



January 2014

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Thomas John Paprocki

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Recommended Citation

Thomas J. Paprocki, *Caring for the Sick: The Catholic Contribution and Its Relevance*, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 447 (2012).

Available at: <http://scholarship.law.nd.edu/ndjlepp/vol25/iss2/12>

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CARING FOR THE SICK: THE CATHOLIC CONTRIBUTION AND ITS RELEVANCE

MOST REVEREND THOMAS JOHN PAPROCKI*

I. INTRODUCTION

Catholicism has made, and continues to make, great contributions to the larger society's care for the sick on both a personal and institutional level. No story of the development of health care institutions in the United States would be sufficient without the acknowledgment of the role of the Church in attending to the sick. In our country's infancy, long before the medical and technological advances of today, the sick were often lumped together with the mentally ill, vagrants, alcoholics, as well as the homeless and poor in public almshouses and poorhouses.¹

Ordained clergy as well as religious brothers and sisters ministered to their own congregants in their own homes upon their arrival in the New World. But the most visible and long-lasting contribution of Catholicism for the sick was the development, primarily by religious orders, most often women religious, of institutions open to the public for caring for the ill. These institutions grew in areas that were heavily (if not exclusively) Catholic, where immigrants of the same background settled. But they also grew in areas that were mostly Protestant and rural, in the South and West. Catholics cared for their own, as well as for those across the whole spectrum of secular traditions.² The contributions of communities such as the Sisters of Providence, Holy Cross, Mercy, and the various branches of the Vincentian charism are well documented.

Well before the popular notion of religious tolerance, Catholic hospitals not only accepted patients of all religious backgrounds, but also fostered a respect for the religious diversity of the growing nation. The presence of religious pluralism, or even a Protestant-dominated attitude, did not undermine the Catholic motivation behind the ministry, nor stifle an evangelical spirit.

* Bishop of Springfield, Illinois; Member of the Task Force on Health Care, U.S. Conference of Catholic Bishops; Vice-President, Illinois Catholic Health Association. J.C.D., Pontifical Gregorian University; J.D., DePaul University College of Law; S.T.L., St. Mary of the Lake Seminary.

1. CHRISTOPHER KAUFFMAN, *MINISTRY AND MEANING: A RELIGIOUS HISTORY OF CATHOLIC HEALTH CARE IN THE UNITED STATES* 1 (1995).

2. *Id.*

Yet, the atmosphere was nearly always one of accommodation to the needs of the patient.³ "While pluralism tended to inhibit strategies of overt convert making, respect for conscience proffered [a] positive anthropology, congenial to an incarnational spirituality and the accessibility of grace."⁴

The current cultural environment, as well as so-called reforms to the health care system, threatens the respect for the Catholic conscience, which stems from the care given to those of every background in our country's infancy.

II. DEVELOPMENT OF CATHOLIC HEALTH CARE

As with almost any new entity, the visible Catholic presence in assisting the sick developed from caring for the needs of a growing population in a new world. As noted above, early institutions were the short step in such care that recognized the unique needs of the sick, who, when they were without adequate means or familial support, were grouped together with indigent, homeless, and the otherwise helpless in society. The separation into places specifically for the sick was a significant step in bringing healing alongside care.⁵

The first half of the nineteenth century saw the need for advancements in the care of the sick as well as the ability to successfully make improvements in care. Lessons from the Civil War helped create a model for care. Even though therapeutic and diagnostic advancements would take decades, administrative and structural progress in the treatment of soldiers translated into developments for civilian hospitalization. As care improved throughout the war, the logistics of hospitalization and the newfound success in cleanliness, order, and ventilation allowed for holding in check the spread of fever and infections, which until then had been considered a natural consequence of grouping the ill and injured together. The lessons learned here were observed by physicians and philanthropists, and were to be the foundation for the growth of institutions for the sick.⁶

Additionally, the cholera epidemic on the Eastern coast of the United States motivated groups like St. Elizabeth Seton's Sisters of Charity to direct their charism toward the impoverished—specifically to the care of the growing victims of widespread ill-

3. DAVID O'BRIEN, PUBLIC CATHOLICISM 212-15 (1989).

4. KAUFFMAN, *supra* note 1, at 4 (citing JOSEPH P. CHINNICI, LIVING STONES: THE HISTORY AND STRUCTURE OF CATHOLIC SPIRITUALITY IN AMERICA (1989)).

