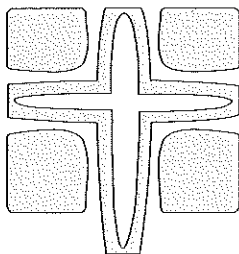


The **MAST** *Journal*

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Dear Sisters, Associates and Friends,

In recent lecture invitations, I have been invited as a feminist theologian to talk about the connection between women's spirituality and domestic violence. My premise is that we need to oppose the use of the Bible as justification for patriarchal codes which subordinate women and legitimate their social oppression. A literal, unquestioned interpretation of scripture can reinforce domestic abuse, whether physical, sexual or emotional. "If anyone hits you on the right cheek, offer him the other as well" (Matt. 5:39). Women who hear this passage can assume there must be a divine recommendation that they make the sacrifice and endure domestic violence as something pleasing to God. More significantly, men can assume they have a divine right to hit their wives, and that women are supposed to "take it" without complaint.

As a former English literature teacher, I argue in my classes for a method of interpretation which is appropriate to the genre of the text. The metaphor "turn the other cheek" can be translated as a message which liberates rather than enslaves women. "Stop the cycle of violence by doing something so unexpected that the perpetrator-victim dynamic is broken." Rather than a passive response, "turn the other cheek" can mean, "Get out of the situation," or "Stop playing his game according to his rules. Make some rules of your own."

This issue of *The MAST Journal* on the theme of caring about health care reflects the competent work of Patricia Talone, R.S.M., of our editorial board. I suggest that domestic violence compels our attention because it affects the lives of women, not only as a criminal matter, economic crisis, or psychological concern, but also as a health issue. Our Mercy-sponsored institutions employ many women. Statistically, a significant proportion of them have suffered, or are currently enduring domestic abuse. The health-related data which I draw from a number of sources is sobering.

- Battering is the major cause of serious injury to women in America, more than auto accidents, muggings, and rapes combined. One study found violence to be the leading cause of injuries to women ages fifteen through forty-four years.
- Approximately 95 percent to 98 percent of the victims of battering are women.
- It is more likely for a female to be killed by a spouse than it is for a police officer to be killed in the line of duty.
- More than 50 percent of all women will experience some form of violence from their spouses during marriage. More than one-third are battered repeatedly every year.
- Nonfatal physical violence between spouses is estimated to occur in one of six homes each year, and females are more likely than males to be injured.
- Each year more than a million women seek medical treatment for injuries inflicted by husbands, ex-husbands or boyfriends.
- Between 15 and 25 percent of women are battered during pregnancy.
- Women who leave their batterers are at a 75 percent greater risk of being killed by their batterers than those who stay.
- The estimated cost of domestic violence in New York City alone in medical expenses, lost work days, foster home care, homelessness, and law enforcement is \$500 million a year.
- In Ohio, 90 percent of abusive or neglectful parents were abused as children. 73 percent of Ohio male abusers were abused as children.

Our Institute Direction Statement calls for attention to the needs of women, and for giving energy to the rights of women in church and society. To find women mentally traumatized and physically injured by domestic violence, we do not have to look very far. We have only to consider our many Mercy-sponsored health care institutions. Domestic violence, which touches all economic and social classes, is painfully and regularly impacting the lives of women who presently serve as Mercy administrators, staff, employees, benefactors, patients, and their family members of all ages. We have a pressing need and system-wide opportunity to be both healers and educators who respond to this mandate: Stop the violence against women.

Health-care administrators interested in addressing solutions for domestic violence at a systemic level can contact the Corporate Alliance to End Partner Violence, Alameda Court, 1457 West Alameda #10, Tempe, AZ, 85282-3228. Phone: (602) 517-0950 Fax: (602) 517-0957.



Sincerely,

Marie-Eloise Rosenblatt, R.S.M.

Marie-Eloise Rosenblatt, R.S.M.
Editor, The MAST Journal

My Experience of Transplant

Marie Ann Ellmer, R.S.M.

IN 1987 AT THE AGE OF thirty-eight, I went to see a doctor because of severe headaches, which I assumed were sinus-related. The doctor diagnosed and treated me for hypertension and sent me for additional testing. For many months, my blood studies showed an elevated creatinine or measure of kidney function. Concerned, the doctor then ordered a kidney biopsy which revealed that a significant amount of my kidney tissue was diseased. Doctors did not know the cause of this disease, although they raised the possibility of a previous untreated strep infection. No one in my family has had kidney disease, and I do not belong to any category of persons likely to suffer early kidney failure.

There remained two things to do. First, I prayed that the kidney deterioration would be slow. Second, because protein can put stress on the kidney, I began a low protein diet. I went for several medical opinions, and although each doctor was certain that my kidneys would eventually fail, the length of time they estimated for this to take place varied from two to ten years. I began a long journey of uncertainty.

I am quite tall and have high coloring, making me so healthy looking that it was difficult for my friends to believe that I was sick. It was even more

difficult for me to believe. At the time, I was teaching in high school, producing musicals, conducting a seventy-voice chorus, and in my spare time, chairing the Congregation's Liturgy Committee. Working with my spiritual director helped me to begin to face the reality that I was chronically ill. I gradually moved from cerebral analysis of my illness to dealing with it before God on a deep, feeling level.

In 1991, my creatinine level rose dramatically, making it clear that I needed treatment for End Stage Renal Disease. No time would have been good for this to happen, but I had just

sis and transplant. I began with dialysis. The early months of treatment were very distressing for me. I began dialysis at a free-standing company-owned unit, because it was close to my home. The center often ran out of needed supplies and sometimes even mixed up the prescribed treatment. One reason for this is that the center was understaffed. During my time there, I rarely met with either a social worker or nutritionist because these staff members had so many other patients. After six months at the first center, I transferred to a local hospital unit and was much happier. I received excellent care and was

After six months at the first center, I transferred to a local hospital unit and was much happier. Making this change took courage and taught me a lot about being active in managing my own medical treatment.

begun a new job as coordinator of liturgical ministries in a huge parish. Actually, my ministry change turned out to be providential because I worked with a staff who were totally supportive. I realized that teaching would have been very difficult at this juncture in my life.

In one sense, I feel fortunate to have a disease for which there are two treatments: dialy-

sis and transplant. Making this change took courage and taught me a lot about being active in managing my own medical treatment. While on dialysis I met so many marvelous nurses and technicians as well as the brave women and men who were, like me, patients. Some had been waiting for over three years for a donor. Others would be on

my sister, after donating her kidney, might develop the same mysterious disease I had.

Those were difficult days of waiting. I was so angry with God and so filled with questions. Why was God allowing this suffering in my life? Why does someone else have to die in order for me to live? Why do I have to wait so long? How could this be happening to me? I have never been sick before. I had given my life in service to God's people and now was struggling just to survive one day at a time.

I had an extremely understanding and compassionate pastor and coworkers as well as a loving community, family and very loyal friends. During this time, I received great strength and support from them. Also, a book I read (*The Spirituality of Hope* by Segundo Galileo) helped turn my heart around. I began to realize that disease and God's friendship are not incompatible. Seeing life as

suffering from a brain tumor, which later took her life. I became her protector away from home. I noticed how drawn to her I had always felt because of her sufferings and imagined that God feels the same compassion and tenderness for me when I am in distress.

My year of waiting for a transplant was like a roller coaster ride. I carried a beeper with me at all times. It would go off accidentally at the most inopportune times, even in the middle of a Mass that I was playing or conducting. Each time the beeper beeped or the phone rang, my heart leapt with hope. Intellectually, I knew that many people waited for a very long time for transplantation, but waiting was still torture for me.

On April 1, 1992 at 5:00 A.M., the transplant team coordinator called with the good news that an excellent match kidney was available and would be coming to Philadelphia from Missouri. This was *not* an April Fool's joke! By painful coincidence, the sister who answered that early morning phone call died a few years later after an illness of only a few weeks. Life is so full of paradoxes. The April Fool's part came later in the day, when someone discovered that a pancreas had taken a plane ride to Philadelphia in a cooler rather than the kidney

on dialysis for fifteen
s—they were not
a transplant. Their
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, offering concrete
w to live through

were frightening because of all the tubes and monitors and because the new kidney had not yet started to work. Finally, she (I named the kidney Betty) was functioning and I was discharged from the hospital in nine days. I was no longer on a restrictive diet, not tied to a machine, and not full of toxins. I was given a new life.

My first two months after transplant were really rocky. I had two episodes which at first seemed to be rejection and a third that brought me very close to death. With quick diagnosis and extensive treatment, I made it through these incidents. I will require a lot of expensive medications for the rest of my life. Although many of these drugs have serious side effects, it seems a small price to pay for a second chance on life.

It is difficult to express adequately what it means for me to feel healthy and be free of dialysis. The older sisters in my congregation called me the "miracle lady" because when they were my age, transplant or even dialysis was not an option.

My own theory is that being sick is really all about relationship.

Being able to eat all the restricted foods was great and it was wonderful to work and travel . . . to live again. As waves of relief poured over me and I thanked God, I thought a lot about how grateful God must be when doctors and scientists unlock the mysteries that help us return to health. How amazing that someone else's kidney

is keeping me alive. Although I did not recognize it at the time of transplant, this was a significant time of integration and transformation in my life.

As waves of relief poured over me and I thanked God, I thought a lot about how grateful God must be when doctors and scientists unlock the mysteries that help us return to health.

Some members of my community and I started a support group for chronically ill religious women. While each one of us deals with a different challenge (lupus, arthritis, etc.), we found that a healthy lifestyle is key to coping with disease or illness. Support groups in which each of us had participated in the past focused on relating to spouse or children. Ours deals specifically with issues of prayer, community, ministry and play. On a very practical level, we also discuss how to stay on top of insurance forms, doctor visits, and medications.

My own theory is that being sick is really all about relationship. The focus is on learning the ministry of self-care and being honest with God and the people in my life. Moreover, my own vulnerability allows others to share their pain with me.

Each year the anniversary of my transplant occurs close to

the celebration of the Church's Triduum. For me the words, "This is my body, given for you," have many levels of meaning. My donor was a

woman in her fifties whose husband and five children made the courageous decision to offer her tissue and organs for transplantation. Up until now, the procurement organizations insist that the relationship between donor and recipient be anonymous. I wrote to my donor family to express my gratitude for this gift of life. I have not received an answer.

Recently I attended a speaker training for Organ and Tissue Donation. The message was very clear: Having the conversation about your intentions to donate with family, friends and community members is essential. It is not enough to fill out a donor card and put it in your wallet or even in an advance directive. You must verbalize your wish to become an organ donor to those close to you. If you haven't already said "yes" to Organ and Tissue Donation, please reconsider. You can say to many those life-giving words, "This is my body, given for you."



Sponsorship

Fidelity and the Future of Catholic Healthcare

Mary Kathryn Grant, Ph.D. and Patricia Vandenberg, C.S.C.

THE LAST DECADES of the twentieth century will have seen more changes in Catholic healthcare than at any other time in its history. Three particularly volatile areas have a significant bearing on the evolution and consequently, because of their interrelatedness on the future of the ministry: changes in the delivery and financing of health care; changes in the demographics and ministerial focus of religious congregations who have historically served as sponsors; and the changing requirements of sponsorship itself.

