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# *The* **MAST** *Journal*

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## **Spirituality of Healing**

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Dear Sisters, Associates, Companions and Friends of Mercy,

We typically think of “Mercy healthcare” as embodied in our sponsored works, the hospitals, community clinics, retirement residences and systems that coordinate them. The theme of this issue, “The Spirituality of Healing,” pays attention to what inspired the building of hospitals and creation of systems in the first place. What in the Mercy charism continues to energize managers, doctors, nurses, staff and patients themselves? What actions express what healing in the Catholic tradition means?

Elaine Wainwright, R.S.M., provides a scriptural foundation for the theme of this issue. In “Telling Stories of Healing/ Proclaiming Jesus as Healer” she focuses on two scenes in Matthew’s gospel, one where Jesus heals the mother in law of Simon Peter, restoring her from a fever; the other where a woman anoints Jesus. Healing is a dynamic interchange between the healer and the one healed. Jesus, in this reading, not only acts as a healer, but switches places as the healed one. He receives healing from the woman when she anoints him; by her consoling outreach, she becomes the healer of Jesus.

Sharon Kerrigan, R.S.M. reminds readers that the Greco-Roman world had a healing tradition that focused on the role of Aesclepius as a responder to people who were sick. She examines several healing stories in the Gospel of Mark to show how the compassionate response of Jesus to the sick and disabled “took over” this tradition. People had to travel to shrines and temples of Aesclepius, but Jesus typically comes to where the sick are. He is present to them in the situation where they find themselves. That is the place where they find healing.

Joyce Turnbull, R.S.M., herself a nursing educator, provides some sketches about persons in Irish and British history who tried to make health-care available to the poor. “The Tradition of Caring for the Sick Poor” places the work of Catherine McAuley in the context of health concerns shared by her contemporaries, including medical professionals. Catherine was influenced by people around her. She shared their desire to care for the sick poor. Visiting the poor in their homes also meant that nursing care was provided them in the home setting. Her treatment of patients suffering from cholera reflected the best medical knowledge then available.

Roxanne Dolak, R.S.M., the last Sister of Mercy on the staff of Kalispell Regional Medical Center, reviews a century of healthcare in this corner of northwestern Montana. Her study, written for the occasion, is “Celebrating 100 Years of Mercy Healthcare in Kalispell, Montana.” She reviews the original collaboration between the city founders and Sisters of Mercy starting in 1910, and the succession of names by which the institution was known. Besides a couple of dramatic incidents, she tells the story of Sister Mary Brendan Phelan, R.S.M. who initiated an after-hospital, follow-up program for patients. The hospital has grown and new community-based programs are flourishing.

Maria Allo, M.D., is a surgeon, specialist in endocrinology, and past Director of Surgery for a medical center in San Jose, California. Her essay, “Getting Well is Not the Same as Healing” tells the story of her own challenges to manage an auto-immune disease as she strove to get through medical school and become a surgeon. What is the benefit to a person of facing a disease honestly and taking responsibility for dealing with it? As a surgeon-healer, she tells the story of several of her patients whose hospital stays were the occasion for healing other dimensions of their lives than their physical ailments.

Mark Hehir, once professionally independent, now disabled by muscular dystrophy, gives a moving, autobiographical account of the way he has learned to cope with loss of physical function, and his efforts to stay active and connected with others. In “A Spiritual Journey: My Experience of Muscular Dystrophy,” he describes his present activities and engagement with life around him. More

fundamentally, he shares his commitment to go on living in a spirit of acceptance and gratitude. His essay is a source of hope and inspiration to readers, whether they are able-bodied, or coping with physical limitations themselves.

Sandra Jewett, Ed.D., provides a personal account of how devotion to Mary offers Latina women a specifically woman-centered source of healing in the Catholic tradition. In “Guadalupe: A Source of Healing for Latina Women,” she reviews the story of the vision to a man in 1531, and how that vision has been adopted by Latina women as the Virgin’s promise to be with them in their sufferings. The Virgin of Guadalupe is invoked as a helper and healer in family crises. Her presence is palpable consolation for women who are facing spiritual crises, as well as the sickness and death of loved ones.

In the section, Wisdom that Endures, the editor acknowledges the assistance of Sisters Marilyn Gouailhardou and Mary Helena Sanfilippo, R.S.M., archivists in Burlingame, California. They retrieved the text of a talk delivered in 2005 by Diane Grassilli, R.S.M., now deceased, “Mission Leadership in Catholic Healthcare West.” The presentation, full of good humor, reviewed the history of the formation of the health-care network of over 40 institutions. Memorably, the talk also recounts the enduring vision and values that propel the Mercy ministry of healthcare, no matter what form it takes.

Sincerely,

*Eloise Rosenblatt, R.S.M.*

Eloise Rosenblatt, R.S.M.  
Editor, *The MAST Journal*

# Telling Stories of Healing/ Proclaiming Jesus as Healer

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Elaine M. Wainwright, R.S.M.

Gerd Theissen in his imaginative work on the historical Jesus, *The Shadow of the Galilean*, tells a wonderful story of Miriam, a young girl in Capernaum who is ill and whose mother Hannah tells her these extraordinary stories of Jesus, a healer who is active in the region.<sup>1</sup> Andreas who hears this storytelling says:

I noticed that these poor people pinned all their hopes on such stories. In them I heard their rebellion against suffering and death. I felt that as long as these stories were told, people would not be content for men and women to hunger and thirst, be crippled and paralyzed, be sick and helpless. As long as they had these stories they would have hope. I asked myself whether Hannah had heard all the stories about Jesus that she had told to Miriam. Had she perhaps invented some of them to comfort little Miriam? I believe that if she had run out of stories I myself would have added some and invented some.<sup>2</sup>

Why would Gerd Theissen who has sought to imaginatively reconstruct the telling of stories of Jesus' healing even during his life-time and ministry have had Andreas say these words: "I believe that if she had run out of stories I myself would have added some and invented some"? One answer may be found in a recognition of the power of stories articulated by Jill Freedman and Gene Combs when they say:

[s]tories inform life. They hold us together and keep us apart. We inhabit the great stories of our culture. We live through stories. We are *lived* by the stories of our race and people."<sup>3</sup>

The gospel or gospels are one such story or set of stories that hold us together and keep us apart. They are stories which we inhabit; which we live through and which live us. And within the gospel, one central set of stories are those of healing. They are the stories that Hannah was telling Miriam to bring her hope and healing. They are the stories which have shaped and informed the healing ministry within Christianity over millenia and the Mercy healing ministry in recent times.

In this article, I want to explore the telling of two stories of healing in the Gospel of Matthew:

One tells of Jesus as healer and another of Jesus himself being healed. I will be concerned with the telling of these stories by a community of believers in Jesus, members of the Jesus movement in the second half of the first century. Such a focus raises questions, however, as to how such stories of healing can function in dialogue with contemporary stories to transform hearts and lives, religious and social imagination, and Christian praxis.

## Matthean Community: Proclaiming Jesus as Healer

Healing is a central feature of the Galilean ministry of Jesus in the Gospel of Matthew and this is manifest in the gospel's early chapters. For the Matthean community, the ministry of Jesus is characterized in his opening proclamation: the *basileia* or kin(g)dom of the heavens is near (4:17). What this calls forth from Jesus is emphasized in the summary verses, 4:23 and 9:35 which frame the Sermon on the Mount (Matt 5-7) and the collection of healing narratives (Matt 8-9): Jesus went about *teaching* in their synagogues; *preaching* the good news of the *basileia*; and *healing* all their diseases and sicknesses. In Chapters 8-9, there are 10 healing stories piled one on another like Hannah's telling of these stories to Miriam.

## Telling Stories of Healing in a First Century World

Before looking at these stories, let me draw attention very briefly here to the fact that there are other places in the Hellenistic world that one could find collections of healing stories. In the Hippocratic texts, associated with Hippocrates, the famous physician from the island of Cos – 460-370's BCE, but spanning centuries later as well, one finds in *The Epidemics* many stories of healings and failures to heal in the field of emerging "professional" medicine.<sup>4</sup> They tend, however, to be like "case studies." We don't have stories from the "popular" or family context as such healing happened in the home. What we do



have are stories of healing from the “folk” sector. On the stelea of the Epidaurian temple of Asklepios, renovated toward the end of the fourth century BCE, there are over 70 stories of healing effected by Asklepios, the god of healing, for those who visited his sanctuary, this being one example.<sup>5</sup>

Alketas of Halieis. This man, being blind, saw a dream. It seemed to him that the god came towards him and drew open his eyes with his fingers, and he first saw the trees in the sanctuary. When day came he left well.

Judaism does not seem to have a tradition of collections of stories of healing. There are a very small number of healing stories scattered amid the later Rabbinic material and the number of healings by prophetic figures such as Elijah and Elisha in the Hebrew Scriptures are miniscule. Overall, therefore, these are very few across many centuries.

Recipients of the gospel story may well have been familiar with the tradition of recounting stories of healings associated with Asklepios as there were Asklepieia/ healing shrines of various sizes scattered throughout the Roman empire, including Syria and Palestine.<sup>6</sup> Recounting stories of healing is, therefore, a feature of the world in which the Gospel of Matthew was shaped. The focus here is to try to understand the function of this telling of such stories. I want to emphasize that I am not seeking to establish the historicity or otherwise of the healings or the cures [and they are different] of Jesus or of Asklepios or the Hippocratic medics although there had to have been some healing effects for the stories to be told. I want to focus on the Matthean community telling stories of healing/ proclaiming the healer; and for us, the import of our ongoing telling or proclaiming of these stories.

## **A Woman with Fever is Raised Up (Matt. 8:14-15)**

The story told in Matt 8:14-15 is of a healing of physical illness – Peter's mother-in-law is lying sick with a fever. The setting or context is clearly significant – it is a “house.” But it is not just any house, but that of Peter. For the community of

reception of Matthew's gospel, the house was not only the actual place of their gathering as community but also microcosm or symbol of the growing *basileia* movement. This may have been particularly so when the house was associated with Peter. By this time he was considered the symbolic leader of the new fictive kinship of believers in Jesus and his *basileia* vision. The setting functions symbolically.

But this house is not completely whole. There is sickness here. Peter's mother-in-law is described as being cast upon a bed or pallet, and hence the household is not functioning fully, not just from a gender perspective. The story of Miriam and Hannah that we discussed at the beginning of this article indicated that the household does not function fully if *any* member of that household is ill. There is also a certain violence in the verb

“thrown down” or “cast down” which captures something of the violence of illness on the human body.

The story then describes the illness of the woman – she is fevered or “sick with a fever.” Fever seems to characterize any number of different illnesses in the Hippocratic *Epidemics* and consequently, “fever” doesn't really specify what the illness was. The description places the woman among many others, both male and female, who were described as ill in this way within the health care systems of Greece and Rome. The focus seems therefore to be on the paralyzing effect of the illness on the woman as well as the household. “Fever” has socio-cultural resonances, but it also draws the attention of the reader to the materiality of the human body which pushes itself up into the text.

An extraordinary feature to this story is that Jesus takes the initiative: He sees Peter's mother-in-law lying sick with a fever. There is no request for healing as is generally the case in a healing story (see for example the healing of the leper: 8:2). This sensate experience of Jesus' seeing the woman begins the healing process. It is a seeing which leads to healing, a seeing which recognizes the dis-ease, the brokenness, the mal-functioning of bodies within socio-cultural and ecological

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systems, all of which are in need of healing. The other extraordinary feature is the description of the ongoing action of the woman following the healing. She is not only raised up free of the fever (as the leper is cleansed immediately), but she goes on to serve. (The imperfect tense of the verb indicates that this is not a once-off action, but an ongoing one).

Given this anomaly, it is possible to compare this story with another within the section of Matt 8-9, namely the call of Matthew (Matt 9:9). When we do this, we find that the healing of Peter's mother-in-law is also a call story. It parallels Matt 9:9 in every phrase except "the fever left her."

This phrase indicates a healing story. And so we can argue that both a call and healing story are here combined and it is included with other stories of healing and the call story of Matthew within Matt 8-9.

Continuing our careful attentiveness to the telling of this story of healing, we notice that if seeing initiated Jesus' healing action, his touching of the woman's hand is the catalyst for the fever leaving her.

Recent studies of touch by French philosopher Jacques Derrida provide insight into such a gesture. For Derrida, touch is a reciprocal action, such that the touching of another is at the same time an allowing of oneself to be touched by what one touches.<sup>7</sup> Jesus touches the woman with a fever. At the same time he allows himself to be touched by her. There is a call and response in the touch: Jesus' allowing himself to be touched in his own touching of the woman. The response in her body (the fever left her) at the same time creates a scene in which Jesus and the woman are engaged in a reciprocal action of healing. Jesus' healing touch of the woman puts him in touch with his own healing power – which he could not have known without his being touched by this woman. She too is called forth by this touch, this being touched in which she also makes contact with Jesus.

As the telling continues, the woman is raised up and she is serving Jesus. Like the function of

touch in the previous verse, the narrator writes on the body of the healing woman the language which is descriptive of Jesus. She is raised up just as Jesus is raised up (28:6). She is also engaged in ongoing "serving" which describes the ministry of Jesus in Matt 20:28. While the "called" Matthew follows (9:9), the called/ healed woman ministers (8:15). Interestingly, the narrative does not return her to the patriarchal household of Peter in which she was cast down with illness, the disrupted household. Rather, the telling of her story of healing launches her onto a new path, that of *diakonia* or ministry. It is the same path as the one who is likewise characterized in this narrative as one who serves, Jesus. It leaves open the

question of whether she is one of the group of women who, with Mary Magdalene, follow Jesus to Jerusalem and the cross continuing to do *diakonia* up to that time (Matt 27:55-56).

Antoinette Clark Wire following her study of the healing narratives speaks of such narratives in terms of "break through points":

They point to a revelation of the holy. They catch up the human experience at the boundary/ limit points which demand elimination. They proclaim this right of elimination as a sacred law and they demonstrate the human refusal to submit to experienced negativity of human existence. They tell of the break-through of the power of God in Jesus into human reality and the break-through of human power into the divine reality. They, in fact, are stories on the boundary and they invite participation, they legitimate participation in the pushing aside of those boundaries so that the power of the risen Jesus may now find expression in our world.<sup>8</sup>

I find myself grappling with this same phenomenon when I consider Jesus as portrayed in Matthew's gospel. The opening of the gospel (1:23) speaks of Jesus as the human child in whom we find the "with us-ness" of divinity, of God. God is with us/ the Earth Community in this child who becomes prophet (Jesus). In him is the point of convergence of the human/ Earth/ divine touch. Healing takes place in and through Jesus at those points of touching, those "thin" spaces between

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Earth and divinity. Telling stories of healing can open up such space.

## A Woman Anoints Jesus (Matt. 6:6-13)

I want to turn now to a story of healing later in the gospel which provides different insights to telling stories of healing, namely Matt 26:6-13. At the very end of his ministry according to Matthew, Jesus tells a final parable, that of the sheep and the goats, proclaiming that the blessed are those who heal the illnesses of society: giving food to the hungry, clothing the naked, visiting [and healing?] the sick and imprisoned, i.e. doing the righteousness/ *dikaiosyne* that Jesus has proclaimed (5:6, 10, 20; 6:1, 33). At the heart of this great parable is v. 40: “Truly, I say to you, as you did it to one of the least of these, you did it to me (*emoi*).”

It is as if such an action is being undertaken in 26:6-13 with Jesus himself as the actual recipient of the healing/ a good work done *eis eme*/ to me in this story/ *emoi* in the great parable.

Matt 26:6-13 is so often read as the woman’s anointing of Jesus with oil proclaiming him as Messiah or *Christos*. However, none of the language of the story supports such an interpretation. There is no “oil,” which is normally the material for anointing – rather the woman uses what is called *myron* or perfumed ointment, which was of a consistency that could be poured, as we know from other documents. The verb “anoint” does not appear in the text and there is no naming of Jesus as *Christos*. We have, therefore, to look elsewhere for the significance of the passage. The clue lies in the intertextuality in v. 7: the woman is described as having an *alabastron* (or alabaster jar) of *myron* and she pours this over Jesus’ head.

