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Caritas et Communitas: An ethnographic account of the ethics and social values of Catholic healthcare in contemporary California

by

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* * *

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Caritas et Communitas: an ethnographic account of the ethics and social values of Catholic healthcare in contemporary California

Simon Jie Fei Craddock Lee

This dissertation documents the ethics and social values at work in the organizational life of Catholic Pacific Healthsystem (CPH). CPH is a not-for-profit network of Catholic hospitals co-sponsored by multiple congregations of women religious (sisters) that also incorporates multiple secular community hospitals to form one of the nation's largest Catholic healthcare systems. Research included sixteen months of full-time participant observation at the system office, multiple hospital facilities and charity clinics capping a six-year engagement with this hospital system. Corporate operations were documented and 25 modified life-history interviews were conducted with sisters, former sisters, lay administrators and priests over the course of fieldwork.

The sisters embody dynamics of power and influence within professional healthcare and their social roles shape the cultural ethos of the larger system. A key team of actors of sisters, former sisters and lay colleagues actively conceptualize the "mission" of healthcare ministry and integrate organizational core values into the highly business-oriented operations of contemporary healthcare delivery. The binary of opposition of religious mission and business values belies subtle dimensions of collective identity engaging both secular and Catholic social ontology, and for-profit and non-profit objectives at the intersection of the gendered social structures of medicine, healthcare and the Church. Anthropological analysis documents the emergence of a new form of non-canonical sponsorship and demonstrates how strategies of secular rationalization are used to integrate religious ethical practice into the daily work of the system.

The dissertation describes the ethical effects of articulation inherent to practices of "mission integration" through language intervention, deliberative processes and social modelling. The analysis posits a "weak ontology"of catholicity wherein an ethico-political engagement of

lived being-in-the-world works to accommodate the demands of contemporary pluralizing society. The Pauline conception of the Church as the mystical Body of Christ manifests through the daily operations of charity care clinics, outreach initiatives, and aggressive advocacy to increase healthcare access. This account of CPH illustrates that healthcare in the US remains an experiment in morality.

Professor and Chair of Dissertation Committee

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Introduction

Bene docet qui bene distinguit

Negative distinctions, meaning in this case what I am not going to do, matter. They help people to understand the terrain you are actually trying to map, the problem you address, particularly given the kinds of categorical assumptions involved in the meaning-laden terms that this dissertation invokes: ethics, social, values, Catholic.

Caritas et Communitàs

The title of this dissertation echoes the Latinate encyclicals and other documents of the Vatican. "Caring and community" is intended to reflect values in the sense of the inherited charism of an order of women religious, their founder or the saint in whose name an order was created and in the spirit of which the order undertakes its ministries. In an anthropological work, I should distinguish *communitás* in this sense from "communitas" as the relationship to time or tempo instantiated by ritual that Victor Turner coined (Turner 1957; Turner 1967). As Rappaport understands Turner's usage, wherein "distinctions of mundane structure are reduced in the condition of society that prevails during rituals...so may the distinctions of discursive logic be overridden....Communitas is a state of mind as well as of society....a ritually-generated state of mind and society very different from the rationally-dominated organization and mode of thought prevailing in mundane time, according to which individuals and groups do their daily business" (Rappaport 1999, p.219, 226).

To be sure, this project has historical resonance with Turner and even the notion behind Durkheim's collective effervescence; this will become clear through the analysis of subsequent chapters. However, I use the term as a central trope of Catholic healthcare, to acknowledge a specifically theological sense of community, in the Roman Catholic tradition. It invokes the

Pauline conception of the Church as the mystical Body of Christ.[1] *Communitás* here refers to a sociality and a consciousness of the collective, as in the following:

> "...[The] supernatural redemptive might of Jesus, as it operates in the Church, is not tied to a single person, so far as he is a person, and is not manifested in a single person, but essentially only in the totality, in the community of individuals. The Spirit of Jesus is objectivised and introduced into our earthly life, not through the medium of specially gifted personalities, but exclusively in and through the community, in and through the union of the many in one....This union, this community, is a fundamental datum of Christianity, not a thing created by the voluntary or forced association of the faithful, not a mere secondary or derivative thing depending on the good pleasure of Christians, but a thing which is antecedent to any Christian personality, a supra-personal thing, which does not presuppose Christian personalities, but itself creates and produces them. The Christian community is not created by the faithful; on the contrary the community creates them" (Adam 1997, p.31-2)

As the dissertation shall show, the religious morality underpinning Catholic healthcare informs the ethical motivation to provide care for the poor and the sick in the modern world, and in doing so, the women religious and the organization they infuse constitute a *catholicity* – a Catholic identity that is at once the descendant of the formal Catholic Church and yet a distinctive response to the demands of the pluralistic environment of contemporary healthcare.

Further distinctions

Many anthropologists have asserted that the core of the discipline is comparative study. This dissertation emerges from fieldwork that is not grounded in empirical comparison. It does, however, engage an implicit comparison for to consider Catholic healthcare necessarily undertakes the question of other forms of healthcare. Why is such a distinction necessary? What is "not-Catholic healthcare"? Further, what is meant by religious- or faith-based healthcare? What

do those terms mean, and who mobilizes those meanings? Each of these questions bears on the organizational life of Catholic Pacific Healthsystem.

Ideal types of Catholic healthcare ministry, via social teachings, circulate that represent the idea of practical arrangements and their attendant characteristics. My work is to background the historically documented distortions that are part and parcel of lived experience in the period of time I spent engaged with a unique organization, and to use that fieldwork experience to further "a systematic inquiry into cultural concepts" (Asad 2003).[2] The analysis attends to how such arrangements are experienced by my informants, both as a group and as individuals, while acknowledging how they are perceived by others outside (both the community and/or public, and also by the medium through which that attention is considered, the anthropologist). Together these elements might map the terrain of the organization and its life.

It matters also to recognize the principle of co-existence that lies at the heart of contemporary pluralism. That same notion of co-existence brings the edge to this anthropology, for informants here are not exotic, distant Others. They inhabit the same Real Time as the researcher and the reader, and yet this study is about what makes them different and distinct as well as similar. It is about identity, and its politics, their external manifestation in the world we share, but it is also about the internal, an ethics of individuals, the self-formation linked to *caritas*, caring for others-- the sense of work and purpose, that is, of *mission* broadly writ. These are the forms of life that Asad gestures to, and acknowledging his reading of Foucault, that he asserts are the substance of anthropological analysis.

This analysis proceeds from the premise that healthcare in the US is a contested modern phenomenon. There are socially-constructed spheres of for-profit and not-for-profit, where health is a vague notion only gestured at, but health services are quantified and allocated monetary value. Those valuations in turn fuel a discourse on commodity acquisition, social position and resources that dictate whether healthcare is something an individual can or cannot get, though an abstract "health" might remain a common good. Social rhetoric, social organization, the law and

government programs follow from the assumptions that accrue to these constellations. And thus, healthcare in the US is an experiment in morality.

Work in the US, often taken up by sociology, has considered culture and group identity largely through the lenses of race, socio-economic status, even class. American anthropological discourse has largely discounted the role of religion as a factor in politics of identity and of difference in this country. Roman Catholic religiosity is crucial to a dynamic network of social actors in healthcare throughout the US. Study of local effects of this mainstream religion in health and medicine is a key task for a modern anthropology of pluralism. The historical demands of philosophy and politics have concerned moral universalities-- for example, what is the good life? But, "the consistent brotherly ethic of salvation religions has come into an equally sharp tension with the *political* orders of the world" (Weber 1958, p. 333). Foucault maintained that the modern State took as its object the statistical, normative model of *healthy man* and created "public health" (Foucault 1973, p.34). This might lead one to construct the problem as one of "State as a theological object." However, the mission of Catholic hospitals entails what Weber would recognize as the appropriation of health as practiced by a religiously-identified institution, not the state. Thus, this research inquiry is quite different because it concerns a new problem produced by the extreme situations of changing fields of knowledge, as well as volatile healthcare markets.

Within a Weberian genealogy, this analysis explores the exigencies of extra-Church religiosity. Weber linked charismatic authority to leadership; women religious cite the "charism" within the founding orders as the vehicle of social values in Catholic healthcare (Kennelly 1989). This study of Catholic hospital administrators, contemporary theological subjects amidst the technical rationalism of healthcare delivery, considers then the redefinition of the Roman Catholic Church-in-the-world through the proliferation of various articulations of the Catholic healing mission by its own professional enterprises in healthcare (McCormick 1984; Cheney 1990; Walsh 2000).

Not-for-profit organizations dominate the hospital industry throughout the US, despite an on-going debate about their value, distinctive contributions, and efficiency (Schlesinger, Gray et al. 1996; Young and Desai 1999). In the words of the late Cardinal Bernardin (1999, 91), non-profit hospitals are "mediating institutions": they stand between the individual and the state, and "mediate against the rougher edges of capitalism's inclination toward excessive individualism." Historically, the Catholic Church has been a primary source of moral values and a pragmatic engagement with healthcare as a common societal good (Redican 1981; Rosner 1987; Risse 1999). The Catholic magisterium has traditionally critiqued American society for failing to articulate an adequate conception of the common good and human purpose (Douglass, Mara et al. 1990; Byrnes 1991; Gaillardetz 1997).

The ethics and social values of Catholic healthcare, then, are not about the number of hospitalizations or surgical procedures that go without reimbursement and constitute charity care in the sense deployed by the state of California for its non-profit book-keeping. My dissertation takes as its object an even broader "community benefit" picture. It is about corporate citizenship, not in the sense of a hospital as a business entity, but corporate in the sense of a collective subject acting in the social world. Many social formations and dissolutions happen around notions of "the good." Catholics in their mission of healthcare negotiate many of the same concerns that others in a pluralist society do; Catholics just do it in a visible and organized way that reflects their particular history as a formal religious institution. As Talal Asad has noted, "Some ways in which symbolization (discourse) can *disguise lack of distinctiveness* are well brought out in MacIntyre's trenchant critique of contemporary Christian writers, where he argues that 'Christians behave like everyone else but use a different vocabulary in characterizing their behaviour, and also to conceal their lack of distinctiveness" (Asad 1993).[3] This dissertation asks is Catholic healthcare practice distinctive, how and to whom? Is religious or values language used to make accommodations palatable or do they signal true difference?

There is a prevailing rhetoric about inhumane, capitalist economics that labor unions and consumer groups use to batter hospital systems like the one examined here, which they perceive as impersonal corporations acting in spite of their not-for-profit designation and, in the case of Catholic Pacific Healthsystem, their religious mission. But the righteous stance of this chastisement itself derives its social weight by invoking an underlying cultural rhetoric suggesting that all spiritual endeavors in the temporal realm are somehow imbued with moral superiority. That is, it indicates an expectation that religious hospitals should, by definition, be held to a higher standard than their secular counterparts. Studies of non-profit healthcare abound that recount finance and policy, but they do not explain how faith shapes ethical practice in people's lives (White 2000). If we are to understand the philanthropic impetus to care for our neighbors more broadly, we must understand how contemporary Catholic hospital administrators navigate the constraints of maintaining a religious identity while collaborating with secular partners to implement their commitment to healthcare provision for the poor. Further, we might consider what cultural meanings adhere to the not-for-profit designation, and the distinctions between faith-based organizations and their supposedly secular counterparts.

Despite an espoused American secularity, religious perspectives continue to inform and influence health and medical policy. I would reference here the membership of the federal advisory committees for bioethics, genetics, and medical technology to which bishops and scholars of religion are regularly appointed (e.g. Karen Lebacqz). Religious expertise is regularly called on in other fields (Luhmann 1990; Voyé 2000). Public figures demonstrate their moral standing by belonging to religious congregations and political leaders convene prayer breakfasts with clerics in the wake of personal scandal. In 1999, the proposal of a Catholic cleric to be chaplain to the US Congress was highly contested; the position has always been occupied by a Protestant cleric in the past. As Asad has noted, religion is used to unite and divide (Asad 1992). "Religious" often continues to carry a cultural caché that connotes moral propriety. This

dissertation is an effort to parse the role of such attribution to the values of healthcare provision and the politics of identity operating in a leading healthcare organization.

My aim is to provide an anthropological "ethnographic account," a description in the sense of Weber and Wittgenstein, but to describe in order that the material stand out in the context of normative liberal assumptions about identity and religiosity. The ethnographic elements are intended to weave a sustained argument about values frameworks in the face of pluralization that also attend to the coherent and consistent thread of Catholic-ness within the lived experience of this hospital system, even as the agents that constitute it work out their own accommodations with contemporary life-in-the-world.

Representations and specificity

The sources in this dissertation all correspond to actual individuals, though in some instances personal attributes of individuals have been masked or amalgamated to preserve anonymity where possible. Consequently, some comments have been altered for narrative flow, but the relevant facts and intention have been retained. Some individuals are cited as external commentators whose professional purview provides context to a dynamic I have observed in the course of fieldwork. Moreover, I have tried to make clear distinctions between analysis and theories that I have developed, and instances when individuals I have studied offer up their own analysis of events or structures. The nature of protracted participant-observation is such that data emerges from both casual conversation and thoughtful, if personal, critique by informants in the course of their own lives. I have endeavored to avoid material that might result in scandal for my informants. However, given the particular meaning of scandal in the Roman Catholic context, I will treat the taxidermy of that issue in an overt analysis in the final chapter.

I developed this research project acutely aware of the way that the charged atmosphere of the United States that persistently reduces the analysis of the Catholic engagement with healthcare to the political (in the policy sense) conflict over reproductive health services, namely

abortion provision or its prohibition. My account neither defends nor attacks the values and "choices" of my informants, nor Catholicism more broadly, on this policy issue. I acknowledge both the willingness of my informants to suffer my presence among them, and their trust in me that my study is neither apologetics nor diatribe. I recognize, however, that depending on the subject position of the reader, there may be temptation to read this account in such a vein.

Studies in the anthropology of reproduction, bioethics and feminist anthropologies have already extensively engaged many of the controversial issues.[4] In the US today, access to reproductive healthcare remains at risk, often represented as in crisis (Bucar 1998; Dinsmore 1998; Baumgardner 1999; Uttley and Pawelko 2002). Many people continue to oppose the presence of Catholic hospitals in their communities because those hospitals are unable to provide particular reproductive services, despite their dedication to serving other local needs. These issues remain critical concerns in people's lives and sites for advocacy and action. They also mark fault lines for successful pluralization in the world, as well as for any anthropological inquiry that takes ethics and politics as its objects. These dynamics are taken up in course of the dissertation and addressed in light of anthropological inquiry in the concluding remarks.

Avoiding scandal does, however, require that I address a methodological concern. Research examined broader conceptions of health, Catholic healthcare ministry and the ethics of social justice that underpin the politics of identity in a particular Catholic hospital system. To do that, I structured participant-observation to attend to issues of community and values integration within the organizational life and structure of CPH. To be sure, issues of reproductive technologies did arise in the course of conversation, interviews and observation and they are reported and analyzed in that context. I did not seek out the issue or elicit discussion from my informants; I did allow informant conversations to play themselves out when it did arise. In retrospect, I believe this approach serves my research objectives while putting reproductive health concerns in the perspective from which my informants see them. I also contend that this is a worthwhile move not solely to recognize the emic context, but also the etic contexts. Abortion

and related concerns exist within a greater set of values around reproduction, healthcare, religion and politics. A reader may judge for herself whether this method of approach was appropriate.

Distinctiveness is real. It is also true that identity politics at the individual level can be driven by ego, an insistence on difference that can itself challenge pluralization (Brown 1992). But perhaps what lies at the heart of this study is the need to accept that calling something "Catholic" makes it distinct from something that is called other than "Catholic" or "not Catholic"-- taking that as *a priori*, taken-for-granted, and then moving closer to see what that difference actually looks like to those who understand it to be so. Identity is multidimensional; it extends beyond Action X to the rationale driving that action. Within a collective of persons, this raises the additional question of collaboration, an identified founding principle of Catholic Pacific Healthsystem. As the analysis shall show, different identities exist under the single label of "Catholic." This is true of both sister-sponsors, individual lay Catholics, as well as the different organizations and social groups operating within the tradition of the Mother Church.

This analysis is an effort to theorize/explore a very particular thing, but as in all anthropology, that exploration aspires to drawing parallels or distinctions within broader phenomena. It is an anthropological project that addresses material within health services research, social organization, moral theology and Catholic anthropology, religious studies and political theory and the outer margins of bioethics with respect to distributive social justice and healthcare. I make no claim that everyone in healthcare, even in the individual hospital facilities I encountered, all think, believe or participate in all the self-conscious, reflective processes that explicit values consideration can entail. Certainly for some, healthcare is simply a job, for some administrators it is a route to renown, to greater income, power or influence that is oriented around self-promotion, providing for themselves and their families-- each itself a legitimate undertaking and understandable goal. But as a whole, as a collective, there is an organization that is manifest as an agent in the political sphere with a specific ethical constitution. Documenting that manifestation happens in the accounts of the individual actors that constitute it.

In this respect, I am not particularly concerned with the parameters of "scientific" inquiry that look to reproducibility, though I maintain the argument can be made for reliability. Qualitative methodologies and analytic processes are not secondary to their quantitative cousins.[5] In the course of fieldwork, I triangulated observations through comparison and discussion with informants in Catholic healthcare outside of Catholic Pacific Healthsystem. My dissertation makes no conclusion regarding whether this analysis holds for all Catholic hospitals or ministries, for all Catholic systems or not-for-profit healthcare corporations. The analysis may well apply, but that has been an incidental concern since the project was first conceived. Indeed, the analysis of ethical reflection in the face of pluralization at CPH is significant precisely because it may constitute a singularity.

These concerns are, perhaps, the mark of passage through fieldwork, something that falls short of going native, firstly because not all the "natives" would agree with my interpretation or projection as I will lay them out below, and secondly, because "going native" is inherently both reductive and historically patronizing. I openly admit to admiration for the engagement, the passion, the "meaning" that so many of my informants find in their work, even when our personal politics might be very different. Tied to their work is a kind of ego-as-contribution where their pride and self-consciousness lies in their understanding of the greater common good to which their hospital system aspires. There are, of course, the inescapable vanities of personal achievement, frustration or disappointment. But our interest is how those individual moments point up a collective endeavor. For them, their "organ-ization" is a contributing part of the greater social body.

Bio-cultural anthropologists will forgive an organic analogy. An organization is some sort of cultural or political whole, but not entirely organic wholes. In the words of Michael Walzer, "it is not the case that if some of their internal connections were broken or rearranged [the organization] would be condemned to political death. Every reform is not a transformation, and even transformations can be accomplished incrementally, over long periods of time. Conflict

and trouble are sure to be features of any such process, but radical disruption and breakdown are not" (Walzer 1997, p.4). Yet, there remains something about the organization that persists at some other level, a tone to the idea of collective that transcends the mundane. And that tone contributes to making this an anthropological analysis, rather than a management study or organizational behavior thesis. Social theorists before me have struggled with ideas of collective effervescence, of *mysterium tremendum* (as in Otto), and found them wanting. And I undertook this project well aware of the discourses around such subject matter as religion, faith, and theology, especially the relevance of Catholic anthropology. But without invoking those legacies here, I want nonetheless to point to a whole that is greater than the sum of its parts. An organization that has a life as a collective that is more than just its member cells, even if the inter- and intra-cellular processes are the mechanisms by which we labor over that whole. Moreover, the members of an organization together, individually and collectively, engage in an ethos or worldview, what Geertz writes is the "tone, character, and quality of their life, its moral and aesthetic style and mood; it is the underlying attitude toward themselves and their world that life reflects. Their world view is their picture of the way things in sheer actuality are [*and should be*], their concept of nature, of self, of society" (Geertz 2000). My emphasis reflects the ethical projection, the prophetic witness, that Catholic healthcare is called to and that is the touchstone for many of the women religious and their colleagues of Catholic Pacific Healthsystem.

In lighter moods, Laura Nader and others might refer to this as muddling through. Intellectual honesty is integral to anthropological inquiry, part and parcel of recognizing contingency and constructed-ness. A commitment to frank humility with respect to the limited possibilities and likely foibles inherent in any individual interpretation. Such an introduction might easily be dismissed as a self-important string of caveats, oftimes prematurely cast as navel gazing. I think it is important to be explicit precisely because the dissertation is an academic exercise and thus my task is to diagnose rather than prescribe, to problematize and elucidate

complexity. Further, a definition of the field of inquiry is crucial to a project that falls within the interstices of interdisciplinarity, of content if not of method.

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[1] In the twelfth chapter of St. Paul's first Epistle to the Corinthians; he was the first apostle to formulate this conception.

[2] Asad invokes Marcel Mauss, through an articulation by Mary Douglas, to make an important distinction between the fieldwork methods anthropology may employ and the comparative analysis of embedded concepts (representations, he allows) and the comparative analysis not of their origins but of the "forms of life that articulate them, the powers they release or disable." It is probably worth noting here that Asad sets up comparison as "between societies differently located in time and space." My work pushes that limitation to arguing that the politics and ethics of identity in the sphere of religion/secularity also call anthropology to examine distinctions among groups within the same time and space.

[3] See (MacIntyre 1971)

[4] See, for example, (Whitbeck 1983; Martin 1987; Lazarus 1994; Dillon 1995; Heriot 1996; Purdy 1996; Ginsburg 1998). Specifically in the Catholic context, see (Mensch and Freeman 1993)

[5] See, for example, (Lincoln and Guba 1985). This is but one instance within a much broader field of analysis.

Prologue

"I went to St. Clare's last night," Catherine said as she walked into her office with me. Catherine is the lead executive with the longest tenure at Catholic Pacific Healthcare system. The previous evening, she had attended an event hosted by a sister Catholic social service agency to honor volunteers, she explained, and a physician from her hospital system had sat to her left during the dinner. Catherine recounted to me their conversation; she had asked him what he thought of St. Clare's and the physician answered with the story of his career. He had started as a medical technician through a state college training program and had then worked to become a physician. "I wanted to find a way to help others," he had said gesturing away from himself. "Last week," he continued, "an elderly gentleman, another man of color, had come to clinic disheveled and limping. I asked to look at his feet, and I kneeled down and pried off damp rotting shoes, and peeled away soiled athletic socks. There were sores and ruined tissue; he needed significant debriding, medication and bandaging." Sitting there before the physician, the gentleman had begun to cry, then to talk about his life. As a youth in colonial India, he had served the army officers, undoing and putting on their dress shoes, cleaning and polishing their boots. Now he was here in the US, elderly, frail, on state aid, and a patient of clinic charity services.

Today sitting in her office, looking out at the pine trees in the courtyard, Catherine said, "This is what a core value looks like. That physician saw this gentleman-- and that's what he called him-- as a person, not just a patient, but a man with history. He told me that the gentleman had nearly cried while the doctor cared for his feet, because he had bothered to speak to him. In that moment, the physician had acknowledged his humanity, and in the process of giving medical attention, also recognized his dignity in the context of his life history."

* * *

Christian history makes reference to the literal and symbolic meaning in the act of washing of the feet.[1] It gains further significance in the account of Jesus' actions after the Last Supper. It invokes the baptism and re-birth in a cleansing and has been adapted into a ritual ceremony throughout Christianity. The Roman Catholic Church has used the accounts to underscore the symbolism of servant-leaders, the humility of those in the service of the Church, the dignity of those in need, the poor and the sick. Indeed, the Vatican produced papal medals depicting the Christ washing the feet under three different popes.[2]

That afternoon episode with Catherine can be unraveled to illustrate the argument of this dissertation exploring the ethics and social values of Catholic healthcare. That account involves a senior hospital system executive, a woman at the nexus of mission and operations, explaining what made a physician special and how a core value was made manifest. Catherine is a lay person but a leader in the ministry of Catholic healthcare. She is not now a woman religious, a Catholic sister, but more than twenty years ago, she was. The physician is not a woman religious, but he is a healthcare provider, from one of the archetypal professions, who in his own words speaks of his drive to care for those in need. Behind the telling of that story, of the physician and his patient, and of the executive and a physician colleague, lies the heart of the purpose of Catholic healthcare as I have come to understand it over several years of fieldwork with one large hospital system.

This dissertation explores the ethics and social values of this organization as it seeks to provide healthcare and fulfill its purpose as a vehicle of Catholic ministry in a diverse environment where both secular and religious identities are value-laden, but contingent and contested. In the Catholic tradition, the meaning and purpose of healthcare ministry is captured in the term, mission, and this dissertation engages the individuals involved in what the hospital system calls mission services and mission integration. I consider the politics of identity in the lives of the contemporary women religious who govern this hospital system, the executives and administrators who manage its daily operations. In some cases, sisters are also staff and some

staff members are women who formerly were sisters. The dynamics of their relationships to the "corporate culture" of administration and operations help to shape the *caritas et communitás* of Catholic Pacific Healthsystem.

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[1] For example, Gen., xviii, 4, xix, 2; Luke, vii, 44; I Tim., v, 10; and the Last Supper as in John, xiii, 1-15.
[2] Alexander VII (1655-67) Washing the disciples feet: Forman servi accipiens; Clement X (1670-76) Christ washing the feet of St. Peter: Dominus et Magister; Clement XI (1700-21) Washing the disciples feet: An. VI. *The Catholic Encyclopedia, Volume XV*, © 1912 by Robert Appleton Company. Online Edition Copyright © 1999 by Kevin Knight. *Nihil Obstat, October 1, 1912.* Remy Lafort, S.T.D., Censor. *Imprimatur.* +John Cardinal Farley, Archbishop of New York

Setting the Site

Historical Context

The story of Catholic healthcare in the United States reflects the history of migration across the country. It follows the efforts of Roman Catholic sisters who sought to minister amidst the poverty and disease that attended new frontier settlements and emerged in the streets and shelters of new cities, like San Francisco. For example, in 1854, already struggling to care for the burgeoning poor trampled in the gold rush of '49, the Daughters of Charity welcomed Mary Baptist Russell and seven other Sisters of Mercy to the Bay area. The Sisters, in turn, were invited to staff the county hospital as a result of their visibility during the epidemic of Asiatic cholera only a year later. When the city defaulted on its contract to reimburse them for expenses, the Sisters withdrew and raised the private funds necessary to open a new Catholic facility, just in time to meet the devastation of the 1906 earthquake and the fires that raged in its wake. One hundred and fifty years later, both orders of women religious remain involved in extensive healthcare ministry throughout the state of California and the US.

The socio-political history of the United States, especially in the latter half of the 20th century, is one of great change. Those forces affected both the climate in which Catholic healthcare is practiced and those who practice it. Though convened abroad in 1963, perhaps the most central event for Roman Catholics was the twenty-first Ecumenical Council (Vatican II) that was held to usher in a new era in the life of the Church throughout the world (Abbott 1963; Varacalli 1983; Lernoux 1989). The American Catholic hierarchy worked to understand its role in national civic life, as well as in the lives of the faithful (Bishops 1983; Bishops 1986; Byrnes 1991). As Darryl Caterine has emphasized, the Council was called just as the first Catholic president was elected in the United States in part by "minimizing the difference between Roman

Catholic and Protestant American identity....Ecclesiastically, the council triggered profound critiques of hierarchical structures in the name of that most hallowed of all American institutions, democracy, while ecumenically the church's claim as defender of the exclusive faith gave way to dialogue with other churches as well as with traditions outside the Christian and even Judeo-Christian faith" (Caterine 2001, p. xv).

No Catholic group took the Council's efforts to heart more than Catholic women religious in the US (Ranke-Heinemann 1990; Quiñonez and Turner 1992; Wittberg 1994). Trained sociologists and themselves Catholic women religious, Quiñonez and Turner in particular provide an incredible review of the social effects of Vatican II on the organization of women religious in the US. They document the emergence of the Leadership Conference of Women Religious of the USA (LCWR) that ultimately became the national association of chief governing officers of religious communities involved in active ministry (that is, not cloistered groups). Changes in language like the decision to refer to themselves as "women in the Church" rather than the traditional "daughters of the Church" illustrate the larger constitutional changes the women took on, encouraged by what many sisters perceived as a new spirit of openess embodied in Vatican II (for example, see Appendix A). The seriousness with which sisters re-designed the process of formation and embraced formal advanced education as a vehicle for social change within their ranks is pivotal to understanding modern women religious. Moreover, the analysis of the place of openly American civic values in the language of the LCWR demonstrates the inextricable cultural identification that marked what Rome had always belittled as Americanism. The spirit of renewal through which American women religious understood Vatican II marks a turning point in the socio-political history of vowed life in the US. The Vatican and even the American arm of the magisterium was taken aback by these transformations and undertook several steps to reassert Vatican authority over religious life. It is crucial to the analysis of this dissertation project to understand the context of independent thought that took hold among

American women religious. I cannot do justice to the breadth of this transformation here but present some examples to signal the import of this period in their social history.

One of the most significant acts to reflect this development came as a result of the first Women's Ordination Conference, held in 1975. The Vatican ordered the LCWR "to disociate itself completely from the conference's proceedings and goals" but the LCWR board unanimously refused. Then in 1979, when the new pope visited the United States, Sr. Theresa Kane, a Sister of Mercy and president of the LCWR that year "greeted John Paul II before a national television audience by telling him that the Church 'must respond' to its own call for affirming the dignity of all persons by allowing women to become ordained. The pope visibly registered his disapproval of such audacity" (Wittberg: 218; Quiñonez and Turner: 157). Tension flared throughout the ranks of women religious and reactions were mixed. The outcome, however, was an affirmation of a new sense of engagement with Rome with a commitment to self-determination grounded in the Church's own teachings. These ideas return in the later chapter on pluralization.

Moreover, American women in general were part of other social movements and cultural attitudes that created new possibilities for women in the world. As one sister remembered:

> "It is true, when many of us entered the congregation, a lot of professions probably did not welcome women. There's always exceptions. But today, women have just unlimited opportunities for all kinds of - all kinds of careers. And it's just a different time."

In addition to civil rights and three waves of feminism, the spirit of the Peace Corps, Head Start, Model Cities, and war resistance all radically altered visions of life and work for women of faith. Extensively documented, the cumulative effect has been a steady decrease in the number of women entering vowed religious life, coupled with the steady aging of the professed. Nationally, the average age in 1990 was 65 among an estimated 94,000 religious sisters; less than 1% were recent recruits to vowed life (Wittberg: 1-2). Today the estimate is 65,000 and the average age is 69 (Fialka 2003).[1]

For the ministries of Catholic women religious, the impact over time was enormous, especially in the central missions of healthcare and teaching. The transformation of American medicine into the dominant industry in the country, the intense level of regulation and the attention to cost-containment measures and other business practices saw substantial organizational repercussions. Staffing shortages among sisters in the hospitals were increasingly a problem as the number of institutions grew. But, as a landmark study of Catholic philanthropy documents, the demands for professionalization in social work and financial management also pressured the sisterhoods and many dioceses changed how institutions were managed in what one scholar terms the "Catholic charity consolidation movement" (Oates 1995, p.86-90). By the 1980s, the end of fee-for-service compensation and the emergence of managed care were accompanied by the rise of the for-profit and investor-owned hospital sector. Together, the challenges of competition struck hard at the backbone of not-for-profit healthcare in the US – the Catholic hospitals sponsored by regional communities of women religious, like the Sisters of Mercy or the Daughters of Charity. This competition conspired with the demographic trends of women religious to increase the growing laicization of Catholic hospital ministry throughout the US.[2] Medical facilities that had once been managed, operated and staffed by Catholic sisters, both in nursing and hospital administration itself, are now almost entirely run by professional lay administrators. And like healthcare administration in general, most senior administrators were male and, even in religious facilities, increasingly not Catholic. Today, some sisters remain active in the philanthropic arm of the hospital foundation, or in particular positions that reflect their professional training. For the most part, however, in almost all Catholic hospitals, sisters retreated to positions of governance rather than operations, the sister-administrator replaced by a lay hospital president.

It is against this recent history that Catholic Pacific Healthsystem (CPH) was brought into existence. The need for increasing means to care for the poor and the sick arose in a healthcare economy marked by aggressive growth and competition in a decade of radical change in the

healthcare services industry. California has been at the forefront of the HMO expansion over the past 25 years and is considered a bellwether state in the nation for managed care trends (Wilkerson, Devers et al. 1996). Such managed care dominance has also made California's health care marketplace one of the nation's most competitive, or the "proving ground for managed competition" (Luft 1996). Managed care, in turn, drove changes in hospital organization and financial arrangements as hospitals were bought and sold, and even multiple facility systems further integrated.

The incorporation of CPH reflected the determination of the Catholic women religious that sponsor their hospitals to resist the incursion of for-profit hospital systems, like Columbia-HCA, and maintain an aggressive not-for-profit voice in the healthcare industry wilderness. From 1994 to 1997, 198 US hospitals changed ownership, the majority of which occurred among investor-owned organizations (Development 1999). The CPH was a leading example of this business growth model applied in the not-for-profit sector. During that same period, in the years preceding my dissertation fieldwork, more than 24 different hospitals chose to affiliate with CPH. Some were county or district hospitals pounded by state and federal social welfare cutbacks, others were community-sponsored not-for-profit facilities pressured by managed care or demographic change that shifted the burden of care for working people with insurance to increasingly partial or uninsured populations. Thus, at the beginning of dissertation fieldwork, CPH had grown to more than 35 hospitals across a huge demographic and geographic swath of the Western United States.

For-profit healthcare companies can make, and are rewarded for making, growth decisions based solely on future revenue. Not-for-profit hospitals, especially those directed by their governing philosophy to commit resources to sustain a not-for-profit presence in healthcare, cannot. At CPH, the drive to sustain not-for-profit hospital-based healthcare in local communities of need significantly shaped the network's growth until the late 1990s. This formative agenda has

had real repercussions on Catholic Pacific Healthsystem as I elaborate in the chapter on the intricacies of margin and mission.

Background: Catholic healthcare ministry in the United States

The United States has repeatedly been unable to enact comprehensive healthcare coverage at the national level. Social safety net measures are enacted and repealed in accord with the vacillations of the economy and electoral politics. Incremental change is espoused as the only effective political strategy. Ironically, in a nation premised on rhetorics of the separation of Church and State, the Roman Catholic Church remains the largest institutional provider of healthcare services, second only to the federal government.

Catholic ministry hospitals constitute the largest single group of the nation's not-for-profit hospitals, almost 11 percent of the nation's total nonfederal hospitals, 14.8 percent of the nation's total nonfederal acute care hospital beds, and 16.7 percent of all non-federal U.S. hospital admissions. To give some perspective on the position of Catholic healthcare providers in the US, as of September 1999,[3] the Catholic Health Association (CHA) had a national membership comprised of 63 healthcare systems, 683 hospitals of which 619 are Catholic facilities, 64 are non-Catholic members of Catholic systems; 354 long-term care nursing facilities, 342 Catholic facilities, 12 non-Catholic members of Catholic systems; 76 home health agencies; 18 hospice organizations; 253 other services along the care continuum (e.g., adult day care, assisted living, senior housing, physician groups, and outpatient services); 284 health-related organizations (e.g., HMOs, community-based services, and foundations). Finally, more than 774,000 employees worked full-time or part-time in Catholic hospitals. The staffs of Catholic hospitals cared for more than 85 million inpatients and outpatients in 2000. Catholic healthcare systems often span multiple states and sponsor regional healthcare networks. They range in size from a few to more than 100 facilities. Catholic ministry hospitals minister through shelters, food programs, and hundreds of other community outreach efforts to people in need, regardless of creed.

The Roman Catholic Church provides healthcare services through a range of non-profit hospitals and clinics that serve very disparate communities throughout the country. This is particularly significant because economic pressure to consolidate healthcare service providers has seen substantial growth in religiously-sponsored systems that acquire struggling secular community facilities. Currently, eight of the fourteen largest healthcare systems in the US are affiliated with the Roman Catholic Church. Moreover, physician group practices controlled by Catholic healthcare systems grew by 43% between 1996 and 1997. The CPH network explored a community partnership model in several instances when the network moved to acquire or assume control of a secular hospital. This level of secular affiliation is unprecedented in Catholic healthcare and is a distinguishing characteristic of CPH. The implications are drawn out in later chapters.

The provision of healthcare constitutes a foundational element of the mission of the Catholic Church in the US. From an applied perspective, a richer understanding of the motivations and rationale behind this private sector approach to a public concern is valuable if only to clarify the utility of this major partner in a social good. In an era of federal devolution of the social welfare and health services that has seen block grants shift these responsibilities to individual states, the Church's contributions to the social safety net has implications for the future direction of American health policy. The rhetoric of federal devolution is one of decreased government bureaucracy in favor of increased local control, and an appeal to individual philanthropy over mandated societal structures. However, this private sector player operates within strict limitations that are central to its religious identity. The expansion of Catholic systems restricts the provision of particular services while the religious identity of the institutions themselves challenges public distinctions in the separation of Church and state. Community and other "secular" partnerships, project planning and development are sites of reflection about the role of the Church or state, "local control," "individual responsibility," or "philanthropy" – situations that call into question the nature of Catholic organizational identity.

Generally, Catholic identity is conferred on an institution by the bishop in whose diocese a facility is located. A Catholic facility is required to abide by the *Religious and Ethical Directives for Catholic Healthcare Institutions*, and is periodically examined by representatives of the local diocese. Catholic hospitals differ from other religiously sponsored hospitals in that they are historically operated by men or women religious, rather than lay people or a more congregational community founded model. Senior management and the sponsoring congregations of women religious are accountable to the local bishop for the operations of their facilities in so far as they impact the public identity of the Catholic presence in the community.[4] When fieldwork for the dissertation began, the *Directives* were under revision by a Vatican committee. This news was met with some consternation by Catholic hospitals and the Catholic press, amidst wild speculation in the general public press. How these changes were disseminated, the reaction to, and dialogue about them can contribute to the contours and depth of the interaction between the Church hierarchy and hospital operators as policy is set and service provision decided. These issues are taken up in the later analysis.

The Catholic Church assumes a stance of action-in-the-world shaped by the perspective of the poor; specifically, the Church is called to voice a prophetic critique of society in fidelity to Jesus' option for the poor. Catholic hospitals must balance the commitment to their religious identity and values with the commitment to caring for people whose beliefs and practices may not conform to those of the hospitals. The mission of Catholic healthcare seeks to implement a religious preferential option to serve the poor (Kauffman 1997). Thus, Catholic hospitals find that ethics and values conflicts can directly impact the provision of services to vulnerable populations: the sick and those who are poor, especially women of color. Many of these hospitals are intentionally located in diverse communities with a disproportionate share of Medicare and Medicaid-supported populations. CPH is aggressively engaged with community projects caring for these populations, reporting $177 million in community benefits in 1998. In 1999, the reported figure under those same guidelines nearly doubled. In addition to a community direct

grants program, the hospital system works with community not-for-profits to increase access to jobs, housing, education, social services, and healthcare for people in low-income and minority communities (McKnight 1994). This was the recent history of the organization when I began dissertation fieldwork in August 2001.

The fieldwork setting: California Pacific Healthsystem

Catholic Pacific Health system, or CPH, is a leading network of hospitals with facilities in several states of the western United States.[5] It was one of the fifth largest systems in the country and was, at the time of my fieldwork, one of the very largest religious-affiliated non-profit healthcare corporations in the country. Due to its size and scope, in terms of patient volume, the hundreds of affiliated physicians and thousands of employees, CPH is a major player in regional healthcare. As a non-profit hospital system, it occupies a significant niche in the state social welfare system and community benefit dynamics in the western United States.

Catholic Pacific Healthsystem was founded in 1986 by the non-profit incorporation of the hospitals of multiple congregations of women religious, whose orders span the Catholic political spectrum. This made CPH unique in Catholic healthcare. In Catholic healthcare, almost all hospitals are part of the ministries of different congregations of women religious, or sisters, rather than diocesan endeavors or direct works of the Roman Catholic Church proper. At the time, CPH was a unique system because of that historical origin as a system assembled by multiple independent orders that initiated a new form of religious sponsorship within the history of canonical ministry. This has had implications both for the politics of identity of the aggregate organization, and for the operations of the system and its member facilities in local service areas.

The range of different orders of women religious who constitute this system make it a key site of pluralism even within Catholic healthcare (Francis 1964; Quiñonez and Turner 1992; Wittberg 1994). These Catholic hospital administrators must balance the official Church teachings, bishops' public policies, and the implications of the Second Vatican Council while

conforming to local, state and federal regulations that qualify their facilities for public funds. Simultaneously, their facilities are buffeted by the healthcare marketplace, particularly the stiff competition from secular non-profits and investor-owned hospitals (MacStravic 1987; Buchmueller and Feldstein 1996; McClellan 1997; Desai, Young et al. 1999). To successfully enact its mission, this Catholic system must offer "standard of care" services to maintain patient volume to compete with neighboring medical facilities; the mediating value lies in the Catholic principle of stewardship (Bishops 1986).

All these interactions occur within one of the most multicultural states – even with its dynamic demography, California is considered the most secular state in the union: 9% of residents reportedly have no religious affiliation (Gallup and Castelli 1989) – in a nation where a civic separation of church and state colors all activities in the public sphere. In my fieldwork, I chose individual hospital sites that have a history of community and partnership interaction, especially secular facilities now operated by this Catholic system (for the general research timeline, see Appendix B). I conducted research at four levels of ethnographic engagement:

1) Participant-observation at a charity clinics operated by member facilities of the Catholic hospital system, nominally the sites of practice for a preferential option for the poor
2) Participant-observation at administrative and executive levels: strategy, planning and operations meetings conducted within the hospital system at the CPH system and region levels with management, medical staff and members of the Sponsoring Congregations.
3) Participant-observation at administrative and executive levels, as above, in local facilities. Two non-religious community hospitals, one in the north (North Protestant Medical Center) and one in the south (Downtown Hospital) , as well as a Catholic hospital sponsored by a different order (St. Catherine-by-Sea) than the Catholic hospital where I had conducted fieldwork in chaplaincy (Incarnation Hospital).

4) More than 20 modified life history interviews with men and women religious and lay Catholics, as well as other key individuals, whose career or vocation entails involved participation in Catholic healthcare operations and policy.

Work at the charity care clinic was designed to observe patient care processes for the poor and the underserved as a specific target of the Catholic healthcare mission (Redican 1981). I observed how indigent cases were handled, listening for moral judgments in the language of providers and how experienced staff may orient new staff. Topics like addiction or pregnancy, harm reduction, prevention, crime or violence all provide entrée into how value frameworks operate in the provision of healthcare. I listened for comments about Catholic facilities and other services available in the region to explore if these providers conceptualize differences in religiously-sponsored and "secular" healthcare. I did not observe direct medical procedures, but monitored daily life in the common areas, the waiting rooms, cafeteria, and hallways. I observed in provider offices and clinic rooms as providers discussed patients and went about their daily routines. When I went on to extended site visits at particular hospital facilities, I spent my free time in similar common areas between observing meetings of administration and operations.

The structured conversations were one on one, private conversations held in closed rooms on hospital grounds or central system offices, and all save one informant allowed me to tape record the sessions. The conversations were modeled on abbreviated life history interviews using a common template of generic questions, further tailored to particular groups: current sisters, former sisters, lay administrators, men religious and/or priests, and chaplains, and particular geographic site locations. I asked about changes in subjects' lifetime, and what drew them to service, and the focus of their occupation or vocation. The interviews lend the necessary perspective on institutional history and social change to provide context and complement the insights gained from participant-observation. In some cases, individual perspectives provide contrast or counterpoint to the collective or official stances, and these comments are reported

precisely to demonstrate the texture and complexity of this organization and the lives of the people who constitute it.

The actual questions differed depending on the informant; previous observations or lines of inquiry that had emerged during my time on-site were often used to guided the interviews. For example, after attending a day-long retreat with several sisters, I attempted to encourage conversation about the role of charisma among the leadership (Weber 1958) and experiences within the gendered history of Catholic healthcare and the role of the Sponsoring Congregations in its implementation. The interview conversations were largely open ended; respondents could comment as they chose. Many times they did resemble real conversations, especially with sisters, where my questions were embedded in commentary because the respondents expressed interest in my work and research processes.

Document analysis constituted an additional aspect of the ethnographic method, where on-going review adds depth of context and provides further points of discussion with informants. Documents can be regarded as part of social life itself, the "elements that enable or prevent or subvert social events" (Asad 1993:8). In addition to their immediate content, documents provided a point of entry to further discussion that elicit informants' own terms and labels, as well as priorities and challenges. Since May 1997, I have collected written material pertaining to this hospital system in the form of memos, newsletters, official publications, press releases, and procedures related to operations. I continued to monitor both the Catholic and secular healthcare industry press in California, as well as the activities and policy positions of the US Catholic bishops and the Vatican. During the course of sixteen months of participant-observation, I had access to current undertakings, meeting minutes, and other internal memos in addition to my own notes taken each day. During the time I engaged in direct fieldwork, the Roman Catholic Church was reeling from charges of child abuse and reports were regularly appearing in national and local media. These issues and implications for the CPH hospital system are addressed in the chapter on ethical scrutiny.

[1] Fialka's history was published as my fieldwork ended. It provides a largely triumphal story of struggle, about the lives of women of faith in the early US and the challenges of anti-Catholicism, a cultural phenomenon often overlooked. However, Fialka's rationale for the decline in women religious is a thin one, leaning heavily on the "reforms" of Vatican II, but with little comprehension of the nature and effect of the Council. Despite the range of possible sources, he cites few of them. Most importantly, Fialka misses crucial differences between essentially monastic forms and practices, and those of active religious who organizational roots lie outside of the monastic tradition. One sister commented during our conversation, Fialka admires their historical strength but seems to regret changes that have been made regarding habits, whether of clothing or structure. As such, his analysis takes on a romantic tone that does disservice to a historical account. A book review by Kenneth Woodward criticizes Fialka's account, but his own musings about the decline are themselves similarly superficial (Woodward 2003). Woodward suggests that abandoning a life of common prayer and the shift to rule by election and committee are to blame – "how else explain the survival of conservative orders like the one founded by autocratic Mother Theresa?" Woodward ignores the international demographic trends that support the growth of more "conservative" orders. In my project, the sisters of CPH celebrate the democratization of their congregations and their narratives suggest a much more complicated social transformation, that I think befits being Catholic-in-the-world.

[2] For an excellent historical narrative of these changes in a Catholic hospital, see "Hospitals at the Crossroads: Government, society, and Catholicism in America 1950-75" in (Risse 1999, p.513-68).

[3] The following data is adapted from Catholic Health Association website, www.cha.org. These statistics reflect the state of the ministry as reported at the time of dissertation fieldwork.

[4] An exception is, for example, the Seattle-based system that is a public juridical person under canon law. That system reports directly to Rome, not to any of the dioceses in which its hospitals operate. Sisters conduct a mission audit as a means of providing oversight, and the corporation communicates with diocese to maintain relations but is not beholden to the local episcopate (personal communication 2001, Bridget Carney, PeaceHealth). That system has served as a contrast/corroboration site for my research.

[5] CPH is a pseudonym. The names of facilities where my research was conducted have been changed to protect those who provide and seek medical care on their premises. Where identifying elements are significant to the analysis, efforts have been made to retain plausibility in the narrative while still protecting individuals and the institutions where they work. In some cases, my informants were not concerned with anonymity, pointing out that, as public figures often speaking to the press etc., their comments were public record. However, it was a stipulation of IRB human subjects protections that my research was conducted on the basis of confidentiality and anonymity extending both to individuals and to the organizations for which they worked. Moreover, such protections were an explicit concern for the AHRQ Study Section reviewers for the grant that supported the writing of the dissertation. Consequently, I presented my research to CPH under these conditions and shall endeavor to abide by them in this and other publications.

Out of Habit(s): Power and Influence

> Everybody is aware of such banal facts. But the fact that they're banal does not mean they don't exist. What we have to do with banal facts is to discover- or try to discover- which specific and perhaps original problem is connected with them.
> - Michel Foucault, *The subject and power*[1]

The sisters, their role and social location are central to this anthropological account of Catholic Pacific Healthsystem. The presence of women religious, both historical and contemporary, is an obvious characteristic that sets Catholic hospitals apart from their "secular" not-for-profit cousins and investor-owned facilities. But this easy observation belies a phenomenon that bears greater consideration. Having earlier sketched the history of American women religious and their hospitals, in this chapter I move to the contemporary situation as it has played out in CPH, working outwards to the dynamics between determinative actors in the system and the organizational identity that they together bring into being.

