal grant to a Catholic hospital. It is for this reason that my work argues for understanding the diversity of actors within “Catholic social welfare” by reporting on the healthcare ministries of women religious in contradistinction to the diocesan efforts of the male Catholic hierarchy.

Service and Strict Scrutiny:

A corporate culture of explicit social values and ethics also serves the public indirectly, in the arenas of public accountability and organizational governance. Outspoken leadership from this hospital system to standardize stringent community benefit reporting at the state level while simultaneously implementing a system-wide charity care policy set new expectations for non-profit competitors and increased accountability to and transparency for the local communities that these hospitals serve. Attempting to live their values means that these efforts begin at home. That determination is reflected in the network's decision in 2002 to become the first major hospital system (at least in the West) to offer dependent health insurance to the families, partners and spouses of all full-time employees at every level through out the organization. The decision was admittedly a substantial contribution to improving relations with union partners but for a network that employs almost 48,000 people, this is a substantial demonstration of the commitment to universal access, as well as a direct challenge to the healthcare industry nationwide to advance social justice through competition.

Efficiency and accountability is not solely the purview of secular organizations, or of for-profit companies. Recent mismanagement in leading investor-owned corporations illustrates the inaccuracy of our cultural assumption that for-profit industry is more efficient and accountable. The network I study enacts what they call "an ethical decision-making process," explicitly designed by a trained philosopher, the system vice president for ethics and justice education, that convenes key decision-makers to work through emerging challenges in operations. For example, the national nursing shortage and impending regulation of nurse staffing ratios led the network to initiate the process over several weeks to consider the ethics of foreign nurse recruitment. The process concluded in a day-long retreat of representatives from nursing, operations, risk

management, and mission integration departments from a range of member hospitals to hash out the implications of such an initiative in light of the core values of the organization. It resulted, among other things, in an open dialogue with the Ministry of Labor of The Philippines to manage the recruitment of health professionals from that developing country. More recently, the ethical decision-making process was adapted to serve the Executive Council in another full day retreat for middle management. The program featured an interactive lecture by the system ethicist, but more astonishingly, the system CFO and the system COO each led the group through two case studies that explicitly advanced expectations for ethical behavior in financial and operations management..

In strategy and long-term planning for operations, portfolio review and the capital allocation program each deploy a series of algorithms designed to evaluate the prospects of particular capital investments among the member hospitals of the network. The algorithm explicitly determines competitiveness in the local market and community need for services to predict return on investment but bearing equivalent weight in the process is the mission component that speaks to the effect new or continued services will have on underserved populations, including the sole provider status of the facility in question. To meet the threshold of capital spending, a hospital must meet budgeted goals in operations, and must further achieve mission standards, including achieving annual expectations to identify Community Investment loans recipients in the local service area.

In Conclusion:

My goal today has been to share some of the story of a group of women religious and their hospital network. Perhaps that may complicate our understanding of what Catholic healthcare ministry means, but such an ethical perspective, formed through the particular charism

that animates their history and tradition, informs how the hospitals understand community, and consequently shapes hospital operations. I hope that sharing such a perspective also helps to contribute to understanding the scope of the Catholic corporate commitment to healthcare.

Thank you.

References:

- Buchmueller, TC and PJ Feldstein (1996). "Hospital community benefits other than charity care: implications for tax exemption and public policy." Hospital and health services administration **41**(4): 461-71.
- Desai, K. R., G. J. Young, et al. (1999). "The impact of privatization of public hospitals on community benefits." Association for Health Services Research **16**: 126.
- Duggan, Michael (2000). Hospital ownership and public medical spending. Cambridge, National Bureau of Economic Research.
- Good, Byron (1994). Medicine, Rationality, and Experience: An anthropological perspective. Cambridge, Cambridge University Press.
- Habermas, Jurgen (1987). Lifeworld and system: A critique of functionalist reason. Boston, Beacon Press.
- Heller, Jan C. (2001). "Organizational ethics in Catholic healthcare: conduct, character and conditions." HEC Forum **13**(2): 132-7.
- Kane, N and W. Wubbenhorst (2000). "Alternative funding policies for the uninsured: Exploring the value of hospital tax-exemption." Milbank Quarterly **78**(2): 185-211.
- Keeler, E. B., G. Melnick, et al. (1999). "The changing effects of competition on non-profit and for-profit hospital pricing behavior." Journal of Health Economics **18**(1): 69-86.
- Montoya, I. D. (1998). "Charitable care and the nonprofit paradigm." Journal of Healthcare Management **43**(5): 416-26.
- Nicholson, S., M.V. Pauly, et al. (2000). "Measuring community benefits provided by for-profit and nonprofit hospitals." Health Affairs **19**(6): 168-77.
- Schlesinger, M., B. Gray, et al. (1996). "Charity and community: the role of nonprofit ownership in a managed health care system." Journal of Health Politics, Policy and Law **21**(4): 697-751.

Vita, M.G. and S. Sacher (2001). "The competitive effects of not-for-profit hospital mergers: A case study." Journal of Industrial Economics 49(1): 63-84.

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² That is, 354 long-term care nursing facilities, 342 Catholic facilities, 12 non-Catholic members of Catholic systems; 76 home health agencies; 18 hospice organizations; 253 other services along the care continuum (e.g., adult day care, assisted living, senior housing, physician groups, and outpatient services); 284 health-related organizations (e.g., HMOs, community-based services, and foundations).

³ Not in the strict sense of Victor Turner, but *community* as collective of interdependent and fundamentally socially constituted beings, and precisely not the mythic assemblage of homogenized but reputedly equal individuals that obscures the structural injustices and disparities under a pacifying rhetoric of human rights that is the underpinning of modern liberalism..