In order to be positioned for a strong and viable future, today's sponsoring congregations need to articulate their future locus of and requirements for sponsorship; to identify the competencies which will be required of sponsors in the future; and to implement plans to identify and develop sponsors with these competencies—religious or lay. Failure to address these three critical areas in a timely and focused way could inevitably lead to the diminishment, or worse to the erosion of health-care ministry in the future. In order to examine more fully the three challenges to fidelity and sponsorship, this paper will first critically summarize the forces at play in the areas of health delivery and congregational fo-

cus before discussing the how and what of sponsorship in the future.

Before proceeding, however, a definition of sponsorship is in order. Sponsorship, as it is used here, describes the relationship between the organization and that body, the sponsor, which is responsible for its integrity as a ministry of the Church. Embodied in this definition are the requirements of Canon Law, namely the stewardship of church property and the faithful administration of the ministry. By extension then, sponsorship becomes the force, as it were, which animates the organization and assures its fidelity and organizational integrity.

The Health-Care System

Reform of the health-care system today is taking place through a variety of drivers: advancements and developments in technology; changing payer requirements; governmental reform initiatives—state, local, and federal; increasing interest in and application of alternative treatment and healing processes; individual's accepting greater personal responsibility for one's health and prevention—to name but a few of the forces reshaping the delivery system. These forces are ineluctably altering the face of health-

care in America today including the face of sponsorship and its corollary—mission integration and effectiveness.

On the delivery side, today we see a more educated consumer of healthcare, one who has access to computerized information on diagnoses and treatment via such sources as the internet; one who takes more personal responsibility for his/her health; and one who has more alternatives with regard to treatment modalities and options. Advances in home care and outpatient procedures have irrevocably changed the locus of delivery sites while at the same time opening tremendous opportunities for creative and innovative approaches to mission integration and development, creating new challenges for ethical discernment, and evaluating the potential for forging partnerships that were undreamed of in the past.

On the financing side, full integration of financing and delivery through participation in the provision of insurance or other financing vehicles and products is becoming a necessity. This development alone creates a whole new world of ethical discernment regarding such issues as coverage, exclusions, qualifications, access, and experience rating—to name but a few. Further, initiatives such as capitation can halve an insti-

tution's or physician's revenue in a relatively short period of time, as well as alter referral patterns, relationships, and business partnerships. These all require new approaches in ethical discernment—for sponsors, trustees, and medical and executive leadership.

What seems clear is that, in the future, Catholic healthcare will not sponsor hospitals or medical centers and long term care facilities per se, but rather it will sponsor complex integrated health systems, in whole or in part. Today, as never before in its history, Catholic healthcare has a critical and vital role to play in American healthcare—not only in sustaining a culture of service and respect for the person in the delivery of services but also in raising a voice of ethical consciousness, moral reflection, and passionate insistence of the right of all to needed health services. The issues raised by the changes cited above have seemed daunting to many current sponsors and have caused some congregational and diocesan sponsors to question whether they will remain in institutional health-care ministry at all; or if they remain, whether that role will be as sponsor or as a hands-on provider of care.

Posited on the belief that without a firm institutional or organizational presence in American healthcare one cannot have an effective moral voice, this paper argues for remaining in institutional health care and thereby helping to transform the American delivery system. American healthcare would be that much poorer

without the presence or with a diminished presence of Catholic health-care providers and sponsors. What is needed, however, is a clearly articulated vision for Catholic healthcare in the face of massive changes and a well defined plan of action to secure its future presence and participation.

Changing Congregational Dynamics

Religious congregations that have historically served in the role of sponsors for Catholic health-care ministry in the United States have been undergoing profound changes in re-

tions have fewer and aging religious to continue either the ministry of direct service or the ministry sponsorship and governance of established ministries. So much has already been written about the aging of congregational members and the corresponding decline in the numbers of members available for governance-sponsorship service that it need not be repeated here. These factors coupled with the continued growth in members' interest in and desire to serve in non-institutional or more social justice oriented ministries have likewise impacted the numbers of sisters available for service in governance or sponsorship.¹

What seems clear is that, in the future, Catholic healthcare will not sponsor hospitals or medical centers and long term care facilities per se, but rather it will sponsor complex integrated health systems.

cent decades, particularly since the second Vatican Council. Four forces impact the future of sponsorship for religious congregations: their changing demographics; the strong bias among many members for non-institutional ministries; the sometimes strained ecclesial relations over ethical issues and institutional self-governance; and the velocity and complexity of issues facing healthcare itself, many of which have been alluded to above.

It goes without saying that American religious congrega-

When these internal factors are juxtaposed against the changing health-care delivery scene, it is not surprising to find traditional congregational sponsors exploring new models for sponsorship and/or examining the desirability of moving to a public juridic model, wherein the requirements of sponsorship are fulfilled by a board, or other specifically designated groups of lay persons. A public juridic person is the "corporate person," publicly recognized as responsible for those assets identified as stable patrimony

or ecclesiastical goods and governed by the requirements of Canon Law. In the past, the public juridic person responsible for health-care ministries has generally been the congregation or diocese which founded or currently owns the assets of the ministry.²

Most, if not all of the more mature Catholic health-care systems including Mercy-sponsored systems, have explored the desirability or feasibility of moving toward this option. The first organization to move in this direction was the Catholic Health Corporation (CHC) which was created principally by the health ministry of the Omaha Mercy regional community. Today, Catholic Health Corporation has become a part of Catholic Health Initiatives formed by Catholic Health Corporation, the Franciscan Health System (Aston, PA), and the Sister of Charity Health Systems (Cincinnati, OH). Covenant Health System, originally sponsored by the Grey Nuns of Montreal, has likewise been recognized as a public juridic person.

These developments are cause for reflection. What does it mean to sponsor today? What actually is sponsored as health-care moves outside the walls of the traditional hospital or long term care setting into integrated delivery systems? What will be the focus of the sponsorship agenda in the future? What attributes or competencies must the next generation of sponsors possess? These are the critical questions facing us today—the answers to which will indelibly

reshape the face of Catholic healthcare.

The Starting Point

To create a future for Catholic healthcare as strong and vital as its past will require serious discernment on the questions above. However, what is lacking today is a well developed and articulated theology of sponsorship as a foundation on which to build models or articulate and evaluate alternatives. Over the years, Catholic healthcare has not carefully or systematically addressed the need for this theological foundation. Today, the need cannot be ignored; Catholic healthcare needs to articulate a theology for sponsorship, one which is rooted in a Gospel spirituality and in a post-Vatican II ecclesiology. These footings are essential to the further evolution and maturation of the ministry—without which there will be only a non-intentional (and perhaps unintended) future.

A theology of sponsorship will need to address the challenges, the direction, and the radical shaping of its response to the times. It must be created in the spirit of praxis. It must acknowledge the call of each person to holiness, to live in a discerning manner, and to selflessly respond to the legitimate needs of others and the need to do so within the community called church (*Lumen Gentium, Gaudium et Spes*). It must also situate healthcare as a vital ministry of the Church. Once this theological foundation has been articulated and reflected on, the praxis must continue

and shift its focus on those individuals who have responsibility for insuring integrity and fidelity to the organizational mission and the qualities, or competencies, which they must possess to sustain and to strengthen the health-care ministry.

The Concept of Competencies

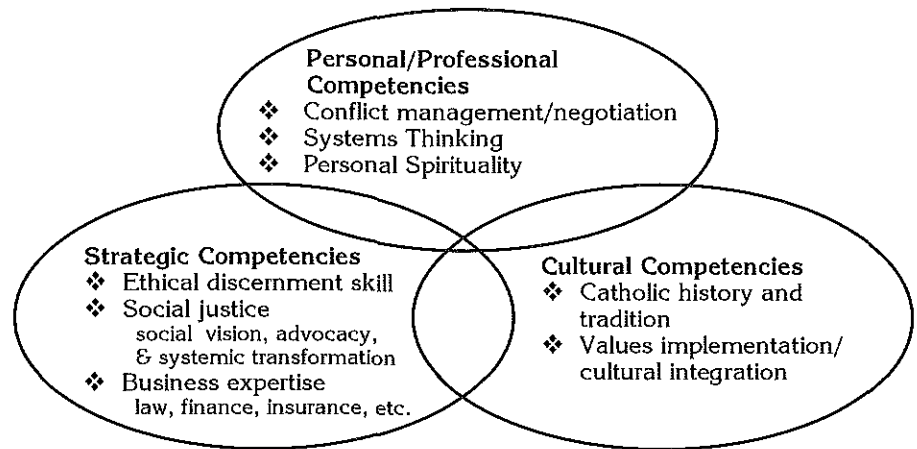
The concept of personal/professional competencies is borrowed from business and refers to those critical skills, behaviors, and attitudes which an individual characteristically and consistently exhibits in performing a certain role or function.³ In other words, they are “second nature” to the individual—not just those characteristics which are in evidence in a crisis, for example. To apply this notion of core competencies to sponsorship may be a most fruitful first step in preparing the next generation of sponsors.

Competencies may be clustered into three categories: strategic, cultural, and personal. The strategic qualifications of sponsors might at a minimum include: skill in ethical discernment; social vision embracing social justice, advocacy, and systemic transformation; and requisite business expertise (e.g., health, finance, insurance, law, etc.). Somewhat harder to name and measure are the cultural sensitivities which must include an understanding of and sensitivity to Catholic health-care history and tradition as well as the capacity to translate historical values into present situ-

ations in a complex, dynamic health-care environment. Personal attributes would call for a personal spirituality; the ability to manage conflict and negotiate win-win outcomes; and a capacity for systems thinking.

The role of sponsor has traditionally been carried out by the religious congregations which founded or acquired hospitals and long term care organizations. As noted above, today healthcare is principally organized around integrated delivery, not around health-care facilities. It finances systems which assume responsibility for the health status of defined communities and not the episodic delivery of care. It assumes the economic risk associated with that responsibility. What could be more consistent with the prevailing emphasis of religious congregations to serve the whole person and to heal or develop communities of persons? Is this not another compelling reason for religious congregations to remain in institutional ministries?

What should be noted in the statement above is that what is actually sponsored today is changing from sponsoring health-care facilities to sponsoring integrated delivery structures, partnerships, and networks in a variety of complex and interdependent relationships. And in the wake of this shift is a corresponding shift in the issues faced by current sponsors. No longer is sponsorship primarily focused on the buying, selling, mortgaging, or otherwise encumbering church property—but sponsors are called to approve partnerships,



joint ventures, outreach initiatives and other interwoven patterns of networking and to do so with an eye to the ability of the newly formed organization to be faithful to the mission and values inherent in the ministry, to be creative in responding to needs, and to be discerning in moving into new relationships. In the final analysis, because the very focus of sponsorship will have changed, sponsors of the future will need a whole new set of skills than those the sponsors of the past needed.

What is needed for today and for tomorrow are competent sponsors: sponsors who are grounded in fidelity to the heritage and the mission of the organization, committed to assuring the integrity of those organizations, and who understand and promote ethical discernment in all decision making. Finally, the very structure of sponsorship will inevitably be altered in the creation of these integrated delivery systems. A structure with the leadership of the congregation as corporate member with reserved powers will most often not be adaptable to the new delivery structure. The locus of sponsorship itself will most likely shift to the governing

board of the Integrated Delivery System.

