The MAST Journal

The Journal of the Mercy Association in Scripture and Theology

VOL. 2, NO. 1 FALL 1991

Healing and Health Care

November, 1991

Dear Readers,

With this issue we begin a new volume and a new era of THE MAST JOURNAL. We enjoyed a successful first year, hearing often from many of you. We hope to bring you three more provocative issues this year. Please continue to let us hear from you if you have suggestions, comments or critiques. And, thank you for your continuous support.

The colors of autumn and the slow dawning of winter call us to more deeply breathe of the new life within and around us. The direction statement of our Institute calls us to recommit ourselves to those who suffer poverty and discrimination and it calls us to appreciate the color within and around us. It calls us to die with winter to all that has kept us from being compelled by God's Spirit.

This issue of our journal also calls us to more deeply breathe of the new life within and around us. Associate editor Elizabeth McMillan from the Pittsburgh Regional Community (currently working at Catholic Health Association in St. Louis) has gathered these articles considering various aspects of health care and our call to serve the sick. As you read, you will consider some of the difficult questions facing our health care institutions as they seek to understand the distinctiveness of their Catholic identity. You will sit at the bedside of the grieving compelled by God's Spirit to remember death as the transition between this life and the springtime of God's fullness. Breathe deep!

Sincerely,

Maryanne Stevens, RSM

The MAST Journal is published three times a year (November, March and July) by the Mercy Association in Scripture and Theology. Members of the Editorial Board are Srs. Maryanne Stevens (Omaha), Joanne Lappetito (Baltimore), Marie-Eloise Rosenblatt (Burlingame), Elizabeth McMillan (Pittsburgh) and Julia Upton (Brooklyn). All correspondence should be mailed to Maryanne Stevens, RSM, 9411 Ohio Street, Omaha, Nebraska, 68134.

Mercy Ministry to the Sick Today

Doris Gottemoeller, RSM

The Sisters admitted to this Religious Congregation . . . must have in view what is peculiarly characteristic of this Institute . . . that is a most serious application to the visitation of the sick.

Rule of the Sisters of Mercy, 1831

Visiting the sick is one of the foundational commitments of the Sisters of Mercy. This corporal work of mercy has inspired generations of sisters to minister to the physical, psychological, and spiritual needs of the sick and dying through personal service and through sponsorship of institutions. But health care has changed dramatically from the days when Catherine McAuley and her companions visited the hospitals and homes of the poor carrying baskets of food and medicine. Today it is a complex, technologically sophisticated, expensive commodity which is bought and sold in the modern marketplace. Mercy institutions participate with those of other Catholic sponsors and with an array of for-profit and not for-profit, private and governmental hospitals in the provision of a valuable human service. At the same time millions of citizens lack access to basic health care or are inadequately served by existing agencies.

What are the implications of this contemporary situation for the traditional Mercy commitment to 'visiting the sick'? What are our congregations and institutions doing to respond in new ways to the Gospel imperative to minister to the sick?

A survey of all that Mercy is doing in the many countries where we minister would be far beyond the scope of this essay.[1] Instead, I will approach the questions by reflecting on Mercy's response to the recommendations of the national Commission on Catholic Health Care Ministry and by suggesting some issues for our future agenda.

The Commission Sets a Direction

In 1987 leaders in the Catholic health care ministry in the United States established a national commission with the charge to develop a vision and strategies to guide the ministry into the twenty-first century. The commission included leaders from the church, religious congregations, health care systems, institutions, and organizations, and experts in theology, law, finance, and labor relations.[2] A year later it published its report, "Catholic Health Ministry: A New Vision for A New Century."[3]

The commission began with the premise that the Catholic health ministry is the responsibility of the whole church — individual members, parish communities, religious congregations, dioceses, and institutions — responding to human suffering with a range of personal and corporate resources. The vision it set forth is a bold one: a renewed commitment to the health ministry by the whole community of believers. Institutions will still be needed as public expressions of the church's commitment, but 'ownership' of ministry to the sick by the whole church should give rise to countless other creative efforts.

. . . the health ministry of the future . . . responsive to the needs of people.

According to the commission, the health ministry of the future should include a range of health-related services responsive to the needs of people. Many programs would be small scale and community-based, but supported with the larger resources of institutions, dioceses, and parishes. In particular, Catholics should seek out the needy and underserved. Our institutions will not have the resources to care for all or even most of the poor. However, they should be leaders in the effort to keep the needs of the poor before the public and to transform the system of access and financing in favor of the most vulnerable in society.

In order to insure creative and committed leadership for the ministry of the future, the commission called for deliberate efforts to identify, recruit, and prepare talented persons who are willing to make a life commitment to the values inherent in Catholic health services. These leaders should challenge and enable employees throughout their organizations to become committed participants in the ministry.

The commission asserted that new models of lay sponsorship will have to be developed to insure continuity and stability in the ministry, as religious congregations withdraw from their traditional role. Whatever the new models look like, they should be subject to uniform criteria of accountability to the church.

According to the commission, the ability to set national directions on issues and strategies central to the mission will be a vital characteristic of the church's future health ministry. Focused priorities, clearly articulated and successfully communicated at local, state, and national levels, will help the church — as an institutional presence and as a community of believers — effectively influence the social and political environment and advocate changes in the U.S. health system.

Finally, the commission identified a number of strategies required to translate the vision into reality. It called on bishops, sponsors, and health care leaders

- to establish a national coalition, representative of

all participants in the ministry, to promote the church's overall mission in health care;

- to plan now for a change to predominantly lay models of sponsorship and to assist current sponsors in effecting changes in their roles;
- to develop and implement programs which identify, recruit, and prepare persons for leadership in the Catholic health ministry;
- to come together, in each region of the country, to plan for all aspects of the local health ministry; and
- to devote a larger percentage of available resources to speaking out on relevant issues.

It called on bishops

- to keep personally informed on relevant trends and issues in the health ministry, to challenge the faithful to greater responsibility for their role in this ministry, and to demonstrate their personal commitment to its furtherance.

Mercy Shapes Health Ministry for the Future

Mercy institutional health ministry has been changing dramatically in the last decade, anticipating in many respects the issues and strategies identified by the Commission on Catholic Health Care Ministry.

One of the most conspicuous changes is the formation of systems. Beginning in the mid-seventies, the various congregations and provinces have aligned their institutions into systems with their own corporate identity, governance, and management. Eastern Mercy Health System (Philadelphia)[4], Mercy Health System (Cincinnati), Mercy Health Services (Detroit), Sisters of Mercy Health System (St. Louis), Catholic Health Corporation (Omaha), and Catholic Health Care West (San Francisco) are all holding companies with multiple hospitals, long-term care facilities, residences for the well elderly, clinics, home health agencies, etc. Some reasons for the formation of systems were to facilitate and coordinate planning across broader service areas, to maximize management and governance expertise, and to achieve greater economies of scale and efficiency in the use of resources.

System formation has been the vehicle for significant inter-congregational collaboration. For example, Mercy Health System is a merger of the health ministries of the Cincinnati and Scranton regional Mercy communities, and Catholic Health Corporation combines the health ministry of the Omaha Sisters of Mercy and seven other sponsoring congregations. The relative size and strength of the systems has also given them the ability to assist other congregations and dioceses with their health ministry through consultation, management agreements, and support services.

The presidents of the Mercy health systems meet quarterly to share vision, work on common projects, and support one another through the exchange of information and experience. They have instigated and supported cooperative efforts by their system personnel in the areas of mission effectiveness, human resources, and public advocacy.

Mercy systems were among the first in the country to design a program for leadership development. In the fall of 1985 the system presidents commissioned the development of a value-based management training program. The generic program was completed in 1988 and has been adopted and adapted by each of the Mercy systems.[5] It has also been shared with many other systems. Its goals are the integration of values by persons and organizations, organizational transformation, and the continued collaboration of the participating systems.

