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**Is a For-Profit Structure a Viable Alternative
for Catholic Health Care Ministry?**

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Identifying Essential Principles for Catholic Health Care

*T. Dean Maines**
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Since 2007, the Veritas Institute has had the privilege of working with several Catholic health care systems. Using a tool called the *Catholic Identity Matrix*, which we developed jointly with Ascension Health, our work has focused upon helping these organizations assess the degree or extent to which principles for Catholic health care have been operationalized within their hospitals—that is, the extent to which these principles have been embedded within the operating policies, processes, and practices that guide how Catholic hospitals deliver care. Our remarks emerge from reflection upon this work. They capture some of the lessons we have learned about Catholic health care’s distinctive nature, about the principles that animate this nature, and about how these principles can be brought to life within organizations.

The title and question for this Symposium, *Is for-profit Catholic health care a viable alternative for ministry?*, challenge us to exercise the virtue of practical wisdom (prudence). They call us to be wise in the practical affairs of Catholic health care. Among the virtues, far-sighted practical wisdom holds a primary place. This is especially true for the professional leader. The challenge to practical wisdom before us can be formulated in a three-part question:

Can a for-profit institution, with its unique legal and financial structures and forms, serve as

- *an effective means*
- *to achieve the end of Catholic health care*
- *in constantly changing circumstances?*

First, *effective means*: Is a for-profit structure an effective institutional form to achieve or realize the essential principles of a Catholic health care organization? Throughout the Church’s history,

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people have created and adapted new institutional forms to help them live a life of faithful Christian discipleship. Today is no different. Monasteries, religious orders, oratories, guilds, mutual benefit societies, cooperatives, credit organizations, universities, and charities are all different institutional forms the Catholic Church has used to evangelize the culture, to bring the good news to the world. Practically wise leaders are precisely that, “practical”: They employ great competency, insight, and creativity to invent new forms of organizational life and to make these institutions effective and sustainable. If one is not competent, skillful, and creative, one cannot be prudent.

Second, *a good end*: We need to keep before us the real heart of the matter, namely, the end, the *telos*, the purpose of Catholic health care. What are the underlying first principles that describe more concretely the institutional goods that Catholic health care promotes? As Stephen Covey has noted, we need the habit of beginning with the end in mind.¹ Or, as John Henry Newman put it, the practically wise person “discerns the end in every beginning.”² As we discern the beginnings of Catholic health care within a for-profit structure, can we see the end? What problems or issues might a for-profit structure pose for Catholic health care? Does the for-profit form itself compromise that end? Conversely, what opportunities might this form offer Catholic health care?

Third, *constantly changing circumstances*: What are the unique circumstances and situations in which we find ourselves? As our former colleague Peter Vaill has wisely pointed out, we live in “permanent whitewater.”³ The rapidity of change within health care is widely recognized and commented on. Change is a fact of life; however, authentic development and growth in the midst of change is not. Future changes could present extraordinary opportunities for Catholic health care. They also could raise significant risks, specifically the loss or diminishment of Catholic health care’s mission and distinctive identity.

¹ STEPHEN R. COVEY, *THE SEVEN HABITS OF HIGHLY EFFECTIVE PEOPLE: RESTORING THE CHARACTER ETHIC* (1989).

² JOHN HENRY CARDINAL NEWMAN, *THE IDEA OF A UNIVERSITY DEFINED AND ILLUSTRATED: I. IN NINE DISCOURSES DELIVERED TO THE CATHOLICS OF DUBLIN; II. IN OCCASIONAL LECTURES AND ESSAYS ADDRESSED TO THE MEMBERS OF THE CATHOLIC UNIVERSITY* (BiblioLife 2009) (1858).

³ PETER B. VAILL, *LEARNING AS A WAY OF BEING: STRATEGIES FOR SURVIVAL IN A WORLD OF PERMANENT WHITE WATER* (1996).