5. CHARLES E. ROSENBERG, THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM 18-20 (1987).

6. *Id.* at 98-99.

ness.⁷ The circumstances of mid-nineteenth century life demonstrated the need for an institutionalized approach for dealing with the larger numbers of sick, which increased dramatically due to immigration, urbanization, and the dangerous conditions brought forth by the growing industrialization of the nation. These hospitals filled a new, genuine need for a growing nation:

One member of the family becomes sick. The watching, nursing, and increased expense impoverish them, in consequence of which they must all be provided for at the almshouse. If the sick person could be provided with a free bed . . . the family . . . would be able to sustain themselves without assistance from the town.⁸

The 1850s saw Catholic hospitals grow out of cooperation between the religious communities who supplied the personnel and rudimentary care, which grew from mostly custodial care to truly nursing care, with private physicians who were ready to use their increasingly science-based medical training in new institutions.⁹ The documentations of these religious communities shows that the Sisters were diligent in recording the procedures for care of cholera and yellow fever patients, and “institutionalized” their approach into nursing manuals well before the first nursing schools were founded in the 1870s.¹⁰

Both civic and religious motivations contributed to the growth of Catholic institutions in the 1850s. Particularly in urban areas of the East and larger Midwestern cities, both bishops, as leaders of local diocesan Churches, and leaders of religious communities desired to provide for the needs of their own peoples. They saw the larger pastoral concern for members of their own denominations, as well as members of their own nationality in the rising immigrant communities, as reason to establish institutions for care for the sick among their other apostolic endeavors.

The focus of nativism and anti-Catholicism generated a response among bishops and priests to develop schools and hospitals that would guarantee the preservation of the

7. KAUFFMAN, *supra* note 1, at 34 (“Because of its flexibility and the directive that the sisters consider the areas of poverty as their enclosure, the constitution adapted from the rule of the Daughters of Charity was particularly suited to American conditions. The decision to enter nursing was influenced by the traditions of the Daughters of Charity in France and by the fact that Elizabeth Seton’s father and brother were highly regarded physicians.”).

8. ROSENBERG, *supra* note 5, at 108 (quoting HARTFORD HOSPITAL, ANNUAL REPORT 1856–57, at 7 (1857)).

9. KAUFFMAN, *supra* note 1, at 65.

10. *Id.* at 10.

faith among the youth and provide devotional and sacramental sustenance to the sick and dying. In the development of hospitals this Catholic benevolence was dedicated to nurturing the immigrant population of the urban ethnic villages. Though they would accept the sick poor of all religious denominations most were founded to serve their own, which included particular hospitals founded for Irish, German, and later Italian and Polish Catholic communities.¹¹

In contrast to the ethnic and religious ties of the Eastern United States and larger Midwestern cities, the frontier and rural communities did not have the volume of Catholic experiences or presence of Catholic culture on which to depend. Instead, religious sisters, in the midst of particular systems, such as railroad- or mining-sponsored infirmaries, took up the cause to care for the sick regardless of their cultural background. Here, they balanced the secular climate with their sacred duties, and, as they were often the only option for care, brought a refined moral order to the middle of a rougher frontier life.¹²

The rapid growth of Catholic hospitals throughout the nineteenth century¹³ was due, not only to the cultural and spiritual connection felt by Catholics, but also to the comfort and care that came with being treated as a paying patient and recipient of good quality care. The majority of Catholic hospitals did charge patients for their stay, though at rates not significantly more than rent at common boarding houses. Other private hospitals, even hospitals of other denominations, generally charged significantly more than their Catholic counterparts. Patronage to Catholic hospitals grew because of the affordability and quality of the care received.¹⁴

The twentieth century witnessed continued growth stemming from an essential balance that incorporated the best of both worlds in the Catholic hospital: an immersion in the rapidly developing medical subculture that kept abreast of professional advances, and an anchor in the traditional Catholic subculture that provided a context for sickness and suffering. The institutions that religious orders had worked to establish became a public witness in countless communities of a Catholic approach to

11. *Id.* at 69.

12. *Id.* at 97.

13. By 1885, there were 154 Catholic hospitals in the United States, more than the total number of hospitals just twenty-five years prior. See AARON I. ABELL, *AMERICAN CATHOLICISM AND SOCIAL ACTION: A SEARCH FOR SOCIAL JUSTICE* 36 (1960).

