Discerning the Future of the American Catholic Health Care Ministry

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Abstract. American health care is in the process of a significant social, institutional, and economic restructuring of the manner in which health services are provided in local communities. The Catholic health care ministry is undergoing the same sort of restructuring. The history of American health care demonstrates that the ministry has experienced at least two similar major restructurings of its institutional framework. The principle of cooperation has been the customary tool to assess the moral propriety of evolving social structures in which the health care ministry has been housed. A process of discernment can lead to the conclusion that the central issue is not moral agency but rather how the ministry engages the secular culture of American society and American medicine. *National Catholic Bioethics Quarterly* 13.2 (Summer 2013): 263–274.

American Catholic health care once again finds itself in a volatile environment. The social and institutional structures that house the American health care delivery system are evolving from a fragmented system to a more integrated and organized one. Reimbursement is moving away from fee-for-service and diagnostic related groupings toward a capitation model. Physicians are becoming employees of integrated delivery networks, now more frequently referred to as accountable care organizations. They are being incentivized to practice population- and evidence-based medicine and are expected to embrace pay for performance. The emerging health care system is focused on keeping people well—specifically, keeping people with insurance

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well—rather than treating those who are sick. These are among the major dynamics that are reshaping the American health care delivery system. The same factors are equally reshaping the American Catholic health care ministry.

As these forces coalesce to reform the health care delivery system, the fragmented elements of the former system will need to come together to form integrated delivery networks. Mergers, partnerships, and affiliations are the legal instruments that enable organizations to create delivery systems in local communities. Among the traits that can make a health care organization a potentially attractive partner are geography, services that a potential partner can bring to the table, the number and array of employed physicians, compatible electronic medical record systems, and a reputation for quality and patient safety. However, for Catholic health care organizations there is another dimension that must be considered in identifying partners.

The litmus test for Catholic health care organizations is that a partnership cannot involve the Catholic organization in cooperating with objective moral evils, such as those procedures inconsistent with the *Ethical and Religious Directives for Catholic Health Care Services*, including direct sterilization, abortion, in vitro fertilization, inappropriate stem cell research, physician assisted suicide, and euthanasia. Part VI of the *Ethical and Religious Directives* stipulates that in the process of evaluating a potential merger or affiliation the principle of cooperation must be used to ensure that the Catholic entity will not become involved in an illicit form of cooperation as the result of a merger.[1]

Two Turning Points

Bernard Lonergan comments on the role of the historian: it is "to grasp what was going forward in particular groups, at particular places and times. By 'going forward' I mean to exclude the mere repetition of a routine. I mean the change that originated the routine and its dissemination. I mean process and development but, no less, decline and collapse."[2] The history of American Catholic health care contains at least two such break points, that is, changes that produced a new routine. The first was the standardization of American hospitals by the American College of Surgeons around 1900. The second was the transition from the hospital to the medical center in the 1960s and 1970s.

American Catholic health care has a history longer than that of the United States. Marie Hilliard identifies the sixteenth-century mission of Juan de Mena, a friar whose ministry included care for the sick in the Southwest, as a first glimmering

[1] US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: USCCB, 2010), nn. 69, 70. Elsewhere I have commented on what I consider to be the limitations of the principle of cooperation in evaluating mergers and acquisitions involving Catholic health care ministries. John A. Gallagher, "A Theological Reflection on the Principle of Cooperation and the Catholic Health Care Ministry," *Health Care Ethics USA* 21.1 (Winter 2013): 1–9.

[2] Bernard Lonergan, *Method in Theology* (New York: Herder and Herder, 1972), 178–179.

of the Church's health care ministry in a land that would become part of the United States.[3] Between 1800 and 1900, Catholic health care established a presence in the larger Eastern and Midwestern cities to provide services to the Catholic immigrant population but also to all citizens in the community. In the West, pioneer Sisters provided health services to miners and railroad builders. During the Civil War, religious congregations provided Sisters to assist the wounded on both sides of the conflict. The Civil War occasioned many religious congregations to include health care among their core ministries and provided the initial impetus for the education and training of Sisters as nurse professionals.

The health services that the Sisters were able to provide were rudimentary by contemporary standards. To describe the health care ministries prior to 1900 as "hospitals" is to employ a retrospective analogy or metaphor. These "hospitals" largely served the poor, the homeless, and abandoned. To a significant degree, their patient population was limited to the dying, for whom they could do little more than provide comfort, food, and spiritual support. Christopher Kauffman notes that the health care ministry prior to 1900 had both a public and a private dimension.[4] The public dimension pertained to the ministries' work within the civic community and was shaped by its needs and exigencies. The private dimension arose from the ministries' link to the goals and objectives of the various communities of women religious.The tension between the public and private and the cultural and spiritual dimensions of Catholic health care has been a fundamental characteristic throughout its history.