As sister-administrators retired or transitioned to other positions in ministry, the nationally projected steady decline in the number of women religious also meant that there were fewer candidates within the congregations with the experience or training to run a hospital. Perhaps more significantly, congregational leadership was more willing to recognize the need to import lay competency into hospital operations. Lay administrators, in some cases individuals who had been second-in-command, were promoted to the position of president; in other instances, new talent was recruited from graduate programs and other hospital systems elsewhere. With the advent of the large federal payor mechanisms of Medicare and Medicaid, together with the hospital facility expansion legislation like the Hill-Burton Act of 1946 that had funded the building of community hospitals across the nation, hospital-based healthcare was a growing industry and offered many new career paths (Starr 1982: 348,375). The concerns of the time were reflected in the 1953 Catholic Hospital Association's (CHA) 38th annual meeting of what one historian documents as "the rapid transformation of Catholic hospitals into businesses." Risse

argues that the increasing reliance on federal agencies and third-party insurers required hospitals to secure competent "budgetary planning and the employment of uniform accounting principles in the areas of purchasing, personnel and in-service training" (Risse: 523) Largely male, this generation of hospital executives held masters degrees in business, healthcare finance and hospital management. Even with incremental changes begun in the fifties and sixties, the historical professional divide between the sexes in clinical care, where nursing staffs were notably female while physician rolls remained by and large male, was further compounded as the sisters moved out of senior administrative positions to be replaced by lay men.

By the mid-nineteen eighties, when Catholic Pacific Healthsystem was first formed, lay management was already firmly established in those Catholic hospitals that were discussing merger and affiliation to create CPH. Where, now, were the sisters whose habits had swept down the hallways of their hospitals, a walking presence of Catholic ministry more tangible in their service than the symbols of the Church that might adorn a wall or lobby corner?

At CPH, the sisters are most visible in positions of governance at the system level and seats on community advisory boards for local facilities. The organizational structure of Catholic Pacific Healthsystem begins with Corporate Members, in effect the board of governors made up of the elected leadership of the congregations of women religious that sponsor the Catholic members hospitals (see chart, Appendix C). This "board of governors" appoints and oversees the fiduciary Board of Directors, who were all leaders from business and medicine including leaders from of other, geographically non-competitive healthsystems, and the system CEO. Three Corporate Members serve simultaneously as members of the Board of Directors. The remaining board members were all lay people selected for professional experience, not religious affiliation. At the time of my fieldwork, the Corporate Members were in the process of enlarging the Board of Directors to also include three members-at-large elected from amongst all the sisters in their sponsoring congregations. In the CPH system office, an executive management team coordinates

system-wide policy, including an operations team that oversee geographically-defined groups of hospital presidents.

At the system office, several sisters held management level positions in administration, legal, finance or the department of mission integration. In some hospitals across the system, there are sisters in management and professional positions; they are both staff employees of the hospital and simultaneously, they are sister-sponsors. As a term, sister-sponsors seems to have become common parlance over the last twenty or thirty years. The Catholic Healthcare Association and people in mission services or administration at CPH use it to refer to the broad swath of sisters "out there" serving in other ministries but whose congregations originally founded, then managed, and in whose collective name the hospitals are now run. It is also a term applied to individual sisters who may hold employee positions in the hospital – laboratory technician, patient relations associate, medical records clerk, security manager, PICU nurse manager – or the system office but by virtue of being women religious, many people consider them to have, as one administrator put it, "a direct line to the top." Certainly, in many facilities, they are perceived by the rank and file of the hospital to be conduits to the facility's powers-that-be, although the nature of that relation is vague, uncertain and perhaps still in flux. This chapter explores those perceptions as a means to understanding the organization itself through the social location of women religious in CPH, both in terms of how they are defined and how they define themselves as Catholic sisters in their work in the organization. The dynamics of governance are addressed in a later chapter in the context of the formal concept of "sponsorship," particularly in light of its implications for Church ministries under canon law. Here I want to focus on the sisters that remain involved in CPH and its daily operations, whether clinical or administrative.

I want to be explicit in defining what is described here. The representation of a woman religious is a social fact. As a social construct, she has an effect on actually existing women, both sisters and former sisters, in Catholic Pacific Healthsystem and its hospitals. She exists as a representation in the minds of actual sister-sponsors and in lay people. She can be analyzed

independently but always acknowledging that her existence maps onto the lives of actual existing women in incomplete ways. In the following accounts, what I am documenting points to both the representation of the woman religious and sometimes real individuals, accounts simultaneously seen through the lens of actually existing women religious who are always and already constituted within the penumbra of that representation. These actual women actively contend with a heritage that is over-determined, yet that process of contending is the very stuff that renders Catholic Pacific Healthsystem an anthropological object.

It is helpful to conceive of the role of sister-sponsors as a dynamic of power and influence: two distinct types of efficacy – one direct functioning within recognized lines of reporting, the other indirect, variably recognized and not reflected in lines of any organizational chart. In some facilities, the influence dynamic is studiously ignored by upper management; in others, it is accommodated, even assiduously cultivated and deployed. In all cases, it is a cultural phenomenon that is actively political and in some cases, vexed. As Sister Liliane mused to me :

> And yet, I think the Sisters' Council at Incarnation, we think that everyone perceives us as the thorn in their side, and perhaps we are. But that's okay. And I think we finally have gotten around, through the things we do ... the things we do as part of the Sisters Council, that we do try to bring up, try to explain. Try to bring up the mission. Our values, our ethical, and the ethics of all this. And I think now, we finally are wearing a little bit of a hole into the thing, because several of them speak to us no longer. But that's all right. And yet there are several, there are several who actually listen and do. Do something about what, or recognize a boo-boo when they see one, and are honest enough to say, "Hey, I really blew it." And then to try to work on it and change it. And even make it publicly known that-you know, "I shouldn't have done that, and I'm gonna work on this, and we're gonna try together to change this." So I think we're making some progress in that way; maybe that's our role.

A Fall Story

In his account of Mercy Hospital in Buffalo, NY, medical historian Guenter Risse invokes Catholic sociologist Andrew Greeley's assessment of the cultural authority of women religious in the Old Country.[2] Risse writes:

> "In carrying out their tasks, the Sisters of Mercy relied on a traditional Irish matriarchal model, widely represented in urban settings in both the old and new worlds. The authority of

> these Sisters was bolstered considerably by their religious status, which conferred additional respect and social prominence. Indeed, since their early days in Ireland, sisterhood had been a most successful strategy for women who desired respect, independence, and social mobility without losing their traditional identity and kinship." (Risse 1999: 516)

In the context of several of CPH hospitals, many of the sisters are Irish- and Italian-American. Risse's account gives a historical dimension to the social location of women much like the sisters I have worked with, and in the time I observed them at CPH, issues of power and influence seem directly connected to representations of the past and the way things "used to be." The stories, and even passing comments, reference the Past as a sort of code that points to how things have changed for the worse. These moments in conversation have the flavor of a Fall Story that reads: "We were called to serve in an earthly Paradise that we built from dust, it was our Incarnation Hospital, and then we were cast out of it." One sister talked about the difference between sister-led management and lay administration in this way:

> You know. It's really like what a lot of the Catholic hospitals had, before . . .
>
> I: Like in the previous generation.
>
> Sister: --the transition to lay leadership. Because you know, there were certain relationships, I think, that sister CEOs shared, and it was the queen mother thing. I mean they were pedestaled, they were, you know, everybody saw them as the center of the universe. You know, as we've made the transition to lay leadership, it's not that the lay presidents are not respected, but there is something about our sponsorship, I mean, that made it very different.

In my daily observation of their work, meetings, and in many conversations, not surprisingly, sisters do see themselves as advocates for patients and their families. However, many sisters also see themselves as advocates for line staff, for nurses and orderlies and other staff who may find themselves subject to management re-organization decisions. As one woman, once hospital administrator more than two decades ago, was to tell me, disgruntled nurses would come seek her out in her office where she now worked for the hospital foundation. "Oh Sister Margherita,' they would say, 'have you heard? They're going to close the step-down unit, or merge the telemetry unit, or do away with the OB wing? What are you going to do?'" she would recount, chuckling in bewilderment at what nurses might dream she could change or undo. But

then, looking to me, Sr. Margherita would purse her lips, and nodding her head with chagrin, lean over her folded hands to confide:

> And people look to us, like in times of trouble, times of difficulty. The employees are out there looking at us, not as nurses and not as, but looking at us as, hey, why don't you do something to save us, and save this? Or, you know, why aren't, where are the Sisters? Aren't we in charge anymore? Or, things like that, and that, and maybe we haven't...I don't know. Maybe we haven't gotten across to them....
> Sister 2: --and it's not longer a possibility because--
> Sister 1: Yeah.
> Sister 2: No, because we
> Sister 1: --there aren't enough of us.
> Sister 2: Yeah.
> Sister 1: Because we think we're living our mission, and the people (hear) such concentration on bottom line, saving this, saving that, efficiency, that they don't see the mission part that we think we see. So how do we, how do we merge the two? How do we even play our roles? Not play it, how do we live it?

Of course, when sisters were actually the administrators, they also tried to make business savvy decisions to increase revenue streams, "stream-line patient through-put," or develop new service endeavors. It is the overlying narrative of the Fall story that, like the fee-for-service narrative of managed care history, paints an all too rose-colored picture. In the past, the story goes, hospital management was always about "mission," never about the "sacrilegious margin," and having sisters in direct control of hospital operations signifies that tale. In reality, sister-administrators have had to make difficult decisions in the past as well. They laid off staff, they closed service lines, they opted not to raise salaries or delayed new staffing schedules, responding to circumstances as all administrators do. But these are erased under the sign of lay administration and the all-powerful and detrimental "managed care." However, in the anecdotes they shared with me, narratives place sisters in opposition to "management" and reify a presumption of values and priorities setting sisters on the side of mission and management on the side of margin that will be further explored in later chapter.

Sisters can exert influence because people, staff and patients alike, often perceive them to have power within the organization they don't officially have, or because they believe that a sister always speaks with moral authority in judgement, as in the case of the sister who recounted how

staff approach her, bemoaning the closure of a service line. Such a tale is polyvalent and complicated to analyze because it is hard to distinguish the self-interest of a staff member who hopes a sister can be mobilized on *his behalf* from the expectation that a sister will always be mobilized to act on behalf of mission over margin. The latter may be underpinned by an often unexamined belief that more services are better than less, or that a reconfiguration of offered services will not enhance care for the sick and those who are poor. In either case, all change is bad and to be opposed and sisters are often seen as the means to do so.

Thus, what I have called the Fall Story and various other moves couched in accounts of the past reflect a role for nostalgia as emotional device that allows individuals within groups to navigate shared but rapid organizational change. Nostalgia in this sense is more nuanced than grief; it connotes both a "resigned acceptance of the impossibility of bringing the past back" and a longing for what was once different (Gabriel 1993: 123). Yiannis Gabriel argues that it nourishes a present-day situation by offering a contrastive fiction of the past to counter current feelings of alienation or disenfranchisement. Nostalgia is a device that offers "a symbolic way out of the rigors of bureaucracy, seeking to re-enchant a long disenchanted world" (ibid.: 137). In his research, Gabriel asserts that nostalgia was most useful as a social device for older employees – and at CPH the sister-sponsors number among the most senior – seeking meaning and explanatory frameworks after undergoing organizational change. He suggests it is a transitory mode that uses a glorified past to make the present more palatable, despite perceived loss.

The more balanced account that recognizes challenges that sister administrators had addressed during difficult times in the past is largely ignored in the face of the present danger: the stereotypical perception of "business first" lay managers, who often come to CPH with business degrees and work experience in *for-profit* healthcare administration. The Fall Story version echoes the lament of older physicians and nurses, patients and advocacy groups that, at different times and for different reasons, point to a formerly Edenic period in healthcare. When pressed,

they will acknowledge the loose veracity of that invoked Past, but it was always "better than it is now."

At one level, this is a positive factor in impression management for one set of sisters who wish to believe they embody mission and that the past was preferable to the present or the trend they perceive in the future. These are the 'passive sisters'-- who could still be mobilized but, at this point, do not feel they have lines of communication or live avenues for involvement and they cast themselves in defensive positions in relation to the lay administration.

For another set of sisters that we might call 'active sisters', the nostalgia and impression management is unreasonable and reductive. It misses their active and continuing roles; certain sisters engaged in on-going work where their effect in daily operations and standing policies is direct. It is important to understand that I am not describing a simple binary; both elements are operative in different locales and situations, sometimes the same and concurrent, all within the same hospital system.

All the sisters, both the passive and the active types, see themselves as actors in the life of the organization, but with varying degrees of power and influence. The passive sisters aspire to a power they perceive themselves to have lost, but are not clear on how to access change from within the new order of things. In my conversations with them, they are aware of the "active sisters" but either don't identify with them as peers or perceive a gulf between their disenfranchised positions at a local facility and the "active sisters" they understand to be operating at the regional level or the system office. Interestingly, being a passive sister is not universally a function of operating at the facility level; several hospitals have active sisters at work in them. Rather it is a function of how they perceive their relationship to lay administrators and their willingness to reach out to sisters at the level of system governance and to engage their influence and re-position themselves as the moral compass for the future direction of the organization's hospitals. In some cases, notably during fieldwork at Incarnation Hospital, it

seemed that the passive sisters are those who have not been able to think beyond the sphere of their local facility and participate as sister-sponsors of the new CPH network more broadly.[3]

Pastoral power

Regardless of whether one accepts the rather simple active\passive typology, the claim to that power comes from some variant on the idea that, as sisters-sponsors, the professed have a claim to moral authority that sets them apart from other people. In either case, the power in a sister-sponsor to which people appeal is not a function of seniority (and the ability to hire or fire) or of simple command, for in most cases the sisters were not approached to rectify a situation with any employee they supervised, but to address systemic problems or changes in the hospital at large. It is not clear where that claim to moral authority originates, nor that all the sisters understand that claim in terms of a moral authority and I want to uncover how that understanding might be woven into the social identity of "a woman religious." In sweeping terms, Foucault has argued that:

> Christianity is the only religion which has organized itself as a Church. And as such, [the Church] postulates that certain individuals can, by their religious quality, serve others not as princes, magistrates, prophets, fortune-tellers, benefactors, educationalists, and so on, but as 'pastors'. However, this word designates a very special form of power. (Dreyfus 1983: 214)

Foucault posits the historical transformation of a particularly Christian code of ethics, distinct in the ancient world, through the fifteenth and sixteenth centuries and the Reformation into what he sees as the crisis of Western subjectivity. He sets this device within a genealogy of a new political form of power unique to the state. In my analysis of CPH, I want to stop short of the state function and consider how pastoral power may be useful in understanding the special dynamic for sisters and their colleagues. I will later argue that this bears on the ontological diagnosis of what is being created in the collective work of Catholic Pacific Healthsystem. The contrast between the traditional Roman Catholic understanding of the distinctive gifts of the religious and what came to be a Protestant counter-claim asserting an inherent equality among a

"priesthood of all believers" bears on our later analysis of the efforts at mission integration at CPH.[4] The capacity of those charged with maintaining the Catholic mission and values of the organization will depend on an ability to accommodate the laicization of healthcare within a society heavily flavored by Protestant secularism.

The Catholic assumption of the distinctiveness of sworn religious has its doctrinal roots in a papal Bull issued by Urban II in 1092. The Bull asserted that "from the beginning the Church has always offered two types of life to her children: one to aid the insufficiency of the weak, the other to bring to perfection the goodness of the strong" (Lozano 1980, p.53). In his treatment of religious renewal, cultural anthropologist and Marist religious Gerald Arbuckle further notes that this elitist view persisted up until Vatican II and set pastorally crippling barriers between the religious and the laity. In his words, "religious were considered within the church as being 'perfect, as close to God' as the human person could possibly be; therefore, they could never be expected 'to understand the ordinary human problems of the laity who were called to a much lower level of Gospel life'" (Arbuckle 1988). That notion of perfectability, however, lingers in the opening Latin of the decree on the Appropriate Renewal of Religious Life, *Perfectae caritatis* (1966) even despite the tone of the central decree of Vatican II (*Lumen gentium*)[5] that it accompanied and that directly sought to counter such an idea, namely that men and women religious were more sanctified than lay folk.[6]

The tendency to assign holiness as the reserve of a 'priestly group' has been a source of internecine debate going back to the gospels, as for example in the writing of Luke Acts. Long a contentious discourse for the emerging Church since the second century when early Church fathers first propounded on various ways of being, notably how concepts of marriage or celibacy relate to a state of "holiness" and the priesthood. It remains a concern for the Church and has constituted a doctrinal problem for Protestant sects since before the Reformation. Indeed, in the collected documents of Vatican II, the Protestant Response to *Perfectae caritatis*,[7] written by an Episcopal priest from the World Council of Churches and official observer at Vatican II, opens

with the declaration that "*everyone* in the Church is called to holiness in his own state of life, not merely certain Christians who have been set apart in monasteries and convents. The point is important, for it meets a Protestant criticism of Western monasticism which has sometimes appeared to hold that the monastic way of life was a higher way, and especially that the celibate life was essentially superior to the married state" (Abbott, p. 483).

Almost by definition, "religious" connotes a moral bearing, an outward sign we see carried to its symbolic extreme by contemporary American politicians who, needing to demonstrate their upright morality, make much ado about documented church attendance. Jon Anderson has suggested that this is part of the "paradoxical outcome" of the second Great Awakening and post-Reconstruction Protestant Christianity, that placed "social issues outside Christian concern if they diverted attention to the world from the imperative of salvation from it; at the same time belonging to and attending church became not a civic duty but a public mark of moral effort and responsibility to which the alternative was the anarchy and irreligiousness...." (Anderson 1995: 82).

Objects of analysis

Historical treatments attest to the ubiquitous presence of sister-sponsors throughout their hospitals. As Guenter Risse writes of the Buffalo, NY, Mercy Hospital circa 1945:

> "At least one or two Sisters worked in each hospital department. Their high profile set the tone for all personal relationships in the hospital. Willingness to help others was deeply ingrained in the Sisters' family background and reinforced by living in a religious community. They greeted each other, the rest of the personnel, and patients with a friendly smile. Although they were protected from the burdens of ordinary life, their commitment and dedication were deemed absolute: 'when they say mercy they mean mercy'" (Risse: 524).

As the times changed the role of sisters in hospitals across the country, a cultural ethos of authority persisted both in the minds of long-term employees and amongst many of the sister-sponsors themselves. My analysis of Catholic Pacific Healthsystem considers the present day

dynamics in terms of that social legacy in order to describe the ethico-political constitution of the organization as a social phenomenon.

In this dissertation, I am working with conceptions of *ethical* and *moral* as distinct but inter-acting categories whose distinction hinges on the orientation of their regard. My analysis is predicated on the idea that orientation is the key distinction between these two related concepts. Ethical refers to a self-regarding course, a cultivated disposition, of attitude and purpose that leads to a particular state of being. It may be about bringing one's self into compliance with a set of rules, wherever those rules may originate. Of course, being a particular sort of person also requires that one acts in the world. Through action, one's ethical being has effect on others. Thus, it is through action that the ethical has bearing on the moral. Moral refers to an other-regarding course in the sense that it reflects judgments made about the actions of others in the world with regard to one's own ethical criteria, and recognizing that the internal motivations of others are not accessible to us but by way of interpreting (judging) their outward appearances.[8]

Recognize here that I am setting the terms for the subsequent analysis in this project. Others may, and my informants do, use them differently. I asked one former sister about those terms when she was describing her work:

> R: What I, what I think I do is look for the chinks in the wall, you know. If the wall is corporate America, and the chinks are the ways or values to sink in somehow to the wall that is conservative, American, in the for profit competition health care industry—well chosen word—then I feel like I am in the infiltration business. I'm looking for places to, not baptize it, so much, but to—and not even really to make it different. Just to make it consciously moral, I would say. And when I think about my colleagues do, you know, what my counterparts in other Catholic systems do, I don't know if that's what they do, too. Probably it is. It's probably, it probably overlaps a lot with what...
>
> I: Is there a difference between ethic and moral? Ethical and moral?
>
> R: Not in the way I just used it. In the, in the literature, there sometimes is and sometimes isn't. And when there is, and when there is here, I tend to use the word ethics when I mean public moral decision making. And you use moral or morality when people tend to think private. Internal. This is what my upbringing, religious tradition, blah blah blah, means. But when I say, when I'm talking to a group of doctors and nurses, and I say something like, 'There's a real ethical question about whether that's the right thing to do...' Or when they say to me, 'Is that ethical?' they mean 'Is it right?' If they said to me, 'Is that moral?' it would be

more like they were saying to me, 'Should I do that?' And that's the way it comes in. When I use the words, I tend to use them interchangeably.

In the course of fieldwork, I repeatedly noted that the women religious of Catholic Pacific Healthsystem do have observably different characteristics. But rather than it being an ethereal intrinsic quality, it is closer to a cultivated virtue that is shaped *through formation* within a religious life engaged in ethical reflection bound to social action. In this sense, then, many sisters might be said to have a greater moral authority in the context of enacting their ministry, here the organization CPH, but it lies in the fact that their particular and individual religious identity, what makes them Catholic, what I have termed *catholicity* is constituted by furthering the work of CPH as collective that serves the poor and sick through healthcare and other functions. Moreover, I contend that the particular qualities of sisterliness have to do with an outward-oriented intention whereby the sisters are focused on eliciting mission in others, and certainly their power\influence is repeatedly invoked in the name of mission. It is not that that the sisters themselves are intrinsically more moral, though they might be more ethical – again in the sense of having been consciously formed, they are self-actualized, reflective, focused on the self in its acting in their mission for others – not on rendering judgment over others. In the words of one sister:

> [It is hard work] trying to figure out what kind of person you want to be. And you fall, you struggle every day. It's not an easy thing. It's not easy. But there's enough grace to see you through. But I think you go for a long time, everything is just hunky-dory, and then all of a sudden, whammo, something hits you. You try to overcome that, then you go into something else. But God is a jealous God (laughing). He can really put you to the test. But it is, it's an interesting life. St. Catherine always said that if women really knew what religious life was all about, they'd have to build walls around the convent because they'd be clamoring to get in. And then, again, I think it's a mystery why some people go and some don't. Like I said, why me, oh Lord? [Laughter]

> Because it is about discernment and reflection and trying to find an honest path. And I think the way that the formation process is set up, they give you ample opportunity to say, 'are you sure?' ....[It's] six years. Six years before you can step – before you go to the final vows. And then – I don't know if you're aware of it, ... like, we have seven sacraments. Well, now, religious life is not a sacrament. So a sister – like a priest, when he's ordained, he's ordained forever. He'll always be a priest, no matter what happens. Not so with religious life. This is not a sacrament. So if a sister decides to leave, she can just leave.

> And I think she has to be dispensed from vows, but that's just a [canonical] legal matter. But it's not a big deal for a sister that wants to leave; she can.

Women on the path to vowed life undertake several years of formation. The process is a training, one that pairs active service with study in theology as well as the discipline of spiritual practices. In this Catholic context, I want to recuperate the notion of *habitus* from Pierre Bourdieu who sought to conceptualize how structural and class positions of individuals are embodied dispositions, with an emphasis on the unconscious processes by which that happens (Bourdieu 1977). Aristotle wrote of *habitus* as a concept regarding the bodily practices that lead to the cultivation of moral virtues, for example, religious piety. Adapted by Christianity, *habitus* refers to a pedagogy whereby internal attitudes are developed in conjunction with external bodily practices or social demeanor.[9] The sisters who co-sponsor this hospitable system by and large put aside the traditional concealing headdress and enveloping robes of the habit in the reforms they undertook after Vatican II. But formation marks a sister, and the distinctions I observe remain about habits, habits of presentation, of demeanor and of speech.

A veil that persists

It would be easy to point to the traditional costume as something more than a costume. A recent article in the *New York Times* reported the retirement of Sister Mary Rose McGeady from the presidency of Covenant House, the nation's largest privately financed child welfare agency. McGeady is a Daughter of Charity who entered the order in 1946. Following a discussion of the strong ties of community life, the reporter writes:

> "[McGeady] wears a blue habit and veil, although the veil is no longer required. 'It gives me a certain identity,' she said of the veil, 'A lot of people look for it. It tells them who is taking care of the children.' When she joined the order in 1946, the nuns wore wide white veils with flaps, or what [McGeady] jokingly calls, 'Flying Nun outfits,' referring to the television series. They were abolished 40 years ago, but she said the day she was given her white veil was one of the most important in her life. 'Folding that white cloth for the first time meant I had entered for life,' she said."[10]

Though the article celebrates the commitment of Sister Mary Rose for her ministry, the reporter cannot resist the narrative color that describing the veil gives to the article, and makes sure to recount the good humor with which Sister refers to that distinguishing marker of a dedicated life. This evocation points up a frequent ambiguity or polyvalence from my fieldwork. Sisters often spoke to me about what they looked like "back when" they wore habits and veils, always in a two toned manner.

> "First of all, I loved the habit. It was a beautiful habit. And the sisters that were there were always so happy and joyful and intelligent, and they were just fun to be with."

Much like the reporter did, a sister would crack a joke about the appearance of the habits, often accompanied by hand gestures indicating the fall of the fabric. But, then she would shift gears, and more often than not, refer to its significance in her life, identifying it as a symbol of her commitment to God and to her community, an intentional adoption that marked religious humility and uniformity. The frequency of this double-layered explanation, both among my informants and in the *Times* article, shows how women religious are bemused by the way that lay people perceive the traditional dress, and behind it, the life choice of service. Yet, while noting the bewilderment and recognizing it as an object of humor in difference, so many of the sisters revere the symbolic dimension of the habit.

> I: So you saw – you were in community through Vatican II?
>
> Sister: Yes. Saw the changes, uh-huh. 'Cause we were in the full habits for a long time. And then I remember teasing that no one's ever gonna see my hair. "They're never gonna see my legs. Never, never." With some nuns, I could see why. And then we went to the short, and then just a little bit of this top part of the hair would show, and then all of a sudden, it was gone – it was painful... Oh, it was painful, yeah. And my father was furious. He said, "Oh, you're not real nuns anymore." Well, you know, their attitude was, a nun is someone wrapped up in three yards of material. They never got beyond the material. [The uniform was what made us.] And, see, the whole concept is that when the order was founded, we were to dress like the women of the day. So we could be with them, mingle with them. Well, we certainly didn't look like the women of the day. So it was a good change.

The sisters take the humor in stride because they recognize that formation does have its effect, it is a training and a discipline that marks the body as well as the spirit. But it is not always easy to identify what sets women religious apart. As one sister recounted:

> My mother keeps saying, "Eunice, act like a nun. Act like a nun." I says, "Well, mom, what do you mean?" And she says, "Well, go find out." But she says, "Whatever you're doing, it's just not right."

Even the sisters themselves express some perplexity that is reflected in their self-reflexive humor.

> Sister: I just can't spend time worrying about it. I just have to do what I have to do and let it go at that. Try to be as nunny as we can. There's being religious, and there's being nunny. We call Anne 'nunny'.
>
> I: And what is that?
>
> Sister: Perfect in every way, everything always just so. You never see her swear, you never see her cuss or take an off-color joke. She is just – they all live together, and they just are very nunny. [But, you know,] they're religious, too.

This chapter describes the social distinctiveness that women religious seem to manifest, how they relate to that difference, and the relation between such social difference, their lay colleagues in healthcare and the flow of power and influence in Catholic Pacific Healthsystem. During all my fieldwork, I spoke with only one sister who continues to wear a modified veil. With that exception, all the sister-sponsors at CPH and in their local facilities that I encountered no longer wear the habit or veil. A handful of sisters from other orders who are employed chaplains or involved in other mission work, but are not affiliated with the sponsoring congregations, were in full habit. It is my contention that while these women religious are accepted as commonplace in a Catholic hospital, as non-sponsors, they do not actively contribute to the organizational identity of CPH. Rather, they are a subsequent product of that identity. That is, because the hospital maintains a Catholic affiliation, non-sponsoring sisters have a place to minister and a recognized social location that goes unremarked on. This seemed particularly true

in Protestant North Medical Center and Downtown Hospital, two formerly community hospitals that had become part of CPH in the decade of acquisitions and affiliations.

The difference of formation also involves a process of socialization in a community that is markedly different from the external secular world. During fieldwork, I observed that for many there is a demeanor and comportment that does seem to set the sisters, even former sisters, apart from their lay colleagues. In some, it is a way of self-presentation. When Catherine addresses a group, for example, she adopts an even-footed stance and holds her hands in front of her with the fingers of each hand coming together and point outwards. Others clasp their hands together, interlacing their fingers, and rest their hands on the table in front of them. Their bodies seem physically grounded and comfortable being still, as if perhaps, from routine time spent in reflection or prayer.

At corporate governance meetings, there are both female board members who are individuals from the corporate business world, leaders in healthcare, investment banking and other leading companies and the sister-sponsors. But it is easy to identify the sisters from their secular colleagues by their attire as well as their demeanor. Sisters rarely wear heels, preferring flat soled shoes. What jewelry they wear is understated, as are the colors of their suits that lean more toward solids, often pastels, and quiet flower patterns. Sisters seem only to wear skirt suits to board meetings. In contrast, the other women wear pantsuits. For several years, the chair of the board was a business woman given to sharp lines, pinstripes or a severe black pant suit with a flame red blouse. The contrast of the collar of her blouses against the suit jacket always caught my attention because they stand in as power ties of her male counterparts. She and the other secular boardwomen might wear gold necklaces and bracelets. The sisters usually only wear the ring signifying their vows and membership in community; some sport an enameled cross or dove on the lapel of a simple suit jacket. Their make-up is lighter, if at all, with styled but practical, short haircuts. When the meeting is convened, the Corporate Members sit with clasped hands, straight backs, not crossed legs but feet firmly on the floor.

Thus, despite what the sister earlier argued about the history of the habit, contemporary sisters still do not match onto the image of the women of the day. Without the habit, they are certainly closer to the appearance of lay women. They retain a distinctive aesthetic, however more subtle. I hesitate to say feminine, despite what some may say about pastels and soft floral prints, for the aesthetic is conservative, understated, grounded but gendered. They are modern women but women apart. As sisters, the Corporate Members and other sister-sponsors come to their positions of responsibility or authority through a collective organization, their sponsoring congregation, independent of men. Their attire reflects an aesthetic based on the values of religious community rather than secular society; it reflects a life of self-cultivation among peers linked through common vows. Obviated by those vows from the hegemony of reproductive roles, their dedication makes possible the care of others and society as a whole. At CPH, in a professional environment numerically dominated by men, the sisters retain a *habitus* that distinguishes them from other women. Even some former sisters still manifest similar body language; it is a habitus that they carry with them everywhere:

> Well, they're known for their joyfulness and their hospitality. And I think a lot of them are outgoing, joyful. They're joyful people. Prayerful. And now that the sisters are out of the habit, they still know you're sisters. You don't need the habit because – my folks have a cabin up in the north woods, and I go up there every time I can; it's like a retreat. It's fun. There's no running water; it's an outhouse. It does have electricity. But anyway, I was up there last December. And I walked in, went into church, and then the next day, I was back on a Monday, and the priest stopped me and said, "Pardon me, are you one of the sisters?" And I said, "Oh, yeah, I am." He says, "I knew it. I knew it." I mean, this is a crowded church. And he said, "There's something about" – and I said, "Well, why is it? Because there's a lot of single women walking around in this church." And he said, "There's a presence about you, and I don't know what it is." And I think that's true, not just with me, but I think there's a presence about the nuns. It's the way they carry themselves, the way they walk, they talk. I don't know what it is, but there's a presence about them that's kind of a mysterious – I don't know .... Well, what embarrassed me at the cabin, 'cause it's rustic up there, I wear blue jeans. I never wear blue jeans, ever, anywhere, but I wore them at the cabin. And I was running late, so I just got the blue jeans on, Levis, but it was kind of a semi – the coat was – it wasn't the waist – it was a longer winter coat, so that nobody'll see me. You wouldn't expect a nun to walk into church at mass with Levis unbleached. But evidently, this priest didn't get that far, to the boots. I was almost gonna apologize to him for not wearing decent-looking slacks.

Sister Melanie understands what I called *habitus* to adhere even to women who had decided to leave religious life because they had undergone the process of formation, something she perceived as life-changing and sustaining. Speaking of a former sister we both know, Sister Melanie said:

> She left because she realized there's another – you can do the same thing as a lay person as a religious, and she just wanted to do it her way...That's great. I mean, [it's about formation, right].You just can't live that lifestyle and not have it infiltrate your whole soul, your whole being.

Leadership: attitude and style

In his study of Southern parishioners, Jon Anderson finds that priests are commonly known by foibles, characteristics of personal demeanor, and relations to parish, for the priest is a model for the parish. In contrast, Anderson argues:

> "Nuns, by comparison, have no such double identities, but instead an extraordinary reputation throughout the South – not only among Catholics – for sacrifice, service and efforts that are institutional. Their more singular identities reflect their long association...with schools and hospitals and the memories adults have of nuns in habits. Priests generally do not enjoy such unmixed reputations among Catholic people...who appreciate their efforts but nonetheless also see them as a more ambiguous category" (Anderson, p.110).

There is also an attitude that extends beyond their physical bearing to their mode of conversation that I noted repeatedly in the course of observing months of meetings and daily work. Sisters and former sisters express many more of what I call, "attending markers" in the course of conversation. They actively listen, and their listening is peppered with utterances like, "hmm, uh-hm, ah, yes, uh-huh, okay." In meetings with other colleagues, but most notably in formal board meetings, many of the women religious and former sisters adopted what seemed to be a strategy of allowing commentaries from colleagues to run their course after an issue was introduced before a sister would air her own comments. This was noticeable even when the sister in question was not leading discussion or acting as a moderator. In many a meeting, it would

seem that sisters more than other colleagues waited to hear the range of colleagues' ideas before lending their own opinion. Their comments were not timid; I do not suggest this was testing the waters. Rather, sisters often listened only to then instigate what appeared to be "course corrections" when the flow of commentary led away from an earlier comment. In one example I recall, the board was discussing forms of alternate investment for the hospital system asset portfolio. A discussion of blind mutual funds was initiated, and several board members moved from initially expressing uncertainty to encouraging further exploration of this asset form. As comments waned, a sister raised her hand to interject, and re-iterated the initial point that such mutual funds were "blind" and consequently could not be screened against the Catholic Socially Responsible Investment criteria that would, for example, prevent the hospital system from investing in corporations that exceeded more than 5% involvement in the military industrial complex.[11] In the course of the discussion the "blind" nature of the funds had fallen to the wayside in the wake of comments about the possibility of successful returns. Sr. Gretchen monitored the conversational flow with a fellow sister-sponsor, exchanging glances across the table, until it seemed the discussion had faltered, at which time Sr. Gretchen raised her objection.

I think the style of participation in discussion that I have observed is a result of extended experience in collective and communal discussion. It suggests an understanding about the nature of leadership, even as it may reflect gendered differences in group speech patterns. One could interpret my anecdote above as indicating that sisters are cautious, as one informant suggested to me, about offering their opinions in discussions about finance or other areas where a sister might be less experienced. On the contrary, sisters that deployed the "wait-watch-interject" model of participation often raised points that were distinctly counter to the flow of conversation or returned to an earlier point otherwise lost. When I approached sisters about my observations, they specifically named perceived issues of power and influence that lead them to adopt this form of leadership participation. The sisters I spoke to were concerned that their colleagues, on the board

and in management, could be too deferential to sister-sponsors. One executive explained why there was an mystique to the sister-sponsors:

> And it's partly because they're women, it's partly because they're Catholic, and partly because they're nuns. All of that's kind of foreign territory to most of those guys. [For many of senior management] their only exposure to Sisters is that they're the Board of Governors. And because these guys don't have any other exposure to Sisters, or maybe to committed Catholic women. There's no context into which to put it. So it's a hundred percent of their experience. Probably not exactly. But that they're the bosses makes it even more "mystiquing."

Consequently, sisters preferred to allow other meeting participants to speak their minds before sisters offered their opinions. When questioned, one Corporate Member was very amused that I was watching this kind of interaction, but nodded her head and said as much to me: "I like to state my mind in the form of open-ended, leading questions rather than pronouncements. I like to 'suggest we think about' rather than insist; I say 'I hope we would want to X,' rather than, 'CPH must do X'. And that seems to have the desired effect. I don't know that they notice; our agenda is always so busy."[12]

I am not asserting that my informants have stylized or monochrome auras and identical behavior patters about them, for the sisters of CPH are engaged in the daily work lives of their colleagues much as the priests of Anderson's South do. But Anderson's observations do suggest an outline of cultural presumption that cloaks women religious. Certainly, cultural effects of gender play a role, together with the literal uniformity of the habit that places the individuality of any one particular sister under erasure. Even if the habit is now historical for many orders, in the cultural imagination, nuns are a category of people, plural in nature to be known by their good works. Their emphasis on the collective and the value of communal decision-making further reinforces their uniformity as a group. Moreover, in positions of leadership, they adopt a pastoral role in their dealings with colleagues at all levels.

Just as they single out the habit has been the external marker of difference, many outsiders to religious life tend to focus on the vows. They perceive them to be particularly

onerous and, consequently, what sets men and women religious apart from lay people. Sister Melanie explained how a man she had worked with in her previous ministry saw it:

> He said,"You've gotta take the vow of chastity, you've gotta live at poverty level, and [he] didn't get a chance to ... I says, "You know what? That's not so at all. We're here because we want to be. The church does not tell us – make us do – our life. It isn't. You have a choice to leave. But it's gotta be what we do from within. We choose this life." And it just amazed him– I never did get to talk to him to say, "No, you got that all wrong, buddy." So I said, "So your wife – you're married to your wife because you've got to be. She won't let you go, or you feel so obligated. I wouldn't encourage anything else, but I mean, what if you didn't? What would you do? Would you have another choice? Well, we have choices, too." But I think they think that the church has the sisters all locked into a lifestyle or a convent, and that's not it. But you don't get to share too much of that with the people. When they did the article on me, I just did get to say that – "Why are you in this field?" I get that asked so many times.

As Sister Melanie tried to explain above, during my fieldwork, the vows were not the distinction that was most often identified by the sisters I worked with at CPH. Rather, their emphasis on the distinctiveness of religious life lay in idea of living in community. "Being part of community," as they referred to it, meant not only living in the convent or together in smaller groups, it meant engaging in a form of consensus-making, submission to the will of the group over the will of the individual. In fact, one woman I interviewed explained the vow of obedience in just those terms:

> ....that's how I sort of thought about joining. It was, it was, you know, the Sixties and Seventies were also, this was a safe—I think I have told you this before—this was a safe, but still very counter-cultural thing to do. It wasn't joining a commune. It wasn't taking drugs and risking your life. It wasn't running off with somebody and...it was really different, and it was communal. It was simplicity. It was poverty, chastity, and obedience. Obedience never really meant anything to me. [laughs] But decision-making in common did. Which is sort of the way obedience got translated, I would say.

Moreover, as the earlier quote from Sister Melanie indicates, the repeated questioning by outsiders of why someone would *choose* a vowed life presumes that it is a life of privation. However, the vows and participation in the collective life are more often perceived as gifts or rewards:

> So I think the more you give, the more you get back. You don't do it to get it back, but it all comes back. And there are some places in scripture where they say that you'll get a hundredfold, and this is the hundredfold. It's just a beautiful life. And it's for not the material stuff that you get back, but what you get in friends – I mean sister friends.

At day-long retreat for long-term employees that focused on appreciating and sustaining their commitment to mission and values at the local CPH hospital, a sister was asked to explain what her vows meant to her. With a nod and a smile, she explained that she understood poverty to be a commitment to living a life of *simplicity*. She raised her hands up and opened her arms toward the circle of people and explained she saw celibacy as *relatedness*, "how much can I love" – all of Creation, not just friends and family. Obedience, which she always struggles with, is about *recognizing* "how God is moving in her life." She ended her comments saying that this retreat was about closing the connection between me and you, that their work at the hospital was "my ministry as supported by you."

I would argue that an element of the power\influence dynamic that continues to adhere to sisters at any level of CPH, but particularly where sisters might not hold positions of power as such, lies in the fact that sisters are perceived to be part of something greater than just the individual woman. I have noted the ability for a sister to come forward and speak, with a much louder voice, because her identity proceeds from a space where, when she speaks about social values and advocates for social justice, a sister knows she has support behind her. As Sister Anne remarked:

> "I deliberately choose to use the 'Sister' when I think it will gain me the kind of access that I need, and I do that internally and I do that with external organizations. Now, once I'm established, and we know each other, I much prefer to be called [Anne]. And I think I invest as much in making people feel comfortable and - you know, it's funny because I just came from the meeting with - and Rebecca [a colleague, sister from another Sponsoring Congregation] was there. And we are so different: she is the skeptic and Rebecca drives the hard bargain. I'm easy. By comparison. And, I mean, I think I can ask the tough questions; I have an idea usually of what I want, and I will definitely hold you to it until I get it. But I'm also not - I don't think, expecting too much...I think that's especially true for the two of us, because Rebecca and I come from .... we're members of two of the sponsoring congregations. I love my job. I'm not afraid of losing my job. I suspect there are people who would be afraid of firing me [laughter]"

Here, Anne points to one of the other factors that contributes to her influence over time – namely, people may perceive that dismissing her will have negative repercussions from the sisters

in power, the Corporate Members who serve as the board of governors. The ties within a religious community are strong, particularly having shared twenty plus years together. Officially, corporate policy sees sister-sponsors as employees subject to the same review and evaluation as any other staff member. But Anne is aware that the influence she has stems from a misperception of her invulnerability. And, ever pragmatic, she makes use of it. Similarly, Rebecca's perceived influence enables her to speak her mind and "drive the hard bargain." Rebecca's staff position involves her in the social justice dimension of CPH and can put her at odds with anyone in finance or operations who is only proceeding from the income/loss perspective.

Vocation and the difference of calling

But there is also an accompanying drawback to the invulnerability of being a sister at CPH. Their work is part of ministry; it is a vocation rather than a career. However, Anne has been a director for more over a decade and has never been promoted. In conversation, Anne is quick to point out she has no interest in becoming a vice president, but what bothers her is the implication that the tasks she performs are not recognized as intrinsically valuable to the organization. "When I started being a director, I had some clout," she says. "I don't now. . . . I'm delighted that I'm not being asked to [take on areas outside of my portfolio, but that would be the promotion]. But it certainly says to me that - where the priorities of the organization are there." Anne is concerned that were she not a sister in that position, perhaps that position would disappear altogether if she left or retired. Moreover, she worries about how CPH might continue that social justice work without being able to offer a lay person a career development track.

Understanding one's purpose in an organization in terms of vocation or calling has distinct implications for behavior quite different from approaching work as a stop on a career path. For sisters like Anne, it manifests as what I have called the *longue durée* perspective, oriented as it is to service rather than career advancement.[13] In this context, the *longue durée* connotes an individual work strategy that is more concerned with achieving incremental, long-

term effects, rather than time-delimited. Thus, Sr. Anne is concerned about her ability to advocate and initiate real social justice reform both within CPH and, by leveraging CPH, in civil society. She is less concerned with simply meeting the objectives of her position description to garner seniority or promotion – these may well overlap. I am pointing this out as an individual manifestation of an orientation I think is operative at the institutional and organizational level. For Sr. Anne, it is an orientation that emerges from her ethical understanding of her religious vocation. For the organization, it too reflects a doctrinal understanding of purpose that derives from the theology of the Roman Catholic Church in the world. As Anne's comments suggest, her vocation and her self-understanding as a woman religious in CPH lend her a moral legitimacy that translates into the authority to speak her mind in finance meetings, an authority she doubts someone who wasn't a sister-sponsor would feel. But that she works to inculcate in her lay colleagues.

An important element of the sociality of religious life for sisters is the concept of the servant-leader. This begins at the heart of the Roman Catholic Church, indeed, the Pope is the first among equals, the bishop of Rome, and "the servant of the servants of God."[14] The internal reforms of their own orders instituted by women religious after Vatican II include the election of congregational leadership by democratic means, breaking with the tradition of appointed leadership. Thus, a sister could quite literally move from her teaching ministry in high school history to a four or six year stint as a member of the congregational leadership team with all its attendant duties, and then return to ministry under new leadership at the end of her term. I met with several sister-sponsors who had made such transitions, moving from rank and file to president or visitatrix and back again. One sister had even held a position assisting a senior hospital executive for several years only to be elected to congregational leadership and thus, became a Corporate Member in system governance at CPH. Consequently, she transitioned from employee to employer overnight. Subsequently, she might take on new challenges elsewhere among her congregation's extensive works in healthcare and education, not necessarily a position

of leadership, but a position where there was need of her skills. In this lies a different understanding, what I call an "institutional humility" that builds out of their understanding of "service." As a sister serving as a utilization data analyst said to me:

> Yeah, and I think they use the word 'service'. You don't even realize – I mean, we do perform a service, but the word 'service' means, like, it's gotta be done. That's what we have to do. And we don't have to do it, but we just do it willingly. And there it is, that what we do, how we perform this job or this service or whatever you want to call it – it's not so much what you do but how you do it. And I keep telling that to the guys: it's not what you say, it's how you say it. Not what you do, it's how you do it. And it's hard to get it through their heads sometimes. Every now and then, the light goes on.

The reforms stemming from Vatican II have operationalized this "institutional humility" among women religious where individuals can be called to lead but that individual returns to the rank and file when another sister is elected to leadership. According to several Catholic brothers I spoke with, this reflects a very different sociality from congregations of men religious. Alan is an ordained priest from a clerical order of men religious, and he serves as a chaplain at a CPH hospital and has worked alongside many sister-sponsors in the last six years. He observed:

> Well, ours is more from the top down, hierarchical. And even just the way we set up, we have regional superiors and area superiors and then they're part of the provincial administration, and - but most of the stuff that happens comes down through the provincial administration and direct us in terms of how we're to be. Whereas, [that particular congregation of women religious], it's really discernment - even how they vote, I remember when I was at a retreat with... how they selected their leadership. They gather in prayer and calling forth people. You know, we [his clerical order] vote. We send our votes to Rome, and Rome makes the appointments from there. It's very different.

Another sister explained her view of the changes to me, noting that in the 1960s and 70s Catholic women religious had become the most highly educated group of women in the United States. Securing that achievement had not always been a simple task, something that one sister recalled with great amusement in her life history interview:

> [W]hat do they say? A different – walk to the beat of a different drum. And 'cause I went to [Georgia] State and got my Criminology degree, then [Michigan] State for my Master's in Criminal Justice Education, and then another Bachelor's at Barry University in just History and Spanish – but it was really the school of hard knocks where you get educated. And even when I was going to [Georgia and Michigan] State, to be the only woman in some of those classes, and then a nun on top, that was not easy.

In the upper hallway of the acute care building on the campus of St. Catherine-by-Sea, strategically mounted on the wall across the corridor from the physicians' lounge, are the photo portraits of the sister-sponsors currently serving in that hospital and its ancillary services. Next to each headshot, a short biography describes the sister's background ending with her current role in ministry. This "rogues' gallery" as it is affectionately known is atypical within the CPH system, not for the display, but because in 2003 there were more than 20 sisters in service at this single hospital – numbers more typical of a previous era. What is not atypical is that a quick review of credentials demonstrates that 98% of these women, again average age 65, holds two masters degrees or more advanced studies. In interview after interview, I was reminded that these people, now in their fifties, sixties and seventies, were an extraordinary group of women. They were highly educated, notably self-determined, and, Sister Georgina reminded me:

> And, the most healthy group of women. That's true, it was. And they always said that women's lib started in the convent. They always say that. I don't know if it's true or not, but with Vatican II, I think that a lot of the women just said, "Alright, let's go." We had – our founders were male, the Rule was written by males, [and we threw that out.] Forget it. It's a different life, different world. So we rewrote our Rule and took it back to the Vatican. They were not happy with it. It took them two or three years before they'd accept it. "Go back and change it. You've gotta have authority. You've gotta have someone in authority," what we call – "There's gotta be a superior." No, she's a coordinator. "Gotta use the word superior." But that makes us, then, feel inferior. It was the language we had the problems with, so we changed all the language, to have a different type of constitution. And the women wrote it. So [the magisterium] were not too happy, but it got through.