We are here focused on the ends, the *telos*, and in particular the principles of Catholic health care. It is helpful to offer a balcony perspective before we move to the complicated terrain of law, finance, and leadership in relation to a for-profit structure. A balcony perspective is needed to gain a deepened understanding of the end, our *telos*, and principles. Of course, there is a danger that our formulations of Catholic health care's ends and principles can become rote, abstract, formulaic, and flat. If so, they will only distance us from the concrete realities before us. But this only reinforces the need for deeper insights on the end of Catholic health care—what Catholic health care is all about. Barbara Ward, a Catholic British economist and social commentator, captured this point well when she stated:

The most important change that people can make is to change their way of looking at the world. We can change studies, jobs, neighborhoods, even countries and continents and still remain as we always were. But change our fundamental angle of vision and everything changes—our priorities, our values, our judgments, our pursuits. Again and again, in the history of religion, this total upheaval in the imagination has marked the beginning of a new life. . . a turning of the heart, a '*metanoia*' by which men see with new eyes and understand with new minds and turn their energies to new ways of living.⁴

This "metanoia," this new way of seeing and living, is very important in terms of how we see and think about institutions generally and in particular the institution we call Catholic health care. One way to frame our thinking about organizations in light of our topic is to place them on an institutional continuum that ranges from a "society of individuals" at one end to a "community of persons" at the other.⁵ No organization perfectly embodies either pole; however, the continuum helps us to see more clearly the risks and opportunities different organizational forms may pose.

Does a for-profit system with its specific structures and forms necessarily move Catholic health care toward a "society of individuals"? This is an impersonal construct where there is little loyalty or connection to a transcendent good; where procedures and

⁴ Barbara Ward, Address to the Pontifical Commission on Justice and Peace (1971).

⁵ For further development on this distinction, see MICHAEL NAUGHTON, *THE LOGIC OF GIFT: RETHINKING BUSINESS AS A COMMUNITY OF PERSONS—PERE MARQUETTE LECTURE* (2012).

processes dominate the institutional landscape to such an extent that they replace practically wise judgment as the basis of decisions; where virtue and trust are displaced by the logic of contracts and the mechanics of the law; and where profit maximization reduces relationships to mere exchanges based on margins. The profit motive, in particular, can create or intensify what some have called the *financialisation* of health care, i.e., the reduction of health care to an impersonal commodity through the draconian application of financial ratios. In other words, does a for-profit structure in health care make it more difficult to have a “shared common good,” and does it move us to a negotiation of individual interests and stakes with focus on survival, security, and individual success?

Or can a for-profit Catholic health care institution incline toward a “community of persons”? This term that has been increasingly used within the Catholic social tradition to describe an institutional life where a theological motive and an ecclesial relationship enable an organization to live out the gospel and humanize the world; where exchanges are not just about individual interests, but meaningful relationships, reciprocity, and even non-equivalence; where trust is developed through moral character and the exercise of virtue by those in the organization, and not primarily through legal contracts; where people are ready to make sacrifices; and where organizational rewards are shared equitably and where people develop integrally. In other words, can a for-profit Catholic health care organization participate in the deepest reality of its purpose, namely, “to continue the healing ministry of Jesus Christ”?

This purpose points us to the ultimate end of Catholic health care; as the French put it, the organization’s *raison d’être*, its reason for being. Most organizations don’t make this *raison d’être* explicit, but Catholic health care must and does. The end or *telos* of Catholic health care cannot be simply growth, healthy margins, survival or even a generic commitment to treating its patients well. These ends just are not good enough for an organization called to en-flesh Christ’s healing work. Yet, to institutionalize this purpose and to engage the question of whether this purpose can be achieved within a for-profit form, we need to “progressively articulate” the institutional goods that are necessary to incarnate this purpose.⁶

⁶ Kenneth E. Goodpaster, T. Dean Maines & Michelle D. Rovang, *Stakeholder Thinking: Beyond Paradox to Practicality*, 7 J. CORP. CITIZENSHIP 93 (2002).

In order to move toward this articulation, we must address two important organizational realities. First of all, we must articulate a *model of institutional life*. What model of institutional life comes to mind when we think of Catholic health care? Does this institutional model help us to see things whole or only in parts? Does it help us see the long-term implications of our decisions or simply their immediate effects? Do we have a model that is capable of describing or depicting all that we mean by the healing ministry of Jesus? The prototypical models of accounting and finance include balance sheets, income statements, and cash-flow statements. Prototypical models for law are contracts, a bundle of contracts, and for some, a social contract. For Catholic health care, these financial and legal formulas or metaphors are necessary and important. However, they fail to capture adequately how a Catholic health care organization can reflect the fuller meaning of a “community of persons.”