The most likely scenarios for the locus of sponsorship are that Catholic healthcare will generally not be the sponsors of the entire integrated delivery and financing systems, but only of some of its parts; that it will not always, and more likely most commonly, not be the majority or controlling partner of such systems; and that that which it controls will not always be the most central or critical component of the integrated system. In other words, Catholic health care may bring the hospital component while other partners bring the financing and other service sites or components of the system. These shifts, while seemingly subtle, will have a profound effect on the manner in which sponsorship is exercised as well as the qualities required in the sponsors.

Personal characteristics of the next generation of sponsors must include the ability to negotiate to win-win conclusions, to place common good and Catholic/Christian identity before the historical self-identity of the organization, and to be able to say *No* when ethical discernment directs nonparticipa-

tion. These are relatively new skills for sponsors who historically may have operated under a different set of norms and ground rules more appropriate to a family owned business than a highly complex economic partnership.⁴ Foundational to assuring sponsorship in the next generation is belief in the power of its values to influence and our spirit and spirituality to animate the transformation of American healthcare—an influence that is posited on Catholic sponsors remaining active players in healthcare. Moreover, a spirit of courage and daring, rooted in personal and organizational integrity is essential

translation and transporting of values into new partnerships and new organizational structures without relying on those vehicles which have made us successful in the past. It goes without saying that the next generation of sponsors must have deeply integrated spirituality and passionate concern for the poor and disenfranchised.

Power: Control or Influence

This reflection would not be complete without some reference to the debate in Catholic healthcare today on the question of control versus influence.

gation in whom these competencies have been developed; or in joint partnership with laity sharing in the role of sponsor, or of laity alone who have been prepared to serve as sponsor. How do we begin today to prepare the next generation to be faithful stewards of the ministry and thus secure a Catholic presence in American healthcare? As Catholic health ministry continues to move from delivering episodic institutional care to being entrusted with the health—in all its aspects—of our communities, we must continue to ask: What will sponsorship mean? What must we tell the next generation?



Sponsor Accountabilities

- ❖ Creation of communities of persons committed to mission
- ❖ Commitment to rigorous ethical discernment
- ❖ Translation and migration of values throughout integrated delivery structure
- ❖ Passionate concern for and commitment to the poor

together with a spirit of detachment from individual corporate or congregational identity and a willingness to forge those partnerships which will insure the future viability of Catholic health-care ministry.

Foremost among the accountabilities of the sponsors in the next generation are: the creation of communities of persons committed to a shared vision and common core values; the willingness to engage in rigorous ethical discernment about resource allocation, partners, and service and strategic opportunities; the successful

Historically, congregations owned, operated, and governed hospitals and other health-care facilities (and thereby had control over these assets). This is certainly not the case today. With the growth of integrated delivery systems, forging partnerships with other providers, payers, insurers, social agencies in local areas, today's sponsors must of necessity sponsor in a mode of influence.

In summary then, today's sponsors must find the energy to develop the next generation of sponsors which may be made up of members of the congre-

Notes

1. See Nygren, David J. and Miriam D. Ukeritis, *The Future of Religious Orders in the U.S.: Transformation and Commitment*, Westport: CT.: Praeger, 1993.
2. See Beal, John P., "Catholic Hospitals: How Catholic Will They Be?" *Concilium*, 1994/5, pp. 81-90.
3. McClelland, David C., "Introduction" and "Definition of a 'Competency,'" pp. 3-15. In Spencer, Ph.D., Lyle M. and Signe Spencer, *Competence or Work: Models for Superior Performance*, New York: Wiley, 1993.
4. See Grant, Mary Kathryn, "Sponsorship in Evolution," *Health Progress*, September 1990, pp. 40-43.

The Challenge of Managed Care

Patricia Talone, R.S.M.

EVEN THE MOST CURSORY attention to daily newspapers, television exposés and social conversation leads contemporary Americans to believe that business and medicine have become almost irrevocably entangled.¹ In a world of managed care, doctors become "gatekeepers" and patients become "capitated" or "covered lives," thus fundamentally changing the way that patients and health-care providers view their relationship. Many people who manage care companies are the *bête noir* of medicine, capriciously denying patients access to needed healthcare and permanently dissolving the sacred physician-patient trust relationship. Such an opinion simplistically reduces reality to an "us vs. them" conflict.

There is no doubt that managed care presents serious ethical issues to both health-care professionals and consumers. Those of us involved in Catholic healthcare must pay particular attention to the challenges and possibilities that it offers. This becomes particularly important to Sisters of Mercy who, through their various health systems sponsor HMOs. Some of these HMOs direct care primarily for the poor while others are for-profit organizations whose revenues assist in Mercy's outreach to the poor and underserved. We must be perfectly clear that

managed care is not intrinsically evil; nor are health professionals and the public helpless in the face of the ethical dilemmas it presents.

Defining Terms

The term *managed care* refers to almost any alternative to conventional fee-for-service agreements. In a broad sense, managed care "encompasses any measure that, from the perspective of the purchaser of healthcare, favorably affects the price of services, the site at which the services are received, or their utilization."² As such, it portrays a continuum from plans that do little more than

including a concern about both quality of and access to health-care.

Physicians, health-care administrators, and nurses often complain about managed care of patients because HMOs initiate rationing. Georgetown University physician and ethicist Edmund Pellegrino defines *rationing* as "organized, systematic, deliberate limits on access to needed healthcare according to some primary principle other than the good of the patient."³ Pellegrino deplores the fact that managed care decisions are often based on a utilitarian consideration about allocation of financial and medical resources

*Physicians, health-care administrators,
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require prior authorization of inpatient stays, to the staff model HMO that employs doctors and accepts risk for delivering a comprehensive benefit package. Most organizations that provide managed care are either HMOs (health maintenance organizations) or PPOs (preferred provider organizations). Ideally, managed care seeks not simply to cut costs, but endeavors to maximize service to and care of persons,

and fiscal bottom line rather than on beneficence toward or concern for the patient. These plans make the primary care physician a *gatekeeper*, or the "agent through which access to and denial of healthcare resources are channelled."⁴ Nonetheless, not all managed care plans are alike, and many actually provide what they pledge to their enrollees. That is, good quality medical care for a reasonable price.

think are their inalienable right. Second, managed care has already reduced escalating health care costs and offers hope for continued reduction in the future. Because we have limited

in prenatal and well-baby programs offered by our own HMOs.

Fourth, whether we like it or not, managed care is forcing the American public into dis-

Many HMOs and PPOs are responsible and ethical. Others are little more than an rationalization for senior management and stockholders to make money from their enrollees.

health-care resources, we must exert careful stewardship of these assets. Is this not part of our Christian teaching? Are we not called to stewardship by our Church's social justice encyclicals and ecclesiastical letters?

Third, many managed care plans help to keep patients healthy by offering broader preventive and educational programs. Notable among these include weight loss and exercise programs, cessation of smoking seminars, blood pressure, breast and prostate cancer

course about both our use of limited health-care resources and about treatment efficacy. For the most part, in 1993 the general population did not engage in needed wide-ranging discussion about health-care reform. Our current discussion about managed care forces a much-needed dialog between the medical community and the business community and thus, serves the general health.

Lastly, because it sets limits on what physicians can offer to patients, managed care compels physicians to tell patients and their families the truth about their physical conditions. Daniel Callahan, in his 1993 book, *Troubled Dream of Life* argues that Americans are profoundly uncomfortable with even the thought of death and

*Systems have better
ace to control the
tion of health care
like fee-for-service
managed care does*

of both medical and financial optimism.

What are the Ethical Issues?

Having noted what is good about managed care, one cannot ignore that it can and does present serious ethical problems to physicians, nurses and health-care administrators as well as to patients and their families. The most significant among these are *divided loyalties*. Edmund Pellegrino and David Thomasma argue for the importance of the physician/patient trust relationship to the medical profession and to the good health of the patient and, therefore, our entire social system.⁷ The physician, they maintain, is the agent and advocate for the patient, and not for the family, the nation, business, or even a political and social system. Because one cannot entirely escape the fact that the patient is, to some extent, vulnerable, dependent, anxious and exploitable, the importance of this trust relationship exponentially increases with the gravity of the patient's illness.

Managed care contracts may cause ethical conflicts for the physician by providing financial incentives to either un-

der treat or not treat at all, thus influencing the quality of patient care. They may also provide incentives to treat patients unnecessarily, for example, by fleeting "visits" to stabilized nursing home residents simply to collect a fee. A few managed care companies have sought to put "gag" rules on physicians, prohibiting him or her from

physicians must disclose the facts to the patient when he or she is forced to deny care for financial reasons. He further contends that the health-care professional is morally accountable for his or her actions.⁸ So too, the HMO or health-care system that negotiates for managed care contracts without properly insuring that the

Managed care contracts may cause ethical conflicts for the physician by providing financial incentives to either under treat or not treat at all.

telling the patient that the HMO prevents the doctor from doing further testing, or procedures.

A health-care professional who knowingly benefits by not providing the best care to his or her patient engages in *moral complicity* if harm is done to the patient. Since nothing can be done for the patient without the involvement of his or her attending physician, the latter cannot absolve him/her self if the patient suffers through negligence or poor quality care. Shifting responsibility to the "system" is simply not acceptable. Pellegrino asserts that

HMO or PPO truly provides for the patient's general health carries similar culpability because it has failed to exercise its fiduciary obligation.

Another danger for the physician is that he or she may be in the position of *rationing* patient care: choosing to treat one patient rather than another. Forced to make value judgments about which patients need certain tests, treatments, and procedures and which ones don't, the physician should ground these decisions upon certain principles and values. Because health-care professionals are human, they may experience and express bias about age, race, ethnicity, class, or lifestyles and give preferential treatment to one patient over another. Pellegrino contends that the fundamental moral demand upon any health professional is to treat those who ask for care regardless of the patient's worthiness.

The physician is the agent and advocate for the patient, and not for the family, the nation, business, or even a political and social system.

The ethical principle of *autonomy* (from "autos" [self] and "nomos" [rule]) insures that patients have the right and ability to govern themselves. Because adults are responsible for their own health, they must make the proper decisions to care for their health and well-being. While no one has absolute autonomy, many physicians and ethicists voice concern that managed care plans usually limit their enrollees in a choice of doctors or services. It must be noted, however, that choosing one's physician does not necessarily secure a strong fiduciary relationship with the professional.

Managed care plans may also challenge another basic ethical principle, that of *informed consent*. Individuals enroll in these plans either through their

tion for their livelihood. Catholic healthcare, too, cannot continue its ministry without financial solvency. Because of these facts, many believe that we are helpless in the face of

should insurance and managed care companies account to the public and their enrollees for their quality of care and for the ethical integrity of their business practices? Whose money

Health-care professionals bear the moral obligation to advocate for patients.

powerful managed care companies to effect changes that will benefit our patient's health and lives. It seems incongruous that health-care professionals, respected throughout the world for their technological proficiency and first-class care, are willing to "roll over and play dead" for businesses that threaten to erode the fabric of

are they using? To whom should they be accountable? State Medical and Nursing Associations as well as state Catholic conferences can lobby at the local level for an accountability system. Individuals working within large health systems can persuade administrators and business negotiators to build accountability criteria into their managed care contracts.

The American Medical Association urges its members to *advocate* for the care they believe will benefit their patients.⁹ Health-care professionals also bear the moral obligation to advocate for patients. It may mean that an institution will have to hire a nurse-ombudsman to contact and bargain with managed care companies. Presently, many institutions employ a physician or nurse to communicate with the HMO. But at present, this person's role seems more directed to obtaining or recovering remuneration that the institution needs than as an advocate for the sick person.

