Catholic Identity Then and Now

By J. BRYAN HEHIR, MDiv, ThD

Any regular reader of *Health Progress* would have to be struck by the attention paid to "Catholic identity" for the past 20 years in Catholic health care. The theme is both traditional and contemporary. But, as with many aspects of Catholic life, the continuity between ancient and modern has been marked by development and evolution. Three stages are discernable:

1900-1950s: Catholic identity in this half-century was simply a given, neither debated nor doubted, because it flowed from the composition and character of the Catholic health ministry. Catholic health care was owned and administered by Catholics (overwhelmingly women religious); it employed predominantly Catholics; and it served predominantly Catholics. Like Catholic schools, the health care ministry was a product of an immigrant church in a Protestant culture. Strong Catholic identity was a means of protection: providing care for many who could hardly afford it and providing space within which Catholic principles and values could be observed in the delivery of health care. In this conceptual and organizational framework, Catholic identity provided the fabric of personal and professional life for those committed to this ministry and those for whom the ministry cared.

1960-1980s: These two decades were times of substantial change within Catholicism and in health care in the United States. Change in the church was rooted in the event and the consequences of the Second Vatican Council (1962-1965). The council's predominant effect on Catholic institutions was less on specific moral questions than it was a reshaping of the church's role in the world. The council's final document, *Gaudium et Spes* (1965), reflected this development. The church was to be a sacrament of unity in the world, open to the wider society and in service of it. More than any single sentence or phrase, this text of Vatican II conveyed a posture for the church, a stance of readiness to dialogue with modernity, willingness to learn, but also seeking to teach. Learning and teaching were both part of a commitment to serve all in need.

During these two decades, multiple changes began in American health care that continue today. Two trends that stand out from these decades are the deepening and broadening engagement of the federal government in health care through Medicare and Medicaid; and the beginning of institutional consolidation in the health care field, driven by economic forces favoring economies of scale. Both changes had an impact on Catholic health care. The first helped the ministry to expand its care well beyond the Catholic community; the second led to the creation of Catholic health care systems within religious communities and among them.

In the face of these deep secular forces, the health care ministry in the church was absorbed in adapting to them. The "givenness" of Catholic identity was still assumed, but the recognition that it, too, required some development and explicit attention, intellectually and spiritually, lagged slightly behind the organizational challenges.

The typography art in this issue of *Health Progress* was developed by illustrator Cap Pannell to highlight a significant passage of text in each article.

1990s-2015: By the last decade of the last century, the question of Catholic identity was ready for renewal. The catalyst came in part from Pope John Paul II, who was concerned about this issue. The leading edge of his concern came directly from his background as an academic and philosopher in Poland. Catholic higher education, in its many forms throughout the universal church, represented the focus of his interest. The classical question was the relationship of faith and reason, a topic that affected all of Catholic teaching, pastoral care and preaching. But the university would provide the most intense locale for this question. And the United States, with more than 200 institutions of Catholic higher education, provided a broadly based case study.

John Paul II's influence was twofold: he called upon colleges and universities to examine their Catholic identity; and he issued the apostolic letter *Ex Corde Ecclesiae* to specify and guide the examination.

Beyond higher education, however, the identity issue quickly moved to health care and social service agencies sponsored under Catholic auspices. In both cases, again, these were questions for institutions across the universal church, but in both cases, the United States offered particularly complex examples of what Catholic identity meant. Unlike the university world, there was no apostolic letter about health care, although there was, of course, the U.S. Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services*.

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The changes in the context of health care required two substantial revisions of the ERDs as a contribution to the wider review of Catholic identity. They pushed beyond the boundaries of the ERDs, focusing on issues of social justice in health care as well as the traditional questions of bioethics. The conversation restarted in the 1990s continues extensively today, as the articles in this issue of *Health Progress* show.

As a contribution to this ongoing dialogue, here are four issues that illustrate continuing challenges to Catholic identity.

The Culture — The United States is a classically liberal culture. A liberal culture uses freedom as the central and specifying value for the organization of a society. It seeks to maintain as wide a sphere of freedom of choice for the citizen as is consistent with other social values and the rights of others.

Catholicism has had a complex relationship with classically liberal cultures. As the U.S. experience has shown, the church has had a productive dialogue with liberalism, particularly in terms of democracy. But, as Pope John XXIII's encyclical *Pacem in Terris* (1963) exemplifies, Catholicism never has been comfortable with shaping a culture around freedom as a single value. John XXIII called for a culture built on four values: freedom, justice, truth and love. The relationship of culture and health care has been precisely in the tensions between expanding personal choices and maintaining Catholic principles of bioethics.

The issues tend to be located at the beginning and end of life; abortion and physician-assisted suicide represent the tension. The abortion debate rather consistently has been reduced to statements about choice. The physician-assisted suicide debate has been played out around the concept of personal autonomy. While both of these questions are far more complex, in human and moral terms, than here described, Catholic health care institutions confront the cultural background for both even as they protect their ability to determine Catholic standards of care and to witness to Catholic moral teaching.

The Courts and the Law — At the core of the U.S. political system is the principle of judicial review. Modern social change derives from legislation and court decisions. Both sources have been responsible for important moral and social progress. Legislatively, the New Deal and its political successors achieved many goals sought by Catholic social teaching; the U. S. Supreme Court played a decisive role in the civil rights struggle. A sophisticated public policy strategy cannot ignore developments in either arena.

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The legislative world protects majority decisions; the judicial review protects individual rights and minorities. While both have produced welcome results from a Catholic perspective, major challenges can arise from either. In terms of Catholic identity in health care, the engagement of state and federal legislators and the courts at all levels of American life have produced new challenges for health care. In the areas of gender, sexual orientation and reproductive rights, the engagement of the courts can change the context of health care in a single stroke. Some of the questions posed in these areas must first be thought of in moral terms, but public policy decisions of courts and legislatures often leave little time for reflective responses.

Technology — Catholic health care stands at the intersection of science and compassion. The ministry is rooted in fundamental religious-moral convictions from which has arisen the nationwide Catholic presence in health care. But the context for this presence is among the fastest changing technological sectors of the American economy. Technological change is welcomed by Catholic teaching as a potential service to humanity, but technology requires direction and choices. Both Pope John Paul II and Pope Francis have stressed that technology has its own logic but not its own inherent limits. Technology must be given moral direction if it is to benefit human beings. Catholic identity requires the capacity to make complex moral decisions about technological change.

Collaboration — A substantial aspect of Catholic health care since the 1960s has been collaboration with state and federal governments through funding. A much newer form of collaboration presently arising is the relationship between nonprofit and for-profit health care institutions. In both areas there lie challenges for Catholic identity. While collaboration with the government has been a standard practice for Catholic health care, changes in culture, law and policies can create new situations of choice. As a case study, the Affordable Care Act illustrates the questions involved; it was handled badly by church and state. But even more complex choices may lie ahead. The possible participation with for-profit entities will require careful social justice judgments to maintain Catholic independence and attention to fundamental ideas in Catholic health care ministry.

Faced with new challenges to one of the basic social ministries of the church in this country, the road ahead requires creative and disciplined choices by sponsors, boards, professionals and the wider ecclesial community. The Catholic health care ministry is a valuable way in which the meaning of faith is continued in this complex society; it deserves protections and support.

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