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The Jungle of Mergers: Making a Path or Finding a Clearing?

by

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The following is the keynote address delivered to a convention of the New England Chapter of the Catholic Health Association, October 6, 1998.

Introduction

It is a pleasure to return to Massachusetts at this autumn time of year and to address this meeting of the New England Chapter of the Catholic Health Association, which I got to know well through Margaret Torrance during my years at the Pope John Center in Braintree. The images of the jungle and trails were suggested to discuss the realities and difficulties of the ongoing reconfiguration of health care. The images seem apt because jungles are by their nature uncharted, mysterious and full of every administrator's nemesis: surprises. Today, I would like to present some "compass points" for those who must forge trails in this jungle. The following is not a scholarly lecture, but a presentation of "compass points" I have found helpful in analyzing the issues, discussing these concerns with sponsors, bishops and various publics. They contain both some issues and the "talking points" that, while not exhaustive, are demonstrative and at some point necessary in discerning a proposal, delineating its nature, tracking its progress and accepting the outcome.

The History and the Five Working Principles

It was foreseen two decades ago that the hospital would not long remain the center of health care—and the 1970s *was* the decade of the acute care hospital's regnancy. It also became a generally accepted, though unproven, thesis that the "stand alone" hospital would die out. Certainly from the latter half of the 1980s, there have been a number of forces at work to "rationalize" health care, particularly as technological advancements led to a significant reduction in the amount of days a patient needed to stay in the hospital, with a concomitant sharp rise in health care costs. These two factors combined to bring formerly competing institutions together both for their own survival and for better quality of service. This institutional reality is further combined with myriad other health care services no longer provided in the hospital: day surgery, clinic based health programs, physician "realignment," hospice and home-based health care services. All this brings us to the need to collaborate and reconfigure both locally (since all health care, like politics, is local, to paraphrase Tip O'Neil) and, given the size of payers, health plans and the like, nationally as well. When one seventh of the national economy begins to move, the jungle changes its character—it is like the rainy season that brings new life and growth.

Catholic health care, comprising some 18% of this jungle, has a significant stake in what is happening, and has responded, much like other providers by first forming institutional "alliances," and then other "joint ventures" and "partnerships" of endless variety. It was precisely to address such "joint-ventures" and "alliances" that moral theologians employed the "principles of cooperation," which had been initially discussed in the manuals, or textbooks, of moral theology throughout the seventeenth and eighteenth centuries, and more coherently and descriptively articulated in the nineteenth and twentieth centuries. While the principles are of some historical interest, they occupy only a minuscule part of the introduction to moral theology in the training of seminarians, perhaps only half a lecture in the first year of theology. There they are applied, classically, to cases of individual Catholics whose work involves some contact with others doing evil. The usual scenario studied would be that of a large city hospital operating room in which an abortion (or sterilization) is being performed. The involvement of the surgeon, the anesthesiologist, those passing instruments, the recovery room personnel, maintenance people, etc. are described with stunning clarity.

Applying this lucidity to the actions of corporations (compromising myriad forms of relationships in themselves), one evaluates the Catholic partner's moral relationship to a set of actions of another partner. Suddenly, the fog in the jungle is dense. We know that the actions of each party are

ethically significant, but the lines of complicity, indifference or propriety are difficult to discern. Personally, I think it would be helpful in the development of theology if moralists could forge “principles of partnerships” which would deal with the actions of corporate persons rather than analogously applying principles crafted for individual agents. I will address the principles of cooperation in greater (though not great) detail later.