Efforts to identify and meet the real needs of people have also been a priority concern of Mercy health ministry. Our systems have led the way in the development of methods and materials for assessing community needs and gaps in service. The Catholic Health Association publication, *Social Accountability Budget: A Process for Planning and Reporting Community Service in a Time of Fiscal Constraint,*[6] acknowledges the contributions of numerous Mercy individuals, facilities, and systems. The appendices include forms and procedures previously developed by Mercy Health Services and Catholic Healthcare West.

. . . priority issues (are) national health care reform and tax exemption.

Mercy congregations, systems, and institutions are attempting to address issues of systemic concern through research, education, and advocacy. The system presidents have made a commitment to creating an inter-system network capable of making an impact on specific state and national issues. They have chosen as priority issues national health care reform and tax exemption. The focus of the latter is to determine to what extent tax exemption is critical to Catholic identity in other than financial terms.

There are numerous mission initiatives, in the United States and abroad, in which Mercy attempts to meet the needs of the sick poor in new and creative ways. Community outreach programs, mobile vans, and specialized clinics provide prenatal care, day care for children and elderly, transportation to treatment facilities, and a host of other services. Congregations, systems, and institutions have established special funds for encouraging innovation and self-help in services to the needy. For example, the Sisters of Mercy Health System of St. Louis's "Catherine's Fund" will award up to a million dollars over the next three years to a new project which addresses health and human

service needs in a specific community. The project selected may have the potential to grow into a new ministry which would require a long-term commitment by the Sisters of Mercy.

New Questions Face Us

The preceding pages would seem to describe a ministry which has successfully adapted to changes in the environment and which is well-positioned for the future. However, change has a way of creating new questions. I would identify half a dozen issues facing our health ministry today, some of them perrenial problems appearing in new guises, others brand new issues.

1. Commitment to Institutional Ministry. According to our *Constitutions*, "We sponsor institutions to address our enduring concerns and to witness to Christ's mission. Within these institutions, we together with our co-workers and those we serve, endeavor to model mercy and justice and promote systemic change" (#5). Institutional sponsorship has long been a source of pride and community identity. The notion of "our" hospital as an expression of the charism and an extension of individual efforts goes back to the founding of the first Mercy Hospital in Pittsburgh in 1847.

We pledge ourselves to serve "the poor, sick, and ignorant."

Today, however, the small number of sisters in the institutions, the prevalence of laity in administration, and the bureaucratization of the ministry contribute to a feeling of alienation by individuals who derive satisfaction in ministry from the feeling of being effective — 'making a difference' — in an organization. An individual sister ministering within a large health care institution or system today may wonder what influence, if any, she has on the overall direction or quality of the ministry. And sisters not directly involved in health care may feel even more remote from it. There is a large gap between congregational decision-making processes and the point of service in health care. Sometimes it seems like there is no real connection between chapter mission statements and significant influence on the ministry.

As a result many — perhaps even the majority — of community members feel indifferent to, or even estranged from, the institutional health ministry. How can these feelings be overcome? How do they jeopardize the authenticity of sponsorship?

2. Integration of Ministries. We pledge ourselves to serve "the poor, sick, and ignorant." While the breadth of this vow orients us toward hundreds of discrete ministries and ministerial situations, they should all be unified in one vision of doing Mercy: "Through direct service and through our influence we seek to relieve misery and address its causes, and to support all persons who struggle for full dignity."[7] Schools, social service agencies, parishes, and congregational motherhouses are all sites for the promotion of human dignity. Those who minister in them should be able to draw on the services of the health care provider, and the latter should create alliances with this network of human service agencies. This is the vision of integrated service that the Commission on Catholic Health Care Ministry put forward. The Sisters of Mercy, with our range of ministries, are in a position to implement the vision in many localities. How can we integrate and network our ministries to more effectively minister to the sick and needy?

3. Renewal of the Workplace. The Catholic Church has historically been a friend of labor in the United States. Beginning in the 19th century, church leaders promoted the rights of workers to organize for better wages, benefits, and working conditions, and to seek progressive social legislation. In so doing they played a key supporting role in the economic and social improvement which the labor movement brought to American workers in the 20th century.

However, when labor first began to organize, church ministries were not themselves large-scale employers, as they are today. Therefore, we have the opportunity and responsibility as never before to translate the church's social teachings into effective practices and policies in this environment. Our health care institutions employ many thousands of individuals. They should be model workplaces which recruit persons of diverse backgrounds, challenge and assist them to develop themselves to their fullest potential, and include them in decision-making about the quality and conditions of their work. How can we assist all employees, especially women and minorities, to achieve their fullest potential through employment in our institutions? How can we promote the dignity of individuals in the context of their families and communities?

4. Competition and Collaboration. At the same time that millions of Americans lack access to adequate health care, there are situations of over-supply of resources. Surplus beds, duplicative services, and redundant technology all contribute to the high cost of healthcare, without increasing access for the underserved. In many instances this duplication is the result of competition between neighboring facilities fighting for market share and physician loyalties by adding unnecessary resources.

In some cases the competition is between two or more Catholic health care providers. While the Mercy systems have achieved some excellent examples of collaboration between and among themselves and with

other sponsors, there are still numerous situations where the public is not well served by the duplication of services by Mercy and another provider. How can we identify and address these situations with maximum benefit to the communities where we serve?

5. Transfer of Sponsorship. The commission foresees the day when at least some religious congregations will no longer be willing — or if willing, be unable — to continue the significant responsibility they have had for health care institutions. To date the Mercy congregations have taken impressive steps to strengthen and reinforce sponsorship. We want to be sure that when and if we relinquish our traditional role, we will be able to turn over a ministry to others which is strong and viable. How soon will that day come? Is it inevitable? Can we prepare for it by some creative experiments in governance or by forging new alliances with other congregations, with dioceses, or with lay organizations?

6. National Influence. The promotion of systemic change to which our constitutions and the commission's recommendations call us requires focused priorities and concerted action. The birth of our new Mercy institute challenges us to use our corporate voice to address issues such as extension of health care coverage, improved access to services, just distribution of resources, the application of new technology, and the empowerment of health care recipients. Efforts are already being made by our health system leadership to impact these national issues. How can we enlarge the circle of dialogue by gathering the experience and wisdom of community members in the formulation of our positions? How can we enlist the efforts of all in the public expression of our views?

* * * * *

These are issues and questions which will not be answered easily or quickly. However, "in responding to the demands of our mission we rely on the Holy Spirit to lead us."[8] Our Mercy commitment to "visit the sick" has been enormously productive in the past; we confidently hope that it will lead us down new paths in the twenty-first century.

Footnotes

1. A recent pamphlet entitled "Sisters of Mercy of the Americas" lists 128 health care facilities currently sponsored by Mercy in 109 cities. In addition Mercy has substantial commitments in nine other countries. (Silver Spring, MD: Sisters of Mercy of the Americas, 1991). For an historical overview of the contribution of women religious, see *Pioneer Healers: The History of Women Religious in American Health Care,* ed. Ursula Stepsis, CSA, and Dolores Liptak, RSM (New York: The Crossroad Publishing Co., 1989).

2. Sisters of Mercy were represented on the commission, the steering committee, and the staff. In addition, numerous Mercy congregations, health care systems, and institutions made financial contributions to the project.

3. Farmington Hills, MI: Commission on Catholic Health Care Ministry, 1988.

4. The cities in parentheses indicate where the systems' corporate offices are located. As the following paragraph makes clear, most of these systems are composed of health care facilities sponsored by more than one congregation, including some which are not Sisters of Mercy communities.

5. *Leadership Development Program,* Copyright Mary Concilia Moran, RSM, 1986. Rev. 1989.

6. St. Louis, MO: 1989.

7. *Constitutions,* #3.

8. *Constitutions,* #10.

Contributors to This Issue

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Mary Ann Getty Sullivan was one of the founders of Mercy Association in Scripture and Theology in 1987. She has held teaching positions in scripture at Carlow College and Catholic University and is currently on the faculty of St. Vincent College in Latrobe, PA. She has written numerous articles and several books, and has served as editor of biblical journals and series. Her doctorate is from the University of Louvain in Belgium.