In searching out these clues, I discovered that this language occurs most predominantly in Book 15 of Athenaeus’ *Deipnosophistae* – the Sophists at Dinner. We learn that the dinner party is the place where alabaster jars of *myron* are passed around after the meal (and generally by slave women, but there is no indication that the woman of Matthew’s story is a slave). What we can also learn from Athenaeus is that one of the purposes of *myron* poured over the head is for healing: “the

sensations of the brain” ...are soothed as well as healed by the “sweet odours” of perfumes/ *myron* (*Deipnosophistae* Book xv.686c) or “a highly important element of health is to put good odours to the brain” (*Deip* xv. 687d).

Readers are aware, however, that this moment in the life of Jesus is not one of relaxing at a dinner party and enjoying the effects of *myron* being poured over his head. The emphasis on healing in the *Deipnosophistae* alerts readers to a significant meaning of the woman’s action. Jesus already indicates in 26:2 that he knows that he recognizes the signs that he is in grave danger. The narrator then indicates that the “chief priests and elders” are plotting against Jesus to arrest him (26: 3-4). At this point in the narrative, between the plotting and impending arrest and betrayal of Jesus, a woman comes up to him in the house of Simon the leper in Bethany. She pours out an alabaster jar of expensive *myron* over his head. It is an extraordinarily lavish act as we imagine it, and its aroma would have filled the room and filled the nostrils and the imagination of all seated at table.

All of this seems to indicate that the language of the text points us in another direction than the one we usually think about in our telling of this story. The gospel is telling the story of a woman who has recognized “the least” in their midst. At this point “the least” is Jesus himself, who is facing capture and possible death. It is a time of incredible mental and emotional anguish for him, revealed a little later in Jesus’ prayer in Gethsemane ( 26:36-46). Jesus graciously receives the woman’s healing ointment and healing action. He resists the disciples’ interpretation of the woman’s action as a waste of the precious ointment. He doesn’t endorse their superior moral posture that the ointment could have been sold and the money given to the poor. What they have missed, that the woman has recognized, is that at this point in time, Jesus himself is the one most in need. He interprets her action in light of his own need: She has done a good work/ *kalon ergon* in me or to me (*eis eme*) echoing the *emoi* of the great parable. She has done it directly for Jesus. After Jesus’ death the good work will be done to those most in need, the ones called the *least*.



Jesus concludes with a solemn statement indicated by the *amen* or truly: wherever the gospel of Jesus the healer is preached throughout the world, across the centuries, the healing action that she has done will be told in memory of her. She is to be remembered in the Jesus story, remembered because she epitomizes the righteous one who brings justice and its healing to the one most in need/ the one called “the least.” This story is to be remembered and told just as the story about Jesus’ second supper where he takes bread and blesses wine, where he breaks and distributes, and where this action is repeated in memory of him. (Note that the direct command “to remember” is not in Matthew 26:26-29 or Mark 14:22-25).

The anointing woman’s healing actions mirror Jesus’ healing actions. The story of her healing proclaims a breakthrough just as the stories of Jesus’ healing did. Her healing act to/ for the one who is Emmanuel takes her to that “thin space” where the divine and human intersect. In proclaiming Jesus as healer in Matthew’s gospel, we must also proclaim those who heal Jesus – namely this woman.

## Conclusion

The gospel stories of healing, as we have seen from just two stories in the gospel of Matthew, speak of healing as a moment of break-through. They do not tell us how this break-through happens. Such an explanation has not been the focus of this article. The emphasis has been that re-telling such stories of healing, in the face of brokenness in human bodies and relationships, brings us to an encounter with the with-us-ness of divinity. This closeness of God to humans is a presence we see both in the portrayal of Jesus in Matthew’s gospel and in the woman who heals/ anoints Jesus. Healing happens in the touch of a hand and the touch of ointment. The healing touch of the suffering one touches the healer. The healing power of the woman engages the healing power of Jesus. Neither would have known this power without being touched by the other. The healed one’s power – whether seen as the woman, or seen as Jesus – is called forth by the touch of the one who offers healing.



## NOTES

1. Gerd Theissen, *The Shadow of the Galilean*, trans. John Bowden (Minneapolis: Fortress, 2007): 93-95.
2. Theissen, *Shadow of the Galilean*, 95.
3. Jill Freedman and Gene Combs, "The Narrative Metaphor and Social Constructionism: A Postmodern Worldview," in *Narrative Therapy: The Social Construction of Preferred Realities*, ed. Jill Freedman (New York: W. W. Norton, 1996): 32.
4. Contemporary studies of healing in the ancient world, especially those undertaken from a cultural anthropological perspective, explain the health care system of the time as functioning in three realms: the professional, the popular and the folk. See John J. Pilch, *Healing in the New Testament: Insights from Medical and Mediterranean Anthropology* (Minneapolis: Fortress, 2000): 94-103.
5. See Lynn R. LiDonnici. *The Epidaurian Miracle Inscriptions: Text, Translation and Commentary*, Texts and Translations 36, Graeco-Roman Religion Series 11 (Atlanta: Scholars, 1995). See p. 99 for the story which follows.
6. A. Duprez, *Jésus et les Dieux Guérisseurs à propos de Jean V*, Cahiers de la Revue Biblique 12 (Paris, Garabaldi, 1968): 68.
7. See Jacques Derrida, *On Touching—Jean-Luc Nancy*, trans. Christine Irizarry (Stanford: Stanford University Press, 2000): 45-46.
8. Antoinette Clark Wire, "Structure of the Gospel Miracle Stories and Their Tellers," *Semeia* 11 (1978): 83-113, see especially 112-113.



# Jesus the Healer and Rescuer

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*Sharon Kerrigan, R.S.M.*

Americans are living in the midst of poverty, violence and prejudice. Twelve million Americans visited a food bank last year. Youth are being killed at an alarming rate. Religious communities of women are being investigated by Vatican officials because of their theological beliefs. All of these factors demonstrate a need for transformation and restoration.

The early Christian communities faced similar challenges. The gospels may provide us with some insights about the process of setting bad situations aright. Christianity developed within the context of the Greco-Roman culture. The Mediterranean world was plagued with disease. Various kinds of infirmities rendered people unproductive and often forced them to live in isolation. Consequently, healing was a major focus for state and religious leaders.

By the first century C.E., Asclepius had become the main deity associated with healing and he was worshipped throughout the Empire. Reflecting this cultural trend, the New Testament writers attach great importance to the theme of healing. For example, Paul ranked healing among the charismatic gifts of the Spirit. One-fifth of the Synoptic material centers on Jesus' healing ministry.

In light of first-century social concerns about disease and healing, this article will review five Markan stories (Mk 5:21-43, 7:24-37, 10:46-52). Prior to my treatment of the stories, I want to provide a brief review of the Greco-Roman healing tradition.

## The Greco-Roman Healing Tradition

Ancient societies believed disease was unnatural. At the same time, the gods were thought to be the source of both health and illness. The Romans linked religion and healing. By the first century C.E., society's interest in healing was reflected in the dominance of the Asclepius cult. Affirming this movement, Emperors built new temples to honor the deity. Asclepius had two

sanctuaries in Rome. One sanctuary was outside of the city and visited by the poor, while the second one was located in the city. Mark's audience, for one, would have been familiar with practices associated with the Asclepius cult. Traces of these cultic practices can be identified in Mark's healing stories.

D. C. Nineham proposed that the Gospel of Mark was written from Rome during Nero's persecutions (62-68, C.E.).<sup>1</sup> During Nero's reign, Christians suffered from hunger and disease; they

felt threatened and marginalized; they were also blamed for the city's fire. It was against this backdrop that Mark wrote his Gospel. The evangelist depicts Jesus as a rescuer who performed many

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miracles to save his people (Mk 1:21-8:26).<sup>2</sup> Jesus healed those who had faith in him. He ministered first to the Jews and later to the Gentiles.

## The Healing of the Woman with a Hemorrhage: Mark 5:25-34

In chapters 4 and 5, Mark states Jesus is Lord over nature (Mk 4:35-41), and demons (Mk 5:1-20), as well as sickness and death (Mk 5:21-4, 35-43). The healing of the woman with excessive bleeding interrupts the narrative of the cure of Jairus' daughter. When Jesus returned from area of the Decapolis, he was greeted by a large crowd. One of the Synagogue officials, Jairus, came forward and asked him to lay hands on his dying daughter. Jesus went with him (Mk 5:21-4).<sup>3</sup> Mingling within the crowd was a woman afflicted with excessive bleeding. She had sought help from doctors for twelve years but her condition grew worse. Since the physicians were unable to cure her, she turned to Jesus. The woman came up behind Jesus and touched his cloak because she believed he would heal her, and immediately the bleeding stopped (Mk 5:27-9).

Jesus asked the crowd who touched him. Realizing what had happened to her, the woman fell at Jesus' feet and admitted she was the one. Jesus said to her, "Daughter, your faith has saved you. Go in peace and be cured of your affliction" (Mk 5:34).<sup>4</sup>

In telling this story, Mark integrated Roman and Jewish healing traditions. The Romans believed touching a sacred object brought about healing. This was a prevalent motif in Mark's Gospel (Mk 3:10, 5:28, 6:56, 10:13).<sup>5</sup> Asclepius cured a blind man after he prostrated himself at the foot of his statue. Jesus cured a woman who approached him. Unlike the situation of the blind man at the statue of Asclepius, the woman was healed not by touching Jesus' garment, but because she had faith in him.

From a Jewish perspective, the woman's condition put her in a permanent state of being unclean, barren and a social outcast. By appearing

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in public without a male companion, she violated social custom. However, she was careful not to touch Jesus, which would have made him unclean as well, from a Jewish perspective (Lev 15:25-7). She only touched his garment. Jesus' response to the woman, "Your faith has saved you" and "Go in peace," really meant she was made whole. She could consider herself entitled to go back fully restored as a member of her community.

### **The Cure of Jairus' Daughter: Mark 5:35-43**

While Jesus was still speaking to the woman, people from Jairus' household arrived and informed him that his daughter had died (Mk 5:35). Jesus told Jairus not to be afraid, just have faith.<sup>6</sup> As they arrived at the house, they were met by mourners – a sign of death.<sup>7</sup> Jesus informed the mourners the girl was not dead, but asleep (Mk

5:39). Jesus entered the house, took the twelve-year-old by the hand and said, "Talitha kum," which means, "Little girl, I say to you arise" (Mk 5:42).<sup>8</sup>

In antiquity, people believed holy people or god-like figures could resurrect the dead. Xenophon (430-354 BCE) told the story of Asclepius raising up the dead.<sup>9</sup> The evangelist makes the same claim about Jesus. Mark's story probably emphasized the girl's age as a notable part of her healing because 60% of the children in antiquity died before they reached their mid-teens.<sup>10</sup>

The girl's age also linked her story with the woman with the hemorrhage. Jairus' daughter was twelve and the woman suffered twelve years. Both females were Jews and were healed because of their personal faith in Jesus, or the faith of their family. Faith in Jesus was a prerequisite for healings performed by Jesus among the Jews. That same criteria applied to the Gentiles.

### **The Cure of the Syrophoenician Woman's Daughter: Mark 7:24-30**

Mark included two Gentile healing stories in his Gospel. He first healed the daughter of a Syrophoenician woman (Mk 7:24-30) and later a deaf-mute (Mk 7:31-7). Jesus began his mission to the Gentiles in Tyre where he met the Greek woman (Mk 7:24).

The woman entered a house where Jesus was staying. She fell at his feet and begged Jesus to drive out the demon from her daughter. Jesus replied, "Let the children be fed first. For it is not right to take food of children and throw it to the dogs." She answered, "Lord, even the dogs under the table eat the children's scraps." Jesus finally relents. "For saying this, you may go. The demon has gone" (Mk 7:27-9). When the woman arrived home, her daughter was healed.

Like Jesus, Asclepius healed his suppliants from a distance. He healed a child while her mother slept in the Asclepion.<sup>11</sup> Healings performed at a distance by Jesus emphasized his divine level of miraculous powers (Mk 7:24-30; Mt 15:21-8). While acknowledging the perception of Asclepius' divine powers and attributing them to Jesus, the healer, Mark also wanted to teach his community something about Jesus' mission.

The woman entered the house to speak to Jesus. This action was conventional behavior because social custom dictated that women were permitted to speak only inside the private space of homes. On the other hand, Jesus' response could be interpreted as belittling the woman, even though she presents her request in a proper setting. Mary Ann Tolbert offers a more positive explanation. She says the term "dogs" was rooted in a social movement of the fourth century B.C.E. This movement opposed some social and cultural customs of (Jewish) society.<sup>12</sup> Mark may have used this metaphor to underline Jesus' mission to the Gentiles. The woman speaks for gentiles who can expect that they, like Jews, can find healing in the power of Jesus. Like Jairus and the woman with a hemorrhage, the Syrophoenician woman believed Jesus would make her daughter well.

### **The Deaf-Mute: Mark 7:31-7**

After healing the Syrophoenician woman's daughter, Jesus left Tyre and entered the territory of the Decapolis. There he met with some people who brought a deaf-mute to him and begged him to lay hands on him. Jesus put his fingers in the man's ears, and after spitting on his fingers, touched the man's tongue. Then, he looked up to heaven and said: "Ephphatha" which means, "Be opened" (Mk 7:35). Immediately, the man's ears were opened and he could speak clearly.

The use of saliva and application of touch to diseased body parts were conventional techniques used in folk-medicine and in the Asclepius cult. On the other hand, Edward Schweizer suggests Jesus' healing techniques are rooted in Israel's deliverance that is cited in Isaiah.<sup>13</sup> The prophet says:

With divine recompense, he comes to save you.  
Then will the ears of the deaf be cleared...then the  
tongue of the dumb will sing (Is 35:4-6).

Mark uses healing techniques familiar to his audience, but also teaches his community that the faith of the Gentiles in Jesus places them at the table with the Jews.<sup>14</sup>

Mark ends Jesus' mission to the Gentiles with a feeding story (Mk 8:1-9). Jesus feeds 4,000 people with seven loaves of bread and a few fish. After all had been fed, the disciples collected seven baskets of food. In Judaism, the number seven means wholeness.<sup>15</sup> Jesus' ministry to the world was complete, and he returns to Bethsaida.

### **Jesus Turns Toward Jerusalem**

After curing a blind man in Bethsaida, Jesus traveled to Jericho. As he entered the town, a blind man cried out, "Jesus, Son of David have pity on me." Jesus asked the man what he wanted. The man replied, "I want to see." Jesus responded, "Go your way; your faith has saved you." Immediately, he receives his sight and follows Jesus (Mk 10:51-3).

Bartimaeus acknowledged Jesus as the Son of David and identified him as the Messiah. This story concludes Jesus' ministry of healing and teaching. It also reveals what a true disciple of Jesus will face – suffering and the way of the cross. Bartimaeus is the symbol of discipleship.

### **Conclusion**

Mark's Gospel was a sign of hope for his suffering community. He explored the meaning of suffering and identified Jesus as the Messiah who came to save them.<sup>16</sup> What do Mark's healing stories say to us today? I think the stories communicate to us the same message Mark gave his community. Jesus promised them a better world. He taught his listeners the meaning of discipleship. His followers must believe in him and continue to heal a global world as he did.

Like the early Christians, we too are called to feed the hungry and heal those who are suffering. The implementation of our Chapter Declaration might be a way in which we begin to create a new society with less poverty, violence and prejudice. The invitation is ours to accept or reject. What will be our response as a Community?