14. ROSENBERG, *supra* note 5, at 111.

sickness and suffering. This balance served the twentieth century Catholic hospital very well.¹⁵ It created a context where attempts at curing illness were successfully interwoven with caring for individuals. The establishment of the majority of these institutions took place in a time of far less governmental regulation, and they existed freely with opportunities to succeed or fail on their own merits.¹⁶

III. A CATHOLIC ANTHROPOLOGY

That context, or anthropology, which Catholic hospitals brought to the experience of sickness and healing is the result of both visible expressions of faith surrounding the practice of healing as well as the underlying identity that sparked the ministry of healing. The physical structure of the Catholic hospital was a constant reminder of the importance of, and the reason for, the work being done within its confines. Hand in hand with medical treatment, the emotional support of religious and liturgical rites in healing, the placing of health within the more broad context of the struggle for good in the midst of evil, and the contemplation for the preeminence of personal spiritual conversion in facing illness and suffering all underscored a hope that even illness and suffering could not extinguish.

A cheerful atmosphere of hope in the positive character of medicine infused with a strong sense of compassion was the regnant ethos in all modernized hospitals. However, strands of Catholic tradition were persistently cultivated and were also manifested in the material culture of the hospital; the central location of the chapel, the display of statues . . . a crucifix, and pictorial renderings of the Sacred Heart of Jesus, Mary Immaculate, and popular saints associated with local devotions . . . added greatly to the religious character of the hospital, but more importantly their presence was a living witness to the immanence of God. The Catholic culture was a soothing balm for those suffering physical and psychic pain and a source of

15. KAUFFMAN, *supra* note 1, at 129 (pointing out an emerging pride in the growth of Catholic institutions, which brought about loyalty and even competition with public and Protestant institutions).

16. The Principle of Subsidiarity affirms that intervention by larger entities should only serve as a last resort for the resolution of conflicts because in general, a smaller, local or lower organization is better suited to address needs than a larger or higher one. See BENEDICT M. ASHLEY & KEVIN D. O'ROURKE, *ETHICS OF HEALTH CARE: AN INTRODUCTORY TEXTBOOK* 263 (5th ed. 2007).

strength and hope for care givers and for families and friends of the sick and dying.¹⁷

All of these factors paint a picture of the reasons why many sought care in Catholic institutions. Perhaps more important than any other reason, the devotions that were a critical part of the life and practice of healing demonstrated a personal connection with the Divine; a God who was approachable, knowable, and concerned with the plight of the sick is a natural extension of the Christian incarnational understanding of God. In this, God is not distant from the sick, but perhaps closest to them. The care afforded to the sick, first and foremost, recognizes a personal dignity in each patient in need. This is not to suggest that personal dignity is excluded from care that is not “Christian-sponsored,” but that the Catholic understanding of ministry to the sick is founded upon the essential truth that personal dignity is an intrinsic and God-given quality equally possessed by all in every stage and status of life.

The place of God as the primary motivation for the origin of the Catholic apostolate for the sick and in ordering its work of healing is crucial for understanding the nature of Catholic health care. From both the doctrinal foundation and practical experience of caring for the sick came the development of a moral code to guide the work of the medicine. This moral code can only be properly understood as a framework built upon reflection on the very purpose of undertaking the work of healing. In the scriptures, God manifests his love through Christ’s healings of physical and spiritual evil:

Without question the Bible witnesses both to the blessedness of life, health and bodily integrity and to the high esteem in which the physician is held. These goods are the worthiness of the healer who ministers to them, unabashedly attested to in these passages from the Old Testament sage Sirach (c. 190 B.C.), are affirmed in the New Testament in the many miraculous healings performed by Jesus and his disciples.¹⁸

The goodness of health and God’s desire for man to be healthy are without question. But in the person of Christ, even health through miraculous healings is linked to a greater good—the manifestation of the kingdom of God for the sake of conver-

17. KAUFFMAN, *supra* note 1, at 199–200.

18. Mark S. Latkovic, *The Vocation to Heal: Health Care in the Light of the Catholic Faith: Scriptural, Theological, and Philosophical Reflections*, 75 *LINACRE Q.* 1, 41 (2008) (citations omitted).

sion and faith.¹⁹ "Thus, [Christ's] physical healings are more than simply astounding deeds but signs that sin and death have been conquered and that salvation has come in His person."²⁰

This demonstrates two important realities for contextualizing the vocation to heal. First of all, as it was for Christ, health is a sign of the goodness of creation and of God's love for his creation. Secondly, just as in Christ, those who minister to the sick are to do so knowing that their power to do so comes from God: "In recalling us to our dignity, and restoring to us the hope of perfect happiness, which God intended when he created us, Jesus Christ worked miracles of healing to encourage us to use God's gifts for the health care even of the most neglected and powerless members of society."²¹

Therefore, the actions of the medical profession are a noble ministry in which persons participate in the work of God.²² However, the key to interpreting this vocation of health care is that it collaborates with and does not replace God's work in assisting the frailty of the human condition.