As something of a satellite tracking mechanism for travelers in the jungle— or perhaps a compass point bringing one into contact with certain stable and constant realities in what seems otherwise wilderness or chaos—the ethicists of Pope John Center some years ago agreed on five principles to forging partnerships, then generally inter-institutional groupings called “alliances” in those days. Looking back, these joint ventures or joint management agreements have a quaint simplicity no longer characteristic today. These new “principles of partnership” are:

1. Cooperation must be mediate material, never formal or immediate material.
2. We can only do together what all partners agree to be appropriate. This means that while the alliance or collaborative effort need not be Catholic, it must nevertheless observe the ERDs as respecting the “corporate conscience” of the Catholic partner.
3. Morally illicit procedures cannot be provided on the Catholic campus.
4. Any morally illicit procedure(s) provided on campuses of non-Catholic alliance partners must be excluded from the new alliance corporation through separate billing mechanisms, administration and governance.
5. All publicity should be straightforward regarding:
 - The need to form an alliance (the good to be done)
 - The good achieved by “rationalizing” health care
 - The exclusion of immoral procedures from the partnership (even if these services will still be available on other non-Catholic sites)
 - The necessity of this publicity appearing also in the promotional literature throughout Newco

We found that this schema of principles was helpful both before the revision of the ERDs and has been helpful since then, because it gave concrete objectives or goals, rather than merely stating the principles of cooperation, which in any audience including theologians, is stultifying. With these principles, only a more basic understanding of the principles of cooperation is presumed. These five principles comprise an important compass point that works both in the administrative office of the health care facility and in its boardroom. Let us turn our attention now to another important office, that of the bishop.

What Makes the Meeting with the Bishop Most Beneficial and Time-Efficient

The next compass point or satellite-tracking device is of primary importance: letting the bishop know about your safari and what your plans in the jungle are all about. While I in no way intend to speak for the bishops, I can tell you from personal experience that a bishop's time is unimaginably structured and limited. Coming to the point with optimal clarity in presentation and expectation is of the highest concern. While each individual bishop has questions and concerns that are particular to a given case in his jurisdiction, it has been my experience that every bishop has been concerned with three broad issues: the fundamental ethical propriety of a given undertaking (or the question of "principle"), *why* the Catholic sponsor is interested in the proposed partnership to begin with, and how to address forthrightly the various "publics" that have an interest in the undertaking (also, more technically, though I think inaccurately called the issues of "scandal.") In other words, the bishop is generally looking at the proposal in terms of whether it is *pastorally* appropriate for a Catholic entity to engage in a particular partnership, apart from the nuts and bolts of legalities and finances. It is doubtful, therefore, that the bishop himself would be interested in the Network Proposal containing recitals, definitions and schedules; however, he may want such materials available ahead of time for his own expert or vicar.

a. The question of principle

One of the major concerns for the bishop, which is best addressed first, is the question of clear ethical propriety. This concern is two-fold: is the non-Catholic partner providing services which we consider morally inappropriate (and this ranges from clear pro-life concerns like provision of abortion and euthanasia, as well as certain forms of fertility intervention, to

contraception in its panoply of forms) and secondly, is there alienation of property? This latter concern for alienation of property is morally significant inasmuch as people of goodwill have donated to the "stable patrimony" of the Church thinking that their gift will be used for the purpose for which it was given, and for which it was willingly received.

Within what was termed the "pro-life" issues, ethical scrutiny of such proposals has employed the use of the "principles of cooperation." These principles were mentioned above. There, it was noted that their original focus was on isolated actions of individuals, and this topic was not in any way a centerpiece of moral theology. Historically, they had a difficult birth, finding an articulation compatible with the teaching of the Church only after a century of controversy. It was St. Alphonsus Liguori (d. 1787) who forged them into an acceptable compass point for the ethical jungle of his day. Moralists who wrote the manuals embellished his doctrine and applied it to cases relevant in their own time, to topics which now sound quaint: can a Catholic stone mason help build a Masonic temple? Can a Catholic priest give (unconsecrated) hosts to a minister for a Protestant communion service? The Congregation for the Propagation of the Faith and the Holy Office of the Universal and Roman Inquisition dealt with questions regarding cooperation in a string of decisions throughout the nineteenth century, generally arising from missionaries in non-Catholic lands. One can readily see, therefore, why moralists agree that these are some of the most difficult principles to articulate and apply.