Father Alan sees his own order as hierarchical, whereas to his eyes, the sisters are more relational. Though earlier in our conversation he had displayed his knowledge of Vatican II and its reforming effects on religious communities, he sees the differences as one of sex rather than modernization. He also extends that relationality to the employer relationship between sister-sponsors and their hospital staff. Again, Father Alan:

> Well, as I was trying to remember their [congregational] assembly, ...I guess what I would say is... it's the feminine nature that the women bring. Growing up in a - basically a masculine culture, and being trained in a masculine culture, just to hear how they make decisions as a community, that is, out of relationship with each other, it's so different from my community experience as a man. So I think that - what I appreciate about the [sisters] here is that they remind me that you have to have this balance of the masculine and the feminine, and that they bring this feminine quality that talks about establishing relationships,

> and so you have this effort to try and see this more than just as a business, but of really trying to be present to people, to employees, to the patients. I think that that value of being women, and how they live their lives with one another in relationships kind of flows into how this hospital operates, people trying to care for each other. I think that's been some of the gain for part of - some of the unionization that's gone on here. I mean, we've been unionized in different departments now. But it's been a slow process, unlike some other CPH hospitals. But I think that part of that has been because of the relationship that the sisters have with the employees.

My move here is an indirect one, linking the special aura that adheres to sisters that I discussed earlier to ideas about the nature of their work as vocation. Sisters themselves see their work at CPH as a facet of their ministry; it is not a career in healthcare, but a vocation to contribute to the care of the poor and the sick, whether through direct clinical care as a nurse, or through administrative roles in hospitals or ancillary divisions of the CPH system. When ascending a career ladder of increasing responsibility and compensation is a secondary concern to the primacy of their collective mission, the servant-leader model provides a template for service based on the needs of the collective for particular skill sets at particular times. Institutional humility sets a tone that prepares a sister to serve as a leader when she is needed, but recognizing that as a servant of God serving the underserved, the goal is not her own advancement but the advancement of the ministry as a collective whole.

This admirable orientation, that seems to be the dominant model at work among these sisters, can have implications within the culture of Catholic organizations like Catholic Pacific Healthsystem. First, in the context of providing not-for-profit healthcare, it sets a cultural expectation for all healthcare workers. Most directly, one can understand it by way of analogy to physicians as a professional class (Freidson 1970; Freidson 1988; Friedson 1994). The distinguishing characteristics of a traditional profession include specialized and restricted knowledge, self-regulation by peers, and a sense of motivation or purpose beyond simple remuneration – what maps here onto the vocation of women religious, recalling clergy as one of the archetypal professions. The conjunction of two professions, medicine and the clergy, undergird the ethos of the not-for-profit hospital creating a backdrop that expects people to be

drawn to healthcare in the spirit of service to those in need, both the sick and those who are poor. In Catholic social teachings concerning the care of the poor and the sick, particularly when it is aligned with the healing ministry of Jesus as it is in the mission statement of Catholic Pacific Healthsystem; there is a dimension to the provision of healthcare that is redemptive. Sisters are women-in-the-world that make possible the care of others. People are moved to care for non-kin because the act of caring elicits an ethical quality in the carer, the person who cares, as well as constituting a moral act with regard to those cared for. The special charism of the professions anoints healthcare staff at all levels, professional, white-collar or not, as special, more compassionate. People across CPH consistently talk about the singular dedication of their colleagues. Sister-sponsors and affiliated religious are particularly given to identifying the compassion and commitment in their long-term employees. Sisters see their hospitals as their ministry and their vocation colors their view of both all the work and extends to the workers in the hospitals. A sister who had been at Catherine-by-Sea for over twenty years now serving in outreach and community services explained:

> ...The nuns, the sisters that came before us, they did the same thing. And I think they laid the foundation. And I always see the lay people, the staff, doing stuff, too. So we hope that what they see will take an effect on them so that – like you say, what happens when we leave? Who's gonna carry this on, this mission? We have some old-timers, dedicated staff, that are really wonderful people. They're so dedicated. I know so many of them were upset when the union came in because they thought that would take away our spirit....But, like I say, the majority of our people are very, very dedicated. They're just nice people to work with. They're just friendly, I guess is the word. They're very friendly, outgoing. Nothing's too difficult. When we had our sisters meeting – we had a long sisters meeting this weekend, and we had a lot of food left over, rolls and juice and stuff. So we take it and deliver it to the ER and the lab– we give it to the staff. We put it in their staff lounge. And they were saying, "Oh, does this look good. We haven't eaten all day." They didn't get a break all day. This was about 1:00, and they came in like at 7:00. So you can see how hard they work. They don't stop. They're dedicated. And I think nursing is a profession all itself, anyway. I admire those nurses. There's no way I could be a nurse. They're wonderful people. We have great nurses. Great, great people. I think they've got a ministry. I hope they realize it's a ministry and not a job because they really minister. But anyways, I guess I don't think of this as a job. If it was, I'd be in the wrong place.

Thus, I am suggesting what I described as the holiness of the priestly group is not solely a condition unique to the state of sisterliness, but a quality ascribed to many lay employees,

physicians, nurses and others in healthcare. This may be true in many healthcare organizations, where the ethos is affected by the iatrocentric history, coupled with the ethic of care rhetoric of professional nursing (Noddings 1984; Chambliss 1996; Bone 1997; Bowden 1997; Benner, Dreyfus et al. 1998; Phillips and Benner 1998). At Catholic Pacific Healthsystem it is further nurtured by the on-going presence of sister-sponsors. Virtues of caring, compassion, dedication, emerge most tellingly in the language of the sisters telling stories and characterizations of their colleagues. One former sister now system administrator who had held a management role at Incarnation Hospital recalled:

> "There was a strike back then for six weeks. We [the employees from Administration] were all in scrubs, you know, cleaning rooms et cetera."

In contrast, Guenter Risse reports that the 1949 printed program opening the new "wings of mercy" of the Buffalo Mercy hospital revealed "that more than 40 sisters work 14-16 hours in the hospital each day without worldly compensation" (Risse: 520). Technologization of hospital work and the increasing professionalization of nursing conspired with the shifting lay/religious personnel ratio in US Catholic hospitals. At the 1953 CHA conference, participants vigorously debated proposals to reduce the work week of hospital sisters, who routinely worked 70-hours seven-day a week schedules, to six days and 60 hour maximums on the supposed grounds of "deference to physicial and emotional health. But, as one nun commented, what would the Sisters do with a whole day off if this *activity was their vocation and entire life*?'" (Risse: 523, emphasis added). At the time, lay nurses followed a 40 hour work week, reportedly opposing split shifts and resisted weekend hours.

The practice of not compensating women religious for their labor was a common practice when the institutions the sisters ministered had direct fiscal ties to their convent. In the past, in Catholic diocesan schools staffed by men and women religious, compensation rates were limited by both by the expectation of the vow of poverty and bishops expected the labor of ministry in return for the room and board within the religious orders. In recent years, in New York and in

California, salaries for lay instructors in parochial schools have similarly understood to have been much lower than comparable private school salaries due to the dual effect of minimal compensation for religious who work in education and the added unspoken understanding that instructors taught more for the good of the students than as a career.[15]

As I will show in the next chapter, the idea of vocation of all people drawn to healthcare is now being actively manipulated as a tool within the Mission Integration strategy. A transformative experience in a senior system executive provided the opportunity to bring the meme out of the cultural backdrop of the sisters to a new life in the actual operations of CPH.

The vignette that follows on the introduction recounts a moment in my fieldwork when the former-sister who is now a very senior system executive tells me about the physician who gave an elderly patient back his dignity by listening to his life story. That moment captures in one anecdote the dynamic I am seeking to illustrate here. The lead executive for mission integration, herself not a sister-sponsor, explains the care with which a physician, a professional but also not a sister-sponsor, attends to the whole person presenting before him, not merely as a patient but as a man with history and suffering to be recognized. Catherine shares that story both to describe what the value of dignity looks like in action and to convey how that physician and his display of compassion are to be encouraged and sustained throughout CPH.

One might think that the special aura of influence and power that surrounds sister-sponsors would serve CPH well. But there is a risk to assigning holiness and through it, organizational efficacy to this particular group. The specific cultural capital that seems to accrue to sisters by virtue of their religious vocation brings benefits but comes at a cost.

The misperception that sisters have a unique power can hold the organization back from its efforts to create social norms, to disseminate and diffuse the values into all physicians, staff and other employees. As the number of sisters continues to decline, the importance of that diffusion/dissemination plan is increasingly important for those who believe in and seek to sustain the distinctiveness of Catholic healthcare. It is not always clear what material effects these

attributions have on actual sister-sponsors. We must consider what real powers are apportioned to someone *by virtue* of what she is perceived to have by others. Sisters are constructed as an Other, in a way that understates their contemporaneity. They are different because individually they resist simple categorization. The added layer of complexity lies in that they also continue to participate in and use a collective identity based on that representation for political purposes when that identity proves expedient. Identity here again is in flux and renders sister-sponsors inappropriat/ed, for sisters both do not fit and refuse to be assimilated (Minh-ha 1986; Haraway 1992).

This chapter's analysis is not intended to stand alone. The interpretation I have presented here is not simply to sketch an outline of personal influence or asserted power but to provide the context, through description of a social fact and its interaction with actually existing people. In the following chapters I will illustrate the concrete effects, interventions and other practices that are brought into effect by the presence of sister-sponsors throughout the organization. After years of struggle, and no small frustration on the part of those charged with mission, within an organization fixated on rapid growth followed by financial crisis, a pivotal moment of opportunity and transformation was coming. Over the sixteen months of my fieldwork, a re-engineered operations structure placed "mission and values" at the table as a serious stakeholder in the future of the hospital network in a turn of events that might seem accidental without an understanding of the key actors. The Mission Integration team at the central office found themselves poised to extend their influence and values direction throughout Catholic Pacific Healthsystem as never before.

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[1] (Dreyfus and Rabinow 1983: 208)
[2] (Greeley 1972: 128)
[3] Here and earlier, discussion of the passive type seems to suggest the degraded ethical state of *ressentiment*, pace Nietzsche via Foucault. I will return to this point in the chapter addressing the ethical effects of articulation, particularly with regard to a weak ontology of *Catholicity* that considers the situation of Catholic Pacific Healthsystem in light of political arguments advanced by Wendy Brown, see (Brown 1992).

[4] Usually attributed to Martin Luther: "Christ has made it possible for us . . . to be . . . his fellow priests." See *Three Treatises* (Philadelphia: Fortress Press, 1960: 290). I will take up this issue in greater detail in the next chapter on mission and margin.
[5] Dogmatic Constitution on the Church, see (Abbott 1963: 9-106).
[6] Note here that women religious are technically lay folk according to doctine, even though most non-ordained don't see them that way. The key distinction being that ordination, not vows, makes one non-lay, though there is slippage even in Roman usage.
[7] Decree on the Appropriate Renewal of the Religious Life, see (Abbott: 462-85).
[8] These conceptions might resonate with discussions of ethical substance and modes of subjectivation in Rabinow (Rabinow, p.16) that I have taken as point of departure and foil for this project.
[9] Anthropologist Saba Mahmood makes a similar argument in her examination of Egyptian women's piety (Mahmood 2001). I am indebted to Paul Rabinow for discussions of Foucault's biopower and disciplinary technologies that were also helpful in conceptualizing chaplaincy as pastoral power, see (Foucault 1981).
[10] Chris Hedges, "A life spent mending the smallest broken hearts" *The New York Times*, June 20, 2003.
[11] The hospital system retains investment advisors whose task it is to screen potential investments against particular social criteria. Many Catholic institutions, as with other faith-groups, will not invest in corporations producing military-related technologies or abortifacients, as well as what they also consider unethical business practices including failure to provide health insurance to employees and/or dependents, minimum wage, "sweat shop labor" or ecologically sound manufacturing. These constraints and their implications are examined more closely in a later chapter on sponsorship.
[12] One could object that the governance role is different from an employee/staff role, and sister-sponsors in governance should properly lead through guidance. What is interesting is that Corporate Members adopt this strategy even with their fellow board members. Further, with the exception of meetings of only sister-sponsors, sisters and former sisters seem to adopt similar strategies at all levels of operations, not only governance.
[13] I borrow and adapt this term from Braudel who suggested the plurality of social time (Braudel 1972), that Immanuel Wallerstein would use to theorize world-systems change (Wallerstein 1979). I revisit this analogy in the later chapter on ethical scrutiny, setting the Catholic institutional element against a more Wallerstein-type backdrop.
[14] This is the title of the Pope that follows a papal document when it is formally promulgated. Thus, the Vatican II document reads: "The Dogmatic Constitution of the Church- Paul, Bishop, Servant of the Servants of God, Together with the Fathers of the Sacred Council for Everlasting Memory...." (Abbott: 14)
[15] Personal communication, 2000, former religious affiliated with Sisters of Mercy-sponsored Mercy High Schools.

After Virtue: Margin and Mission

The rapid growth of the early 1990s that saw Catholic Pacific Healthcare expand from half a dozen hospitals to over 40 facilities by 1998, had left the system spread too thin to adjust to the steady ratcheting down of reimbursements and a ruthless managed care market. CPH had humbling losses on its acquired physician practices and capitated contracts with health insurers. At its nadir in 1999, CPH had lost close to $50 million on its affiliated physician associations. This drove CPH to reduce the medical foundation physician rolls by one-third, cutting annual losses down to $5 million, according to the then-vice president of finance. The system had also invested more than $300 million in establishing a centralized back-office services unit for its hospitals that the system now abandoned due to unexpectedly high costs because individual hospital facilities had not been adequately prepared and resisted such radical centralization. The organization struggled to exit losing capitation contracts while renegotiating managed-care contracts. In some cases, the system achieved payment increases in double-digits. The system was also able to lobby in some geographies for improved reimbursement for services covered by state and federal healthcare payor agencies, the system CFO would summarize for the credit agencies.

The severity of the losses at the end of the decade led the Corporate Members, the sister-sponsors in system governance, and the board of directors to seek new executive leadership. They selected an energetic and charismatic candidate as the new president and CEO, a healthcare executive of another much smaller faith-based system in the East who had built a reputation on his commitment to "organizational culture." Confronting catastrophic operating losses and decreasing revenue, however, set the focus on reforming business practices and restructuring operations throughout CPH. It was a critical task that everyone acknowledged would determine the very survival of the system, and for such a flagship of religious healthcare, the repercussions of failure would be far reaching across not-for-profit sector. Though this new system president

came in on wings of "organizational culture," people affirmed that his mandate, first and foremost, was to redesign Catholic Pacific Healthsystem's operations and salvage the system.

Re-structuring the corporate body

The president began by creating a new system management team that then initiated a corporate restructuring in two phases over two years. In the first year of the new millenium, CPH was a $5 billion plus corporation that employed more than 40,000 people system-wide. The new plan for corporate restructuring, first, brought 10 geographic regions into four divisions, and a year later, consolidated the governance structures to transform CPH from a holding company to an operating company. Nearly 350 people in the regional and corporate management had their positions eliminated. While this saved the system more than $100 million annually, more importantly, the reorganization re-allocated operational control to the system management team. It further concentrated governance and fiduciary responsibility within the system's 14-member board of directors. Previously, CPH's structure had been much more of a holding company over separate subsidiaries. Each of CPH's 10 regions had functioned as a separate not-for-profit corporation with its own CEO and local governing board, only guided by the system office. The new structure subsumes those regions into four divisions, each run by a group vice-president of operations, managed by the system Chief Operating Officer. The 10 former hospital boards were replaced by community boards that follow greographic market lines and would accomplish an agenda set by the system's board of directors. With this centralization, the CPH system emerged as a true operating company.[1]

As CPH got its internal house in order, the system also undertook a significant plan toward solving its labor relations concerns. In late 2001, Catholic Pacific Healthsystem announced a tentative agreement with the Service Employees International Union local affiliates on a new contract covering more than 1,600 employees at three CPH hospitals in one major urban area. This was shortly followed by a system-wide SEIU contract with the remaining hospitals

several months later. The system management team then parlayed that social capital into a system-wide negotiation with the other labor organization that had until then been resistant to advancing a common agenda.[2] Almost immediately following the corporate restructure, the system extended dependent health coverage to the families of all 40,000 employees. This decision served to both further mollify the unions and settled the nerves of rank and file employees anxious that the corporate restructuring had yet to filter down to them. Moreover, the system's market presence in the state meant that this health insurance extension challenged its hospital competitors to seek ways to match that policy. This served a further goal of demonstrating to the sisters-sponsors across the CPH system that their Catholic organization was leading the charge to further universal healthcare access, in this instance, by increasing insurance coverage for dependents across the state. Competitors were furious but, publicly, could only celebrate this corporate advance.[3] Together these measures put to bed the extremely ugly memory of the union corporate campaign of 1997-8 that had torn hospital staffs apart and antagonized the sister-sponsors who had been particularly targeted for union vitriol.

These changes to management and corporate structure had real, positive results. By the end of fiscal year 2002, CPH had posted only $47.4 million in operating losses. Still substantial, it was nonetheless a radical 64% decrease from FY 2001 and a significant "sign of a financial turnaround" after combined losses of $933 million over the four previous years, the *Sacramento Bee* reported.[4] The system expected to squeeze out net income of $10 million [in 2003], a profit margin of 0.2 percent, with hopes to raise that to 2 percent by 2005, the chief financial officer commented to a California business periodical at the time. When I concluded fieldwork in January 2003, CPH was indeed in a much stronger financial position; credit ratings were slowly turning back toward their previous triple-A levels of the earlier decade and the system was better prepared to strategize about the looming deadline mandated by state legislators to retrofit all California hospital facilities to withstand future earthquakes, to the tune of more than $500 million systemwide by 2007.

Corporate rationalization: growing the margin

> Although the modern hospital is not as a rule operated for profit, it is nonetheless the product of capitalism not only....because the capitalist process supplies the means and the will, but much more fundamentally because the capitalist rationality supplied the *habits of mind* that evolved the methods used in these hospitals.
>
> – Joseph Schumpeter[5] (emphasis added)

The need for these radical changes in system infrastructure was translated into a need for a different kind of management with a different perspective on operations. The new senior management team was heavily front-loaded with executives from the for-profit sector. In a meeting of the new vice-presidents for group operations and the system COO, himself recruited from the new president's former not-for-profit organization, one vice president was so determined to ensure the system's financial turn-around continue that he proclaimed that he would not hire any new people unless they had extensive for-profit experience and "came from that world." This emphatic assertion met with no objections, comments to the contrary or even furrowed brows, but rather nods of agreement.

The problems of the past were identified as operational, but were cast in terms of the culture of not-for-profit organizations. The conversations of senior executives and the new teams they hired in system management and local hospital leadership were about responsibility, accountability and transparency. At a system-wide meeting of the hospital presidents, the new system CEO opened his remarks with a friendly sports-oriented anecdote but soon got down to business and allowed the new shape of things to come out in his tone. The cajoling was over:

> "Ladies and gentlemen, we are into eight weeks of running and whining. Our transition to an operating company is fully underway, and we [CPH] are not going to act as a holding company. This is our opportunity to cost-reduce, but I will not accept individual or groups that attack our efforts to turn this ship around. I understand you will continue to [complain] and whine. But understand my first objective is to support the hospitals. What we provide you are, one, achieving economies of scale efficiently; two value-added consultative services that will enable you to optimize our performance as a system, and this will be evaluated at the hospital level.Value is always a judgement but if there is not value added, we pay... We have to perform, live up to our commitments. I'm having fun here, but I am sending serious messages.There is a dynamic tension between corporate and field offices, this is historical.

> Since the beginning of the corporation. You are not alone, we all commit to making CPH and its ministries the best we can. The ministries we stand for are compelling."

Though he ended with a reminder of the underlying rationale for the difficult changes of transition, his message was a hard one that sought to clearly define how the centralized system would run and just how much he expected facility leadership to adapt and conform. Moreover, the system CEO was careful to do establish his credibility with the hospital presidents, each individually concerned with the very real day-to-day functioning of their respective facilities but who were now expected to align themselves with system directives: "I was in ops, I've been the guy who was always asking why cut this, why cut that."

At Executive Management Team meetings, the reflections that opened the weekly sessions were often anecdotes that highlighted leadership and a new found sense of purpose. One executive from Finance encouraged the group to ask themselves, "Now that we have new leadership, what is opportunity now? What should our purpose be?" And the reading told the story of a ship's compass heading at sea, and the tale called on the crew to renew without despair or doubt the course the ship plotted after the storm.

The themes of system management meetings revolved around the implementation of change, and sought to galvanize individuals and raise motivation. The rhetoric of system team leadership, cast in terms of seeing "ourselves in partnership with hospital leadership," was bantered about with great enthusiasm. But a few days before system leadership convened the hospital presidents together, the answer to what would provide that motivation was revealed when the senior vice president for human resources took the floor to walk his system peers through a new plan for performance indicators and employee evaluations that redesigned an employee retention plan with a new incentive structure aimed at the leadership teams in each hospital through to the system team itself. He urged the team to "sell it to the hospital presidents as an integrated tool as part of the turn-around, not a separate item, more like layering." He went on to link individual incentives to the greater picture of hospital growth and medical care, saying:

"Marketshare growth is dependent on improvement in patient satisfaction and this ties it directly to the economic blueprint." A re-commitment to focus on the workforce and what was referred to as "worklife" in a strategic plan that called out "Our Patients, Our People, Our Future" was aimed at "creating purposeful culture to redeem and justify hard work."[6]

What these moments taken from fieldnotes demonstrate is a new orientation toward the hospital operations of the CPH system, emphasizing the slim margins between profit and loss and the successful operations that would result from structural changes and cost reductions, facilitated by new expectations for executive accountability and performance rewards. The long standing anecdotal opposition of the binary of margin versus mission was stark.

This focus on business practices as the salvation of Catholic Pacific Healthsystem was buttressed by a marked increase in the confidence placed in new management technologies designed to consolidate central control through aggressive reporting, quantifying and evaluating. At the presidents' meeting, the system executives spread out in teams of two to each table of presidents for a group exercise that began by identifying systemwide initiatives, correlated with operational tools already in place to facilitate them, followed by brainstorming about the necessary metrics to monitor progress and prevent back-sliding. The rhetoric of the meeting emphasized the key role of hospital presidents in driving their respective facilities down a path this group would collectively determine. But, in fact, the meeting carefully followed an agenda choreographed in advance by the system team. The presidents' meeting built momentum and brought each local leader into step as CPH began to cohere as a collective juggernaut rolling down a single road, even as the language of reform celebrated "local tactics" and "system strategy."[7]

I want to focus now on one particular component of hospital operations because it lends itself to a conceptual analogy that will facilitate the transition to describing the effects of the restructuring\reorientation on the other face of Catholic Pacific Healthsystem, the people engaged in mission services. At the heart of hospital operations lies the practice of medicine, which is as

many continue to assert, as much art as science. The contemporary calls for evidence-based medicine have sought to bound the place of individual art and judgment by increasing the reliance on process and outcomes based on continual monitoring, data collection and routinized reporting. At CPH, the financial turn-around was coupled to improving medical practice, specifically the work of physicians and uniform healthcare delivery procedures across the system. The division of labor at CPH that was charged with such improvement is called Care Management. I want to suggest that Care Management is a sort of exemplar of a Weberian rationalization in the practices of CPH under new leadership – that is to say, a pragmatic, means-ends, market-oriented type of rationality.[8]

These modalities are not in themselves ground-breaking and will be familiar to anyone aware of contemporary hospital trends. I call out these examples to lay the ground work for a parallel development in the realm of mission and values, a development worth remarking on for it bears directly on the kind of transformation of Catholic identity emergent in the particularity of this system.

System control: managing the care

> In 2002, Care Management at Catholic Pacific Healthsystem involved:
>
> systems, processes, and metrics related to... clinical practice improvement, service excellence, patient safety, medical management and formulary management. Performance improvement targets are established each year in these four areas at three different levels. 1) Systemwide goals (e.g. all facilities are working toward a common target using a common metric); 2) Systemwide measures, with facility-specific goals (common definitions and reporting, but individualized goal setting); 3) Facility-specific measures and goals.
>
> – from the Chief Medical Officer written report to CPH Board Quality Committee, January 2002

To give a sense of the processes that were being monitored in over 40 hospitals at the time fieldwork was conducted, the following were reportable metrics for each of the three categories indicated above: for clinical quality, Aspirin usage within 2 days admission for Acute

Myocardial Infarction (AMI); Beta Blocker on the last 2 days for AMI; Statins used on last 2 days for AMI; ACE inhibitors used on last 2 days for Congestive Heart Failure (CHF); Discontinuation of IV antibiotics for Community Acquired Pneumonia (CAP); Time to first dose for CAP; Anticoagulant on last 2 days of stay for Ischemic Stroke (IS); Anti-thrombolytics on last 2 days for IS; Primary C-section rate\birth related outcomes. In the patient safety category, implementation of a Renal Dosing program; and a Weight-based Heparin protocol. For patient satisfaction, Inpatient pain management; "Nurse anticipates needs"; and overall patient satisfaction, each from an externally conducted survey response. For medical management, Medicare discharge opportunity index, for both tertiary and non-tertiary facilities; average length of stay for CHF and CAP. And in home health, the stabilization of oral medication and the stabilization of pain medication management. Every measure was supported and managed by an indicator and benchmarking program initiative, that in the Board Quality report laid out the management program rationale, appropriate indicators and common definitions, identifying the denominator and numerator that produced the statistic or percentage, and the comparable sources for this indicator in the published literature, along with comparative definitions from alternative non-CPH origins like the Diagnostic Related Group from a federal agency (CMS/HCFA) and comparative values for performance measurement.

The Board report goes on to link CPH system monitoring efforts to widely-touted national expectations in care management-related areas established by the hospital accreditation association:

> We have begun the process for Fiscal 03 goal setting. JCAHO is mandating established Core Measures as part of their ORYX initiative. Beginning in July 2002, all hospitals must select 2 core measurement sets (with between 3-8 indicators per set) and begin reporting on specific metrics. The measurement sets are specific to [AMI, CHF], Pneumonia and Birth-related Outcomes (*not coincidentally, the same areas CPH has been focusing on for the past two years).*

Senior care management staff determined that a red-yellow-green coding for performance indicators was the best format for reporting summaries, because the coding could both

communicate current state and indicate trend migration within percentiles in an easily visualized media:

> As part of the system-wide improvement process we performed an initial analysis doing a percentil ranking of all the clinical indicators. Those that were in the 90th percentile were color-coded green, between the 50th and the 90th were coded yellow and below the 50th were color-coded red. Part of the *rationale* was to be able to track *progress* (with progressively more green and less read).

The focus on metrics occasionally could slide into a zeal for report formatting. Leadership insisted on this format even when it was discovered that the coloring consistently blocked out the detail and numbers being reported in printed reports, but especially on the overhead projections produced for meetings. However, the red-yellow-green display that reduced a complex range of numerical data was so enthusiastically championed for board presentations by some staff that the formula soon bled over to finance and strategic planning for use in the internal assessments of the CPH facility portfolio. It seemed like a case of the rationalization exceeding the practicality of the technology, and some quietly suggested as much.

The Chief Medical Officer reported on Patient Safety, covering 19 different measures. He was frustrated because improvement was largely "scatter shot with minimal movement":

> "We need a united effort... to make the annual goal of 1%, nevermind the 3% over three years, not without visible and sustained leadership, no consistent change.... Direct supervision in order to manage stretch targets and see true improvement beyond random variation. We *hover* at 1%."

At this figure, he grew adamant, "the long-term goal of 3% is *not* negotiable because..." and he went on to cite studies from Southern California and compare findings from other healthcare organizations like Baptist Health in Miami, UAB and Brigham Young. Again, he reiterated, "we must have a *dramatic* commitment throughout the system."

The restructuring that removed a layer of middle management from between the system office and the hospitals also pushed the system office itself to justify its own budgeting and to re-conceptualize what it offered the member hospitals in the parlance of "value-added." So the

system office re-constituted itself as "CPH Support Services" in an internal directory distributed to member hospitals where in each department provided a service rationale, management philosophy, a list of key internal customers, central activities and leading current challenges. Quantification and reporting modalities similar to those of care management were established or redesigned in the departments of operations, treasury services (investments), corporate finance, supply chain management, information technology, compliance and internal audit, managed care, corporate real estate, risk services, corporate communications and marketing, human resources and the legal affairs division. One example of reporting technologies that spanned departments were up-to-date "flash reports" to system executive management, hospital presidents and the CPH boards in between formally convened meetings. System staff followed up with local hospital leadership to review the latest "flash report" at regular intervals. This "flash" would provide summaries of top issues confronting member hospitals, operating income and investment incomes as compared to budget, by service area and by individual hospital, year-to-date, on a monthly basis. The reports were emailed across the system providing an overview of the system for leadership and management. Additional information, like rates of admission and discharge; average cost and length of stay; full-time employee productivity; cash flow; consolidated balance sheets; liquidity ratios; earnings (net income) plus interest, depreciation, and amortization expenses, or EBIDA ratios were also distributed in a monthly "highlights" spreadsheet for executive management and governance.

The latter two data points, liquidity and EBIDA along with debt to capital ratios, were key performance indicators because particular thresholds were used by the credit rating agencies as a guideline for bond rating determinations. For a non-profit-hospital in turn-around mode, achieving those benchmarks would permit the system to raise capital on the bond market for capital improvement projects and other future initiatives postponed by the staggering losses of the previous era. For the hospital presidents and the system leaders to whom they reported, the ability to compare individual hospital performance within service areas, or against equivalent service-

focused facilities, was intended to serve both as an inducement or a goad to improve while building a greater sense of system-awareness.

The concentration on technical efficiency extended beyond financial processes, for example, to supply chain management and purchasing. Again, notes from a presentation at a second hospital presidents' meeting made the case for local facilities to align themselves with the system collective, to support a rationalization process that started with "price management that stood to save the system $3 million, commodity standardization $5 million, followed by reconciling clinical preference among CPH-affiliated physicians, then applying a clinically appropriate utilization reduction screen."

All of these data flows were designed to feed the decision support systems of the hospitals, and assure that system leaders had the information they needed to guide those processes. The challenge for such a new centralized program was that "garbage in, garbage out" had to be nipped in the bud, as one hospital president complained. He argued for better reporting tools and the need to invest in new material technology to overcome the software incompatibilities of information systems (in acquired hospitals, for example) if his team was to deploy useful data producing comparable outcomes for real-time evaluation. In some cases, the tools existed but they were not uniform nor applied consistently through out all facilities. The restructuring and transformation into an operating company gave the system office leadership new powers to demand conformity from the forty plus member hospitals.

The rationalization process was also applied to creating a centralized procedure and explicit criteria for capital allocation that further consolidated system control and hospital conformity. A review committee with peer representatives from across the system would now vet requests for capital improvements from individual hospitals. Having a representative committee not only created a sense of "fair evaluation" but furthered the idea of explicit judgment conducted in the open rather than arbitrary decisions of closed door meetings. The nature of each criterion its relative weight and value in the final decision was intensely debated but ultimately settled.

Hospitals that did not meet budget in operations were denied access to capital; it was a stick versus carrot approach, enacted on a quarterly basis. At a subsequent hospital presidents meeting, one participant queried whether the technical assessment really got to the heart of the technology problem, "for it seemed that monies go only to the volume-producing facilities," and the process needed to engage the question of whether the population to be serviced will rise or fall. The almost rhetorical answer from a system office executive illustrates the new worldview of the restructured organization:

> Volume grows volume, and quality. For example, let's talk about the "cath jockeys" [catheterization for heart work, free standing "cath labs"]. First we ask the doctors, then we ask the think tanks that ask those same doctors, then we go to industry that produces the device hardware products: *Predicting the future is hard.* Consider the technology of [a new procedure], we ask ourselves, what is the technology anticipated, how does it function within this committee? There are two new criteria, or questions then to consider, for this process is about looking into the future: how do we do technology anticipation, and what are the implications for facility redesign?

For three months I shared a cubicle adjoining the system care management staff. It seemed that the tide of reports flooded into the system office only to be followed by a new series of report requests issued to the facilities. Before the end of each month, volleys of email, telephone calls and faxes flew back and forth as facility managers asked for clarification, were told to re-format, or data calculations were re-run to meet deadlines or overcome software system incompatibilities. Staff worked late to meet the production demands for data to contribute to the system's new Operations Group's Monthly Operations Report, or MOR. Cited by name in two positive reports from credit rating agencies and then picked up in industry press coverage, the MOR had become a technology of redemption that would bring CPH out of the red.

At the local facilities, the demands of the MOR were met with both incredulity and great fervor. Each month, the data analysts at each hospital spent a week running reports, the management team spent the next week reviewing the reports and communicating with the system office about the preliminary data summaries they had submitted and those that were often

returned to be re-run. Turn-around time on both ends meant the hospital team would ultimately spend an entire day preparing for the tele-conference with system representatives and the regional vice president of operations; the actual MOR teleconference would itself consume more than two-thirds of the following day. System managers travelled or conference-called with their counterparts in each hospital seemingly all month long as one hospital review finished and the next would begin, in three geographical groups, for forty hospitals each month. As the vice president of patient care and chief nurse executive of Denomination North lamented to her chief financial officer, "I don't know how we are supposed to have time to run the hospital in between managing the data." The printed copy of the MOR that sat on her knee as she juggled a place for her morning cup of coffee was nearly three inches thick.

With this description of Care Management and other operations divisions, I have tried convey the focus on quantification and rationalization, and the further changes to the system bureaucracy that CPH undertook in the wake of the new executive leadership. Each of these elements together are intended, of course, to have direct effects on the ability of each member hospital to care for its patients. The relationship of the new operational transparency, in the form of monitored clinical indicators, is most obvious in the discussion of Care Management. However, this concentration on data may be understood from another perspective or dimension in terms of the system's object of care. Historians of science and medicine have shown that the increasing reliance on statistical data in health and medicine serves political, moral, and economic ideologies and interests. In the context of Catholic hospital ministry, the concerns of benevolence, social amelioration and Christian redemption are made explicitly. There remains a further second order interpretation then, as Dorothy Porter argues, for statistical knowledge provides a particularly useful technology to understand the poor or the sick – the patients admitted to CPH hospitals – for reasons other than scientific accuracy. Porter writes:

> Much, probably most, statistical study of human populations has aimed to improve the condition of working people, children, beggars, criminals, women, or racial and ethnic minorities ... Middle-class philanthropists and social workers

> used statistics to learn about kinds of people whom they did not know, and often did not care to know, as persons. Accounting was not impeded but encouraged by their alienness, for averages must always appear less meaningful when drawn from a population of strong and interesting personalities. A method of study that ignored individuality seemed somehow right for the lower classes.

Thus, quantification served as what Theodore Porter (1995) calls a 'technology of distance,' a concept directly related to Geertz's notions on 'experience distant' anthropology and other efforts to produce knowledge of populations (1988).[9] At Catholic Pacific Healthcare, however, the structural changes in the clinical and financial operations of the system were also accompanied by transformations in a division or department that is unique to Catholic hospitals and some of their other religiously-sponsored counterparts. What might otherwise constitute distancing technologies focused on re-gaining the performance margin is carefully mediated by the work of the Mission Services department, now reborn in the new era as Mission Integration.

Values integration: preserving the mission

> "We believe in healing. This is our ministry. This is why we exist. Our ministry is a calling we've carried out for a century and a half. Healing takes faith. Compassion. Skill, backed by the finest technology. And because we are more than simply sinew connecting muscle to bone, veins pumping blood to our hearts, true healing involves more than our bodies. True healing tends to our spirit and soul as well. True healing takes people. At CPH hospitals and clinics, thousands of individuals perform extraordinary acts of healing every day. Lives are saved. Hope is rekindled. Dignity is restored."
>
> - CPH website text, May 2003.

When sister-sponsors were ubiquitous to the halls and wards of their hospitals, it was often taken for granted that patients and their families could recognize in a tangible way that a facility was Catholic and it was assumed that such an organizational identity needed little elaboration. With sisters working at their sides, physicians, staff and other employees would absorb the sense of dedication, purpose, and the commitment to the underserved of the community in a process rather like social osmosis. With sisters in positions of authority across the

healthcare delivery spectrum, people coming to work for a Catholic hospital would encounter the collective religious identity first hand.

However, over time the nature of healthcare changed. Sister-sponsors in governance recruited lay administrators to manage the daily operations of their hospitals, and increasingly the communication of Catholic identity and the mission of the sisters' hospitals emerged as an explicit concern for new leadership. Subsequently, the lay leadership needed an identifiable resource that was part of facility operations and a sister was often appointed as a member of the hospital staff to lead "Mission Services." Increasing diversity in the hospital workforce, together with advances in technology and shifts in financing mechanisms, made the hospital a very different workplace even as the number of sisters decreased. Over time, mission services seemed to become less about a rigorous "Catholic identity" and a more ambiguous "Catholic way of doing things" until the department or unit became a repository for what some CPH staff have referred to as "the feel-good stuff." Mission services in many places took on the feel of human resources and organizational development. With a focus on elements of daily work life, Mission Services committees would undertake holiday planning, heritage celebrations, and employee recognition types of functions, in addition to coordinating with the hospital auxiliary and volunteer services active in every CPH hospital, overseeing "candy stripers" from the local community college or high school, staffing the welcome desk or the in-patient lending library.

In 1986, the affiliation of several hospitals that would ultimately become Catholic Pacific Healthsystem resulted in a system headquarters – first of a dozen then fifty and finally, over two hundred employees at the system headquarters and two regional offices by the mid-nineties. A department of mission services became a part of the system office infrastructure, both to provide services for the system office itself and to coordinate mission services work in the member hospitals. Then, when the system acquired its first secular community hospital member in 1993, people spoke of the importance of sharing the mission with these non-Catholic facilities, a point we will return to later in this chapter.

When I first encountered CPH in 1997, the infrastructure of Mission Services was personified at the system office with a single lead individual, Catherine, one of several senior vice presidents (SVP) on the system management team, who had responsibility for mission services and human resources for the system as a whole. After the new millenium, the arrival of the new president and CEO marked the deployment of an almost wholly new senior management team. Only two individuals remained in executive management from the previous era, senior vice presidents who had been part of CPH nearly from its inception: the lawyer that had designed the formation of the system now SVP of Legal Affairs, and Catherine leading human resources and mission services. Under the new president, human resources were assigned elsewhere as a distinct responsibility and Catherine's purview was re-constituted with the title of SVP of Sponsorship, Mission and Community Benefit. The implications of this title change will become evident below.

Catherine would now oversee a departmental team of directors and managers for system level functions, and convene a system-wide council of mission services personnel from the various member hospitals. The team included several women religious and three former sisters now lay people. The hospital-level mission personnel were also largely sister-sponsors, and of those sisters, almost all were from the congregation that originally sponsored that particular hospital before it had joined CPH.

The changing face of Mission

A review of Catholic identity materials in healthcare as early as the 1900's will show that the literature primarily focused on the conduct of Catholic physicians and nurses in providing care.[10] Particular attention is given to the areas of divergence from other faith-group practices and only later, what are understood as secular facilities. Administrative attention focused on issues in reproductive health, end-of-life care, as well as ensuring that sacraments and other religious practices requiring access to a priest were available to Catholic patients. Thus, one can imagine

the natural progression whereby sister-sponsors, as obvious contacts for local Catholic parish priests and their parishoners, would become concerned in their new role as mission services staff with chaplaincy services as it evolved in the modern hospital system. I have elsewhere examined the transformation of chaplaincy into spiritual care services (Lee 2002). Here, I want to note that chaplaincy often finds itself allied with mission services as mutual advocates in the face of the more materially oriented perspectives of revenue and expense in operations. As I will demonstrate below, this alliance reflects a common objective of rendering programmatic agendas out of areas once considered esoteric because their religious or spiritual orientation. Now the restructuring and the determination to foster an organizational culture capable of securing a financial and operational turn-around for the CPH system had prepared the way for a systemic intervention aimed at thorough "mission integration." I will explore more closely the reinforcing role of misson integration in spiritual care in the chapter on ethical articulation.

Prior to the structural change initiated in 2001 by the system's new executive management team, two types of mission people were visible in CPH: sisters, largely in the Catholic hospitals, and non-sisters, usually women in middle or upper management who already had two or three responsibility areas: chaplaincy, ecology, nursing, human resources, even communications and marketing. When a secular community hospital joined the CPH system, the hospital president found that they needed to appoint someone to the position of mission leadership, and invariably tacked it on to the reponsibilities of an an existing full-time employee somewhere on his organizational chart. In at least two cases, the Vice President of Patient Care/Chief Nursing Executive found herself also "wearing the mission hat," as one put it in an interview.

A close reading of the vision and mission statement for Catholic Pacific Healthsystem will introduce what is at stake in this discussion of mission and values (see figure on following page). The semantics of the identity statement reveal a political economy of mission and values that is a defining characteristic of CPH. The identity statement begins with the assertion of a common

vision, what the strategic planners called the "desired future state," what the sisters would call "prophetic" for it looks to the future and calls into being "what should be" – an ethico-moral projection of organizational character. It emphasizes the subjunctive while reflecting actual elements of the here and now. The vision cites a tripartite source (congregations, community, physicians/employees) as the origin of the entity called into being. The sister-sponsors are immediately invoked for their founding "passion" in the sense of conviction and emotion-compelling action. Yet, in the Catholic context, passion also points to the suffering of Christ who, acted on by the external force of the Spirit, gave himself up to devotion on behalf of mankind. CPH is secondly inspired by the commitment of their community partners, by which the system identifies both the secular hospitals that have joined with their Catholic counterparts and those organizations in CPH service areas that also work in health and social services. Physicians who partner with and employees who work for the system contribute their dedication. Together, the system is driven by values to undertake its work, calling out four areas, caring for not only individual patients but the larger communities around the hospital facilities as well. When the Corporate Members, the sister-sponsors in governance, met to craft the draft of this statement, they were intent on communicating the directive force, the active role of values in the system. In their meeting, they rejected "values-based" as too passive and debated the merits of "compels" versus "drives," settling on the sense of values being in control, rather than an external force.

The Catholic concern for the whole person is reflected in the words "healing and health improvement" rather than illness or disease. Further, the hospital system does that work filled with "compassion," that resonates with the founding emotive and empathetic energy of the sister-sponsors. The vision statement calls out specifically the ongoing nature of the system's commitment to "those who are poor, vulnerable and dying." This identifies the recipients of particular attention in keeping with a visionary objective that seeks to create justice in the world.

Catholic Pacific Healthsystem

VISION & MISSION STATEMENT

VISION

Inspired by the passion of our founding religious congregations, the commitment of our community partners and the dedication of our physicians and employees, CPH's vision is to be a values-driven health care organization providing the best clinical outcomes, health promotion, care management and spiritual care for those patients and communities we serve.

Our focus is on healing and health improvement through services and technologies that are accessible, coordinated, efficient and delivered with compassion. Our organization will be in partnership with our physicians.

We remain committed to carrying out our special mission to those who are poor, vulnerable, and dying.

MISSION

Catholic Pacific Healthsystem and its sponsoring congregations are committed to furthering the healing ministry of Jesus. Our Mission is to:

- Deliver compassionate, high-quality, affordable health services.
- Provide direct services to our sisters and brothers who are poor and disenfranchised and to advocate on their behalf.
- Partner with others in the community to improve the quality of life.

VALUES

Dignity: Respecting the inherent value and worth each person possess as a member of the human family.

Collaboration:Working together with people who support common values and vision to achieve goals.

Justice:Advocating for change of social structures that undermine human dignity, demonstrating a special concern for those who are poor.

Stewardship: Accountability for human, financial and ecological resources 56entrusted to our care as we promote healing and wholeness.

Excellence: A shared commitment to quality in our work and services through teamwork and innovation.

The Mission statement is a careful construction. Reversing the sponsor initiative of the vision statement, the mission statement begins with the system itself in an alliance with its religious sponsors, who together advance the "healing ministry of Jesus." This is the Christian foundation of any Catholic system but the semantic choice here is very deliberate. The sentence does not invoke the Roman Catholic Church or its traditions; it invokes the stories of healing of a historical figure, Jesus, and not the Christian Messiah, Christ. The Corporate Members deliberately crafted this statement to retain the religious origins of Catholic Pacific Healthsystem while creating a faith-neutral mission statement that could be embraced by secular community hospitals also engaged in healthcare provision. The Mission then enumerates three aspects of its purpose: what it does, who it does it for, and who it does this with. The word order that sets "sisters" before "brothers" is again a deliberate move to privilege women in a remedial tactic that acknowledges both the women-founded nature of the organization and historical oppression and marginalization on the basis of sex. Having identified the recipients, the statement calls out the aim of the organization not only to provide services but to advocate. Moreover, partnering with others is for the purpose not only of providing services but to improve the very quality of life in the areas that CPH hospitals serve. Thus, CPH hospitals are corporate citizens, collective entities with civic duties to act in the public sphere. Providing healthcare is a political act born of ethics.

The five core values of the system are the tools to enacting the mission and achieving the vision of CPH. *Dignity* invokes a central tenet of Catholic anthropology as an understanding of the fundamental uniqueness of each person and the intention to address individuals holistically, not only as objects of medical intervention. In the context of healthcare, it sets a conceptual expectation for who and how the hospital serves: CPH has particular concern for persons at their most vulnerable – when sick, dying, poor, young and old – as persons in a state of being, not as consumers or purchasers of service commodities. *Collaboration* invokes the unique history of the system in the merger of distinct hospital ministries of several different women religious, as well as the formative decision to partner on an equal basis with secular community facilities engaged

in a common mission, supported by common values. While many Catholic organizations hold dignity as a core value, collaboration is almost unique to CPH in this sense. As it plays out in system operations, this value is a defining element to the particular catholicity that is brought into being by this organization. As we will see, mission integration efforts struggle to keep this core value central to CHP, both in its rhetoric and in the practice of system-locality relations. *Justice* projects the value of dignity forward into a deliberate call to action; the hospital system works to produce an actual social reality and the structural forms that reflect the inherent dignity of each person. The value of justice is exemplified in actions addressing the circumstances of those who are poor. *Stewardship* reflects the not-for-profit nature of the organization, where its purpose is to shepherd the resources and capacities not for the system itself but for others in need. I use 'shepherd' deliberately because stewarding here implies pastoral care. This value is applied both to financial practices and investments, and also to the social and ecological impact of the system's practices over time. Again, the statement provides an opportunity to reiterate the goals of "healing and wholeness," linking stewardship to dignity and to the mission of providing care to the whole person. Finally, *Excellence* provides a counter-balance to the sense of longevity and safe-guarding through stewardship that could regress to inertia. The system will strive to achieve and consistently attempt to improve on existing capability, again through collaboration and, to link the back to the founding inspiration, to use the collectivity to create new means to achieving the mission.

The place of mission

> "Ministry must always guard against the type of reasoning that leads them to believe they are doing things for the sake of ministry when in fact their actions harm the ministry in the long run. They must bear in mind that if they sacrifice our soul just to stay in the game, Catholic healthcare has gained nothing and might as well cease to exist anyway."
>
> - Michael R. Panicola[11]

The refrain of margin vs. mission is one of the first things I heard when I started spending time at CPH hospitals. It was a common remark, often wryly made, by sister-sponsors, physicians and employees of all stripes, especially when news of some additional challenge spread through the halls: legislative amendments, budget shortfalls, failed contracts, or a new service line at another hospital competing for marketshare in the game of cost-shifting in a nation without universal healthcare and growing numbers of uninsured and the more recent demographic, "the working poor." It asserts a cognitive binary opposition, two elements in precarious balance, easily invoked as the distillation of every problem.

In the spring of 2002, the system ethicist for a respected Catholic hospital company in St. Louis published a column in *America*, the Jesuit-operated periodical of US Catholic news and commentary, re-examining how to sustain Catholic identity and integrity while surviving the contemporary hurdles of the marketplace.[12] Panicola's article revolves around an argument by Richard McCormick, once a leading theologian and scholar of Catholic life now deceased, who expressed doubt about the ability of Catholic healthcare to maintain its identity and integrity in the face of irresistible influences from secular society. Panicola seems to agree, but his article strikes a different tone. Rather than focusing on the external or environmental challenge for continued ministry within the industry, Panicola sets his sights higher on a target both nearer and dearer. He calls attention to internal factors, specifically "the loss of the traditional mission-bearers in Catholic health care," which I take to mean the sister-sponsors. Panicola suggests there is an underlying concern across Catholic America, namely, the fear that "some of today's ministry leaders do not fully understand what our mission entails and do not recognize that our mission is the primary reason for our existence and the lens through which we evaluate all our activities." Despite the many commentators who have held forth on the trials and tribulations of healthcare ministry, Panicola argues that few people are able to put this essential analytic into operation.

By invoking "traditional mission-bearers," Panicola is playing on the same field as those in Catholic Pacific Healthsystem who still restrict their understanding of mission to some inherent virtue unique to sister-sponsors. His article refers repeatedly to the unspecified "ministry leaders" – it is unclear if he means executives or another group that have succeeded the traditional bearers – and exhorts them to recommit to imagination and mission, and thereby stem the tide of misunderstood, or worse, diluted mission. Panicola writes: "...in the current context the danger is always present that ministry leaders could lose sight of our mission and core values, much as the pigs of *Animal Farm* lost sight of theirs, for it is all about the modification of commandments..." Like Panicola, I have heard many times that Catholic hospitals will "always care for the poor," but I have just as often heard Mission personnel quip that this is distinctly different in meaning from the statement that Catholic hospitals will "always care for the poor if we receive adequate reimbursement."