The distinction between attending to the suffering and the attempt to replace aspects of the human condition that are manifest in the reality of suffering is a crucial concept in the evaluation of the proper role of medical intervention. Jacques Maritain suggests that from the sixteenth century on, secular humanism has made modern man overly confident of the potential within his own nature, a "self-completeness" of man, which can be demonstrated in his scientific advancement.²³ Such a view of nature supposes man to be his own master, and therefore demands that he proceed to bring under his control without constraint the limitations of his condition, manifested in his own suffering.

IV. CONTEMPORARY TENSIONS

Acknowledging the duty of man for the bettering of himself, the question of the appropriateness of a particular medical inter-

19. *Id.* at 42.

20. *Id.*

21. ASHLEY & O'ROURKE, *supra* note 16, at 34 (citing *Mark* 1:32-39; *Mark* 26:31-46).

22. PONTIFICAL COUNCIL FOR PASTORAL ASSISTANCE, CHARTER FOR HEALTH CARE WORKERS para. 4 (1995) ("To serve life is to serve God in the person: it is to become 'a collaborator with God in restoring health to the sick body' and to give praise and glory to God in the loving welcoming to life, especially if it be weak and ill." (citations omitted)).

23. JACQUES MARITAIN, *THE RANGE OF REASON* 186 (Charles Scribner's Sons 1952).

vention on the body requires a concrete theological anthropology. Catholic anthropology was both the main ingredient in and also the result of the work of Catholic health care institutions in the United States. Perhaps the most concisely articulated anthropology that also demonstrates current cultural tensions comes from Dr. Edmund Pellegrino:

Catholic health ministry sees care for the sick as a sacred ministry pursued in fidelity to the example and teachings of Jesus Christ. It is dedicated to the relief of suffering within the constraints of the divine law. It gives primacy to man's spiritual destiny as well as his temporal well being. Contemporary culture for its part also seeks to relieve suffering and to improve the quality of human life. Its restraints, however, are imposed by human law, and its end is primarily the quality of man's material life, without reference to divine law.²⁴

Pellegrino makes the observation that there are four cultural threats to the Catholic anthropology of sickness and healing, and therefore detriments to the future of Catholic health care. They each exercise control over popular opinion and undermine the foundation upon which Catholic care is delivered. The first is the ideology of *Scientism*, where scientifically provable claims become the only dependable sources of knowledge, and the great progress of medicine and science replace the themes of man's ultimate meaning, a new utopia, or even man's greatest hope and salvation.²⁵ The Church is quick to warn that criticism of this ideology of Scientism is not a critique of the role of the scientific method or a negation of its positive contribution to man's state in life. The Church has never opposed science, but advanced it in the universities that it had established and relied upon its contributions to be successful in delivering quality care for the sick. But this Scientism has advanced the "technological imperative," which argues that all that can be done technically should be done for the very fact of its possibility to advance a human need. Those who question any proposed progress should be dismissed:

The Roman Church, the mother of universities in the West, is condemned for standing in the way of our chances to cure every disease, to enhance every physical and mental capacity, to give parents perfect babies and all of us perfect

24. Edmund D. Pellegrino, *Catholic Health Care Ministry and Contemporary Culture*, in *URGED ON BY CHRIST: CATHOLIC HEALTH CARE IN TENSION WITH CONTEMPORARY CULTURE* 13, 14 (Edward J. Furton ed., 2007).

25. *Id.* at 19–20.

bodies. Increasingly, the ideologists of scientism urge us to subject religious belief to the scientific method to show religion's inadequacies.²⁶

This undercuts the moral code upon which Catholic health care is founded: the absolute dignity of each individual person, for this cannot be scientifically proven in any manner.