The first break point, which set the American health care ministry on a new routine, occurred between 1900 and 1925. The American College of Surgeons implemented a program of hospital standardization, creating guidelines and procedures that were intended to ensure a set standard of care within American hospitals. Catholic hospitals were now expected to operate in accord with guidelines created by a secular organization. In addition to changing the manner in which Catholic hospitals were run, the standardization movement created significant issues in the lives of the women religious who staffed the Catholic hospitals. Habits were changed from black to white. Questions were raised concerning women religious attending meetings with members of the laity, as well as their meeting with men and women not affiliated with the Church. Should women religious be allowed to work in maternity units? Should they be allowed to care for male patients? In other words, the culture of American medicine was shaping the institutional culture of Catholic hospitals.[5]

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[3] Marie T. Hilliard,"Contraceptive Mandates and Immoral Cooperation," in *Catholic Health Care Ethics: A Manual for Practitioners*, 2nd ed., ed. Edward J. Furton (Philadelphia: National Catholic Bioethics Center, 2009), 275.

[4] Christopher J. Kauffman, *Ministry and Meaning: A Religious History of Catholic Health Care in the United States* (New York: Crossroad, 1995), 129.

[5] Ibid., 168–192.

The need for standardization was the consequence of many developments in the practice of medicine that had occurred in the prior fifty years:

> During the first half of the second century the hospitals gradually moved toward a central position in the care of the sick. This came about as the result of many factors, including the following: more attractive and more functional design of hospitals, better control of the intramural infections by antiseptic and aseptic methods, the increase in the amount of complexity of surgery and the operating rooms, recognition of the importance of well-organized and skilled nursing care; the need for centralization of expensive laboratory and X-ray equipment to serve many physicians caring for many patients; the change in the hospital's image from that of a hideous death house to that of a haven where illness could be cured and lives saved; and the provision of suitable accommodations for both the rich and poor.[6]

These are among the forces that led to the creation of the American hospital system; these are the forces that gave rise to early 20th century American Catholic hospitals. What emerged in both instances was an institutional social structure to support the contemporary practice of medicine.

The second major transition in American Catholic health care occurred in the 1960s and 1970s, when the evolution of the medical center replaced the hospital as the institutional paradigm where medicine should be practiced. The medical center acquired its hegemonic role in the American health care delivery system for several reasons. As medical technology increasingly came to play a major role in medicine, the medical center was the place where the most recent technology could be found. Medical technology was associated with medical specialties and subspecialties; the medical center was where specialists practiced. The medical center was also a teaching institution where both medical students and residents could learn their trade. In order to finance the cost structure of the medical center, bonds needed to be issued, loans secured, and the support of foundations and major donors pursued. The introduction of Medicare and Medicaid provided new sources of revenue to fuel the growth and expansion of the medical center. Although not all, in fact, not even most, hospitals became medical centers, the medical center became the paradigm of where and how medicine should be practiced.

This paradigm had an impact on American Catholic health care. Some Catholic hospitals acquired medical center status, while most were satisfied to make limited accommodations toward that model. Part of this process within the Catholic community was the separate incorporation of the hospital or medical center so that it was no longer legally tied to the sponsoring congregation. The hospital or medical center became an independent corporate entity with a board of trustees that was composed predominately of lay persons. Religious congregations retained certain reserved powers, such as the appointment of the CEO and oversight of the mission of the organization. Increasingly, lay men and women moved into leadership positions in Catholic hospitals or medical centers, positions that formerly had been held by

[6] James Bordley III and A. McGhee Harvey, *Two Centuries of American Medicine: 1776–1976* (Philadelphia: W. B. Saunders, 1976), 279.

religious women. Once again the social structure of the Catholic health care ministry was reshaped by the standards created by the culture of American medicine.