Similarly, Panicola fears slow modication whereby the principle that "prudential judgments outweigh laws and regulations" is compromised to become "prudential judgments outweigh laws and regulations so long as we are not sued or stripped of our identity or accreditation.... As though morality yields to lawyers, the Joint Commission [on Accreditation of Healthcare Organizations, JCAHO] or right-wing conservatives." One sister at Catholic Pacific Healthsystem expressed her fears beginning with an account of the Fall:

> Well, we worry about – we worried about CPH when – see, before, it was all sisters in charge, and they stuck to their mission. We're afraid that the people in charge, even like from [the system CEO] on down, that the mission will be forgotten. And if they don't listen to the sisters like they should – in other words, we should filter up to the top, and we don't feel that we are. And it's money is the answer – keeping ourselves out of the red. That's not – if you go in the red to help somebody to do something, to minister, then you go in the red, but for the right reason. And so I think we have a fear that administrators will lose the sense of our mission to serve the poor. And who knows, in ten years, the nuns tease and say there just will be a cross on this hill saying, "St. Catherine-by-the-Sea used to stand here." Because we'll go back to health care, home care. Hospitals will change in the future.... But what I'm saying is, health care – I think we're gonna see some drastic changes. I don't what they're gonna be. But we just do have a feeling that the mission will be lost.

There is a fear in this sister-sponsor that lay administrators do not understand the centrality of mission, even in their own domain of budgets, revenue and expenses. As she says, all hospitals do change but, in her eyes, the continued security of mission is a thing of the past, part of a previous era. Like many in *Health Progress*, the magazine of the Catholic Healthcare Association, Panicola's article sounds a clarion call for mission but falls short of offering a methodology of intervention.

The time I have spent immersed in the daily work of CPH and its hospitals suggests that, in many ways, it is a question of working amongst two overlapping but very differently oriented worldviews. The challenge of the business specialists is to incorporate commercial business practices in accounts receivable, revenue generation, investments and marketing that can enable a hospital, like Protestant North Medical Center or Downtown Hospital, to *compete* with neighboring facilities, including investor-owned chains as well as the new specialty outfits. The time when a Catholic hospital could rely on a steady stream of patients *ending up* in their patient beds was long over. Neither state nor private insurance reimbursement levels meet the cost of care and every hospital actively solicits almost every variety of patient. Simultaneously, and perhaps less transparent, is the challenge for the sisters and their colleagues in Mission Integration to continually re-assert their worldview that prioritizes, first and foremost, the care of the poor and the sick in a spirit of charity and respect for inherent human dignity. The means to this reassertion at CPH lies with their efforts to make the mission and values the *raison d'etre* of each of those new business practices and capitalize, so to speak, on the vigor with which those practices are implemented to create new inroads for the every-day practice of the system's core values.

By 2002, CPH was clearly in the midst of a marked financial turn-around. The management changes and corporate restructuring has been extensive, but in the eyes of the sister-sponsors and their mission colleagues, the risks lay in the distinct possibility that reform through

new business models would erase the fundamental religious values that drove not-for-profit healthcare at CPH. As one CPH sister-sponsor puts it:

> ...For us, the mission is the bottom line and the bottom line is the mission. There's no difference. And so it's very easy for somebody to say, "Well, the Sisters represent the mission, and we'll take care of the bottom line." And I think that there's where the rubber hits the road, in a sense. That you've got folks who will acknowledge there is no difference, but they're not folks of significance in terms of the business aspect of the hospital! And those that are involved with the business, I'm sure scratch their heads wondering what we are even here for, or about....And I just think that in the course of a day, you may spend some time clarifying your role to help somebody get over their bias as to what your purpose is, and in some instances you actually educate people, and they'll say "I never knew that before." ... But I know that if I was on the nursing units, I would not have to worry about the longevity of my ability to provide service. But when you are in an area that is literally, in a sense on the fringe because it's seen more as a charity, then you struggle, maneuvering how to keep it alive.

Members of the Mission team were similarly vocal in their concern and, as the new edicts of the structural and financial renewal came down, Catherine and her team worked quickly with the sisters in governance to inject Mission Integration into operations in new ways. Taking advantage of a new CEO who had been hired for his interest in sustaining organizational culture, Corporate Members emphasized the significance of their sponsorship as he began to acclimate to the job. As the regular and direct conduit to the Corporate Members during and after he was hired, Catherine was able to leverage her long tenure with the system and she found herself increasingly utilized as a touchstone for how things might be done in the new order. Other newer senior executives made note of Catherine's long-term history with the sister-sponsors and saw her as a resource to understand the nature of the system they were joining.

When the CEO assembled his executive management team, those senior leaders similarly interacted with the membership of the Mission Integration department almost as an on-site extension of Corporate Members. As a hybrid group of women, including both sister-sponsors and former sisters, the Mission Integration team lent a daily visibility to mission, significantly colored by a perceived sister-sponsor presence. For example, at a lunch meeting, a lead executive in hospital finance learned in casual conversation with a Corporate Member that she had known the system ethicist since high school, even before they had been in religious community together.

This revelation seemed to lend greater political import to the way that finance greeted the ethicist's comments thereafter, or so she noted to me.

This political interpretation of Mission Integration is not intended to detract from their individual competencies. Rather I am calling out the situational conditions of the department's perceived ties to power and authority. As I have earlier suggested, the charism of the sisters extends to the work style attributable to this group. Catherine, the senior vice president, manifests a personal style that lends itself to her role as facilitator, not merely in the functional context of meetings, but in the larger domain of facilitating her colleagues' growing connection to the culture of CPH, specifically to the mission and core values that shape it. As one member of the Mission Integration team told me, while everyone would like to be taken seriously purely on the merits of a reasoned argument alone, if this social-political connection meant she had that much more opportunity to bend an ear to the ethical implications of pending initiatives, then so much the better.

While the corporate restructuring lends itself to beginning the analysis of Mission Integration at the system office, the actual daily work of inculcating mission and values lies with the personnel "out in the facilities" across the system. There, a mission lead serves a largely lay leadership team in each hospital, facilitating values dissemination and communication from the system team perspective. When the Mission Integration leaders convened from across the system, several participants were struck by the uniformity of its demographics. Of the nearly forty people at that meeting, only one was a man, and even he was a Catholic religious. The Corporate Members had recently re-asserted the need for CPH to aggressively work to achieve a representative diversity of "racial and ethnic" populations in management positions and above, with particular attention to recruiting women executives at the hospital level. Thus, as the Mission Integration group sat down, one of the agenda items added to the table was how to diversify their own group to include more men and balance the dynamic between sister-sponsors and lay people in mission leadership.

Engendered dynamics

The for-profit business mentality that is being imported into operations areas of CPH is not exclusively male. It would be a mistake to infer an oppositional relationship between men and women in Catholic Pacific Healthsystem, either explicit or *sub rosa*. The reigning expectation, and momentum, is collegial and held to an expectation of collaboration as an explicit core value of the organization itself. That said, there remain noticeable cultural differences. However, any suggestion that there is a gendered nature of those cultural differences stems from the fact that the founders and governance of the system are sister-sponsors, and as one Corporate Member is fond of noting, "sisters *are* women." The initial ground of Catholic hospital culture is female-identified due to the historcal demographics of the nursing profession and because it was once completely managed by women religious. In the past, men in a hospital were either physicians, and thus less facility-identified, or part of support services. Any change in the operations labor force will stand in contrast to that starting point. Senior lay administrators were drawn from a pool of male professionals and their arrival transformed the hospital environment. There is clearly resonance here with the institutional sex/gender role differences of women religious and the exclusively male Church hierarchy. But while gender matters as a contributing factor in the cultural changes of hospital identity, it is a factor interwoven throughout the social fabric rather than an isolatable causal strand.[13]

Presidents, in contrast to the people I have worked within the Mission Integration positions across the system, only relate to each other on one or maybe two dimensions. The presidents are mature individuals with long-term backgrounds in hospital administration.The presidents council is also a male team; of all the hospitals in CPH, only three are led by female chief executives. Only Sister Lucinda is both sister-sponsor as well as president and chief executive officer of a CPH hospital. Many presidents have for-profit management experience, others have risen to their leadership positions through an exclusively not-for-profit career. But

they interact with each other as professional colleagues, and perhaps in a few instances, as collegial friends.

In contrast, the majority of lead staff in Mission Integration functions are sisters or former sisters and, as a result, have known each other for many years. The consequent scope of relationships is much broader and this feeds into a tangible "sub-culture" of what one manager calls "the Mission folks." Moreover, it is their task to meld the theological motivations of the Sponsoring Congregations into not-for-profit hospital operations and to diffuse and disseminate a "values-driven" perspective across the CPH system. The process of fulfilling that charge involves substantial reflection, even discernment, discussion and ultimately articulation. I have earlier sought to describe the effects of "sisterliness" in terms of power and influence. This chapter elaborates the two forces loosely gathered under the concepts of "mission" and "margin" that swirl though Catholic Pacific Healthsystem. A further step is to consider more directly what sisterliness disseminated through mission and values by way of the Mission Integration function means for healthcare operations. I do this in the next chapter on the ethical effects of articulation. First, I want to show how the restructuring and rationalization of the system has provided an opportunity for Mission Integration to consolidate its departmental and functional legitimacy by making its work transparent to the rest of the organization. This transparency extends from articulating expected competencies for each mission job description to creating measurable and reportable interventions that could be documented at each hospital and for the system overall, much the same way that Care Management set out its work plans.

Under Catherine's direction, the department reconstituted its purpose as the implementation of fourteen Mission Integration Standards, encompassing the areas of Mission and Values, Spirituality and Spiritual Care, Ethics, and Community Benefit. Together these Standards would be parsed out into goals and objectives, with work plans and accountable personnel for periodic evaluation. This rationalization, through the implementation of Standards, would also enable the Mission Integration team to demonstrate how mission and values were at

operative in the work of each hospital and system employee, and consequently, how each employee was ultimately responsible for sustaining the CPH mission.

Rationalization of mission

Although it has been demonstrated that identities can be powerful political tools that can be manipulated to access power and influence (Briggs 1996; Fox 1996), such a deployment may be empowering in one situation but actually contribute to the loss of power and continued marginalization in others (Schein 1996). One reading of the residual power/influence dynamic adhering to sisters-sponsors suggests that aura of moral authority could itself be an obstacle rather than aide to their charge. Put bluntly, the very presence of religious might distract from the ability of the organization to diffuse and integrate mission and other social values into the broader workforce of lay people. For example, mission leader positions had often been allocated historically to sister-sponsors solely by virtue of her being a sister rather than by proven competency or training in how mission could be inculcated in the work of non-sisters.

With its new seat at the high table of operations, the charge for Mission Integration was to insure that a mission lead in a CPH facility was a competent professional with management skills and, as one Mission colleague put it, "not simply the retired high school teacher who had been made redundant from medical records and was now called back as a mission lead simply because she was a sister-sponsor." Marie explained that, in the past, when hospital presidents found that they needed to appoint a mission lead, many presidents were so preoccupied with hospital operations and were still not clear on what that work would entail, that rather than conducting a full search, he would simply call the sponsoring congregation and ask for a sister who was available to join the hospital. Without a position description or a clear understanding of the required competencies, the hospital president simply assumed that any sister would be qualified to be a mission lead. It is this presumption that Risse's history points to when he quotes

a hospital co-worker asserting that the Sisters " 'automatically had a position of authority' extending from the superintendent, director of nurses, chief dietician, librarian, chief X-ray technician, to the head of the surgical and laboratory technicians" (Risse: 524).

Now, Mission Integration was implementing mission standards for the system and for each facility, and new position description stipulated that the mission lead be a member of each hospital's senior management team, with the ability to function as a team member at that level. Some sister-sponsors did have the necessary background, but many did not. Moreover, some current mission leads wanted that kind of responsibility, others did not. The system office team had to work with the group individually to determine how the new order would play out in each facility according to its own local culture and local resources, both human and budgetary. Existing corporate personnel policy stipulated that all openings required a job description and system-wide search for candidates, and specifically addressed how sister-sponsors participated in the same formal hiring process and review. At the system level, the establishment of Mission Integration Standards engaged the Corporate Members in their design and formation as a function of governance. Thus, the Mission Integration team was able to communicate back to the sponsoring congregations the formalized expectations for mission integration leaders. Individual sister-sponsors could still be put forward for a position, but would be evaluated together with all other candidates against explicit competencies. Importantly, the implementation process set new expectations so that hospital presidents and their teams could plan for the future and, if they read the writing on the wall, recognize that these elements of mission would be part of their own productivity evaluations going forward.

The mission standards themselves were created to codify and explcate through action what was previously taken for granted as an inherent condition of Catholic hospitals. Mission standards and their "metrics" constitute a Weberian rationalization that specifically transform in lay-administered hospitals what was previously perceived as inchoate, intangible mission and values.[14] The standards create a process, a functionality, that allows for quantification, accounting

and reporting. By enumerating functions and markers that delineate a path for growth and improvement, mission and values cease to be the unique domain of sister-sponsors that the elect can be counted on to provide. It enables a broad diffusion of once virtu(e)al core values into the operations of each local hospital and the CPH system where each element can be monitored, evaluated, tested and improved. More importantly, when made explicit and integrated into operational work plans, everyone can become aware of what their contribution to the overall mission and values is expected to be.

Priesthood of all believers

Mission integration standards are designed to explicate how core values can be put into action at every level of the hospital system, in the work of each CPH staff person across the spectrum of operations. The standards are intended to communicate the ethics and social values of healthcare ministry that were historically the province of women religious outward into the rank and file of the hospital system. I want to consider a theological parallel as a sort of heuristic model to help us understand the cultural dynamics of this integration effort within CPH.

The priesthood of all believers is a Christian doctrine founded on the First Epistle of Peter (II:9):

> But *ye* are a chosen generation, a royal priesthood, an holy nation, a peculiar people; that ye should shew forth the praises of him who hath called you out of darkness into his marvellous light. (King James Version)

This text is often used to argue that the Christian faithful are a chosen people analogous to the descendants of Abraham, called by God for His special purpose. Many Protestant Christian denominations believe that likening the whole body of believers to the priesthood of ancient Israel obviates the need for a spiritual aristocracy or hierarchy within the faith group.[15] God is equally accessible to all the faithful; no one Christian has been set above others with regard to faith or worship. Thus, some assert that the doctrine of the priesthood of all believers is a foundation of socio-political human equality, particularly when set in the context of texts that say

that God is no respecter of persons, and in his eyes, there is thus "neither Hebrew nor Greek, slave nor free, male nor female" (Galatians III:28).

When Martin Luther nailed the Ninety-five Theses on the church door Wittenberg in 1517, his response to earlier disputations rejected the Church's doctine of salvation mediated through the priesthood via the sacraments, what later came to be called sacerdotalism. Luther argued against a Church that reserved the right of holy intercession, particularly in the forms of pardons and indulgences, but also against the broader penitential theology of which indulgences were only a part. He asserted the priesthood of all believers, based on the equality of souls, rejecting the special sanctity that the Church had linked to priestly ordination: "Every truly contrite Christian has plenary remission from punishment and guilt due to him, even without letters of pardon. Every true Christian, whether living or dead, has a share given to him by God in all the benefits of Christ and the Church, even without letters of pardon."[16] Luther asserted that the declaration of belief in Christ connoted priestliness in the sense of the chosen quoted in Peter's First Epistle: "A shoemaker, a smith, a farmer, each has his manual occupation and work; and yet, at the same time, all are eligible to act as priests."[17] He would later call for a future where the faithful "will know that he who is a Christian has Christ, and he who has Christ has all things that are Christ's, and can do all things."[18]

Protestant theologians of many stripes contend that the biblical doctrine of the priesthood of all believers is found throughout the Scriptures and was practiced in the early Church.[19] They argue that sacerdotalism was a political theology asserted by the Church fathers in efforts to unify and consolidate power, beginning in the third century, notably Cyprian, Bishop of Carthage. Cyprian treated "all the passages in the Old Testament which refer to the privileges, the sanctions, the duties, and the responsibilities of the Aaronic priesthood, as applying to the officers of the Christian Church."[20] Protestants counter this historical decision by citing the Epistle to the Hebrews, arguing that the Christ is "the only High Priest under the Gospel recognized by the apostolic writings."[21]

On the other hand, until Vatican II, Roman Catholic theologians would interpret the sanctity of the priesthood through succession from the apostle Peter, following the death of Jesus. The Roman Catholic Church takes Peter to be the first bishop of Rome and the priesthood proceeds from him along direct line perpetuated through ordination. The sacraments of the Church are delivered by the ordained priesthood (Vaticana 1997, arts. 1120, 1566). Since eucharistic sacraments are necessary for salvation (§1129), the ordained priesthood occupies a unique place in the Church community. Hence, for some, a defining distinction between the Roman Catholic Church and the Protestants churches.[22]

The Second Vatican Council initiated a radical shift within the historical identities of the Catholic faithful. *Lumen Gentium*, one of the Council documents that speaks directly to the nature of the Church in the modern world, emphasizes that *all* members of the Church have received an equal call "to the fullness of the Christian life and the perfection of charity" simply by virtue of their baptism (§13-15). As Wittberg reminds us, "the importance of this seemingly innocuous statement cannot be stressed enough. *In one stroke, it nullified the basic ideological foundation for eighteen centuries of Roman Catholic religious life*" (italics in original). For the first time, all baptized Christians were called to holiness, not just men and women religious. While priests could continue to recognize themselves of a separate state through ordination, women religious were "dislodged from a protected, clearly demarcated (and elite) 'state'" (Quiñonez and Turner 1992: 37). As I indicated in setting the context for the dissertation, Vatican II was a pivotal moment in the self-determination of women religious and the sisters internalized the opportunity within their own leadership organizations.

For lay Catholics, however, there remains an uncertainty about what is now taught to be the diffuse nature of the equal call to holiness across all the laity. Among many lay people, expecially those raised to see women religious as different and apart from other Catholics, sisters are seen to embody a distinct religiosity. Though now the Church and its documents teach otherwise, in the cultural and social world of Catholic hospitals, sister-sponsors still seem marked

by difference, a dynamic I have described in the earlier chapter on power/influence. Other kinds of organizations do not suffer from the same historical differentiation in sacred status. Ironically enough, the continuing presence of women religious within Catholic Pacific Healthsystem may itself impede the organization's efforts to diffuse and disseminate mission and values among the entire system community. As subsequent chapters will support, this is what makes the efforts of the larger Mission Integration team so important to the future of the system as an ethico-moral collective.

The Church is a living social institution and it does undertake reinterpretation to varying degrees. Two of the former sisters now part of the Mission Integration team summed up one take on the changes in the modern Church by saying that before Vatican II, the slogan was "Where there is the Church, there is salvation" and after Vatican II, "Where there is salvation, *there* is the Church." The significance of this summation cannot be understated. It represents a radical departure from previous Church doctrine that emphasized the unique, singular Truth of the holy, catholic and apostolic Church.[23] For that reason, such an interpretation is not uniformly accepted and just how much can be read into the documents of Vatican II remains a point of great contention among contemporary theologians and the magisterium. Many commentators have noted that the current papacy has spent many years trying to reign in broader interpretations, particularly with regard to how lay Catholics take up the charge (Vaillancourt 1980; May 1987; Dulles 1988; Gelm 1994). My point here is only to note that these sister-sponsors do align their efforts to "evangelize" mission and values outward through lay administrators and other employees at CPH with a modern sensibility of a Church-in-the-world. More to the point, the sister-sponsors also find in Vatican II the impetus *for collaboration* to engage non-Catholic people in the common goals of serving the sick and those who are poor. This provides the foundations for the system's efforts to align with non-Catholic community hospital partners in sustaining not-for-profit healthcare in the Western US. I will take up other considerations of

salvific diversification in a later chapter that focusing on the implications of such an ethos of pluralization for the catholicity of Catholic Pacific Healthsystem.

Moments of Grace: a question of leadership

Every few years, the Catholic Health Association organizes a week-long trip for the leaders of major Catholic healthcare systems to make a visit to Rome and the Vatican. The goal is bi-directional education. The president of the CHA is a recognized Catholic theologian who conducts a program on the legacy and traditions of the Church intended to provide a socio-political context to the contemporary mission of Catholic healthcare underway across the Atlantic in the United States, while the American delegation builds bridges between the leaders of US Catholic healthcare and the political leadership of the Church, that is the cardinals and bishops involved in furthering healthcare and other social ministries, especially those who interact with the religious institutes or congregations of women religious around the world. The program is intended to educate both the Americans and the Romans.

In 2002, after CPH was restructured, a decision was made to send Luke, the new Chief Operating Officer, as part of the CHA delegation rather than the president and CEO. As noted earlier, Luke had worked with CPH president several years earlier in another healthsystem. Luke was an outgoing and affable, a Midwesterner with a confident but determined sense of leadership from a Protestant background. He was an internal appointment to head of system-wide operations from his former position as the lead executive for a regional CPH division. Luke's appointment as COO had been warmly received for he was well-respected by his colleagues throughout the system. The decision to send Luke to Rome as the representative of the largest Catholic system in the US was a political affirmation within CPH that the CEO really intended Luke to act as the lead executive for all hospital operations.

On his return, Luke recounted the trip and the program to his colleagues at a morning meeting of the senior executive team. He was ecstatic about his experience. He spoke a little bit about the high quality of presentations by the CHA president and about their colleagues from other systems. But he was emphatic about the significance of going to St. Peter's Basilica and the impact of seeing groups of people assembled for Mass from all over the world, reflecting the reach of the Church into so many different societies and cultures. Luke explained that the history lecture had helped him to realize how his own Protestant faith was connected to the Roman Church in ways he had not considered. At one session, the CHA theologian had spoken about the Catholic concept of *grace* that Luke admitted he had never really thought about before. Explained as free and undeserved divine help that opens persons to all the works of God, Luke said he began to see the opportunity of the trip to Rome as a series of moments of grace that bore directly on his role as a lay leader of Catholic healthcare ministry.[24]

He explained to his colleagues what he meant by recounting a dinner meeting with a certain Cardinal Worcester at the Vatican during which His Eminence had expounded to the CHA delegation that without the leadership of Catholic religious there could be no Catholic healthcare ministry, that left up to lay administrators there *would be no Catholic healthcare*. If it *is* done by lay, then whatever it maybe, it isn't Catholic ministry, the cardinal asserted.

Apparently, this had brought Luke up short and he had found himself indignant that a Roman cardinal was telling him that as a lay administrator, moreover, a non-Catholic, Luke could not contribute to that social mission. He reflected that the Cardinal had most likely been deliberately provocative in order to initiate a conversation among the delegation about lay leadership. But Luke had found himself galvanized. Sitting at dinner that night in a dining hall near the Vatican, Luke was struck with the weight of the mission that had been passed to him and his lay colleagues. He returned to California with a new sense of purpose, a commitment to service and a fervent belief that he would find a way to engage the integration of the mission and values of Catholic healthcare in every aspect of hospital operations under his purview.

Conferring in the hallway after the senior management meeting, Catherine affirmed Luke's experience; she believed it was particularly important at this juncture in the common history of CPH and the state of US healthcare. Luke wondered aloud whether there were other concepts in Catholic teachings that might be useful for CPH in organizational development, especially the topics of that morning's meeting like succession planning. He raised with Catherine the concept of religious formation as a model for new hires to be oriented and continuing staff to be re-acquainted with mission and values, for certainly formation was a process of inculturation.

After his report, the hospital president suggested Luke to re-tell his experience to the Corporate Members when they met later that week. The sister-sponsors were unreservedly delighted with his account of the trip to Rome, which one of them cast as a pilgrimage and another lightly teased him with the language of conversion, making joking reference to Saul of Tarsus falling off his horse, only to come to and take up his calling as the aspostle, Paul.

The centralization of operations under a single operating company and the application of Mission Integration standards coincided in the area of the system policy on charity care. I introduce this arena to show how the process affected another lay individual. During my fieldwork, I had opportunity to observe various components of this process and discuss strategies with two of the central players in the charity care project. Nancy is a lay Catholic woman who worked as an analyst with the hospital activities that addressed community benefit.[25] She works closely with Lynn, one of the sister-sponsors in the system office, and I participated in a preliminary discussion with them about charity care. Nancy had brought a copy of the existing corporate policy, adopted at the Board level years ago. The initial task was to consider existing policy in light of state legislation that had been proposed that year. Looking at the adoption date, Sister Lynn pointed out that the CPH policy was archaic – it had not been looked at since the inception of the system. Nancy explained that corporate policy documents were a formality, a background acting to formalize an intention, but standards were designed to implement practices. Now that the Ortiz bill had been proposed, they tested the policy against language like "without

expectation of payment" and "community assistance." At CPH, charity care was a matter of geography: there was a budget within each individual hospital, and various kinds of tracking systems in place; available funds could shift across the CPH system as needed. Sister Lynn explained that shortfalls or uncompensated care might be considered community benefit in some instances, but it was not what the system policy intended as charity care.

Sister Lynn raised the suggestion that the two consider how to function as an audit team, reviewing hospital practices and flagging concerns where they found them. For example, she offered in explanation, hospital foundation expenses could not be categorized as charity care even as a form of outreach to the poor and loose accounting practices wouldn't be acceptable. The audit function would communicate a message that the system office was paying attention to local practice in this area. "They'll know someone from system is watching," Nancy said with a smile. The idea of an audit team was met with some glee. Sister was amused but righteous about improving accountability; Nancy was energized. She explained that the community advisory boards to date had been focused on hospital finances, but had not as yet focused on community investments or other programs, like charity care.

The two women helped convene several different constituencies to examine the various individual facility policies already in place and design a common set of procedures that could be implemented locally and bring the hospitals into compliance with the single system policy. Perceived by some as a test of the system's internal politics to realize a uniform set of practices, bringing such different stakeholders together became critical task. Several weeks after a representative work group had been established, chaired by a well-respected but no-nonsense Vice President of Risk Management, Nancy brought me up to speed on the process with this email:

> As we continue to work with system representation it is becoming more apparent that the need for establishing this system wide policy was very great. I would have assumed that the policy was, in fact, a statement of the status quo; but I have found that it most definitely is not. We are uncovering a variance in how charity care is allocated and how it is reported. Perhaps the most profound lesson I heard from one of the [Patient Financial Services] staff

> members was that if we are to truly *provide direct services to our sisters and brothers who are poor and disenfranchised... and partner with others in the community to improve the quality of life*, then our work must be to the whole person. We must work with our poor and advocate for/with them in efforts to channel them into government and other public programs. This will help to ensure they have access to health care services beyond the acute episode that brings them to our emergency room. The other benefit is one of stewardship of our resources – appropriate use of the health care "system." We often forget that there is a system. When all these components come together, when we partner, when we *serve*, our work is true ministry, and the work is holy. (emphasis in orginal)

The Cardinal in Rome brought out as a challenge to the delegation the idea of continuing the religious ministry through lay leadership. It is the kind of values inculturation that informs Nancy's work; she makes explicit links to the language of the system's mission and core values and she sees the purpose of her contributions to policy revision and implementation in terms of the bigger picture, in the presence of the hospitals in the communities they serve.

I want to suggest that Catholic Pacific Healthsystem is the site of a conceptual move wherein the special virtues of women religious, and the aptitude for mission and values that is inculturated through the formation process by which Catholic women become sisters, is shifting to an understanding of mission as a capacity of the priesthood of all believers. The compassion and "devotion" of healthcare professionals that is used as a rhetorical device, raised in the earlier discussion of vocation, links diverse healthcare workers to the sister-sponsors. The power\influence dynamic remains active throughout CPH because sister-sponsors have a continued presence in hospital operations through their agents in Mission Integration.

Structural binaries: Arguments of ideal type

It is not a simple matter, however, nor a one-to-one correspondence to align formation for women religious with the successful orientation of lay people. The inculturation of values remains a complex and multi-dimensional social process. When I asked what a former sister what she thought of the idea of the "formation" model for lay administration at CPH, Marie had been emphatic that [the development staff] will never be able to create formation in CHW. "The

project leads may be excellent at organizational development and training, but that is *not* formation," she insisted. Marie reminded me that no matter how good the organizational development or succession planning was to be, formation involved years of real time, personally initiated commitment after considerable reflection constituted over the long term.

This chapter has focused on the "rationalization" of CPH under new leadership: quality indicators, flash reports and management dashboards, and the care management side of business operations. The Mission Standards, then, capitalize on that drive to rationalize, much as Clinical Pastoral Education enables chaplaincy to be reborn as spiritual care services – rational, replicable, testable and reimbursable as a tool for better patient care in a pluralistic world (see Lee 2002). I described Care Management and the Mission Integraton projects to make the case and it is possibly too stark an oppositional contrast. But I set up this binary of margin versus mission as an initial analytic trope.

As Sidney Mintz has observed of the construction of the Caribbean, "anthropologists employed paired polarities in order to develop some analytic formulation that might permit them to deal with very complex realities."[26] Arjun Appaduria too has suggested "anthropology's excessive dualism."[27] Theodor Adorno similarly deploys what he termed a negative dialectic that considered phenomena through their connection and negation, as in terms of what one is *not* vis-á-vis the other (Adorno 1973). However, Adorno insists that a resolving synthesis is only possibly if the dialectic sheds the trappings of history for the realm of abstract thought, as in Hegel.

But the opposition exists *in vivo* amongst different groups at CPH. When pressed they are fully aware that mission and margin should be mutually constitutive within the operations of the hospitals and the system as a whole. But in the course of regular conversation, the oppositional relationship is used as a daily short-hand for the pressures and challenges they face in their own roles. The culture of business in healthcare encourages operations staff to understand "mission" as only a form of *doing*, and thus easily overlooked and devalued in the struggle for the system's

survival. For others, it is a form of *being* inherent to people that cannot and must not be alienated from hospital operations. As Panicola chastizes in his commentary, mission cannot be a fair-weather friend if Catholic hospitals are to retain their identity and integrity through time.

In this chapter, then, I have set up a simplistic oppositional binary in margin versus mission. I have described a highly simplified conceptual alignment of business practices only concerned with margin and values integration practices only concerned with mission. But the margin and mission binary reflects other oppositions in the realm of healthcare ministry: profit and surplus, bad debt and charity care, reimbursement and community benefit. These concepts function as indexes of two domains of value, like Weber's value spheres that co-exist in the social reality of hospitals. The challenge for CPH is to engage those spheres for their mutual improvement. In a rationalizing process, ideals of discipline and order are applied to what was formerly lacking in systematicity. Codified for explanation and accuntability, and perhaps more importantly, reportability wherein outcomes can be compared between facilities and provide demonstrable results to governance, the new centralized authority functions as an operating company to create behaviors, policies and practices standardized across all hospitals in the hope of creating a true system.

As this chapter's opening quotation suggests, a not-for-profit language, much as philanthropy is only an after-effect of success in a capitalist market, is a weaker language but it also represents a tool. The next chapter will bridge margin/mission binary through an examination of the ethics of articulation, particularly in the use of language in Catholic Pacific Healthsystem.

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[1] The explanation for the historical strucuture of CPH lies in its Catholic identity, as do the implications of the new centralization. The politics of sponsorship particularly amidst modern pluralism are taken up in a later chapter.

[2] This and the subsequent three paragraphs on the re-organization of the system is summarized from extensive coverage both in external industry press sources, like Moden Healthcare and various California publications, as well as from internal memoes made available to me during 16 months of fieldwork.

[3] Personal communication. Several hospital system CEOs called the CPH president to express their frustration, but at least one fellow executive of a religiously sponsored system was "personally delighted at the mission implementation, but bitterly challenged to manage it in his own system.

[4] A significant proportion of 2002 losses was due to unanticipated $80 million increases for workers' compensation reinsurance guarantees and premiums due to delayed settlements exacerbated by the

underwriting industry's reaction to September 11, 2001. Further, the system suffered a loss of $15.5 million on investments, a huge swing from $32 million in profits in fiscal 2001 and $265 million in fiscal 2000. Had investment income been near past levels, CHW might have broken even. Reported in Sacramento Business Journal, September 2002.

[5] See (Schumpeter 1950: 125-6)

[6] This quote from a member of the system executive management team resounds, ironically enough, with the Protestant work ethic if one recognizes that the vision statement discussed in a later section of this chapter calls for CPH to be the *best*, read elect, system based on health *outcomes*, the outward sign.

[7] The idea of a common system directive allowing local control resonates with the Catholic principle of subsidiarity. This is explicitly identified at CPH and will be addressed in more detail in a later chapter.

[8] For a larger application of Weber and rationalization applied to institutions, see (Douglas 1986).

[9] I am indebted to Ben Peacock for making this clear to me. I thank him for sharing his work on the anthropology of epidemiological public health and for many useful discussions about the creation of anthropological objects over the years.

[10] I reference here the work of Edmund Pellegrino (Pellegrino, Langan et al. 1989; Pellegrino 1993) and others that provide overviews of the trends in medical ethics.

[11] (Panicola 2002)

[12] Ibid.

[13] It is also important to note that my study, in concentrating on the dynamics of this hospital system, does not address the very different dynamic of the history of Catholic charity: "Over the course of the nineteenth century, laity, religious and clergy had worked in partnership to develop a large and diverse system of charities marked by considerable lay control and disproportionate reliance on female initiative and management. These features were certainly extraordinary in the society of the day, and particularly noteworthy in a hierarchical church" (Oates, 1995: 71). As Oates' careful research illustrates, the larger trends of Catholic charity are more complex, with shifting maneuvers and vying for control between diocese, lay boards, and national episcopal controls.

[14] The structural binary that I'm pointing to might be one like: A) spiritual, poetry & religion, speculative philosophy, vague metaphor, intangibles; B) material, economics, applied science, rigorous theory, measurables, economists. See (Douglas 1986: 64).

[15] I use "denominations" here advisedly for it is peculiar to groups in the Christian context. "Sects" are technically splinter groups from the official "Church" but in contemporary secular culture, many people feel "sect" is a disparaging term. In other contexts, less specific to the Christian diaspora, I use "faith groups" as a value neutral term. As I have noted elsewhere, "protestant" is itself a Catholic term; most Protestant groups rarely use this term in reference to themselves, for reasons similar to the explanation of sect – it presumes the primacy of the Roman Catholic Church as true Church. Margins are only marginal to something else.

[16] Benjamin Breckinridge Warfield, *Studies in Theology,* Vol. 9 (Grand Rapids: Baker Book House, 1981), 487-8.

[17] Woolf, *Reformation Writings of Martin Luther*, Vol. I, p. 116.

[18] *Luther's Primary Works* , ed. Henry Wace and C. A. Bucheim (London: Hodder and Stoughton, 1896), 399.

[19] That is, in Exodus 19:6; Hosea 14:2; Psalms 50:23; Psalms 51:17-19; Psalms 141:2; 1 Peter 2:5-9; Hebrews. 13:10-16.

[20] J. B. Lightfoot, *St. Paul's Epistle to the Philippians* (Lynn, Mass.: Hendrickson, 1981), 258.

[21] Ibid. 263-4.

[22] William Connolly explores shifts in identity of the Southern Baptist movement, in particular the "Priesthood of the Believer" decision by the Convention in his examination of foundations and politics (1995: 109-11).

[23] For a useful discussion of this issue in its historical context, see (Adam 1997: 164-70). I am necessarily reducing a much more nuanced set of deliberations for the sake of argument.

[24] See paragraphs 1996-2005 in (Vaticana 1997).

[25] Commmunity benefit is a state regulatory term encompassing the range of activities, services and philanthropy that the hospitals undertake in keeping with the not-for-profit covenant.

[26] I appropriate this citation from a thoughtful discussion of analytical devices in the studies of ethnicity and identity by Aisha Khan, "Journey to the Center of the Earth: The Caribbean as master symbol", *Cultural Anthropology*, 16(3): 271-302.
[27] (Appadurai 1986: 13)

Ethical effects of articulation

Academic research in the US, supposedly a site of impartial, objective intellectual evaluation and innovation, is itself subject to the vagaries of culture. As a product of modern social structures, academia more often than not suffers from a conceptual blindspot, namely that secularization is a universal phenomena and, thus, the religious faithful are anomalies or hold-outs from modernity that need to be explained.[1] Consequently, many academic researchers often proceed from a questionable presumption that religious knowledge as a means to organizing daily life and political action in a liberal society is obsolete or inappropriate.[2] The "culture wars" may reflect the challenge that such an unexamined stance can present. For many people that presumption would be over-reaching. For the Catholic faithful, diocesan programs in many states seek to affirm the place of Catholic faith in the practices of modern life.[3] San Francisco is one of the most politically significant archdioceses in the US because of its long Catholic roots, the ethnic and cultural diversity of the Catholic demographic that draws on both Eastern and Western European and Asian Catholic communities. The weekly Catholic newspaper there reports on the events and activities within the archdiocese, focusing on parochial schools and universities, but carrying news from Rome and the Catholic diaspora world-wide. It also carries editorials and opinion columns applying Catholic morality to daily life with commentary on current events, the family and spirituality. Film reviews, often a staple of local papers, are a syndicated series from the Office of Film and Broadcasting of the US Conference of Catholic Bishops and each review ends with a moral rating system paired with the US MPAA rating.

A critical reading of the newspaper demonstrates a distinct difference in understanding the role of religion in social life than academic discourse would suggest. It presents a religious ethic that being "Catholic" involves acting Catholic; *catholicity* is made manifest in the way one lives and structures daily life. Religion is reflected in the choices one makes and in the acts or

works one undertakes either alone or collectively. The vowed life of Catholic women religious necessarily formalizes that premise. In the case of the women religious with whom I have worked, healthcare provision is the explicit ministry and Catholic hospitals are both the symbolic and pragmatic instantiation of the mission to be-Catholic-in-the-world.

Mother Catherine McAuley, founder of the Sisters of Mercy, established the unity of prayer as the basis for an *active* apostolate for her order. McAuley argued that "love of God (and) love of neighbor....are as cause and effect,...*for the proof of love is deed*" (Bolster 1990, 75). The Sister of Mercy who researched McAuley's biography writes that Mother McAuley's spirituality was original due to a "novel synthesis of contemplation and action, a preferential option for the poor in whom she found Christ and in which she anticipated...the encyclical *Populorum Progressio* which stressed a social mission which is at the same time profoundly religious that it permits those who practice it 'to be present to their brothers and sisters in a deeper way in the charity of Christ" (Bolster: 104).[4]

This chapter documents the daily and programmatic interventions of Mission Integration into the operations of Catholic Pacific Healthsystem. The examples I use will document the tactics of mission agents, both sister-sponsors and lay people, in a strategy I have labeled the ethics of articulation. First, I will consider the work of Mary Douglas and George Cheney within an anthropology of organizations to set the stage for a discussion of identity and group dynamics. Then I will examine a Catholic perspective on the ethics of discourse using John Courtney Murray, that together contribute an analytic frame for the social life of CPH. As a chapter title, I set my analysis against a background of the work of Charles Taylor and others, marking the discourse that emphasizes the role of qualitative distinctions in defining identity and the role of narrative in literally making sense of human lives. The terms in\through which people live their lives cannot be separated from the explication of ethico-moral choices, particularly in regard to what makes a social "good" as well as "moral sources" for such goods.[5] One might consider the CPH mission to care for the sick and those who are poor as an echo of what Taylor calls a "hyper-

good." These are higher-order goods "which not only are incomparably more important than others but provide the standpoint from which these must be weighed, judged, decided about" (Taylor 1990, p.63). Taylor's argument works through the problem of naturalism that results from the embedded-ness of values wherein we perceive existing valuations as objective. Naturalism obscures the possibility of value pluralism and tends toward an ethic of inarticulacy that Taylor dismantles (ibid.: 67-72). An ethic of articulacy develops from a range of ethical views that see reason, in the sense of the logos – the linguistic articulacy – as part of the telos of human beings.[6] Such an ethical view suggests people are "not fully beings until we can say what moves us, what our lives are built around" (Taylor: 92).

In the context of my ethnographic account of CPH, the suggestion of a hyper-good is not one of the broader society in which the system operates, but one of the collective ethico-moral constitution of Catholic Pacific Healthsystem, understood as crucial to the formation of organizational identity precisely for the ability of such an orientation to provide a distinctive qualitative dimension to the *catholicity* or Catholic-ness of the hospital network. It is precisely the articulation of those values that supports a common understanding of the good *for* CPH, *as* CPH. Further, as I will later demonstrate, the means by which that good is articulated, as a deliberative and collective process, enables Catholic Pacific Healthsystem to engage its diverse inspirational constituencies in such a way that accommodates an ethos of pluralization and incorporates that ethos as means to a common end.

Modes of engagement

The challenge of identity always lies in its communication. For an individual, how identity is recognized and affirmed within herself, as well as how it is made manifest to others is a dialogic process; similarly for an organization, how identity is constituted and shared within the group and manifestly demonstrated for those who interact with it involves a social dialectic, stages of production both deliberative and less so. What this means in this context of Catholic

Pacific Healthsystem is a move to recognize that values-work involves first, a recognition of self, and what follows, the recognition of the Other. I am thinking in this sense of Hegel and Gadamer – what Charles Taylor synthesizes as recognizing "Verstehen is a Seinsmodus" – namely, recognizing the action of conversation and dialogue within which interpretations of ourselves and of others come together (White 2000, p.53). At CPH, one might tally up the constituent groups as the sister-sponsors, lay colleagues including the secular community hospital partners, agents of Mission and Margin, and of course the communities they all serve. "Intercultural" conversations have some unifying *telos*: in articulation and conversation lies possibility for connection, reconciliation between what seems initially to be irredeemably incommensurable. For our purposes, the significance of Taylor's argument in *Sources of the Self* lies in the assertion that in the space of late modern conversation there is no single trump card with regard to moral sources. The utility of foundational arguments is not about their specific truth value, but their contribution to a motivation to care for conversational engagement between ontological constellations and the dedication to interpretive work that engagement requires.[7] The ideal, as political theorist Stephen White points out, is not the guarantee of progress but the motivation to try. As subsequent details will illustrate, CPH is an entity that takes this effort seriously. In some cases, the effort falls short but the commitment of the organization to such an orientation toward becoming is grounded in its very identity.

White argues that having knowledge of one's values is equivalent to the claim that "one has an explicit understanding about one's form of life, moral source, etc. adequate to know its precise boundaries." Thus, he suggests, to declare irreconcilability with others is to fail to recognize "that the very activity of articulating those things that are morally and spiritually crucial to one's form of life unavoidably puts one in a position of seeing/feeling them in new contexts and with new possibilities." That is to say, conceptualizing values requires that one also conceptualize what is external to those values. Acknowledging this conceptualization of internal/external bounds of values, the "what is/is not," resonates with Adorno's *negative*

dialectic that I pointed up at the end of the previous chapter in explaining the narrative artifice of the margin\mission binary. In essence, White's argument is that since self-understanding is a linguistic act – of articulation to the self – that very determination is transactional and carries with it the potential for reconciliation by shifting the bounds within the conceptualization.[8]

To the extent that the ethico-moral conundrum of modernity lies in the realization that "underneath the agreement on moral standards lies uncertainty and division concerning constitutive goods" (Taylor: 498), strong ontologies that insist on any particular fundamentalisms about self, other and the world are contestable. However, such foundations lie at the heart of a reflective and ethical life. We are inclined then to consider what White calls "weak ontologies" that reflect fully the processual aspects of self-cultivation marked by the "petits recits" that Lyotard asserts are the trademark of the times (White: 12). To the extent that it is possible, I want to look to the common deliberations that mark CPH's daily operations as something that approaches *phronesis*, as goods of social interchange that contribute to the rational life of the ethico-moral collective embodied in the hospital organization.[9] As Mary Douglas expounds, institutions do not have minds of their own, but they do confer identity (Douglas 1986).

Organiz(ing) ethics

In the 1985 Abrams lectures, anthropologist Mary Douglas sought to push through the Durkheimian inheritance of supra-personal cognitive systems constitutive of institutions and social groups. She has maintained that a theory of institutions is needed to "amend the current unsociological [sic] view of human cognition" while a theory of cognition is needed "to supplement the weaknesses of institutional analysis" (Gregg 1999: 31). In her introduction, Douglas reminds readers that the theory of rational behavior presumes that each thinker is a sovereign individual. Rational choice seems at odds with the idea of true cooperation and solidarity that, arguing from Durkheim and Ludwig Fleck, Douglas claims would require that individuals share the categories of their thought (Douglas: 8). The Abrams lectures, *How*

institutions think?, are intended to bring rational choice and solidarity to a theoretical rapprochement. Douglas seeks to construct a better functionalist argument while addressing the objection that rational choice undermines any collective action that causes an individual to act against her self-interest.

Douglas builds outwards from a foundation in Durkheim's division of labor. If, as he argued, the increasing division of labor breaks down the shared symbolic universe on which solidarity was based in primitive society, then in industrial society, sacredness is "transferred to the individual" and solidarity shifts to become "dependent on the workings of the market" (Douglas: 13). Fleck's treatment of organizational structure, the gradations from thought collective (more bound) to thought community (looser constraints but still remaining members), works for Douglas to provide a positivistic counterbalance for Durkheim's apparent invocation of a "mysterious, super-organic group mind" that Douglas is wary of affirming. Douglas chides Durkheim for using "religion" as the escape system to answer the problem of the collective acting against individual self-interest. As Douglas reminds us, Fleck understood a system of knowledge itself to be a public good, thus religion cannot be the exception that Durkheim claims it to be.

Juxtapose to Douglas' anthropological treatment George Cheney's analysis of corporate rhetoric in which an organization is understood as a system of communication that involves the persuasion of individuals and groups (Cheney 1990). His case study revolves around the creation of the 1983 pastoral letter, *The Challenge of Peace*, by US Catholic bishops. At the center of his analysis is the question of how an organization maintains a traditional identity yet adapts to external change without risking the loss of internal authority and legitimacy. Citing sociologist Kenneth Burke, Cheney proposes to understand organizational rhetoric, literally persuasion, as the management of multiple identities as it relates to intended audience and organizational message. Though under-theorized from an anthropological perspective, Cheney recognizes identity as a focal point in contemporary social theory and emphasizes its role in the symbolic representation of perceived shared interests. Thus, Cheney addresses a lacuna in Douglas's

theorizing – how to make the move to observed phenomena in the contemporary world. His answer is to examine the development of position statements and other "corporate" documents of the organizational body, though he runs the risk of treating an organization as individual writ large. He considers individual principal actors as directional influences in the broader management of multiple identities but concurs with Douglas that the effect of organizations is to embody, read incorporate, decisions for individuals, setting categories for thought and fixing identity (Cheney: 164). They proceed from different frameworks; where Douglas uses Durkheim and Fleck, Cheney deploys Weber and Burke.

I discuss Douglas and Cheney to point to a consistent problem in anthropological inquiry that these authors begin to address. We can identify an organization as an entity, but it is not solely reducible to a group of individuals for it bears a collective identity. But when we speak of a religion or faith group, there is an appeal to that collective, supra-personal construction. But how does such an entity act, evaluate and prioritize, and then sustain those processes against the arrival and departure of individual actors within it? Religion and religious practice is necessarily concerned with the metaphysics of human experience, however, those concerns are acted out in the social realm and take on social forms. My subsequent analysis of documents and bureaucratic processes within the hospital system is set against participant-observation of individual actors and agent groups in hopes of filling in that analytic gap within this anthropological inquiry.

Ethics of discourse

A similar emphasis on the possibility inherent in discourse underlies the critical contributions to contemporary Catholic social politics of John Courtney Murray. Murray was a key contributor, if not central voice, of *Dignitatis Humanae Personae*, the Declaration on Religious Liberty produced by Vatican II. The Declaration expresses three doctrinal elements: an ethical doctrine of religious freedom as an individual human right, the political doctrine on limits

and functions of government in matters religious, and the theological doctrine of the freedom of the Church as the basis for relations between the socio-political order and the Church itself (Murray writing in Abbott 1963: 673). It is the third aspect that concerns us here.