The second threat is the growing *secularization* of contemporary culture. Among other things, this leads to an erosion of trust in the magisterial teaching of the Church. Running parallel with the growth of Scientism, the increased secularism calls into question the long held moral convictions of religious thought when they are perceived as an obstacle to expediency in biotechnological development. Conscience and conviction on ethical matters lose their voice in the wake of the scientific imperative.²⁷

Thirdly, Pellegrino cites the *nihilistic tendency* of contemporary moral reasoning. With the outright secularization of bioethics, current ethical debates have lost their foundations and have drifted toward relativism:

[P]hilosophical ethics have drifted away from its normative responsibilities [B]ioethics is often a technical exercise, not a search for moral truth. In clinical ethics this often implies the abandonment of the search for right and good decisions in favor of any decision that resolves conflict or is mutually agreed upon. Ethics is simply a matter of individual choice.²⁸

This leads to a type of moral neutrality or lowest common denominator approach to ethics, which silences the conscience of one who might challenge the ethical legitimacy of proposed actions.

Fourth, the current *polarization* of society and the procedures for policy formulation in a pluralist society have stripped religion of significant influence in ethical discourse. Pellegrino argues that bioethics has shifted from being formed from religious convictions about right and wrong uses of modern biotechnology to transform human life as we know it, to becoming decidedly anti-religious and often anti-Catholic.²⁹ If religion is no longer a reasonable means for moral guidance, then believers are often ostracized from ethical debate, even if their arguments are based on reason and natural law. What can be politically

26. *Id.* at 20.

27. *Id.* at 21.

28. *Id.* at 23.

29. *Id.* at 24.

expedient and then established legally soon becomes what is ethical.

To these could be added another threat: *commercialization*. Commercialization refers to the economic mindset that capitalism brings to society's culture. Its inevitable seepage, like the above threats, into the psychology of institutional actors shifts the moral context. For example, in both for-profit and non-profit health organizations, it is not unusual to refer to patients as "customers" or physicians and nurses as "revenue generators" or correspondingly "cost-centers."

The above developments in cultural attitude are not consistent with the ideals that founded the very successful development of Catholic health care in the United States. That success was based upon the freedom of conscience, which religious orders, those in medical practice, and philanthropic endeavors had, to do the work that advanced the mission and mandate of Christ as their personal vocation to care for the sick. As contributors to the infrastructure, therapeutic, training, and research dimensions of health care, their experience is crucial to understanding the proper role of medical intervention in society. The degree to which these endeavors were successful is a testament to their courage and generosity. It also demonstrates the wisdom of the Catholic approach to care, care sought after by Catholics and non-Catholics alike, which speaks to the common understanding of the God-given dignity of each person, in which those who are sick equally share.

V. CATHOLIC HEALTH CARE AT A CROSSROADS

As a consequence of the contemporary tensions described in the previous section, Catholic health care finds itself in many ways at a crossroads. Some of these factors present themselves from within the realm of Catholic health care, while others stem from external sources. Catholic health care has changed significantly over the centuries, but that change has been organic within a moral and ecclesial continuum that traces its roots to the Gospel message of Jesus Christ. The resolution of these tensions may well determine whether Catholic health care will continue to change within the framework of that moral and ecclesial continuum or whether it will mutate into something so entirely different from its past that Catholic health care in the truest sense of its historical ethos will simply cease to exist.

Among the internal challenges facing Catholic health care is the shortage of religious vocations. Religious institutes of consecrated women and men have been the backbone of Catholic

health care. Nuns and religious brothers often cared directly for the sick not only in pastoral care but also as nurses and other caregivers. They frequently served as institutional leaders and administrators. As their numbers decline and replacements are lacking to assume these roles, some religious sponsors have begun to turn their management, ownership, and sponsorship to other persons and organizations. Sometimes this transition has been to other Catholic entities with new canonical forms such as private juridic persons and public juridic persons, with lay people serving on their boards of directors.³⁰ At other times the transition has been to non-Catholic not-for-profit health care providers and even to for-profit entities.³¹

These transitions need not lead *per se* to the diminution or disintegration of the Catholic health care ethos, but they do present unique challenges. Operating for profit has long been viewed by many as inimical to Catholic health care, but there is nothing inherently evil in working to make a profit as long as the profit motive is not characterized by greed. Catholic doctors, dentists, nurses, pharmacists, and other health care providers often work for profit-making entities and do so quite well while operating within the parameters of Catholic medical ethics. Hospitals and other institutions can do so as well if they follow the *Ethical and Religious Directives for Health Care* issued by the Catholic bishops.³²