While individual professionals may feel that taking on a managed care company is analogous to David confronting Goliath, associations and

Because adults are responsible for their own health, they must make the proper decisions to care for their health and well-being.

employer's *fiat* or through their own initiation. Managed care companies have a moral obligation to inform enrollees if the plan restricts referrals to specialists or rewards primary care physicians for financially reducing costs. In fact, plans should inform enrollees about any restrictions of their plan.

What Can We Do?

Health-care institutions and the professionals who care for the sick depend upon remunera-

their relationships with patients and their own understanding of the healing vocation. We are not powerless and we must muster our considerable resources to effect change within managed care systems themselves.

One of the first things needed is a clear program of *checks and balances*. If acute-care institutions are subject to JACHO regulations and long-term care facilities must submit to state monitoring bodies for licensure, then how much more

health-care systems must *exert moral muscle* on behalf of patients. This means that systems contract with health-care plans from a position of moral strength, insisting that certain fundamental criteria like informed consent, clear appeals

as a nurse helping a patient to phrase the correct question for his HMO provider. Or it may involve a social worker carefully explaining to a patient how to access the PPO's appeals process when she has been denied needed care. Systems

provide health-care professionals the avenues they need to maintain personal ethical integrity and ensure that the American health care system remains healthy and caring.



Managed care plans are here to stay for the foreseeable future. Expendng one's energy railing against HMOs and PPOs does little to provide better care to patients.

policies, acute-care as well as preventive coverage are offered to enrollees. If we care about the health of our communities we must call managed care plans to accountability. Many HMOs advertise about the numbers of people they have enrolled. But exactly how have they effected change in the health of newborns? the elderly? the mentally ill? Slick slogans and catchy advertising spots do not tell of an HMO's success. Only the health of the community can do that.

Until now managed care plans and even employers' human resource departments have been woefully negligent in educating the public about managed care. If these groups fail in their duty, then health-care professionals must confront these serious issues. It is incumbent upon hospitals and other health-care agencies to instruct patients and their families about the benefits and limitations of managed care. Often this may be something as simple

themselves can maximize corporate communications departments to develop videos and pamphlets that might accompany speakers who can go out into the community to educate the populace in "Managed Care 101."

Conclusion

The United States does not yet have a single-payer system of health insurance. Governmental health-care reform has failed. Therefore, it is safe to predict that managed care plans are here to stay for the foreseeable future. Expendng one's energy railing against HMOs and PPOs does little to provide better care to patients. Rather, health-care professionals must freely and openly debate the serious ethical challenges these companies pose for all of us. Concerned individuals must rally forces within associations and systems to contest any diminution of medical or ethical standards. Public discussion and internal appeals processes

Notes

1. See, for example, *Time* (January 22, 1996) for an extremely negative assessment of the way that managed care impacts patients and their families. This article appeared in an earlier iteration in *MedSurg Nursing* (June, 1996).
2. Peter Fox. *Overview of Managed Care Trends Forward*. In National Health Lawyers' Association, *The Insider's Guide to Managed Care*. Washington, DC National Health Lawyer's Association, 1990:1.
3. Edmund D. Pellegrino. "Managed Care and Managed Competitions: Some Ethical Reflections." *Calyx: Ethical Issues in Paediatrics*. (Fall, 1994):1.
4. Ibid.
5. Callahan argues this point in much of his writing. See: Daniel Callahan. *Setting Limits: Medical Goods in an Aging Society*. New York: Simon & Schuster, 1987.
6. Daniel Callahan. *The Troubled Dream of Life*. New York: Simon & Schuster, 1993.
7. Edmund D. Pellegrino and David C. Thomasma. *For the Patient's Good: The Restoration of Beneficence in Health Care*. New York: Oxford University Press, 1988.
8. Pellegrino. "Managed Care and Managed Competition."
9. American Medical Association, Council on Ethical and Judicial Affairs. "Ethical Issues in Managed Care." *JAMA* (January 25, 1995) vol. 273, number 4:330-335.

Material Cooperation

Clean Hands in a Dirty World

Marilee Howard, R.S.M.

MANY OF YOU, especially if you have any connection with developing affiliations and associations in health care, have probably heard the term "material cooperation" at some point. I hope to clarify some of the mystery that can surround this term by addressing two basic questions: What is the principle of material cooperation? How can this principle assist in our moral assessment of various situations, especially some of those currently being experienced in health care?

What is Material Cooperation?

The basic question addressed by the principle of material cooperation is how one can maintain clean hands in a dirty world, or how to sustain morally right action while engaging in the commerce of the world. This is especially important in a system of moral analysis that defines some actions as wrong in themselves, or intrinsically evil. The goal of clean hands would be to avoid any involvement with such actions, or at least any morally relevant involvement. The principle of material cooperation is a tool to aid in assessment of the moral relevance of a person's or organization's involvement with another's wrong doing.

Some Christians have responded to the goal of maintaining clean hands by removing themselves from involvement in the commerce of the world to the greatest extent possible. Either they have lived solitary lives, or they have formed cohesive communities built around shared values. When the beliefs, values and accepted behaviors in a group are fairly uniform, there is less chance that one member's action will contribute in some way to a wrong done by another since all are striving to live by the same standards. In such situations, there is little need to apply a principle such as material cooperation.

The choice of many Christians, however, and certainly the call of the Second Vatican Council, is to be involved in the world, to be the presence of Christ in the midst of society. This means association, not only with committed Christians who share one's values, but with a variety of others with differing beliefs and values. In such a setting, some persons will hold an action morally acceptable that is judged wrong by the faith community, or the person of faith. Others may act on motives that lead them to disregard moral assessment of right and wrong.

A Christian engaged in the commerce of the world may

find that it is difficult, I would even say impossible, to remain completely insulated from all involvement with actions he or she regards as morally wrong. Clean hands become an unattainable goal if understood absolutely. For example, if Marie chooses to operate a kitchen wares shop to meet the legitimate interest of persons in equipment for food preparation she will need to sell a number of items, including kitchen knives, to have a successful business. At first glance, operating such a shop seems morally neutral in itself. It serves a useful purpose for Marie's customers as well as providing Marie with income. If successful, it may create additional jobs in the community and provide other community benefits. However a good kitchen knife can be an effective murder weapon. Marie cannot possibly know that all of her customers buy knives with the actual intention of cutting vegetables and other foodstuffs. Nor can she be sure that a knife she has sold may not later become the weapon of choice or opportunity for a killing. Ideally, clean hands would mean no connection, however remote, with any murder. Practically, it means determining whether a particular activity is morally justified, even when it may involve some degree of

involvement in the evil done by another. The principle of material cooperation provides a tool for assessing when the degree of association with evil, such as the murder in this example, would make the cooperating activity (selling a knife or operating a kitchen wares shop) morally problematic.

The principle begins by distinguishing between situations in which a person agrees with or consents to the wrongful action of another, from situations in which such agreement is not present. In Marie's case, if a customer discusses with her a desire to kill a given individual and Marie helps in the selection of the most suitable knife, she has moved from merely selling kitchen wares to assisting a murderer (or at least a potential murderer.) She has taken a fairly active role in bringing about the killing by advising the murderer and selling the knife, knowing the purpose of the purchase. This involves agreeing to the action, consenting to play a role in its completion. In such a situation, the principle of material cooperation classifies the cooperation as formal rather than material. Formal cooperation can be defined as participating in some way in a wrongful action of another, with willing agreement or consent. Material cooperation in evil can sometimes be justified. Formal cooperation, because it involves consenting to the evil, cannot. In either case, the participation involved is generally providing means, opportunity, information, or assistance that facilitates

another in carrying out the wrongful action.

Material cooperation, as distinguished from formal cooperation, includes no agreement or consent in the

the wrongdoer from being able to carry out the wrongful action; the seriousness of any reasons for providing cooperation; and how directly the cooperation was related to the wrongful

But even when cooperation is clearly limited to providing means, opportunity, information, or assistance, that is, when it is material rather than formal, there may be situations in which the participation has moral relevance.

wrongful action. If Marie simply sells the kitchen knife to the murderer in our example, and has no reason to suspect the purpose of the purchase, she would probably be appalled to learn of the murder, and regret that she was involved, even remotely, in its commission. Marie does not agree with the murder and has not consented to her service (selling the knife) being used in this way.

But even when cooperation is clearly limited to providing means, opportunity, information, or assistance, that is, when it is material rather than formal, there may be situations in which the participation has moral relevance.

There are several key factors to consider in determining when material cooperation is morally appropriate. These include: the character and seriousness of the wrongful action; the proximity between the cooperation and the wrongful action; whether withholding cooperation was likely to prevent

action. I will consider each of these briefly, presenting the terminology generally used in the Catholic tradition. While each factor can be analyzed separately, it is only in considering the relationship of all of them in a given situation that a final moral judgment can be reached. Full understanding of the application of each of the factors would require more extensive development than is possible here.

Character and Seriousness of the Wrongful Action: Not all wrongful actions have the same seriousness. Killing is much more serious than causing a lesser injury. Common social lies hardly qualify as wrongful, while deception in an important matter may involve serious wrong-doing. Whether from the perspective of the harm caused by the action, or the relationship of the action to the moral character of the person acting, there is a vast range of seriousness of wrongful actions.

Material cooperation in a wrongful action is judged, in part, in relation to the seriousness of the action. Cooperation with a minor wrong can be more readily justified than with a more serious wrong.

Necessary or Contingent: If one can prevent a wrongdoer from acting by withholding cooperation the cooperation is

since the person involved has an opportunity to prevent the wrongful action entirely. When it is more likely that the wrongful action will be done regardless of whether the cooperation is provided, the additional duty to prevent harm is not a consideration.

Proximity and Directness: Cooperation may be closely re-

If cooperation is necessary it requires greater justification since the person involved has an opportunity to prevent the wrongful action entirely.

considered necessary. If, on the other hand, the wrongdoer will be able to proceed without the cooperation it is considered contingent. Cooperation may be contingent because the assistance will only make the action easier, or because similar help can be obtained from another source. As an example, assume I have a ladder that will help a criminal break into a second story window. If it is likely that the ladder will be used, whatever I do, or if another means of getting in the window is fairly readily available the cooperation is contingent. I do no good by resisting use of the ladder, while risking harm to myself. On the other hand, if no other means of getting in the window is available, the cooperation is necessary. I have an opportunity to prevent the crime and must weigh this factor in deciding what I will do.

If cooperation is necessary it requires greater justification

lated to the wrongful action in time and space, and in causality, or the cooperation may be more remote. It may also be more or less directly linked to the wrongful action in various ways. A nurse who assists in surgery is closely associated (proximate and direct cooperation) with whatever action is carried out in the surgery. A technician who prepares the room for surgery or obtains test samples required for any surgery patient is involved more remotely and indirectly.

The more proximate and direct the cooperation, the greater the justification needed for the cooperation. "Proximate" and "remote," "direct" and "indirect" are the terms used to describe the relation in time, space and causation between the cooperation and the wrongful action.