In considering a Catholic health care system or hospital, we specifically should think about three interdependent objectives or dimensions of institutional life.⁷ These dimensions are:

- *Mission*: the impact or effect an organization has on the world, especially in light of the service or product it provides;
- *Identity*: the organization’s inner life, its culture and the kind of work that should be done in the organization; and
- *Stewardship*: the strength and viability of the institution, its ability to carry on its identity and mission into the future.

These three institutional objectives map with what people want from their work. Alasdair MacIntyre explains that:

Most productive work is and cannot but be tedious, arduous, and fatiguing much of the time. What makes it worthwhile to work and to work well is threefold: that the work that we do has a point and purpose, is productive of genuine goods [mission]; that the work that we do is and is recognized to be *our* work, *our* contribution, in which we are given and take responsibility for

⁷ See PONTIFICAL COUNCIL FOR JUSTICE AND PEACE, *VOCATION OF THE BUSINESS LEADER: A REFLECTION* (2012), available at <http://www.stthomas.edu/cathstudies/cst/VocationBusinessLead/>; see also DAVID SPECHT & RICHARD BROHOLM, *THREE-FOLD MODEL OF ORGANIZATIONAL LIFE* (2009) at http://www.seeingthingswhole.org/uploads/Watermark-Three-Fold-Model-of-Organ-Life_729153.pdf (last viewed Dec. 21, 2012).

doing it and for doing it well [identity]; and that we are rewarded for doing it in a way that enables us to achieve the goods of family and community [stewardship].⁸

Second, while these three dimensions help us to see an institution whole, what essential principles should inform and guide Catholic health care within each dimension? Without principles, a model of institutional life is morally blind. That is, its purpose or *telos* is unclear and it can serve any number of ends, some of which may be morally problematic. Conversely, lacking an adequate, capable model of institutional life, moral principles are impotent. In other words, they function as moral abstractions. They struggle to gain traction within the concrete realities of life. Locating moral principles within an institutional model helps us to see their practical implications more clearly.

For these reasons, we want to do more than provide a laundry list of moral standards for organizations to follow. We want to think about moral principles within the context of institutional life—that is, in relation to mission, identity, or stewardship—so that we can identify more readily what they call a Catholic organization to do and to become. Our proposed framework integrates the threefold model with seven principles for Catholic health care in the following manner:

Mission

- Holistic Care
- Respect for Human Life
- Solidarity with the Poor

Identity

- Dignity and Subjective Dimension of Work
- Subsidiarity

Stewardship

- Creation and Just Distribution of Wealth
- Act in Communion with the Church

The seven principles above are grounded in the broad Catholic moral tradition. More specifically, they draw upon the *Ethical and*

⁸ Alasdair MacIntyre, *How Aristotelianism Can Become Revolutionary: Ethics, Resistance and Utopia*, in *VIRTUE AND POLITICS* 323 (Paul Blackledge & Kelvin Knight eds., 2011).

*Religious Directives for Catholic Health Care Services*⁹ and the Catholic social tradition. They also are rooted within the experience of Catholic health care leaders, as articulated within the Catholic Health Association’s “Living Our Promises, Acting on Faith” project¹⁰ and its *Shared Statement of Identity for the Catholic Health Ministry*.¹¹

MISSION

The term “mission” comes from the Latin *missio*, meaning “to send out.” Thus, the mission dimension of the threefold model is externally focused. It considers the organization’s effect upon the external world, and upon those in the world who are helped or served by the organization.

The mission dimension recognizes that the work of institutions has tremendous significance for humanity. Institutions produce products and deliver services, and many of these are essential to human flourishing—for example, food, clothing, transportation, education, and healing. Within the mission dimension, a moral litmus test is whether an organization is delivering “goods that are truly good, and services that truly serve.”¹²

Considering Catholic health care institutions, the mission dimension raises two critical questions. First, who is Catholic health care called to serve? Second, what impact should Catholic health care have upon these individuals or groups? More specifically, what kind of healing should Catholic health systems or hospitals provide?

Three principles help to answer these questions. The principle of *holistic care* calls for health services to be provided in a way that recognizes that patients are not merely bodies, but persons.