Murray's broader works concerned the mode of Christian engagement with public life, asserting particularly a reliance on persuasion, rather than historically sanctioned coercion or manipulation (Hooper 1986, p.187-9). Importantly, Murray's effort to broaden the lines of dialogue were based on an authorization principle that recognized the active, ethical agency of the people in contrast to the hierarchical model of Church authority (Hooper: 82-120). The actual argumentation is complex, bringing in both historical observation and philosophical treatise, but the central theme advocates an openness through which not only the teachings of the Church but the Church itself as a socio-historical entity continues to experience moral growth. To fulfill its own mission, and to behave responsibly within the actual environment of the larger social world, requires ethical conversation – public theological discourse for the Church to its own,[10] and public socio-political engagement open to the possibility of moral, and even religious, insights that might arise outside of the Church, to which the Church should attend. It is these precepts for ethical discourse that affirms for the Church the secular value of religious liberty (ibid.: 169). Indeed, to return to Vatican II, the Declaration itself not only acknowledges non-Catholics and non-Christians but directly addresses them. The Response to the Declaration points out that the assertion of religious freedom begun as work among the faithful is "completed in the reshaping of the created order" by explicitly engaging these non-Catholics as audience and partner in social life (Abbott 1963, p.700) Such a folding back on itself is a distinguishing characteristic of White's weak ontology such that contestability is enacted and not simply announced (White: 8).

Understanding CPH as an ethico-moral project hinges on the fact that my informants actively engage in reflection and articulation of the purpose of their work and relate it to a larger teleology of social engagement. Their conscious efforts to link their actions to social and religio/spiritual values only begins with the superficial work of linking things to the literal "core

values" of the hospital corporation, as treated extensively in the chapter on mission and margin. It is most significantly manifest in the small disciplinary techniques of individuals, mainly in mission services, sisters and former sisters, who alone and together, conceive and shape an organizational culture that is more than just the action plan of organizational development (OD) in the Human Resources department. Rather, the explicit goals and objectives of the OD staff result from the tactical maneuvers of these mission agents.

Explicit processes: Exteriorizing interiors

As the lead ethicist in the system, Marie sees part of her role as she understands it is to make things explicit. She says of herself:

> ...understanding how those functions work, then I can make the connections....And one way to be effective is to learn more about other people's work. And then show them by not doing anything basically, how they're already doing what they think I do. They're already doing it. Giving it a name, giving it a language, giving it a legitimacy for conversation [that's my task]....

The idea of being explicit – of articulating an ethics – invokes concepts of authenticity and sincerity. Further, the intention that underlies naming – which the process of legitimation that Marie's comment points to – obliges us to recognize that a form of linguistic ideology is at work. Language use, in this sense, makes an interior state transparent through articulation. Sincerity reflects the idea that thoughts and words constitute a parallel discourse that correspond to each other; even though thought precedes the spoken word and shapes it, they match.[11] At CPH, the Mission Integration team has as its charge the articulation of an ethics of *catholicity,* particular to this collectivity of CPH. Marie's role, as she herself reports, is to engage CPH employees, physicians and other professional staff and assist them to see "how they're already doing what they think I do [as the nominal ethicist]" in their own work. That is, her efforts help her colleagues to be reflexive about their work in healthcare, undertaking ethical decision-making, and then ultimately, constituting CPH as an ethical collective entity. With this guidance, they are

able to make *conscious*, to make explicit the values underlying actions and thereby to extend into new spheres a *signifying practice*. Another sister put it this way:

> You know. It's the conversation that keeps - try to keep people on that thin line of integrity. And the fact that there's conversation around it probably is a very healthy sign.....You know. If there's no conversation around it, that might be a very dangerous thing, too, that everybody should think it's all hunky dory.

The earlier chapter on margin and mission suggests the social risks of insincerity, of mere lip service to values that do not, in actuality, reflect an internal state. We only ever have incomplete access to motivations; however, we also need to acknowledge that one's form of life is tied to the language that interprets the larger life-world within which that form manifests. Like etiquette, using religious language in the CPH context may merely be a matter of observing social forms. Both Taylor (1989) and Asad (1993) have developed the idea that an individual's interiority is the main site that can elude political coercion. It is unclear how such a view may reflect a broader protestant-ization that could be an element of secularization; the Calvinist view that actions and behaviors are external manifestations of an always-and-already elect is very different from the Catholic conception of spiritual practices wherein particular behaviors repeated can lead to correct internal states – a parallel I suggested in the discussion of *habitus* and the cultivation of virtues. Here, I want to think about the connection to Foucault's genealogy of ethical discipline that he argues emerges from the Christian conception of the pastorate, particularly, the idea that it is possible to know what is in people's minds (Dreyfus and Rabinow 1983, p.214). Taylor argues that the concept of having responsibility for one's desires and motives is distinctively modern. Foucault's work defines modern forms of subjectification through which the subject is "tied to his own identity by conscience or self-knowledge" – a necessary element to the functioning of pastoral power (1983:212). If his typologies hold as marked characteristics of modern subjectivity, life at CPH also suggests that there is a Catholic dimension to that subjectivity that carries threads of older forms through into the contemporary. The catholicity here is a subjectivity constituted through pastoral care that creates a collective

which undertakes to consciously care for the Other. *Communitas*, then, is both the collective that is CPH-as-organization that mobilizes external agents in society to care, as well as the group of Others for whom the hospital cares, or the social body from which the cared-for are drawn, what the hospital literature repeatedly refers to as the "community," as in community outreach, community services, community needs, or community assessment.

The Mission Integration structure, its functions and its members are a social intermediary that is key to pastoral power in the Catholic sense (see organization chart, Appendix). In Protestant conceptions, that power is understood to be internalized in the individual, thus obviating the need for an intermediary agent. The Mission Integration structure echoes too the denominational contrast between the notion of assigning holiness to a particular sanctified "priestly" group, relevant to the analysis of sisterly power and influence, over the more democratic ideal of a "priesthood of all believers," that I pointed to in the earlier analysis of mission and margin. The Mission Integration team occupies a "middle ground as social technicians articulating a normative or middling modernism" for the hospital system (Rabinow 1989, p.13). In CPH, the application of social technologies, like the mission standards, are deployed to cultivate norms and forms of caring and of community, emergent values motivated by a religious orientation. It is difficult to imagine a Catholic hospital without some form of mission agent. It is precisely the fact that ethical reflection and organizational self-fashioning is an articulated role tied to actually budget items and full-time equivalents (FTE) in personnel that distinguishes this Catholic system from its non-Catholic secular counterparts. Other systems and facilities may have organizational development staff within a larger human resources, but at CPH, mission and values extends well beyond organizational development because of the ontological legacy embedded in a religious history of identity. It remains to be seen the extent to which the mediation of the Mission Integration may be a transitional medium from the previous era of Catholic hospitals, replete with sisters, to new and emerging forms yet to be called into being. I am diagnosing a context that may be part of a larger transition, though in fieldwork that context

constitutes a distinct ethico-moral moment. Another way to conceptualize this development is to consider how mission integration might be different if it took place in a Protestant hospital. That is, can it be helpful to imagine this account as a sort of "protestantization" of Catholic healthcare: the diffusion of the values from religious specialists (the sister-sponsors) to the broader group (the priesthood of all believers) that in this sense follows a "secular rationalization" model as I have argued in the chapter on mission and margin.

The approach of Mission Integration Standards resembles a "theology of inculturation," a Catholic pastoral strategy that re-valorizes indigenous cultural forms and culturally specific expressions of universally translatable Christian values and themes. The "theology of inculturation" represents a reformulation of liberation theology, ascendant in Latin American in the 1970s and early 1980s but resisted and arguably co-opted by the Roman magisterium. Originally, liberation theology espoused a dissident pastoral approach articulating a class-based rhetoric for structural change grounded in Christian values; the theology of inculturation is a discourse of ethnic solidarity and identity politics. The reformulation is understood by some to be a conscious and conscientious project of the Roman magisterium to recoup the revolutionary theological doctrine of priests and bishops of whom Rome had become wary particularly in the revolutionary context of Latin America. At CPH, the Mission Integration philosophy seeks to routinize local appreciation of posited parallels between indigenous sensibilities and the values of the Christian founders in collaboration with the historical commitments of the secular, not-for-profit hospitals. For example, orientation for new hires at Incarnation Hospital is a program that is largely led by Sister Josephine. Standing in front of the assembly hall, in her lavender blazer and cream skirt suit, a dove and cross pinned to her lapel, Josephine is a living example of the religious origins of the hospital's socio-political legacy and she repeatedly uses the history of her congregation to explain what employees at all levels are contributing to in their new role within Incarnation. Down the road, at City Physicians' Hospital, the same new hire orientation program is led by Marsha Cooper, a registered nurse who has worked at City Physicians' for nearly 20

years. Beginning as a staff nurse, she has risen through management to become the Vice president for Patient Care Services and Chief Nurse Executive. Instead of setting out work at City Physicians' in terms of the larger religious history of Catholic Pacific Healthsystem, she begins with the story of a small group of physicians and their decision to build a hospital to serve the city and the demographic change that have shaped the facility's commitment to serving the needs of the immigrant poor, for the hospital sits between an established, wealthy neighborhood and a transient low-income area towards downtown. Marsha explicitly positions her narrative at the level of this secular community facility, that "is not a Catholic hospital" but sought out CPH as a parent system in order to sustain its not-for-profit commitment to the needs of the local populace. As an original site of the Catholic system, Incarnation sets its identity firmly within that legacy. City Physicians' spokespeople are wary of losing their secular history and make conscious efforts to distinguish themselves as community partners, even as their operations are increasingly regulated and standardized according to the dictates of the parent system.

Mission Integration standards build on the impetus of rationalization in care management and other operational functions, adapting by casting themselves as simply another system-driven process compatible with the locally accepted trends already underway toward greater quantification and reporting.[12] Mission integration agents see themselves as something other than another bureaucratic process; they perceive a purpose in their interventions that lends an additional dimension to their work. In the realm of faith and belief, "spirituality in the workplace" is something more than a vehicle for making the office more pleasant. Some see the department as the soul of the system; others are uncomfortable with such a designation, arguing that it reifies the perception of precisely the "priestliness" they are trying to dismantle in the diffusion of values and mission amongst all CPH employees and partners.

Our Patients, Our People, Our Future

The strategic plan produced by a broad swath of the various constituencies and guided by key actors in the CPH system office during my fieldwork brought new attention to organizational development and the focus on the system as a "learning organization." Indeed, when I first began participant-observation at the system office, I was welcomed in under the auspices of the Mission Integration department because Catherine perceived my presence at CPH – the outsider perspective – and the discussions that might ensue as contributing to that "learning organization." The strategic planning process was met with enthusiasm in Mission Integration because discussion of employee recruitment and retention began to focus on ideas of continuing education and training that could allow for succession planning. Furthermore, the planning process represented an opportunity to integrate the mission and values perspectives across the spectrum of CPH's action plan for all operations. Even the title, *Our Patients, Our People, Our Future*, suggested a trajectory and this resonated strongly with the mission agents who were still thinking over Luke's idea to adapt religious formation as a model for CPH.

The religious sponsorship of CPH and its Catholic hospitals, especially incarnated in the social vision of sister-sponsors stands out as a distinguishing characteristic that sets CPH apart from other not-for-profit hospitals. Evocations of Catholic identity may rub off on other Catholic players, but as the dominant Catholic system, CPH does not risk much in its geographic markets.

In the face of economic crisis, the system strategists in Strategic Planning and Corporate Communications converged on the religious history as a marketing message. That convergence indicates how the charisma of the past as an inalienable possession – our unique history of ministry -- can itself be used as a commodity. Thus, the media specialists in CPH Corporate Communications became unexpected collaborators with the Mission Integration department. Consultations were scheduled and people across the system worked to market the history of the hospitals, especially capitalizing on lay perceptions of women religious. This collaboration saw a resurgence in the language of healing and caring (as opposed to scientific or technical vocabularies) in system and hospital publications, especially caring for the whole person through

spiritual care, discharge planning, palliative care, and birthing suites that recognized the familial needs of obstetric patients. Telling those stories in CPH ad campaigns, website narratives and internal newsletters, recounting the redesign of wards and service lines as indicators of a historical religious orientation that underlay CPH also articulated how the system operations reflected mission and values. A cynic would see savvy approaches to niche marketing, a romantic ministry ideals. In truth, both things converged. To cast back to Mary Douglas's Fleck, from a very different context, "the development of knowledge depends on how the knowledge is expected to intervene in practical life. Thinking has more to do with intervening than with representing," (Douglas: 50).[13]

Expression, or articulation, is an aesthetic process. In articulating what we find within us, Taylor argues, we also make something manifest, and bring something of fundamental human nature into expression (Taylor: 374). Two distinct qualities characterize this act, first that which is brought to expression is "not something that was already fully formulated beforehand; rather its very character is partially constituted by the expression. Second, this curious quality of creating and\or discovering has to do both with the being engaged in articulation and the wider world (White: 59). In this sense, anthropological fieldwork too has an effect; during interviews and hallway conversations, my inquiries become part of the social processes through which articulation occurs. During the time I was part of their daily work lives, my participant-observation was interpolated in discourse and reflection around my informants' ethical stances and other aspects of their worldview.[14] Similarly, what is repeatedly constituted as "operations" within a hospital system, in fact, means people collectively engaged in a series of practices; "management" happens as a social exchange between people not in paper trails as such, though documents may be the medium through which that exchange takes place. Thus there is validity to observing meetings, strategy sessions, mission department meetings as a participant-observer that converges with the overall argument for the ethics of articulation: articulation has ethical effects derived from the possibility of reconciliation and collaboration.[15]

As I read Taylor and White then, the fundamental ontological center of gravity in moral life is the process of articulating moral sources and even perhaps, as Taylor has argued elsewhere, contributing to a refocusing on the good of a flourishing culture in ethical-political terms. In any event, when we ask how is such an ethic articulated, it is done in the language of an organization and its members. Syntax and semantics are fundamental elements of rhetoric. In this sense, they are political tools of persuasion. Language choice represents an aspect of how values are set; it is through language that mission is made explicit and how practices driven by CPH core values are set as an expectation. Language is thus a representation of a way of being, and as we know, representations are social facts (Rabinow 1986).

Language marking culture

In the chapter After Virtue, I recounted a comment about selectively hiring from the for-profit sector. This comment was heard in other venues, for I heard it reported back to the Mission Integration team as a whole in a department meeting one day. It was met with some consternation, and taken as partial proof of the need to aggressively orient new leadership to CPH mission and core values. Anthropologist Stacey Leigh Pigg writes of the incommensurability of language, and the social production of commensurability (Pigg 2001). I want to suggest that this may be a useful way to think about the efforts of Mission Integration to intervene in the perceived cultural ascendancy of the margin-oriented.

In her work on international public health interventions in Nepal, Pigg muses on how language can be used for political expediency (Pigg: 508). She turns to linguistic anthropologist Michael Silverstein's treatment of code-switching to illustrate how language practices can reflect tensions created by social difference and stratification. She goes on to argue that language can be a tool to reconfigure social position. I want similarly to suggest that the values language of faith, mission and values in CPH is used to soften otherwise blatant "business language" marked

concepts. "Languages and their locally recognized variants become emblems (iconically essentialized indexes) of their users' positions in a shifting field of identities" (Silverstein 1998, p.411). Thus, at CPH, the core value of "stewardship" can also be appropriated as the gloss for corporate right-sizing, itself a recoded term that began as down-sizing. Code switching as a social practice "must be seen as the socioculturally meaningful creation and transformation of interactional context through the use of entextualized forms" (Silverstein: 413). In her work on the problem of disease prevention in developing countries, Pigg uses this explanation to explain how AIDS education sessions are particular entextualized forms that are, in practice, communicative events that actually *aim* to transform interactional contexts by creating new forms of awareness. Thus the social complexities that underlie word choice as Pigg points out. At CPH, a strategic intervention by sister-sponsors or their allies in mission carries a similar transformative hope: they want to routinely re-categorize business practices as extensions of mission and core values.

I was present for a number of conversations among various managers and directors, as well as senior management about the use of the label, "corporate," for internal descriptions of the CPH system. One manager maintained that ever since some senior executives used the word, the sense of familiarity among people had changed. Another disagreed, blaming the changes on both rapid growth and significant staff turn-over in what were formally the regions and divisions, as well as the system office. When sister-sponsors heard this during the lunch before a governance meeting, there were discussions among staff and sisters about whether "company" had a softer tone to it, as in their sister-colleagues to the south in the Little Company of Mary. The political stance in the US that considers corporations as individuals with constitutional rights of free speech and other protections may resonate here. One explanation, given to me by staff at St. Catherine-by-Sea, shared the following:

> ...a legal 'corpus,' a body, [of] an organization that allows it to assume debt and make convenants that exist beyond the physical life of the people who created the company. Some... might observe that the problem with many modern corporations is they are...legal

> bodies that are without any spirit or soul. They are alive legally, but dead when it comes to having feelings that link the sols and spirits of those who are part of the corporation.

Someone pointed out that corporation really echoed "corpus" and liked the idea of the system as part of the body of Christ. This initiated a larger debate and some executives scoffed that this kind of semantics had little bearing on reality. When the Corporate Members convened after lunch, they discussed their discomfort with what seem like a language of a colder for-profit world, particularly given the CPH stance on access to healthcare as a fundamental human right. While they regretted the permeating effects of market capitalism, they were quite out-spoken on stemming the flow of military language into common parlance. One of the sisters reported that she had overheard a discussion among strategy department people about efforts to "kill" legislation by the state hospital association that tied community benefit to a percentage of net revenue.[16] Another sister agreed, saying she thought we could find a better way to communicate itemized lists than "bullet points," and "hitting targets." She expressed her disgust at recent news coverage explaining the US State Department and Pentagon's use of "collateral damage" to refer to unintended violence done to non-combatants, civilian buildings etc. The Corporate Members asked Catherine to communicate their concerns to senior management, asking them to endeavor to seek alternatives. "Our documents, our strategic plans, should reflect who we are and what we stand for, just as much as our mission statement and our investment practices," Sister Mary Frances told me, reaching for her meeting binder. Returning to the notion of the corporation as an individual, the sisters recognize their corporate documents as speech acts of a legally constituted person. This is why the choice of language is important. Policy and procedure are the means by which the public identity of the organization is presented and language constructs that representation.

Language is an issue, but one with multiple meanings for different people. The Corporate Members adopted the stance that even minor slippage could create an inappropriate familiarity with terms that otherwise connote violence and other aspects of culture that they did not want

their organization to foster. One politically active sister very much involved in daily operations of a CPH hospital's information systems shared this perspective:

> P: You know, with so many different professions, like in the health care - you know, so many people come from different strands of professional education, and they bring with it that language. So it seems to me that this is just - just my own reflections on it, so you bring in people, let's say, in terms of management or finance, they bring with it a management/finance language. Right? And - whereas, if you bring in somebody from the clinical side, they're gonna bring in a clinical language. So that - we almost have like a cacophony of sounds coming out from different traditions.
> You know, what I remember in higher education, when schools started trying to figure out - tried to figure out how well they were managing, we got into this long-range plan, and then we got into strategic planning, and I remember taking courses - and kind of smiling at the language. I remember back in the '80's, that the language was - in strategic planning - now, you were supposed to identify your cash cows and the dogs. I love that. I can't imagine going to the faculty and telling them that their medieval Latin was a dog and not a cash cow. But it came out - it seems to me that it came out that those words and that whole concept of strategic planning came out of an engineering tradition, or military tradition. You know, a lot of things we've learned, we learn out of the military organization, which is kind of interesting. Not - probably people wouldn't enjoy that, but a number - so that there's a - there - words are created out of certain disciplines, and then they - then they're borrowed by other disciplines, and they adapt, because everybody's adapting, trying to get the best ideas in order to function. But we bring in these words, like cash cow and dog (laughs). I used to think of that, and I thought, oh, my, I could figure out what the cash cows were at this college, but I sure wouldn't want to tell anybody that they were dogs, but obviously, they were the ones that we're losing money on, you know. But you know, to an engineer, that would just roll off the tongue - they'd roll that out without any sense, right? Now, in the sense of ministry, you're more concerned about the feelings - can you imagine using that language? ...
> The concept made sense. You're continuing to give this class, and no one's taking it, you're paying the professor, right, the context was fine but the language was way off. So I remember, even in some of our schools, the faculty would be horrified, if we were talking about strategic planning, because they thought it was just so - I mean, out of our culture. Well, of course it was a way of saying, lookit, we've gotta be realistic about what we're doing here, right? So we get into - now, this is just - I'm thinking - but anyway, when you get into a system, where you're trying to bring in people with a variety of skills - financial, legal, clinical, whatever, clinical, ministerial, right, the chaplains are not gonna - right, they're gonna be horrified with some of this language. So - and I hear some of our people - not often - I went back there and I don't pay much attention, but occasionally I've heard people say, oh, you know, the language at corporate office is so – harsh and military. Well, I'm wondering if ... There's a good possibility that they were attracted to the system and what it stood for and its values, but the language that they speak hasn't quite caught up with it. I don't know if I see it as some kind of a - you know, a plot to destroy the organization. You know. Does that sound too wild?
>
> I: Yeah. I think it's largely unconscious.
>
> P: I do. I think - and I think we are great imitators. We pick up words unconsciously and find ourselves repeating something, if we're associated with people who kind of, will phrase - use a phrase we hadn't heard before, and it fits, and we find ourselves borrowing it. So

> there's a lot of imitation in language. And [the hospital's senior vice president] would probably say, "she's off the wall." But - so I don't know if - if we can say that the system is headed for - is headed for bad times, or that we're getting off course with our values system because we have all these mixed expressions that are there. I think more important is what we do. You know, how - people can talk about having values, but when you look at your budget, and what do you spend, does it reflect your values. That to me is what's real. That's where it's right, whether I'm coming from an engineering school or a military school or medical school or theological school, it seems to me, the values are really reflected in the decisions. Long-range planning and strategic planning essentially goes nowhere unless there's a decision-making mode that goes with it, right? It's the decision-making mode, to me, that's the heart of the matter. And that's really what the problem is, you know. But now, you're probably more in tune for that than I am, and maybe hear more about that [mild expletive] language, but then see, and I probably would be less sensitive - maybe I should be more sensitive to it. (laughs)

Furthermore, as anthropologist Stacey Leigh Pigg suggests, there is also a power element at work in the substitution of language by Mission Integration. Language choice (calling it stewardship) reintroduces the hierarchical structure of the organization. Even the sister-sponsor quoted above uses terms of an economic/financial origin: cash cows; the language of capitalism is ubiquitous. In CPH, users are cognizant of where particular language choice comes from, and why it is being deployed.[17] Those lay staff who dismiss language terms as insignificant nonetheless change the terms they use in speech and organizational documents. The power/influence of the sponsors may be the cause, and lay staff may retain their skepticism about the actual effects of such semantic juggling, but the result is that values are made evident in the products. Transformative ethical effects take place, becoming habit, and such practices repeated result in new internal states at the organizational level. Some might argue this is also true at the level of the individual.

Code switching does enable entrée into particular levels of social legitimacy: medical in the case of Pigg's Nepal, and in the conference rooms of CPH, religious. Just as mentioning "charism" marked me as a mission ally for sister-sponsors and former sisters because I can "speak catholic theology," it mattered to my field informants in operations and administration that I could toss about the language of managed care contracting, the economics of physician reimbursement and banter about "DRG creep" and the significance of Medicare waivers. While

my label as an anthropology researcher made people uncertain of my position, my graduate student status allowed me to be categorized as a subordinate, and my use of coded terms from the business of healthcare made me something of an insider. I am trained in the modalities of public health and healthcare administration, and I care about the practices of the organization in the social world. This suggests the complexity of complicity that may be inherent to anthropological inquiry.

To import yet another insight from Pigg's concept of the social production of commensurability, in the healthcare setting, specifically here in a hospital system, two dominant epistemologies of medicine and business together organize arenas of life and social interaction. Both demand recognition and, as the sister quoted above points out, invite emulation. Catholic healthcare ministry, as a configuration of both "not-for-profit" and religio-spiritual values, continually seeks to resist the dominant epistemologies, at once trying to engage them as vehicles for its own ends, while avoiding co-optation within those efforts. The task of mission integration is to facilitate engagement without being marginalized as simple window-dressing. While it may be that the margin makes the mission possible, the mission makes the margin necessary. As the last quote of the sister above emphasizes, the concern of ethical practice does not end in language use and speech acts. Action, "what we do," is important for talk is cheap; budgets and spending reflect real values. Later discussion of an explicit "process for ethical decision-making" will link these two sites of concern.

It is the practice throughout CPH for an individual participant, assigned in advance on a rotating basis, to read a "reflection" before any meeting, both large and small. This represents a mapping of morality into each operational session at CPH; no matter what area of concern, the participants and guests are obliged to observe a moment of reflection that calls people to the task at hand in the context of an organization founded on religious values that bear directly on their mission in healthcare that day. The practice that began with the sister-sponsors has been codified

into corporate system-wide policy in the mid-nineteen nineties but was re-affirmed in the mission standards created in 2002:

> *Mission Standard 9*: CPH promotes spirituality in the lives of its co-workers and in the work(s) of the organization, (d) All gatherings and meetings begin with prayer/inspirational reflection.

Because each person who "does the reflection" is free to chose their own selection, the practice allows for the diversity of the employee body while still creating an ethical space that derives from the religious heritage of its sponsors.[18] Consequently, there is general acceptance of this practice in the system office and many of the hospitals, especially the traditionally Catholic facilities. At Denomination North Hospital, however, the management meetings over a three month period rarely ever began with a reflection, except for the new staff orientation session. There, the reflection provided an easy entrée into a discussion of the hospital's culture, and what it meant to be a part of Catholic Pacific Healthsystem.

Senior management at Denomination North happily trotted out the obligatory reflection for conference calls with the system office, but its reading would elicit smiles and twinkling eyes from the on-site staff. Denomination North holds on tightly to its secular community identity, exacerbated by its competitive history in the local geography dominated by the ancestral group of hospitals that co-founded CPH. The resistance to reflections is allowed by the hospital president as a gesture of good humor for a management staff that has been struggling to keep the hospital successful, particularly because he feels that the hospital is a leading example of a mission-driven facility suffering as it is from rapidly changing demographics. This hospital serves a largely indigent population on insufficient Medicaid reimbursements and a new specialty center down the road that does out-patient surgery and obstetrics is a significant challenge to patient flow as well as a dilution of Denomination's marketing efforts. Run by the other leading not-for-profit hospital chain, the new center seems to skim the self-insured patients from the community pool. Nonetheless, Denomination manages to do well and is quite respected within the CPH system.

Interestingly, even finance and business management staff have adapted to the organizational expectation of an opening reflection; one vice president of finance at a southern hospital read from Adam Smith at a revenue stream meeting. Most people exert themselves to find poems, literary references, inspirational anecdotes or new stories, often combing the internet or soliciting their friends and family for good "reflections" that in many cases seek to address the task at hand. Some staff people find it easy to read selections that are overtly religious from a range of faith traditions, others reach for quotes from Ghandi, Thoreau or Faulkner. After September 11th, and throughout the earlier Gulf War, many selections were culled from translations of the Qur'an or quoted from leading Arab intellectuals with the specific goal of consciousness-raising during a difficult time. Many executives keep a file. There is a thriving CPH intranet barter trade in reflections shared between co-workers across the system, and people recommend colleagues' selections to others in different departments over lunch and coffee breaks. I have even heard people introduce an out-of-town colleague, as in "Oh, you'll remember Sheila, she read that great reflection on homelessness for the video conference last fall."

At a system board meeting in the fall, the board member who had been earlier assigned to lead the opening reflection was sick. The board chair appealed to a sister-sponsor and asked her to fill in. Putting aside her breakfast orange juice and smartly pulling her chair up to the table, the sister said: "I knew it, I knew it. We have to change the culture so that it isn't just Sister who can *offer* a reflection." She responded with good humor, but her point was not lost on the group some of whom looked sheepish at having dodged the appeal to lead. The practice of reading a reflection represents a commitment to catholic (in the universal rather than sectarian sense) pluralism that nonetheless resonates with a Catholic tradition of mission, understood here as workplace spirituality. The intent is to systematize an explicit articulation that reflects an organizational identity through ritual practice. Conformity is expected, but how one conforms is individualized and demonstrates an accommodation of intra-group diversity across the CPH system.

In his examination of international health interventions, P. Stanley Yoder posits that operative intervention models treat culture "as a set of beliefs, values and individual goals that pattern behavior....individuals are constrained by their image of normative action as they seek to conform to the values of their society" (Yoder 1997, p.135). At CPH, Mission Integration uses language as a tactical tool within a broader strategy to set the organizational expectation of an articulated mission and values to which business practices, and other social behaviors, are expected to conform.

A problem of distinctions

But is there a *real* distinction? Both Talal Asad and Charles Taylor have made the suggestion that language differences can, in fact, be used to mask the absence of true difference. Asad notes:

> Some ways in which symbolization (discourse) can *disguise lack of distinctiveness* are well brought out in MacIntyre's trenchant critique of contemporary Christian writers, where he argues that 'Christians behave like everyone else but use a different vocabulary in characterizing their behaviour, and also to conceal their lack of distinctiveness.
> (Asad 1993: 33)[19]

What then is real? How does a group constitute a cultural mode of allegiance to particular linguistic forms? As the example of the sister who decried "collateral damage" suggests, dramatic differences in metaphor that play themselves out in language are representative of larger issues. Ruth Shalit, writing in the New Republic, raised a parallel question for the emergent industry of bioethics consultants (Shalit 1997). Shalit asked: "Just who [are] the ethicists really serving? A swelling corps of HMO utilitarians are cashing in on their ethical expertise, marketing their services to managed care executives eager to dress up cost-cutting decisions in Latinate labels and lofty principles" (1997: 25). But does such labeling only signify a politically expedient strategy in

the CPH setting, or are other dynamics at work? One researcher uses the phrase "the language of reflexive spirituality" to describe the way in which people seek to relate to religious meaning.[20] That approach asserts this language use acts as a cultural resource that my informants use to re-ground modern life that may share the transcendent quality of a concept or experience without necessarily agreeing on the content or meaning that emerges from it. What is useful here is the emphasis on religiosity's cultural, communicative dimension. Modern expressivism, post-appeals to nature, reason, post-Schopenhauer, post-Nietzsche, "our sense of the certainty or problematicity of God is relative to our sense of moral sources" (Taylor: 312). As White argues, what that means is that God as a moral source is functionally related to subjective articulation, or as Taylor seems to argue, "theology is indexed to the languages of personal resonance" (Taylor: 512). The ethos of CPH is one that recognizes these dimensions and seeks to foster them within the bureaucratic processes of corporate operations.

Sisters in governance, and mission integration staff have consistently encouraged language awareness, most particularly in strategic planning-related meetings. Marking language choice as culturally significant at the governance level initiates a policing effect in management. And as language choice and term sensitivity becomes an explicit expectation, mission integration opens a space for further discussion of motivation and the values that should drive decision-making according to the precepts of this (C)atholic organization.[21] Operations practices are endowed with explicit mission/values dimensions by marking risk management and resource/supply chain management as functions of stewardship, as well as the more obvious management of investments. When the vice president presents her quarterly report at the board meeting, it is the "Stewardship Report" that she reads detailing the state of revenue and expenses from operations and investments.

The struggle for CHP is to resist the tendency for operations managers to simply dress up decision-making processes in the language of Catholic ministry or social teachings. This is a challenge because administrators want to make their projects and decisions appealing to

governance—board members who want to be ethically sensitive, as well as the sister-sponsors who hold the final say. For example, at an executive meeting, the topic at hand was how to hold executive attention to system dictates, and particularly whether a traveling in-system consultant team would ever be utilized by local facilities. Here is an excerpt of the dialogue around the table:

A: what would it look like? How to pay or reward, down at the granular level, who is our audience?
B: Process-wise, yes, but what about the goal. We are "stymied."
C: I question what is appropriate to establish the driver of leadership attention; I want to see 25% of the time, not 5% of time for each president.
D: On the 27th, give to the message to the hospital presidents, articulate the expectation. Make it part of the fabric of operations, to make them decide if they need outside help.
B: It's about internalization, yes. So how do we do this?
A: Make the mission values connection, I say. Frame it as dignity, that'll sell better than the economic perspective.
E: Yes, I agree, push the connection between HR and mission/values integration.

There is an explicit appeal to mission language as something that allows another goal to be cast in different objectives. Economic motivations are perceived as somehow less palatable than changes set forth as mission values. It is a risk that the language will simply be appropriated without the possibility of ever achieving actual values inculturation. It bears saying that not all values-driven decisions are easy or painless, just as religion or spirituality in healing is not limited to the warm and joyful dimensions of human experience.

Mission Integration stake-holders hope to ensure that they are engaged in the processes from the ground up, to truly integrate ethics and values into processes well before administrators begin to consider how to market plans to their governing boards. This is where the Mission Integration department as staff are critical to the ethics of articulation because they are a part of the daily meetings and routine functions of the system and the hospitals. This is why a chief objective of the Mission Standards was to set the expectation for Mission leads to be part of senior management in each facility, and why a new job description and competencies were circulated to presidents as part of the new standards to which they'd be held accountable.

Earlier, I suggested that equating corporate right-sizing as an enactment of the core value of "stewardship" is problematic and unresolved. Dr. Panicola, the system ethicist from St. Louis,

would argue that such an equating in fact becomes something else. He might assert that such executives forget that the mission is original justification for operations and that everything must be interpreted in that light. As we will see, at CPH the equation is still heatedly debated at the capital allocation meetings and discussion of the system portfolio. There, a vigorous argument is made that without successful operations, there is no surplus for charity and other mission endeavors. Consequently, facilities that cannot be made revenue-positive must be sold. The role of mission integration lies in a process to support "ethical-decision-making" that the system has developed to work through these concerns in an explicit way. Once the decision to sell is made, for example, how will it proceed and what considerations must be made to ensure that the needs of that geography continue to be served.

As the system ethicist for CPH, Marie was a key actor in designing what came to be called the CPH "Process for Ethical Decision-making" (see Appendix D, latter section). These process guidelines offer "a way to explicitly review options in the light of the values of our Philosophy Statement," asserting "some decisions clearly touch the heart of what we are about, affect many people and shape our future because of the critical choices that are being considered. In these instances we want to be as clear as possible about our values, our multiple responsibilities and our Mission." The guidelines for conducting the process specifically invoke a tradition of ethical reflection with a Catholic syntax: "We witness to Mercy and Truth when we pursue integrity of word and action in our life and in our decision-making."

The guidelines were never intended as a guarantee of an ethical decision, rather they articulate a procedure designed to elicit a social process of convening, reflection and discussion among multiple stakeholders from across the system, or a hospital, with the explicit intention of bringing the core values directly to bear on a problem facing CPH. The process expressly recognizes that such a social process could require multiple cycles to move participants forward. Those stakeholders in the problem, not all senior executives, prepare a summary explanation for review by the senior management team, again at the system level or the hospital as appropriate.

An example will illustrate how the mission-oriented dimension of the process for ethical decision-making aligned with the concerns of operations executives for a centralized system strategy for CPH.

During my fieldwork, healthcare organizations across the state of California were beginning to engage with state and national projections that indicated an enormous shortfall in the nursing workforce needed to provide care into the 21st century.[22] Several hospitals in the system had initiated efforts to address their individual facility needs and at least one member hospital had undertaken plans to recruit nurses from developing countries for relocation to their service areas. In February 2002, the system office recognized that member hospitals were moving ahead without a systemwide plan; somewhat belatedly, they convened a Foreign Nurse Recruitment Summit. In this forum, consultants reported information other systems showing very mixed results and a team from regional division of the CPH system showcased its experiences as "lessons learned." Unfortunately, it was clear that go-it-alone initiatives were not consistently successful and the duplication of preparatory work was not cost-efficient. Moreover, as 2002 progressed, several nurse executives expressed concerns voiced by their staffs around the system, raising questions about the ethics of a foreign recruitment strategy.[23] The new relationships with healthcare worker unions contributed to the complexity of the issue for CPH and the sister-sponsors, particularly those from congregations with histories of Irish nursing in the US, had made it clear that governance was interested in nursing staffing solutions that were in keeping with the system's mission and core values.

Many stakeholders were uncertain about the implications of such a strategy, namely ignoring local education needs and job creation opportunities, "brain drain" in developing nations, ethnic and racial prejudice, acculturation, financial investment, short term objectives and long term goals. In a different vein, system senior management wanted to ensure that CPH would be able to adopt a uniform plan that would best leverage the system's resources as a whole. The sister-sponsors in governance and the system CEO imposed a system-wide freeze on new

recruitment efforts abroad. A leadership group of chief nurse executives, business development and strategic planning staff approached Marie for guidance and the group decided to implement the "process for ethical decision-making" to work through their concerns in an ordered and engaged way.

The guidelines and practices that Marie and her colleagues developed goes beyond the policing of language that I earlier documented to actually foster social practices of group reflection. Identifying the project as an ethical undertaking within the organization seems also to diminish the gate-keeping normally exhibited by functional areas concerned wary of surrendering control of an initiative's direction. In this case, business development, care management and senior nursing leadership were positioned as co-equal collaborators (a core value) where their respective competencies were called on to deliberate over the ethics of a proposed project. Under the cover of "an ethical problem," stakeholders were more disposed to take in broad considerations of the proposed strategy rather than blindly championing their disciplinary perspective and the needs of their department. Moreover, during the deliberations that Marie led, the participants were visibly determined to think through the issues and earnestly conscientious about giving each other time to sit with an objection as well as to raise new angles. In its ultimate effect, casting the problem as an ethical issue also allowed the system to centralize control of foreign nurse recruitment planning. The usual asides and grumblings of local facility management that "corporate was taking over again" and "no one that understands that our local issues are unique" were noticeably absent. In fact, several participants commented informally that they felt the system leadership was taking their fears seriously in providing a forum for a sustained treatment of the issue among colleagues from distant geographies within Catholic Pacific Healthsystem. The final recommendations to system senior management called for CPH to approach a foreign government directly and to seek formal permission to recruit nurses with the goal of avoiding the exploitation of developing countries. The recommendations also insisted that

CPH commit resources to local service area training programs to facilitate job creating and tracking within the US.

It seems that people perceive an "ethics problem" to involve determining the good and right action from wrong. Further, while everyone wants to "be good" and "do the right thing," only Marie is a recognized "expert." As a result, there is little jockeying for control of the process by participants, rather casting it as an "ethics problem" sets it in a different light that participants approach differently. The process for ethical decision-making creates a space for group process to go beyond the particular goals of an individual department or function to enable multiple facilities to work together as an actual unified system. Ironically, mission integration in the form of the process of ethical decision-making seems to benefit from the "otherness" associated with framing an issue as an "ethics problem."

After my fieldwork had ended, I learned from another staff person of an internal quandary within CPH about advocating against increased development of specialty hospitals with one state legislature, while simultaneously opening one such CPH hospital in another state service area. The ethical decision-making process was again implemented, this time at a higher level of management, highlighting ethical dilemmas between maximizing reimbursement and providing better services for more seriously ill patients. Participants floated a justification about not-for-profit cost-shifting that allocated revenue from one source to cover expenses, like charity care or other services oriented towards the poor and the uninsured. The discussion extended beyond the particulars of a new services to consider CPH and its larger social role.

Perhaps the most fraught context for engaging seriously with explicit mission and values criteria in system decision-making lay in the work of the Capital Allocation Committee. Catherine's involvement with Luke's senior management operations team led to the incorporation of particular mission criteria, like service demographics and other annual targets for established levels of charity care and community benefit activities, in the evaluation matrix that the committee used to determine if a hospital would be successful in petitioning the system for access

to capital in a quarterly cycle. For the first time, mission criteria formed a formal necessary condition along with financial performance targets and utilization reviews. Again, as with foreign nurse recruitment, casting a possible operational change as a concern for mission and values enabled system leadership to bring local facilities into line with a centralized plan or strategy while using a transparent process to allow individual factions to make their case and express their local perspectives.

As the system moved through its operational reforms and management restructuring, system management also began to consider an internal assessment of all forty-plus hospitals. Acknowledging the problems of history of such rapid organizational growth and hospital acquisition strategy, the system management team began to collect data in order to assess the individual hospitals that might be "weak or low performing assets." This internal assessment, alternately called a "portfolio review" had to be carefully presented not only to allay rumors that would travel across the system generally, but specifically to temper the reaction of sister-sponsors who might react viscerally to the idea of abandoning a ministry in particular areas, particularly the emotional commitment to a facility that a group of sister might have managed for over a century, not to mention the potential unmet needs of the community around the hospital. Under-performing assets more often than not meant exactly those hospitals in depressed areas without an insured, employed population but with plenty of poor and working-poor families who relied community facilities, both religious and secular, for their healthcare needs.

The application of the process for ethical decision-making here suggests what could happen were such a process not explicit within operations. In a national environment predicated on healthcare as commodity acquisition within a framework of for-profit capitalism, it would be easy for the priorities of margin to eclipse mission. Management decisions that might result in reductions or closures of service lines, never mind whole facilities, must be reviewed against a criteria of purpose to ensure that operational decisions are not merely business-expedient. It is important to emphasize that the process does not guarantee that the resulting action will not be an

identical end, but that the means to that end are consistent with the greater mission and core-values context of the organization. Further, mission and values provides a more neutral ground over which to convene and unify disparate perspectives (the local facilities or functional groups within hospitals) in a way that facilitates central system leadership and oversight. Through these examples, the organizational behavior of CPH demonstrates how margin and mission can be mutually constitutive when mission integration department perspective is engaged with operations.

Translation

In *Writing Culture*, Talal Asad writes that "the process of cultural translation is inevitably enmeshed in conditions of power" (1986:163). The faith-based hospital organization is still speaking from within a framework premised on the for-profit worldview, no matter how values-driven it may be. But within CPH, the role of sister-sponsors in governance, as the Corporate Members who sit above the CEO *and* the board of directors, deploys power relations to set expectations, even if it is counter-cultural to the rhetoric of the free-market economy in the United States.

Translation is transformation, following Walter Benjamin. There is no one-to-one correspondence; the hybrid forms that emerge from translation are subject to reigning dynamics of power, and of inequality. Having worked through a schema to describe the power\influence dynamic that results from the historic and continuing presence of sister-sponsors in the CPH system, I want to trouble the power relations suggested by opposing margin to mission. Sister-sponsors occupy the highest position of official authority. As one colleague wryly observed of the Corporate Members, "if there is a buck at CPH, it stops there." CPH had become an operating company undertaking significant steps to centralize control. Consequently, the system that had been nominally Catholic but was, in reality, a diffuse assemblage of different kinds of hospitals

sheltering under a Catholic umbrella now finds itself a Catholic hospital system in ways it had not been before.

As Asad suggests, using Christian language has meanings and effects, though they may be indirect or other than intended. For some staff in community hospitals, even their presidents, Catholic language is threatening. Allegories, allusions, evocative descriptors that would go unremarked upon in a facility with a tradition of religious sponsorship, in a community facility can make people nervous. I have suggested elsewhere the significance of language labels in the context of hospital facilities with differing histories and identities with regard to chaplaincy versus spiritual care services (Lee 2002, p. 343). At the traditionally religious Incarnation Hospital, clinical pastoral education (CPE) is provided through the Chaplaincy Department, while in the traditionally secular community City Physicians' Hospital, CPE is based in the new department of Spiritual Care Services. "Chaplaincy" has a specific connotation in the Catholic context. I draw attention to that correlation because my observations occurred at the particular moment when pastoral care provision was extended to a new community partner in a religiously-sponsored system. The administrators planning that extension of service were sensitive to cultural nuance, and sought to dispel any anxiety at City Physicians' Hospital that "the Catholics were taking over." Consequently, while the CPE program was identical in the services it would provide at each facility, the distinction in labels revolved around the perceived different between "religion" as a social organization of belief and practice within a particular faith community (e.g. Roman Catholic, Methodist) and "spirituality" understood here as "the experiential integration of one's life in terms of one's ultimate values and meaning," without the institutional element connoted by "religion" (ibid.).

Using a theological or religious lexicon is not evangelism or proselytization in the sense of an effort to convert people to allegiance to one doctrinal institution.[24] That language choice does however constitute an explicit attempt to win over a business-orientation to an organizational culture that has a particular sense to how people speak and behave in the idea that

the ways that daily hospital operations or system office practices are undertaken should articulate with the collective ethics of the organization, its mission and its core values. One might ask whether what I have documented describes competing values systems, or competing truth claims about the world. That is the heart of Catholic identity.

Faith in Agency

A substantial counterculture element to religious life involves the valuation of virtues, like humility and modesty that are no longer appreciated in the same way by secular society. In the modern world, post-feminist activism, such traditional virtues are often associated with passivity and inaction. This association works at one level if the analytic reference point is an emancipatory agenda framed by the "flat narrative of succumbing to or resisting relations of domination" (Mahmood 2001) posits that operative intervention models treat culture "as a set of beliefs, values and individual goals that pattern behavior....individuals are constrained by their image of normative action as they seek to conform to the values of their society." But there are other frames through which to view these virtues that are more applicable to the situation of the women religious at work in Catholic Pacific Healthsystem.

In her writing on the women involved in the Egyptian Islamic revival, anthropologist Saba Mahmood posits a definition of agency "not as a synonym for resistance to relations of domination, but as a capacity for action that historically specific relations of subordination enable and create" (p.203). This supposition is provocative within feminist discourse because, as Mahmood writes, feminism maintains a dual character that is both an *analytical* and *politically prescriptive* project (p.206). Such analyses then are largely built on a foundation of liberal assumptions about emancipatory frameworks; thus, agency is understood "as the capacity to realize one's own interests against the weight of custom, tradition, transcendental will, or other obstacles (whether individual or collective). Beyond Mahmood's effort to parochialize the normative feminist subject, the significance of her scholarship lies in the move to account for

contemporary women who explicitly constitute themselves as ethical subjects in and through the very structures of religiosity, supposedly oppressive, from which liberal theory would ostensibly seek to free them.

A theme in this dissertation is the heterogeneous character of what it means to be "Catholic" in contradistinction to what is often an unexamined presumption of uniformity. Such presumption is understandable given the voice the Church often deploys, the historical and publicly visible individual Holy Father and his magisterium, independent of the theological implications of the Apostolic Authority of the "one, holy, catholic, and apostolic Church. The diversity of peoples who call themselves Catholic, as well as the countries and nation-states that identify themselves as Catholic, is such that that cultural manifestations of what that identity and faith in practice may mean to lived experience are worthy of anthropological analysis.[25] Just as Mahmood's work in Egypt has shown us, analytical and political distinctions are easily erased and forms of life and self-fashioning are flattened out obviating the significance and meaning such efforts hold in people's lives.

A character of Western modernity is some acknowledgment that the dominant conversations have "often been carried out with a false, universalist self-understanding" (White: 57). Catholicity, or Catholicness, may play out as an identity theme that is diverse and variable, but the Church always mounts a universality in a hegemonic claim; certainly, the history of the Church in early Europe engaged a constitutive cultural hegemony. Today, the Church proper still represents one of those dominant conversations, a historic "strong ontology" emerging from a doctrine of the singular Truth in the One True Church and invested with that particular history of Church as sovereign nation-state.[26] But the nature of identity within the push-pull dynamic of power and resistance is such that there are niches or margins even within such a universal claim, and a consequent diversity and variability with regard to what the lived experience of Catholicness might be. It is useful to recall Foucault here because the genealogical method draws attention "to the way dominant conversations might contain hegemonic silences or may be drawn

into certain paths rather than others simply through the subtle force of dominant discursive formations" (Ibid). It is my contention that we can understand the sisters' identity/ethical articulation as happening in such a space in between. It is from that space that the sisters and their organization comes into being.

The sisters act in their capacity as ethical agents whose spiritual convictions give them an official role within a religious identity and institution, not from within a framework of oppression or domination. It would be a mistake to characterize the experience of women religious as "marginalized" or "peripheral." Such descriptors are referential and always demand, peripheral to what? In their own mission and ethical constitution, women religious are the actors and the center. There are historically situated structural constraints to how that role was constituted, drawn up as it was in a masculinist theology, along lines of biological sex then articulated in terms of ecclesiology.[27] But, as Mahmood has argued in her ethnographic engagement with contemporary Egyptian women, an analytic that reduces these experiences to a simple narrative of religious oppression or false consciousness and then narrates "moments of disruption of, and articulation of points of opposition to, male authority" does violence to the ethical reality of the women religious (Mahmood: 206). When you speak to sisters about the facilities, they clearly refer to them as "our hospitals." Moreover, the tenure of their ministries in many locales signify their moral commitments to the healing mission of the Church, quite distinct from local churches, missions or new cathedrals. Indeed, in the course of years of interaction with Catholic Pacific Healthsystem, the sisters and their colleagues rarely if ever made reference to the works of their religious brothers (fathers?) in the Church. As I indicated in the chapter discussing dynamics of power and influence, I must emphasize the independence that the sister-sponsors articulate for their own ministries. As Gene Burns has written, "American sisters with a quite different set of priorities than the bishops, are an excellent example of the power of the powerless to turn their exclusion into an asset of autonomy" (1992: 5). Some sisters have bluntly drawn distinctions between what they call the women's Church and the men's Church. Consequently, when the

sister-sponsors speak of the "Mother Church," they are invoking a very different political and theological entity than that which the magisterium imagines when it uses that term.