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1. D. E. Nineham, *Saint Mark* (New York: Penguin Books, 1963; reprinted, 1981), 39-40.
2. Raymond Brown says Jesus is the fulfillment of Mal 3:1 and Is 40:3. See *Introduction to the New Testament* (New York: Bantam /Doubleday /Dell, 1997), 128.
3. The laying of hands on a person is a Greek custom. See Eugene La Verdiere, *The Beginning of the Gospel*, Vol 1 (Collegeville, Minnesota: Liturgical Press, 1999), 135.
4. Miriam Feenberg Vamosh says skeletal findings in Herculeia indicate 41% of the women suffered from an iron deficiency. See *Women at the Time of the Bible* (Herzlia, Israel: Palphot, 2007), 50.
5. IG, XIV, no. 966. Falling at the feet of someone implies a lower social status.
6. Paul Achtemeier states a similar phrase appears in the OT when God is present (Gen 15:1). See *Invitation to Mark* (Garden City, New York: Doubleday, 1978), 86.
7. Edward Schweizer notes that even the poor hired two flutists and one female as mourners. See *The Good News According to Mark* (Richmond, Virginia: John Knox, 1970), 119.
8. The use of foreign or magical words was part of a miracle formula. See Morna D. Hooker, *The Gospel According to Saint Mark* (London: Hendrickson, 1991, 1997), 150.
9. Xenophon *Cynegeticus* 1.1-6.
10. Mary Ann Tolbert, "Mark." In *Women's Bible Commentary*, ed. by C. Newson and S. Ringe (Louisville, Kentucky: Westminster/John Knox Press, 1992), 268. IG, IV,<sup>2</sup> nos. 121-2.
11. Tolbert, 269. Hooker offers another theory. She says the Jews called the Gentiles dogs. See Hooker, 183.
12. Schweizer, 154.
13. La Verdiere, 203.
14. Werner H. Kelber, *Mark's Story of Jesus* (Philadelphia: Fortress, 1979), 39.
15. Bruce Malina and Richard Rohrbaugh, *Social Science Commentary on the Synoptic Gospels* (Minneapolis: **Fortress**, 1992), 177.

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# Caregivers and Caring for the Sick Poor

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*Joyce Irene Turnbull, R.S.M.*

## Setting

Nineteenth century Ireland's Catholic poor had known generations of squalor, disease and early mortality. Over the period of two centuries of unemployment, persecution and hunger, many Irish immigrants had found work in England's burgeoning industries. Enfeebled and malnourished, they may have found jobs, but their ability to sustain employment was cut short by illness and injury. The Irish poor, separated from family and friends, filled the hovels of Birmingham and the infirmaries of Bermondsey in England.

During this century England had devoted its primary energy to development of its industrial power. War-making from the previous century had subsided. This was a period of colonial outreach, and England didn't give as much attention to its War Department as to its industrial interests. It became distracted, however, by the efforts of Russia to assert control over routes to the Holy Land via the Crimean peninsula. England wanted to interrupt this intrusion of Russia into its commercial routes to the middle east. It had a commercial interest in maintaining its industrial work force, but it needed to induct soldiers into its armed forces. England took advantage of its resident Irish immigrant population of desperate, poor and starving men. One-third of the soldiers sent to the Crimea were Irish immigrant inductees.<sup>1</sup>

## Intent

This essay explores the experience of seven nineteenth century professionals whose careers as caregivers of the sick poor overlapped. Their work had the effect of comforting the sick and caring for thousands in cholera outbreaks in Ireland, England and the Crimea. Educated or self-taught, their commitment to the poor, their intelligence, their values, and their beliefs gave them courage to visit and care for victims in several settings. It is useful to consider what they did, what they learned from each other, what new

roles they helped shape. And finally, the essay will consider their vision of healing: who could claim the need for healing, what inspired their contribution?

## A Survey of Care-Givers Whose Careers Overlapped

### Catherine Callaghan (1750's-1819)

Mrs. Callaghan was raised a Quaker, a society committed to serve the poor. In the late 1800's she married William Callaghan. Childless, she spent her days serving the poor. In 1803 the couple welcomed a young woman, the sister-in-law of William Armstrong, Miss Catherine McAuley, to serve as companion to Mrs. Callaghan. In 1809 they retired to a large acreage and home outside of Dublin called Coolock. Catherine was much loved, like a daughter they never had.

As Mrs. Callaghan became infirm, Catherine took over her mistress's Quaker ministry of feeding, clothing and nursing Coolock's regular visitors. This practice of her employers must have had an influence on the future foundress. Mrs. Callaghan also taught Catherine McAuley the practice of reading the Scriptures. The friendship they enjoyed must have been associated in Mrs. Callaghan's mind, as she lay dying, with a desire to be baptized in the Catholic faith.

### William Callaghan (1750's--1822)

Mr. Callaghan was Protestant by upbringing. Like many Protestants, he disdained Catholicism. Intelligent, he had been educated as an apothecary physician. He married Catherine Callaghan in the 1770's. The couple resided in Dublin, then traveled to India. He was a close friend of William Armstrong, founder of Apothecary Hall and brother-in-law to Catherine McAuley. In 1893 William Armstrong joined the newly-founded Apothecary Hall, becoming one of its major sponsors. William Armstrong initiated legislation to protect the public from tainted drug manufacture and improper dosing of medications.

He established policies to assure the safety of training for apothecaries and helped create procedures for their examination and licensure. Aspects of his knowledge of medicine may likely have been passed on to Catherine McAuley, caregiver to the ailing wife's of William Callaghan.

William Callaghan loved Miss McAuley as a daughter. When he was ill she also cared for him until his death in 1822. Her manner of caring for him changed his attitude against Catholics. He was also converted to Catholicism, and left his entire estate to his all-but-adopted daughter.

### **Elizabeth Gurney Fry (1780-1845)**

Born to a middle-class family in Norwich, England, she was one of twelve children. Her father was a banker. Elizabeth was raised a Quaker and given a basic education at home, which included Scripture and the value of caring for the poor. She joined her mother on visits to the hovels of Norwich to bring food and clothing to the needy. When she was only twelve, Elizabeth's mother died, leaving to her the care of her younger siblings. She had some spiritual experiences and these insights directed her the rest of her life.

She married a banker, Joseph Fry, in 1800, and raised eleven children, adding to her house responsibilities visits to the sick poor. In 1828 her husband's bank failed. Helped financially by a relative, the family was able to recover. Elizabeth began to visit imprisoned women and children in London's Newgate Prison. She became the only woman ever to testify before the House of Commons on prison atrocities. Known as the Angel of Newgate, she gathered followers who began an education program for children in prison. She also promoted improvements in the conditions of prison confinement. Royal funds and government support continued her venture. Elizabeth helped reform mental asylums and founded a nurse-training school which drew the attention of Florence Nightingale. In 1845, Florence Nightingale commissioned some of Elizabeth Fry's nurses to serve in the Crimea.

### **Catherine McAuley (1778-1841)**

Born in Dublin of a middle-class Catholic family, she received a solid early education. Her

father had a lasting influence on the faith life of little Catherine. When she was only four, he took her on visits to the neighborhood's poor. His early death led to the family's loss of income, and necessitated they go to live with Protestant relatives. Their objections to Catholicism shaped Catherine's thinking about her religion. Her vision for the Mercy community can be linked to her early experience of prejudice against Catholicism. Her faith was a refuge and strength for her during those troubled years of family disputes over religion.

In 1798, when she was twenty, Catherine was orphaned by her mother's death. Now totally dependent on relatives, but not wanting to burden them, Catherine became a live-in companion to William and Catherine Callaghan in 1803. Accustomed to navigate the beliefs and values of her Protestant relatives, it was not uncomfortable for her to adapt to the Callaghans' Quaker practices and thinking. What she had in common with them was the important maxim of her own Catholic faith – to care for those in need. Mr. Callaghan's competence in medical matters was likely communicated to Catherine, making her more competent in caring for the sick poor, even though she didn't have formal training. The couple's affection and admiration for Catherine led them to make her sole heiress of their estate.

With money now available, Catherine built a workplace and shelter for homeless women and children on upscale Baggot Street, Dublin in 1827. She called it a House of Mercy. By 1831 it became home to a new religious community, the Sisters of Mercy. Ministries of teaching and nursing began to flow out from there to the rest of Ireland, but her home base was Baggot Street. She spent her happiest days in that community, and later bequeathed its spirit as the Institute's legacy of charity.

### **Dominic John Corrigan, M.D. ( 1802-1880)**

Born in Dublin, baptized Catholic, son of a poor shopkeeper, he was exceptionally gifted. Helped to pursue studies in medicine, he graduated from Catholic College of Maynooth. Encouraged by the College's attendant physician, Dominic later received his doctorate at the prestigious University of Edinburgh medical

school. Known for his pioneering efforts in cardiology, Dr. Corrigan practiced endlessly at three city hospitals for indigent and vagrant poor: Cork Street Fever Hospital, House of Industry Hospital and Jervis St. Charitable Infirmary. It was Dr. Corrigan who would facilitate Catherine's entry into these Protestant-governed Dublin hospitals. Later, Dr. Corrigan would care for some of her sick Sisters. After her death, the nursing competence of her Sisters prompted Dr. Corrigan, in 1854, to assign them the management of Jervis St. Charitable Infirmary. This assignment lasted until 1883.

### **John Snow, M.D. (1813-1858)**

Born poor, John Snow was the first of nine children in a deprived, water-polluted area of York. The family's Anglican faith was central. Their house, adjacent to the Ouse River, was polluted by ships, an environmental factor that later influenced John's medical career.

In 1827 he entered England's less costly medical apprenticeship program, receiving his medical degree in 1836. While he was a student, John Snow noticed the high death rate among cholera victims. It became his life's mission to cure cholera. His own meticulous, insightful research led him to see it was water, not bad air (miasma) that spread cholera. Through the financial help of a favorite uncle, he completed his studies toward his doctorate at London's Hunterian School of Medicine.

During his short life, there was little support for his theory about the cause of cholera. Cholera outbreaks caused alarming death rates in the Crimea, and there were eruptions later in England and Ireland. He died without recognition. It took the facts of low death rates, and how the spread of cholera was controlled by non-contact of patients with polluted water – from such authorities as Florence Nightingale and hospitals run by the Sisters of Mercy – to convince England's department of public health about the correctness of Snow's diagnosis. By the 1860's Snow was hailed as the father of germ theory, medical hygiene, and modern epidemiology.

### **Florence Nightingale (1820-1910)**

Born to upper-class, non-conventional, politically-active British parents, she was educated

in the best schools. She traveled widely, and was concerned about both high death rates among injured workers in factories, and cholera outbreaks

Florence was raised a Unitarian, an eighteenth century liberal Christian denomination, but she was opposed to formalized religion. When she was young, Florence felt called by God to serve the poor. She engaged in works of charity, first teaching at London's "Ragged School" where she called the poor children her "little thieves." This first contact with poverty brought home her awareness of England's societal upheaval. A trip to Germany to Theodor Fleidner's Kaiserswerth Hospital answered her life's quest – liberation of women to become educated and do something great for society. Fleidner's deaconesses showed her just this, a role outside the home, caring for the sick poor.

Returning to London in 1853, she was hired as Superintendent for Sick Gentlewomen in West London. National recognition came when the British Secretary of War, Sidney Herbert, appointed her Superintendent of Women Nurses for the Crimea in 1854. The appointment of Florence Nightingale to superintend a group of nurses was unprecedented. No woman had previously held an official position in the Army.<sup>2</sup>

Following the Crimean War, Florence's life was spent establishing secular hospital policies, secular nurse-training programs, a military nurse corps and protocols for synchronizing medical and nursing practice. Over her life of ninety years, her genius for reform would impact health care worldwide.

Catherine McAuley never knew Florence Nightingale, but the foundress had some qualifications to give instruction about nursing care. Her protégé, Sister Mary Clare Moore learned from Catherine how to care for cholera patients. In turn, Mary Clare Moore shared this knowledge and skill when she worked under the famed Florence Nightingale in the Crimean War.<sup>3</sup>

## **The Sick Poor Now and Advice for Care-Givers**

What might these seven care-givers who paid attention to the sick poor say to us today?

- First, physicians and nurses should identify with the persons they serve and the satisfaction



that comes with it. The caregivers we have studied didn't make their work for those in need a matter of status. Be open to colleagues' knowledge, methods and hunches.

- Second, few of us have seen, heard and smelled the agonies of dying cholera victims. What these seven care-givers possessed by education and mission overcame their discomfort in facing the ravages of the disease. To the degree care-givers are more concerned about their patients, and less about themselves, they are able to give better care.
- Third, since bed-side technology has replaced some interaction of the patient with other human beings, this distancing needs to be overcome. Caregivers can make their bedside visits, however brief, an expression of compassion. They can use touch to remind the patient that another human being is present to them.
- Fourth, care-givers can imitate their historical predecessors by teaching both their patients and their own family members the knowledge and skills for healing that they possess. This will empower patients to return to health sooner, and greater knowledge about health-maintenance in the general public will help reduce costs for medical care.
- Last, caregivers need to keep themselves updated on ethical issues. Speed of action to save a life in this century has raised complex beginning- and end-of-life issues, such as, "When is an accident victim dead in order for the surgeon to remove the heart to place it in another's chest?" Care-givers today confront technology and ethical issues that were never dreamed of in Catherine McAuley's day.

## Other Medical and Ethical Issues for Caregivers

One important ethical issue concerns determination of death. This was an issue in Catherine's day. How did one confirm the death of cholera victims? Apparently the foundress had seen patients who looked dead, who were removed to nearby burial sites, only to learn that some were still alive.

"Catherine would allow no one to be buried till she had assured herself by personal inspection that life was really extinct, nor would she allow the nurses to cover the faces of those supposed to be dead, till a stated time elapsed."<sup>4</sup>

The historical care-givers whose contributions were highlighted here all gave attention to the plight of the sick poor. The theme of poverty runs through the continuing scholarly work of Mary C. Sullivan, R.S.M, author of *Catherine McAuley, The Path of Mercy*. In a paper she presented at a Mercy Scholars meeting in November, 2006, she addressed three world trends to consider:

extreme poverty and maldistribution of resources among the world's most vulnerable 'have-nots;'" and 'inadequate, even debilitating, ignorance of basic human, spiritual and religious understandings, even...among Catholics."<sup>5</sup>

What expressions of kindness are an essential part of caring for the sick poor? To the end of her life, Catherine McAuley never ceased to stress "great tenderness in all things" for the sick. This was a term which embraced her own Sisters as well as those whom they visited.<sup>6</sup> Early chroniclers wrote of the calming effect which the presence of the Sisters had upon the cholera victims...against earlier accounts of the panic which prevailed.<sup>7</sup>

Mother Frances Bridgeman's diary records, for example, the kindly action of the Sisters giving care to soldiers just admitted from battle to a Crimean hospital:

Most of these were so prostrate as to be unable to aid themselves. It was necessary to cut and comb their overgrown hair and beard, wash their faces and even feed them like babies. Many a time the poor fellows burst into tears on being spoken to and exclaimed, "Oh, it is long since I heard a kind word before"....<sup>8</sup>

Fealy has summarized the Mercy legacy of caring for the sick poor as a distinctive style that combined both professional expertise and compassionate personal presence. "By the late 1880's the Sisters of Mercy had a well-developed system of sick nursing that had greatly improved the care of hospitalized persons."<sup>9</sup> He adds that the Sisters did not focus as much on technological advances as on devotion, caring, (and) ...acquisition of formal professional skill.<sup>10</sup>



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### GOOD-BYE MY FRIEND

Good-bye my friend  
 Once you prayed for more time  
 One more Christmas; one more birthday  
 Death was still an abstraction  
 Bargaining with God was a regular event.  
 Yesterday assumed a tomorrow  
 Even as your body withered.

Memories will not die with you  
 You shared your best with those of us who loved you

Find comfort in your remaining days  
 Remember that rainbows follow a storm  
 Imagine a place without suffering --  
 Earthly trivialities ignored  
 Nothing left behind but the pieces of your heart  
 Doled out to your lucky friends.

Maria Allo January, 2013

# Celebrating 100 Years of Mercy Healthcare in Kalispell, Montana

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*Roxanne Dolak, R.S.M.*

Kalispell Regional Medical Center in northwestern Montana was born in 1910. In August of that year, a group of businessmen in Kalispell formed a board of directors which became the legal entity Kalispell General Hospital Corporation. Hearing of the businessmen's desire to open a hospital, John Carroll, Catholic bishop of the Helena diocese, asked Mother Mary Gertrude, Sister of Mercy at Sacred Heart Convent in Cedar Rapids, Iowa, to consider sending sisters to Montana for that purpose. (This same bishop is the one for whom Carroll College in Helena is named).

The Corporation then entered into a contract with the Sisters of Mercy to construct and operate a new hospital. One of the members, Judge Smith, rented a cottage on the corner of Fourth Avenue and Third Street East to serve as a temporary hospital.