A more subtle challenge comes with the transition to lay leadership in Catholic institutions. This is not to suggest that lay leadership cannot be authentically Catholic, but only that the education and formation of lay leadership presents new and different challenges due to its nature. In the past, members of religious institutes had a long period of formation in their religious communities beginning with the novitiate and continuing throughout their shared communal life. Through their vowed affiliation with their religious institutes, religious sisters and brothers brought a certain stability to their assignments and were not as likely to change very frequently. Lay leadership, in contrast, tends to be more mobile and transitory, so that even if the

30. Mary Kathryn Grant & Margaret Mary Kopish, *Sponsorship: Current Challenges and Future Directions*, HEALTH PROGRESS, July–Aug. 2001, at 19.

31. See Lorene Yue, *Holy Cross Hospital Selling to Vanguard Health Systems*, CRAIN'S CHI. BUS. (Dec. 15, 2010), <http://www.chicagobusiness.com/article/20101215/NEWS03/101219917/holy-cross-hospital-selling-to-vanguard-health-systems#axzz1AIFIEVyq>.

32. U.S. CONFERENCE OF CATHOLIC BISHOPS, *ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES* (5th ed. 2009), http://www.usccb.org/meetings/2009Fall/docs/ERDs_5th_ed_091118_FINAL.pdf.

lay CEO of a Catholic hospital has had a thorough education and formation in the principles and ethics of Catholic health care, that CEO may move on in a few years and be replaced by someone without such education and formation, so the effort is ongoing, and must start again and be repeated more frequently.

The most serious internal challenge comes from the apostasy by some from the authentic teachings of the Church and its concomitant rejection of ecclesiastical authority. An example of this can be seen in the case of St. Joseph's Hospital in Phoenix, Arizona, which had its Catholic status revoked by Bishop Thomas Olmstead due to "a litany of practices in direct conflict with Catholic teachings."³³ Chief among these problematic practices was a direct abortion performed at the hospital intended to save the life of the mother, despite the clear ethical teaching of the Catholic Church that the end does not justify the means. In addition to rescinding the Catholic status of the hospital for this ethical violation, Bishop Olmstead also declared that a nun acting in her capacity as an administrator of the hospital had been automatically excommunicated for her role in approving the abortion.³⁴

The unfortunate response of some has been outright defiance. For example, William W. Bohnert, M.D., past President of the medical staff of St. Joseph's Hospital and past Chairman of Catholic Healthcare West Arizona, wrote in *The Wall Street Journal*, "St. Joseph's Hospital will remain a Catholic Hospital in name and mission as it has for the last 100-plus years, but not as decreed by Bishop Olmstead."³⁵ Similarly, Chris Kozen, Executive Director of a group based in Portland, Maine, that calls itself "Catholic United," wrote that "Bishop Olmstead's verdict remains nothing more than an opinion."³⁶ Such rejection of the official teaching authority of the Church as exercised by her Bishops, the successors of the apostolic mission entrusted by Jesus Christ, demonstrates a fundamental lack of understanding of the nature of the Catholic Church and seems more in keeping with the schismatic path taken by Protestants for centuries.

In a similar vein, the contrary view adopted by the Catholic Health Association in opposition to the United States Conference of Catholic Bishops with regard to the Patient Protection

33. Anne Hendershott, *Catholic Hospitals vs. the Bishops*, WALL ST. J., Dec. 31, 2010, at A9.

34. *Id.*

35. William W. Bohnert, Letter to the Editor, *St. Joseph's Imbroglia Raises Many Issues for Catholics*, WALL ST. J., Jan. 5, 2011, at A14.

36. Chris Kozen, Letter to the Editor, *St. Joseph's Imbroglia Raises Many Issues for Catholics*, WALL ST. J., Jan. 5, 2011, at A14.

and Affordable Care Act in 2010³⁷ does not bode well for the future of Catholic health care.³⁸ To prevent further deterioration in this regard, it will be incumbent on the leadership of the Catholic Health Association to show that they can work in concert with the Catholic Bishops of the United States. Recent statements of the Catholic Health Association affirming the role of the local Bishop in Catholic health care³⁹ and expressing support for the proposed federal Protect Life Act⁴⁰ and the Abortion Non-Discrimination Act⁴¹ are encouraging signs of a renewed commitment on the part of the Catholic Health Association to collaborate in unison with the United States Conference of Catholic Bishops.