Freedom: Cooperation may be freely given, or given only un-

der some degree of duress. Cooperating freely and knowingly with a wrongful action involves some degree of consent or agreement with that action, and thus involves an element of moral responsibility for the action. But duress implies that cooperation in the wrongful action is not freely and willingly given. The most obvious forms of duress would be when a person is threatened directly by another to obtain cooperation. A bank teller who gives a robber cash while threatened with a gun acts under duress. However, duress also applies to situations in which withholding cooperation would result in harm or the loss of some good. If Marie refused to carry knives in her kitchen wares shop, she would avoid cooperating in murder, but might be unable to operate the shop successfully, leading to the loss of her investment, the livelihood she earns in the shop, and the other goods a successful business offers to the community.

The seriousness of the harm to be prevented or the importance of the good that would be lost must be considered in choosing a course of action. Refusing to cooperate may require heroic virtue in some situations. Material cooperation may even be morally required because refusing to cooperate would involve failure in another serious moral duty. Some sources refer to this element by the terms "necessary" and "free." Necessary cooperation is provided in response to duress while free cooperation is provided without duress. Generally, free cooperation would

imply some agreement with the wrong action, since there is no balancing harm to be avoided or good to be safeguarded by avoiding cooperation.

Scandal: In addition to the other factors related to the character and circumstances of cooperation, one must also take into account the potential of the situation to create scandal. This may involve the likelihood that others will dismiss the wrongness of an action because of the cooperation. They may be led to commit similar wrongful acts. They may be led to question the actual teaching of the Church or be giving a wrong impression that the Catholic person or organization was acting contrary to Church teaching. One can often guard against scandal by providing an adequate explanation of the grounds of one's decision, explaining that one is providing cooperation, for good reason, without agreeing with the wrongful action. The bank teller mentioned above could explain that she gave the robber the money only because she was threatened. Still, as with each of the factors, the specific circumstances related to the likelihood of scandal must be considered in relation to the other factors in this moral assessment.

One might say then, that maintaining clean hands is not an absolute judgment for those who engage in making Christ present in today's world. Rather, it is a matter of maintaining integrity in one's moral convictions, and judging carefully those circumstances that

may involve some connection with wrongdoing. Material cooperation is one tool that can help in that judgment.

Material Cooperation in Moral Assessment

All of the elements of the principle of material cooperation come together in the moral assessment of particular situations. There is no simple formula that can be applied to such assessment; rather, each situation must be considered in its particular circumstances. Moral judgment requires a degree of moral wisdom, that allows for a careful weighing of elements in the light of the law of love.

the world, it will need to develop partnerships and various other relationships with providers and organizations such as physicians, long term care providers, insurers and others. What criteria or guidelines can a Catholic organization apply to such partnerships?

In some situations a Catholic health care provider may be the only reasonably available source of medical services for patients and physicians. Physicians may find their ability to practice in good conscience is impaired if they are restricted from offering certain services. What can guide the Catholic organization in determining the practices and policies it

If the Catholic organization is to continue to witness to the healing presence of Christ in the world, it will need to develop partnerships and various other relationships with providers and organizations.

In the present health care environment, the application of the Catholic Church's moral judgments is critical in certain situations in which it may be helpful to apply the principle of material cooperation. In most parts of the United States health care organizations are developing integrated delivery networks to provide patient centered care and respond to market driven forces affecting the way health care is provided. If the Catholic organization is to continue to witness to the healing presence of Christ in

needs to adopt in such circumstances the services in question are considered morally wrong in Catholic teaching?

The principle of material cooperation offers some help in responding to such questions. For this general work, it is probably most helpful to consider questions that can be used to analyze a situation from the perspective of material cooperation. A specific moral judgment can only be made in the particular concrete circumstances faced by a specific organization.

1) Who is the agent carrying out the morally wrong action? If a person or entity other than the Catholic organization carries out the action, the principle of material cooperation may be helpful. This person or entity is the primary moral agent and assessment is applied to the involvement of the Catholic organization in the action. If the Catholic organization carries out the morally

well as the seriousness of the action are important elements of the analysis. As the seriousness and closeness of the relationship increase, more serious reasons restricting the freedom of the Catholic organization would be required to justify the cooperation.

5) Would the morally wrong action be carried out even if the Catholic organization did not cooperate? There

would do so, although there may be overriding reasons that it must provide the cooperation, and accept the occurrence of the morally wrong action.

These questions can be applied in the concrete circumstances facing Catholic health care today. There is no easy formula for coming to conclusions. A careful application of prudential moral judgment is required. It is essential for Catholic organizations to be in ongoing dialogue with their diocesan representatives when making such prudential judgments. With this in mind, I will offer a few comments on each of the situations mentioned above.

In assessing potential partnerships, it is critical that Catholic organizations consider whether the proposed partner operates from a value base that is compatible with the values of the Catholic organization.

wrong action (the Catholic organization is the primary moral agent) the situation is not one of material cooperation and other methods of moral analysis are needed.

2) Is the cooperation limited to providing means, opportunity, information or assistance? More direct involvement in the action would move beyond material cooperation to direct participation in the morally wrong action and would not be acceptable.

3) What is the character and seriousness of the wrong involved?

4) How closely is the Catholic organization involved with the morally wrong action? The character and closeness of the relationship between the Catholic organization and the moral agent as

will be some degree of duty to prevent the wrongful action if it would be possible to do so.

6) What are the Catholic organization's reasons for cooperating? What harms or serious threats of harm will occur if cooperation is not provided? What goods would be lost if cooperation were not provided? These questions are aimed at assessing the degree of freedom the Catholic organization has to refuse to cooperate.

7) Is it possible for the Catholic organization to provide the cooperation without agreeing with or consenting to the morally wrong action? This question does not presuppose being unaware of the action or its likely occurrence. It does mean that if the Catholic organization were able to avoid cooperation in that action it

In assessing potential partnerships, it is critical that Catholic health-care organizations consider whether the proposed partner operates from a value base that is compatible with the values of the Catholic organization. Issues most often arise in relation to the Church's teaching on reproductive issues, but it is equally important to consider matters such as social justice (i.e. how does the potential partner relate to its employees, the environment, the community), commitment to care for the poor, and focus on promoting the health of its community. If some part of the potential partner's practice is unacceptable from the perspective of Catholic moral teaching it will be critical that the moral assessment of the suitability of this partner and of the character of the relationship be carried out with great care. Responding to the questions related to mate-

rial cooperation can be one part of this assessment.

A variety of moral goods are relevant to consideration of the situation where a Catholic organization is effectively the sole provider for certain patients and physicians. These include confidentiality, the physician and patient as moral agents, and access to needed medical services. Often, the issues involve procedures and practices related to sterilization and contraception. The position of the Church is that any action that is intended to block the natural fertility of sexual intercourse is morally wrong.¹ This means that sterilization and contraception are judged morally wrong, and providing assistance to another to obtain or use such means would be cooperation in a wrongful action. However, in a statement dated March 13, 1995 the Congregation for the doctrine of the faith affirmed that "the traditional doctrine regarding material cooperation . . . remains valid, to be applied with the utmost prudence, if the case warrants."² This is probably one of the most difficult arenas in which to apply the principle of material cooperation, but its application may be critical to continuing Jesus' ministry of healing within the Church.

Conclusion

The principle of material cooperation is not the appropriate tool of moral assessment for all of the serious issues facing Catholic healthcare today. Even when it is the best tool, it does not provide easy answers, but

requires careful application with truth and integrity at its base. Still, in a world in which it is not possible to continue the healing ministry of Jesus without some involvement with others whose beliefs and values do not agree with our own, the principle of material cooperation can be useful in assessing just what relationships and involvements are morally appropriate. This requires a great deal of prudential judgment in each individual situation.

I considered presenting cases that would further illustrate the application of this principle in specific health care settings, but it very difficult to describe cases that are sufficiently specific to be useful while maintaining the confidentiality of the organizations involved. In addition, while a case can illustrate the application of the principle, no case can take account of all the nuances of judgment that would have to be brought to a discernment based on material cooperation. So I will gladly discuss specific cases with persons who are interested, but believe it would be counterproductive to include them in an article of this scope.

Ultimately, using the principle of material cooperation involves acknowledging that maintaining absolutely clean hands is not compatible with the good, or in some cases even the survival, of the healing ministry. Rather, we must weigh the total situation and determine the appropriate response to competing values in the complexity of the world in which we live and minister Christ's

love and healing to those in need.



Notes

1. See *Catechism of the Catholic Church*, #2370.
2. *Origins*, 6(3), June 10, 1976.

Some Helpful Resources

- Henry Davis, *Moral and Pastoral Theology: Volume One: Human Acts, Law, Sin, Virtue*, Sheed and Ward, London, 1945. Also, any of a number of older moral theology textbooks and manuals deal with aspects of material cooperation.
- The Catholic Health Association of the United States, *Issues in Collaboration and Joint Venturing*, St. Louis, 1986.
- Libreria Editrice Vaticana, *Catechism of the Catholic Church*, 1994. See especially #2297, 2366–2371, and 1730–1742.
- National Coalition on Catholic Health Care Ministry, *Catholic Health Ministry in Transition: A Handbook for Responsible Leadership*, Silver Spring, MD, 1995.
- United States Catholic Conference, *Ethical and Religious Directives for Catholic Health Care Services*, see *Origins*, 24(27), Dec. 15, 1994.
- United States Catholic Conference, *Health and Health Care*, 1981.

Teaching Effective Nursing Skills to Home Health-Care Students

Joyce Turnbull, R.S.M.

WHAT IS NURSING and how is it practiced today? Historically, nursing was a profession, an affirming and devoted role of caring for ill or injured persons who were unable to care for themselves. A patient is defined as one who suffers, who is put upon. This definition shaped the ministry to the sick-poor of Catherine McAuley's time in the mid-19th century and endured into the 1960s with the development of substantial nursing theory. Nursing gradually came to be understood as a profession distinct from the practice of medicine. Nursing focused not only on disease but on how the individual was coping with that condition, and on how to help the individual stay healthy once cured.

Caring for Clients

Today, the American Nurses' Association defines nursing as "the diagnosis and treatment of human responses to health and illness."¹ Nurses rarely use the term patient, but now address someone in their care more rightly as "client," that is, a person of competence who seeks professional help. If a client is declared non-competent, then the nurse usually refers to the family or significant other as the "client." The nurse focuses on how to restore a client's self-functioning, minimize disease

processes, and ease pain. The nurse acts as a client's advocate, also guiding clients into reflection on the meaning of their illness or injury, thus serving their spiritual needs.

Nursing is a holistic profession. A surgeon may spend several years learning only two things well—removing a tumor and avoiding residual injury. By contrast, a nurse is prepared to exercise a variety of interventions, such as: invasive procedures, how to teach clients various skills, how to identify psychological problems, how to respond to spiritual distress, and many other needs the client may have while under the nurse's care. Nurses are taught to evaluate the client's situation or milieu, be it affluent or poor, stressful or stable. A nurse does not resolve all identified needs, but takes initiative in making appropriate referrals.

Systems Model and a Holistic Perspective

A systems model describes part of the theoretical framework for nursing practice and outlines the areas which nurses consider in diagnosing and treating clients. Briefly, this assumes that persons are "open systems." Open systems are impacted from within by disease processes which are both psycho-spiritual and patho-

physiological in origin. Open systems from the outside, as diverse as family members, the physician, the nurse, the health insurance company, the next-door neighbor, the family pet and the weather, all affect the client for good or for ill.