And so it was that on a rainy September 1, 1910, at 11 a.m., three nursing Sisters of Mercy, motivated by a vision and faith in God's providence, arrived by train from Iowa to start the operation. Sisters Mary Philomena, Clement, and Vincentia had just settled down for lunch at the cottage when a call came from Dr. O'Neil. He had a patient who was very sick with typhoid fever. The man was promptly admitted, and Kalispell General Hospital became a reality. He was cared for and then discharged "improved" on September 12, 1910. His total bill for those twelve days was \$28.00.

Eventually, the cottage services moved to the site where construction was started on a new hospital at 745 Fifth Avenue East. It was completed in May, 1912, at the cost of \$46,000. \$20,000 was contributed by the people of Kalispell, and \$26,000 by the Sisters of Mercy. The Medical Staff was organized in 1922. The executive committee members included Dr. A. Brasset, in whose honor was later established the Brasset Award, given each year to the Employee of the Year who has been recommended by hospital peers.

Through the years, additions were made to Kalispell General Hospital, including a new wing on the south side in 1949, and a convent wing on the north in 1963. The hospital building also endured some challenges, including two earthquakes.

Another unexpected event occurred on December 12, 1925. The Sisters were eating a late supper when

they smelled burning rubber. They were looking for the source of the odor when a loud explosion occurred, followed by a tremendous shattering of glass. Broken glass was everywhere, even on the patients' beds. It turned out that the hospital had been dynamited. A woman was trying to get rid of her husband, who was a patient. She'd gotten a neighbor boy to push a dynamite stick with a lighted fuse through the window of the Sisters' dining room on the ground floor. All the windows on the south and west sides of the building were blown out and extensive damage was done to the plumbing. Patients were badly frightened and three left the hospital in sheer terror. The rest remained, and the Sisters thanked God that no one was injured. The citizens of Kalispell chipped in to clean up the mess and repair the damage.

In September, 1973, the collaboration between the Sisters of Mercy and Kalispell came to an end when plans were made to build a new hospital on Buffalo Hill on the north side of town. The Sisters of Mercy decided not to be involved with Kalispell General Hospital. However, several Mercy Sisters continued to work at the newly named Flathead Health Center, including Sister Mary Brendan, after whom Brendan House has been named, and Sister Mary Regis, a native of Whitefish. George Clark was the new administrator.

On January 17, 1976, the new hospital on Sunnyview Lane was opened and named Kalispell Regional hospital. As it expanded and opened up new services over the years, the name was changed to Kalispell Regional Medical Center, the name that continues today. The old hospital building became Courthouse East and was used by Flathead County for various offices until a new courthouse building could be constructed.

At one time there was talk of tearing down the old building. Eventually it was bought by some businessmen who completely renovated it and turned it into Eastside Brick, which houses condominiums and offices. But that original old building, still standing today, contains so much hospital history.

Although the Sisters of Mercy no longer operate the hospital in Kalispell, the vision and faith of those pioneers continued under the guidance of George Clark and down through the present day by Velinda Stevens and her administration. They have constantly put the



healthcare needs of the people of Northwest Montana at the forefront.

Some of the services that have been expanded over the past 35 plus years include:

- A focus on outpatient services (infusion, respiratory, same day surgery, etc.);
- ALERT – Advanced Life Support Emergency Rescue Team – the second helicopter air ambulance service established in the United States;
- Home Options, including home care and hospice services;
- New Addition, the birthing and newborn center;
- Renal dialysis;
- Social services, which now is included in Case Management;
- Pathways, a free standing mental health center;
- Expanded ER with nurses and board certified doctors on duty 24 hours a day;
- The Summit, a gym & health promotion conference center for public use;
- In patient rehab unit;
- Heart catheterization and open heart surgery;
- A mobile mammogram unit which serves nearby towns;
- The Health Center with its Women's Imaging Center
- A barometric pressure unit for wound care;
- Intensive care nursery unit;
- Cancer radiation center;
- The Bass Center for treatment of breast cancer;
- Employee assistance program;
- Kid Kare/Dinosore: child care service for on duty employees;
- Expanded OR, lab, imaging, computer services, medical records;
- In house chaplain service;
- A new patient tower in 2002;
- A second tower in process (2012) which will house new surgical suites.

One service I would particularly like to acknowledge came about partly due to the influence of one nun, Sister Mary Brendan Phelan, R.N., whom I mentioned above. Before she entered the convent, Sister Brendan had been a nurse for General Motors in Detroit and would ride in the ambulance with injured employees when they were taken to the hospital. When she came to Kalispell, she started as a nurse on the floor in the old hospital. At about that time, administration was realizing the hospital had a need for patient-discharge planning. Sister Mary Brendan was asked to set up a program.

It soon became obvious that there was no place where a patient could go for intermediate skilled-care between discharge from the hospital and final placement at home or some other facility. Flathead Valley was in need of more long-term nursing-care beds. Sister Brendan began to have a vision that such a building could be right here on the campus. But Sister Brendan did not just stop with faith in God's providence – she pestered George Clark and the administration until they acted. The completed building was dedicated on April 1<sup>st</sup> (April Fools' Day), 1985. Imagine her surprise and delight when the curtain was pulled and the name Brendan House was revealed.

Sister Brendan died several years ago. I like to think that she and all the other Sisters who have worked here, especially those pioneers who came in 1910, continue to smile down on us from heaven and ask God to bless Kalispell Regional Medical Center.

When our new patient towers were being constructed in 2002 and 2012, beams for the buildings were set out on the grounds so that employees could sign them. I missed out on that opportunity. When Don Williams, who was in charge of construction, heard about it, he appeared at my office door and took me outdoors. I was equipped with a hard hat and taken by a worker in a lift to the top of the building. There I wrote the following blessing on one of the beams, as the last Sister of Mercy to serve at the hospital:

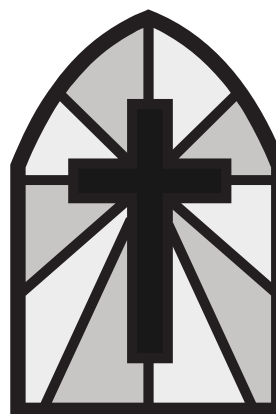
"God, bless this building and all who enter here."

Sister Roxanne Dolak

Sisters of Mercy

March 14, 2002.

And so whenever you come into these buildings, you receive a blessing, no matter what service you need. Happy 100<sup>th</sup> Anniversary to all of us at Kalispell Regional Medical Center. Let us continue, with vision and faith in God and our mission, to serve the health care needs of the people of Northwestern Montana.



# Getting Well is Not the Same as Healing

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*Maria Allo, M.D.*

Much of the discussion about medical care today relates to access, cost containment and administrative policy issues. Patients are referred to as clients; and caregivers are providers. Yet it behooves us as health care professionals to remain sensitive to the spiritual needs of our patients, even in the face of time constraints, mounting paperwork, and other distractions that undermine our ability to be the sensitive, compassionate healers we aspired to become when we embarked on a medical career.

One needn't suffer with an illness to understand its impact, and to be an effective caregiver. However, living with chronic illness offers an opportunity to understand the various ways patients respond to illness. One response is to deny its existence and become angry that it keeps looming its ugly head. Denial can also take the form of non-compliance with medications or treatments, with the false hope that time has brought forth a cure, and that miraculously, no further intervention will be indicated. In reality, chronic illness is more like a bridge hand than a poker hand. Successful play of a poker hand relies on the luck of the draw. In duplicate bridge, it doesn't matter what cards you are dealt, because winning is determined by how well you play the hand compared to others dealt the same hand. In chronic illness, a patient's attitude, while not everything, contributes much to the outcome.

## A Surgeon's Personal Story of Coping with Illness

I was diagnosed with a serious autoimmune disease when I was twenty-five years old. At that time I was a medical student attracted to a career in general surgery. It was the 1970's when women were not exactly welcomed into that specialty. Even for men, the residency training was brutal. In my program we worked 36 hours on call, then 12 hours off – for six years. At the time of my diagnosis I was told I'd be lucky to

live until age forty, and that it would be selfish to “waste” a surgical residency position for a short-lived career. I was told that I should look for another specialty, but my heart was set on surgery.

My father always told my sisters and me that it didn't matter what we did in life as long as we strove for perfection and did it with passion and dedication. A medical career was not a job; it was a vocation. Would I be physically able to do this? Absolutely. Would I be able to put as much heart in something else? Probably not. Would I allow myself to put unknown barriers between me and my calling, when the rest of the world was already laying out fences and hurdles? Absolutely not. I would do the best I could each day, and keep my eye on the prize.

Now, more than thirty-five years later, I can say with certainty that I have never regretted my decision. I still wonder how I could be lucky enough to do something I like so much and actually get paid for doing it!

There have been many challenging times, but none that couldn't be overcome. Aching muscles

**I learned that chronic illness gives you only two choices: deal with it, or become a slave to it.**

and swollen hands meant getting up at least an hour before I needed to do anything. With morning rounds at six a.m., living

in a state of sleep deprivation was a way of life. I learned to cope with cold-induced vasospasm in my fingers (Raynaud's phenomenon) by wearing oven-mitts to retrieve items from the refrigerator, and dressing like an Eskimo to maintain a warm core. In the 1970's the only medication used to treat this caused a significant drop in blood pressure when taken at an effective dose. To compensate, I would drink a quart or so of water and eat a bag of pretzels before going to the operating room. It was inconvenient but it beat passing out. Eating on the run exacerbated the esophageal dysmotility and reflux, so I carried a brown bag of Gaviscon in my coat pocket and would surreptitiously swallow a slug like a drunkard guzzling booze.

Over the next several decades I learned to deal with the day-to-day inconveniences in a manner which disguised the fact that something was not right. More importantly, I learned that chronic illness gives you only two choices: deal with it, or become a slave to it. The experience has colored my doctor-patient relationships. I understand the anger, frustration and ultimately the resignation that my patients experience. Hopefully, I have helped and even inspired them to live life to the fullest extent possible. They come to appreciate, as I have, the importance of taking responsibility for managing symptoms, recognizing potentially important changes, and being grateful for every good day.

## **Illness Can Be a Wake-Up Call to Re-Appraise One's Life**

Sometimes illness may be the wake-up call that prompts an appraisal of how one's life is being lived. Mr. L was a young man who was stabbed during a drug deal gone bad. His injuries included wounds to the liver that penetrated his portal vein and hepatic artery. He survived an operation to repair his injuries, which required technical heroics and a lot of good luck.

During his time in the intensive care unit, he was rude and abusive to the nursing staff. His sister, from whom he had been estranged, visited him often and prayed for him at his bedside, only to have him curse her and try to drive her away. He refused to cooperate with treatments.

Finally it was necessary to confront him with the choice of whether he was going to live or die. He was reminded that many people obviously cared whether he survived. Now it was his turn to make a decision about whether he would live or die. He also had to decide if he did live, how he would change his life. He was asked to verbalize his choice – become a partner in his recovery or not. He chose to become a partner, with the understanding that his behavior would thereafter reflect this choice.

Translated simply, this meant there would be no more refusal of treatment, and no more cursing or abusive behavior toward his family and the care team. Each day that he succeeded in making some change, his sister and the staff greeted him with positive reinforcement. By the time he left the

hospital, he had a new game plan for his future. In his case, a tragic, nearly fatal event was his catalyst for finding meaning and purpose for his life.

## **The Story of R: Coming to Know She Was Loved**

For some patients, the care team can become a second family. R's life had been wrought by bad luck and worse decisions. She had been abandoned by her drug-addicted partner, and left alone to raise their son. With little education and an expensive drug habit, she relied on prostitution as her main source of income. Her son became drug-addicted at an early age and was convicted of drug trafficking. At the time his mother R became a patient, he was serving a long prison sentence. She had to have multiple operations for recurrent bowel obstruction, which resulted in multiple fecal fistulas draining out through her abdominal skin, and short-gut syndrome which made it impossible for her to absorb any ingested food. To keep her alive and prevent her from becoming septic, she relied on intravenous feeding and extensive wound care. It was impossible for her to get care outside the hospital. She was angry, and took her anger out on the nursing staff.

Over time, however, she came to realize that her caregivers were not only her lifeline, but also people who genuinely cared for her in a way she had not previously experienced. Her life and well-being were important to them. She was a person deserving of their care and respect. For perhaps the first time in her life, she was able to develop meaningful relationships, share her story, express her feelings, and come to respect her personhood.

One day she told a nurse that she was tired and that she knew her life would never get any better. The nurse helped her into bed and held her hand. R thanked her for all she had done for her, closed her eyes and stopped breathing. She died on the hospital ward that had become her "home."

It took a grueling hospitalization to transform R. from the hardened, world-beaten soul that entered the hospital into a person who knew that she was loved by others.

## The Art and Challenge of Being a Surgeon-Healer

Most of us don't want to confront our mortality. We live our days with the expectation that there will be a tomorrow. But when a person is faced with the uncertainty of another day, every moment becomes important. The assumed life becomes the examined life. An unfavorable diagnosis or an acute traumatic event can be a catalyst to mend relationships, check off items on one's bucket list, and embark on a journey of self-discovery.

Surgeons have a unique opportunity to discuss issues of mortality, spirituality and values as part of a larger conversation addressing the potential outcomes and expectations of an operation. Often, patients may have never thought about, let alone discussed, these possibilities. Unlike the patient with chronic illness, a person about to undergo an operation has an expectation of complete recovery. This makes heady conversation less threatening. Because the surgeon will not be the patient's long-term health care provider, there can be a sense of anonymity as well as intimacy between doctor and patient.

The art of being a surgeon-healer requires the skill of quickly developing rapport with each patient, and understanding that surgery, no matter how minor, is always a sentinel event in a patient's life. Of course, there is a technical side to surgery. One needs to learn how to sew, what to cut and where to avoid cutting. These skills come with practice and get honed every day in the operating room. There are also intellectual aspects: finely tuned diagnostic acumen; a large knowledge base; judgment about when to operate, but more importantly, when not to operate. Both the technical and intellectual requirements can be taught.

In my experience of training surgical residents, I never encountered anyone who didn't have the potential to master technical and intellectual skills. Whenever someone left the practice of surgery, it was for lack of what I will call the spiritual side. In what other profession does one need to possess the *hubris* to believe he or she can perform an operation and care for a patient as well or better than anyone else? At the same time a surgeon must possess the humility to

face his or her fallibility, which in some cases can cost the patient's life. If one lacks this combination of *hubris* yet humility, how can a surgeon ethically take the responsibility of asking a veritable stranger to relinquish control as a patient, and turn over to a surgeon the power of intimately handling his or her body?

A surgeon has a moral responsibility to believe in his or her ultimate medical competence. If that is not the case, the surgeon should refer the patient elsewhere. At the same time, a surgeon must have the humility to accept mistakes, technical mishaps, lapses in judgment, or even loss of a life, and make them learning experiences to be avoided again at all costs.

**Most of us don't want to confront our mortality. We live our days with the expectation that there will be a tomorrow. But when a person is faced with the uncertainty of another day, every moment becomes important.**

Most surgeons participate in Morbidity and Mortality Conferences during which complications and deaths are rehashed with brutal honesty. The individuals present their own cases, and their actions are scrutinized by peers with the intention of educating everyone present, thereby improving everyone's practice. Yet even the most scathing criticism by peers pales in comparison with the self-flagellation that follows an unexpected outcome.

I will never forget the day Mr. JC died in the operating room. I had performed three operations on him in the previous seven years. He suffered from advanced adreno-cortical carcinoma, a disease for which there is no effective chemo- or radiation therapy. The usual life expectancy, once diagnosed, is less than five years, but with aggressive surgical debulking of the tumor, survival can be prolonged.

On the day of his death, he was brought to the operating room and the anesthesiologist began to administer general anesthesia. Unfortunately, the anesthesiologist inadvertently administered anesthetic gas when he meant to give oxygen. The patient developed a fatal cardiac arrhythmia and



could not be resuscitated. I was heartbroken but appreciated that the anesthesiologist had been honest enough to tell me exactly what had happened. Although he never received an operation that day, I left the room and explained what had happened in detail to the family. We mourned together. They thanked me for taking care of JC. Since that day, I relive that time in the operating room a thousand times, and even today, more than twenty years later I still vividly remember the incident.