⁹ U.S. CATHOLIC CONFERENCE OF BISHOPS, *ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES* (5th ed. 2009), available at <http://www.usccb.org/about/doctrine/ethical-and-religious-directives/>.

¹⁰ This project was initiated by the CHA board of trustees in 2002 to “identify and measure the ways in which Catholic health care organizations are living out their Catholic identity.” See generally Ed Giganti, *Living Our Promises, Acting on Faith: Year Two Update of CHA’s Performance Improvement Project in Health Ministry*, 82–1 HEALTH PROGRESS at 32 (Jan.–Feb. 2001).

¹¹ CATHOLIC HEALTH ASS’N OF U.S., *SHARED STATEMENT OF IDENTITY FOR THE CATHOLIC HEALTH MINISTRY*, at <http://www.chausa.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=802>.

¹² Kenneth E. Goodpaster, *Goods That Are Truly Good and Services that Truly Serve: Reflections on “Caritas in Veritate,”* 100 J. BUS. ETHICS 9, 9–16 (2011).

Patients are multifaceted beings who have a physical, social, psychological, and spiritual dimension to their existence. Holistic care calls for all those dimensions to be attended to in the healing process. Jesus healed people radically. That is, he healed them physically and psychologically, but his healing touched their innermost being, it penetrated to their spiritual core. Carrying forward the healing ministry of Jesus into the contemporary world, Catholic health care is concerned with the radical healing of those it serves. It aspires to transform the experience of sickness and healing into an experience of God's saving love present in the midst of suffering, an experience of redemption that leads not only to restored health but also to greater wholeness.¹³

Practically, holistic care requires advanced medical expertise to be integrated with the ministrations of other professions within particular settings—for example, an emergency department, a cancer center, a hospice. Thus, Catholic health care's characteristic approach is interdisciplinary. It unites the insights of clinicians with those of social workers, psychologists, and chaplains, to promote healing in body, mind, and spirit through caring, compassionate relations.

A second principle relevant to mission is *respect for life*. At the heart of the broad Catholic moral tradition is the conviction that each human being is made in God's image and likeness, and thus possesses intrinsic worth simply by virtue of his or her existence. The English word "respect" is drawn from the Latin *respectare*, to relook, to look a second time. Respect for human dignity calls us to move beyond first impressions, to look again, to seek and recognize the unique value of each individual as an unrepeatably, irreplaceable personal reality.¹⁴

Respect for human dignity makes multiple moral demands upon us. Taken as a whole, the principles for Catholic health care highlight the range and varied nature of these demands. Among other things, respect for human dignity requires us to demonstrate a profound respect for all human life, throughout the entire cycle of human existence, from conception through birth, through childhood, adolescence and maturity, all the way to natural death. Showing respect for human life in its most vulnerable stages—that

¹³ BENEDICT M. ASHLEY & KEVIN D. O'ROURKE, *HEALTH CARE ETHICS: A THEOLOGICAL ANALYSIS* 135 (4th ed. 1997).

¹⁴ We are indebted to our colleague Ken Goodpaster for this insight.

is, at the beginning of life and the end of life—is a fundamental and essential way in which we manifest respect for human dignity.

The third principle, *solidarity with the poor*, further develops the themes of respect for human dignity and concern for the vulnerable. The general principle of solidarity emphasizes the unity of all humans and our interdependence. It calls us to serve as our brothers' and sisters' keeper, regardless of their distance from us, whether we measure that distance socially, culturally, or economically. Catholic health care institutions act upon this general call by being places that welcome all community members who seek healing.

But while we are called to exercise solidarity in our relations with all people, in the Christian tradition, as well as other religious traditions, the poor and vulnerable, those who live at society's margins, are recognized as having the most urgent claim upon our attention and conscience. Both Jewish and Christian Scriptures underscore this point, revealing God's special concern for the poor. Solidarity with the poor emphasizes the duty of Catholic health care institutions to act for the good of the poor who live within the communities they serve. They must attend to their health care needs, but they also are called to be with the poor in their plight, to listen to them, and to advocate on their behalf. Attention to and service of the poor should be a hallmark of every Catholic health system and hospital.