Patricia Talone, RSM, (Philadelphia) teaches theology full-time in the humanities division of Gwynedd-Mercy College, and gives about 16 hours a week to Mercy Health Corporation in Philadelphia as ethics education coordinator. She likes the balance between theory and praxis that these two aspects of her ministry afford her. Pat has a doctorate in religious studies from Marquette University.

Healing, A Personal Reflection

Mary Ann Getty Sullivan

A Sister friend of mine once described "mercy" as "an experience of grace and healing." I pondered. I had received a ton of grace by that time in my life. In thirty-something years glorious things had happened to me. I enjoyed the affection of my family and friends, the love and approval of a community, the benefits of a wonderful education. But what of "healing"? It seemed I had yet to learn even the meaning of suffering.

Of course, as a teacher of scripture, I knew about the concept of suffering. Already in the Creation and "Fall" accounts the related notions of dominance, fear, betrayal, distrust and even death are present. And then there are Cain and Abel, the barren and sad Sarah and Abraham, the trials of Jacob and Leah and Rachel, the saga of Joseph's ordeals with his brothers, the complaints of Elijah and Jeremiah and Ezekiel. Even in the stories of the inauguration of God's kingdom, there are the tribulations of Paul, of Peter, and of Jesus. So, as a teacher who knew scriptures' content, I had been introduced to the perennial religious issue of suffering and its Judeo-Christian "resolutions."

Suffering . . . is a mystery to be lived, not merely a problem to be solved.

Suffering, especially the issue of innocent suffering, is a mystery to be lived, not merely a problem to be solved. Gabriel Marcel is one who made such a distinction, stating that a problem could be identified, objectified, and resolved. But a mystery is something so close and intimate that it must be lived, participated in, and integrated. The God of Abraham and of Jesus does not intervene to prevent suffering. Rather, the innocent just person of the scriptures walks the tightrope of faith, suspended between cursing God or accusing oneself of sin. The sting of suffering is the strain it puts on faith. But faith is the lesson of suffering; witness to God's fidelity is what remains after suffering. This much I did know.

What I did not know was anything of healing. For me there had as yet been no significant deaths, nor even grave illnesses. I did not know personal failure or persecution or enemies or abuse or violence. But life has a way of maturing the most reluctant adult. Healing is the "rest of the story" that almost invariably follows suffering whenever it is finally accepted. And suffering, sooner or later, almost invariably visits us all. In this short article, I offer some very personal reflections on healing, based on convictions that grow out of my life experience. I no longer have any failsafe wisdom or free advice applicable for all. I offer only what I have learned to be true for me.

Miracles as Healing

The gospels attest to Jesus' ability to perform miracles. This is clear. But while many were cured, miracles did not always work to heal the people. To understand the role of miracles and perhaps the differences between a cure and healing, we need to understand the biblical optimism that God would surely work miracles on behalf of believers and also the gospel skepticism about miracles as an adequate vehicle for revealing Jesus' identity.

1. Biblical Optimism About Miracles. The biblical person is, by definition, a believer in God's ability and willingness to perform miracles. Biblical people, totally dependent on God, expect power from God. The basic reason for such optimism stems from the believers' pessimism about the world and about their own ability to control the world. Whether things go well or badly, believers focus on God. If well, God is ordering things. If badly, God will come and save. For believers, there are so many potential setbacks and enemies threatening: floods, earthquakes, famines, persecutions, mighty armies. Clearly we are powerless to confront and conquer all these.

Indeed, Jesus goes so far as to say that when we encounter an enemy who would strike our face or steal from us, we should offer no resistance. Evil has many manifestations which include threats to life, to peace of mind, to our future. People of faith put their trust in God alone, confident that God is faithful and will either save us from disaster or give us the ability to endure hardship and pain. The end will prove God and us victoriously faithful. So it is the very inability of the biblical person to vindicate herself in the face of overwhelming power that gives her the courage to expect God's miracle.

The biblical person's view of history is like the rower in a boat who sits facing backwards. This stance is contrasted with our ordinary way of seeing the past as behind and the future before our eyes. The rower looks to where she has been and considers the future behind her. On the basis of past experience, with the past always before her eyes, she proceeds confidently, knowing that the same One who has guided her this far will guide her to the end. The past is evidence that her own fears and anxieties, centered as they are on her own inadequacies and limitations, are inconsequential and a waste of energy. If we lack confidence in ourselves, the remedy is to firm up faith in God. Here there is a tremendous return on investment. God

does not change and the source of our firm confidence in the past and in the future is God.

Paul expresses the thoughts of the true disciple when he, frustrated by the many problems he was having with the Corinthian community, found himself forced to speak in his own self-defense and also in defense of his apostleship. Referring to his ministry, Paul asks rhetorically in 2 Cor. 2:16: "Who can qualify for a ministry such as this?" And part of his answer as continued in 2 Corinthians 4 is that his sufferings have qualified him for apostleship. He says, "We hold a treasure in earthen vessels that the surpassing power may be of God and not from us" (4:7). Paul continues, "We are afflicted in every way but not constrained, perplexed but not abandoned, struck down but not destroyed . . . so that the grace bestowed in abundance on more and more people may cause the thanksgiving to overflow for the glory of God" (4:8, 15).

One thing only is sure: God is faithful.

Speaking of his friend Lazarus, who was so ill he died, Jesus says, "But this illness is not unto death but so that the glory of God may be revealed" (Jn. 11:4). The significance of miracles is that they are occasions for God's power to be revealed. Humans long for God to come and save. Miracles are reminders that God will and does come and save.

But miracles are also problematic for the evangelists. The biblical expectation is not a faithless one. One thing only is sure: God is faithful. But sometimes humans are not and sometimes their expectations get in the way. Sometimes God does not have a miracle in mind. Sometimes we are not called to avoid or overcome suffering, but rather to grasp and accept it. So we can be led to understand the gospels' skepticism that miracles, after all, may not be a good way to understand who Jesus is.

2. Biblical Skepticism About Miracles. There is a paradox in expectations. We need them and they can be an expression of hope, but expectations can also blind us to the surprises of God and, more importantly, to the God of surprises. The Bible and especially the NT, seem to be warning that God is all powerful and "every good and perfect gift comes from God," yet "God's power is made perfect in weakness." According to the synoptics, Jesus warns his disciples three times that he is on his way to Jerusalem to suffer and die. When his reluctant disciples protest against this part of Jesus' mission, Jesus warns them, "You are thinking not as God does but as human beings do. Whoever wishes to come after me must deny herself, take up her cross and follow me" (Mk 10: 33-34).

Central to the mission journey of Jesus are the Passion predictions. The miracles performed so frenetically in Galilee cease as Jesus nears his destination of the cross wherein God's most perfect gift to the world is revealed. Only when Jesus dies, not when he performs miracles, does any human being recognize him as the "Son of God" (Mk 15:39). The gospels thus manifest a certain ambivalence and even skepticism when it comes to miracles. They may be a means to get our attention, given our weaknesses and attraction to the grandiose. But the gospels illustrate, also for our reflection, that those who were cured often did not become disciples (e.g. the blind man in Mk 8:22-26). Many who witnessed maladies removed did not become followers and some even increased their hostility against Jesus because of miracles. Cures lack the power to convert. The learner-disciple is getting ready for apostleship (being sent). Healing qualifies disciples to be sent out to do even "greater works" than Jesus did (see Jn 14:12). Healing requires the slow, patient followship that painstakingly teaches the message of suffering and of the cross. There are no shortcuts.

Healing as Conversion

Healing requires change and conversion. Life is change. Yet we tend to establish routines and patterns of behavior that make us comfortable and help us avoid change. That suffering was a part of Jesus' message was unacceptable to the disciples. They erected boundaries, hoping the walls of denial, refusal to hear, rejection and neglect would make the message go away.