## **Contrast Between Surgeons and Family Doctors**

The surgeon-patient relationship is unlike the Marcus Welby-patient relationship. The former is like a torrid love affair that may not last a long time, but will always be remembered; the latter is more akin to a comfortable marriage. One of my mentors often said that there was no minor surgery, only minor surgeons. Every surgeon embraces a covenant between himself and the person undergoing an operation. It is different from the covenant between a patient and his

primary care physician. The surgeon's contract is usually for a single problem, like that of a defense attorney to his client awaiting trial. The primary care doctor is more like a general-practice lawyer on retainer.

I chose my specialty because it provides immediate gratification and tangible results, and because I enjoy the intensity of the relationships I have with my patients. The choice of specialty is a highly subjective personal decision, and each area of medicine has its unique role to play in the care and well-being of its patients.

Regardless of specialty, a physician's role is twofold: to cure disease and to make the patient feel better. In the best of circumstances, both ends can be achieved. The reality is that even when there is no cure in sight, one can always make the patient feel better. Pain can almost always be controlled if not completely eradicated. A kind word, a gentle touch, some extra time, and an understandable explanation transcend the chasm between caregiver and care recipient, and by doing so, truly heal.

### LAMENT FOR A DYING FRIEND

I know you will not be here much longer  
Your prayers which asked for more time:  
Now plead for less pain.  
We once planned and schemed and looked to the future  
Today I hear only your reminiscences and good-byes,  
And even they become less audible as you back away.  
Even as I long to make firm our close connections  
You drift off into another realm as if you've already bade farewell to the past.  
Once you are settled wherever you will be,  
Please visit me in my dreams.

Maria Allo, January, 2013

# A Spiritual Journey: My Experience of Muscular Dystrophy

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*Mark Hehir*

A few times throughout my journey I've had people question the quality of my life. They have tended to judge who I am by what they see externally, rather than looking at me as the person I am. How can we truly know the quality of another person's spirit by just looking from the outside? It's something many of us might do at some point.

We can look at someone else's life journey and wonder why they don't seem to have as many challenges and obstacles as we do. They live in an expensive home and have all the comforts that money can buy. They seem to be living the easy life. God, however, doesn't really care what a person's financial net worth is. God wants to know how rich a person's spirit is, a wealth that all the money in the world can't buy.

This development can only come by waking up the spiritual part of yourself and acknowledging your faults and weaknesses. After this recognition you can begin to learn to grow as a person of spirit, not focused on material advantages.

My spiritual awakening began at an early age. Because I was born with muscular dystrophy, I was never physically as strong as other people. At times, this made it challenging to make friends at school. I was sometimes treated as being different because of my physical weakness and limited abilities for running and jumping. There were also times when the physical education instructor would tell me to watch from the sidelines as the other kids played a game like flag football. It wasn't that I didn't want to play. The instructor was worried I would get injured because I was so thin and frail-looking. The first couple of times this happened I was embarrassed and saddened because at that time, I didn't understand why I had to sit on the bench. However, this isolation helped me to focus internally as I sought out the answers to the question, "Why am I different?" It was during this time that I started to learn how to accept who I was, and as I began to have more confidence in myself, my life path started to become illuminated.

For most of us, our life paths are dotted with many obstacles and detours. We try to make the right decisions along the way, though sometimes it is by trial and error and often we have to repeat to ourselves the

words, "When will I ever learn?"

A friend of mine once asked me why she kept making the same mistake over and over again. I replied, "Because you haven't learned the life lesson from that mistake and, until you do, you'll keep repeating it." This realization is what I have experienced throughout my life journey, trying to learn from my mistakes and then continuing on my spiritual journey until I came upon my next life lesson.

Even though I was limited physically, I still was very fortunate to be able to experience many things, like traveling around the United States and to other countries. Along the way, I met people from different cultures, different religions. I had conversations with some who traveled along their spiritual journey guided by their own philosophy of life. From these experiences, I learned not only more about the world around me, but also more about myself. I might not be

physically strong, but I could still strengthen my spirit. This inner strength would one day test me like I'd never been tested before.

After having a dramatic personal experience, some people reflect how that point in time changed their lives. For me, that

life change came in the summer of 1996.

I don't remember much of the first two weeks at Good Samaritan Hospital, just a few images of doctors and nurses hovering over me. What I do remember, though, was seeing myself inside of a dark, swirling tunnel. I could feel myself being pulled up into this vortex as voices called out to me. It was at that moment that I realized that I was being given a choice. Did I want to live, or did I want to give up and end this life journey? For one who had always enjoyed life, I fought with all the strength I could summon.

Sometime later, I woke up in the ICU and found out that due to the progression of my disease, I would from now on require the use of a wheelchair and, even worse, a ventilator to help me breathe.

Later that night, as I listened to the breathing machine emit a sound with every breath I took, I realized that the life path I had been traveling for 40 years was closed, but a new life path was now being laid out before me. All I needed to do was put my faith in God and take that first step forward.

In nature, if creatures are to survive, they have to

adapt to their environment. This also applies to one's own everyday life. In my case, I spent the next few months adapting to my new way of living. Wherever I went and whatever I did, I would always have to have my ventilator with me. Before, I had been living the life of a single person, enjoying the freedom of going anywhere I wanted to. I had a good job, a nice apartment, and whenever I needed to get away and go somewhere, whether it was to the beach, or a weekend trip to a ski resort, all I had to do was to get into my car and drive off.

Now, though, I required the help of others to do many of the things that I had once taken for granted. This became one of my biggest challenges. Even though I had learned to accept who I was, with all my flaws both physical and spiritual, now life was teaching me to accept, without guilt, the help of others.

Just as we use tools to get things accomplished in our everyday lives, I will use certain words as tools to help keep my spiritual foundation strong. Besides using the word "acceptance" I also use the word "thanks" to help reinforce my spirit. I'll say this word quite often and for simple, ordinary reasons, like being able to go to the beach, explore a wheelchair-accessible forest trail, or even to make a short trip to the grocery store. For each one of these experiences, "Thanks" is given.

The reason I'm so grateful by saying, "Thanks," is because my disease is progressing and, with each

**God ... doesn't really care what a person's financial net worth is.  
God wants to know how rich a person's spirit is...**

passing year, things are becoming more physically challenging as my muscles continue to weaken. In return, though, by knowing and accepting this, my life path is much clearer and more focused. Those little things in life that we can at times get upset over aren't as important to dwell on, because each day of life is just too precious to me.

There always seems to be a new life lesson for me to learn and to understand. Sometimes, when my spirit is weak, I'll wish I weren't so limited by how far and how long I can be away from home due to medical issues related to my disease. There are many places I would like to travel, like Japan. I have siblings and friends who live far from here. I wish I could go visit

them. During times like this, though, God will remind me how blessed my life is and how I need to appreciate what I have around me, for I am still able venture out and enjoy many places nearby. Many people on ventilators and in wheelchairs don't have the luxury of enjoying this kind of recreation. Sometimes, I just need to turn on the news and see how well off my standard of life is compared to others.

My family and friends have made sure that I am well taken care of. Whenever I need help with something or want to go somewhere, they always answer my request. A person's spiritual life, though, is about more than just receiving. It's also about giving. This became another big challenge for me. How does one give back when one has very limited physical abilities?

Because I am still able to visit places like the beach, the zoo, or one of many State parks that have wheelchair-accessible trails, I began to take pictures and make movies of these adventures. I wanted to share them with others who might be wheelchair-bound. I also have some computer skills, so I offer my help to family and friends whenever they need typing and printing or fixing their computer. Giving back, though, doesn't have to be a physical thing. Just saying, "Thank you,"

from your heart and with a smile can be a way of giving back for some kind act that was given to you. That's something I try to do on a daily basis.

Every day is like a session in the school of life, for there is always something new to understand and learn from. That is one of the reasons, at the end of each day, I'll say a prayer of thanks for this day of life. Another reason for this prayer is because many who were born with muscular dystrophy never made it to adulthood. I am one of the few lucky ones with this disease to have been able to live a long life. This gift of extra time that God has blessed me with has let me try to learn as much as I can about myself so I can become a better person and, even more importantly, spend time learning from, growing with, and loving my family and friends.

A few years ago, one of my doctors asked me how was I handling being disabled and breathing on a ventilator. As I told him back then and what I say each day, "I take each day as it comes with hope and a smile in my heart." My favorite daily saying is, "Life is good!" And thanks to God, my family, and friends, it is very much so.



# Guadalupe: A Source of Healing for Latina Women

Sandra Jewett

As Catholics, we hold Mary of Nazareth in a very esteemed place. On the surface, we know that she was a young, uneducated Palestinian girl, of humble beginnings, who lived in an intolerant male-dominated society. Yet, this ordinary Palestinian woman who lived two thousand years ago is a courageous figure of faith, courage, and strength. She is a woman who has transcended all time, both through her example for women, and through her apparitions. Mary is a living figure who is constantly reminding us to seek Christ in all things.

As I reflect on my past and on my life, with its many gifts and challenges, I have realized that as a Latina, my spirituality as a woman is deeply rooted in my family tradition. I come from a family of very strong women whose spirituality was tied to Mary. My mother, my grandmother, my great-grandmother, and my ninas (godmothers) – all the women who surrounded me – found comfort and strength in Mary of Guadalupe.

For me, as for many Latinas, whether or not we are fully practicing Catholicism, our sense of spirituality is deeply rooted on our relationship with Guadalupe. And just like my mother, her mother, her mother's mother, and other female relations, we have all found strength through each other's love and support. Similarly, I believe that one's personal relationship with Guadalupe spills over the Latina's spiritual life as she responds to her daily challenges and her interactions with other women.

## The Vision of Guadalupe

In an effort to put things into the appropriate context, let me briefly say that the *conquista* (when Hernán Cortéz overthrew and conquered the Aztec empire in 1521) totally destroyed the Aztecs' elaborate and coherent symbolic system that helped them make sense of their lives. In ten years, the Spaniards demolished the Aztec culture,

destroyed all their temples, killed their nobility, raped the Aztec women, and brought disease. Within a short time after the *conquista*, they stripped the Aztecs of a sense of human dignity. A conquered people began to believe that they had no value as persons. However, in four days, Our Lady of Guadalupe (hereafter she will be referred to as Guadalupe), restored the Aztec people's self-worth, dignity, culture, language, and spirituality. Moreover, she promised that she would always be with her people; they just needed to ask for her help.<sup>1</sup>

From December 9<sup>th</sup> to 12<sup>th</sup> in 1531, Guadalupe appeared to Juan Diego, an impoverished Aztec who had converted to Christianity. And just as Mary spoke to Bernadette in French at Lourdes, or in Portuguese when she appeared in Fatima to Jacinta, Lucia and Francisco, Our Blessed Mother spoke to Juan Diego in Nahuatl – his mother tongue.

When she appeared to Juan Diego on the slopes of the Hill of Tepeyac, she told him that she was the ever Virgin Mary. She instructed him to see the Spanish Archbishop, Fray Juan de Zumárraga and to relay her request to him. Juan Diego's first reaction was to ask Guadalupe to pick one of her priests or

someone equally important. Upon her insistence, he responded, "I am a nobody, I am a small rope, a tiny ladder, the tail end, a leaf."<sup>2</sup> His reply certainly reflects the deep level of worthlessness that he and his people had experienced after the *conquista*. Needless to say, this is the reason why it was so important for him to be the bearer of Guadalupe's request.

Upon hearing Guadalupe's request via a "mere" Indian, Archbishop Zumárraga required a sign to prove her identity. On December 12, 1531, Guadalupe asked Juan Diego to gather roses from the top of the arid Tepeyac Hill. There, in the

**I believe that one's personal relationship with Guadalupe spills over the Latina's spiritual life as she responds to her daily challenges and her interactions with other women.**



middle of winter, he found Castilian roses, not native to Mexico. She arranged them in Juan Diego's tilma cloak and asked that he only give them to Zumárraga. When Juan Diego was finally allowed to see the Archbishop, he dropped the flowers to the floor and miraculously imprinted on his tilma was the image of the Virgin of Guadalupe.<sup>3</sup>

The image of Guadalupe is filled with symbolism. For example, the mantel that covers her head is turquoise, a color that symbolized nobility in the Aztec culture. Her greenish eyes are cast downward in an expression of loving concern. Her hair is black and her complexion is olive – the intermingling of two races – Indian and European. She stands leaning forward as a mother would lean over to ensure that her child was safe. The image is imprinted on a tilma, which is made of a cactus fabric, coarse and unsuitable for a painting. Yet, even after more than 450 years, the image of Guadalupe remains brilliant, and despite a number of natural and man-made disasters, it remains intact. The image itself is filled with mystery and has been the object of scientific speculation.<sup>4</sup> Replicas can be found all over the world. The original can be venerated at the Basilica of Our Lady of Guadalupe in Mexico City.

## The Role of Guadalupe for Latinas

I would like to point out that Guadalupe is not a submissive woman willing to accept oppression and marginalization. Guadalupe is a complex woman of faith, courage and strength, who serves as a constant role model. For Latinas, Mary of Guadalupe is our confidant, helper, and intercessor – our unconditional friend who will never let us down. In her apparition to a marginalized Indian in Mexico City at Tepeyac Hill, she reminds us that as our mother, she will care for us; we just need to ask.<sup>5</sup>

As a result, Guadalupe has continued to be a transcendent figure who personifies motherly love, empowerment, strength, healing, courage and compassion. For Latinas, Guadalupe is a relevant, powerful teacher and a dynamic role model who gives us hope and lovingly shows us the way back to what is most important to us: her son.

Culturally, Latinas find inspiration from the many women who are responsible for shaping our lives. These women, whether our mothers, grandmothers, aunts, or sisters, inspire us to reach our potential. Hence, Guadalupe plays a double role in our lives. As our loving divine mother we can turn to her at any time. She serves as our best friend who understands our problems and our pain. From Guadalupe, we draw strength and healing. In other words, Guadalupe is not only the mother of the living God, but she is a woman like us, who understands us because she walked in our shoes. She who listens because she, too, experienced despair. By her promise she will lift us even when all seems hopeless.<sup>6</sup>

In her apparition to Juan Diego, she assures him that his people have worth, that they are equal in the eyes of God, and that she will always be a loving mother to all. For Juan Diego and the new *pueblo* or community of *mestizos*, (the offspring of the indigenous peoples and the Spaniards), the encounter with Guadalupe not only validated their self-worth, but also honored their language, culture, and experiences as descendants of a proud and ancient civilization. In his book *Guadalupe: Mother of the New Creation*, Elizondo describes this new race as neither Spanish nor indigenous, neither Mexican nor North American, but as a dynamic mixture of all these root cultures. Elizondo describes Guadalupe as the mother of the

**Guadalupe is a complex woman of faith, courage and strength, who serves as a constant role model. For Latinas, Mary of Guadalupe is our confidant, helper, and intercessor...**

new generations to come, who provides hope and inspiration for Mexican Americans struggling to embrace their *mestizo* identity as a blessing, to synthesize the richness from their parent cultures and to be transformative agents of Guadalupe's power to harmonize diverse peoples.<sup>7</sup>

## Life Experiences of Mary

My own relationship with Guadalupe is quite intimate. I have grown to love and admire her, not because she is the unreachable Mother of God, but

because she is a woman of action. Guadalupe is not a pious woman in heaven, who meekly looks down at the flock. Rather, she is an empowering figure, always leading us back to God. Perhaps a simpler reason why Guadalupe, Jesus' mother, is so relatable and relevant to Latinas is due to her life experiences. In fact, in one way or another, women from all walks of life share many of Mary's experiences. Like many young newly immigrant mothers-to-be, Mary found herself, without her mother's guidance and support, when she gave birth to Jesus. Like many immigrant

**...Guadalupe is not only a mother of the living God, but she is a woman like us, who understands us because she walked in our shoes.**

families, she too left her beloved family and fled from her homeland only to wonder if she would ever see her parents again. Equally frightening, she too experienced the confusion in arriving in a country where her language was not spoken.

Like many single mothers, she became a widow and raised her child single-handedly. And tragically, she experienced the worse pain of all – witnessing the killing of her son and the deep pain of burying her child. Certainly, her life experiences are far more than any of us could understand or possibly endure. So then, whether we think of Mary as a daughter, a teen mother, an immigrant, a wife, a friend, or a widow, Mary was no stranger to affliction, discrimination and oppression. However, through God's grace and her deep sense of faith and courage, she kept her relationship with God in the forefront. As a result, Guadalupe plays an important part in the daily lives of Latinas. Regardless of their socioeconomic status, the modern Latina, invites Guadalupe into her life and in doing so, Guadalupe becomes the core in how Latinas relate to our loving Creator.