In most rudimentary form, the principles teach this: cooperation takes two forms, inappropriate and appropriate. Ethically inappropriate cooperation involves either the direct performance of an evil action or the direct facilitation of an evil action actually performed by another. These two forms of ethically inappropriate cooperation are called "formal" and "immediate material" cooperation, respectively, in the theological tradition. Neither are ever permitted. Ethically appropriate forms of cooperation are called "mediate material cooperation" and generally involve something like the manufacture of some product that is used by another for an immoral purpose. The sale of wine in one's grocery store is not ethically inappropriate simply because it is misused by some customers. This realm of mediate material cooperation covers a spectrum of relationships ranging from the very remote and contingent to the very proximate and necessary. Often, distinguishing between very proximate and necessary forms of mediate material cooperation and forms of immediate material cooperation are very difficult and sometimes contentious.

Dusting off this chapter of moral theology and bringing these principles to bear in the realm of corporate actions has not been easy. However, it was the employment of the principles of mediate material

cooperation that led to the creation of the "carve outs" so dear to corporate attorneys. The carve out allows prohibited procedures (generally only sterilizations) to remain on the non-Catholic campus while at the same time to be removed completely from the partnership and owned, operated and controlled by a residue of the non-Catholic corporation in a private manner. Separation in this way— financially, administratively and in terms of governance— allows for the partnership itself (generally called "Newco") to respect the consciences of all participants, including that of the Catholic partner. Sterilizations may remain in the non-Catholic partner, but they do so as a private enterprise of the non-Catholic partner, not an activity of the "partnership" between Catholic and non-Catholic parties. Again, the principles of cooperation were not foreseen to carry the freight of contemporary application to actions of "corporate persons." This application has proven not to be rocket science.

While this looks good on the blackboard, this sort of structural reorganization is fraught with difficulty: it is difficult to present to the general public as it can appear to consist of winks and nods, it often involves the abolition of abortion services entirely from the non-Catholic campus which raises the hackles of those ideologically committed to the restriction of personhood from the unborn, and civil libertarians who advocate the option of physician assisted suicide. These social concerns will occupy a large part of the conversation with the bishop as well; however, no other issue can be addressed with the bishop unless this primary and fundamental issue of the non-violation of ethical principles is resolved to the bishop's satisfaction.

The determination of whether the proposal involves appropriate or inappropriate forms of cooperation should be clearly addressed in a separate memorandum provided to the bishop by the health care sponsor and administration. He will probably have his own diocesan personnel (a vicar or health care coordinator) look this over and perhaps have it reviewed by a disinterested third-party moral theologian as well.

Even with all this, however, ethical propriety is only one factor in the decision to form a partnership. Even though it may be perfectly ethically reasonable, it may not, in the end, be pastorally prudent. So, even the resolution of the question of principles does not dictate the final outcome. In the traditional understanding of the principles of cooperation, more is necessary to involve oneself in cooperation than determining it to be mediate material cooperation, which means no moral absolute is violated. There must also be an important reason to entertain the proposal.

b. Why would the Catholic partner consider cooperating?

This aspect is what moral theologians call the “sufficient reason.” This would be the second point to address with the bishop. If the first point dealt with the ethical safety of the safari in the jungle in terms of moral principle, the second point deals with why sponsors propose to take the safari on this course to begin with. On the Catholic side, this is generally a “mission” question, that is, it derives from the sponsor’s desire (in religious terms, “vocation”) for some work of apostolic charity. Most often here, there is a sponsor’s concern to enhance the quality of care for the patient population in question, particularly the health needs of the poor. This is generally the sponsor’s founder’s reason for establishing the religious order engaged (or formerly engaged) in the apostolate. In the meeting with the bishop this point may in fact well be the first in the presentation and the question of principle may come second; however, I list them in this order in terms of their ethical logic rather than their intrinsic or apostolic logic. The sponsor representative or CEO is the most appropriate presenter of this point. It is, after all, the sponsor who has perceived the need for the proposed partnership as a good to be achieved. And the sponsor has employed the use of civil and canon lawyers and moral theologians to work out the details. However, quite apart from legal and ethical considerations, the bishop will want to know the reason why the proposed course of action is being contemplated. While this may be self-evident in this forum, it can often become obscured by lawyers and theologians whose job it is to talk about trouble rather than the much more joyful purposes of apostolic charity.