Certain concepts expand on this model. *Equifinality* means that a system can reach its final state from different initial conditions and by many different paths. *Holism* refers to the idea that the whole is greater than the sum of its parts. *Circularity* means that patterns of influence are circular and involve feedback. Context-open living systems are in constant interaction with their environments. Basic concepts of modern nursing theory such as these assume that a nurse focuses not only on someone's disease, but on the whole person.²

Fundamental to the practice of nursing is a recognition that each person's situation is unique. Essential to the understanding of nursing as a ministry is the principle of respect for the individual person. Peplau stated that "the nursing process is educative and therapeutic when nurse and patient (client) can come to know and to respect each other."³ Orlando emphasized that when a relationship is unique and immediate, arising out of a singular situ-

ation, it is then a nurse acquires the understanding needed in order to be of help.⁴ Travelbee saw that in order to relate as human being to human being the role relationship of nurse to patient (client) needed to be transcended.⁵ Lastly, Brown urged professional educators engaged in clinical practice to give increasing attention to patients as persons.⁶

Goals for Students Preparing for Home-Health Care

I once directed a graduate school research study to determine what effect there would be if nursing students were given alternative titles (namings) to refer to the subject of their studies, such as "the patient" or "the client." Would one title rather than another promote a more personalized concept of the person? A control group of students had no additional namings for patients introduced into their lectures. By contrast, it was shown to be statistically significant that those students in the experimental group who heard lectures with plenty of personal names and titles to describe their patients or clients did indeed have a more personalized concept.⁷

My current ministry is the instruction of nursing students for home care, and I base my presentations on a person-oriented theoretical base. I have developed strategies that teach students how to give holistic, person-centered nursing care. Once students have identified their interpersonal relationship

skills, and learned basic nursing assessment practices, they are ready to begin the more complex determination of the client's biological, psychological, social, and spiritual status.

Nurses look at two aspects of the spiritual realm: 1) spiritual distress and 2) potential for enhancement of spiritual well-being. According to the first diagnosis, the client experiences some disturbance in the

casian clients and families to be "foreign turf" rather than the familiar one of a hospital setting.

At first, their focus is narrow and concrete. They only see the wound or the client's immobility as problematic for nursing. Yet, as their worksheets indicate, and with much coaching from their instructor, they begin to experience some success. By the fourth week,

Nurses look at two aspects of the spiritual realm:

- 1) spiritual distress and*
- 2) potential for enhancement of
spiritual well-being.*

belief system. Here, nurses are directed to assist clients to provide what they need, be it time to pray, or time with a spiritual leader, among other interventions. In the second area, the nurse intervenes by supporting helpful spiritual practices and reducing barriers to them.⁸

In my course, students learned to use this skill in the home setting. Most of these learners are in their early twenties. Most are bilingual and spent their childhood in another culture. Usually English is their second language. It is no small hurdle for them to learn English well enough to practice the complex skills of biological, psychological, and spiritual data collection. They carry out their work in individualized settings. Some students may consider the home setting of senior, Cau-

they are asking more complex interview questions which touch psychological, social, and spiritual areas, such as, "What does it mean for you to be confined like this?" or "What gives you strength to continue with these treatments?" Other questions cover ethnicity and certain cultural practices such as folk medicine. The questions are a cumulative, holistic survey of what the School of Nursing sees to be a holistic view of an ill person's needs.

After being asked the question, "What did you learn today?" one student wrote on her report:

I think I understand definitions of components of psychosocial assessment more clearly. I'm ready to dive in and start practicing, asking these questions so I'll be able to form my own style. I just

feel a little anxious about asking someone about these things because I don't want them to think I'm getting too personal. But I'm actually looking forward to doing it. How weird!

What these students began to discover was the sudden increase in good rapport with the clients following these holistic assessments. The profession calls this "the therapeutic relationship" necessary for the return of well-being. Implementation of a person-centered theory base for students' learning enhances the beneficial influence of a nurse on a client.

An important area of nursing practice, especially in home nursing, is client advocacy.

An important area of nursing practice, especially in home nursing, is client advocacy. An advocate is a person who stands in the place of another person who is not able. A good example of advocacy comes from the field of social work. Advocates are those who speak for the child's interests before a judge about to decide the child's fate.

In nursing, each new client must be informed about advanced directives. Nurses assist clients in expressing their intentions and decisions for these directives, such as legal documents which advise the family and physician about what the client wants done in a case of emergency or state of unconsciousness. Other examples of advocacy include teaching cli-

ents how to be self-sufficient and when to report the side effects of medication. Nurses collaborate with other professionals and disseminate information to their clients about community resources. The common denominator here is empowerment of clients which sustains their dignity, and promotes their peace of mind.

Conclusion

I have attempted to describe principles essential to the development of the profession of nursing. The position of the sick or injured person has

changed. In the time of Catherine McAuley, it was one of passivity. Today, it has assumed a more participate, decision-making dimension. Since the 1960s, and thanks to the development of substantial nursing theory, nursing has become recognized as a distinct profession. The central theme that informs my own philosophy of nursing is the uniqueness of the human person.

By teaching students a home health nursing course, I was able to observe that these student nurses experienced positive results in their relationships with clients when they practiced holistic interviewing skills. In a variety of ways, nurses empower their clients by serving as their advocates.

An early Christian writer once referred to Christ by the title of "Nurse."

... He [God] wished us to have faith in his loving kindness, to consider him [Christ] Nurse, Father, Teacher, Counselor, Physician, Mind, Light, Honor, Glory, Strength, Life . . ."⁹



Notes

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Sister Ignatius Sumner

c. 1825–1895

Mary Paulinus Oakes, R.S.M.

WITNESSING THE SHELLING of Vicksburg, nursing wounded in the newly established school, following major civil war battles, traveling a three state area by railroad box cars with wounded, praying with dying soldiers. All are vividly described in the journal of Sister Ignatius Sumner. She gives accounts of the significant daily happenings from 1860, when she and her five companions arrived in Vicksburg, until her death from malaria fever in 1895. This pioneer Mercy nun records events of the yellow fever saga where one half of the population is decimated, including six of her dearest sister companions, the parish priests; even the bishop was mistakenly reported dead. She, as an excellent teacher, was lent to the group to start an outstanding educational institution; she reports with frankness, candor, humility, humor. This teacher turned wartime reporter and nurse mentions very little of herself. What is between the lines speaks volumes. Years afterwards, she tries patiently to reconstruct parts of the journal from memory after pages have been care-

lessly lost. She sensed "that the record, the only one, may be interesting to our sisters at some future time if preserved."

After seventy years of living life "in war and rumor of war," pestilence, pain, sorrow and the cross, writing and teaching, Sister Ignatius ironically dies from malaria fever. Her life was a constant paradox; her ministry a greater paradox. Sister Austin Carroll, Mercy historian and contemporary, states that "perhaps no other community ever had so many obstacles in its incipient stages."

This teacher turned nurse downed by a fever! What a

This essay by Sister Mary Paulinus Oakes supplies biographical data to contextualize the diary of Sister Ignatius Sumner, which is being prepared for private publication by Sister Mary Paulinus in 1997. The transcribed diary is about sixty single-spaced typewritten pages and covers the period of the work of the Sisters of Mercy in the South from 1860 to 1895, especially their activities during the Civil War and as nurses in yellow fever epidemics. The original, handwritten manuscript of Sister Ignatius is located in the archives of the Sisters of Mercy, 103 McAuley Drive, Vicksburg, Mississippi, 39180. Sister Mary Paulinus is also preparing a biography of Sister De Sales, the foundress of the Vicksburg foundation, who was one of the first to enter in Pittsburgh with Sister Frances Warde.

paradox to live through the bloody Civil War, to spend nights acting as a human tourniquet—this sensitive lady of the nineteenth century, a mix of gentleness and toughness; detachment, survival; a giver of compassion, a recipient of callous prejudice. This genteel, cultured lady, gifted musician, writer, steeped in literature, a woman with the best education America would provide in the 19th century in the arts; this talented teacher spends her energies on the battlefields of the Civil War doing rudimentary nursing. Fingers cultivated for the piano used to cover the bleeding artery of a teenage soldier. This woman of lofty education, genteel and refined, spends her days visiting the crowded homes of poor immigrants on the levee, cooking and delivering soup to their sick, defending the right of the Irish shanty-boat children to attend school with their lace-curtain countrymen. This well-read lady spends countless hours visiting and consoling prisoners of the city jail. The dispossessed of her time were instructed by word and example in the rudi-

ments of Christian living. With an unusual zest for life and the beauties of music, art and literature, she spends her peak years consoling many a soldier on his deathbed, sharing her rations, preparing bodies for burial.

The Maryland annals tell us that "the hardships that this group of sisters endured cannot be estimated this side of eternity." Though very hungry herself Sister Ignatius would say, "Let's pray like there is something to eat."

The hardships that this group of sisters endured cannot be estimated this side of eternity. Though very hungry herself Sister Ignatius would say, "Let's pray like there is something to eat."

The funeral home records in Vicksburg show that as treasurer of the frugal community she spent money on many shrouds for men, women, and children to be buried with some shred of dignity. Besides bathing the brows of those dying with fever, praying and consoling the dying and their survivors, she took on the responsibility of providing for twenty orphans whose every family member had died after the pestilence of 1878 had passed.

What were the roots of this valiant nineteenth century Christian woman? Sister Ignatius was born Frances Sumner, to a Unitarian family whose religious origins dated back to sturdy Puritan stock from Massachusetts, Cotton Mather being an early ancestor and In-

crease Sumner, a 1797 governor of Massachusetts. Her father, Henry Sumner, was from Roxbury, Massachusetts. He served in the War of 1812 and served in the battle of North Point in 1814. Her mother was Frances Steele, daughter of John Steele, leading merchant of Baltimore in 1800. Her great uncle, Henry Payson, a devout Unitarian, built the church in Baltimore where a memorial bust of him still stands at the church on Franklin and Charles

Street. Henry Payson came to Baltimore during the Revolution. He was influential in raising money and fortifying troops in Baltimore. He and his associates were responsible for repulsing the British at Fort McHenry in 1813, and in the Battle of North Point, thus saving the city of Baltimore. He later helped to found the Baltimore Stock Exchange. A street is named in his memory for being a prominent citizen and patriot. Having no children, Henry adopted his favorite niece, Frances Steele, Sister Ignatius's mother. Charles Sumner, the leading abolitionist of the era, was her uncle, her father's eldest brother. Another uncle, Horace Sumner, participated in the Brook Farm experiment of the Transcenden-

talists and was drowned in a ship accident off New Jersey near Fire Island with Margaret Fuller, the renowned American author, while returning from Italy.

Henry Sumner died and left Frances a widow at age thirty-eight. She bore nine children, five of whom survived to adulthood. She turned to religion for comfort. Through reading, studying and finally, through the faith and example of her Catholic servants, she became a Catholic. For this, she was alienated from her friends, derided by relatives, and disinherited by her uncle, although he remembered her children in his will. One by one her children followed her example and became Catholics. Her two sons, John and William became Jesuit priests in the Baltimore Province.

How unfortunate that no letters have been preserved. From Jesuit obituaries and biographies, it is noted that both brothers were popular teachers and esteemed members of the society. Their students "held them in great affection and admiration."