## **The Story of Isabel**

Most of us, in one way or another, have experienced traumatic events, such as illnesses and near-death experiences that have moved us

deeply. These have served as wake-up calls to a deeper realization that life and those we love are precious gifts from our living God. This reminds me of Isabel, a successful professional, who angrily left the Church after her divorce, but did not lose touch with Guadalupe. On the contrary, she saw Guadalupe as the powerful motherly figure in the life of Jesus and an influential figure in her life.

As she continued to seek God in her life, Isabel found solace in her own spirituality through meditation and inspirational writings. For about ten years she managed to avoid “churchy” events until she met Francisco, who was a practicing Catholic, and whom she eventually married. Subsequently, her love for her husband brought her back to the Church. For the most part, all was going well in her life, her marriage, her home, her career, and her finances.

But late one afternoon, she got a phone call from her mother, letting Isabel know that she had been diagnosed with breast cancer. It was devastating news for the family.

Isabel's elderly parents, Carmen and Roberto, had moved back to a small town in Sonora, Mexico in an effort to live a comfortable lifestyle, while keeping the cost of any future medical bills down. However, Isabel's elderly parents had not thought about how this decision could impact Isabel's ability to care for them, now that they were living hundreds of miles away.

Isabel's immediate reaction was to request, on her Facebook page, prayers for her mother Carmen. As the days went by, Isabel waited to hear any news from her mother's oncologist. As much as Isabel attempted to concentrate, she couldn't help the tears welling up in her eyes. She became frustrated at her own inability to meditate or pray. She spent most of her time in front of a computer, learning everything she could find about breast cancer, its phases and cures. The more she learned about this terrible disease, the more devastated she felt. Moreover, as time went by, the prospects for her mother's return to health did not appear to be getting any better.

Isabel began to question whether or not her prayers were being answered. She found herself either crying for hours, negotiating with God for her mother's return to health, feeling guilty for

being such an emotionally distant daughter, or becoming angry at God for making her mother go through such a horrible experience. She spent most of her hours praying, reading up on breast cancer, crying, and praying some more.

Francisco, Isabel's husband, suggested that she take an extended family leave through FMLA (Family Medical Leave Act) and return to Sonora, Mexico, to care for Carmen. Isabel could not thank Francisco enough for his understanding and support. She was overwhelmed by her conflicting emotions. On one hand, she was so scared of losing her mother, and on the other hand, she felt blessed to have such a loving and supportive husband.

One afternoon, while her mother napped, Isabel found herself digging through old family albums and accidentally found a small medal of Our Lady of Guadalupe that she had worn at her First Communion. Her mother had neatly secured both the medal and chain to Isabel's First Communion picture. Isabel was surprised to see the old medal and chain; she had forgotten about it. While holding it, she flashed back on her childhood and could relive the moment she first noticed Guadalupe's tender look. She remembered feeling so taken by her glance that she was certain that Guadalupe was rejoicing at her celebration.

As she looked at the album, she could see how her mother Carmen had lovingly secured her child's favorite medal to this photograph. Isabel could feel her mother's love pouring right through the medal. At that moment, Isabel felt like a little lost girl who couldn't find her mother. Isabel just kept on holding on to the medal and noticed that Guadalupe's posture appeared to be saying, "Are you not under my protection?"<sup>8</sup> Isabel broke down in tears and began talking to Guadalupe, as if she were sitting across the table from her. Isabel put on the chain, and sobbed. She shared with Guadalupe her fears and her pain. The more Isabel unloaded her heavy burden on Guadalupe, the more she began to feel at peace. As a greater sense of peace enveloped her, Isabel took a deep breath and realized that she was feeling God's love and presence in the midst of chaos and uncertainty. It was as though she was experiencing the unique opportunity to be in total

communion with God and herself. And at that moment, Isabel realized she was not alone.

This realization totally took her by surprise. During her childhood, she learned that God was love; in her growing years, she learned to believe that God could be found in church. At 40, she turned inwardly to find God within her. Now at 50, Isabel found herself in her parents' country, walking with Guadalupe, down the long hospital halls. But unlike the Road to Emmaus, (Luke 24:13-35), where the apostles did not immediately recognize Jesus, Isabel recognized the presence of Mary and Jesus. She drew strength from the daily encounters she had with these two persons whom she had never actually physically met.

## Isabel's Responsibilities

Perhaps it was the awe of the experience that helped Isabel recognize how, despite the tragedy of the situation, she was blessed to be surrounded by strangers who supported her as unconditional friends. This was no easy task. Isabel was a strong, take-charge woman, who made things happen for her and those she loved. Yet, as if in the blink of an eye, Isabel realized that she had absolutely no control over the disease, the situation or the outcome. Equally unsettling, Isabel replayed the many times she could have been a better daughter. Her memories of being selfish, rude or dismissive of her mother's comments caused her to break down in tears of regret and shame. She wanted to take all those memories away and be a better daughter.

Certainly, intellectually, Isabel accepted that her behavior as a teen had been "normal," but the thought of being so insensitive towards her mother's feelings made her feel guilty, helpless and inadequate. She could only pray and accept her husband's unconditional love for her and for his mother-in-law. Perhaps it was this realization that allowed her to fully embrace everyone's help, including the support from total strangers, who through their actions, reminded her that she was not alone in this journey. She found Guadalupe's motherly love everywhere and at any time.

Even Francisco's inflexible boss offered to accommodate Francisco's 5-day work schedule to 4 days a week, allowing Francisco to spend weekends in Sonora with Isabel. Then there were

those back home, who gladly house-sat, fed the cat, and took the dog out for its daily walk. Or Carmen's family friends and acquaintances, who offered to bring food, run errands, and donate blood for Carmen's multiple transfusions. In short, Isabel and Francisco found themselves surrounded with the love of old and new friends. Truly, Guadalupe's, motherly love permeated the halls of that hospital, touching the hearts of many people.

In the midst of her mother Carmen's sickness, Isabel's stepfather Roberto had to be taken for dialysis a couple of days a week. Roberto was a kind man, who loved his faith and the Catholic tradition. Since childhood, he had developed a love for Guadalupe and warmly shared how Guadalupe was a member of his family; moreover, Guadalupe was of his race. His mother had died when he was ten, but he remembered how important Guadalupe was to her. So every week, he would make a point to take a rose to his heavenly mother, Guadalupe and to Elena, his mother, who was in heaven. He was convinced that both women had watched over him throughout his life, particularly during the Great War.

Roberto, a veteran of WWII, was filled with stories about the war for anyone willing to listen. He was proud of having been part of the "Bushmasters" who were in the 158th Regimental Combat Team, an Hispanic regiment that had been deployed to protect the Panama Canal. He proudly recounted his many experiences of jungle training. However, the highlight of his stories always came back his involvement in the liberation of the Philippine Islands. He excitedly recalled how General MacArthur referred to the Bushmasters as "the greatest fighting combat team ever deployed for battle."

However, Roberto was now in his 80s and his health was rapidly failing. His wife Isabel found herself having to make daily life-or-death decisions for either her mother or for her stepfather. Though Isabel was in daily contact with her husband Francisco and her closest friends, she often found herself overwhelmed. The prospect of losing her mother saddened her. She often found herself in deep thought, regretting the time she had wasted away instead of building a

stronger relationship with her mother and appreciating her mother's wisdom.

Her parents' illnesses became a period of uncertainty, stress, and anxiety. As time passed, Isabel took over the responsibility of becoming the sole caregiver for her two elderly parents. Carmen's recovery was uncertain and Roberto's diabetes continued to worsen; he now needed dialysis 3 to 4 times per week and she had to make sure that he would abide by a very strict diet. Ironically, Isabel's faith and strength was fueled by her mother's doctors. When Isabel's faith faltered, she found herself deeply taken by the doctors' faith in God and their relationship with Guadalupe, as evidenced by the religious icons in their offices, and their practice of praying together at the hospital chapel, and asking for healing and acceptance of God's will.

Isabel was also taken by the physicians' and hospital staff's commitment to treat Carmen as their own mother. The hospital room was always filled with caring doctors and nurses, who never hesitated to return to the hospital at the wee hours of the night, to ensure that Carmen was resting comfortably. Without fail, at every point in this journey, when Isabel thought she was going to literally collapse from trying to care for two sick parents, someone would unexpectedly arrive to help alleviate the burden, giving her enough time to nap or to shower.

## **Mother's Recovery and Father's Accident**

Finally, after a couple of surgeries, complications, and four months in the hospital, Carmen was released to go home. Carmen would now have to undergo six months of chemotherapy and upon completion, she would return to see her doctors for regular check-ups. It was a happy day when Carmen was released from the hospital. The hospital staff made certain to stop by with big smiles and best wishes as she prepared to leave the hospital. It was agreed that Roberto would wait at home, so that there would be enough room for everyone to sit comfortably in the small sedan. But as the saying goes, "When it rains; it pours." When they arrived, the three of them had a shock. Isabel opened the door to her mother's home and they saw Roberto lying on the floor, attempting to



get up. Apparently, he had slipped and fallen as he went to turn off the teakettle. He was now unable to stand.

Once again, Guadalupe was near. Not only had they arrived in time to help Roberto and to turn off the stove that otherwise could have caused a house fire, but Roberto's personal doctor arrived a few minutes later. He explained that though he had not planned to visit Roberto, he had just decided to stop by. After undergoing a brief examination, it was apparent that Roberto had broken his hip and needed immediate surgery.

Though the surgery was successful, within a couple of days, Roberto's health took a turn for the worse. Carmen's concerns revolved around their health issues, finances, insurance, and were further complicated by their new and unexpected pile-up of medical expenses. Isabel's primary concern was to ensure that her mother would focus on her own recovery and that Roberto could die knowing that all would be well for Carmen and the rest of the family.

When Isabel found herself at a loss for how to provide assurance and comfort to her mother, which seemed to be often, Isabel directed her conversation to Guadalupe and asked for her intercession. The doctor had indicated that given Roberto's condition, he had little time left. Despite his pain, Roberto was holding onto his life and attempting to continue with his regular routines as much as he could. Roberto loved to pray the rosary, but now, he was much too weak to pray, so while Isabel prayed, he held onto his beads and followed along.

One day, while she was praying the Glorious Mysteries, something compelled Isabel to stop, hold Roberto's hand, and assure him that it was time for him to let go. Her words conveyed her love and concern for him, while also assuring him that all would be well with his wife. He looked at her and smiled and said, "Yes, you are right, it is time to return to "Papa Dios." Because "Papa Dios" is a loving term used to describe God as a

loving daddy, Roberto's intimate relationship with God gave her an insight into how he saw God – a loving father who awaited him with open arms and gave him the strength to trust that God was in charge. Roberto's ability to let go was an answer to her prayers, since she only wanted him to live and die in dignity, while ensuring that her mother would be well during her last phase of treatment.

As each of those last days went by, Carmen began to worry more and more about her husband's health, and became less focused on her own recovery. Just as stress began to take a toll

**For them, Guadalupe understood their challenges, ... because she is a woman who also understands, first-hand, the love for one's parent and spouse. Through this intimate relationship, they ... sensed that God's healing hand had never left them....**

on Carmen's recovery, Roberto peacefully passed away, while holding his rosary. Roberto's death allowed Isabel's mother to refocus on her own health, which gave her strength to endure the arduous six-month chemotherapy treatment.

Today, Carmen is in remission. But as Isabel and Carmen look back at that time in their lives, they have no doubt that Guadalupe's intercession and Christ's healing hands had touched everyone around them, from the doctors to the orderlies, from the nurses to the cooks, from the paramedics to those in the mortuary. Each of them played such an essential part in ensuring that Carmen's recovery was successful; while providing for Roberto's last moments to be filled with dignity and comfort. Both Carmen and Isabel admitted that they held Guadalupe near, as both their confidant and consoler.<sup>9</sup> For them, Guadalupe understood their challenges, not only because she is Jesus' mother, but because she is a woman who also understands, first-hand, the love for one's parent and spouse. Through this intimate relationship, they both sensed that God's healing hand had never left them, no matter where they were.

## Lessons for Other Believers

Whether through an experience similar to Isabel's or Carmen's, we have all faced moments in our lives when the pressure mounts beyond what we believe we can handle, and we find

ourselves thinking that we do not have the strength to carry on. Sometimes, it might feel like we are trapped below the hard surface of a frozen lake.

**For Latinas in particular, Guadalupe helps ordinary women find meaning in their lives as they see the parallels between their lives and the life of Guadalupe.**

The obstacle appears to be impenetrable. When we do break through it, we find that a deep well of strength, inspiration and grace was trapped beneath that icy barrier the entire time. Sometimes we break through by cutting a hole into our resistance with the love and support of others, and sometimes we melt the ice with compassion for our healing and ourselves. Either way, each time we break through, we reach a new understanding of God's loving presence in our lives.

Likewise, just as we overcome a major obstacle or illness, we find a consoling presence waiting for us the moment we finally catch our breath. Sometimes, like Carmen, we endure one loss after another, wondering when we will get a break from life's travails. It does not seem fair that life should demand more of us when we feel we have given all we can. But as Isabel learned, Guadalupe stood by her side, allowing her to feel her protection and compassion. Isabel felt that she had an unconditional friend and a loving heavenly mother who would help her meet the challenges she faced, while healing her from guilt and remorse, bringing her mother back to health, and allowing for her stepfather to die with dignity, surrounded by loved ones. For Isabel in particular, she learned that Guadalupe had kept her promise of El Tepeyac – Guadalupe cared for her, Carmen and Roberto. Isabel only had to ask. Then she learned that healing is not founded on control, but rather in the letting go and knowing that “with God all things are possible”.<sup>10</sup>

Guadalupe unites Latinos, as people of God, in search for healing, compassion, peace and human dignity for all. However, for Latinas in particular, Guadalupe helps ordinary women find meaning in their lives as they see the parallels

between their lives and the life of Guadalupe. And just as women traditionally seek women friends to find comfort and belonging, Latinas seek Guadalupe as their source for strength and meaning in their daily lives. For Latinas, Guadalupe is a strong, courageous, loving and empowering figure, who is never tamed. She comes to our aid when the road is long and our hearts are broken, ever ready to rekindle our relationship with her and her Son.



## NOTES

1. Carl Anderson and Eduardo Chavez, *Our Lady of Guadalupe: Mother of the Civilization of Love* (New York: Doubleday, 2009).
2. Luis Laso de la Vega, “Nican Mopohua”, 1649. (<http://www.sancta.org/nican.html>).
3. Ibid.
4. Jeannette Rodriguez, *Our Lady of Guadalupe: Faith and Empowerment Among Mexican-American Women* (Austin: University of Texas, 1994).
5. Luis Laso de la Vega, “Nican Mopohua”, 1649. (<http://www.sancta.org/nican.html>).
6. Ibid., 4th Apparition (<http://www.sancta.org/nican.html>).
7. Virgilio Elizondo, *Guadalupe: Mother of the New Creation* (New York: Orbis, 1999).
8. Luis Laso de la Vega, op. cit.
9. Luis Laso de la Vega, op. cit.
10. Matthew 19:26.



# Wisdom That Endures

## Mission Leadership in Catholic Healthcare West (2005)

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Diane Grassilli, R.S.M.

The title is “Mission Leadership in CHW” because the planning committee first called it that, and I kept missing the deadline to change it. Based on what they asked me to speak about, it didn’t seem to match, so they said I could re-name the talk on the spot after I prepared my presentation.

So I thought about calling it “From Where I Stand.” That sounded familiar, as though someone famous wrote a book with that title, so I went on Amazon.com to see. There were 1,100 books with that as all or part of the title. So, it’s doubtful if any of this presentation will be original since I can’t even muster up an original title.

In any case, I’m going to look both back and ahead. So, for want of a better title, let me call it “From Where I Stood, From Where I Stand, and From Where I’m Perched.”

The Haitians have a proverb that says, “Where you stand determines what you see.”