c. The questions of scandal

Traditionally, scandal is a consideration of how others will perceive and ethically evaluate our actions. Scandal of the innocent leads others to assume that evil is good, or that the agent acts or appears to act as though it is permissible to act in a way that contradicts a teaching of the Church. There is also a type of scandal called “pharisaical” which points to the agent’s conduct—which is not evil—and tries to bring discredit to the agent as being duplicitous. The Church is old enough to realize that the world has not outgrown either form of scandal, not even in these enlightened times.

This category has actually grown beyond the traditional forms of scandal to include any aspect of the “public relations” angle of any action taken by health care sponsors. Today, dealing with the traditional forms of scandal, that of the innocent and that of the pharisees, is often conducted in the media which have their own “lens” of perception. Michael Eisnor, the

president of Disney said in an interview on NPR's "Freshair with Terry Gross," "the proximity of appearance and impropriety is perhaps too close in our day." It may appear that your safari is a war party, or imperialists desirous of destroying the rain forest in the interests of global warming. There is any number of angles by which media will treat a proposal. And on the bishop's mind is the fact that the decision made regarding a given proposal will in some way be national news, and will affect every other bishop in the country. It is precisely in this murky realm that the question of whether an otherwise ethically upright proposal is, at the end of the day, a prudent course of action or not, may be answered in the negative.

Beyond media concerns, and really at the basis of media concerns lie agents of ideology who have their own interests to protect or project about the proposed partnership. These agents reside inside and outside the Church. Some of these agents act thinking they are protecting the Church from being destroyed. Others plan the Church's destruction. And still others, at best, want the Church out of the way because of a cultural rejection of the Church's moral code and the vestiges of religion.

Merger Watch is at least this. It is part of a contemporary cultural movement which gerrymanders the notion of tolerance to forge a most rigid intolerance to religious expression in social institutions. Planned Parenthood and myriad other local and world organizations are driving forces of this process as well. The herculean effort expended by the Holy See for the U.N. conference in Beijing attests to the magnitude of this problem. Without venturing out into the battlefields of the culture wars that characterize our times, these forces must nevertheless be located by our compass in this jungle and carefully studied. Failure to do so is perilous. Organizations within the Church are surely becoming available to keep us ahead of the curve in this regard. In my experience, bishops are very savvy about this aspect of the Church's actions in the world.

In the meeting with the bishop, if the question of principle is addressed by an ethicist and the *raison d'être* of the proposal is discussed by a representative of the sponsor, then the discussion of "scandal" is probably best discussed by the bishop since he knows the diocese and its individuality better than the other groups, because often the sponsor's representative is from out of town and so is the ethicist (the very definition of an expert.) The meeting with the bishop is truly a collaborative event. Each party has its role and responsibilities.

d. Other concerns: "Catholic Identity Impact Study" and annual follow-up

It would be my recommendation also, that the bishop develop some

formal means of reporting to him or to his delegate on a regular basis. Some dioceses have implemented "Catholic Identity Impact Statements" which essentially compile the information mentioned above, and more. In these the sponsor clearly delineates the type and form of partnership contemplated, maps out the ethical aspects and the overall purpose to be achieved, and also includes a projection of how the project would develop from the perspective of the Church. Will this proposal strengthen or enervate the Catholic identity of health care both immediately and, say five years in the future? This instrument should also have a mechanism of annual reports to the diocese regarding the progress of this partnership over the past year. These reports would become benchmarks to chart progress and propose revisions. It would be a proactive form of communication with the diocese that would avoid the "I'll call when there's a problem" scenario that only breeds bad blood. Bishops really like to know when things are going well. It might be an act of charity toward the bishop to assure him that things can go well!