IDENTITY

In contrast to mission, the identity dimension of the threefold model is internally focused. It centers upon an institution's inner life, the unique character or distinctive personality of its culture. It pays particular attention to how employees interact with one another.

While employees or associates are the principal stakeholder here, this dimension has particular salience for an institution's leaders. In his book, *Leadership in Administration*, Philip Selznick examined the process by which an organization acquires a distinctive culture or identity. This process entails the inculcation and maintenance of moral values, of moral principles. Indeed, Selznick identifies the leader's role primarily with this task of promot-

ing, integrating, and sustaining moral principles.¹⁵ Embedding moral principles within an organization's operations fosters a unity of intention and action that gives that organization its distinctive character. It also transforms the organization from a collection or "society of individuals" into a "community of persons"—in the case of Catholic health care, a community focused on the healing ministry of Jesus Christ.

For Selznick, the moral principles in question here focus especially upon relations inside the organization, without losing sight of the moral principles that guide its relations with external parties. So the critical question for the identity dimension is, "who are we?" in the sense of "how do we work together to serve the needs of others?" What kind of relationships and structures should we form inside the institution, to carry our mission out to the world?

The Catholic social tradition offers Catholic health care a rich tradition of reflection on work and organizational life. Two principles from the social tradition are vital to the identity dimension. The first principle, the *dignity of human work and the subjective dimension of work*, is foundational. This principle offers two insights. First, it recognizes that all work has dignity, whether it is performed by a chief executive officer, a physician, a nurse, a clerk, or a janitor. Our work expresses our distinctive personalities; it helps us provide for our needs; and it enables us to contribute to society—both the "small society" of our families and the broader community. Second, this principle recognizes that work has both an objective and subjective dimension. Objectively, our work affects the world around us—for example, material objects, social arrangements, and other people. It enables us to shape the world; it gives us an opportunity to participate in God's ongoing creative activity. Subjectively, work influences how we develop as persons, who we become. In the words of Pope John Paul II, "work is a good thing for man. . . because through work man not only transforms nature, adapting it to his own needs, but he also achieves fulfillment as a human being and indeed in a sense becomes 'more of a human being.'"¹⁶ Work can help us develop our capacity for forming right relationships with others; it also can help us expand our skills, our

¹⁵ PHILLIP SELZNICK, LEADERSHIP IN ADMINISTRATION: A SOCIOLOGICAL INTERPRETATION 62–63 (1957).

¹⁶ Pope John Paul II, *Laborem Exercens*, in CATHOLIC SOCIAL THOUGHT: THE DOCUMENTARY HERITAGE 9 (David J. O'Brien & Thomas A. Shannon eds., 1999).

abilities, and our knowledge. Conversely, work can also stunt or distort our development as human persons. Commenting upon the industrial organizations of his day in *Quadragesimo Anno*, Pope Pius XI lamented this latter tendency. Pius noted that dead matter went into factories and came out ennobled—that is, transformed into useful goods—while workers would go into the same factories and come out degraded, having served for hours as mere cogs in rote, mechanistic production schemes, with little time to relax, no time to reflect, and no opportunity to contribute with their minds as well as their hands.¹⁷

Because work has dignity and influences human development, leaders of Catholic health care institutions must ensure work is organized so that it helps employees grow authentically through the use of their intelligence and freedom, to achieve shared goals and create morally good relationships with one another and those served by the institution. Doing this requires leaders to observe a second principle, *subsidiarity*. Subsidiarity guides the distribution of authority, autonomy, and accountability within the context of community. Subsidiarity directs leaders to place decision-making at the most appropriate organizational level, keeping in mind that those closest to the work often know the most about it. Thus, decisions that affect the entire institution should be made by those who carry responsibility for the organization as a whole, while decisions whose impact is primarily local should be made locally, for example, at the unit or departmental level. Subsidiarity also calls leaders to provide associates with the support, education, and resources they need to responsibly exercise decision-making. Furthermore, it requires them to establish a “line of sight” between the institution’s mission and the work of each subgroup, so that local decisions align with the organization’s overarching purpose.