Religious Mission

Throughout the history of the American Catholic health care ministry, and despite fundamental changes that occurred within the American Catholic health care ministry, there is a constant, a line of continuity that stretches from the early formation of the ministry to the modern hospital and finally to the medical center models. In each of these three periods, there is a work of mercy focused on the probing question in Matthew 25: 39–40: "Lord, when did we see thee sick … ? And the King will answer them, 'Truly, I say to you, as you did it to the least of these my brethren, you did it to me.'" In caring for the sick, in caring acts of love toward one's neighbor, one also loves Jesus. The message of the beatitudes is the message of the Good Samaritan. There is an inherent link between love of neighbor and love of God. This is the unifying religious or theological element. The primary rationale for the American Catholic health care ministry is the religious conviction that loving and serving the sick is an embodiment of what it means to love God. This is the core that has not changed and this is the core that should not change.[7]

Yet change has been endemic to American Catholic health care. We should be neither surprised nor overwhelmed. It is the same music, just in a different key. The bishops acknowledge the evolving character of American health care in the opening sentences of *Ethical and Religious Directives for Catholic Health Care Services*: "Health care in the United States is marked by extraordinary change. Not only is there continuing change in clinical practice due to technological advances, but the health care system in the United States is being challenged by both institutional and social factors as well."[8]

In the maelstrom of change, the principle of cooperation can enable the Catholic health care ministry to avoid entanglements that might associate it with prohibited procedures, but it cannot enable the ministry to discern. Discernment is the reflective form of institutional decision making that can enable the ministry to preserve its core meaning and purpose: "When the natural and human sciences are on the move, when the social order is developing, when the everyday dimensions of culture are changing, what is needed is not a dam to block the stream but control of the river bed through which the stream must flow."[9] Discernment is the effort to control the river bed.

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[7] Daniel P. Sulmasy,"Without Love, We Perish," *Health Progress* 90.4 (July–August 2009): 30–36. Rev. James Keenan has suggested that the works of mercy constitute the distinctive element of the Catholic system of morality. James Keenan, *The Works of Mercy* (Lanham: Rowman and Littlefield 2007), 2.

[8] USCCB, *Ethical and Religious Directives*, preamble.

[9] Bernard Lonergan, "The Future of Thomism," in Bernard Lonergan, *A Second Collection* (Philadelphia: Westminster Press, 1974), 52.

Theological Categories

"Theology," Rev. Bernard Lonergan proposed, "is a product not only of the religion it investigates and expounds but also of the cultural ideals and norms that set its problems and direct its solutions." [10] Such a definition of theology resonates with anyone currently engaged in assessing the future of Catholic health care in the United States. The conundrums that face the leadership of the health care ministry do not arise primarily from developments from within the ministry but rather from the evolution of the American health care delivery system. The theological problem is the extent to which the culture of American medicine may "direct its solutions." How does the ministry remain truly authentic to its core meaning and purpose and at the same time be able to function within the secular culture of American medicine?

The goal of this section is not to answer this question directly but rather obliquely, that is, by suggesting some theological categories that can set the context for responses to this question and a form of ministerial discernment that may enable leaders in the Church—both bishops and ministry leaders—to create and identify appropriate responses. As Lonergan indicated, these categories are expressions of the theological understanding of basic cultural ideals and norms. "Institution," "moral agency," and "culture" are examples. Shared understandings of these categories are presupposed to fruitful theological discussion.

Institution

"Institution" is a central theological category for any discussion regarding the Catholic health care ministry. Rev. Bryan Hehir comments that "the Catholic Church is institutional by instinct and by nature." [11] He continues, "If one seeks to influence, shape, direct, heal, elevate and enrich a complex industrial democracy, it cannot be done simply by the integrity of individual witness. It is done by institutions that lay hands on life at the critical points where life can be injured or fostered, where people are born and die, where they learn and teach, where they are cured and healed, and where they are assisted when in trouble."

Hehir's comments capture several fundamental understandings associated with the theological category "institution." It is part of the essence of Catholicism to organize itself as a Church into an institutional structure, both the hierarchical Church as well as its core ministries of health, education, and charity. The mission and ministries of the Church have historically and contemporaneously been organized into institutional settings rather than through the efforts of individuals. In fact, the origins of the vast majority of religious orders and congregations lie within the good works of a founder or foundress that evolved into an institutional structure, a religious order or a congregation. Institutions have a more profound impact on the culture in which they exist than the efforts of individuals.

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[10] Bernard Lonergan, "Theology in Its New Context," in Lonergan, *A Second Collection*, 58.

[11] J. Bryan Hehir, "Identity and Institutions," *Health Progress* 76.8 (November–December 1995): 18.