The boundaries we erect define the limits to which we are willing to go. We are so anxious these days to know the "bottom line". With regard to God, to ourselves, and to others, we tend to establish limits which we justify, saying that "we just do not want to be hurt." But healing involves surprising ourselves, surpassing these limits, breaking out of our boxes, extending ourselves yet again. It never ends. Idolatry for us, like for the ancient Israelites, means creating golden calves that can be counted on to be there, exactly where we put them. A personal God who asks a return of love and fidelity is beyond us. For ourselves, too, we draw limits, because it seems to be too exhausting to continually grow and change and stretch. We are prone to be spiritual couch potatoes. And when the needs or demands of others become too much for us, we long to return to the comfort of a quieter domain, where people stay where we put them and don't move, and where there are no surprises.

Naturally we approach others coming from our own backgrounds and identity. But the limits of our own experience must keep us humble and open. Human nature is a great leveler. Openness is better served by realizing and repenting our limitations than by imagining that we have none. To change is to suffer. And the greatest change of all, no doubt, is death.

Death as Healing

Death, it would seem, is the opposite of healing. But, for the Christian, things are often not what they appear. So it is with death. Such is the fundamental lesson of the Resurrection. Having experienced the sudden deaths of my mother, of my fourteen-year old nephew, of a forty-year old cousin, and the more gradual deaths of a Sister cousin and of an uncle, I have come to understand how death can be a kind of healing.

. . . there remains grace and healing for those of us who suffer the loss of loved ones . . .

First, we can reflect on the healing that comes in the witness of the dying person, sometimes even in those who might have had no knowledge of their impending death. And then there remains grace and healing for those of us who suffer the loss of loved ones and struggle to "re-member" them well.

My mother, for example, left a beautiful testament. Everything in her life had been simplified and was in order, although she died quite suddenly and unexpectedly within a month after her doctor had pronounced her perfectly fit in a routine exam. Her last day was a typical one, spent with her husband, cooking and ironing and house-sitting for my vacationing sister. My mother died the way she lived, quietly, about two weeks after her seventy-second birthday. One thing was strange, though. Although she often telephoned her children and friends, she was not a letterwriter. But she had written to each of her children and to many other people on the occasion of her birthday. Her sister-in-law attests that it had probably been thirty-eight years between her "birthday letter" and any previous one she had received from my mother. Mother's letters to each of us, in a special way, spoke of how grateful she was that we were part of her life, thanking us, adding that she was happier than she had ever been. For her last two years she was free of an addiction that had afflicted her for over forty years. She was ready. And her words and example of quiet acceptance are how we re-member her today. She did a lot of healing in those last two years and especially in the legacy of her manner of living and dying.

My little nephew, Joseph, was killed in a freak auto accident. He was a spirited fourteen-year old who was mischievous and inclined to danger, but charming. The last words his parents or siblings remember him saying that Mother's Day as he left to visit a friend were, "I love you." That is our healing memory.

It is as a healer that I will always remember Mary, a Sister of Mercy and cousin, who battled cancer for 25 years before finally surrendering her life last October 4th. Mary was always beautiful, poetic, witty, bright, and a lover of life. She entered Mercy Hospital only because she was unable to breathe, ten days prior to her death. She preferred to fight her disease out in the open, at work and in the mountains, continuing her swimming, hiking and eating well. Even the day before she slipped into a coma, we painstakingly filled out her hospital menu, thinking not only of the individual foods she liked, but, as she said, making sure it all went together, matching taste and color and texture so that it could be relished.

Mary insisted that she see all her cat scans, ultrasounds, xrays, charts and records. She wanted to "know" about her medications, doctors and prognoses. She expressed a fear of pain that somehow surprised me — wasn't she an expert on pain? She had a long history of cancer, of migraine headaches, of chemo and radiation and nausea, of nursing her mother with alzheimers and her father who had suffered a stroke. Yet she had not missed work because of illness until the day she was admitted to Mercy.

Two days before she died, the doctors who had been considering chemotherapy until that day, held a bedside conference with her, her closet friend, and me. She had been so anxious to know about her treatment. The doctor pulled no punches. There was no longer any hope for chemo or any other medical intervention. In response to her expressed "fear of pain" he assured her that she could be kept comfortable with very little medication, especially since she had had so little up until then. His manner was priestly, compassionate, and gentle. But the message was relentless and brutal. She would die very soon. Although her imminent death had been clear to all of us for days already, those words and that moment are etched in my memory. No cover possible; no further avoidance of delay tactics were viable. We had encountered something new.

At last the doctor asked, "Sister, do you have any more questions before I go and order some medication?" Mary smiled and said, "No, class dismissed!" Once again her wits saved us and we all could smile in relief. When the doctor had left the room, Mary said to us, "Friends, we did good, didn't we? We didn't come in until the last blow of the whistle. We did good."

Those days Mary gathered all of us. We were so eager to be there and so sorry to leave her presence. She did not spend time preoccupied with herself. She cried a little to be sure, but mostly she made us laugh. She asked me to read snatches of things — Anne Morrow Lindbergh, Robert Frost. She read and looked long at every card and note and wondered aloud at the thoughtfulness of people to be thinking of her. She asked for songs to be sung sometimes, and sang herself, in that beautiful voice. And her poetic soul was nourished. She dozed and ate and visited as long as

she could.

She concerned herself with those she was leaving. A dear friend asked what he could do; "Anything!" he exclaimed. She instructed him to "go down to the Fifth Avenue deli and get a corn-beef sandwich with mustard and pickle, and a can of beer." He was then to come back and give them to his "bride" who, Mary said, "looked hungry." These were among her last instructions and she had to whisper them. Then she smiled and we all chuckled. His wife of thirty-five years had one pet peeve, as Mary and the rest of us there knew well — she thought being called his "bride" ridiculous. But Mary was healing as she died, laughing so that we would not take ourselves too seriously.

I was so impressed by her acceptance, her peace of mind, and her absolute and apparent lack of regret. Yet she loved life so. On Wednesday she lapsed into a coma and died Thursday night around 11:00 p.m. But the healing was not finished once she was comatose. The kind of influence she was for others continued to uplift and hearten us.

. . . she had never before realized how similar were the rhythms of dying and of giving birth.

Betsy, Mary's niece and namesake (Mary's religious name had been Elizabeth), is a nurse. Betsy came to visit every evening after work. Thursday night Betsy healed our sorrow in a beautiful gesture of remembrance. Like the disciples in the Garden, some of us were sleepy with grief. We had said all we knew to say and the room was heavy with the labored sounds of Mary's slow breathing. I thought of an article a colleague had written years ago about the death of her mother. She said she had never before realized how similar were the rhythms of dying and of giving birth. While I was thus absorbed in thought, Betsy breezed in and quietly announced herself to Mary. I may not remember the exact words, but I think I shall never forget the gist of what she said and did and their healing effect.

"Mary, this is Betsy. I have been at work and was thinking of you. And now I am so happy to be with you, seeing you. I am going to freshen you up a little and maybe make you a little more comfortable." Describing exactly what she was doing as she worked, Betsy combed Mary's hair, wiped her face with a damp towel, brushed her teeth, adjusted the pillows and set the bedclothes right.

After she had finished these little services of a loving friend, Betsy took a seat and continued to speak quietly, "Mary, this is Betsy again. We know that you are very close to death. But before you go, I want to tell you that your friendship and care for me have always been appreciated. I am very proud to be related to you. Thank you for all those walks and talks, for all that we have shared about so many things. Thank you for the way you took time to ask me questions about myself and got to know me, for helping me with my life, my plans. I love you, Mary, and always will." Thus breathed the spirit of Betsy's farewell to Mary. And Betsy gave this as a gift of healing for all of us who were graced to be present. Betsy said what none of us had the words or the energy or the will yet to say. But later when I thanked her for speaking my heart, too, Betsy hardly knew what she had done. It was so natural.

I once knew a man who had a near death experience it seems. Joe is a recovering alcoholic. He is in a second marriage and has a young daughter. Despite his good recovery and many years working as a counselor with other alcoholics, Joe suffered still a lot of guilt about the active alcoholism and the amends he felt he never could adequately make, especially for events that happened in this first marriage. This guilt kept him from true freedom. One night Joe had a terrible pain and, suspecting a heart attack, left his sleeping wife and baby and drove himself to the hospital. By the time he arrived or shortly afterward, he had a cardiac arrest. He was revived. Today he is well and strong.