STEWARDSHIP

The stewardship dimension of the threefold model concentrates upon the institution’s sustainability, broadly understood. It focuses upon how the institution employs the resources entrusted to it, to strengthen the organization and assure its continued existence. Stewardship also concerns itself with issues of governance,

¹⁷ Pope Pius XI, *Quadragesimo Anno*, in *CATHOLIC SOCIAL THOUGHT: THE DOCUMENTARY HERITAGE*, *supra* note 16, at 135.

with an eye toward sustaining the continuity and vibrancy of an institution's purpose. Stewardship has particular salience for an institution's leaders, including those charged with its governance, since these individuals are charged with maintaining the organization's well-being and integrity over the long haul.

Two interrelated standards from the Catholic social tradition guide the management and allocation of resources, namely, *wealth creation and just distribution*. Like the good stewards in the Gospel parable of the talents, Catholic health care institutions are called to produce wealth by creatively utilizing the resources at their disposal. They must steward these resources responsibly and find innovative ways to produce more from what they receive. Leaders of Catholic health care organizations are called to do this with respect to the various types of resources entrusted to their organization: the skills, knowledge, and abilities of employees; financial assets; and facilities, property, and equipment. Furthermore, Catholic health systems and hospitals must act as good stewards of the natural environment. Relevant to this principle are such topics as revenue growth, market share, margins and profitability, service quality, operational effectiveness, productivity, employee development, and environmental impact.

Wealth creation brings with it the concomitant task of wealth distribution. The principle of just distribution calls for wealth to be allocated in a way that renders to others what they are due. This principle raises a set of knotty and enduring moral challenges for leaders, challenges that touch upon fundamental questions of equity and fairness. In a sense, these issues are never solved once and for all. Rather, they must be revisited again and again, as the institution's circumstances change. Among other things, the principle of just distribution calls leaders to discern and account for the moral implications of how they set prices, compensate employees, manage payables and receivables, and allocate benefits and support within their service area. These decisions affect relationships with a number of stakeholders, including patients, payers, associates, suppliers, and the communities in which the institution operates. These decisions also impact the very viability of the organization.

The principle of *acting in communion with the Church* highlights the fact that Catholic health care institutions are not isolated entities. Rather, these institutions participate in a set of realities that

are communions, things that are held in common. These communions inform the activities of Catholic health institutions. Catholic health systems and hospitals are called to cultivate these communions to ensure the continuity and vitality of their purpose through time.

First, Catholic health care institutions participate in an incarnational or sacramental reality, Christ's salvific work, and his healing ministry in particular. This work is not an historical artifact, but an active, vivifying presence here and now. Catholic health care institutions en flesh, or incarnate, the healing ministry of Jesus Christ in today's world. Consequently, leaders in Catholic health care have a responsibility to ensure that their institutions are instruments that make present God's love in every healing encounter.

Second, Catholic health care institutions participate in an ecclesial reality. Christ's saving work is entrusted to the Church as a whole. As ministries of the Church, Catholic health care undertakes Christ's healing work on behalf of and as part of the broader Church. Catholic health care institutions, then, are in relationship with other groups within the Church. For example, many Catholic health care institutions are authorized to participate in the healing ministry of Jesus through their sponsoring religious orders or congregations. Thus, they have a responsibility to cultivate their relationships with these institutes, whose distinctive charisms inspired their founding and have animated their operations through the years. A Catholic health care institution also has a responsibility to cultivate its relationship with the bishop in whose diocese its facilities are located. These are not optional activities, but the necessary bonds of ecclesial communion that ground Catholic health care in the healing ministry of Jesus Christ.

Third, Catholic health care institutions participate in a moral reality, a tradition of teaching, scholarship, and reflection that articulates the moral implications of these incarnational and ecclesial realities. Concretely, this tradition is expressed within the *Ethical and Religious Directives for Catholic Health Care Services*,¹⁸ additional teachings on biomedical questions, the Church's social teaching, and other magisterial pronouncements. Catholic institutions have a responsibility to follow those teachings, but also to contribute to

¹⁸ U.S. CATHOLIC CONFERENCE OF BISHOPS, *supra* note 9.

their ongoing development. The men and women who staff Catholic health systems and hospitals are uniquely positioned to help the broader Church discern the moral implications of emerging developments in medical science, as well as new approaches to clinical practice.