These points are developed in greater detail in Avery Cardinal Dulles's *Models of the Church*.[12] His notion of the Church as servant reflects the manner in which the Church strives through its institutional ministries to serve the existential needs of persons. The Church as herald reflects the role of the institutional ministries to bring the *kerygma*, the proclamation of the Gospels, to bear upon the questions and concerns of contemporary culture. Thus the institutional structure of Catholicism is not simply its organization as a social entity but also the manner in which it organizes itself to influence culture and those outside the Church.

The sociologist Philip Selznick defines an institution as "the emergence of orderly, stable, *socially integrating* patterns out of unstable, loosely organized, or narrowly technical activities." [13] Institutions organize, focus, and coordinate human activities in order to secure social goals or goods. Churches, governments, corporations, and benevolent organizations, can each be examples of institutional organizations. In his discussion of the human good, Lonergan depicts institutions as the social instruments that bring together the skills, operations, and plasticity of human endeavors into cooperative enterprises that create and sustain the goods essential to human flourishing.[14] Institutions are the social instruments human beings form in order to create and sustain a way of life. They are reflections or embodiments of the essential social connectedness of human life and well-being. The Catholic tradition has long maintained that the Church, government, and family are natural institutions, that is, they are spontaneous elements within human life. All the other institutions that frame, structure, and support human well-being are the result of human creativity, the plasticity of human nature that enables human beings to create a human environment.

Institutions have such a powerful influence on human well-being not only because they structure and organize human activities but also because they mediate meaning and purpose. John Calvin's *Institutes of the Christian Religion* was an effort to identify the beliefs and actions consistent with his view of the Christian life. It defines the social and ecclesial structures of the church of Geneva and outlines the systems of belief and way of life consistent with membership in that church. The term "institutes" referred to the education or instruction suitable to members of the church.[15] The term "institution" resonates theologically with a social structure that organizes human life but also with the instruction and education that mediates values, meaning, and purpose into the lives of persons impacted by institutions.

Finally, institutions are, for the most part, the creations of human ingenuity and creativity. They are not persons, although I will return to this point in a moment. The goods and services created by institutions pertain to the common good. Persons

[12] Avery Dulles, *Models of the Church*, expanded ed. (New York: Doubleday, 1987).

[13] Philip Selznick, *The Moral Commonwealth: Social Theory and the Promise of Community* (Berkeley, CA: University of California Press, 1994), 232, original emphasis.

[14] Lonergan, *Method in Theology*, 48–49.

[15] John Calvin, *Institutes of the Christian Religion*, ed. John T. McNeill (Philadelphia: Westminster Press, 1960), xxxiii.

pursue human goods such as food, housing, and clothing for the benefit of themselves and their families. Institutions provide an array of goods that are part of the common good and derivatively support the welfare of individuals and families. In contemporary life, which has moved away from subsistence farming, the building of one's own home, and the sewing of the clothes for a family, the majority of goods that support the life and well-being of families are provided through the common good. Contemporary health care is such a good. Preventive medicine, population health management, and acute care services come to individuals through the common good. The culture of American medicine is embedded in its institutional structures. Indeed contemporary medicine has medicalized dying and human reproduction. This means not only that dying and reproduction are likely to occur within an institutionalized context, but also the goals, meaning, and values associated with that institution deeply affect our comprehension of these basic human processes.

Moral Agency

The *Report on a Theological Dialogue on the Principle of Cooperation*, the product of a multi-year dialogue among theologians and bishops, reached the conclusion that "institutions are considered to be moral agents, though analogously." [16] Institutions perform actions for which they can be praised or blamed: "The moral agency of institutions is recognized in civil and canon law, in business, and in many other fields." [17] In the light of such assertions, how is one to construe the role of analogy in the above assertion, and how is institutional moral agency to be understood?

In his book *Legal Fictions*, Lon Fuller proposes that depictions of institutions or corporations as persons are fictions that are created to sustain a utility. It is helpful to society to construe institutions as persons. The fiction enables the institution to sue and be sued; it enables the institution to be viewed as a unity rather than a system of loosely related parts. This legal fiction can be praised, blamed, and corrected by "extracting from the word 'person' (when it is applied to corporations) all those qualities and attributes not legally appropriate to the corporation." [18]

An institution can be construed as a person for the purposes of theological ethics in the same manner in which an institution is deemed a person in the law. The institution is considered a person in theological ethics in order to render understandable the fact that institutions are capable of significant moral good or moral evil. Institutions can feed the hungry and care for the sick; they can also deny individuals their rights to immigration and migration. Institutions can provide a strong educational system that will prepare the next generation with the skills and competencies to sustain the common good into the future. Institutions can also fail to educate and thus leave their students with marginal skills to sustain themselves and their families. Sinful social structures are perhaps best associated with the activities

[16] Catholic Health Association, *Report on a Theological Dialogue on the Principle of Cooperation* (St. Louis, MO: Catholic Health Association, 2007), 8.