This was not to be just a cure but a healing experience for Joe as well as for his wife and friends with whom he shared this experience. He telephoned one day to say he had a message from my mother and nephew. The message was that they are "all right and everything is all right." Joe went on to say something like this. "You know that I love my wife and little baby. But if I had died, that, too, would have been all right. I would want them to know that, too. All the things I used to worry about, about my former wife and family, I can now let go. It was as it was meant to be. I cannot change or bring back anything, but only live today as fully as possible. I know a new peace, a new freedom and a new happiness." Joe is sure that he died and has risen. Through death came healing.

Conclusion

Health and wholeness have significantly more to do with healing than with unblemished youth and vigor. It requires a certain quality of living, of maturity and of suffering to experience healing. Healing is a process of acceptance, of learning from the past and of facing reality in the present with courage and confidence.

Health Care for Poor Women and Children

Part I: The Experience of a Nurse-Midwife

Kate McHugh, MSN, CNM

"I didn't know it would be this hard." This blunt statement came from my friend, a nurse-midwife new to our practice in the hospital clinic. Very experienced in care of pregnant women and their families she nonetheless was acutely aware of the special demands of working with the poor. What are the differences that the maternity caregiver must appreciate in working with women whose lives are defined by their poverty? Why is this hard and how can we support and nourish the caregivers who make a commitment to working with poor families?

Women who are poor and pregnant suffer from resource deprivation . . .

Women who are poor and pregnant suffer from resource deprivation that includes material deprivation such as lack of adequate food and housing. Customary prenatal counseling on nutrition and baby equipment collapses in the face of statements like "I ran out of food three days ago." Inadequate food supplies, unstable housing situations and lack of rudimentary baby supplies are a frequent reality of many poor women. Many times the maternity care-giver knows little of this reality because no one cares to ask the careful questions. Maslow[1] speaks of the hierarchy of needs that govern human behavior. If we accept his theory it follows that it will be impossible for a woman worried about the primal needs of food and shelter to give psychic energy to many of the traditional learning tasks of pregnancy and early motherhood. Such women may be labeled by the caregiver as disinterested or lazy.

Resource deprivation that follows a lifetime of poverty is more than just material. Women raised in impoverished circumstances can grow to adulthood lacking many life skills and experiences that are the norm in middle-class life. Experiences such as traveling (even in one's own city), banking, budgeting, driving a car, negotiating with outsiders, contracting for work to be done, or making large purchases may be totally unfamiliar. The familiar, comfortable world is usually very local and access to the world at large is frequently under the control of a male partner or relative who has a car. Care providers who do not realize these issues will not understand the anxiety and hesitation of the pregnant woman who is told that her high-risk maternity consultation is at the Medical Center three miles away. Those three miles may seem like three hundred to a woman whose entire life experience has been within walking distance of home.

Resource deprivation of all sorts eats away at the spirit of the woman who is poor. If her family of origin was poor the likelihood increases that her early years were marked by family stress of all sorts and her life may seem to have always been out of control. As children, many poor women did not receive the quality of parental attention necessary to feel valued as individuals. A chronic feeling of worthlessness may result. This lack of self-esteem is a road block the care-giver encounters when she asks the pregnant woman to make healthy lifestyle changes for the sake of herself and the fetus. "Oh, I couldn't do that" is frequently the response to discussions of decreasing cigarette smoking or changing dietary habits. In fact, many caregivers never discover that the litany of prenatal teaching and anticipatory guidance savored by the middle-class pregnant woman seems like irrelevant chatter to the poor woman who lives from crisis to crisis.

A lingering sense of worthlessness and narrow life options contribute to the pattern of violent relationships that many poor women cannot extricate themselves from. Pregnant women in particular are vulnerable both psychologically and physically. As the emotional needs of the pregnant women increases during pregnancy the already pressured male partner may react in a psychologically or physically violent way. His response may be the only type of response to intimacy with which he is familiar. The care-giver trying to unearth what is occurring in the relationship may be doubly upset to find out that the current abuse is merely the latest chapter in a woman's lifetime of physical and sexual abuse.

Maternity caregivers frequently voice their frustration that the abused woman does not leave her abuser. This viewpoint presupposes a sense of identity and valued personhood that is foreign to a woman abused since childhood. Many abused women blame themselves for the violence they encounter and spend most of their waking hours "trying to keep the peace". Interventions by the maternity caregiver must keep a delicate balance. Many pregnant women will subsequently regret any information they give the caregiver about their abusive situation. They begin to skip appointments, avoid any counseling efforts and generally withdraw from or become hostile to the caregiver. Fearing consequences from their abuser, they maintain a code of silence that frustrates any change-oriented efforts of the concerned caregiver. Since it is rare for a poor woman to have adequate access to quality programs of psychological support, the life cycle of abuse and feelings of worthlessness will continue.

A health care system that ignores these harsh realities will not be successful in caring for the poor. One day a postpartum patient tried repeatedly to extend her hospital stay with vague complaints. Close, attentive discussion revealed the real issue to be that her boyfriend had spent all of his paycheck on cocaine leaving her without cash to buy sanitary pads for herself and diapers for the baby. She sobbed in embarrassment that her only option was to stay in the hospital until some money could be found. None of the caregivers had known of her dire social situation, living in a drug house. The exasperated nurse exclaimed, "I just can't imaging living like this" — which seemed to the perplexed midwife to be the core of the truth. There is nothing in the life experience of the middle-class professional health care provider that compares with these problems. To be so poor, to have so few options, is beyond our life experience.

Caregivers who practice mainly with poor families become frustrated with the system as well. The health care system does not reimburse adequately for health care needs of the poor. Clinics are the "poor stepchild" of most hospitals. The physical plant may be small and ugly, and the support staff are frequently inadequate to deal with the magnitude of problems the pregnant poor woman brings with her. The clinic environment itself sends a message to the woman that she is not valued. Caregivers may feel ambivalent or angry about being assigned to "the clinic", and show little motivation to meet the special needs of the pregnant poor. Negative or punitive remarks by the caregiver are tolerated by the institution which feels glad it has somebody to "cover the clinic".

Potential caregivers should understand that the hospital intends to live its mission through the care it gives the poor.

The best of caregivers may soon feel overwhelmed if there are no support systems such as counseling, social work or substance abuse groups with which to link the pregnant woman. Caregivers who are given ten-minute appointments with prenatal patients become numb from the volume of problems and hold back any efforts at intervention. As one skilled caregiver said, "I've stopped asking her what is happening at home because there is no time to try to help her." The numb caregiver eventually copes by either leaving the system or by slowly shifting the blame onto the pregnant poor woman. Blaming-the-victim helps us cope with our disbelief that in this wealthy country pregnant women can be so alone and needy.

There have been recent initiatives at the state and federal levels to reimburse services for pregnant women such as counseling, childbirth education, substance abuse intervention and nutrition counseling. These comprehensive prenatal programs, lined with Medicaid, are being found in more and more states. However, not every institution has the necessary resources or obstetrical volume to qualify as a comprehensive prenatal program site. There remains a body of poor women who are uninsured but ineligible for Medicaid.

In order to design a prenatal program that will affirm the personhood of both the pregnant women and the caregivers, an assessment of needs is critical. What has to be determined is: Who is the community to be served and what are their particular needs: housing, substance abuse intervention, transportation problems, other medical or dental services? Are the women teenagers or older women with large families at home? What educational level have most of the women attained? Is it a population with male partners in the home or is it a female dominated culture? Are most women eligible for Medicaid, and is every attempt being made to establish their eligibility? What is the prevalence of substance abuse and domestic violence? What services or clinic characteristics do the current pregnant patients desire? What are their current frustrations with their maternity care?

If the institution articulates a philosophy of care it must live that out in its hiring practices in the maternity clinic. Potential caregivers should understand that the hospital intends to live its mission through the care it gives the poor. The obstetricians, nurse-midwives and nurses should be involved in planning for humane and comprehensive care. Nothing will facilitate this care more than adequate staffing and uncrowded clinics.