Again, as was stated earlier, each bishop will have other concerns that will need to be addressed in the meeting with him. However, the three broad areas relative to the principles of cooperation are of concern to every bishop. And rather than waiting for him to pull them out of the conversation, it makes most efficient use of his time to make this a centerpiece of the sponsor's presentation. See the bishop or his delegate in the manner we vote in Boston: early and often. The Catholic Identity Impact Statement helps to map the safari's progress and status in the jungle.

Also, and equally importantly, know and communicate what the sponsor's expectation of the bishop is. This should be in a letter that precedes the meeting itself. What is the bishop expected to do? Is the partnership a matter of "approval" inasmuch as the Catholic health care facility is a diocesan facility that needs the bishop's actual approval? Or is it a proposal made by a community of Pontifical Right, and therefore, according to the ERDs requires the bishop's "Nihil obstat?" Or is this a meeting to familiarize the bishop with possibilities and an exploration of his future expectations about forthcoming information? These are very different expectations and require very different glucose levels in the respective cranial regions.

Related Concerns

I would now like to turn to a cluster of related concerns. The first concerns the role of the ethicist or moral theologian. Secondly, concerns about "regional morality." Third, what is the Vatican's role or concern in this process? Finally, reflections on the future of Catholic health care.

a. The role of the ethicist/moral theologian

The role of the moral theologian is an important one in considerations about health care partnerships. First and foremost, the moral theologian must be a person who knows, is conversant with and stands without hesitation within the theological tradition and within professedly orthodox faith.

A primary responsibility of the theologian is to analyze the proposed partnership especially in light of the principles of cooperation mentioned earlier. The theologian should also be thoroughly conversant with other moral and doctrinal issues, particularly those of the social teachings of the Church. But, beyond analysis and judgment there is another crucially important role for the theologian to play. It is perhaps best expressed in the words of Cardinal Maida. He was the Chairman of the Board of Pope John Center when I was newly hired as the Center's Director of Education. As you may know, as a priest, Father Maida served as both a canon and civil lawyer, of great expertise. In a meeting with the Center's ethicists regarding a particular proposal, he asked, "How can we help this happen?" In his mind, any kind of expertise is meant to facilitate what can be a great good. Law and theology, are to *serve*, not merely to analyze. In order to serve, theology, then, must not only analyze, but also recognize and attempt to resolve problems and conflicts, not only by abandoning certain avenues, but by re-carving and re-orienting them — by being creative. There is an old scholastic maxim, "one divides only to unite." In these health care proposals, the ethicist must analyze situations, recognize moral roadblocks and also help resolve them *always without violating one's principles, but by nimble use of them to overcome roadblocks*. Cleverness is not evil, and is essential in the jungle.

This said, however, the theologian must in no way become an advocate for one side or the other. The ethicist must be dispassionate in finding ways to follow one's conscience uprightly and also in accepting that once the question of principle is resolved, decisions in the prudential order are even more complicated and open to criticism. The ethicist should not take sides in a particular proposal (which must be very difficult if one is employed by a sponsor.) But this is so in order to insure objectivity and to respect decisions that are not the ethicist's to make.

So, to summarize, the theologian must fulfill the role of memory of the tradition, respect for the Magisterium, facilitator for creative solutions through thorny issues to a faithful resolution, and a disinterested third party. Theologians must be selected with care and approved both by the sponsor and the bishop.

b. The problem of "regional morality"

A perplexing problem arises for sponsors and administrators of large systems whose health care facilities are present in several, or even many dioceses. The problem, as they see it, is one of "regional morality," where a partnership is approved in one diocese and a nearly identical partnership is not approved in another diocese. There are several causes of this. First, as any sponsor or administrator knows, no two partnerships are identical. About alliances, it is said, "when you've seen one model, you've seen one model." The divinity or the devil is in the details, I haven't figured out which one. But it is certainly true in partnerships. The legal documents of network agreements are generally confidential, based on professional/client privilege; therefore, how alike or different two apparently similar partnerships are is objectively difficult to determine. The details can contain deal-breakers.