John, the eldest sibling, was born in 1819 in Baltimore. When the mother and family converted to the Catholic faith, John was in his teens and unconvinced of Catholicism. He was indignant at his mother having the children baptized, especially William and Helen, since he thought they should be allowed to choose for themselves when older. He remained close to this Unitarian pastor, Jared Sparks, the noted historian;

they were lifelong friends even after he chose to become Catholic and join the Jesuits. Archbishop Spalding asked him to gather the literary men of the day so he could meet them. John brought poet Henry Wadsworth Longfellow and his uncle, Charles Sumner, to dine at Sparks's dinner table. As a young man, he served as librarian at the Mercantile Library in Baltimore, one of the best libraries in the United States. He contributed articles to the *Southern Literary Messenger*, possibly the leading magazine in America. He entered the Jesuits in 1856 at the age of thirty-seven, one year after his sister entered the Sisters of Mercy. He coedited the *Messenger of the Sacred Heart* and started the *Georgetown College Journal*. A popular teacher, John served at St. Joseph College, Philadelphia, Holy Cross, and Georgetown. His obituary in the journal was written with great grief by one of his students who affectionately describes his "venerable tobacco box which he shared bountifully with his students." He died suddenly, predeceasing his mother in death by two years. William administered the last rites. John is buried in the old Georgetown cemetery.

William, second boy, and fourth sibling was born in 1834; he was a civil engineer and a French scholar. As a young man he served as an official in the Baltimore post office and was twenty-five when he entered the Jesuits in 1859, three years after his brother. Undoubtedly, Sister Ignatius's entrance to the Sisters of Mercy

had profound influence on both brothers.

William was one of the founders of the Maryland Historical Society. He did a family genealogy and was probably instrumental in re-establishing

vent back from the Federals after the war. John directed one very talented young lady, Frances Kelly from Baltimore, to enter in Vicksburg with Sister Ignatius as her mentor. She became Sister Regis and was a

During the Yellow Fever epidemic in 1878, the school closed for six months and the journal indicates that the Sisters would have been unable to subsist without donations from the Sisters' relatives.

ties with Charles Sumner. He spent fourteen years at Georgetown as French teacher. He waited sixteen years before ordination because of his humility and his awe of the priesthood. Interestingly, William spent the year 1867-68 in Spring Hill College, Mobile for health reasons. Surely he was able to visit Sister Ignatius at this time. He taught at Gonzaga and Boston College for short stints. Back at Georgetown, he was superior of junior scholastics and served his last thirteen years at St. Ignatius Church while also teaching. Here he was a most popular confessor. He died in 1905 and was buried at Woodstock.

Surely these two brothers were an integral part of Sister Ignatius's life. However, there are only a few incidents where any contact is recorded. They were generous contributors to the sisters in Vicksburg, giving an oil painting of the crucifixion and the altar in the convent chapel. It is believed they used their influence to get the con-

fine artist. Probably both brothers directed other promising young ladies to the Vicksburg foundation since the records show many young women from Baltimore entering at that period. During the yellow fever epidemic in 1878, the school closed for six months and the journal indicates that the sisters would have been unable to subsist without donations from the sisters' relatives.

Sister Ignatius had two sisters, Valerie and Helen. Valerie, the oldest daughter and second sibling, married a man named Williams and was widowed at the time of her mother's death in 1882. Helen was the youngest, a year younger than William. She figured prominently in her sister's life and in U.S. history. Helen came to Vicksburg and served as fund raiser for the school after the war. She put on numerous plays and city-wide pageants to entertain the people of Vicksburg and raised money for the school buildings which had

been stripped and vandalized, thus freeing the sisters to teach and practice the works of Mercy. The expanded journal tells that in 1867 she had a series of tableaux and a fair which raised \$4,500, a remarkable sum at the time because of floods and crop failure. The sisters bought a piece of ground adjacent to the original building to erect the convent and additional rooms for the school.

Helen's obituary in 1887 is informative:

She Nursed the Wounded on
the Field

Mrs. Helen Sumner Bradford, aged fifty-two, wife of Jefferson Davis Bradford, died on Sunday at midnight . . . her mother-in-law was Amanda J. Davis, a sister of Jefferson Davis . . . Mrs. Bradford was the daughter of the late Henry P. Sumner and grandniece of Henry Payson. She was an ardent Southerner and nursed the wounded on the Gettysburg battlefield . . . Funeral from the Cathedral at 9:30 Tuesday morning.

In her scrapbook, Sister Ignatius had a tiny wedding card announcing:

St. Peter's Church
Half-past 8 o'clock, p.m.
Tuesday, July 21, 1868
Jeff D. Bradford
Helen P. Sumner

Helen and Jeff lived in Yonkers, New York. At the request of Sister Ignatius, after the war, the couple took at least one young southern girl whose family had been impoverished by the War and helped educate her in the same manner as their family had been educated. The girl was Clara Julienne of Jackson, Mississippi, who later en-

tered the Sisters of Mercy and became Sister Margaret Mary, an accomplished musician and teacher.

Another entry in Sister Ignatius's scrapbook must have been the marriage of Helen and Jeff's son. Only this:

Virginia Patterson to
Colonel J.D. Bradford of Indian
Territory
marriage in St. Matthew's
by Father Sumner

Another famous relative was Charles Sumner of Massachusetts fame. He was an ardent abolitionist of the time and an avid advocate of public education and prison reform. Charles Sumner could be abrasive in defense of his causes and suffered greatly from being beaten with a cane in the Senate by an opponent, Preston Brooks. He was nephew of Senator Andrew Butler, author of the Kansas-Nebraska Act. Charles Sumner and Henry, Sister's father had a family argument before Henry's marriage. Thus began their open enmity; they never spoke to each other again. Sister never mentioned Charles Sumner in her journal, but she had a picture of him and Henry Wadsworth Longfellow in her scrapbook. Her brother John re-established family and social ties much later in Baltimore. Sister Ignatius certainly shared Charles's tenacity and ability to see injustice but was blessed with a good sense of humor and her mother's "genial manner" and "unfailing charity."

Charles Sumner and Henry Wadsworth Longfellow were close friends. One has to wonder if Charles knew his niece was nursing wounded Confed-

erate soldiers when he penned his congratulations to Sherman for his victory in Vicksburg and Jackson. When Longfellow penned his tribute to the Sisters of Mercy, did he have his friend's niece in mind when he wrote:

*Other hope had she none, nor wish in
life, but to follow
Meekly, with reverent steps, the
sacred feet of her Saviour,
And with light in her looks, she
entered the chamber of sickness,
Moistening the feverish lip, and the
aching brow, and in silence
Closing the sightless eyes of the dead,
and concealing their faces,
Where on their pallets they lay, like
drifts of snow on the roadside.
Many a languid head, upraised as
the Sister entered,
Turned on its pillow of pain to gaze
while she passed, for her presence
Fell on their hearts like a ray of sun
on the walls of a prison.*

In her humility throughout the journal, Sister Ignatius never makes mention of her family.

She refers to her blood sister, Helen as H.S. In the rewritten pages, we later find out it was Helen. Other sources are necessary for family information. No letters were kept and no picture of her is available. The Maryland Annals describe her as "a distinguished looking woman, tall, graceful, and well-proportioned. She was charmingly dignified in manner and could appear to advantage in any society into which she was introduced." As Sister Ignatius said, she was a great favorite with the sisters in her community because of her sweet, amiable disposition.

Fannie Sumner reigned as a belle in the most exclusive Baltimore society. When she entered the Sisters of Mercy in Baltimore, the congregation was young, having been formed from the Pittsburgh group only a few years previously. All had been on staff of the Washington Infirmary. All were young with the exception of Sister Catherine Wynne, the leader. Later, Sister Camillus, Catherine McAuley's godchild, was sent to help (she was in her mid 30s) and Sister Ligouri was lent to give experienced educational leadership to the young group. Fannie's mother gave her daughter to the Mercy Order with some uncertainties but un-failing faith and humility. Preparing her trousseau to enter the convent, she was required to bring a wash board. Her mother wrote to Sister Catherine Wynne: "Please have patience with my Fannie; she has never had experience with a wash board, but she learns quickly."

When she entered, the sisters had staffed the Washington Infirmary, a teaching hospital with a distinguished faculty of doctors. She was under the spiritual tutelage of Sister Catherine Wynne, the third person to join the Sisters of Mercy in the U.S., and Sister Camillus Byrne. This novitiate consisted of some of the finest women that the community produced.

One of Sister Catherine Wynne's gifts was a discernment for fine young women and their training in the Mercy way.

Sister Ignatius, as all of these early members, served

her term nursing in the wards of the Washington Infirmary. In 1855 and 1856, she and Sister Vincent Browne and Sister Alphonsus Atkinson were trained together by Sister Camillus Byrne. The latter brought the true spirit of a Sister of Mercy straight from Dublin and association with Catherine McAuley who reared and educated her. Sister Camillus was present at the death of Catherine McAuley. She instructed her charges in the visitation of the poor and sick, jail and penitentiary, and the works of mercy dear to the original spirit of the institute. Sister Catherine Wynne and Sister Camillus were ideal models, a mixture of Mercy prayer and works, ideal to form new aspirants in the Mercy spirit.

Sister Ignatius worked in the Washington Infirmary for a short time, learned the nursing skills of the day, went on to teach at the academy and later went into fund raising.

Sister Catherine Wynne and Sister Camillus were ideal models, a mixture of Mercy prayer and works, ideal to form new aspirants in the Mercy spirit.

Sister Ignatius had been groomed as a teacher at the Academy of Our Lady of Mercy Baltimore. The academy was opened in 1855 (same year as she entered the community) and was attended by daughters of the best families in the city. There was such a large initial enrollment that Sister Ligouri McCaffrey was sent from Pittsburgh to get the school organ-

ized and the faculty trained. She had been educated in a first-class academy in Carlow, Ireland and had come to America in 1843 with Mother Xavier Ward and the pioneer American group. The school which Sister Ligouri had attended had been opened by Catherine McAuley who had given instructions there to Dr. McCaffrey's three daughters, one of whom was Sister Ligouri. In Pittsburgh, Sister Ligouri was an outstanding school manager and administrator. With this Mercy educator, Sister Ignatius's potential was utilized to the maximum. After a very short span, the archbishop closed the school so all the sisters could work in the "poor" parochial school. Within a year he realized that the Sisters of Mercy always followed the example of Catherine McAuley, their foundress, by running academies in order to be able to finance the free schools. Many of their vocations to the order

came from the academies. A hallmark of Mercy from the beginning was networking the rich to the poor. Sister Ignatius was again placed in the academy and given the leadership in soliciting financial aid from friends and relatives for a new building. She was a successful development director, and soon a serviceable building was erected. Along with her skill as

a teacher, she was also an adroit fund raiser and accountant.

During these first years, Sister Catherine Wynne was dying of cancer. She was particularly fond of Sister Ignatius. They had shared many an early hardship. Catherine had come to Baltimore, one of the largest cities in the country, with three companions and no money. She had been given an empty shell

on the new mission. With the Baltimore foundation only four years old, she parted with four of her dearest sisters and two postulants. However, in deep faith, she felt that God would bless the community for the sacrifice by sending new members. Indeed it happened, but the price was painful. The separation scene was poignant for all and would long be remem-

Sisters risked their lives trying to get patients out of the burning building. The hospital was relocated and renamed Douglas Hospital. Sister Ignatius's dear friend and contemporary, Sister Alphonsus, assumed leadership of the community in place of Catherine Wynne. Her friend, Sister Colette, became administrator of the hospital. Twenty-two sisters nursed there during the war. Sister Colette died on duty in 1864. At the demand of the soldiers, she was buried with full military honors and the rank of a major.