[17] Ibid.

[18] Lon L. Fuller, *Legal Fictions* (Stanford, CA: Stanford University Press, 1967), 117–118.

of institutions rather than individual persons. There are serious reasons to understand the institutions of society as moral agents; they need to be held accountable. But the fiction must be understood for what it is, a fiction that allows society to hold its institutions accountable. Institutions are not persons, except by metaphor or analogy.

Institutions are not persons in a literal sense. Institutions lack intellect and will, the basic faculties that enable persons to be moral agents, at least as this has been understood within the Catholic tradition. There are several manners in which institutions are analogous to moral agents. First, whereas persons are bearers of multiple meanings, purposes, and values, institutions are more narrowly focused. Health care institutions are focused on maintaining the health and well-being of a community; they are engaged in healing and caring for the sick when that becomes necessary. Health care institutions do not feed the hungry or cloth the naked as a person might.

Second, the fundamental goal of an institution defines its role within society. The scope of its interests, what is relevant and meaningful for an institution, sets key parameters to how it understands its role within society. The fundamental goal of the organization, construed from within the culture of which it is a part, sets the horizon, the context of meaning, and purpose that should shape its behaviors. Third, whereas the moral agency of individuals is primarily directed to the goods essential for one's well-being and one's family, the moral agency of institutions is focused on the creation, maintenance, and enhancement of the common good and thus the goods and services that support human well-being and flourishing.

Finally, the moral agency of institutions is accountable to a number of outside entities and responsible for its own meanings, purposes, and values. Catholic health care institutions are accountable to local ordinaries, but also to any number of accrediting, licensing, and certifying organizations. But they are also responsible to their sponsors, leadership, associates, and the wider community to function in a manner consistent with their meaning, purpose, and values. Accountability pertains to the moral agency of the institution to entities external to itself; responsibility pertains to its authenticity as an institution within the horizon created by its particular set of meanings, purposes, and values in relation to those of the wider culture.

Culture

Clifford Geertz defined culture as the "historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate, and develop their knowledge about and attitudes toward life." [19] Several elements of this definition should be noted. First, "historically transmitted" concerns the content of a particular culture that is evolving and yet serves as a bond between one generation and the next. Culture enables its membership to "communicate, perpetuate and develop their knowledge … and attitudes." Thus culture provides coherence to a way of life; it serves as the criteria by which membership in the group is determined and the stranger identified. Finally,

[19] Clifford Geertz, *The Interpretation of Culture* (New York: Basic Books, 1973), 89.

culture provides both knowledge and attitudes toward life. Culture enables persons to form and share a way of life, to identify what is meaningful and significant, and how persons should live together in harmony.

According to Geertz, human nature and culture are intrinsically intertwined: "We are, in sum," Geertz writes, "incomplete or unfinished animals who complete or finish ourselves through culture—and not through culture in general but through highly particular forms of it."[20] He continues, "Man is to be defined neither by his innate capacities alone, as the Enlightenment sought to do, nor by his actual behaviors alone, as much contemporary social science seeks to do, but rather by the link between them, by the way the first is transformed into the second, his generic potentialities focused into his specific performances."[21] Being human, according to Geertz, is the amalgam of how the basic natural human capacities—the intellect and the will—realize themselves in the creation of a culture, a way of life, and a system of meaning and purpose. But how can this social scientific conception of culture become a general theological category?

History and culture are the matrix in which theology develops. Lonergan has already been cited as stating that cultural ideals and norms set the problems for theology and direct its solutions. In the Patristic era, Platonism and neo-Platonism provided the patterns of thought in which the Church's understanding of revelation found expression. In the middle ages, Aristotelian philosophy became the dominant philosophy that structured and provided a coherent intellectual framework through which theologians articulated the core beliefs of the Catholic tradition. Cultural development has enabled the Church to alter its teaching regarding topics such as usury, slavery, and freedom of religion. Over the past century, Catholic social teaching has not only addressed the moral responsibilities of individual men and women but has also consistently striven to shape the culture, especially the social, economic, and political milieu, in which human life is lived.