Scholar Wendy Brown, who has written extensively on the interstices of political theory and feminism, argues cogently to the limitations of what she calls "injured states" (Brown 1992). Her analysis points up the challenge of basing a political analysis on the basis of a perceived identity based on having been wronged. In her thesis, speaking from a concretized identity of oppression can never be liberatory because the terms of one's very ethical constitution are fixed, bonded to those lacunae. The sister-sponsors and their healthcare ministries in CPH do not proceed from such concretized identities. They have distinct and explicit faith in their agency.

Philosopher Charles Scott engages the implications of the tendency of ethics and politics to drift towards universalization and a consequent tribalism (Scott 1996). In this respect, his work echoes Connolly and others I have engaged elsewhere. I want to be mindful of my informants within CPH who try to walk that line with care, both maintaining the historical tradition of an originating organization (the Church, their Sponsoring Congregations) that asserts a transcendental notion of the good, and the lived reality of the indeterminacy of normative claims when they extend beyond communal standards and habits (as in sponsoring a community hospital, or serving a non-Catholic population through a religious hospital). It is a challenge to sustain such an affirmative ethical identity, cognizant of fears for the loss or erosion of ethico-political sensibility, while remaining open to the possibilities that pluralization may bring to even stronger reconfigurations. As one Corporate Member insisted: "We will not become catholic-lite."

Bridging the individual: sister-sponsors to ministries

The central current of the work of Peter Berger is a consideration of how groups, as well as individuals, construct meaning and create the relevance in their world out of a range of life experiences (Beckford 1989: 87-107).[28] Rather than following Parsons' appeal to normative

functionalism and systematicity, Berger's method emerges out of symbolic processes and social interaction. Not surprisingly, his earlier work includes several collaborations with Thomas Luckmann, one of the first sociologists to treat the phenomenology of Alfred Schutz in English. For Berger, the creation of meaning ties intentionality to individual action (externalization), that is cemented in community (objectivation (sic)) in the forms of belief systems, institutions, ideologies, moral codes (Berger 1967: 8,11). These social facts come back to the individual (internalization) as standards for discourse, acceptable behavior, and credible explanations of reality (Berger 1967: 15). Only the organization of these meanings (knowledge), and their symbolic counterparts, provide "structure" and even then only through intersubjective, collective participation in those symbols (see also Wuthnow et al. 1984, p. 25). Berger avoids the simple structural-functional tautology by always returning to the individual as the site of legitimation. The challenge becomes discerning how legitimization for the individual transfers to the organizational level.

This is precisely the ethical effect behind the concept of canonical sponsorship. Having demonstrated the ethics of articulation, I want to move now to the implications of such an ethic in the context of additional values, particularly the non-Catholic worldviews of the secular community partner hospitals and the communities that make up the service areas of CPH hospitals. With an anthropological description of that ethos of pluralization, I can then address what that means for *catholicity* in terms of the transformation of sponsorship that the sister-sponsors have brought into being in the governance of their system.

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[1] An excellent treatment of the "conceits of secularism," particularly with respect to resolving the challenges of contemporary social pluralism, see (Connolly 1999).

[2] Sociologist Peter Berger has repeatedly noted that the far better project is to explain why the professional knowledge industry is not theistic (Berger 1992); a more recent essay considering this phenomena is (Brooks 2003). It is worth noting that Berger is a Christian and has written several works specifically engaging the experience of working as a Christian sociologist. e.g. his recent *A far glory: Faith in an age of credulity*, 1992, as well as the earlier *The Precarious Vision* 1961.

[3] Practices, which is what this chapter is about *after all*, are the forms of "socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to... that activity...with the result that...human conceptions of ends and goods are systematically extended" (MacIntyre 1984, p.187).

[4] The biography itself is a by-product of the historical documentation that the author, a Sister of Mercy, submitted in support of the Cause, the formal process by which the Roman Catholic Church considers individuals for advancement towards sainthood. In 1990, Mother McAuley was elevated to the level of Venerable. The official recognition of the works and dedication of their founder acts as a reinforcement and validation of the active charism of contemporary Sisters of Mercy throughout the world.

[5] Taylor's treatment of these elements lies in *Sources of the Self*, in particular his chapter, "Ethics of Inarticulacy," pps. 53-90.

[6] I am reminded that *anthropos*, what Kant called humanity or Foucault called *l'homme*, reflects a being with the capacity to be moral through his rational faculties. The language of that moral becoming, or *logos*, informs what I am calling an ethic of articulacy. This then is *anthropology* and clearly resonates with the theological anthropology (the nature of being human in relation to God) within the Catholic tradition. My approach is formed in part, and much beholden to, the discourse introduced to me by Paul Rabinow. For an analysis of the conceptual apparatus available for such ethical examination, see (Rabinow 2003).

[7] White sketches the modern situation that Taylor narrates in *Sources of the Self* (see pp. 50-1). Taylor's three ontological constellations vie amongst each other to underpin a superficial concordance over "life goods." The three constellations as Taylor sees them are the original theistic model where God is the constitutive good; then, the Enlightenment naturalism of disengaged reason, one form of which is utilitarianism which denies any implication of a constitutive good; and the third constellation is a romanticist notion where the moral source emerges from individual creativity and expression – the latter stands as a reaction against the two former.

[8] I do not here want to wander into the well-worn but nonetheless murky terrain of moral absolutes. No doubt they exist for some, but such a digression into the conditions of relativism is not something I can pursue here. It does return in the final chapter in the context of enduring scandal.

[9] Phronesis: in Aristotle's ethics, the complete excellence of practical intellect comprising a true conception of the good life and the deliberative excellence necessary to realize that conception in practice via choice; contrast with *sophia*, in the theoretical sphere (*thewria)*, in the context of the notion of well-being and man as both ethical and political animal.

[10] The idea of public theological discourse, that is open discussion of Church doctrine, interpretation and application suggests that Murray has also attended to ethical relations with the magisterium and its teachings. This issue returns in the treatment of Sponsorship.

[11] This argument builds on work by Web Keane, as in (Keane 2002, p.74-5). That article examines marriage exchange among Dutch Calvinist Sumbanese and its transformation under Protestant religious conversion. His argument rests on the ideas of authenticity and sincerity that underpin *conversion* as a socially real phenomenon. My later discussion of language will consider the problem of fears of conversion that are caught up in ideas of religious social action, below.

[12] Perhaps the simplest way to put it is that Mission Integration saw the wave coming and caught the swell. In the form of standards, it remains to be seen how well they ride in to shore. There are clearly rocks and the sand may well resist the surf.

[13] Douglas refers here to Ian Hacking, "Representing and intervening: Introductory topics in the philosophy of natural science" 1983: Cambridge University Press. In contrast, Arendt asserts that thinking makes things visible: through speech, thought objects are made "an appearance" (Arendt 1981). My analysis invokes both understandings as below.

[14] Particularly in the sense that experience is "écrit aprés coup." Martin Jay helps us past the post-structuralist takes on discourse and experience using Bataille and Foucault in (Jay 1998, pp. 62-78)

[15] Others have explored a parallel conceptualization under the rubric of "complicity." The most obvious is probably George Marcus (Marcus 1998, pp.105-31).

[16] Interestingly, while some might argue that CPH would oppose such legislation because they are such a large volume system, in fact the system resisted it because they felt that community benefit levels should remain constant even when net revenue was down for any given year. With their fiscal history, this is indicative of their commitment to fulfilling not-for-profit obligations.

[17] A more detailed analysis of the transcript of a CPH meeting might reveal the specific ways in which this happens, but also the extent to which it is simply politically expedient window-dressing (see below). Such an analysis is beyond the scope of this chapter.

[18] For a different example of this kind of moral mapping through religious ritual, see Muehlebach's analysis of "Making place at the United Nations: Indigenous cultural politics at the UN Working Group on Indigenous Populations", Cultural Anthropology, 16(3): 415-48.
[19] Referring to (MacIntyre 1971).
[20] See, for example, (Besecke 2001).
[21] My use of a parenthetical 'c' in (C)atholic draws attention to the specific emergence of a particular identity label at CPH that I am arguing draws on both the formal Roman Catholic Church identity and the catholic-as-universal. Together, in the context of the pluralistic demands of the contemporary healthcare environment, the ethos of CPH is neither purely Catholic, nor catholic but (C)atholic.
[22] "Competing for talent: Recovering America's hospital workforce," Health Care Advisory Board, The Advisory Board Company, Washington DC, 2001.
[23]Cris Prystay, "US solution is Philippine dilemma" *Wall Street Journal*, July 18, 2002.
[24] I will return to the social reaction to intimations of "evangelism" and "proselytization" in the next chapter addressing the implications of sustaining and operating within an ethos of pluralization.
[25] For a prime example of Catholic-collaboration anthropology see (Anderson and Friend 1995). The edited volume is a group study of Catholics from Virginia to eastern Texas and Oklahoma, researched and commented on by anthropologists, bishops and other religious scholars in a sponsored project of the Catholic University of America. The volume was certified *nihil obstat* by an official of the magisterium, indicating that with regard to essential orthodoxy, nothing stands in the way of publication. The existence of that imprimatur, however, speaks to the fact that exploring the idea of varieties of lived experience under the common label of "Catholic" raised concerns and is in itself sociologically significant.
[26] This dissertation is not a work of Catholic moral theology. With that caveat, the analysis should be able to resist claims of running fast and loose with interpretations within the tradition. The flexibility of lived experience, which anthropology takes as its object, lies in the fact that there is less need to structure human understanding to the tight logic required of philosophical treatises, rather the challenge is to manage the contingent decisions, even the absurdity, of experience.
[27] Only men are eligible for ordination to the priesthood. Consequently, Catholic women who wish to undertake a life of service in the Church are in other ministries, notable education and healthcare. Men religious (brothers, monks) may opt for ordination as well as service.
[28] Beckford has suggested that one could argue Berger's psychological functionalism but that Berger doesn't assert a systemic imperative for order, "[religious] order in society is first and foremost an emergent product of social interaction" (Beckford 1989).

Ethos of Pluralization

> What has been well called the long conversation of mankind may be growing so cacophonous that ordered thought of any sort, much less the turning of local forms of legal sensibility into reciprocal commentaries, mutually deepening, may be impossible. But however that may be, there is, so it seems to me, no choice. The primary question, for any cultural institution anywhere, now that nobody is leaving anybody else alone and isn't ever again going to, is not whether everything is going to come seamlessly together, or whether, contrariwise, we are all going to persist sequestered in our separate prejudices. It is whether human beings are going to continue to be able, in Java or Connecticut, through laws, anthropology, or anything else, to imagine principled lives they can practicably lead.
>
> -- Clifford Geertz[1]

Toward the end of my fieldwork, Catholic Pacific Healthsystem convened facility representatives from the constituent areas of mission, spiritual care, policy advocacy, community benefit and ecology for a two day meeting at an off-site retreat center. Billed as the CPH Mission Summit, the program cohered around the metaphor of "mission as leaven," the catalytic agent that causes dough to rise and, in the presence of heat, become bread. The round tables throughout the hall had baskets as a centerpiece, with sheaves of wheat and loose grain collected in a cloth napkin, and the motif on conference materials was a basket of breads set below the CPH corporate logo. In a Catholic context, the symbolic echo of coming together in "communion" resounded through the event.

The purpose of the Summit drew from the secondary meaning of leaven as an agent that mingles or permeates in order to modify, alleviate, or vivify. Like yeast, mission injects the spirit of life into hospital operations. Each morning of the two day meeting had begun with an opening reflection that is standard for CPH meetings, as I have described earlier. The first day opened with a keynote address by a sister from a sponsoring congregation who is a prominent professional speaker in organizational development and leadership training, though not personally involved in the governance of CPH.[2] After lunch, in a session titled, "Reflecting with CPH Co-Sponsors," the group listened to presentations from two Corporate Members, each from yet another of the sponsoring congregations; the second day had each constituent groups break out

into more targeted sessions focusing on their particular responsibilities. The first presentation sought to explain the role of the religious congregations in sponsoring CPH hospitals from the personal perspective of a sister-sponsor in governance. The second overtly embraced the metaphoric role of mission as "leaven" in healthcare ministry. The second sister who spoke made reference to biblical passages like the Letter from Paul to the Corinthians, and parables of the mustard seed, treasures in the field, and fishing nets cast in the sea. She spoke of the Kingdom of God as "ordinary baking women changing the whole nature of the dough, transforming passive flour into a seething, heaving mass of dough." "We are that flour," she went on, "God is the woman who adds yeast to make us rise to new heights." She linked the CPH mission to the works of Jesus:

> Jesus was a countercultural force bringing new, right relationships. Not merely kingship, but justice, peace and love, in contrast to the earthly kings. Jesus turned it all upside down and placed the power in the poor and the marginalized. It would be through them that the world could be transformed through forgiveness.

The Summit was adjourned on the second day with a "Closing Ritual" where the grain from each table was collected and brought by representatives from the five "mission" constituencies to a center display table to become loaves of bread that sisters and their colleagues had baked earlier in the day.

The aim of the summit was to bring a diverse group of mission agents together to instill in them a sense of the story behind CPH, connect the various diverse mission agents to the Sponsoring Congregations through inspiring presentations, and build cohesion within each constituent group for common work in their areas of shared responsibility. The Summit succeeded in this last objective, but the results were less than perfect in their other goals. The language of the speakers was poetic, evocative, and rich in the allusion to a vibrant Christian tradition. Unfortunately, in the context of structural changes that centralized authority in the system office, the language and examples of the speakers seemed to chafe with participants, particularly those who came from the many secular community hospital partners within the

system. Many people seemed to feel awkward and uncomfortable with the consistent and overtly religious imagery. As important as it was to "tell the stories" of their hospitals in terms of their religious tradition, the sister-sponsors missed their opportunity to further an ethos of pluralization, in the form of the stories of the secular community hospitals, their overlapping mission, and the dedication of their founders.

It was particularly striking that some of the most vocal concerns about this discomfort came from the chaplains, both Christian and non-Christian. In one of the discussion sessions, one chaplain spoke to his sense of "grieving and sadness", while two of his colleagues lamented what they saw as "the loss of history, of the legacy of their own institutions in joining CPH." The Summit had provided no structural counterbalances to set the community hospitals on an equal footing with their religious counterparts, at least with respect to a tradition of not-for-profit service and dedication to the care of the poor and the sick. What could have been presented as stories of a common human tradition of leadership in compassion and healing were received by some as sectarian and exclusive. The language of metaphor and analogy that could have been beautiful was instead, for many, alienating.

After the first Corporate Member presentation, some participants tried to expand the allusions to include the community hospitals, particularly during the explanation of sponsorship. Lay staff from system office Mission Integration asked leading questions: "Can you talk about the Corporate Members' responsibilities to non-Catholic hospitals?" Marie asked the speaker. "When you refer to the 'healing ministry of Jesus' what are are you projecting?" asked Linda. "The Catholic hospitals have sister-sponsors. How do we [CPH] get feedback from non-Catholic facilities?" asked Anne. The answers were strong and suggested points of connection to the secular community mission and common values. But without a structural counterpoint that explicitly positioned the secular collaborators within the system on equal footing with their Catholic sponsors, people were left unsatisfied.[3] The language of Christian and Catholic legacy was overwhelming.

Founding ontologies

In the preceding chapter, I demonstrated that CPH undertakes an ethic of articulation, beginning with its statement of philosophy, the mission and core values of the organization. That ethic of articulation was not "religious" or even particularly Catholic, but self-consciously pluralistic. But sustaining such an articulation in an ethos of pluralization is a continual challenge, particularly in light of the strong tradition that Catholicism signifies and the official positions that sister-sponsors, especially Corporate Members occupy, as representatives of Sacred Institutes. It is not always clear that they recognize how that doctrinal identity, which originates in the Church, while a valuable tradition is not the most easiest identity to assume for the hospital company. In light of their heritage and the founding history of the system, it is – and should be – called Catholic Pacific Healthsystem. But if CPH is to sustain the mission of non-profit healthcare, with a special attention to the needs of the sick and those who are poor, the hospital system must undertake to tell the common stories and anticipate – meaning speak to in advance – the anxiety and resistance that I saw at the Mission Summit.

This chapter renders an account of the social dynamics and the politics of identity that attend Catholic Pacific Healthsystem. I will describe the cultural background in the US that informs American Catholicism post-Vatican II. In particular, the ways in which issues of authority and legitimation are taken up color how an organization like CPH is perceived within American Catholicism and delineate the broader socio-political dynamics with which the hospital system must contend.

This chapter describes a condition of multiple interacting social elements – religious, community and secular – and tries to recognize an aspiration to a future state, an ethos of pluralization. I use pluralization deliberately; following William Connolly, pluralism seems to reference a fixed state of things to be preserved, whereas pluralization gestures toward a politics of becoming that cultivates reciprocity, forbearance and critical responsiveness. With respect to

the Sponsoring Congregations, it reflects the cultivation of magnanimity in the bright light of their strong ontology tradition. From the perspective of other collaborators throughout the organization of CPH, it is reflects a flexibility.[4] In all cases, it suggests a "weak ontology" that is based on security in one's own foundations, while acknowledging the possibility of contestation that other perspectives can legitimately bring to those foundational premises. In that recognition lies an openess that lends itself to unorthodox combinations and new possibilities. As Connolly puts it, "the hope is to pluralize the contemporary sacred/secular duopoly control over the cultural currency of morality." Stephen White documents the turn toward weak ontology in recent political theory; William Connolly proposes such a pluralizing imagination to modern society, indeed to the world at large. My intent is smaller in scope, though it aligns with this greater trajectory. I want to provide a contemporary diagnosis of a condition of becoming within the bounds of the ethico-moral collective that is CPH as a Catholic system supporting not-for-profit healthcare in the facilities of both Catholic and non-Catholic member hospitals.

Why does this matter? Why is pluralization important for the contemporary world? What does it allow us to do? As I have previously explained, Catholic Pacific Healthsystem is unique and path-breaking organization with its origins in multiple Sponsoring Congregations and many secular community hospital partners. It represents a historic decision by the sister-sponsors, even as agents of a strong ontology tradition, made in recognition of political contingency to answer radical changes in the healthcare marketplace. In the wake of the creation of CPH, the organization made strategic decisions to affiliate with struggling community hospitals, furthering a journey toward a new ethico-political form.[5] Mobilizing core values of collaboration and justice, in their words, the dignity of the communities they serve and co-collaborators, CPH sponsors – religious and secular both – banded together under an umbrella of not-for-profit healthcare to further the provision of healthcare and social services for the most vulnerable.

What, then, to make of my account of the Mission Summit? It is evidence of the effort, not always successful, but nonetheless worthy in the attempt. From the vantage point of the

outsider, there are several contributing factors to which we might attribute the "stories" of the Mission Summit coming out as they did, and why they had such a mixed reception. Using the problematization of "culture" in the Catholic tradition as a backdrop, I want to map some of the issues of authority and legitimation that contribute to a Catholic organizational identity. These elements feed into social expectations and presumptions that inform both the catholic identities and the broader, perhaps secular, streams of identity and orientation that bear on Catholic Pacific Healthsystem and the site of weak ontology that the system is *becoming*.

Cultural trapping(s)

> Religious practices are popular sites of idelogical critique and for the elaborations of civil society. [With a nod to cultural location] what I see are ordinary people making choices under circumstances they did not choose. These circumstances include religious practices shot through with ideological traces that both constrain and enable resistance to unjust social relations, that both trouble and comfort those with vested interests in maintaining those relations.
>
> - William D. Hart (p.37)

In the 1970s, Edmund Pellegrino addressed the Catholic Health Assembly on the true Catholic identity of hospitals: "We can no longer assume that hospitals that are *canonical* Catholic are de facto Catholic or even totally Christian."[6] In his comments, Pellegrino pointed to the social policies of President Johnson's Great Society and a range of other influences that continued to impact and, as Pellegrino asserts, to secularize religious institutions. While Catholicism can clearly be read from within the frame of ideology, power/knowledge relations are always morally plural, or at least morally multivalent and often morally ambiguous. We cannot disregard the idea of discourse as power/knowledge relations (ideology) for the possibility of opening up a frame to recognize that plurality.[7]

American Catholicism always exists within the space of "American" with the specter of the history of "Catholicism as Anti-American" which means nationalism and other purist notions of cultural identity are never completely foregone.[8] The history of American Catholics as a social

minority – a religious population but also an identity troubled by prejudice conflating it with ethnic identity – is marked by discrimination, even persecution, by a distrusting majority.[9] That experience provides ample explanation for why Catholic healthcare discourse often seems to adopt a defensive stance in its self-expression. For an easy example of the rhetorics of *ressentiment*, or a political identity-based on injury,[10] see any edition of *Health Progress*, the monthly newsmagazine of the Catholic Health Association. Many articles are written from the standpoint of Catholic healthcare values under assault, on the edge of extinction, in crisis or otherwise loosing their handhold in contemporary US health and medicine. The alternate narrative voice in many cases is a self-satisfied, lone-voice-in-the-wilderness article that trumpets the superiority of Catholic healthcare, even as it decries the descent of modern healthcare into the abyss. But historical antagonisms are not the only source of this narrative. There is a more particular construction within Church doctrine that also contributes to such a stance.

Culture has become such an over-determined term leaking from anthropology into the wider world, its meaning is now manifold. Moreover, "for a great many, the term *culture* invokes assertations of "timelessness," "coherence," "unity," and "boundedness," and so distorts the fluid and contradictory character of human experience.[11] A number of anthropologists have consequently called for its abandonment, proposing purportedly more specific terms of their own (Gupta and Ferguson 1997a; Kuper 1999; Borofksy, Barth et al. 2001). I find the object useful here for two reasons. First, culture is a term from organizational behavior and management that CPH Human Resources uses and, consequently, it was bandied about by my informants at CPH in unavoidable ways. Secondly, "culture" itself is a conceptual category that has a particular interpreted history in doctrine and social teaching of the Roman Catholic Church. The Catholic Church and its teachings have a very particular relationship to a concept of "culture."

A survey of interviews with various members of the magisterium, Vatican Congregations (departments), papal pronouncements and other reportage from Rome points to a continuing conception of "culture" that has its roots in historic arguments that positions the Church as an

Institutional vessel of unchanging Truth devoted to the eternal task of redemption and salvation, and fostering the relationship of mankind to God.[12] In that schema, "culture" is a worldly phenomenon, a product of man, and thus a function of man's imperfection, at least in contrast to the works and word of God. I want to sketch here briefly two examples of that schema, even as the Church fathers labored to open the Church to the "signs of the times."

Landmark documents emerging from the Second Vatican Council, promulgated in 1963 and 1965, are particularly relevant: the Dogmatic Constitution on the Church (*Lumen gentium*), as distinguished from the Pastoral Constitution on the Church in the Modern World (*Gaudium et spes*). These two constitutions clearly delineate two broad but separate fields. The first addresses the Church *ad intra*, in itself, but with observations intended to better respond to its mission in the world, and the second addresses the Church *ad extra*, the Church facing the external world in the present moment (Burns 1992). The 1965 Council document, *Gaudium et spes*, addresses itself to the proper development of culture. The introduction grounds the discussion in terms of the *person* coming into fruition only through the cultivation of "*natural* goods and values". Culture in its general sense indicates all those factors by which man refines and unfolds his "manifold *spiritual and bodily* qualities." The Constitution itself states: " . . . it follows that human culture necessarily has a historical and social aspect and that the word 'culture' often takes on a sociological and ethnological sense. It is in this sense that we speak of a plurality of cultures." (GS §53) The Council delineates culture as something of Man yet bounds it within a framework of natural law and the spirit, while explaining the social science perspective as a logical consequence of progress and the breadth of humankind.[13]

Anthropologist Michael Angrosino problematizes the Church's understanding of "culture," arguing that the Church only focuses on the interpretive meaning of symbols and thus misses the power of social relations in constituting culture (Angrosino 1996). The Roman Magisterium uses a limited aspect of the concept of culture that emphasizes ritual but distances itself from the social context in which the ritual takes place. Angrosino maintains that this neo-

conservative stance derives from the understanding of the Church as a model of perfect society. The theological task of the Church is to call mankind to a transcendent truth where "culture must be subordinated to the integral development of human persons, the good of the community, and of the whole of mankind" (*GS* § 59).[14] The Roman Catholic Church has largely abandoned the possibility of its historic identity as para-nation-state, certainly outside of Vatican City. What Michael Walzer casts as "rigid sectarian closure" is not an option for a religious institution like the Church (Walzer 1997, p.27). However, the struggle of the Church proper to maintain internal coherence resonates with the topography of tolerance that Walzer engages. Furthermore, past efforts to cast "culture" as external to the Church and current efforts to reconcile with the "signs of the times" are themselves reflections of those struggles.

The Pastoral Constitution articulates the context for the proper development of culture with headings including "new forms of living", "man as the author of culture," and "problems and duties." It gives particular attention to a range of concerns, including the relation of faith to culture, and the harmony between culture and Christian formation. This doctrinal conception of culture directly informs the Institution's stances on the question of authority and the idea of dissent that pluralism evokes within the traditional hierarchical structure of the Church worldwide.[15] These concerns bear on issues in the operation of Catholic Pacific Healthsystem in very distinct ways.

The CPH organization is a contemporary theological subject operating within the technical rationalism of healthcare science. In effect, I am arguing that the system represents a redefinition of the Roman Catholic Church-in-the-world through the proliferation of various articulations of the Catholic healing mission by its own professional enterprises in healthcare (McCormick 1984; Cheney 1990; Walsh 2000). CPH is a site of institutional practices that is both transformed by and integrative of what was Catholic theology prior to the new modalities of contemporary healthcare (cf. Kelly 1979; Seidler and Meyer 1989). To use another lexicon, it represents a possible modernity within a Catholic "modality" where some "countermodern

inhabitants" retain some form of belief in a transcendent faith, even as they are located within a functional entity that presumes the possibility of multiple moral sources (Faubion 1988; Faubion 1993, p.7).

Authority & legitimation

The Roman Catholic Church stands out in American healthcare through its visible commitment to building material institutions as symbols of Catholic witness to the sick and those who are poor. The tradition of Catholic faithful who had taken vows to join active congregations, rather than contemplative orders, brought an institutional presence to the Catholic religion in the US that other faith groups did not have.[16] As an extension of the preeminent European socio-political entity, the Roman Catholic Church inherits a hierarchical model of institutional structure for its operations in this country. Bishops are the local authority at the diocesan level and bishops, working in concert, provide pastoral guidance on issues confronting American Catholics and American society at large. Bishops also enforce the doctrinal positions of the ecclesiastical bodies that make up the Vatican hierarchy under the authority of the Pope. Most Catholic hospitals look to their local bishops for symbolic leadership of ministries active in his jurisdiction (Wittberg 1994: 50-3).[17] In Catholic ecclesiology, the magisterium is the necessary pastoral structure that guides Catholic faithful. To the extent that a Catholic hospital is perceived by the public, both Catholic and otherwise, as something "Catholic" that would concern a bishop, sister-sponsors endeavor to maintain working relationships with the various dioceses in their hospital service areas.

The Church in the US began in a small and unassertive minority but the waves of nineteenth and twentieth century immigration fundamentally changed the evolving institution. The Church became largely an organization of the proletariat and poor farmers, and even US bishops came from that demographic, a distinctly different model from the aristocratic

episcopacies of Europe (Burns 1992: 74). This minority history strongly shaped the political realities of US Catholicism. Immigrant and lower-class Catholics were targets of prejudice well into the early twentieth century and the American hierarchy was sensitive to the impression that Catholics were not perceived as loyal Americans, both because of their allegiance to a foreign power (the pope) and their recent immigrant status. Moreover, the early history of America as a protestant refuge continues to color civil religion and civic identity to this day (Bellah 1967; Bellah 1992; Bellah 1992). The Roman centralization of Church authority and early Church stances toward Church-state alliances were consequently conflict-ridden positions for the early American bishops and their congregations.[18] The American doctrine of church-state separation further reinforced the need for a new mode of allegiance. It is in this context that the Vatican II declaration on religious freedom, discussed earlier, gains such significance. In the past, Catholic doctrine discouraged the faithful from associating, celebrating or collaborating with Protestants and the Church resisted affirming the obligation of states to protect the freedom of religious choice because it conflicted with the Vatican assertion of Catholicism as the one True faith.

Religious studies scholar, Mark Massa, has attempted to use Geertz's interpretive model to understand the role of cultural symbols in divisions within American Catholicism over political support for Senator Joseph McCarthy (Massa 1999). While his application of Geertz' interpretive model is analytically loose, Massa argues successfully for two contemporaneous but distinct American Catholic systems. Massa points toward two broad demographic groups that are drawn on class lines, based on education and income. This is an observation that gains strength if set in the context of more historically informed accounts of American Catholicism as a minority and largely immigrant Church.[19] Massa's argument highlights a problematic that runs through any examination of Catholic material. The categorical distinction between theology, politics, or faith and morals and socio-economic concerns is an imposed framework that is itself historically contingent. Moreover, these categorical assertions are strategically deployed: defining the terms of the debate is always an exercise of power (Schattschneider 1988, p.66); cf. (Foucault 1977).

There is no pure "politics of the Catholics;" there are doctrinal stances that may have political implications for the Church proper as an institution in America, and there are implications for a Catholic populace cross-cut by other characteristics that only together create a political identity. The Church is a social organization and it will continue to enact temporal objectives as means to spiritual/theological ends.

Together with the simple geographic distance from Rome, the political history of Catholics in the US has contributed to the frequent assertion that the Vatican Magisterium fails to comprehend the particularity of the American Catholic context (a charge made again in 2002 by many American Catholics, see final chapter). The US Bishops are faced with promulgating Roman doctrine but in a social setting where such external origins threaten to alienate American Catholics' fellow citizens who are unlikely to engage some of the more subtle inflections of Catholic doctrine and instead see them as the dictates of an external authority.[20]

The Second Vatican Council can be understood to respond to some of these concerns by advancing the principle of collegiality (*Gaudium et spes* § 18-29) that declared that bishops ruled the Church collegially with the pope, a move which some interpret to signaled a retreat from the centralization of the prior era. Within the US, the bishops often support the principle of subsidiarity wherein larger structures respect the jurisdiction of member units, thus local players are presumed to have a more informed perspective than the more distant hierarchy. Together, these positions promote an intellectual environment that favors discernment. Religious submission of the will and the mind implies the effort to reach accord that the teachings of the Magisterium reflect Christian truth (Gula 1989: 155-56). The Church has retained significant authority by invoking a methodological presumption of prudence in moral issues, namely that moral teaching involves complexity beyond our individual resources of judgment. Thus, the Magisterium or a Council as a collective requires conditional assent of moral certitude; it carries a presumption of theological accuracy. Responsible disagreement after Vatican II is a legitimate and valuable means of incorporating the plurality of informed opinions into Church practice.

Theologian Richard Gula considers, for example, the criteria established by the US Bishops in a 1968 pastoral letter. Responsible disagreement precludes scandal, requires a well-founded rationale, and must not impugn the teaching authority of the Church (Gula 1989). Dissent is understood, however, to be reserved for Catholic scholars and theologians whose work ultimately contributes to the development and formation of Catholic doctrine, much as Vatican II sought out a plurality of voices to inform the preparation of the documents which ultimately emerged from that Council.[21]

The historical legacy of the Roman Catholic Church-as-state bears directly on the contemporary institution identity as Church-as-moral author(ity). Too often, "moralism refuses the ascesis, proper to intellectual life, of stepping back – as a methodological moment – from the moral focus to pursue an analytic recognition of [the] modern cultural soil" (Coleman in (Yuhaus 1990, p.45). We might oppose to that model of the Church's characteristic means of asserting authority and policing allegiance the tasks of the modern state as Asad has done.[22] In the move to define the modern world as an object with which it now had to contend, the Church has sought to assume a modern stance that mirrors the move of the social sciences to construct religion as a problem to be understood as a bounded object distinct from other phenomena in the world. Similarly, the conscious designations of Church *ad intra* and *ad extra* constitute a doubling of observers (the Church) observing observers (the Church).

Catholic theologians and social theorists recognize distinctions that are reflected in how morality versus politics are conceived. Commentators have noted that documents from Vatican II and afterwards are not consistent in analytic method. Some documents reflect a historical consciousness regarding the Church's stance on moral issues while others respond to modern developments from a more classicist position (Gula 1989: 35). Gula emphasizes McBrien's observation that contemporary moral theology exists in a dialectical tension. The challenge for contemporary Catholic moral theology is "to preserve the clarity, consistency, and precision of the classicist worldview while at the same time respecting human freedom, the uniqueness of the

historical moral situation, and the unfinished character of the moral life so valued by the historically conscious worldview (1989: 36)." Gula further highlights two changes in moral theology that can be associated with Vatican II. In addition to a shift in worldview, he cites a change in focus and a change in method. The first is a move away from moral theology as a discipline for confessors toward greater attention to faith in living "where values are primary and laws [regulation] secondary (1989: 30)." It is the change in method that resonates strongly with the emergence of science and the place of reason in critical investigation that reflects an awareness of contemporary epistemological developments in science and technology. Grounded in a historically conscious worldview, the shift in method was toward inductive empiricism. Human experience is perceived in its particularity; the social context of that experience and – importantly for the moral life lived amidst pluralism – the shift in method opens a space for conscientious dissent and accommodates growth in society and the Church.

Sociologist of religion, George Burns, attributes the inconsistency of method to a process of separation of ideological content (Burns 1992). In the last century, issues of "faith and morals" constitute a field of doctrinal conservatism, and issues of "politics and social problems" constitute a field in which the Church as an institution sometimes appears to be radically progressive. As Burns understands it, concerns of faith and morals are much less flexible because they are grounded in immutable dogma while concerns of politics and social problems are subject to the historical consciousness that Gula indicates. This distinction reflects, in part, the dual nature of reason and culture as divine capacities but human implemented activities. It may also be understood as a distinction borne of the Weberian separation of spheres of value and the increasing compartmentalization that comes with such rationalization. Understanding this distinction as it bears on how the Church perceives itself matters as we think about institutional longevity and the challenges of survival in an evolving social world.

Faith and morals are God-given whereas political and social issues are products of human action and history. Over time and under changing temporal conditions, the Church can provide

social teachings that do evolve with history. However, as Burns and other scholars note, the categorical distinction of ideological content also reflects the Church's own history during which the papacy surrendered the papal states to the new Italian republic, retaining only the Vatican city-state. A concomitant decline in secular political influence relaxed the role of the Church in the traditionally Catholic European states. Thus, in the 1931 encyclical, *Quadragesimo anno*, Pius XI asserts the Church's role in proclaiming the moral principles of the "social order" not temporal particulars.[23] Here, the interests in Church-state alliances are preferences not doctrinal obligations because the papacy has determined that the advocacy of specific state arrangements lies outside the Church's competence. However, the papal exclusion from "temporal concerns" is balanced by increased autonomy over "religious concerns" of internal Church organization and Catholic doctrine, namely, issues of faith and morals (Burns 1992: 31-44). As Talal Asad remarked on divisions within the Catholic Church:

> the democratizing tendencies of the "liberals" in the Roman Catholic Church since the Second Vatican Council has been met increasingly by authoritarian measures on the part of the 'conservatives.' . . . Ironically, it is the conservatives who are committed to separating the 'properly religious' concerns of the church from the 'political.' Thus their strenuous opposition to liberation theology is in effect a rejection of the church's too-intimate involvement with 'the world.' It is because liberation theology confounds religion with politics, they say, that its intellectual content is so thin and its spiritual grasp so feeble. (Gregg 1999: 31)

Earlier chapters have approached CPH first through the character of the sister-sponsor and then through the contrastive view of management technologies in hospital operations. The subsequent attention to identity statements – the CPH Statement of Philosophy and the ethical technology of the "mission and core values" – bring out the the religiously informed dimension of the organization, but to fully appreciate how the onto-political character of the system is formed requires this larger background of American Catholicism. This institutional history colors, enriches and, perhaps, complicates how any group of contemporary Catholics, like the sister-sponsors of CPH, navigates their own social identity. Their self-understanding is always influenced by their relationship to the larger Church, and to that institution's history in this

country. What it means for Corporate Members to be Catholic and, consequently, what it means for the hospital system that they founded to be "Catholic Pacific Healthsystem" cannot be isolated from the identity effects of their socio-moral genealogy.[24]

Weak ontology

> In a secular, liberal state that subscribes to the principles of religious toleration, historical religions (including secularized versions of religious traditions) are part of civil society. The political tensions this generates in modern societies is notorious – not only because different classes and institutions often compete unequally over national resources, but because people's sense of belonging (and therefore of security) may be differently affected by their particular religious formation. For although religious *beliefs* may not be coerced in a religious state, some religious *identities* appear to be more at home in a given nation-state than others are. And even if personal beliefs (as Lockean liberal theory claims) are essentially voluntary, social identities are not.
>
> - Talal Asad [25]

We can approach the challenge of pluralism by considering how Christians, indeed any person with an articulated belief system, can engage full-faith in a politics in the public sphere. Of course, the engagement of Christian ethics in American political theory and discourse is long-standing. It is only a dilemma in a society that has adopted liberal conceptions of religion as a function of the private realm.[26] Some Protestant theological ethics assert that Christian participation in public conversations and policy making can be justified from a decidedly religious perspective. Theological ethicists like H. Richard Niebuhr assert conversionist approaches to Christian engagement that are opposed by liberal theorists, like Rawls, who argue for restraining the voice of religion in the public sphere, and also run afoul of those who argue that Christianity and liberal democracy are incompatible for other reasons. Niebuhr and others represent attempts to think through a more robust liberalism that can accommodate theological foundations. They argue that Christian discourse contains moral concepts and norms that are fully understandable to a wider (non-Christian) audience with only minimal translation. This stance rejects those communitarian perspectives that feel liberalism threatens the distinctive elements of religious identity because denominational language are usually neutered, translated, before

entering public moral discourse.[27] On the Catholic side, as I discussed earlier, theologian John Courtney Murray advocated for political participation based on a social philosophy of discourse ethics hinged on an understanding of society as a field of meaning that "does not disguise but brings to light the differences of men" (Murray 1966).

Stephen K. White, observes an ontological turn in contemporary political theory (White 2000). In his assessment, he describes that turn as an attempt "to think ourselves, and being in general, in ways that depart from the dominant- but now more problematic- ontological investments of modernity" and he refers to those new attempts as "weak ontologies." Strong ontologies are those that "claim to show us the way the world is, or how God's being stands to human being, or what human nature is. It is by reference to this external ground that ethical and political life gain their sense of what is right; moreover, this foundation's validity is unchanging and of universal reach." He argues that the underlying assumption of certainty "- both about how things are and how political life should reflect it - allows such ontologies to provide what seem today to be answers to our late modern problems that demand too much initial forgetfulness of contingency and indeterminacy" (2000: 6,7).

The construction of theory here is important in its relevance to the contemporary situation of pluralization and the lived experience of liberal society. The challenge of overlapping spheres of value in the public realm are particularly evident in healthcare where religious and secular ontologies vie to articulate assumptions of medical science, instrumental versus teleological, while different articulations of sociality are lived out by those who seek and those who provide healthcare services.[28] This is the basic problematization, to follow Foucault, that requires an anthropological analysis of Catholic healthcare.

In White's treatment, weak ontologies resist both the inflexibility inherent to strong ontology and the strategies of a good deal of liberal thought. They proceed on the basis of two important premises. One, weak ontologies are able to provide direction while recognizing the idea that "all fundamental conceptualizations of self, other and world are contestable. [Two], there is

the sense that such conceptualizations are nevertheless necessary or unavoidable for an adequately reflective ethical and political life. The latter insight demands from us the affirmative gesture of constructing foundations, the former prevents us from carrying out this task in a traditional fashion"(White 2000: 8). Put another way, a weak ontology recognizes that those moral sources or foundational tenets for life and right action that an individual holds may be mirrored in another person by a different set of tenets equally fervently held. This recognition can permit a bracketing of ultimate moral sources. What I see in that suspension is the possibility of collaborative action on the basis of derivative principles, for example, the care of the sick and those who are poor. On the one hand, one may see the ethical construction of CPH as a prioritization of fundamental values in mission (caring etc.) over sectarian identity (a Catholic system insisting collaborators also be Catholic). But given the centrality of the fundamental values to Catholic ministry and Catholic identity itself, I would argue that CPH represents not a re-prioritization per se, but a return to core values of mission and purpose intrinsic to that identity on the common ground of sustaining not-for-profit healthcare through collaboration. It is for this reason I have repeatedly used the idea of a "catholicity" and the terms of my informants that refer to the idea of "catholic" as universal as a deeper dimension to "Catholic" meaning the institution-defined identity.

For the purposes of working through the contemporary situation of Catholic Pacific Healthsystem, I have engaged White's readings of Connolly and Charles Taylor because their argumentation resonates with the way I have approached my fieldsite and constructed that anthropological object. Taylor proceeds from a theistic stance but argues for engaged conversation between opposing positions regarding the "inescapable questions." Connolly draws on Nietzsche and Foucault to de-center the inquiry away from previous dispositions and presumptions to the end of translating the late modern experience into a "more generous pluralism."

One day, I was sitting with a sister-sponsor in a hospital garden, talking over lunch about current events. Conversation had turned to representations of Islam in the media, and she reflected on the inter-relation of the major religions, in the context of her own faith tradition's tribulations:

> But the humanness and the weakness, to me, makes the whole thing of the church surviving absolutely remarkable. I mean, there's absolutely nothing that would show you it was because it was good leaders and - always right. Nothing in the history will give you any reason why the Catholic church is still around, except in - those of us who believe, that the Holy Spirit is guiding this - this whole thing, and we just seem to be able to walk through it. And that's true of other churches also, so it's a human - it's the human endeavor in a kind of cooperative mold with divine. We're so totally reliant on the other. So when you talk about the Catholic church and its impact on civilization or on the history of the world and the like, it is true. And - and I'm wondering, out of this whole conflict, if we can't get to an appreciation, too, of the richness in the Islamic tradition. The real Islamic tradition. Or in the Jewish tradition. I think - somebody said that Christians are really spiritual Semites. We really are. You have to understand Judaism to understand Christianity....And the connections between - I mean, this is where I lament public culture, such as it is, is, we - most of us don't recognize the ways in which Islam embraced Judaic scholars and Christian scholars, much more than any - either the Christian church or Judaism ever did the reverse. And you know, Christ Jesus isn't the Christ figure for Islam, but he is a revered prophet. You know. And, we seem to miss that, when [Americans] talk about them as "the other people".

The sister here expands on the core idea of weak ontology, even as she talks of the three great Abrahamic traditions. She uses the language of the Holy Spirit but explains the human practices of society and the effects of the contingency of cultural difference.

In his exegesis of Connolly, White contends that there is no possibility of a fully detached self, in the following sense. He argues that the ideal of a self "cleansed of resentment (*ressentiment*) who strolls disinterestedly into agonistic space to choose his opponents forgets that even the agent who succeeds in dampening his resentment has not thereby extricated his identity from the ontological dynamics of identity/difference. [Rather] to do justice to this dynamic, one needs to exercise the virtue of forbearance in relations with others; in doing so, one affirms that "ambiguity of being" which always lodges traces of otherness within me" (White 2000: 117).

Connolly speaks to the possibility of collaboration that can emerge from holding a weak ontology when he writes: "You now exercise forbearance toward adversaries who help to

crystallize your spiritual identity even while deflating claims some advance to completeness. You invite them to reciprocate. You might do so, partly from attachment to the ambiguity of being, partly through appreciation of the role distance between you and others plays in opening space for new candidates to lobby for a place on the cultural register of being, ... partly out of gratitude toward the difference of the other in helping you to crystallize what you are, partly through encountering traces of the other in your identity, and partly out of a prudence in a world in which you seldom know now which allies you will need in the future" (Connolly 1999: 160). So, CPH brings together the Catholic sponsors, and their diverse charisms, with the tradition of local secular, community hospitals under a common banner of not-for-profit healthcare.

Representations

Invocations of overlapping consensus, ontological minimalism, nonfoundationalism, and the primacy of epistemology combine with the political unconscious inscribed in the textual designs of social scientists to screen out interrogations of the ontopolitical dimension. Connolly presents a critique of such strategies of concealment in order to bring show the pretense in ignoring the ontopolitical in social analysis. He contends it is critical to recognize those

> ... historically specific discursive practices within which people are engaged prior to achieving a capacity to reflect upon them. We humans typically respond to and cope with things within previously established contexts of engagement. These contexts help to constitute us and the objects represented to and by us. Representation does occur, then, but these are representations by historically constructed agents ... engaged with historically constituted objects . . . Representation, that is, occurs within historically particular contexts that fix both the things to be represented and the terms through which representation occurs. Representation always involves the representation of prior representations. This duality, or doubling, eventually confounds representation, not as an indispensable social practice but as a detached, neutral method of accumulating knowledge (Connolly 1995, p.9)

It is a process not only of representing the world but of recognizing the interlaced multiplicity of modes of discourse. I am arguing that an ethic of articulation active in Catholic Pacific Healthsystem brings into being a kind of collective organization, a way of life, if you will, that acts as "a set of discursively mediated practices through which things are constituted in the

process of dealing with them [and thus] both undercuts the search for a neutral, transparent mode of representation and acknowledges the steady infiltration of ontopolitical presumptions into established cultural understandings, institutional demands, affectional dispositions, personal identities, social skills and instrumental resources." To understand my argument, to see the conditions I am describing in the organizational life of CPH, we have to recognize the larger historical frames through which we perceive the Catholic label, or identity. That is a lens made of representations of prior representations that can obscure our vision of what are, in reality, multiple forms of religious identity contingent on and responsive to particular politico-social contexts.

The social embeddedness of organizations in so-called complex societies means the implications of pluralism and pluralization cut both ways. Any engagement with any form of Catholicism is fraught with analytic difficulty. As anthropologist Jon Anderson reminds us, "the very notion of 'Protestant' is a Catholic and theological one, little used among Reformed churches and then mostly historically in relation to Catholicism. For 'Catholics', the emphatic part of the work is 'protest,' which makes 'Protestant' any innovation or divergence from what is presumed to be received practice" (Anderson 1995: 82). With the institution-*qua*-institution, *sine qua non* of the Western world, one must contend not only with delimiting the object of study, but also acknowledge that our analytic apparatus itself has been influenced and shaped by the intellectual history of that larger institution.[29] For example, when I have identified Catholic hospitals as religious or faith-based, by default the other form in the typology is a "secular community" facility. As many of my informants have pointed out to me, Catholic hospitals are community hospitals. But their religious label often eclipses the reality of their local formation. Furthermore, "the secular" itself is a conceptual category originally formed and advanced by Catholic thinkers.