I have an unusual vantage point because not only was I the Director of Mission Services at the time the system was formed, but I had the opportunity to help ghost-write some of the foundational documents. In that role and in a subsequent role as assistant to the President, and then as a board member and corporate member, I have attended every corporate member meeting since CHW’s founding and every board meeting with the exception of one year. So I have been standing around a lot, and have seen my fair share, believe me

As I began thinking about this presentation, I asked a Sister I live with if I could borrow her copy of the book by Parker Palmer, *Let Your Life Speak*. Of course she asked me why I wanted the book. I said, “I don’t know exactly, but I do know it’s going to tell me what I need to tell them.” So here I am and here we are – letting our life speak.

In his book, Palmer says, “I lead by word and deed simply because I am here doing what I do. If

you are also here, doing what you do, then you also exercise leadership of some sort.”

Later, I’d like to say a few words about what I hope we do, but let me begin with what I do. When Thomas Merton was asked this question about his life as a monk, he said something like, “What I do is pray; what I wear is pants.” So I can say what I do is pray – but not enough. What I wear is size 8, mostly. And what I do today, right here this morning, is tell some stories.

That is one way to lead because dictums never inspire and policies rarely motivate an organization, but stories can. If you think about it, stories can be very powerful.

Elie Weisel introduces his book *Gates of the Forest* with a story that sets the tone. He begins:

When the great Rabbi Israel Baal Shem-Tove saw misfortune threatening the Jews, it was his custom to go into a certain part of the forest to meditate. There he would light a fire, say a special prayer, and the miracle would be accomplished and the misfortune averted.

Later, when his disciple the celebrated Magid of Mezritch had occasion, for the same reason, to intercede with heaven, he would go to the same place in the forest and say, “Master of the Universe, listen! I do not know how to light the fire, but I am still able to say the prayer.” And again the miracle would be accomplished.

Then it fell to Rabbi Israel of Rizhyn to overcome his misfortune. Sitting in his armchair, his head in his hands, he spoke to God: “I am unable to light the fire and I do not know the prayer; I cannot even find the place in the forest. All I can do is tell the story, and this must be sufficient.” And it was sufficient.

As leaders within CHW we must continue to tell our stories. One of the stories I was asked to share with you is – from my perspective – why CHW came into being back in the mid-1980’s, and how we arrived at who are today. This includes a little about how sponsors and board

**“Where you stand  
determines what you  
see.”** (Haitian proverb)

exercised its leadership in this process, and still do.

CHW began with the vision of Sr. Maura Power, R.S.M., and Sr. Terese Marie Perry, R.S.M., who were Presidents of the Auburn and Burlingame Sisters of Mercy. Besides their compelling vision of bringing the Mercy health ministry together, there were in 1986, familiar themes of:

- Better not to go it alone; even small systems won't survive;
- The future is in joining together;
- Think of the efficiencies;
- Think of the borrowing power and lower interest rates.

But all was not completely rosy. Some of you in this room were around at that time. To be candid, there were also some people on staff voicing nervousness about knowing we were engaged, and not really sure if we wanted to get married. Some others were informally voting with certain buttons.

While this may have been background noise, the sponsors, in fact, were the ones driving this new moment. What the sponsors wrote in the first mission statement was their desire:

- To strengthen existing ties;
- To stimulate new linkages in the West, and
- To advocate for the poor.

The vision and intention of the two founding Mercy communities – from where I stood – was:

- To reinforce the ministry they knew;
- To anticipate how the ministry would evolve; and
- To dream about the voice they could be in the public square.

We did indeed strengthen what we had begun. The two systems became stronger as one. We weathered some pretty difficult early days with a downturn in the market. We did stimulate new relationships. We knew the Dominicans were going to consider their future structure within a few years. That was why we moved from a Mercy-related name to the more descriptive name of Catholic Healthcare West. The Adrian Dominicans joined us in 1988 and became the third sponsor of CHW.

The genius of that moment in 1988 was to “put our money where our mouth was.” The Sisters of Mercy hoped that CHW would be a true co-sponsored system. When the Adrian Dominicans were looking to join us, there was a clear decision made in the boardroom one day: We would be *equal* co-sponsors. Regardless of the assets brought to the table, the seats around that sponsor table would be equal in relation to each other. We would honor the various sponsor traditions, but we would work toward a shared CHW culture.

It is a little-remembered fact that CHW's five corporate values that you see listed everywhere were not part of the original documents. It was well into the 1990's when we articulated those. We had a few years of lived experience at that point, and those values were named and adopted formally through a system-wide process. However, the draft was written through a group process of asking the entire corporate staff in a general staff meeting. Everyone including executive coordinators to the CEO's – to name what they thought were CHW's values. We agreed on five and that list was then tested within the hospitals. The language for the descriptors was the work of a small group. It was carefully approved by the board and the sponsors. (But the final author was one of the leads on our communication staff, a woman who now is with Kaiser and one of the key writers who helped create their very successful marketing campaign, *Thrive*.)

Around that time we also made serious efforts to move toward greater collaboration of sponsors and lay colleagues. In 1991, the sponsors delegated many of their reserved rights as the corporate members of this system to the CHW board. They retained only those powers that were required to maintain oversight of the ministry and hold it in trust.

We realized that we were not just trying to bring together many cultures. Rather, a shared CHW culture had begun to be created. This hope was spoken most clearly by the Adrian Dominican sponsors during discussions among the corporate members.

What we didn't know at the time was that we would not just link up with hospitals which shared



our particular faith tradition. What we could not imagine then was that we would shortly join with hospitals solely because they shared our values. This was a huge leap for our original sponsors, but a welcoming that has enriched us many times over, and not just through the balance sheets.

First, the Dominicans, and then each subsequent group: the Daughters of Charity, the San Rafael Dominicans, the Sisters of Charity of the Incarnate Word, the Kenosha Dominicans and the Franciscans – and then our community-based hospitals. All brought us, as Sisters of Mercy, into places that we might never have come on our own.

The linkages – perhaps different from the ones envisioned in the first mission statement – expanded as more and more hospitals in the West viewed their future in a larger system and especially as the for-profit systems entered the local markets.

Beginning around 1994, we saw phenomenal growth with hospitals asking to join CHW – both Catholic hospitals, and those that did not spring from the Catholic tradition, but whose values we shared. Sometime they even put us to shame in how they lived out those values.

By 1995, the Daughters of Charity had joined CHW. As we began to re-organize our governance structure and plan for the greater growth we saw coming, we realized that is every group of Catholic sponsors made good on their exploration of CHW, we would go from four sponsors to sixteen! Let alone other systems which were knocking at our door.

As it was, we assimilated five more sponsors in a period of about two years.

There were a number of gradual changes:

- We began to move from an equal number of seats at the sponsor table to understanding and expressing our equal responsibility for the ministry.
- We began to appoint Sisters from the various co-sponsors to boards that had been traditionally been named by only one sponsor.
- We began to welcome an even larger number of other not-for-profit community-based hospitals.
- The CHW board expanded to include different areas of expertise.

By this time we had a lay CHW board chairperson and two more followed him. At the height of our growth, we counted almost 50 hospitals, ownership interests in several medical foundations and physician organizations, and several joint ventures which provided specific local services.

We asked ourselves, “What did we create here?” And, “Who exactly are we?” There were moments when we had a stunned feeling from the tremendous growth and we were at a loss for words to describe what was happening. In 1996, I gave a presentation to the annual conference of Consolidated Catholic Healthcare. When I was asked about how I experienced the growth of CHW, I facetiously used the words of the artist Jasper Johns. When he was questioned about his artistic process, he said, “It’s simple. You just take something and do something to it. Then you do something else it. Pretty soon you’ve got something.”

There were moments when that was all you *could* say, and frankly in my sometimes cynical view, it pretty much described some of the arrangements we had gotten into.

But contrary to what some people may have thought, this growth was really deliberate and purposeful, clear at least on the part of management. While the board and sponsors may have been swept up a bit in to management’s enthusiasm, they did not go into this period with their eyes closed, by any means.

The strategy at the time was to be first or second in key markets within our three western states. By building integral relationships with physicians and being the “must have” hospitals and physician groups in the major managed-care markets, we believed our presence would have both meaning and effectiveness.

Truly this was more about strengthening our role in health-care delivery, and in some ways preserving non-for-profit health care. But in the back of our minds – though not articulated often enough – was the vision that maybe we could finally be a large enough presence to have a voice in shaping public policy. This was one part of the dream in our original mission statement.

At this point we also gained a new understanding of an old insight:

- We could make a difference in our communities;
- We could provide not just acute care services, but partner with other who were trying to create healthier communities;
- As often the single largest employer in a regional community, we didn't have to be the whole show, but could join with others who knew how to address certain needs in ways more effectively than we ever could;
- We could leverage our presence and our resources.

By this time, the Mission Statement was revised to be what we know it today, furthering the healing mission of Jesus by:

- Delivering compassionate, high quality affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

I am sure you can understand that it was difficult to assimilate all this growth in so short a period. Deals were being closed every few months, and sometimes within weeks. Certainly not enough attention was being paid to integrating the variety of cultures and communities into the CHW culture, which by this time had begun to emerge.

In 1986, the sponsors envisioned themselves as advocates for the voiceless. By 1996 we were big enough that we had begun to be recognized by government, payors, physician groups and labor. However, our voice was still feeble and sporadic. We were leading our health care colleagues to recognize our social responsibility. However, we were invisible in the halls of government. When we did gain visibility, we were unwelcome because of our entanglement with organized labor.

In ten years, we had gone from implementation of our philosophy, to mission effectiveness, to a broader concept of mission services. Nevertheless, we were far from an understanding of mission integration. "Community benefit" was a concept that struggled to get onto the agenda of management and governance. Still, we were riding a wave.

From time to time, some unfortunate themes surfaced. One of the worst and most odious slogans in Catholic healthcare ministry was, "No margin – no mission." This phrase, unquestioned and so catchy, nevertheless undermines the integration we strive for in Catholic health care. The phrase "no margin, no mission" has the unwanted effect of creating a kind of split-personality within an organization.

It can be a justification for a focus on the bottom line that excludes consciousness of why this health-care organization exists. It can give primary attention to financial resources, and diminish a focus on people, our patients and our communities. The phrase spawns a false dichotomy. I hear people make reference to "our mission work." I wonder what this is, as opposed to our real work. Saving the current institutional form cannot be our goal. Rather, the goal is our presence and service in our communities, in whatever shape the current age calls for. This is what is central to our ministry today.

Essentially our efforts are not aimed at a bottom line so we can survive. But that's unwittingly what the message of "no margin, no mission" becomes. Good stewardship of our

**In ten years, we had gone from implementation of our philosophy, to mission effectiveness, to a broader concept of mission services.**

financial resources, and our people and our earth, is absolutely integral to our mission, not separate from it. Bob Johnson, CHW's first general counsel, use to say, "We are not a business with religious overtones. We are a ministry run like a good business."

Now don't get me wrong. I like and can spend money with the best of them. But I come from a group whose foundress, Catherine McAuley, said things like, "While we place all our confidence in God, we must act as if all depended on ourselves." And "Since very little good can be accomplished without money, we must look after it in small as well as great matters." These insights were tempered with equally clear comments, such as, "Prayer will do more than all the money in the Bank of Ireland." The foundress of the Sisters of

Mercy had a balanced view. She saw our resources as a tool, one we need to use responsibly to serve people.

It's also important to keep the context in mind. One of the principles of Catholic social teaching is that of community and the common good. The human person is both sacred and social. Our tradition believes that human dignity can only be achieved and protected within a larger context – the context of community.

Parker Palmer speaks of the integration of stewardship within our mission this way:

In the human world, abundance does not happen automatically. It is created when we have the sense to choose community, to come together to celebrate and share our common store. Whether the scarce resource is money or love or power or words, the true law of life is that we generate more of whatever seems scarce by trusting its supply and passing it around. Authentic abundance does not lie in secured stockpiles of food or cash or influence or affection but in belonging to a community where we can give those good to others who need them – and receive them from others when we are in need.

That was a bit of a digression, but back to my story. We were ten years into this adventure we call Catholic Healthcare West. We were somebody and we were somewhere, but really, the journey had just begun. In the late 1990's as large as we were, our fortunes tumbled into the great abyss. You've seen the graphs. You know the acronyms that begin with S. You've heard the stories. You've heard some of the names and logos we toyed with. We lost our focus in the midst of the mergers surrounding us.

There are probably several themes that converged, but I will say that it was the sponsors serving on the board who first called the question. When they shared the board discussion with the full group of corporate members, they responded in effect, "Finally...what took you so long?"

Then began the real adventure. We had a change in leadership. We deliberately asked a member of one of the sponsoring congregations to serve as interim president. She was clearly

qualified, but we also needed to send a signal to our public that we would not implode. A sponsor had the benefit of more than a century of congregational commitment behind her. (Not that she herself was that old!) The message was clear: We were not going away.

A search committee was formed, and their first question was, "What kind of person are we looking for?" There were several key decisions at the beginning of a search of this importance. The one I want to highlight is the discussion about the kind of person we wanted to look for. We had to decide between someone who would be a turn-around specialist, or someone who would transform the system. Unanimously, we decided on transformation. At that point Lloyd Dean came on board, and I do think we are a different system today than when he arrived in 2000.

His first major challenge was to re-organize the system. We were well into this process when it became clear to one of our sponsors, the Daughters of Charity, that we had different understandings of what it meant to co-sponsor. They wished to withdraw, and form their own health system. That was a defining moment for all the co-sponsors.

The other co-sponsors were kind, but candid in the discussions that followed. While it was a very difficult time for all of us, it had its positive effects as well. A new executive team had just been brought on from other locations where they were already successful and had job security. What was passing before their eyes, when they learned the decision of the Daughters of Charity, was at least interesting to watch. However, I knew, and it was confirmed immediately, that

the other eight co-sponsors would not waver in their intention to continue with CHW. In fact, all the sponsors clarified why we were together, what we wanted CHW to be, and what we wanted to do.

Parker Palmer goes on in his book to make a case for letting your life speak by delving deeply into your heart and doing your inner work. We did our inner work in that period. We delved deeply into our own hearts and that of CHW, and we emerged stronger because of it. If the system

**Our tradition believes that human dignity can only be achieved and protected within a larger context ☐ the context of community.**

was going to break apart, this was going to be the moment. But that didn't happen.

Palmer also says, "The gift we receive on the inner journey is the knowledge that ours is not the only act in town." Not just the sponsors and the board, but the entire system has to say "Yes" again to this adventure in order for the future we have now to become a reality.

So today, from where I stand, are we perfect? I can see several things. We have stabilized and are more focused geographically than in the late 1990's. We are organized in a more purposeful manner. We are beginning to grow again, but more deliberately. We have somewhat better relationships with organized labor. We have clear mission integration standards. We audit these during the same meetings we audit our financial performance. We scored 74 in effectiveness in the DOC survey in Spring of 2004. This was up from 56 in the baseline score in Fall of 1998.

I also see that the tools to serve our communities are not all stored in San Francisco, but lie within the system at the individual hospital level, and within the communities themselves. We have moved from defining the community as the hospital's primary service area; instead, we define it as the area around us which has disproportionate, unmet health needs. We have advanced from health improvement with a private patient/ enrollee focus to one with a focus on a whole population's health. We have moved from a focus on charity care to sustainable community health improvement. We have shifted from random acts of kindness to coordinated programming. We have moved from proprietary planning and implementation to collaborative efforts. Finally, we are participating in initiatives to improve community benefit planning, and widen the scope of that benefit.

I can give an example of the last shift. In 2003, our community benefit expense was \$422 million. 95% was in reaction to the demand for healthcare services; 5% was invested in the communities for health promotion and disease prevention. In 2004, more than half a billion dollars was contributed, with 86% going to healthcare services and 14% to pro-active investment.

That's not all. Since the 1990's we have granted over \$19.5 million to more than 1,100 community-based organizations to promote the broader health of the community. Each year the program grows. In 1990 we awarded \$220,000 in grants. In 2004, 157 organizations received over \$2.2 million.

We have lent \$22 million at below-market-rate interest to community-based non-profit organizations working to provide affordable housing, employment training and social services to low-income families.