Nowhere is the effort to shape culture more clear than in Pope John Paul II's encyclical *Evangelium vitae*, in which the Pope addressed issues associated with a culture of death. Perhaps there have always been voices in the Church that harkened back to St. Vincent of Lérins and proclaimed that orthodoxy was *quod ubique, quod semper, quod ab omnibus* (what has been held always, everywhere, by everybody). Yet Catholic theology has always found expression in the intellectual patterns of thought in each of the ages it has lived through and, particularly with regard to some key ethical teaching, has rethought some basic positions in response to cultural developments and deeper insights into the meaning of the Gospels.

Discernment

There are many systems of discernment used throughout the Christian community. *The Spiritual Exercises of St. Ignatius of Loyola* is perhaps one of the better known. What is envisioned below is a mode of discernment that bishops

[20] Ibid., 49.

[21] Ibid., 52.

and the leadership of Catholic health care organizations might engage in as part of the process to assess mergers, acquisitions, and partnerships between Catholic organizations and non-Catholic entities. Most Catholic health systems already have processes by which they review ethical issues associated with specific transactions.

The goal of discernment is to ensure that decisions regarding mergers are most likely to be instances of "progress and development" for the Catholic health care ministry, and that they do not lead to "decline and collapse." At the core of the ministry is a work of mercy that cares for the sick in a manner that expresses the unity of the love of neighbor and love of God. That core ministry is embedded in a complex corporate entity that is shaped by the culture of American medicine and the financial arrangements that support it. Discernment presumes that financial, clinical, and ethical due diligence has already been done; the outcomes of that due diligence are among the materials to be reflected upon in discernment. The focal point of discernment is that "other dimension" mentioned in the introduction to this essay, the dimension that pertains explicitly to the ministry, to the spiritual and religious dimension that is essential to Catholic health care. Discernment should be a key component of the planning of every merger and partnership; its purpose is to maximize the likelihood that the transaction will nurture and support the spiritual and religious dimension of the ministry going forward.

What can general theological categories add to the discernment process? Legal contracts include a list of terms and their meanings for the purposes of the contract. So general theological categories define or at least clarify the meaning of the terms to be used in the discernment process. Second, general theological categories identify the theological, religious, and spiritual meanings associated with terms such as "institution," "moral agency," and "culture." General theological categories pertain to the religious and spiritual dimensions associated with them; thus these categories go beyond their origins in the social sciences and moral theory. Finally, general theological categories, for the reasons indicated above, are able to sustain theological argument and processes of discernment. Along with special theological categories (grace, incarnation, redemption, etc.), general theological categories constitute the language of theological discourse and religious discernment. The danger in theological reflection and discernment is to begin to use these terms in a manner forgetful of their religious and spiritual connotations and thus revert to purely secular discourse.

The principle of cooperation was not developed to eliminate cooperation in the morally evil act of a principal agent. Rather the principle presumes that relationships in the world are so complex that they may result in one person cooperating in the moral evil of another. Further, the principle does make it clear that formal cooperation, consenting to or embracing the morally evil act of the principal agent is always illicit. The *Report on a Theological Dialogue* leaves open the question whether proximate immediate material cooperation can be tolerated.[22] Discernment may enable, on a case by case basis, a resolution to whether proximate immediate cooperation can

[22] Catholic Health Association, *Report on a Theological Dialogue*, 9.

be tolerated. Is there a sufficient theological rationale that can support a decision to tolerate such a situation?

Institutions, their moral agency, and the culture in which they exist are what they are. Institutions exist within a social context that defines what constitutes the standards of care that should prevail within a health care setting. The moral agency of a health care organization can be assessed only in the relationship of accountability to outside organizations and the responsibilities associated with its internal constituents and those associated with its Catholic identity. Discernment needs to assume the realities of what the health care ministry is as an institutional entity with a specific type of moral agency that seeks to thrive within a contemporary culture. In a preternatural world there would be no need for a health care ministry, there would be no sin, and there would be no sickness and disease. Death would not be feared. The health care ministry, like the broader Church of which it is a part, exists in a postlapsarian world that is characterized, in part, by sin, sickness, and death.

The Loss of Ministry

For many years, when Catholic health care organizations entered into transactions, what was most important to Church leadership was that the patrimony of the Church—the financial worth associated with a ministry—be protected so that organizations would continue to be deployed in support of a ministry of the Church. This remains a legitimate concern, but perhaps today there is an even more fundamental concern. If the Church loses its health care ministry, or if the ministry becomes alienated from the wider culture of American medicine, the Church will lose one of its most important vehicles for shaping American health care and American culture.