Catherine Wynne's legacy was in the women of faith and courage she left behind: "the small but noble band of self-sacrificing women consecrated to the highest ideals."

of a building for a school. She states: "Many a time have I walked up and down the empty rooms, wondering within myself where the necessary furniture was to be procured, or whence the next meal was to come."

God sends her the enthusiastic, energetic, talented Fanny Sumner who has a penchant for raising funds, endears herself to her fellow sisters, and who charms the archbishop into reopening the academy.

Now the archbishop makes the request for a group to go to the Vicksburg, Mississippi territory. With so few sisters, how could this take place? What a heroic response to say "yes" to the request. What a poignant thought to separate. Catherine Wynne knew that with her progressing cancer, she would never again see the sisters going

bered in the minds of those six: Sister DeSales Browne, Vincent Browne, Stephana Warde, Sister Ignatius (lent until the group got established) and two aspirants, Kate Reynolds and Mary Madigan.

Catherine Wynne died within a year. Her last duty was to change the Washington Infirmary into a military hospital. The medical faculty gave it to the military but insisted on the sisters remaining in charge.

While Sister Ignatius and her five companions were traveling Mississippi and Alabama with the Confederates, her peers were nursing hundreds of sick and wounded of both armies. Terrible battles were fought along the Potomac and in D.C.

The day of Catherine Wynne's internment, the Washington Infirmary burned. Three

In far away Mississippi, Sister Ignatius and the group arrived in 1860. Ten days after arrival, the school opened and Sister Ignatius taught advanced English classes and presided over the music department. In May, the second year of school, bombing began and life as itinerant nurses was underway as described in her journal: From Vicksburg to Jackson to Oxford to Canton, back to Jackson then on to Meridian, to Shelby Springs, Alabama; then back and forth negotiating with General Henry Slocum, Union Commander, to get the sisters' property back from the Federals.

During this time, she kept the little money the sisters had and negotiated charitably but astutely for provisions. The Confederate government never gave them any remuneration other than rations. Her tone is

Catherine Wynne's legacy was in the women of faith and courage she left behind: "the small but noble band of self-sacrificing women consecrated to the highest ideals."

charitable, but she is astute in judging character or the lack thereof. Her chronicle is anecdotal and swift. She tells it "like it is." She records scanty food. Her journal is non-judgmental. The callow officer's swagger, crude male nurses jumping into cots to play victims and receive food, bartering for eggs from a camp follower—all come to life in her descriptions and snatches of dialogue. Her devotion to wounded soldiers was unflagging whether Union or Confederate. Her faithfulness in transcribing, even when weary, was admirable. While transporting more than 900 wounded from Jackson to Shelby Springs, they were attacked by wildcats smelling blood. Etched in granite in Shelby Springs on a monument is a quatrain of her original poem composed while reflecting on death, an ever-present reality in her life.

*The silent dead, the silent dead
I've lingered where they sleep in peace
Where care, and want, or thought of
dread
Their anguished vigils cease*

When the war was over, the Baltimore community for the second time tried to get her to return, but she begged to remain during Reconstruction.

After the war she used her connections in the North to network further to secure places for the education of many daughters of families who had lost everything during the war. She even accompanied some of the young ladies to flourishing academies where they received comparable college educations.

Her obituary states: "Many of the young business men of this city will in memory go back to their early school days when she was their patient teacher." This is a tribute to her ability to see a need and answer it by teaching at night young men who had to work in the day.

Sister Ignatius was the assistant to Sister DeSales, founder of the Vicksburg community, and convent treasurer.

*In her tactful, charming manner, she
defied the clergy and saw that a
magnificent, efficient and aesthetically
pleasing building was raised.*

It was she who determined to build a first class auditorium and academy and went to Chicago to see the best and most efficient buildings which might serve as models to imitate. In her tactful, charming manner, she defied the clergy and saw that a magnificent, efficient and aesthetically pleasing building was raised although it was much more expensive than that sanctioned by the hierarchy. Since she basically raised the money, she got by with it. She continued to teach the young ladies by day and night school in the evenings. In later years, her sight failed her, but her mind was so well trained and stored with knowledge she continued classes in reading, history, and math.

At the end of the journal she writes a note to Sister DeSales saying, "Please keep these manuscripts for us after you have finished with them as all the latter part is from memory

and we have no other Record than this, which may be interesting to our sisters at some future time if preserved." Someone took six pages of the manuscript and failed to return them. So when Sister's eyes had failed she dictated her memories to Sister Angela Fedou who transcribed them; thus the lack of chronology in the original but the enriched, expanded journal. Placing a capital letter

on "Record" shows how important this was to her. She must have emphasized to the young sisters this importance of keeping a written record for posterity since Sister Angela Fedou kept a well-documented, meticulous diary of the yellow fever epidemic in Edwards, MS in 1897; the Sisters served there for a year. Sister Marcelline Street kept a less detailed but interesting diary of the sisters' mission with the Choctaws in Tucker, Mississippi from 1885-1903 when the government relocated the tribe to Oklahoma.

The headlines of the *Vicksburg Evening Post* Monday, June 17, 1895 obituary article seems an appropriate summary of this Sister of Mercy's life:

Sister Mary Ignatius Had Love,
Charity
Entire Life was Devoted to the
Highest Ideals



Contributors

Marie Ann Ellmer, R.S.M. (Merion, PA) is director of liturgical ministries at St. Andrew Parish in Newtown, PA. Marie Ann holds a Masters of Music from Catholic University in liturgical music. She remains active in congregational liturgical planning as well as in her volunteer work with the Delaware Valley Transplant Program. She is a member of the National Association of Pastoral Musicians.

Mary Kathryn Grant, Ph.D., is the executive vice president of sponsorship and mission services for Holy Cross Health System Corporation in South Bend, Indiana. She has worked in various health care organizations; Consolidated Catholic Health Care in Westchester, Illinois; and Catholic Health Association in St. Louis. She was executive director of Mercy Health Conference in Farmington Hills, Michigan. She holds a doctorate in English and American studies from Indiana University, Bloomington, and was involved in Catholic higher education before her career change to health care.

Marilee Howard, R.S.M. (Auburn), holds a Ph.D. from Georgetown University with a concentration in bioethics. Her background includes work as a medical technologist. For four years she was director of ethics and justice for Catholic Healthcare West in northern California. She currently serves on the regional leadership team of Auburn, California where she facilitates communications, engagement in Mercy Housing, and a women's outreach program called the Women's Wisdom Project. Active on several hospital boards and review committees, she is also a musician and regularly leads the singing at a local parish.

Mary Paulinus Oakes, R.S.M. (St. Louis), originally from Vicksburg, Mississippi, confesses that she is a history buff with a long interest in the Civil War. She has an M.A. from Xavier University in Chicago and a degree in religious education from Loyola University, New Orleans. For twenty years she was on the adjunct faculty of Hinds Community College in Jackson, Mississippi, teaching American literature. She has also served as elementary school principal and high school administrator. During the last decade, she has worked as a hospital chaplain, and presently does chaplaincy ministry for the chemical dependency unit of St. Dominic's Hospital in Jackson, Mississippi.

Patricia Talone, R.S.M. (Merion) is associate professor of humanities, Gwynedd Mercy College and also ethics consultant for Mercy Health Corporation of Southeast Pennsylvania. Her Ph.D. from Marquette University is in theological ethics. She has published a book on the ethical issues of caring for terminally ill patients, *Feeding the Dying* (Peter Lang, 1995). She serves on the editorial board of *The MAST Journal*.

Joyce Turnbull, R.S.M. (Burlingame) received her R.S.N. from University of San Francisco School of Nursing in 1958, and her M.N. from the University of Washington School of Nursing in Seattle. She has a credential in public health nursing from the University of San Francisco. She taught at Mercy College of Nursing in San Diego, California from 1965-69 and at USF School of Nursing 1969-77. She has published in *The American Journal of Nursing*. Emphasizing nursing practice and care of the adult, she has spent fifteen years in home-health nursing practice and as a case manager in California. She is currently instructor of home health nursing at San Jose State University School of Nursing in northern California.

Patricia Vandenberg, C.S.C., is a sister of the Holy Cross, and is currently president and CEO of Holy Cross Health System in South Bend, Indiana, a multi-institutional health system consisting of nine major subsidiaries with consolidated gross revenues of over \$1 billion and twelve hospitals with over four thousand beds. She holds an M.H.A. from Duke University in North Carolina. Her past administrative roles have included president and CEO of St. Alphonsus Regional Medical Center in Boise, Idaho and vice president of clinical services at Holy Cross Hospital in Silver Spring, Maryland.

Discussion Questions

Caring About Health Care

1. (Ellmer) "Being sick is really all about relationship." How has the experience of a life-threatening illness or surgery affected your spirituality and relationships?

2. (Grant/Vandenberg) "Catholic healthcare has a critical and vital role to play . . . in raising a voice of ethical consciousness, moral reflection, and passionate insistence of the right of all to needed health services." To support this ideal, how is a "theology of sponsorship" being communicated in your institution?

3. (Talone) "Critics argue that managed care prohibits physicians from holding out hope of recovery to their patients, while proponents say that truth-telling to patients has long been neglected . . ." Which side of this argument is taken by the administrators and board of trustees of your institution?

4. (Howard) "The seriousness of the harm to be prevented or the importance of the good that would be lost must be considered in choosing a course of action . . . Material cooperation may even be morally required because refusing to cooperate would involve failure in another serious moral duty." How do you describe the conflicts in your own situation, and what values lead you to make a choice between one serious moral duty over another?

5. (Turnbull) What difference would there be in rapport if nurses and physicians at your institution related to ill persons as clients rather than as patients?

6. (Oakes) "While Sister Ignatius and her five companions were traveling in Mississippi and Alabama with the Confederates, her peers were nursing hundreds of sick and wounded of both armies." How has the interplay between healthcare and education shaped the ministerial history of your own regional community?

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What is MAST?

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MAST is the Mercy Association in Scripture and Theology.

Can I belong?

Any member of Mercy who is interested in scholarly writing and speaking about theological concerns is welcome. Remember: theologians and Scripture scholars need scholars in other fields (history, sociology, philosophy, English, etc.) to keep them in the real world! So, if you are in another field and are inclined to interdisciplinary work with theologians, please consider membership in MAST.

When does MAST meet?

The annual meeting is held just after the annual convention of the Catholic Theological Society of America in June, and the location is determined by the city in which the CTSA is held.

Are there dues?

Yes, membership dues are \$20 per year, payable to Marie Michele Donnelly, R.S.M., *MAST* treasurer, Convent of Mercy, 515 Montgomery Ave., Merion Station, PA 19066.

When and where is the meeting this year?

In 1997, MAST will hold its annual meeting in Minneapolis from Sunday, June 8th through Tuesday, June 11th.

What goes on at these meetings?

Plenary sessions and special interest sessions are arranged based on participants' ideas gathered at the previous meeting. We have task forces on: healthcare ethics, Scripture, spirituality, liberation theology, and justice. An executive committee plans each year's meeting sending out an agenda to those on the mailing list.

How do I get on the mailing list?

Call or write: Julia Upton, R.S.M., executive director, St. John's University, 8000 Utopia Parkway, Jamaica, NY 11439 (718) 990-1861, Uptonj@stjohns.edu.



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