External challenges include financial constraints and efforts in the political and legal spheres to erode or even eliminate conscience protections for faith-based health care providers. For example, the American Civil Liberties Union has urged federal health officials to force Catholic hospitals in the United States to perform abortions in violation of their ethical commitment to protecting the lives of unborn babies.⁴² The fact that such a position is being proposed indicates the seriousness of the threats that loom for the rights of conscience of health care workers and health care institutions in contravention of the free exercise of

37. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 25 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

38. To learn more about the disagreement between the Catholic Health Association and the U.S. Conference of Catholic bishops, see Helen M. Alvaré, *Bishops v. Nuns in Jeeps? Why a Facially "Intra-Catholic" Health Care Dispute Matters*, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 563 (2011).

39. Press Release, U.S. Conference of Catholic Bishops, Catholic Health Association Affirms the Role of the Local Bishop in Catholic Health Care (Jan. 31, 2011), available at <http://www.usccb.org/comm/archives/2011/11-024.shtml>.

40. Letter from Sister Carol Keehan, President and CEO of the Catholic Health Ass'n, to Representative Joseph R. Pitts, Chairman of the House Energy & Commerce Subcommittee on Health (Jan. 24, 2011), available at <http://www.chausa.org/WorkArea/DownloadAsset.aspx?id=2147489220> (discussing the CHA's support for the Protect Life Act, H.R. 358, 112th Cong. (2011)).

41. Letter from Sister Carol Keehan, President and CEO of the Catholic Health Ass'n, to Representatives John Fleming & Dan Boren, U.S. House of Representatives (Mar. 25, 2011), available at <http://www.chausa.org/WorkArea/DownloadAsset.aspx?id=4294967383> (discussing the CHA's support for The Abortion Non-Discrimination Act of 2011, H.R. 361, 112th Cong. (2011), which would "permanently codify protections for individual and institutional health care providers' conscience rights").

42. See Robert Knight, Editorial, *Playing God with Catholic Hospitals*, WASH. TIMES, Jan. 5, 2011, at B03.

religion guaranteed by the First Amendment of the United States Constitution.

To help offset these trends, new programs for formation and hiring for mission can be specially designed and developed. Local hospital sponsors could work to establish and fund leadership formation programs within an ecclesiastical province so that standards are uniform in design, implementation and auditing. For example, the Board of Directors of the Illinois Catholic Health Association, in consultation with the Bishops and Sponsors of Catholic health care facilities in the Province of Illinois, have engaged the National Catholic Bioethics Center to develop and provide a six-hour class for chaplains interested in practicing in any Catholic health facility in the Province of Illinois. The course will provide a review of the Sacraments, Catholic social teaching and the Ethical and Religious Directives for Catholic Health Care Services (ERDs). Prior to being endorsed by the local ordinary, chaplains need to complete this course within their first year of employment.⁴³ The purpose of this additional education is to provide standardization of education and understanding across the Illinois Province so that chaplains can express a consistent message and interpretation at all Catholic-sponsored institutions in Illinois. This course will also provide new chaplains an opportunity to review recent changes in the ERDs and explore their own questions concerning the Sacraments, Catholic social teaching, and the ERDs.

Similarly, the Catholic Health Association of the United States as the industry leader could work with the United States Conference of Catholic Bishops to set up national training programs for all Catholic health care leaders and trustees. Catholic universities could fund programs in training future leaders through their nursing and MBA programs. Catholic dioceses in concert with other local faith groups could dialogue as to what they found helpful as best practices in leadership formation within Protestant health care.⁴⁴

In conclusion, Catholic health care has enjoyed a rich history in this country. There is no reason why the future of Catho-

43. *Chaplin Education*, ILL. CATHOLIC HEALTH ASS'N, <http://www.il-cha.org/go/Education/ChaplainEducation/tabid/67/Default.aspx> (last visited May 23, 2011).

44. For an example of health care provided by Protestant organizations, see *History*, ADVOCATE HEALTH CARE, http://www.advocatehealth.com/body_full.cfm?id=1869 (last visited Mar. 7, 2011) (providing the history of Advocate Health Care by the United Church of Christ and the Lutheran Churches).

lic health care cannot continue to thrive and flourish if these internal and external challenges can be met, which they certainly can be, with the help of God's grace.