The end result of these efforts will be a staff that feels supported and valued. Their energies will be renewed by this support and they will provide the careful attentive listening and problem-solving that is critical to working with the poor. The woman who is the recipient of this attention may for the first time feel respected and valued. Many caregivers believe that this awareness that she is valued is the best starting point possible for any life change.

Footnote

1. Maslow, A.H., *Motivation and Personality*. New York: Harper and Brothers, 2nd edition, 1970.

Health Care for Poor Women and Children

Part II: Some Pressing Ethical Questions

Patricia Talone, RSM

Catherine McAuley did not shrink from the ugly social difficulties of her day, but rather creatively responded to empower the needy, especially poor women and children, to take their proper place in society. Her method was one of direct, hands-on involvement with and service to the poor, providing them with nursing care, education and employment in order to enable them to live life fully. Our contemporary, North American Roman Catholic Church, viewed by insiders and outsiders alike as "pro-life", might well learn from Catherine's example some resourceful means to answer the silent yet desperate call of innumerable poor women and children crying out for adequate health care.

This paper presents statistics which report the deplorable health conditions of poor women and children, examines underlying causes of these problems, suggests some ethical principles for addressing them and offers a feminine perspective that could be incorporated in the response to these problems by Catholic health care and educational institutions alike.

The Reality of the Problem

A cursory glance at any daily newspaper attests to the fact that the plight of poor women and their offspring is worse now than it has been in over twenty years.[1] The infant morality rate has long been cited as a country's index of social welfare and general health conditions. Generally, infant mortality rates throughout the United States have improved over the past ten years chiefly due to major technological advances utilized in neo-natal intensive care units. However in the United States, a black baby is still twice as likely as a white baby to die during the first year of life.[2] Among developed nations, the United States ranks 19th in infant survival.[3] Although my own city, Philadelphia, boasts six major medical schools, its infant death rate ranks in the lowest ten percent of counties nationwide with sections of the city rivaling the island of Haiti in newborn deaths. Low birth weight typically demonstrates a child's potential failure to thrive; low birth weights for blacks nationally is 13 percent, while for Philadelphia's black infants it is 15.6 percent.

On paper, public and private clinics offer health care for indigent women. However such clinics are often grossly overloaded with cases, making access unrealistic if not impossible. *The Chicago Tribune* (25 November 1990) reported that pregnant women had to wait 125 days for an appointment with a physician at a public clinic in that city. Hence, women in Chicago who had no other recourse to health care had to delay pre-natal care until well into the second trimester of pregnancy.

Although much of the reported data recounts the story of African-American, inner city children, the problem is by no means limited to this group. Similar situations exist in rural counties as government cutbacks close the doors of women's health clinics, effectively shutting off health care for poor women and their children.[4]

Reasons abound for the disheartening health care conditions poor women and children experience. Among them are drug abuse, smoking during pregnancy, improper diet, inadequate pre- and post-natal health care, lack of access to health care, lack of health care insurance or under-insurance, lack of education, locality, lack of transportation and the general helplessness of poverty.[5]

. . . no single remedy will improve the state of needy women and children.

Since the problem of inadequate health care for the poor is systemic, remaining deeply embedded in our American economic and social system, no single remedy will improve the state of needy women and children. Even if there were abundant federal and state monies available to pour into women's health programs, bureaucratic responses could not take the place of a more feminine approach to these problems which centers more on relationships, one-on-one education and empowerment of women. Such an approach arises from a feminine consciousness, grounded in the experience of impoverished women and is consistent with Catherine McAuley's practical, impassioned commitment to poor women.

Underlying Ethical Issues

An adequate examination of social problems like those faced by poor women and children demands consideration of the underlying ethical issues. In a paper of this scope we can explore only briefly the complex and interwoven social and ethical issues which contribute to the existence of inadequate health care for the poor.

I would argue that **sexism** is the major root cause of inadequate prenatal care. Some might say that sexism is a red herring and that hoisting a feminist banner hides deeper sociological problems. However there is no doubt that health care for women and children ranks low on priorities set by federal and local govern-

ments, as well as most hospitals. Common understanding about the treatment of women remains primitive in many areas, with some professions treating gynecological difficulties as psychosomatic or non-existent.[6] Although women make up half the American work force, society does not view us as significant and contributing members; therefore, male health care needs take precedence. Furthermore, many needy women are unemployed and on federal assistance, thus making them not only economically unproductive, but a drain upon the national budget.

Because obstetrical and gynecological care generally is not high-tech, it does not offer good return on the dollar for health care providers. In recent years, many hospitals have closed their ob/gyn departments causing women to travel farther to receive the care they need. Furthermore, until recently, medical education considered pregnancy and childbirth a disease to be "treated" rather than a natural process to be assisted. The attitude of physicians shapes women's own self-image, making the uneducated woman much less likely to utilize obstetric or gynecological services.[7]

A second root cause of the woeful health conditions for poor women is **racism.** George Lundberg, M.D., in a recent editorial published in the *Journal of the American Medical Association*, argues that "long-standing, systematic, institutionalized racial discrimination is one of the major causes of our nation's shocking health care access."[8] Health care is not as available to poor African-Americans and hispanics as it is to insured, middle-class whites. Welfare recipients trying to access the system frequently experience frustration and rejection, getting caught in an ocean of paper work and endless waiting to see physicians who don't know them.

Statistics suggest that the decades after the civil rights advances of the sixties have brought little improvement to America's African-Americans. In December 1990, the Joint Center for Political and Economic Studies released a report stating that nearly half of the nation's black children live in poverty, many in families headed by single, unmarried, unemployed women.

That same month the Food and Drug Administration approved the use of Norplant, an implanted contraceptive device that can prevent pregnancy for up to five years. *The Philadelphia Inquirer*, a Pulitzer-prize winning newspaper, printed an editorial linking the two news stories and openly suggesting that this new contraceptive could be "invaluable in breaking the cycle of inner-city poverty." The best way to control African-American, inner-city poverty, the editorial exhorted, was to reduce the number of children because those having children are the ones least capable of supporting them.[9] The editorial elicited a storm of protest, charging the author with racism and Social Darwinianism.

The latter theory originated in the early part of the nineteenth century and endorses the survival of the fittest, stating that disease and poverty naturally weed out weak and undeserving classes. During the early years of the Industrial Age, inner-city indigent people tended to proliferate, thereby exacerbating multiple social problems to the consternation of their more affluent and "superior" country men and women. The theory did not die with the turn of the century. In the not-too-distant-past, Indira Ghandi's administration used mass sterilization to decrease the lowest caste, supposedly improving India's economy and society in general.

Are children the root cause of poverty, or . . . part of the wealth of a nation?

While the Norplant approach might seem like an effective solution to some, it ignores much deeper questions. Are children the root cause of poverty, or are they rather, part of the wealth of a nation? Is a white baby more deserving of health care and compassion than an African-American or hispanic baby? Suggesting that contraception will reduce the "underclass" not only smacks of genocide, it ignores the complexity of the sources of poverty.

A third cause of our country's high infant mortality statistics may be attributed to **drug abuse** which renders young mothers unable to care for themselves or their children. In New York City, in the years between 1981 and 1987, the number of infants born to drug-abusing mothers rose from 6.7 per 1000 live births to 20.3, tripling the rate.[10] In Philadelphia, a survey of city hospitals estimated that in 1989, one baby in six was born addicted to crack cocaine. Statistics do not tell us why these young women are using crack, nor even what happens to addicted babies whose first weeks of life are spent in detoxification. Studies on addiction and co-dependency do tell us that children born to addicted parents do not receive the basic care enabling them to develop emotionally, physically or intellectually.