Second, there may be an honest disagreement between the theologians or ethicists about what kind of cooperation is involved. If a bishop gets advice that the line is crossed from ethically appropriate to ethically inappropriate forms of cooperation, he is not likely to proceed to points of sufficient reason and public relations. If there is static at this level, the partnership may well violate Catholic teaching by undertaking it. Talks would be suspended until other means of achieving the goal are worked out.

Finally, as mentioned above concerning the principles of cooperation, the fact that something is determined to be mediate material cooperation, and therefore not *immoral*, does not mean that this is an appropriate or prudent course of action. Each person has his own sensitivity about how close is too close in a given situation of this nature and a bishop is no different. He may not go near anything that is "proximate" or "necessary" mediate material cooperation. The principles of cooperation involve a panoply of concerns that must be assessed not only in terms of principle, but also in terms of prudence. And prudential decisions—other than our own, of course—can seem unnecessary or obtuse. But at that point, we must remember, that charity is the form of all the virtues.

c. Roman concerns

We all know that in addition to consultation with the local bishop, certain decisions require approval of the competent dicastery of the Holy See. Alienation of property in excess of a certain amount requires the approval of the Congregation for Religious and Institutes of Consecrated Life for sponsors of pontifical right. Diocesan sponsors would require the

approval of the Congregation for the Clergy, and the like. The Church is very solicitous that Church property not be wasted. Originally, the threshold amount for Roman approval was \$3 million, it then went to \$7 million—which is fine for smaller operations. However, larger sponsors of health care institutions can have that threshold raised, given the amount of money they habitually work with. (Some amounts of money are so large one forgets if these are dollars or Italian lire!)

Secondly, bishops may ask for other dicasteries to review the dossier, or even the competent dicastery may seek the advice of other competencies. These questions could involve not only financial matters, but doctrinal as well. From the perspective of practical Americans, it would seem helpful to have some agency to unify the process and expectations by which dossiers are sent to the Holy See—something like a committee that instructs each of the cases as they are sent to the Vatican. Likewise, it may streamline things if there were some mechanism or agency to receive all these dossiers to assure proper instruction before moving them to the respective dicastery of the Roman Curia. But this is perhaps too delicate an area to make this suggestion. Be that as it may, sponsors should not be under the impression that permissions of this type are rubber-stamped. They are carefully reviewed and the *votum*, or opinion, of the bishop is most important.

d. Issues of Catholic identity

Finally, there is a cluster of “identity” issues that have been in the literature for over two decades. These questions appear in a variety of forms: “What is ‘Catholic’ about health care?” “Can Catholic hospitals survive?” There are some bleak answers to that question from very distinguished authors with whom I have been in scholarly conversation over the years in various journals.

Without going too deep into this very large question, I would make a few observations. First to ask “what is ‘Catholic’ about health care?”, or education for that matter, is based on the presupposition that health care and education can be bodies without souls. But we know from theology that the only bodies without souls are dead. That is, there is no value-free service, be it health care or learning. These public services emerge from a culture that is very value-laden (or “soulful.”) One lesson to remember from the disaster in education over the past generation and a half is that there is no such thing as value-free education. For us, the health care apostolate is the recognition and response to a human need for the love of the Lord, and a realization that He is being encountered and served in the exchange. The great eschatological discourse in Matthew 25 — When I was hungry you gave me

food, when I was thirsty you gave me drink, when I was sick you tended to my needs... Whatsoever you do to the least of my brethren, that you do unto me— has inspired the Lord's disciples ever since He preached this sermon. Saints Paula, Benedict, Vincent DePaul, Louise de Merrilac, Elizabeth Ann Seton and Mother McCauley all heard these words in a profound way. Each found a need, and found the Lord there as well. Their apostolates and vocations were neither easy nor always clear cut. Their problems were unique to their times, as ours are to this time. But, beyond the particularities of our contemporary situation, I have a profound conviction that health care (as well as education) is so important a human service, that the Church must respond in an organized apostolic way inasmuch as wherever human culture is, there the Church should be, because there one finds human problems that need the balm of faith-filled service.