Each year, CHW uses its investment portfolio to engage 20 companies on important issues ranging from access to prescription drugs to reduction of greenhouse gases. Since 1996, we have worked to provide our health care services in a way that optimizes patient and employee health and safety, and minimizes our environmental impact. We were the first health care provider to sign the CERES principles. In 2004, at the invitation of the California EPA secretary, we became the first health care provider to join the California Climate Action Registry, a program for assessing, reporting and reducing greenhouse gas emissions.

We are actively creating and participating in the Ministry Leadership Center which will provide our management the opportunity to understand who they are as ministry leaders.

We have established spiritual care programs in our hospitals with trained and certified chaplains working side by side with the clinical team. (An aside on that discipline. In my early days as a Sister of Mercy, pastoral care meant a Sister visitor or a volunteer dropping by.) To have certified chaplains from many faiths present in our facilities is a marvelous gift. Families and patients are at their most vulnerable when they are in a hospital.

I have witnessed first hand how chaplains can be an integral part of the care team and serve patients, families and employees. While we have established patient/ chaplain ratios for the first time – an accomplishment in itself – we are far from where we would like to be. Yesterday, the sponsors spent some time at our meeting discussing this topic. We talked about the need to understand the chaplain's role on the care team,



clearly identify what we are trying to accomplish in this service, how best to evaluate our progress and what is the appropriate staffing within the system? Why did we talk about this? Because we recognize that spiritual care is an integral part of our health ministry, and it needs to be brought forward, recognized and supported. We have also defined Advance Care Planning, and are paying attention to palliative and end of life care.

We have a stronger voice in the public arena at all levels of government. We have defined advocacy priorities. We have greater influence and are beginning to have a hand in shaping public policy.

That's just what I know about. No, we are not perfect, but we *are* different from who we were even three years ago.

So what do I see on the horizon, from where I am perched on my mountain-top?

I see how far we have climbed. Do I get discouraged? Yes, even in my place in the organization, it happens. But before I turn around and see another mountain up ahead, let me sit up here for a minute and reflect on something else Parker Palmer tells me to tell you. He writes.

We have places of fear inside of us, but we have other places as well – places with names like trust and hope and faith. We can choose to lead from one of those places, to stand on ground that is not riddled with the fault lines of fear, to move toward others from a place of promise instead of anxiety. As we stand in one of those places, fear may remain close at hand and our spirits may tremble. But now we stand on ground that will support us, ground from which we can lead others toward a more trustworthy, more hopeful, more faithful way of being in the world.

So from this ground let me tell you what I want for us as an organization, but more importantly what I want for us as a community where each of us is important and together we are stronger.

I want us to use the voice we have found almost 20 years after our beginning. I want us to speak clearly for those who cannot yet speak for themselves, for those who are on the margins of

our communities, who can't get to our door. And if they do, they don't have the means to cross the threshold without jeopardizing the little they have.

I want us to welcome all who seek comfort and healing from our gifted hands and to have their spirit touched as well. When the doors of the next world begin to open before them I want us to stand along side and usher them into the presence of their God.

I want us to model for our colleagues how to care for our patients *and* care for our earth.

I want us to link arms with others in our communities to address the underlying causes of pain that too often result in the wounded striking out to wound others.

I want us to share our resources and convince others to leverage theirs to enable those who have lost hope to begin again.

I want us to recognize our core values in every program developed on our floors, in every discussion heard in our administrative suites and in every decision made at board-room tables.

I want us to give as much attention to *how* we do things as we do to doing them.

I want our human resources to be as important to us as our financial resources.

I want us to treasure one another for the gifts we bring to our work, for the commitment that keeps us climbing to new heights, for the humor that lightens our steps.

I want us to recognize that we, all of us, are the ones who make CHW a community “where we can give those goods to others who need them and receive them from others when we are in need.”

I want to take this moment as a sponsor and board member to say thank you for your commitment and your gifts, for making the mission more than words on paper.

Finally, I want us to delve deeply into our own hearts so that we can truly lead from within, so that even when we are unable to light the fire and do not know the prayer, and cannot find the place in the forest, we can tell the story, and it will be sufficient.



## Discussion Questions

**(Allo)** How has illness been a wake-up call to you to reappraise your life? What changes, adaptations and adjustments did you make as a result?

**(Dolak)** As you look at the development of our health care institutions over several decades, what shifts have taken place from “primary care” to other expressions health-care? How have the later programs reflected a shift in thinking about what “health-care” and “healing” mean?

**(Grassilli)** In considering the hiring of laypersons to lead Mercy health-care institutions, what sort of person is needed for these different moments of institutional life: start-up, stabilization and maintenance, turn-around, re-organization, and transformation? What skill-set is needed for each “moment”?

**(Hehir)** *“This gift of extra time that God has blessed me with has let me try to learn as much as I can about myself so I can become a better person and, even more importantly, spend time learning from, (growing with, and loving my family and friends.”*

If you have a health condition that’s chronic, what are the healthful attitudes that you have adopted that go along with the medical treatment you receive?

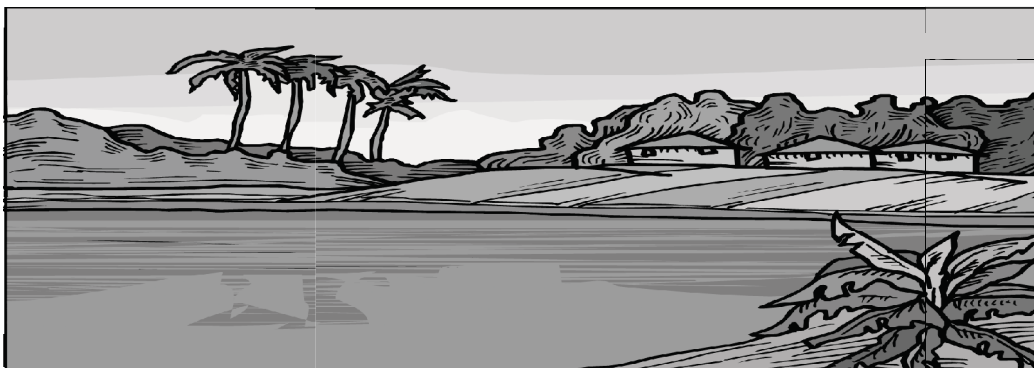
**(Jewett)** *“Hence, Guadalupe plays a double role in our lives. As our loving divine mother we can turn to her at any time. She serves as our best friend who understands our problems and our pain. From Guadalupe, we draw strength and healing. In other words, Guadalupe is not only the mother of the living God, but she is a woman like us, who understands us because she walked in our shoes.”*

How is Our Lady of Guadalupe a distinct apparition for women, compared with other apparitions, such as Our Lady of Fatima and Our Lady of Lourdes? What is the theological and devotional uniqueness of the Guadalupe?

**(Kerrigan)** This article surveys the healing of the hemorrhaging woman, the daughter of Jairus, the daughter of the Syrophenician woman, the deaf-mute and the blind man. After the healing of such a person, what is the “after-care” plan that a health-care professional might prescribe?

**(Turnbull)** Catherine McAuley didn’t attend nursing school, but evidently learned a great deal about how to care for the sick from people around her, and from medical professionals of her day. Even if you didn’t have nursing training, what things have you learned to do that promote healing of the sick? What practices have you adopted to maintain your own physical health, and mental and spiritual well-being?

**(Wainwright)** In your experience, how does the touching of someone have a healing or reassuring effect in a way that words alone don’t? What perspective on the humanity of Jesus is brought to the fore when we consider that Jesus needed healing and consoling, as suggested in the account of the woman who anointed him?



## Contributors

**Maria Allo, M.D.**, is currently Professor of Surgery (Clinical Affiliate) at Stanford University School of Medicine and Attending Surgeon, Division of General Surgery and Trauma at Santa Clara Valley Medical Center in San Jose, CA. She received her medical degree from University of Michigan Medical School, Ann Arbor, MI in 1975. Her M.S. is from Worcester Polytechnic Institute, Worcester, MA., and her B.A. from Smith College, MA. In addition, she holds a certification in Interior Design. From 1989 to 2006, she served as Chairperson of the Department of Surgery and was Chief of the Division of General Surgery at Santa Clara Valley Medical Center in San Jose, CA. She has been Associate Professor of Surgery at Stanford University. Prior to coming to California, Dr. Allo was Medical Director at Johns Hopkins Hospital as well as Associate Professor of Surgery and Oncology with a specialty in endocrinology. Prior to this she was on the medical staff at Denver General Hospital as Chief of the Critical Care unit, and at the University of Colorado as assistant professor in the Dept. of Surgery. She currently serves on national boards of several healthcare organizations.

In fall of 2012 Dr. Allo spent several weeks in Nepal teaching local doctors how to perform routine surgeries for people living in rural settings who are unable to access medical care in cities. For the last 20 years, Dr. Allo has sung in major performances of sacred music with the San Jose Symphonic Choir and serves as music librarian for the 100-person choir under the direction of Maestro Leroy Kromm.

**Roxanne Dolak, R.S.M.**(West Midwest) holds a B.A. in Music Education, and a B.S.N. from St. Catherine University in St. Paul, Minnesota. For the first 15 years of her ministry she taught music and elementary education at schools in Iowa and in Kalispell, Montana. After receiving her nursing degree, she worked as a staff nurse on the medical floor of Mercy Hospital in Cedar Rapids. In 1975, she applied for a job at the hospital in Kalispell. Although the Sisters of Mercy no longer owned the hospital, there were two Mercy Sisters who had stayed on. She held various positions there from 1975 to 2000: Staff nurse on the surgical floor, supervisor on the evening shift, and supervisor of the 12-hour day shift. In 2000 she applied for the position she presently holds, R.N. chart auditor. She is an avid hiker. Over the years she has hiked and backpacked over a thousand miles in Glacier National Park, the Bob Marshall Wilderness, and other Northwest Montana mountainous areas. She reached the top of Mount Cleveland on August 16, 1989, the highest peak in Glacier Park at 10,470ft. About 10 years ago, she purchased a piano and has again taken up playing after a hiatus of nearly 30 years.

**Diane Grassilli, R.S.M. R.I.P.** (West Midwest) Diane Grassilli was born in San Francisco and grew up in Burlingame, California. She attended Mercy High School and from there entered the Sisters of Mercy in Burlingame in 1967. She initially taught high school and engaged in several artistic and future-planning projects for the regional community. She transitioned to health care and for several years served as special assistant to the President of Catholic Healthcare West, and as Director of Mission Services for CHW. She was then elected to congregational leadership, first as vice-president of the Sisters of Mercy of Burlingame, then as President. She gave the CHW address printed in this volume in 2005. She was diagnosed with cancer in early 2006, and died in office July 16, 2006.

**Sandra Jewett** holds an Ed.D. in Catholic Education and M. A. in Theology from the University of San Francisco, and an M.A. in Instructional Leadership from National University. She served as a bilingual K-12 teacher, dean, vice- principal, director at San Jose Unified School District, site principal for the Diocese of San Jose, assistant superintendent at Alum Rock Union School District, vice president for educational services at Edison Learning, Executive Director at the Oakland Dio

cese, and adjunct college professor for National University in the College of Education for K-12 Teacher Preparation programs. She has published and facilitated workshops for school principals, teachers and parents. She has been a contributor to several publications: *Collaboration and Peak Performance, Bridging the Student Achievement Gap* (2012); *Communication and Templates for Busy Principals* (2009), the National Catholic Education Association (NCEA); *Season of Holiness: A Monthly Newsletter for Busy Principals* (2008), the National Catholic Education Association (NCEA) and the Curriculum workbook to accompany *House on Mango Street* by Sandra Cisneros, Miller Educational Materials. (1997). She has spoken on the subject of the Guadalupe at national religious education workshops.

**Mark Hehir** lives in San Jose, CA. He was born in Swindon, England, and is the third oldest in a family of 14 children. He holds a B.A. in Accounting. He retired from Agilent Technologies Inc. due to the progression of his muscular dystrophy. One current project is making videos of parks located around the San Francisco Bay Area that have wheelchair accessible trails. His blog has videos of various parks and places, along with essays he has written: <http://irishseamark.blogspot.com/>

**Sharon Kerrigan, R.S.M.** (West Midwest) holds a Ph.D. from the Graduate Theological Foundation, a D.Min. from Chicago Theological Seminary, and an M.A. from Loyola University. She has been a professor of social science and religious studies as well as an administrator in college and university settings. She has been an adjunct professor at St. Xavier University and System Director of Mission and Spirituality for Provena Health and Provena Senior Services. She is currently Assistant Administrator at Mercy Convent in Chicago, involved in the construction of the retirement center for Sisters of Mercy. She serves as a personal contact person for West-Midwest community members, and is also on the Editorial Board of the MAST Journal.

**Joyce I. Turnbull, R.S.M.** (West Midwest) holds an M.A. in Nursing from the University of Washington. Since 1961, she has held a number of ministerial positions in health care. These include medical-surgical floor nurse at St. Mary's Hospital in San Francisco, CA and Mercy Hospital in Bakersfield. She has also served as a practitioner in home-health nursing with Mills-Peninsula Home Health in San Jose, CA, and as hospice nurse with Hospice in San Jose and San Mateo, CA. She has also been a nursing instructor in the nursing school departments of the University of San Francisco, San Jose State University and City College of San Francisco. From 2005-2007 she was a founding faculty member and Nursing Director of the California Nurses and Vocational Institute in San Francisco, CA, educating women for an LVN license so they could provide home-healthcare to the elderly and sick.

**Elaine Wainwright, R.S.M.** (Brisbane, New Zealand) is Head of the School of Theology at the University of Auckland in New Zealand. An expert in the Gospel of Matthew, she holds a Ph.D. from the Ecole Biblique et Archéologique Française in Jerusalem and an M.A. from Catholic Theological Union in Chicago. She is a frequent lecturer at theological conferences in Australia, New Zealand, and internationally, and has been visiting professor at the Ecole Biblique, at Harvard Divinity School, and Ecce Homo in Jerusalem, among other institutions. Her publications include *Shall We Look for Another: A Feminist Re-Reading of the Matthean Jesus* (Orbis, 1998); *Women Healing/ Healing Women: The Genderization of Healing in Early Christianity* (Equinox, 2006). *The Bible and Popular Culture: A Creative Encounter* (Society of Biblical Literature, 2010); "Gender and Theology—Spirituality and Practice" *Concilium* (Vol. 4, 2012).





## **MERCY ASSOCIATION IN SCRIPTURE AND THEOLOGY**

**MAST**, the Mercy Association in Scripture and Theology, met for the first time in June 1987 at Gwynedd-Mercy College in Gwynedd Valley, Pennsylvania. Called together by Eloise Rosenblatt, R.S.M. and Mary Ann Getty, twenty Mercy theologians and Scripture scholars from fourteen regional communities formally established the organization to provide a forum for dialogue and cooperation among Sisters of Mercy and associates. The stated purpose of the organization is to promote studies and research in Scripture, theology and related fields; to support its members in scholarly pursuits through study, writing, teaching and administration; and to provide a means for members to address issues within the context of their related disciplines.

**MAST** has been meeting annually since then, and the organization now numbers fifty, with members living and working in Australia, Canada, the Caribbean, Central and South America, as well as in the United States. Aline Paris, R.S.M., currently serves as MAST's executive director. MAST is holding its annual meeting in **Omaha, at College of Saint Mary, June 14-16, 2013**. Members act as theologians in the Church and carry on theological work in their respective disciplines and ministries. They also seek to be of service to the Institute of the Sisters of Mercy by providing a forum for ongoing theological education.

For information on becoming a member and being added to MAST's mailing list please contact the association's Executive Director, Aline Paris, R.S.M. by e-mail at [aparis@csm.edu](mailto:aparis@csm.edu) or by mail at College of Saint Mary, 7000 Mercy Road, Omaha, NE, 68016.

Dues can be paid by check, payable to MAST and sent to the association Treasurer, Marilyn King, R.S.M., The Laura, 1995 Sam Browning Road, Lebanon, KY, 40033-9162.

Since 1991, *The MAST Journal* has been published three times a year. Members of the organization serve on the journal's editorial board on a rotating basis, and several members have taken responsibility over the years to edit individual issues. Maryanne Stevens, R.S.M., was the founding editor of the journal, and Eloise Rosenblatt, R.S.M., currently serves in that capacity.

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