In his meditations on modernity and globalization in the context of Sumbanese Calvinism, anthropologist Webb Keane acknowledges that many of the claims he makes can be

attributed to a wide range of contemporary religions. But he reports that one reviewer rhetorically exclaimed, "We are *all* Protestants now"; Keane argues this exclamation alludes to a" world-historical configuration that exceeds particular doctrinal identifications (Keane 2002, p.68). Describing the ethical composition of Catholic Pacific Healthsystem is similarly complicated by the interaction effects of the larger society, and possibly cultures, in which it is situated. The debates abound over the very nature of the concept of "the secular," especially how social scientists conceive of the social condition in the US in order to address the specifics of sect or religious identity.[30] During fieldwork, there were instances where behaviors or attitudes observed had both religious and spiritual aspects, where it was not clear whether the phenomenon could be ascribed to a Catholic identity in a facility, or reflected some broader more muted dimension of a civic religion with its Protestant origins.[31] Certainly, the chapter on margin and mission could be re-framed to suggest the drive to produce surplus (profit) to meet operating margins reflects some secularization of the Protestant ethic that, some have argued, adheres to capitalism. There is, further, the idea that financial success in the labor of the organization is a demonstration of the value of the mission, even independent of the theologically-derived mission of charity and preferential option for the poor that is made possible by effective cost-shifting within the operations of a not-for-profit hospital (similar, perhaps to a sign of the elece within Calvinism). But it is a complicated proposal to present the culturally Protestant elements of Catholic hospitals, even if allowing that such organizations are embedded in the larger social fabric of the modern Western US.[32] In the context of conversion, Keane and others note that the relationships between material things and language shifts. The critical problematic for Keane in addressing Protestants here serves the idea of communitas within CPH:

> To the extent that words and things circulate among persons, requiring acceptance or uptake by them, the very conditions for people's objectification, self-knowledge, and identity necessarily involve other persons. To the extent that certain varieties of Protestantism entail a project of fostering and authorizing autonomous, individual selves, this embeddedness may pose a threat. [33]

Apologia and its risks

My larger thesis here has revolved around the efforts of the sister-sponsors and their agents to foster in the organization they have created a collective ethico-moral community that is not only cognizant of the mission and core values but, as an organization, also strives to engage those elements in its collective operations and social behavior. Not for profit healthcare, the Roman Catholic healthcare in particular, must be understood as an experiment in morality. Not-for-profit healthcare is a challenge "to fixed conceptions of will, identity, responsibility, normality, and punishment."[34] Building on Connolly's construction, the vision of healthcare ministry then "opens up new uncertainties within established terms of judgment; it may incite punitive reactions among those whose sense of moral self-assurance has been jeopardized" (Connolly 1993, p.365). To add a layer of complexity to my reading of the Mission Summit, one might read the reaction of the chaplain and others to reveal their liberal presumption of a neutral silence around the Catholic origins and ontological history of the organization. It is possible to interpret the Catholic religious expression of the presenters as wounded indignation, softly righteous as their moral self-assurance has been shaken. In other words, I am not only ascribing the Mission Summit to an errant manifestation of Catholic strong ontology, for liberalism has its own.[35]

In 2003, I attended a large interdisciplinary conference devoted to the issues of faith-based organizations and the social welfare system in the US. In several heated sessions regarding federal funding – by which one means mediated public sources – several organization directors from across the country aired their bewilderment at the level of suspicion associated with public discussions (newspaper reporting, editorials, radio shows) of Catholic-identified social service agencies applying for federal funds. As one program manager interjected, that at the end of the day, each government social service agency and social service not-for-profit, whether religious-based or not, has the same goals. But there was never the same politics of suspiscion leveled at

non-faith based organizations. I would suggest that it is a case of representations and fundamentalist – of the liberal variety – reactions to particular "identities" as they are understood by the public, primed in this society for concerns about the separation of church and state that emerge in very specific modes: proselytization and the threat of conversion. Moreover, it is important to recognize that the American history of anti-Catholic bias engages here with a broader social suspiscion of religion as fundamentalist.[36]

Stereotypes of Catholic, or even more broadly religious, adhere. "Proselytizing" is a rhetoric, a defensive declaration spoken from within a secular framework based on an oppositional identity presumed to apply to a religious character.[37] "Yet when we look at what religious believers are actually like in practice, we discover that a great deal of talk about proselytizing and witnessing is really rhetoric, and has little relationship to what religious believers actually do," contends Alan Wolfe, professor of political science and director of the Boisi Center for Religion and American Public Life at Boston College. Wolfe recounts an anthropological study at McMaster University of the intervarsity atheletic fellowship where sectarian or theological language was confined to use within the bible fellowship, and not used when Christian athletes socialized with non-Christian athletes.[38] Linguistic markers deploy religious vocabulary and concepts to build and affirm intra-group fellowship but not in extra-group situations. It is precisely not a case of proselytizing or conversion; rather it is code-switching (see Silverstein, loc. cit.).

Caring as ethico-political practice

The concept of care as an ethico-moral concept has a long and distinguished history of theoretical analysis.[39] It has also been the subject of examination in various forms by the disciplines of medicine and nursing. The concept of an ethic of care have been taken up by feminist philosophers of ethics, as well as tactical engagements with empathy, and argumentation

proceeding from the encounter with the face of the Other, each deployed in the context of healthcare and medicine.[40]

Catholic traditions of teaching the young, enlightening the unaware, healing the poor and the sick is reaching out to people in their moment of vulnerability to facilitate or reinstate their dignity. Within CPH, this is made manifest in a host of programs from attending to pain management and palliative care, to community outreach efforts as at St. Catherine-by-Sea where a monthly women's forum was initially created to teach such basics as household budgeting and automative maintenance, or a tatoo-removal program for incarcerated gang-bangers. It is exemplified in stories of commitment to service regardless of rank during now-distant labor strikes at Incarnation Hospital. In the midst of negotiations, even senior management came down to recovery units and long term care wards to scrub floors and change bedpans. The Catholic iconography depicting the washing of the feet is not limited to the stained glass in the various chapels of the system's hospitals. It is captured in the opening vignette recounting Catherine's tale of the physician washing the feet of his patient in the charity clinic.

The limitations of perceiving life through a frame of political liberalism presumes that self-fulfillment is linked to individual autonomy where the process of realizing oneself comes to signify the ability to realize the desire of some true internal will. Catholic healthcare ministry presents an alternative, perhaps additional, dimension wherein the process of realizing oneself emerges in the practice of serving the Other. That mission sought out partners from amidst the pluralism of contemporary society to create common ground for a collective effort that sustains collaborative energies that perpetuate and grow an organization that sets such caring as its reason for being. The determination to sustain and advance that mission prompted the Sponsors, first to seek partners within different congregations of women religious, then to initiate and champion affiliation proceedings with secular community hospitals that were also struggling to survive the vicissitudes of the marketplace. Not-for-profit healthcare was at risk if individual hospitals tried to stand alone. A fervent belief in healthcare access as a fundamental human right made not-for-

profit healthcare their common ground. This enabled Catholic sisters to look beyond religious identity to recognize common purpose and the power of collaboration. Different means, a common end; by hook or by crook, a loftier tower. In this sense, the weak ontology that comes into being within CPH is less a teleological model of cultivation, despite its Catholic origins, than being open to "the possibilities of agonal interdependence between an enlarged set of constituencies" created through response to contingency (Connolly 1995: 27). Connolly emphasizes the on-going flexibility that is needed lest there be back-sliding into identity based on consensus or consolidated, already fixed identities. Indeed, the challenge inherent to the ethos of pluralization is precisely this continual recalibration between agonistic respect and critical responsiveness. What I have characterized as the failure of the Mission Summit illustrates the importance of this on-going recalibration.

Michael Walzer reminds us of the public/private distinction inherent to the liberal nation-state norm. But in this context, the public/private sphere is a reductive binary (White: 16,17). It is useful to draw heuristic distinctions as we describe, diagnose and explore. But such divisions, like those between individual and collective, are always culturally mediated and variable, if not directly malleable, within the crucible of time and history. Catholic hospitals are public actors that do not have the luxury of restricting belief to private thought. Consequently, they represent an affront to liberal sensibilities that provide the basis for toleration. The social controversies that seem to attend Catholic hospitals point up the naiveté of a regime of toleration that casts spirituality as a private element of identity. Public unease results when supposedly personal spirituality manifests a dynamic that insists on public action to instantiate itself. In this case, catholicity exceeds the liberal expectation of spirituality when it engages the collective, and takes on a public and necessarily political flavor of religion. The Mission Summit was a representative instance of that dynamic.

CPH is an institutional provider of acute care services. At the same time, it operates as a guarantor of subsidized loans, a philanthropy for community health and social service non-profits,

a change advocate at the regulatory and legislative level, a corporate shareholder, and a partner in social justice campaigns with erstwhile antagonists like the major labor unions on issues of common cause.[41] The extent of CPH's active engagement as a progressive civic corporate citizen are unparalleled in healthcare. Other hospitals do not undertake this scope of engagement with society. Even those hospital systems with comparable size and consequent fiscal leverage do not undertake comparable actions (Kaiser Permanente, Sutter Health etc.) to mobilize their leverage as social actors (government lobbying efforts aside). Other individual Catholic hospitals may engage at a much smaller level, but even the larger Catholic systems do not approach the scale of CPH's civic portfolio; indeed, CPH is a model within the CHA.

From the ontological dimension, these practices sketch the outline of an ethical sensibility with several noticeable characteristics that parallel the Foucauldian model:

> The development of a generous sensibility that informs interpretations of what you are and what you are not and infuses the relations you establish with those differences through which your identity is defined. Such a disposition enables the exploration of new possibilities in social relations opened up by a "weak ontology," particularly those that enable a larger variety of identities to coexist in relations of "studied" indifference on some occasions, alliance on others, and agonistic respect during periods of rivalry and contestation (Connolly 1993: 368)

An example, elaborated elsewhere, of how such a sensibility might play itself out within an organization is the transformation of chaplaincy into spiritual care services. Using the vehicle of Clinical Pastoral Education, Incarnation Hospital was able to extend its vision of holistic patient care into the realm of its system partner, City Physicians' Hospital, in a way that respected the "fixed identity" of that facility as a secular community organization (Lee 2002). When City Physicians' first responded to the idea of chaplaincy, managed by their new Catholic partner, Incarnation's Director returned with a proposal for a multi-denominational and interfaith team. In this sense, CPH practices an ethical sensibility that allows it to address contingency through pragmatic relations, and in this case, turn contestation into alliance.

The Church proper, in the sense of traditional doctrinal identity, reflects what Connolly understands as transcendental egoism, "it silently takes its own fundamental identity to be the source that must guide moral life in general; it is transcendental because it insists that its identity is anchored in an intrinsic Purpose or Law that can be known to be true. In Nietzsche's language, such transcendental egoists insist 'I am morality itself and nothing besides is morality'" (Connolly 1993: 368). This is the element I have evaded, of course, because traditional doctrinal Catholic identity necessarily implies, if not requires, the grounding of such foundationalisms. In the contemporary world, the Church proper must adhere to that doctrinal stance, politically if not ontologically. Not engaging in theology *per se*, the sister-sponsors need not necessarily adopt such a stance, taking it instead as their own internal motivation. In public, within CPH, their moral stance begins with the charge to care for the poor and the sick modeled on the historical figure of Jesus the healer. The possibility that for the sister-sponsors that figure might also represent a redeemer or messiah remains unspoken, *agere sequitur credere* [we act according to what we believe ourselves (to be)]. It is in this sense, then, that such interior ethics and external moralities may reflect more a liberal secularization than a Protestant secularization of a Catholic organization.

Catholic pluralisms

In a landmark ethnographic study of Southern Catholics, anthropologist Jon Anderson laid the premise for his group study using the concept of a Geertzian cultural system. Anderson argues that this approach is more than simply value profiles, but also styles of narrative, decision-making and of gathering...as well as "[the] filters of expectation, interpretation, understanding, practice and experience and the meanings that people attach to them..." (Anderson and Friend 1995: 80). Similarly, my analysis is not an attempt to construct a normative religious identity. Such anthropology is grounded in the particular though there is by necessity appeal to the original source of Catholic identity, the Church and its organs, but recognizes the abstraction that such

officialdom connotes. The fieldwork engaging with the lived experience of people and the organization they constitute has shown how that identity is actively managed in the face of the contingency of gender, culture and now various pluralisms.[42]

The organizational identity that I attribute to CPH does reflect some distinct "cultural" characteristics of particular developments within a Roman Catholic ministry. Engaging with the actors and various situations within the hospital system illustrates how the expression of ethics and social values results from a constellation of factors and influences to which this organization is subject. First, it is an identity informed by the particular history of affiliation and merger. Second, it engages what Samuel Hill has called the Catholic Imagination:

> [that] points beyond theology and ecclesiology, the content of belief and practice, to their methods that, in extending religious sensibilty into the world, are themselves extended beyond the realms of religious belief and practice. It points to usage and implementing of ideas, understandings and practices that people apply to additional domains of experience (Anderson and Friend 1995: 3)

In the religious-cultural milieu of the US healthcare industry that these particular Catholic women religious find themselves as hospital operators, they both accommodate that socio-political environment and contribute to it their own ethical integrity in the provision of healthcare services.

One of the priests I worked with struggled to explain the differences he felt in working in this healthcare ministry, especially in terms of his relationship with sister-sponsors. He articulates the pluralizing element that determines their particular vein of catholicity in terms of gender, though he had begun the conversation in terms of the particular charism of the sponsoring congregation associated with that hospital.

> P: I learn a lot from these women. They're such an inspiration. Particularly because of their vision of church – it is a much broader experience of church than the institution.
>
> I: Can you say more about that?
>
> P: Well, as I was trying to remember their [biannual] assembly, one of the things that - I'm trying to remember - I was trying to remember if there was a - I guess what I would say is - what I - it's the feminine nature that the women bring. Growing up in a - basically a masculine culture, and being trained in a masculine culture, just to hear how they make

> decisions as a community, that is out of relationship with each other, it's so different from my [religious] community experience as a man. So I think that - what I appreciate about the women here is that they remind me that you have to have this balance of the masculine and the feminine, and that they bring this feminine quality that talks about establishing relationships, and so you have this effort to try and see this more than just as a business, but of really trying to be present to people, to employees, to the patients. I think that that value of being women, and how they live their lives with one another in relationships kind of flows into how this hospital operates, people trying to care for each other.

I have mentioned elsewhere there are women religious in the local CPH facilities who are visible in the hospital but are not sister-sponsors. As members of their own congregations, they undertake particular ministries, such as chaplaincy or even management positions. For example, a Sister of the Order of the Presentation worked as a staff chaplain at Incarnation Hospital, just as a sister originally from Nigeria was now a chaplain on staff at Denomination North Hospital. Their congregations are not canonical sponsors of CPH, but they lend not just their good works to the system but are also a visible Catholic presence walking the halls as they provide pastoral care to patients. As non-sponsors, they inhabit an intermediary social space in the hospitals that loosely resonates with some of the power/influence dynamic I have described in sister-sponsors but not others, while also embodying features of lay administrators. In particular, non-sponsors do not participate in the same proprietary relationship to hospitals, and so align more closely to the social sphere of physicians or other staff. However, not all lay staff recognize the distinctions between women religious active in a local hospital facility.

The involvement of administrative professionals who are former women religious constitute a special case of lay administrators. These women have chosen over time, for one reason or another, to renounce their vows and leave religious community. This is particularly evident in the Mission Integration team. Though several key actors are no longer sisters, they are still considered to be insiders; indeed, some suggested that being a former sister-sponsor lends one more access and political influence than being sister affiliated with a congregation that is not a CPH sponsor. Certainly, "there is no shunning amongst sisters," as someone joked, and if women leave the congregation but choose to remain involved as lay people, their efforts are

welcomed. I suggested their continued involvement in the ministries was an effect of formation, a case of the apple not falling far from the tree; Marie preferred to see it as "when fruit from one tree falls and rolls over to rest at the base of another" that reflected a greater sense of free will, rather than lasting institutional effects. She contrasted this from the behavior of many in the priesthood towards their former colleagues who have given up the collar, something that was confirmed in my conversations with the father.

When I raised the issue of former sisters with Marie, she strongly emphasized the distinctiveness of this group within the Mission Integration team. She argued that I had to recognize them as a different specie, least likely to conform to the idea of "lay" because of their personal history of reflection and self-examination with regard to how theology plays out in their identities. However, she argued that as a result of having made the decision to leave religious life, they are least likely to have personal belief systems that align with the traditional, doctrinal Catholic Church, however strongly influenced they may have been in undertaking such self-reflection. Consequently, her colleagues may have "a stronger engagement with spiritual sense-making." For example, it is not accidental that the strongest advocate of spiritual care services in the system is a former sister, who affirms the significance and value of a trained and diversified chaplaincy program but fully aims to set spirituality as a hallmark of the system – in the workplace, as well as in patient care. And yet this might be exactly why they are a significant element of the Mission Integration department for the system. She spoke about the lasting effects of formation, and the perspective that lends to working within CPH:

> Yeah. Because I have a way deeper understanding of and more courage for things, frankly. I have a deeper understanding of what the Church's thing is, how the Church is in the world. Which even somebody like [a Protestant ethicist from another system], from the outside, doesn't have. And I think a lot of Catholics on the inside don't particularly have it. They have the idea of—I mean, I think you need to be schooled as an adult in theology, ecclesiology, to have a different understanding of what the Church does in the world than what most people who are Catholics going to church have. So even if those people were in Catholic health care, I don't, I don't think it would, I don't think it's a grown-up enough view of the Church. I also think, one of the reasons, well, the other thing, this is an aside. But I do think the other reason that being a former nun makes a difference to me, because I'm not

> afraid of those ladies at the top. I know exactly how they tick. And I know how, kind of how they live, and it's just, it's nothing to be afraid of, you know.

It is precisely their presence that enables the kind of "lower-case C" catholicism – the distinctive catholicity operative in CPH – that the system seems to bring into being. What several of us took to calling "lower-case" catholicism is not a dilution, that is, any less really Catholic (if there could be such a thing)[43] but precisely the weak ontology I have discussed here.

This matters, for it complicates my analysis. The majority of fieldwork was spent in the CPH system office, though my time in other locations counted together was greater than the time spent there. My participant observation there is colored by several years of familiarity with the individuals on the Mission Integration team. Moreover, my entrée to the system occurred through that group of women. Thus, it is possible that I over emphasize their significance; however, their role in the structure and implementation of mission integration strategies is irrefutable.[44]

Oikoumenē

The presence of these outliers, non-sponsor sisters and former sisters, within CPH demonstrate the elements internal to the organization's catholicity. Also while I do not intend it as a straw man, my construction of the traditional doctrinal Church identity cannot be a water-tight framing. As the discussion of encyclicals indicates, the Church has undergone some, perhaps significant, efforts at addressing pluralism, liberalism, most particularly in *Gaudium et spes* and the historic moves to address Rome's sister Churches, relations with the Protestant churches, non-Christian religions, indeed, all of mankind. All of which is so inadequately summed up in the concept of "post-Vatican II."

Social change happens everywhere and, as socially constituted entities, religious organizations must contend with such shifts, reconciling them as they can with theological interpretation and/or divine inspiration. The challenge that social ministry presents is that even grounded and driven as it is by theological tenets, what the ministry calls people to do makes

religious concerns necessarily political. Ethics are politics, if who you are is inseparable from what you do in the world. Being Catholics-in-the-world make women religious very different from other Catholics involved in the Church's other forms. The sticking point of identity comes out in the adherence to particular prohibitions regarding sanctioned behaviors (abortion, some cases of assisted reproduction). It is present in the foundational recognition given to of the "healing ministry of Jesus," even invoked as a historical figure representative of human compassion rather than the salvific incarnation of Christ. Even as they negotiate the norms and forms of their contemporary organizational identity, I have heard Corporate Members reiterate their commitment to driving a real mission integration that means sustaining a fully dynamic facility if it is to bear the CPH name. When the conversation turned to holding onto hospitals that could not live up to that expectation, there was no support for hospitals that are merely "Catholic-like." A CPH facility would be held to uniform expectations and standards of operation, not merely financial survival, but civic engagement and transparent community benefit; what that meant was "let's don't pretend; if we can't we can't, let's be honest with the community."

Back at the fish pond, in the hospital garden, an older sister-sponsor continued to reflect on her years with hospital ministry. In her time, she had taken her turn leading the Congregation, managed a hospital service line, initiated, revived and juggled multiple community outreach programs, raised matching funds, redesigned nursing units, cajoled unions and recruited physicians. She told me she did see her own work in terms of a vocation, as a calling that made her a Catholic woman religious. Though she had earlier described it in terms of the moving of the Spirit, she had detected a generous sensibility about those with whom she had worked:

> P: Sometimes I think we think that only people who have some kind of a religious belief understand ministry. I really think people, even if they are - think of themselves as atheists, can have kind of a civic commitment to serving their fellow human beings. That sustains them. You know. Entirely different motivation, coming out of a different source. It's here. You have it here, in this hospital. And so even though our core belief comes out of a Judeo-Christian tradition, people can relate to that because they come at it because of the outcome for what it does for their fellow human being.
> And who's to understand, you know, I'm not saying one is better than the other. I'm sure that had something to do with why in the system - maybe not directly, there are hospitals that

have joined the health-care system and - not out of any kind of a religious tradition, but simply out of just this common value of service. In a health tradition, right? I mean, that's essentially what it is. And so there's that language, too, you know, because we unconsciously or consciously kind of associate ministry with belief in a god, and in particular in Jesus Christ. Whereas somebody else can come to this whole sense of ministry and not believe in either one. You know, which makes it interesting....

Common ground: secular ministry

As I have suggested, a central challenge for the actors from the religious dimension of CPH is the struggle to recognize their own misperceptions of their secular community partners in the context of the particularly acute power dynamics that stem from the political history of the CPH system. Many social formations and dissolutions happen around notions of "the good." As the sister's reflections suggest, it is not only on those engaged in explicitly religious work. Not-for-profit organizations dominate the hospital industry throughout the US, despite an on-going debate about their value, distinctive contributions, and efficiency (Schlesinger, Gray et al. 1996; Young and Desai 1999). The Catholic magisterium has traditionally critiqued American society for failing to articulate an adequate conception of the common good and human purpose (Douglass, Mara et al. 1990; Byrnes 1991; Gaillardetz 1997). In the words of the late Cardinal Bernadin (1999: 91), not-for-profit hospitals are "mediating institutions": they stand between the individual and the state, and "mediate against the rougher edges of capitalism's inclination toward excessive individualism."

There is a prevailing rhetoric about inhumane, capitalist economics that unions and consumer groups use to batter hospital systems like CPH, which they perceive as impersonal corporations acting in spite of their not-for-profit designation and, in this case, their religious mission. But the righteous stance of this chastisement itself derives its social weight by invoking an underlying cultural rhetoric suggesting that all spiritual endeavors in the temporal realm carry a tone of moral superiority. That is, the expectation that religious hospitals should, by definition,

be held to a higher standard than their secular counterparts. The for-profit orientation that encircles hospitals like CPH and other not-for profit hospitals represents a second paradigm also operative within the pluralization framework.

Two secular community facilities in CPH, Denomination North and Downtown Hospital, both struggled financially in the years during which I was engaged with the system. However, they were consistently called out for being two of the most "mission-driven" facilities in the system. Despite the fact that this was accepted as common knowledge and repeated several times in different places throughout the system, the two facilities did not come up as exemplars for the Mission Summit stories, as they might have.

These two hospitals both have close-knit management teams. In one case, there is a history of competition with the precursor of CPH before it affiliated, and in the other, the senior management team was constitued only relatively recently. Both, however, feel a belabored relationship to the system, particularly as member hospitals within the cohort of non-Catholic facilities. One management team largely wants to be left alone to do what they do, and resents the system's centralizing trajectory. The other also has trouble with the mandates but seems to have developed close relationships with the mid-level managers from the system office with whom they work regularly, rather than the senior leadership. In both hospitals, I repeatedly heard the hospital president describe the situation as one of "not understanding the local situation." In both cases, the speaker was a male executive with a for-profit background *and* an articulate champion for comprehensive mission integration, whether or not he was identified as the "mission lead."

Individually, and with respect to the leadership teams each had built around him to manage their respective facilities, these presidents had themselves made the transition into the CPH system but were not recognized for having done so. That adjustment reflects a parallel adaptation to a weak ontology of a different sort. Though the leaders, and their facilities before them, had signed on to the mission and core values when each hospital affiliated, the perception in the wake of the centralization transformations remained that they were somehow not on an

equal footing with their counterparts. In this instance, it seems the cultivation of an ethos of pluralization was also obstructed.

In this chapter, I have stepped back from the daily operations of a Catholic hospital in a modern California town, past the role of the CPH system in healthcare rationalization, to think about what such a social object suggests for how we think about the social constitution of identity and the enactment of values in the social sphere. Recalling the practical observation from Geertz that marks the beginning of this chapter, I engaged contemporary political theories on pluralization can provide a lattice work on which to hang the social fabric woven at CPH. I have tried to suggest that the ethos of pluralization is both something that seems in moments to exist within CPH and yet also to be a state that is still in the process of cultivation. In the next chapter, I return to the particularity of the Catholic Pacific Healthsystem to engage the new form of catholicity it represents in the concept of co-sponsorship, and delineate all that concept entails for the system and the people it seeks to serve.

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[1] (Geertz 2000, p.234)

[2] The lecture was a spirited explanation of the challenges for leadership in the "faith-filled post-modern organization." Despite some confusion about the Gospel as metanarrative and various "post-isms," people seemed to appreciate the idea of change inherent in the message that "modern solutions to postmodern crises are insufficient and likely to prove futile."

[3] The atmosphere also seemed to condone a sectarian identification that might otherwise have remained marginal. Community colleagues were particularly disgruntled, and many of the Mission Integration staff shocked, when a staff person from one of the small rural hospitals, a self-proclaimed born-again Christian fundamentalist, used the speaker's references to the "healing ministry of Jesus" as a launching point to expound on her own experience of "saving a patient." This initiated a quiet intervention by several of the spiritual care leaders a few weeks later to re-examine the parameters for chaplaincy and patient care in that service area.

[4] Connolly briefly treats "tolerance" and sets it aside (1995: xvii); I find his argument persuasive and eschew that term here for the ambiguity of tolerance remains vexing. For a different take on how toleration works, see (Walzer 1997).

[5] "Affiliation" was the CPH term of choice during the growth phase of the 1990s. When other hospital systems like investor-owned HCA and Tenet were undertaking "mergers and acquisition," CPH chose to affiliate, with the explicit attention to how the new member hospital would perceive the change. This approach is examined in the later discussion of Co-sponsorship, see next chapter.

[6] Pellegrino, "The Catholic hospital: Options for survival" *Hospital Progress* 56 (February 1975): 42. Cited in Risse, p. 554.

[7] See (Hart 2000, p.79)

[8] See for example Kenneth Woodward's review (New York Times, February 16, 2003) of John Fialka's recent history, *Sisters: Catholic nuns and the making of America*, St. Martin's Press: 2003.

[9] Similarly the diffused Protestant culture of the US gets hung up on perceptions of what Catholic connotes, namely popery. Witness the controversy that ensued around Kennedy's presidential candidacy. As recently as 1999, the proposal of a Catholic cleric to be chaplain to the US Congress was highly contested; the position had always been occupied by a Protestant cleric in the past.

[10] As referenced earlier, see Wendy Brown's *States of Injury*, 1995.

[11] Brad Weiss, "Thug: realism: Inhabiting fantasy in urban Tanzania" in *Cultural Anthropology* 17(1): 93-124, p.99.

[12] During my fieldwork engagement with CPH, I monitored and collected official transcripts from the Vatican through an electronic weekly summary produced by Zenit, a news agency that documents official reports from Vatican City and issues in the Catholic diaspora. I do not wish to exaggerate the externality of "culture" for it is a multi-dimensional argument that bears a more extended treatment engaging a host of doctrinal and social teachings I cannot undertake here. However, several dozen documents collected through Zenit over the years demonstrate that Roman Catholic political rhetoric continues to cast "culture" as Other, arguably in the sense of *ad extra*. Further work on this argument and its implications will follow the dissertation.

[13] For a Roman example, see "Towards a pastoral approach to culture," Pontifical Council for Culture, Zenit, June 4, 1999. See also "Cardinal Poupard on the divorce between faith and culture," Zenit, June 5, 2002.

[14] Angrosino uses *Vatican II: the Conciliar and post-Conciliar Documents*, rev. edition. Austin Flannery, ed. pps 903-1001, 1992: Northport, Costello Press. Abbott 1966 reads: "culture must be made to bear on the integral perfection of the human person, and on the good of the community and the whole of society."

[15] As I have elsewhere argued, the Church's long-standing oppositional stance towards "culture" impacts the question of the place of reason in human life and plural worldviews particularly on the purpose of science and technology as facets of modernity.

[16] Other faith groups established hospitals for other reasons; for example, discrimination (refusing Jewish physicians admitting privileges), faith/belief that affected practices (Seventh Day Adventists prohibitions on the use of blood products). Catholic practitioners often faced similar issues, but only the Catholic tradition had the relationship of vowed women to the establishment of their healthcare facilities.

[17] There are a few facilities that do not have this same relationship to diocesan bishops, namely organizations that are constituted as private juridical persons under canon law; for example, PeaceHealth, a system that operates in the Pacific Northwest.

[18] One of the most respected voices addressing ecclesiological authority is (Sullivan 1983). There is an extensive body of work concerning the shape of American Catholicism, see for example, (Varacalli 1983; May 1987; Hollenbach 1988; Weigel 1989; Greeley 1990; Yuhaus 1990; Elshtain 1994; Gelm 1994; Hollenbach and Douglass 1994; Topman 1995).

[19] As, for example (Burns 1992).

[20] There is an extensive literature on *authority* in the Catholic context. An important treatment is found in (Dulles 1988). For specific attention to lay people, see (Vaillancourt 1980), and (Weaver 1995) on women and women religious.

[21] Any discussion of papal encylicals or other documents produced by Rome or the broader magisterium should recognize that the political history and social construction of authoritative doctrine, analogous to the documented creation, for example, of the Treaty for the Establishment of an International Criminal Court (see for example (Lee 1999)). The final product is often treated as a singular phenomenon, erasing the complex social processes that underlie its creation through committee, conference, drafting, editing and administrative politics. The Spirit may indeed provide the inspiration or otherwise guide the work of Church fathers but such doctrine is created through a mundane and social process.

[22] Asad's s interest here falls on the nature of the state in the modern world. He perceives that the distinctive characters of secular state are strategic and administrative disciplines, that in turn may give form to the political ambitions of contemporary "fundamentalist" movements that dot the modern landscape (Asad 1992, p. 11). Further consideration of this point is not possible here. Cf. (Faubion 2001) and (Crapanzano 2000).

[23] *Quadragesimo anno* celebrates the 40th anniversary of the 1891 encyclical, *Rerum novarum*. Catholic scholars consider that document from Pope Leo XIII to be the founding articulation of social doctrine. It reflects, however, that pope's aristocratic background in its paternalistic concern for the working classes

and, at the height of the Church's rejection of liberalism, clearly asserts a more *ancien régime* type of social organization onto the contemporary world.

[24] I have elsewhere referenced the literature of historical and sociological accounts of Catholic women religious.

[25] In (Asad, 1992: 10).

[26] The critical literature of liberal secularism is vast. For a compelling treatment that engages some of the analyses referenced here, see (Connolly 1999).

[27] Early American examples include Puritan Roger Williams; some writing by Stanley Hauerwas follows this line of thinking, for example (Hauerwas 1983).

[28] An excellent contemporary treatment can be found in (McKenny 1997).

[29] This resonates with the intense, if not always elegant argument laid out in Blumenberg's *The Legitimacy of the Modern Age* (Blumenberg 1983).

[30] See, among others (Marty 1959; Gehrig 1979; Marty 1981; Bellah 1992; Bellah 1992; Walsh 2000).

[31] Clinical Pastoral Education may represent on such manifestation, particularly in the context of healthcare economics, organizational rationalization and contemporary religiosity, see (Lee 2002).

[32] For example, consider what argument might be made of the secularization of Christian theology, in the way that a metanarrative of redemption can be read into the ministry of healing rendered within the capitalist structures of profit exchange and taxation which enable a not-for-profit to come into being.

[33] Keane notes the relevance of Ernst Troeltsch's work on modernity and Protestantism wherein the thinking of freedom, personality and of the autonomous self that characterizes modernity emerge from the Protestant schism, see (Troeltsch 1958).

[34] Arguably metaphoric, the sisters (and I) see this last as bitterly real, in the sense that contributors to the capitalist economy are rewarded with healthcare, while those denied or unable to participation in production, the sick and poor, are "punished" by lack of access.

[35] Certainly this is what lends legitimacy, in academia and elsewhere, to criticisms of "political correctness," see (Connolly 1999).

[36] Again, anthropologist Vincent Crapanzano's recent work is useful here, see (Crapanzano 2000).

[37] It is precisely this spectre of proselytization that so galvanized participants when the evangelical Christian staff member shared her patient care experience at the Mission Summit.

[38] Alan Wolfe, opening plenary session: "Politics, religion & the public interest." 2003 Spring Research Forum, March 6, 2003. Washington DC. Independent Sector and the Roundtable on Religion & Social Welfare Policy. See also (Wolfe 2003).

[39] See, for example, Hauerwas and Campbell in (Lammers and Verhy 1987: 262-73).

[40] For example, (Tronto 1993; Bowden 1997); and on empathy (Spiro, McCrea Curnen et al. 1993; Halpern 2001); on the encounter with the Other, see (Welie 1998).

[41] The hospital system's relationship with unions, as well as the model of civic engagement that CPH espouses are considered in greater detail in the context of sponsorship in the next chapter.

[42] What I have sought to do through anthropological analysis of Catholic Pacific Healthsystem might also be done with various groups within the Vatican or the Holy See, as well as the US Conference of Bishops. For one effort with this last group, see (Angrosino 1996; Angrosino 1996b; Angrosino 2001). For a worthy account of Vatican society, see journalist Paul Hoffman's (Hofmann 2002). Legalists may note that Hofmann's title collapses the State of Vatican City (civil administration) with the semantic expression of the unique sovereignty of the papacy, a distinction he clarifies in the fifth chapter.

[43] "Authenticity" is another anthropological object entirely.

[44] Moreover, in the tradition of qualitative research methodologies, the fieldwork timetable was designed to compensate for this bias. Because my initial engagement with CPH had occurred in the system office, dissertation fieldwork began first in a local charity clinic for several months before turning to the system office, followed by several months spent in local facilities well removed from headquarters.

Sponsorship & Prophetic Witness

> "The Catholic response is similarly withdrawal into a religious project, but one with different goals and means [from Protestant Christianity in the post-Reconstruction US]. Besides the sanctuaries marked from the world at large and from other Christian church buildings as sacred spaces, this religious project extends to institutions (monasteries and convents, schools, *hospitals* and orphanages) that convey and embody a Catholic presence in the world"
>
> - Jon Anderson[1]

Though foundational in their motivating force, faith and belief can constitute a problem in the understanding of the politics of identity at work in a Catholic hospital. Some might argue that in a liberal setting that hinges so much on pluralism as the ground on which collaboration can proceed that issues of faith or belief should be dispensable. Such a claim dogs secular analysis and may represent one of the great failings of liberal tolerance. Lauren Winner criticizes just that mistake in her review of the book, *Spiritual genius: the master of life's meaning* by Winifred Gallagher. Winner writes:

> Gallagher fails to make room for the unfashionable belief, shared by the orthodox of most of the world's faiths, that there is something exclusive about the nature of religious truth claims....[In her earlier work] she concluded that religion needn't focus on belief. ... but for evangelicals listening to [the interviewed preacher]'s sermons, Gallagher's dichotomy between worthy social action and discomforting belief in the uniquely salvific work of Christ would be unintelligible.[2]

Faith and belief are inseparable form action in the world. For Catholic women religious, belief is not dispensable in the public sphere. Their hospitals are manifestations of a belief system, a value system, that is intrinsically political in nature. They are a site of action, for being-in-the-world that is emblematic of a worldview that holds access to healthcare up as a human right. It is an actor in caring and a witness to suffering.

In the 1951 encyclical, *Evangelii Praecones*, Pope Pius XII had suggested that Catholic hospitals could serve as a means to bringing other Christians closer to the Mother Church.[3] Thus, sponsorship carries with it multiple meanings. It is a symbolic presence in a community, as suggested in the quote by anthropologist Jon Anderson, and that symbolic presence can act as a

witness to people in need, people of faith or not, as Pius XXII perhaps intended. Certainly, in the course of my fieldwork, no one in a Catholic hospital understood "bringing closer" to mean attempts at conversion or proselytizing in the crude sense of recruiting a person to Catholicism. As I have argued through the ethics of articulation, religious language carries meaning and intention. When different "value spheres" overlap and interact, lexical dimensions similarly shift (cf.Weber 1958; Heller 1999). But the reigning liberal presumption of faith as a private matter means that religious language can engender discomfort when it "intrudes" into the public realm.

At a forum on issues of federal funding and the faith-based social welfare system that I attended last year, "proselytization" and "evangelization" were broadly hailed as the great rhetorical bogey with which faith-based service providers must contend.[4] Researchers and providers from faith-based organizations were quick to point out that, in their experience, proselytizing, meaning blatant attempts at sectarian recruitment, never happened on their watch. This is not to dismiss the possibility that proselystization might well be an objective for some faith-groups or faith-based organizations. It is to challenge the presumption that faith-based organizations, by definition, necessarily engage in such practices, and furthermore, that this would be the primary justification for prohibiting public funding of such service organizations. During my fieldwork, "evangelizing" carried a different sense. For example, when my research appeared in a peer-reviewed journal, my informants at the system office shared the article with the sister-sponsors in governance. A colleague at the system office wrote to the sisters:

> His article helps illuminate why spiritual care is so important to Catholic health care today, particularly in its commitment to holistic care...[CPH] is clearly a leader in bringing professionalized spiritual care services to all who come to us for care. One of the reasons we expanded [CPH] from only Catholic hospitals to include "community" hospitals was to bring that holistic, spiritual care to patients. Simon's paper documents one geographic setting where that form of *evangelization* was a success."
>
> (Email communication 2003, italics mine)

Here, the evangelization is the sharing of the Gospel-based worldview that patient needs are holistic and require that hospitals make spiritual care services available for all patients, in the form of interfaith, ecumenically diverse chaplaincy staff that the CPH system supports in its facilities. It was not about bringing individuals into the Roman Catholic Church, adopting Christian beliefs or pushing patients to engage with spirituality. If there has been a "conversion," it is not of patients, but of a hospital environment where, in the eyes of the Catholic sisters, their decision to sponsor as part of CPH a community hospital has enabled that facility to provide healthcare in a way that promotes the principles of human dignity and religious freedom, per the Ethical and Religious Directives for Catholic Healthcare Facilities.[5] Moreover, since 1995, "patient access to pastoral care and counseling" is a evaluation criterion for the national (and secular) accreditation process for hospitals by the Joint Commission on Accreditation of Healthcare Organizations, or JCAHO.[6] As this electronic communication to the governing board reflects, sponsorship lies at the heart of identity in Catholic Pacific Healthsystem.

In the last chapter, the discussion of the ethos of pluralization suggested a number of different threads that contribute to the fabric of catholicity within CPH. I indicated how the priority placed on sustaining not-for-profit healthcare opens the way for collaboration with secular hospital partners. I have suggested that several former sisters, with their central role in mission integration, might have a further pluralizing effect on an already diverse group of sister-sponsors (from multiple sponsoring congregations, each with their own traditions and legacy). Sisters already represent themselves as and, seem to me, to be the more progressive – read democratic social group – within the larger Church, in part, because their calling to serve sets them in-the-world, and the legitimacy of their Catholic identity lies in their witness and advocacy rather than doctrine or liturgy.[7] Many of the Sponsoring Congregations behind CPH are outspoken champions of social change; the national Leadership Council of Women Religious (LCWR) is particularly noted for its willingness to engage in public advocacy efforts. Again, their catholicity is about service that brings them closer to the people for whom they care. That

engagement is further complicated by the distinctions drawn by the magisterium between issues of faith and morals and issues of temporal concerns like culture and politics that I drew out in the effects of Vatican II documents on the ethos of pluralization.

This chapter considers the concept of sponsorship in the context of that ethos of pluralization. Beginning with the traditional canonical understanding of ministry sponsorship, I examine the new form brought into being in Catholic Pacific Healthsystem, constituted by multiple congregations of women religious and their collaboration with secular community sponsors of other not-for-profit facilities. Such expanded definitions open the way for understanding the ethico-moral effects that such (co)sponsorship allows in terms of its objectives in the world.

Multiple identities

Sponsorship is the externalizing of identity and therefore it engages a politics of representation. During fieldwork among CPH governance, I could almost see the metaphorical hats change as conversations among board members and sisters tracked different concerns. One morning, a sister was in the midst of a conversation about access to healthcare and how to support a postcard campaign among Californians to push such an agenda in the state legislature. But when conversation shifted toward US policy on undocumented persons, that same sister seemed to stop speaking as an individual board member and, reinstantiating her role as the elected leader of a Roman Catholic congregation of women religious, she was outspoken in her assertion of the congregation's public stance even as she sit at a table with her own fellow board members. It was also a reminder that however large a player CPH is in the region, it is only one of many ministries that her Sponsoring Congregation sustains. In another instance, when CPH senior management began discussing what came to be called "Portfolio Review," it was no surprise that the sister-sponsors in governance were very pragmatic and emphasized the need for rigorous criteria to

determine how the evaluation might re-shape the system. At the same time, the possibility of selling or closing a Catholic facility that had been a sponsored ministry for more than a century prompted the sister-sponsors to ask very tough questions. Sisters understood that CPH had not been able to turn operations around at the facility in question, thus prudent stewardship would indicate sale or closure. Their concern remained how that local community would be served going forward, particularly persons without insurance and the poor.[8] The questions of the Corporate Members prompted staff to consider more seriously non-hospital forms of ministry that might be initiated if St. John of God were to close its doors.

Returning to the earlier account of the Mission Summit, one might ask why the speakers and they called the "stories" of their Congregations and their hospitals held such a Catholic flavor, and why no one anticipated the need for a structural counter-balance that offered similar "stories" from the secular community hospitals. It seems the Corporate Members who spoke at the Summit rose to speak in the persona of official leadership of their congregations, rather than in the dimension of their leadership of CPH as an organization that collaborates. Sisters feel very strongly about their traditions and the distinctive charisms that color their respective religious communities. In "telling their stories" in the context of the inaugural mission summit, they spoke from an authentic space of Catholicity, rather than from the more particular space of catholicity. When identity politics are made public, the leaders are often compelled to express their formal and official roles, in this case, Corporate Members as leaders of Catholic religious orders. Other scholars have noted trends in visibility, and political flexibility, depend on public scrutiny. For example, Robert Burt notes Church relations with US legislators were "discreet" and "reticent", the legacy of anti-Catholic sentiment, until the Supreme Court case of Roe v. Wade initiated a "publicly visible political campaign."[9] Here, the public visibility of presenting at the Mission Summit changes how representation is manifest in the concept of (co)sponsorship, and the relationship between articulated core values of the broader Catholic Church and the mission of the Catholic sister-sponsors that drives CPH. Which hat a Corporate Member wore at

any given moment was particularly revealing for what it highlights in the ethico-moral construction of the identity of the hospital system.

There are contemporaneous but often-times opposing streams within identity. Remaining and maintaining a clear and coherent connection to the identity of the formal Catholic Church, through the ongoing involvement of sister-sponsors across the organization, the identity of Catholic Pacific Healthsystem runs along parallel but different tracks created by the need to create an accommodation that facilitates collaboration, endears partners and allies, and welcomes patients and community to receive services. Agonistic respect acknowledges there will be points of friction. But pragmatism, derived from being-in-the-world, is the operative frame for the sister-sponsors and thus the ethical character to which CPH aspires.

That said, when push comes to shove – at "identify-yourself-time," as one former sister in Mission Integration called it with a smile – those same sister-sponsors who have initiated the catholicity particular to CPH do ascribe to a meta-narrative that informs moral valuation, and they recognize their roots in a strong ontology of fixed transcendental egoism. The question that stands then, is when does the push come to shove? Obviously when challenged they assert themselves as a legitimate arm of the Church, but when the identity challenge comes from elsewhere within the Church, then they hold their ground quite differently.

Meaning of Sponsorship

The ministries of Catholic sisters are diverse. For example, one of the largest orders of Catholic women religious is the Sisters of Mercy of the Americas, with nearly 15,000 sisters worldwide. Only 12% are involved in healthcare ministries like Catholic Pacific Healthsystem. The majority of the Mercy sisters are engaged in education (21%), prayer ministry (24%), parish and pastoral services (12%), as well as social services, justice and advocacy, housing, support services and administration in much smaller numbers.[10] Other religious traditions or faith groups

also undertake to sponsor healthcare ministries in their own way reflecting the traditions of their faith group. The Kendal Corporation is a non-profit Quaker organization founded thirty years ago. Like the low-income housing initiatives that the Sisters of Mercy sponsor, Kendal Corporation builds and operates retirement communities, with facilities in five eastern states. In addition to being a non-profit organization, Kendal facilities have a policy of not using pharmaceutical or physical restraints even for the very frail elderly and the facilties' physical design aspires to the Quaker tradition of practical simplicity.[11] Similarly, CPH hospitals champion palliative care and aggressive pain management protocols that reflect their religious values. Their interest in spirituality extends beyond patient care to the employee workplace so most CPH facilities have a dedicated space – sometimes a chapel, sometimes just an office furnished as a meditation room – for contemplation, reflection or prayer in the course of the work day.

In healthcare, as well as other ministry specialities, the Catholic tradition of sponsorship is linked to the history of the Church's organizational structure. Following the Church model of vertical hierarchy, sponsoring congregations have undertaken activities and projects that reflect their particular calling to minister. The field of their sponsored ministries is most commonly a historical artifact based on the work of their founder. Venerable Catherine McAuley, founding mother of the Sisters of Mercy, was moved to care for the urban destitute in Dublin of the mid-1800s. Despite her family's wealth, and an additional legacy bequeathed to her later in life, McAuley assumed a simple life of service and dedicated her personal fortunes to the schools and houses of refuge she established. That "charism" inherited from McAuley continues to inform the character and nature of the Sisters of Mercy today while it directs the focus of their current ministries.

Charism is a complex term in the Catholic world, because it extends beyond psychological and social characteristics into the spiritual and ethical dimensions of identity. One sister tried to explain what charism meant to her, noting that younger sisters might reach for more

psychological terms. She felt she was more of the old-school and thought that identifying with the charism of a foundress enabled her to have a human exemplar of the Holy Spirit. In this respect, charism also describes the ontological register that sisters seek to emulate both individually and as a collective; the relationship between the ministries and one's fellow women religious reinforce each other across space and time. The sister continued, trying to describe it in terms she thought would resonate with me:

> But to me, charism is like a corporate personality center, that's what it is, I think. And it usually - and it's shaped by a variety of things - history, traditions, formations, education, but formation, for ministry and your experience. Our congregation for many years didn't - really never even had regions. And we have regions now, but there are some communities that have regions that hardly knew each other. In our congregation, we started out with one mother house, you know, and so even though we're regionalized, you can go back to [the location of her Motherhouse] and see somebody from Florida or something else, and you can say, oh, we taught together in [St. Nick's] in Chicago. You know what I mean? So that - so - that - that shapes the charism. But I realize it has more of a depth to it, but somehow or other, it just strikes me as being similar to a corporate personality.

The more institutional manifestations of sponsorship, as for example the hospitals in CPH, have long operating histories in the communities they serve representing decades-long commitments of resources. The charism model contributes significantly to the organizational identity of the sponsoring congregation. This plays itself out in the politics of selection and representation, and helps explain why mission services positions in the past were often filled by a quick call from a hospital president to the sponsoring congregation rather than through a more formal search with explicit competencies and professional expectations as the Mission Integration standards now hope to establish. A sponsoring congregation would naturally feel proprietary about mission and how it is enacted in *their* hospitals.

Thomasina is a women religious who has held a number of directoral positions related to various management structures within CPH. She has played a crucial role in many of the community hospitals assisting senior administrators to acculturate to their new role as part of a Catholic system. When asked to reflect on the efficacy of her position in the organization, Thomasina immediately affirmed the significance of being a sister for her particular tasks. A

slight, bright-eyed woman with shocking black hair, a laughing voice and bird-like energy, Thomasina was uncharacteristically soft-spoken as she related her past experience as a sister from outside the Sponsoring Congregations.

> [When that hospital affiliated], there was not an opportunity for, you know, applying through Mission Services [now Integration]. [My colleague] was immediately appointed as the regional [person] in mission, and I was told goodbye. So twice it happened to me, you know, where I wasn't a sponsor. The sponsor had the edge, even though I probably had more experience and credentials for the position. So it's been an interesting dynamic in CPH around this whole sister thing.
>
> I: You're the only member of your community at CPH? Is that hard?
>
> P: Not really. The harder part is, you know, the reality that there is the feeling, at least I feel, that the preference is to have your own [sisters]. I felt it very strongly with [one sponsoring congregation]. I don't feel it with the [another congregation] with the current team at all. It's definitely the case with the [a third congregation]. I don't think it refers to the case of [a fourth]. And well, [a fifth congregation], those are the folks I worked for, I'm adopted into their community, and so, I mean that's not an issue.

As we spoke, she explained the transitions she had weathered and her perception that after nearly ten years, the different groups of sister-sponsors were truly beginning to understand the nature of co-sponsorship – not only with their secular community partners, but with each other.