A fourth cause of inadequate health care for poor women involves a sense of **powerlessness** in the face of poverty, and lack of education. Unwelcome choices about sexual activity also render many young women passive or hopeless. They feel, if there is no joy or expectancy in a future, why bother to care for one's self or one's offspring? Recently an epidemiologist recounted to me a conversation with a young, fourteen-year old woman. She came to the hospital's emergency room with a high fever, complaining of aches and pains, symptoms usually indicating flu or virus. Upon examination, the physician discovered that the

young woman had syphilis, chlamydia and genital herpes — sexually transmitted diseases arising from three separate viruses. Trying to explain to her the consequences of promiscuous sexual behavior, he described infertility and even the likelihood of contracting the HIV virus. Her only response was to ask how long she would have before she got AIDS. "I'm convinced," he confided, "that there is such hopelessness in these young people that the future has no meaning. Their primary concern is their present existence; and if one of the ways to survive on the streets is prostitution, that is what they'll do."

Finally, **lack of insurance or under-insurance** can contribute to inadequate health care. Between thirty-one and thirty-six million Americans lack public or private health coverage. Who are these uninsured? They are generally children, and adults between the ages of 19 and 24. Twenty-nine percent of Black Americans and 41.4 percent of hispanics are uninsured; 18.6 percent of whites are uninsured. Given the need for preventive and early interventive health care for the young, these findings are cause for serious concern.[11]

While this list of underlying causes of inadequate health care is by no means exhaustive, it illustrates the complexity of the problems facing anyone endeavoring to respond to the plight of poor women and their children.

Ethical Principles

Catholic medical ethics grounds itself on three primary principles: the dignity of the human person, sanctity of life and stewardship for life.[12] Because we believe in the goodness of creation, rooted in the Hebrew revelation that God created humans in God's image and likeness, we recognize that each person, regardless of age, race, sex, or contribution to society, deserves respect and care. Dignity arises not from what we do but from who we are. Recognition of this inherent dignity in persons enabled Catherine McAuley to minister lovingly to those who were not grateful for her care; Catherine looked not only at what people were but what they could become.

. . . life is a gift from God, unsolicited and undeserved.

Sanctity of life or reverence for life arises from the good creation and realizes that life is a gift from God, unsolicited and undeserved. Theologians speculate about whether appreciation of life's sanctity originates from nature or is something that we must be taught.[13] Events during our own century like the Jewish Shoah, the Pol Pot massacres and even the indiscriminate drug killing on our cities' streets provide empirical data that if sanctity of life is recognized innately, thousands have hardened their hearts to this dignity.

If life is a gift, then it carries with it a concomitant responsibility. *Jede Gabe ist eine Aufgabe*, German theologians assert; every gift is a task as well. The fifth commandment negatively prohibits killing, but positively it demands much more of the believer — a reverential care of our own and others' bodies. Stewardship for life is the theological principle operative when one consciously cares for one's body by a healthy regimen of diet, rest and exercise. Unfortunately modern medicine concentrates more on curing diseases than preventing them. As we stated earlier, the focus in obstetrics and gynecology remains more disease-oriented than on providing common-sense care of the body during and after childbirth.

While these principles — respect for human dignity, sanctity of life and stewardship for life — are inherent within many religious traditions, society still must foster and maintain reverence for life. Government programs can't instill this, nor can legislative fiat. One learns these truths as one learns one's faith — through a careful handing on of a tradition rooted in experience, reflection and articulation.

Toward a Feminine Response

Nel Noddings, in her book, *Caring: Toward a Feminine Theory of Moral Education,* insightfully suggests that "it is the memory of caring and being cared for that forms the foundation of moral learning."[14] Noddings' theory of moral education provides one model of response to the dilemma of providing adequate care for poor women and children.

Complex problems usually require complex solutions. However, I maintain that no amount of money, legislation or advertising campaigns will instill in poor women the kind of empowerment to help them to care for their children. We have rather haphazardly tried economic, "high tech" approaches to health care education, and they have not worked. Having babies, even in our modern age, is not a high-tech activity. Women have been assisting other pregnant women since the beginning of time. Women learn how to be a wife and mother from other women.[15]

Noddings writes about both the mother's voice and the father's voice in moral education. The latter is objective, conceptual, logical and legalistic while the former is more subjective, affective and relational. One needs both voices in moral development, but in infant and child care, the direct, subjective, relational model confirms and supports women in their efforts to bear and rear their children. Our medical models have been primarily individualistic, based on patient autonomy. In infant and child care, what we need is a model of caring more like what Noddings proposes — one that shows a young woman what to do, how to care for herself and her baby. A young woman needs to meet the same health care provider visit after visit — an

adult who knows and cares for her, one whom the woman can trust and to whom she becomes accountable.

Models already exist offering this more feminine approach to pre-natal care. Midwifery programs gradually establishing themselves throughout the country provide a young woman with a health care professional skilled in gynecological and obstetrical care. Midwives are willing to take the time that overbooked physicians cannot seem to give. Hospice programs geared to the end of life accompany individuals on their journey at the end of life. This model of individual attention could be adapted to life's beginning through mentors visiting a pregnant woman on a weekly basis. While both these models would most properly work out of a health care setting, another way to approach the issue is through in-school programs

Catholic high schools reject distribution of condoms as an inadequate answer to teenage sexuality. Yet, "just saying no" is not enough. Could not courses geared directly for at-risk teens, extending beyond the basic "health" curriculum to self-esteem, knowledge and reverence for one's body, and good child care emphasize the Church's commitment to the dignity of human persons, the sanctity of life and the proper place of married love? Pilot programs already exist in some inner-city schools, educating future mothers and fathers in family and child-rearing skills. More programs are needed to meet an ever-growing demand. None of the suggested programs are high-tech. Their greatest cost consists in personnel and a regular place to meet with needy young women.

Unleashing the power to address medical access for poor women is not an insurmountable feat. Part of Catherine McAuley's gift to the Church and society is the fact that, with grace and hard work, she made the impossible possible. Catherine's zeal and determination to assist the poor is needed as much in our own century as it was in hers. As George Lundberg commented in the *Journal of the American Medical Association*, "If the Iron Curtain can be lifted, the Warsaw Pact dissolved, and East and West Germany politically reunited, all quite rapidly, because it was the right thing to do and the time had come — surely we in this rich and successful country can manage to provide basic medical care because it too is the right thing to do, and the time has come."[16]

Footnotes

1. Report of the National Commission on Children. 24 June 1991. The commission cited ample evidence that children today are worse off than they were twenty years ago. *The Philadelphia Inquirer*, 25 June 1991.

2. Alfred Yankauer, "What Infant Mortality Tells Us." *American Journal of Public Health*, (June, 1990) :653.

3. Teri Randall, "Infant Mortality Receiving Increasing Attention," *Journal of the American Medical Association.* (16 May 1990) :2604.

4. *The Philadelphia Inquirer*, 19 April 1991. See also, Ebin, Makii and Buss, "Combating Infant Mortality," *Health Progress*, (June, 1991) :39.

5. Sarah Brown, ed., *Prenatal Care: Reaching Mothers, Reaching Infants.* (Washington, E.C.: National Academy Press, 1988), 54. Brown examines in depth the financial, medical and social factors working together to militate against prenatal care.

6. It is only recently, for example, that the Centers for Disease Control have begun to list "feminine" problems among those diseases which might signal a depleted immune system and therefore warn of the presence of the HIV virus. Until 1991, AIDS had been described by the CDC primarily as a male disease even though on the east coast the disease was spreading most rapidly among minority women of child-bearing age.

7. For commentaries on this topic see: Barbara Ehrenreich and Dierdre English, *Complaints and Disorders: The Sexual Politics of Sickness*, (New York: The Feminist Press), 1973; likewise, The Boston Women's Health Book Collective, *The New Our Bodies, Ourselves*, (New York: Simon and Schuster), 1984, part VII, "Women and the Medical System"

8. George D. Lundberg, "National Health Care Reform," *Journal of the American Medical Association* (May 15, 1991) :2566-2567.

9. *The Philadelphia Inquirer*, 12 December 1990.

10. Theodore Joyce, "The Dramatic Increase in the Rate of Low Birthweight in New York City: An Aggregate Time-Series Analysis," *American Journal of Public Health* (June, 1990) :683.