We think the experience of Christian universities highlights the importance of these communions, these vital connections, to the task of sustaining institutional purpose. In his book, *The Dying of the Light*, James Burtchaell examines how the original Christian mission and identity of 17 universities—Dartmouth College, Wake Forest University, and others—gradually weakened over time. Burtchaell's research suggests that one factor contributing to this attenuation was the severing of each school from its founding ecclesial community. With the loss of that link, each school's identity and mission moved from being distinctly Methodist, Lutheran, Presbyterian or Catholic to being generically Christian, to being spiritual or humanistic, to ultimately becoming secular, focused upon the faculty's professional goals or simply the school's survival. Broadly, this experience suggests that absent a conscious cultivation of these communions, an active participation and cooperation in these shared goods, the distinctive identity and purpose of a Christian institution is prone to deflation and loss.¹⁹

CONCLUSION

All of this brings us back to what we discussed at the presentation's beginning—practical wisdom. To be wise in the practical affairs, we must address many questions about the for-profit form, in light of the principles of Catholic health care as they are applied within the context of the three-fold model. These questions include the following:

Mission

- In light of the continuing pressures to reduce the value of health care services to a price (commoditization), do for-profit structures intensify the barriers to implement the principles of holistic care, respect for life, and solidarity with the poor?

¹⁹ JAMES TUNSTEAD BURTCHAELL, *THE DYING OF THE LIGHT: THE DISENGAGEMENT OF COLLEGES AND UNIVERSITIES FROM THEIR CHRISTIAN CHURCHES* 819–51 (1998).

- Are the demands of respect for life and solidarity with the poor at risk within an organization that must be principally responsive to investors?
- Does a for-profit legal status make it more difficult for a hospital to be distinctively Catholic in the care that it provides?

Identity

- Does a for-profit structure place burdensome restrictions on hiring and on the development of the kind of culture needed to maintain a Catholic health care system? Are there unintended secularizing consequences here?
- How might a for-profit structure affect the moral and spiritual formation programs offered within a Catholic health care system?
- Are we overly dependent on thinking that structures alone can carry Catholic identity? Are we guilty of “dreaming of systems so perfect that no one will need to be good”?²⁰

Stewardship

- What implications does a for-profit structure have for the just allocation of wealth among stakeholders, including investors?
- Could a for-profit ownership structure impede “communion with the Church”? What unintended consequences of a “private” ownership system might impede the establishment of robust ecclesial relationships?

To address these and others questions raised by this Symposium, they have to be considered in a way that reflects the virtue of practical wisdom; three important qualities must inform our conversations:

1. *Memory*: We need to remember, to recall, be mindful of the best of what lies deep within the Church’s tradition, our wider culture and each of us. That is, we need to exercise what Plato and (more recently) Pope Benedict XVI have called *anamnesis*.²¹ In our desire to be practical, we must

²⁰ T.S. Eliot, *Choruses from “The Rock,”* in *THE COMPLETE POEMS AND PLAYS 1909–1950* at 106 (1971).

²¹ Joseph Cardinal Ratzinger, *Conscience and Truth,* in *ON CONSCIENCE* 30–36 (2007).

avoid the error of forgetting the moral and religious principles that must guide our deliberations.

2. *Counsel*: We need counsel. Sr. Melanie DiPietro has gathered experts in finance, civil and canon law, moral theology, and management. It will take a good deal of intelligent conversation, careful listening, and careful questioning for us to avail ourselves fully of the counsel available in this setting.
3. *Foresight*: Finally, we need foresight. Foresight challenges us to anticipate the consequences entailed by a shift toward for-profit structures, especially unintended consequences. We are not fortunetellers; nonetheless, we must anticipate and judge the outcomes that are likely to result from our decisions. Again, Burtchaell's *Dying of the Light* offers an important lesson: While the leaders of Christian universities did not intend to secularize their institutions, over the long-term their decisions had the cumulative effect of moving them in that direction.

So, *is a for-profit system an effective structure to achieve the principles of Catholic Health Care within our current, dynamic environment? Is it a viable alternative for this ministry?* If we can bring forth this virtue of practical wisdom grounded in the principles of the Catholic tradition, and resist the temptation of answering these questions based purely on expediency and ideology, the participants of this Symposium can make a vital contribution to the ongoing development of this most important ministry of the Church for the world.