I do share three broad areas of concern with others who write in this field, they are briefly: the health care dollar, technology and pastoral care. In terms of financing, it is a great concern to all that the cash flow is such that it is increasingly difficult to serve the poor, the uninsured and under-insured. This service to the poor is integral to the very essence of Catholic health care. There is a great possibility that payment mechanisms will separate Catholic health care from its primary beneficiaries, the poor and the vulnerable. American society must make further resolve to give assistance to those in need, and this must be reflected in health care policies, not originating in the boardrooms of insurers.

Second, technological advancement has made dizzying advances in reducing mortality rates and in driving down the number of inpatient days. My concern is that often, patients are not in long enough to receive the Sacraments or meet with pastoral care personnel. While there is absolutely nothing wrong with reducing the trauma of a hospitalization, patients who in former times recuperated for some time in the hospital, now have less chance to benefit from processing their human drama of illness in a matrix of meaning through pastoral care. And in this sense, the blessing of technology does cause a large shadow of depersonalization. There is a big role for parish-based health care to play here. (But it needs to be created first!)

And this leads to the third point about pastoral care itself. Over the past three decades, the clergy shortage and professional chaplain accrediting agencies, and, more recently market-oriented policies, have led to a decline in availability of the sacraments in many places. It has been noted in publications that there is often no 24 hour coverage by a priest for sacraments and no 6:30 a.m. Mass. This is more than curious in a hospital claiming to be Catholic. The Mass, it must be remembered, is primarily for the benefit of staff *and administration* who find sacramental nourishment for their apostolate or ministry.

And perhaps this is most profoundly the issue with the Catholic identity of Catholic health care, which must find a place on our compass through this jungle: Catholic health care, says Father Richard McCormick is not about jobs, but about a great cause. Catholic health care, he continues, was "organized around 'the greatest story ever told.' The Catholic hospital exists, therefore, to be Jesus' love for the other in the health care setting... If that is [not] the case, then the heart of the Catholic health care culture is gone. The mission has become impossible." (*Origins* vo. 23, no. 39, 648-653).

These are certainly grave concerns and serious challenges that threaten to choke off the progress of the safari as the jungle thickens and threatens any hardy band. But the compass must always point ultimately to Jesus who lifts us from the mire as he lifted Peter from the ravages of the sea. When we consciously serve Him in the work, He rewards the effort and sacrifice. But we must remember that the challenges of money and markets and technological advance are not the gods we serve, but the angels we wrestle. Today's Catholic health providers inherited the tradition from the religious of a now increasingly distant past. As they recede from view, it is important to remember that tradition is not a museum piece that is dead because it did not develop. It is a living culture we are entrusted with to carry on as we see fit. Father McCormick identifies a problem today as a "lack of identifiable culture-bearers." (*America*, 7/4/98, 6) This is true. I would put it this way: in the past, the symbol, or icon, of Catholic health care was the religious sister. With the disappearance of sisters, we are now in need of a new icon, a new symbol of Catholic health care. But, certainly, even without a visible sign, the safari of Catholic health care continues in those engaged in the work.

Can the soul of Catholic health care be saved? Certainly, its body is changing rapidly. As Charles Osgood says, "as I get older, I realize my body is playing by different rules." This is true of health care. But I hope that the changes in the body signal a development in maturity rather than being symptomatic of some terminal illness, contracted in this jungle. Let us hope that these changes are the dawn of mid-life rather than the departure of the soul at death.