11. Emily Friedman, "The Uninsured: from Dilemma to Crisis," *Journal of the American Medical Association*, (15 May 1991) :2491.

12. While these principles are not exclusive to Catholic medical ethics, and are not the only principles to which the Catholic tradition appeals, they do form the groundwork of the Church's teaching about sanctity of life.

13. For discussions upon this topic see: Edward Shils, "The Sanctity of Life," *Life or Death: Ethics and Options*, Introcution by Daniel H. Labby, (Seattle: University of Washington Press, 1968), 12; Daniel C. Maguire, *The Moral Choice*, (New York: Doubleday, 1978), 84; Paul Ramsey, "The Sanctity of Life," *The Dublin Review*, 511 (Spring, 1967), 9-10; Karl Barth, *Church Dogmatics*, Vol. 3: *The Doctrine of Creation*, part 4, trans. A.T. Mackay et al, (Edinburgh: T. and T. Clark, 1961), 339-340.

14. Nel Noddings, *Caring: A Femine Approach to Ethics and Moral Education*, (Berkeley: University of California Press, 1984), 1.

15. Having said this, one cannot ignore the fact that maternal and infant health care programs demand sufficient funding in order to provide the kind of committed staff required to attend to even the most basic needs.

16. Lundberg, 2567.

Book Review:
Women Take Care: The Consequences of Caregiving in Today's Society

By Tish Sommers and Laurie Shields Reviewed by Maureen Mulcrone, RSM

As I began reading Tish Sommers and Laurie Shields' *Women Take Care,* I found myself recalling a biblical theme in three parts: the enjoinder from the Hebrew Scriptures to care for the widow and the orphan; the gospel story of the widow's mite; and the story of the man who had dedicated his wealth to the temple and was therefore unable to assist his aging parents. Each of these stories finds an echo in Sommers and Shield's book which details the consequences of caregiving in a society where women more often give than receive care and where care of the elderly is relegated to a lowly rung on the social funding ladder.

Society . . . provides little financial, medical or social support for caregivers of the elderly . . .

The authors describe their book as "both a statement of fact and a warning" and their description is apt. Since women's income in the U.S. still averages less than 70 percent of men's, women in their older years are more likely than men to be poor (if they are single) or to become poor with the death or impairment of a spouse. Women, who make up the majority of caregivers, are often expected by society and family (and may assume this themselves) to give up virtually every part of their life, including employment and their own health, to the care of an ailing spouse. Society, however, provides little financial, medical or social support for caregivers of the elderly, more than 80 percent of whom are cared for not in nursing homes, but by their families. In approximately 75 percent of the cases the caregiver is a woman.

Women Take Care grew out of the Older Women's League (OWL) Taskforce on Caregivers and its attempt to "bring the invisible problems women face in their later years to public attention and to work toward their solution" (pg. 15). OWL co-founders Sommers and Shields, assisted by the task force, researched the data on aging and caregivers. In addition they interviewed more than two hundred caregivers about their experiences. These narratives punctuate the text with caregivers' compassion, and pride, but also their guilt, loneliness, anxiety, exhaustion, risk of financial ruin, anger, and frustration with social and medical structures which leave them victims of what feminists have called "the compassion trap." (The title of the book might, alternatively, be punctuated: Women, take care!)

This is not a handbook for avoiding the problems of caregiving. Some of the statistics cited have changed slightly since its 1987 publication, and services vary from one part of the country to another. But the book offers a helpful overview of the issues women face in caring for aging spouses and parents. This very readable book also highlights many of the ethical dilemmas which US social policy forces on female caregivers. Most caregivers "are older women, who themselves . . . have health problems" (pg. 21). If home health services were generally available at reasonable cost, home care might be possible even for these women. As things stand, however, in caring for an incapacitated spouse — and in avoiding what may be inadequate care in a nursing home — wives face loss of their own health. But while caring for a husband at home may be life-threatening, putting her spouse in a nursing home may mean that the rest of her life would be spent in poverty. Nursing home costs can quickly consume savings and, since Medicaid is designed as a welfare program, people qualify for benefits only when their assets are below the poverty level. Protecting assets legally is difficult. Some women transfer assets to a third party, but risk losing their autonomy by doing so "because there is no legal way to make sure that person will later give them back" (pg. 63).

A chapter on "special caregiving situations" touches on the additional challenges of, among others, minority women, lesbian partners and caregivers who are unable even to care fully for themselves. These women often face discrimination and further legal or financial complexities in what is already an enormously complex challenge.

In short, the authors illustrate how existing social and medical policy has failed to provide services which would eliminate having to choose between one's own health and welfare and that of a loved one. Sommers and Shields suggest reforms in our way of thinking as a step toward eventual policy reform: 1) recognize the current low social value of caretaking (and "women's work" in general); 2) bring compassion to the center of social policy; 3) socialize "boys and men to provide hands-on care for older relatives, just as girls and women are now socialized" (pg. 184); 4)

recognize the rightness of giving quality care at the end of life; 5) recognize "that providing this care is a shared responsibility between society and families" — and provide "a comprehensive program for long-term health care for the chronically ill, including a support program for caregivers providing economic assistance, when necessary, to make it all possible" (pg. 185).

"Caregiving for someone you love through a final illness can be a deepening, rewarding experience," the authors believe. "If the experience is freely chosen, if the caregiver gets support from medical professionals (training for her new tasks, answers to her questions...), if caregiving doesn't lead her into poverty, if she has help so that the work doesn't overwhelm her, if she gets some respite . . . if excellent care in an institution is available when she feels it is necessary and she is not made to feel guilty for choosing it, then caregiving can be a meaningful close to a loving relationship" (pg. 177). Sommers and Shields ought to know; they have faced the situation themselves. In the process of writing *Women Take Care,* Trish Sommers "became so ill with cancer that she needed constant care . . . Laurie Shields became her primary caregiver" (pg. 187).

Virtually every woman faces the opportunity — or the risk — of caring for a parent, spouse or friend. This book provides a candid, helpful and often inspiring view of what the caregiving experience can be — and an equally candid view of the devastating experiment it can become.

Like other women, religious women should be attentive to the lessons in *Women Take Care.* Once prevented by rules from caring for family members, religious women may now be viewed by their families as the most likely caregivers for aging parents. Unencumbered by children, sometimes perceived as not needing to earn a living ("Won't the other sisters take care of you?") and socialized to put the needs of others before their own, religious women can easily become victims of the compassion trap. On the other hand, religious women can link arms with other women and use their influence together to bring about the kind of reform which Sommers and Shields propose.

Women Take Care: The Consequences of Caregiving in Today's Society. Tish Sommers and Laurie Shields. Triad Publishing Company, Gainesville, Florida, 1987. 224 pages.

Questions for Study/Reflection

1. Return to Doris Gottemoeller's article and reflect on the provocative questions she raises in relation to each of the six issues she sees facing our health ministry today: Commitment to Institutional Ministry; Integration of Ministries; Renewal of the Workplace; Competition and Collaboration; Transfer of Sponsorship; and National Influence. How are you as an individual struggling to resolve or respond to these issues?

2. Mary Ann Getty Sullivan speaks of healing as a process of acceptance and reflects upon her "healing" experiences of death. In what ways have we experienced "healing" in our own lives, in our personal experiences of death or painful tragedies? In what ways does our faith in God broaden our definition of healing and our openness to receive healing? Where in our lives do we need healing?

3. How does the description of "mercy" as "an experience of grace and healing" (as suggested by Mary Ann Getty Sullivan) affect our understanding of ourselves and our mission as Sisters of Mercy, Mercy Associates, and friends of Mercy? Does the description challenge or enhance our vision of what and how we are called to be for others?

4. Kate McHugh and Patricia Talone's articles emphasize the needs of economically poor women and children within our health care system and explain the special attentiveness their health and well-being requires. How well do our Mercy medical facilities meet the needs of poor women and the needs of caregivers as well? How can we be more affirming of the worthiness and dignity of the poor women we serve? What are we doing to address the problems caused by sexism, racism, drug abuse, the sense of powerlessness, and inadequate insurance?

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