Nominalism

In the early nineteen eighties, the name of the new hospital system was a source of great deliberation among the representatives of the sponsoring congregations. Traditionally, an individual Catholic hospital might be named after a figure, saint or founder, of historical significance to the group of women religious who sponsored it. If a congregation had a number of hospitals in a region linked together as a system, the system often took the corporate name of the women religious. Thus, the SSM health care system in St. Louis is named after its sponsors, the Sisters of Saint Mary, even though that community of sisters themselves later merged with the Sisters of St. Francis and refound themselves as the Franciscan Sisters of Mary.[12] "Local

ministries and their sponsored systems often had their own logos, and more importantly their own identification with a single religious congregation and organizational structure...[organizational changes of sponsorship in a larger system] are made more complex by the huge diversity in ethical stance of the broader society in which we live *and the church in which we minister*" (italics mine).[13] Reverend Michael Place, who leads the Catholic Healthcare Association, defines sponsorship as "the instrument by which an institution or public ministry of the church is carried forth in the *name of* and *on behalf of* and in communion with the family of faith."[14] Sponsorship is apparently a relatively recent term to Catholic healthcare, coined to describe the continuing relationship between a congregation of religious and their hospital or other ministry. The term's use seems to coincide historically with increasing moves by sisters nationally (as I described in the Introduction and Setting) to surrender the day-to-day management and operations of facilities to lay administrators and assume a governance relationship in its stead.

When the first congregations of women religious in California first came together to found Catholic Pacific Healthsystem, they recognized the historical legacy and the social tradition that adheres to the naming process. Envisioning a totally new form in which unrelated congregations would bring their hospital assets together for their mutual survival and strategic advancement, the sisters deliberately selected a neutral name that returned to the common heritage of Catholic identity. A later but similar example are the Sisters of Charity of the Incarnate Word, Houston and San Antonio, who brought their hospitals together and adopted the name CHRISTUS Health. Though sponsors of CHRISTUS are two geographic or regional communities of the same Religious Institute, the sisters in governance chose the name as an anticipatory strategy should the time come that other congregations might bring their hospitals into the fold of the CHRISTUS Health system, as has happened on the West coast with Catholic Pacific Healthsystem.

The significance of the new entity name, moving away from a particular congregational tradition and towards a collaborative model based on a common mission rather than the

particularities of individual charisms, informs the transformation I have tried to signal in the discussion of (C)atholic versus (c)atholic identities and a theoretical alignment with the concept of weak ontology. The new model of co-sponsorship built on the original concept of sponsorship to emphasize collaboration now that more than one congregation was involved – as in CHRISTUS with two congregations of the Sisters of the Incarnate Word, and in CPH where multiple Sacred Institutes (for example, Sisters of the Incarnate Word plus Daughters of Charity) would come together. The founding Corporate Members worked carefully with senior management in CPH's legal and mission integration departments to delineate the organizational expectations involved in co-sponsorship and produced guiding documents to explain these understandings.

Co-sponsorship is a reconstitution of conceptual formulation of organizational identity that is radically new. Sponsorship reflects the canon law definition as the Church interprets the term: it is restricted to one Religious Institute, one sponsored organization in ministry. Because canon law does not recognize collaborative sponsorship, the team at CPH laid out "Sponsor relationships to CPH" to explain distinctions between the canonical concept and the new idea of co-sponsorship. Co-sponsorship was deliberately created outside of canon law categories, designed to function in the world, though the language they used in the document clearly builds on the pre-existing understanding of the canon law concept (document text follows below). Where *sponsorship* recognizes "the rights, responsibilities and obligations outlined in Church law" that the Sacred Institute has to its healthcare ministry facilities within CPH, *co-sponsorship* articulates that "a Religious Institute joins and collaborates with the other Religious Institutes to support the mission, values and strategic vision of the CPH system and to develop and promote its advocacy priorities." In its understanding of the obligations entailed by the new model for CPH, the document identifies that a Co-Sponsor must be "able and willing to support the Church's ministry as well as the system's mission, values and strategies *beyond the facilities with which it has canonical responsibilities* (item 5). Moreover, a Co-Sponsor must demonstrate a

commitment to collaborating with women and men *outside the Religious Institute*, with a primary emphasis on *collaboration and influence* in its position as a CoSponsor *rather than control and ownership*.[15] The document establishes an expectation of open communication within governance and to management, and expects full participation in a *joint public leadership role* regarding health system reform and advocacy priorities including the poor and underserved (item 7, points 1-4). Lastly, the document specifically calls attention to the fact that co-sponsorship as undertaken within CPH is a living process, born of contingency, that may well continue to develop over time (item 7, point 5).

This CPH document was primarily produced because the Corporate Members change periodically, following the cycles of elected leadership of the Sponsoring Congregations that sponsor the Catholic hospitals within the system. Leadership succession might bring well a sister with no prior experience of the particularities of the CPH system into governance where she would need to understand both her relationship to her fellow Corporate Members and to the rest of the hospitals in the system, not merely those with a canonical tie to her Congregation. It also turned out to be important for the sister-sponsors to clearly understand the distinctions that the system had drawn between canon law responsibilities and the organizational responsibilities that a Congregation signed onto when joining CPH. Canon law codifies the formal relationships with of identity and relations between Catholic organizations and the Mother Church. While the system was created to perpetuate Catholic healthcare ministry, and the structure and leverage of the system were designed to improve operations for member hospitals, the governance and management of those hospitals (both Catholic and later non-Catholic) had to work in conjunction with the rest of the system in a framework of reciprocal cooperation. Moreover, as I explored in an earlier chapter, system success hinges on the ability of the member hospitals to participate in a centralized hospital operations strategy.

This new form of ministerial (co)sponsorship that Catholic Pacific Healthsystem has pioneered, together with the consequent size of the system's assets and patient volume in the

Western US has garnered the system a distinct prominence in the eyes of the Roman bureaucracy, especially the Congregation for Institutes of Consecrated Life (CICL), the branch charged with overseeing relations with men and women religious. Several of the Corporate Members have individually commented that CPH is an object of Roman attention in a way that other Catholic systems in the US are not. Generally, the Catholic Health Association is the intermediary with Vatican authorities with oversight of healthcare ministries. But after the extraordinary growth of the system in the late eighties and early nineties, CPH itself was on their radar.

Sponsor Relationships to CPH (Approved 3/19/02)

Sponsorship

Sponsorship means a Religious Institute influences, nurtures, and develops the health ministry for the CPH facilities with which the Religious Institute has rights, responsibilities and obligations outlined in Church law.

CoSponsorship

CoSponsorship means a Religious Institute joins and collaborates with the other Religious Institutes to support the mission, values and strategic vision of the CPH system and to develop and promote its advocacy priorities.

Corporate Membership

Corporate Membership means one or more Sisters from the Religious Institutes exercise the governance responsibilities of members described in CPH's articles, bylaws, governance matrix and applicable civil law.

Qualifications and Commitments of CoSponsors

A Religious Institute which is a CoSponsor of CPH should have all of the following qualities and commitments:

1. Is a Sponsor of Catholic healthcare ministry in CPH
2. Demonstrates a sponsorship relationship to its sponsored facilities that effectively exercises rights, responsibilities and obligations outlined in Church law.
3. Provides appropriate support to facility leadership in its sponsored facilities in its efforts to capably manage operations and successfully integrate mission and values
4. Exercises fidelity to the *Ethical and Religious Directives for Catholic Health Care Services* in its sponsored facilities
5. Is able and willing to support the Church's ministry as well as CPH's mission, values and strategies beyond the facilities with which it has canonical responsibilities
6. Commits to orienting the Religious Institute's incoming leadership team to its responsibilities to CPH and its other CoSponsors
7. Demonstrates a commitment to:
    - Collaborating with women and men outside the Religious Institute
    - Primarily emphasizing collaboration and influence in its position as a CoSponsor rather than control and ownership
    - Openly communicating with other CoSponsors, Corporate Members, CPH Board and management
    - Participating in a joint public leadership role regarding health system reform and advocacy priorities including the poor and underserved
    - Continuing on the path of CoSponsorship as it evolves within CPH
8. Encourages qualified Sisters to serve as members of Community Boards, the CPH Board and their committees and to minister in their facilities
9. Appoints qualified Sisters to serve as Corporate Members
10. Commits to hold their health care assets in trust for the Church's ministry

Secular community

> "The consistent brotherly ethic of salvation religions has come into an equally sharp tension with the *political* orders of the world"
>
> - Weber [16]

The new form of (co)sponsorship was radical for its effects on intra-Catholic collaboration. It is also important to remember, however, that not only did Catholic sisters extend their sponsorship to non-Catholic hospitals, but the non-Catholic hospitals agreed to accept direction from an umbrella Catholic corporation in order to bolster and continue their common mission of not-for-profit healthcare provision and their commitment to the broader health of the communities they serve. This was intended to be a bi-directional merger of interests made on the basis of an explicit alignment of common values.

In the 1990s, the decision to pursue a strategy of affiliation with non-Catholic hospitals to become part of Catholic Pacific Healthsystem raised a number of issues about sponsorship and co-sponsorship. Reviewing the document, Sponsor Relationships to CPH, clearly suggests that the term, "sponsor," refers in that context to Catholic women religious in relation to the Catholic hospitals. As the document calls out, Sponsors commit to supporting Catholic hospitals within CPH in exercising "fidelity to the *Ethical and Religious Directives for Catholic Health Care Services*."

As they considered affiliation with CPH, secular community hospital staff and boards were reluctant to bind themselves to doctrinal and social teachings of an institutional religion well beyond the scope of sustaining not-for-profit healthcare providers. To accommodate these concerns, the staff and sponsors of CPH labored together to articulate an appropriate institutional ethical identity statement that responded to the new ethos of pluralization into which they were embarking. The resulting document, CPH Statement of Common Values, lays out the centrality of collaborative partnerships with non-Catholic facilities to the very identity of the

system (see Appendix D). The document invokes a "spirit of ecumenism" to underpin their collaboration, recognizing that "the social fabric must be woven in partnership with all who have a call to serve the community." When we discussed this in the garden one afternoon, the sister explained:

> You know, and it doesn't mean that they have to be converted or I have to be converted, it's just - you know, that's where they are. But we can work side by side with each other because we're trying to - motivated toward the same thing. And hopefully - and I would think - I've never heard otherwise, that these hospitals are not in a proselytizing mode of trying to convert everybody. But the motivation for what we do comes out of that tradition. That's really the difference, I think.

As I have distinguished elsewhere, the sister here makes a contrast between proselytizing as conversion and extending collaboration through a motivation from religious tradition. The document asserts that CPH "champions" (the core value of excellence) such collaboration because it enables a response to the community's needs that is "holistic and comprehensive, rather than fragmented or duplicative" (the core value of stewardship). I will show below how this language reflects the CPH commitment to an agenda of constructive social change in keeping with a call to prophetic witness.

The document proceeds to delineate the purpose of the hospital system, its understanding of the nature of healthcare provision, and the role of the system in the social world. The values to which the sponsors hold themselves and the system are understood to be held in common with many of their partners, but the document was created with the explicit intention of articulating the values to which a partnering hospital will subscribe through its membership in the CPH system. Those values address how the system behaves as an employer and as a civic entity engaging the public world; they lay out in a narrative what is intended by the core values of the system, as explained by the CPH Statement of Philosophy analyzed earlier. It reaffirms the focus of social justice, naming the dignity of persons without regard "to age, gender, sexual orientation, culture, race, ethnicity, economic, immigration or employment status" and in doing so, the

Sponsors address both the traditional concerns of Catholic social teachings and anticipate the contemporary concerns that secular organizations might manifest over working with an identifiably Catholic organization.

The Statement of Common Values calls out the "pastoral and spiritual responsibility of healthcare providers," the nature of the professional-patient relationship, and issues for the care of the dying. The statement calls attention to the system's dedication to the poor, emphasizing the intention to help them "through direct service and acting as an advocate to change structures that keep them in poverty." They assert "a special responsibility to those individuals at the beginning of life's journey as well as those who have shared so much of their wisdom throughout their years -- children and elderly" in order to situate the delineation of those procedures which are not performed.

The Statement invokes a "consistent ethic of life" recognizing the sanctity of life from the moment of conception *until death*.[17] In this context, the document explains those procedures that will not be performed in CPH facilities: direct abortion, assisted suicide, physician aid-in-dying or euthanasia, and artificial reproductive procedures. Each procedure is accompanied by clarification to further define the exclusion or distinguish it from permitted procedures, for example, pain management or feeding and hydration in the case of terminally ill patients.

The Statement ends with an explanation and recommendation of the "process for ethical-decision making" in order to address "resolution of unforeseen issues." Much as the Sponsor Relations document allows for an evolving understanding of sponsorship, the Statement of Common Values concludes with the observation that:

> [i]n any affiliation between partners of differing histories and cultures, there may be situations in which the appropriate application of values we hold in common has not been anticipated. In such situations, we agree that a collaborative dialogue is necessary to come to an adequate resolution.

In these respects, the Statement of Common Values conceptualizes the implications of an ethos of pluralization and articulates the ethical stance of the system in a way that facilitates the affiliation of non-Catholic hospitals.

The "Common Values" document represents what sponsors and the board of CPH recognize as the "moral bottom line." In it, CPH and affiliating facilities lay out what they agree to hold in common as the basis for their organizational collaboration. Though articulated in the best of the natural law tradition, it is distinctly different from the Catholic *Religious and Ethical Directives*. As I have tried to demonstrate, the Common Values are stated in the kind of language that "all persons of good will can access, understand and, CPH hopes, embrace." It does not prohibit sterilization because affiliating secular community hospitals, as non-Catholic, community-sponsored institutions, will continue to provide that service. It does, on the other hand, specifically forbid abortion and euthanasia (should it ever become legal in CPH service areas), because these are interventions from which CPH explicitly distances itself. Moreover, in this document and in the open spirit of the very affiliation process, CPH communicates that the system does not see itself as appropriate partners for *any* organization, even a non-Catholic one, that engages in those procedures for the reasons articulated. These are important, vital identity issues for an organization (facility or system) that explicitly identifies as Catholic. As my earlier his is different from any particular beliefs that an individual Catholic sister (or, for that matter, any other individual working within CPH) might hold. Individual persons may hold any number of opinions about their own particular stance towards certain values over time. But as a Catholic organization, these are the stances that CPH adopts when it functions in the world. I return to examine this issue in conversation with an informant in the last chapter on ethical scrutiny.

Throughout this analysis, I have used the term "secular community hospitals" to distinguish those hospital members from officially Catholic hospitals within CPH. In that sense, those hospitals are secular because they are not Catholic, though individual facilities might actually have a history of other religious involvement, like Denomination North Hospital.

However, to quote a newly recruited executive expressing his bewilderment over the labels, "Catholic hospitals are also community facilities." Historically, for example, even after Hill-Burton federal funds were available in the 1950s, 70% of Catholic hospitals reporting construction projects had not requested federal funding. Their building efforts were supported by local philanthropy and grass-roots fundraising from the local communities the hospitals served. To reiterate a distinction made earlier, as ministries of women religious, these hospitals are independent of diocesan activities and, while seed monies might be granted, in no way was the Church proper building hospital wings; private funds from the local community raised most roofs.[18] Moreover, Catholic hospitals explicitly serve the communities in which they stand, calling out especially the sick and those who are poor or otherwise underserved. The term of "community" to identify the non-Catholic hospitals is a historical artifact that emerges from the creation of the CPH system, that began as an exclusively Catholic network of facilities that evolved to engage other hospital partners.

For the first decade of CPH affiliations, careful negotiations brought many secular community hospitals into the CPH fold, often preserving certain rights to a community hospital's local fiduciary board. Prior to the centralization and restructuring of 2001, CPH was designed as a holding company for a number of subsidiary affiliations with member hospitals. It is still not clear what the implications for sponsorship are now that CPH has undergone the transformation into a single operating company with a single fiduciary board. In the canonical sense, sponsors still only "sponsor" Catholic facilities, though in the terms of the "Sponsor Relationships to CPH" document, the language clearly indicates that they "co-sponsor" *all* CPH facilities, including the non-Catholic facilities.

As a holding company, the primary organizing vehicle concerned the articulation of common values rather than the religiosity of the Catholic hospitals. This allowed CPH to undertake its strategy of aggressive growth and affiliate with community hospital partners up and down the state. As one colleague put it, this was in fact "dancing round a thorny issue," for the

legal complexities that enabled the system to come into existence also allowed CPH to avoid "confronting the hard reality" of organizational religiosity, to the benefit of enabling struggling hospitals to survive the vascillations of the 1980-90s market. Today, the challenge for the operating company is that CPH has really become one Catholic corporation and the system can no longer dodge the fact that "religiosity drives the organization." This is one of the issues with which Corporate Members were beginning to struggle with when my fieldwork came to an end. As various staff noted, the sister-sponsors can "talk ecumenically but when they are called upon to wear their Sponsoring Congregational hats, this is their *obligation*." This is the significance of multiple identities, public roles and the spectrum of the ethico-political constitution of an organization. It brings us back to the problem of the Mission Summit.

The individual reponsibilities of sister-sponsors are to sustain the Catholic identity of the facilities their Congregations sponsor under canon law. Some might deny this, but that this is the crux of the problem. Even in the explicit articulation of a collaborative ethics, there remain spaces of productive silences within the dominant discursive formations to which Foucault called attention. Some things must remain unsaid, others must be articulated. Identity is a product of language and labels, as well as attitudes and practices. Explicit articulation and reflexivity do not always resolve the concers that attend political collaboration and much can remain vexed in an ethos of pluralization.

Constituting community

The technicalities of organizational structure and management are not what constitute the meaning of (co)sponsorship. While these elements define and delineate the relationship between the religious and non-religious components of CPH, cosponsorship is a vehicle for the mission of the organization. Catholic Pacific Healthsystem exists as an ethico-moral construct made possible by the new form of sociality that cosponsorship describes. To understand the ethics and social

values of this new catholicity requires moving out of the board room and returning to the site of healthcare provision in order to see caring as an ethico-political practice.

I began dissertation fieldwork with several months in the hallways of Blessed Angel Health Center where more than 5,000 people come seeking outpatient medical attention and other healthcare services each year. Geriatric patients make up about 20% of all visits; 40% of the vistors are Indo-Asian, 20% are Hispanic, another 20% are Caucasian; and 10% are African American patients. According to the clinic's statements, requent diagnoses range from hypertension to diabetes to substance abuse and cardiopulmonary problems. Approximately half of the patients have no health coverage and receive their care free of charge. The clinic is located in a building opposite the main hospital campus, just off a city thoroughfare, linked to the rest of the county by four public transit lines. Just beyond its doors lies the largest public park in the county, acres of public green space and home to a substantial population of people who are otherwise homeless or transient. The health center is a full service site with nine teams, each with three residents of increasing seniority, managed by one of several attending physicians and a primary nurse. The rationale of this "team" structure is one of continuity of care: a patient knows a member of the team no matter who sees them on any given visit. Each specialty operates on a rotating basis over the days of the week. According to the chart schedules in the physician workroom, there are three chief medical residents, overseeing physician staffs of residents and interns offering adult primary care, cardiology, dermatology, gastrointestinal, gynecological, HIV services, opthamology, and surgical specialities. There is also an on-site pharmacy and dietary/nutrition, rehabilitation and social services available each week.

From a more general care perspective, the clinic is staffed with over 30 personnel with an extensive skill mix including nurse practitioners and a physician assistant, peer counselors and treatment advocates, case managers, translators and medical social workers. Medical assistants and patient care coordinators function as care extenders, for their contribution to patient care is not medical but more about witnessing and organizing, listening and advising that may contribute

to the actual social experience of a clinic visit more than the moments of clinical care during which medications are prescribed or infections actively treated.

One morning, Grace sauntered in off the elevator for her intake appointment and announced to Mary-Ellen, the receptionist and scheduler at the front desk: "Quote of the day: be cool, be cool." Mary-Ellen used her hand to cover the microphone of her headset and said, "Thank you, Grace. See, this is why we like it when you come by, we need your sense of humor and your smile."

Mary-Ellen had her sit down and started up her file. The patient indicated that "everything was reported in the ER on Sunday; I had a very good person." So Mary-Ellen explained that she asks about previous visits to make follow-up easier, and then explains that Blessed Angel can provide care on a sliding fee scale, "so we make sure all your stuff is updated and qualified." Mary-Ellen does not say "community or charity," but rather explains that Grace needs to set up an appointment with the financial counselor, "unless you don't need financial assistance." But Mary-Ellen makes it clear by her tone and demeanor, this is light-hearted and humorous. The implication seems clear: we all need financial assistance, or would take it if offered. "All set, got you a new card, this is for your visit today. Every time you get a new one." Mary-Ellen chats about where Grace patient works; apparently, there was a branch office near her that is now closed. They share for a bit until Mary-Ellen says, "Well, welcome to the clinic. Hope your care here will be good."

The structures of the clinic create trans-ritual episodes in which daily social hierarchies of gender, age, and wealth recede, even as those markers of social location persist in the exchange of capital through charity, creating the moment for a pseudo-ritual community. After several weeks of observing the clinic, it is clear that many patients know each other, from shelters and other sites out in the world, but also from regular routine visits to the clinic for healthcare and social services. They chat in the waiting room, make recommendations to new faces about which local coffee shops are worth the walk, and share urban tactics about which bus route moves fastest at

which hour. Their conversation with each other is peppered by banter with the staff as they hustle to and fro in and out of the waiting room and offices. The staff laugh and share jokes, and remember to ask after patients they haven't seen recently. Staff treat their patients as full persons, and as I listen to them, they reveal their familiarity with the social contexts of their patients' lives. One week, a nurse practitioner called the half-way house where her patient, Chuck, was staying when he missed an appointment. When she found out he had been admitted to the county hospital, on the other side of the city, she had visited him there over the weekend. The next Monday morning, she was on the phone again to county to see how Chuck was faring.

Simultaneously, with its affiliated strands of counseling sites, peer-led activities and trainings, information sessions and orientations, the clinic is a dissemination site of both information and sociality, and an anchor within a larger not-for-profit web of social services throughout the city.[19] In some situations, especially in the HIV Care office, for example, core providers and patients can be mutually constitutive social categories (though this is not always the case). From the standpoint of advocacy structures, staff emerge from the ranks of the cared-for: "peer" counsellors and ethnically identified mental health positions (African-American Men's Health counselor- funded by a county grant), the translators, social work staff and others are all points of social contact and validation. Some staff are on the hospital payroll, others are funded by grants or on-site representatives of other not-for-profit agencies that collaborate with the hospital to use the clinic as a point of entry for a patient to access other services. They each contribute to a consistency of place that many patients lack in their lives out in the world. Spending time there day after day, it became clear that many patients had a proprietary air to the space and recognized that they were patient-clients not simply charity cases getting by with whatever they could. This was their clinic, their social network and their providers, where they received care and services like any other patient, who also had to deal with third-party payors or the rigamorole of determining eligibility.

It is significant that in the midst of this bustling charity clinic, located on the same floor, off the same hallway, are facilities for the student health services of a nearby Catholic university. It is symbolic of the hospital's commitment to universal dignity that privileged undergraduates receiving a private education use the same entrance, elevator, hallways and restrooms as the clients of the charity clinic. The student clinic has a regular clinical staff of two nurse practitioners, while the larger charity clinic has both physicians and nurses, medical technicians and assistants. The only place where patients were identified as the poor, or recipients of charity was in the written language of the hospital newsletter and fundraising materials. (The Hospital Auxiliary gives $200,000 to patient care delivery services each year.) In the charity clinic, the constitution of community reflects the creation of a space that belongs to the clients, that is made for them.

Blessed Angel Clinic is also a nexus of signifiers embodying as it does so much of the CPH mission and philosophy. When the whole hospital was in "turn-around mode" from the financial crisis of the preceding year, the clinic was perceived as a cost center rather than revenue center. Among the financial operations staff, there was banter that clearly indicated some saw clinic patients as crazy, poor, and not truthful. The clinic manager shook his head, saying that all of those things could be true of any patient, "but they do know exactly what they need and we can't always give it to them." In the course of my fieldwork, the manager discovered an accounting record error where clinic revenue was being incorrectly allocated as a budget item to the regional office. Rather than being a cost center, the clinic was in fact a revenue generator: it had actually contributed $855,000 to the hospital margin in 2000.

The Health Center also serves a medical education role in the rotation of physician residents. One proctor at Blessed Angel recounted his experience of cocky medical residents who expressed dismay at caring for the homeless, and resented their rotation in the charity clinic because "charity patients smell." I observed him directly confront medical residents who lamented their turn at service in this way. He articulated his role as preceptor to include forcibly

reminding these young physicians of their social role in caring for the underserved, instantiating "the ethics of their Hippocratic oath." He took great pleasure in explaining the structural injustices responsible for why such "patients smell," often asking the residents to imagine the effect on one's dignity and pride if you knew that every day your body smells but still have only limited daily access to bathing facilities. The attending physician was quite insistent that such a rotation encouraged the residents to recognize "the moral liability" of their profession.

Fieldwork among medical providers suggests that this kind of caritas is the crux of professional motivation for many types of providers, especially in other sites predicated on not-for-profit healthcare. The difference within CPH, and possibly for other faith-based healthcare organizations, is that the clinical encounter is only the beginning of an explicit commitment to such caritas. The remainder of this chapter describes the instantiation of that broader commitment in the organizational works of the Catholic Pacific Healthsystem.

Being in the world

> Modes of practice which interacted with indigenous cultural forms to yield a Christianity that stood in vivid contrast to colonial orthodoxy. The emergent religious spectrum...came not only to objectify the stark lines of differentiation within the modern context; it also opened up a general discourse about estrangement and reclamation, domination and resistance.
>
> -- Jean Comaroff (1985:11)

Anthropologist Jean Comaroff has exhorted us to re-examine social consciousness, focusing on social action as a communicative process, to understand the interconnectiveness of context, consciousness and intentionality (Comaroff 1985). Her fieldwork among the Tshidi points up the semantic and pragmatic dimensions of socio-political action wherein adaptation to changing social contexts can be conceived in terms of symbolic mediation. She has allowed that such signifying practices (by which Comaroff means the process through which persons, acting upon an external environment, construct themselves as social beings) are only partially subject to explicit reflection (1985:6). My efforts lie in tracking such reflection in the collective record of

this hospital system. Comaroff maps the relation between the natural body and the social body in the creation of the modern Tshidi subject in the South African Churches of Zion. CPH reflects an ethico-moral project that coheres through social action over the bodies of the poor and the sick, as witness to the conditions of the social body.

In an earlier chapter, in the section on cultural trappings, I suggested that an unexamined presumption of a uniform and monolithic "Catholic" identity is an obstacle to understanding the contemporary dynamics of Catholic Pacific Healthsystem. Traditional structures of authority and legitimation act to eclipse the distinctive ethical form the organization occupies and a doctrinal identity incorrectly substitutes for the actual lived experience of the modern Catholics in the world, namely the sisters and their ministries collaborating within an ethos of pluralization.

The Corporate Members and their congregations sustain the hospital system to treat the bodies of the poor and the sick. That ministry represents a social critique as well as an extension of compassion toward the individual. As an ethico-moral collective, CPH serves as a witness to suffering and as a testament to the resistance of those social conditions the sponsors and collaborators believe should not exist. Their healthcare is one phalanx in their battle against sociocultural injustices. Further, as an not-for-profit organization, CPH stands at odds with broader societal structures (weak government social safety net) of political economy and the isolating drive of personal responsibility for health that is reflected in the institution of managed care. It is complicated by a vexed relationship with real and perceived hegemonic ideologies active within the Church proper and the resulting struggle for a Catholic identity that is fully responsive to politics of identity of Catholic women religious (see Comaroff: 9).

Organized labor

The relationship between work and worker, labor and employer is prime ground on which to consider the relationships between doctrine and identity politics. One vehicle through which to do this are the Catholic social teachings. Such teachings are documents for interpretation and the collection of documents that are collectively referred to as "social teachings" within Catholicism reflect the social changes of the Western world in the last hundred years (O'Brien and Shannon 1992). They generally embrace as primary documents the papal encyclicals from *Rerum Novarum* (1891) to *Centesimus Annus* (1991) and the American bishops' pastoral letters on peace (1983) and on economy (1986). The inclusion of these later two documents indicates the influence that the culture and politics of the United States has had, not only on the secular world, but on the Roman perspective that has slowly had to adjust to recognize the growing significance of a formerly almost adjunct constituent within the Catholic diaspora.

These individual documents together lend a substantial weight to Catholic-being-in-the-world. They focus Catholic doctrine on specific social issues at once broadening the Church's reach into the lives of people everywhere. But while reacting against social conditions, Rome gives increased attention to directly shaping how doctrine is applied in local political contexts. *Rerum Novarum* addressed the conditions of labor. US Catholics drew on it to address the upheaval of the Great Depression when, thirty years earlier, few had acknowledged its relevance in better economic times. *Quadregesimo Anno* lent further influence as bishops, priests and lay people clamored for greater unionization, social welfare legislation and reform. Blue collar workers numbered largely among American Catholics in the 1930s and the stance of Catholic social teachings on organized labor has fluctuated as interpretations and applications vary with the times.

The history of union relations in Catholic hospitals is complex and a detailed examination is not possible here.[20] However, some of the historic antagonisms stem in part from the changes incurred by the shift from sister-administrations to lay management. An increasing distance between employees and sisters also accompanied the ceding of power as the latter group

transitioned over the years from daily operations to governance. Many sisters worried that union representation would bring yet another layer of interference that would prevent transparent relationships between employers and the employed.[21] As I suggested in the discussion of vocation and calling, sisters value the compassionate dedication of their hospital staff and one sister I spoke to seemed particularly concerned that regulations stemming from unionization would impede staff in their ability to go above and beyond:

> "And before, we just did it, sister, because we're dedicated," a staff person said to me. "Now, we can't do it because the union won't let us." So it takes away our – something, that they did not like, and a lot of them voted against it. But a majority went with it, and the majority were those that – they weren't here long. Which is okay. I'm saying I think the union has a place. But the way they come at the people, like, "[The hospital] doing you in, you're not getting your fair this and you're not getting that," that's not true at all. But the union is more than just helping people. They're out to get their big bucks.

Her comment also indicates the distrust for campaign tactics as well as the suspicion that unions operate out of their own self-interest, rather than advocating for workers as they purported to do. This attitude became particularly entrenched when a major union launched a corporate campaign against CPH. The rapid growth of the system that brought in so many secular community hospitals, had altered the levels of union activity in the hospitals. Moreover, labor organizers recognized the system's transformation from an odd regional system to a dominant player across the state and organizing efforts accelerated in the 1990s as unions hoped that gains within CPH would have political currency with other hospital systems and other large employers. This culminated in an aggressive corporate campaign against CPH by one of the largest labor unions in the state.

Over the years that I have observed the system, Catholic social teachings were routinely invoked in discussions about unionization as various levels of management and governance struggled to determine policy and procedures. The principle of subsidiarity, in particular, has exhibited a variable application. The social teachings of the Church elaborate the principle as follows: "a community of a higher order should not interefer in the internal life of a community

of a lower order, depriving the latter of its functions, but rather should support it in case of need and help to co-ordinate its activity with the activities of the rest of society, always with a view to the common good" (Vatican, § 1885). The interpretation in the context of labor organization by the management of many Catholic hospitals argues that operations should be carried out by the lowest level of activity capable of providing those functions. Thus, decision making should happen at the proper level where there is direct responsibility and accountability.[22] This was implemented as a contributing rationale whereby "CPH hospitals prefer to remain union-free," despite the fact that CPH hospital unionization varied widely by geography.

Several years later, I still heard frustration and residual anger from individual corporate members who recognize the challenge and have struggled to move forward because sister-sponsors were particularly targetted for public vitriole during the union's corporate campaign. In 2001, one sister-sponsor recounted that when she arrived at a hospital, she had passed a union agitator who was yelling and screaming, and handing out flyers, and she stopped in front of him and she said, "You know, I have to identify myself. I need to tell you that I'm a sister sponsor, and I really need to tell you that your union leadership and our system have discussed things. We have ground rules, and right now you're acting outside of them. And you need to know that this isn't acceptable anymore, that we have moved forward, that we are, we're trying to work in a spirit of collaboration," and then she went back into the hospital, and she said, "I can't believe I managed to keep my temper." She was so annoyed because it brought back the memory of the earlier conflict.

However, after several years of conflict and in the wake of the union's corporate campaign, CPH began to feel "immense pressure from the US Conference of Bishops" to reach an agreement. Union leaders had been making public and private requests of California bishops, in a state with a significant Latino Catholic population with significant numbers employed in the healthcare workforce. The visibility of the system, again, made it a lightning rod. The new CPH president and CEO decided that the relationship with the major unions was distracting from the system's ability to fulfill its mission. Thus, during the restructuring and centralization, CPH also

signed on to two system-wide agreements with each of the two major unions active in West coast healthcare.

The agreements met with great acclaim but they were also historic breakthroughs because CPH had negotiated for a concrete, collaborative advocacy agenda where the unions and hospital system would work together on common political reforms in Sacramento, as well as operational initiatives like implementing new worker safety processes to control worker injury compensation claims.[23] When announcement of the system-wide agreements was made, the president and CEO was confident, saying "I think most of our sponsors will stand tall with us on this," because the common agenda represented a significant achievement in mobilizing the core values of the organization and the sister-sponsors were happy to put the past behind them.

Interpretation of the principle of subsidiarity seemed to shift as hospital executives worked to determine what the system-wide agreement meant for each local facility. A system vice president for operations explained that the system-wide agreement set expectations and parameters for how relations would be conducted and set ground rules for negotiation and the resolution of disputes. "Leadership is embodied in charismatic leaders" and don't need external distractions that demand attention but have nothing to offer to the greater whole. He cautioned "against a uniform strategy," allowing the system-wide agreements "just to articulate the expectations and allow local level to determine how that will be achieved." I am not suggesting these events show hypocrisy. The issue of labor illustrates a fundamental problem that modern pluralization presents. Sustaining values requires an ethical reflexivity that facilitates accommodations that can be responsive to contingencies of the social world. CPH represents an effort to construct a more flexible catholicity capable of such adaptation. The final chapter will elaborate on the challenges of a values-based identity for the larger Church proper.

Prophetic voice

Your daughters shall prophesy.

– Joel 2:28

"(Religious are to be) a kind of shock therapy instituted by the Holy Spirit for the Church as a whole. Against the dangerous accommodation and questionable compromises that that Church as a large-scale institution can always incline to, they press for the uncompromising nature of the Gospel and the imitation of Christ. In this sense they are the institutionalized form of a dangerous memory within the Church."

– Theologian Johnannes Metz [24]

As with the study of Bible-belt Catholics by Anderson and his colleagues, other theorists and anthropologists have worked with the concept of the social or political imaginary (Anderson 1991; Comaroff and Comaroff 1992; Comaroff and Comaroff 1999). In describing a distinct form of catholicity within CPH, I have suggested the formation of something that might resemble a Catholic imaginary, but to use that term exclusively is worrisome, for fear of losing sight of the concrete processes that occur in Catholic hospitals through which a collective consciousness of Catholic healthcare is engaged in the world. Moreover, a strictly "theological imagination" would suggest that the ultimate trajectory of possible futures is already known- a teleological vision of God's Kingdom on Earth. The women religious I have worked with do link through the term, "prophetic," their work in advocacy and social justice. But as one sister-sponsor warned when I interviewed her, that future reality is "only possible if we each individually and collectively allow the Spirit to work through us." Such prophesy is socially salient when it points to actions that incrementally call into being corrective and collective reform. This is not the ground of rupture (of globalization, for example) where the *a priori* dissolves and social life can only be maintained by the imaginative (Appadurai 1991, p.193). In contrast to some readings where imagination seeks to restore a once present solidarity, this Catholicity invokes a future cognizant of difference through which solidarity can be created.

The prophetic role of Catholic healthcare emerges from the institution's call to witness. A primary objective of Catholic hospital ministry is to engage the problem of social inequalities, sometimes understood as suffering, a central concern of Christian ethics. As I suggested above, the ethico-moral identity of CPH engages with the bodies of the poor and the sick in their own right as ends in and of themselves, but also the ground on which to mount a critique of the greater social body. Jean Comaroff suggests it is not surprising that:

> as biological metaphors come to represent sociocultural realities, they signify not merely relations and categories but also contradictions in everyday experience; it is very common, for example, for sociocultural conflicts to be apprehended in terms of the archetypical metaphor of contradiction, physical disease (Sontag 1977, Turner 1967:3598ff). It makes sense therefore that the effort to allay the debilitating effects of social disorder tends to involve exertions to treat and repair the physical body, and vice versa; the body social and the body personal always exist in a mutually constitutive relationship. (p.8)

In her study of Southern Africa, Comaroff notes how "mission Christianity failed to mitigate the neocolonial predicament and to account for the manifest inequalities that now dominate the experience the Tshidi and other black workers. Thus, although the Church continued to serve as an accessible source of signs and organizational forms, these became the elements of a syncretistic *bricolage* deployed to carry a message of protest and resistance, and to address the exigencies of a runaway world." Anthropology's engagement with Christianity has largely focused on its place in the colonializing and the civilizing mission of Western Europe's expansionist history. Consequently, critical anthropological theory usually engages syncretic Catholicism, or more recently, new developments at the margins of mainstream Christianity, as in the cultural phenomenological analysis of healing within Charismatic Renewal movement of American Catholicism (see (Csordas 1994)). Comaroff's work assists in a more oblique argument. The critical eye of post-colonial studies helps us to recognize the transformative dimension common to the civilizing process of colonialism and the prophetic dimension of Catholic ministry.

The philosophical underpinnings of healthcare ministry maintain broad associations connecting social conditions to physical health of individuals and of the social body. Catholic healthcare has a moral theology tradition that is more in line with critical public health than medicine. Religious stances, and practices – as providing care to the indigent might be construed – operate on the material universe but Catholic practices also make claims in the moral universe through remedial and prophetic actions taken in the public sphere.

The prophetic element involves maintaining simultaneous frames. For example, clinics provide direct services while the system empowers other agents to keep their attention on the horizon with a view to changing the system and modifying the socio-political factors that create conditions of vulnerability. Thus, Leadership Conference of Women Religious members vote to "advocate for legislation that will help people move out of poverty as the welfare act of 1996 comes up for reauthorization in 2002" in a resolution at their National Assembly that laid out goals and objectives for social action for congregations of women religious, including the sponsors of Catholic Pacific Healthsystem.

The work that "not-for-profit" can do for Catholic ministry is to provide a political legitimacy both as a major provider of direct healthcare services for the insured, and as a source of charitable care for the underserved, that enables the sisters to be aggressive advocates for social change that challenges the status quo. It gives new meaning to what Vincanne Adams refers to as an empty signifier: "rather than always referring to either a set of epistemological or empirical claims, it simply provides political legitimacy" (Adams 2001). As an organization with the purchasing power of over 40 hospitals, CPH is in a position to leverage its influence both as share-holder and as a buyer that makes progressive politics part of contract negotiating. As the manager of the Blessed Angel center quipped to me over lunch, when the system really uses its clout, CPH is engaged in the "pro-vision" of healthcare.

From the outset, CPH endowment investments are vetted by a Catholic social justice screening criteria that rules out, for example, investments in corporations involved in producing

or distributing abortifacients. But the system's financial operations also have a significant presence in various industrial sectors and provide various opportunities to exercise its influence. For example, a sister-sponsor recently collaborated with her colleagues in materials and supply management to extend the effect of shareholder advocacy. When a Fortune 500 corporation was considering how to invest in research and development of non-CFC producing refrigerator units, Bethany facilitated a two-pronged approach. She collaborated with other environmental groups to organize the filing of a shareholder action while negotiators for CPH purchasing indicated the $100 million contract for clinical refrigeration units was dependent on how the Fortune 500 parent company pursued ecological technology alternatives. During FY 2002 CPH engaged 22 major companies on 13 issues ranging from access to pharmaceutical products and development of alternatives to PVC (polyvinyl chloride) medical equipment to research of renewable energy sources and adoption of environmental and human rights standards for operations worldwide.[25]

Catholic Pacific Healthsystem, like other major non-profits, floats bonds on the market to raise capital for structural improvements and new initiatives in how they do healthcare. This leads to extensive relations with major banking conglomerates. Sister Anne follows up with those lenders to investigate the banks' records on minority lending practices, small business loans to community non-profits and low-income housing development efforts. One afternoon at the system office, I met Anne wheeling her carry-on bag out of the elevator. Standing in her purple blazer, an enamel cross on the lapel, Anne recounted her morning meeting with a bank where she was received by a team of junior executives to talk about their lending practices. Her back was straight as she smoothed the ruffles in her high-neck blouse. She clasped her hands in her lap and her eyes twinkled as she spoke: "I shook hands with each of them, sat back and listened. When they were done, I smiled and said, you know, I am so happy you could all make the time to meet with me today. Do you know if the diversity represented here this morning is representative of the rest of the Bank? I'd like to talk for a minute about your recruitment and retention policies. I'm sure such a large corporation is really making an effort and I know it is something Catholic

Pacific Healthsystem would like to encourage in our business partners." It is little moments like this, for example where she has placed phone calls as "Sister," she explained to me, where Anne knows that she can push that little bit more and get away with it. "We had a meeting to talk about lending practices to minority communities and my concern about red-lining, but when I saw all their faces, I thought, I just have to ask for their hiring numbers." In this account, Anne is not just a staff member in public policy and advocacy, but a sister who advocates. Her opportunity to influence change as staff from the system office of a huge hospital company is enhanced by the interpersonal effect she knows she has as a woman religious, what she jokingly refers to as "the charisma of the white-haired nun."

In 2002, the protests against the US decision to invade Iraq were also about making a moral claim in the public sphere. When Sister Rebecca emailed her colleagues across the system to tell them about a protest march downtown near the corporate offices, she told them she was participating along with members of her local parish. Her decision to march and her announcement of her intention reflects both her moral stance and an aspect of her ethics, her personal self-fashioning. The sisters, through their organization assume what Foucault called the speaker's benefit, especially speaking truth to power. CPH stands as a symbol of resistance to evil, "not as actions by immoral agents who freely transgress the moral law but evil as arbitrary cruelty installed in regular institutional arrangements taken to embody the Law, the Good, or the Normal" (Connolly, 1993:366).

In a conversation about her frustration with a public policy and advocacy agenda that was, in her eyes, nothing more than government relations that lobby for better hospital reimbursement, Sister Mary Patrick said:

> It's propping up a broken system... It is an unjust, unethical and immoral system in the United States. Even if we just look at our own population, if you take it, you want to do the worldview even more so. And, there comes a point that, by participating in it and helping to prop it up, we are...aiding and abetting. ... I'm not ready for my [sponsoring congregation] to pull out at this point, but I think we need to look at that. And unless we can have the kind of advocacy as an organization that calls that out and demands change, I think there is a point when we've to say, you know, the [network] is doing the very best it can, but it doesn't

need religious sponsorship to do that. ...And when I say that kind of advocacy I don't mean, [my role] is saying that, I mean that [the company CEO] is saying that.

As I finished my fieldwork at the system office, a sister from a different congregation mused aloud while she poured herself a cup of tea in the lunchroom, and in effect, asked me to imagine what would happen if one morning, every Catholic healthcare and social service organization in the country didn't open, and as a whole said, "we will not participate in this system... it's wrong." "What kind of change could we force on civil society, on elected government, if altogether we just said, no more, fix it?" she asked.

To the sisters, not-for-profit healthcare is an idiom used to critique the "immorality of capitalism" as exemplified by the failure of US society to provide universal access to healthcare and the rising levels of uninsured. While the rhetorical musings above imagine full national participation, the work of CPH and its sponsors is pragmatic and based on incremental change; it is a prophetic witness matched with realism. As Anne admitted, she "knows it's hard to do what we're asking them to."

Caritas

There are signs that mission integration has begun to take root, even among those who cut their teeth on for-profit healthcare. When the strategic plan for the coming years was drafted, the executive who introduced the "economic blue print" to management made an assertion that was striking for the admission it made about the past as well as the re-orientation for the future: "profitless growth must be avoided, unless its mission driven area." The struggle for CPH is to balance the call to serve the underserved while sustaining system resources to continue services into the future. CPH is engaged in re-distributive justice. Mission work is often about cost-shifting where revenue-producing service lines support both outright charity and uncompensated care. This is the delicate dance of mission and margin.

The expectations have been set, but the sister-sponsors and their colleagues in Mission Integration know that inculcating the same levels of responsibility and accountability in mission areas as are understood to be required of finance and operations takes time and acculturation. They worry about the state of the not-for-profit sector, and hope that CPH represents a movement forward, rather than a lone organization wandering the wilderness. The point of Mission Integration is to keep the right vision in place:

> I think if we ever got to the point where the non-profits were simply - you know, moving in the same direction as the for-profits, that - society in general - or those who have been waiting out in the wings anyway for a reason to force the non-profits ... to be tax paying as everybody else, would simply use it as a way of saying, bring them into line, and it would be justified. I mean, right?...But the distinguishing mark for a not-for-profit, especially if it comes out of a ministerial mold, or related to a church or religious mode of some kind, there should be some distinguishing marks that set it apart, other than the fact that they don't pay taxes. There's gotta be something really - you know, something significant. And that is going to continue - that - you can never just state it and then forget it. You live with it every day, you have to think about it every day, you have to struggle with it every day, and essentially I think that's what we're doing. You know. It's the conversation that keeps - try to keep people on that thin line of integrity. And the fact that there's conversation around it probably is a very healthy sign.....You know. If there's no conversation around it, that might be a very dangerous thing, too, that everybody should think it's all hunky dory. And I'm sure the sisters - not exclusively, but many of the sisters probably are - maybe more sensitive to the direction some of the system is taking, you know.

I would contrast the comments of the sisters with those of a new employee I overheard, a Clinical Nurse Specialist who had just joined one of the more rural hospitals, but had served the previous thirteen years in the US Airforce. The occasion was a senior staff meeting in this secular community hospital within the Catholic network. At the time, a system-wide charity policy was being promulgated from network's headquarters. A long-time director of admitting had introduced the policy and sought input on where public signs and explanations should be posted. I heard the new CNS say, "I don't know if you noticed, but look at the text, it says 'provided without regard to race, ethnicity, religion or national origin.' I have my own opinions on that," she said, "but it means you don't have to be a US citizen to receive charity care." The room sat in a sort of shocked silence and, after an awkward pause, conversation resumed discussing where in the Emergency Department to hang the signs.

Among senior staff implementing hospital or service area-wide policy, it is clear that the sister-sponsors dictate, through the board of directors, that CPH hospitals provide healthcare as a service not as a right of national membership. This exchange helps to illustrate the contrast between the organizational ethics at work here. "Organizational ethics asks whether the individual conduct fostered and reinforced by such factors [as culture, policies and procedures], is morally right and whether the individual character being shaped by such factors is morally good, given the environmental conditions within which an organization exists and operates" (Heller 2001, p. 135). As ethicist Jan Heller points out, this applies as much for the individual agent as for the collective moral agent that is the organization in which individuals work. The CNS had recently come from an institution operating within a moral framework premised on national identity, the Armed Forces Joint Services. The sister-sponsors speak from within a moral framework that seeks to promote a more universal, a more "catholic" if you will, caring community. Both illustrate that the practice of healthcare in the US is premised on moral assumptions that underpin ethical stances and point up the reframing effect that CPH seeks to have through its works.

The CPH system provides direct services like any other hospital system. What makes it different is that the system also asserts a broader understanding of its role in creating healthy communities. The assertion flows form its ethico-moral self-conception, that in turn is the operationalization of the sister-sponsors understanding of theological purpose, particular Catholic social teachings, and the enactment of core values stemming form what it means to be Catholic-in-the-world. For example, CPH maintains a community grants program to fund local non-profit organizations that extend the concept of health beyond medical care to social services, low-income housing and job training. Every year, each member hospital contributes 0.05% of their total expenses from the previous fiscal year. Seventy percent of that fund is earmarked for proposals from community organizations in each hospital service area for projects tied to the health priorities already identified by the state-mandated regional needs assessment. Twenty

percent of that fund is allocated to proposals responding to an annual system-wide focus, such as domestic violence intervention. The remainder supports an endowment to boost community grants in following years. In the years 1997-2000, the community grants program distributed $6.26 million to 372 different community non-profits throughout the hospitals' service areas.

The theological principle of subsidiarity, manifest as local control, is implemented from the very beginning when all local non-profits are invited to submit proposals. Then, in the proposal review process, where a team from each local hospital matches grant proposals to the needs assessments done in conjunction with community representatives. This means that local needs dictate where the grants go – not network leadership but providers at the hospital level. In one urban community, for example, the local needs assessment identified the lack of social support for gay and lesbian senior citizens, and last year, a local 501(c)3 organization received a grant from the local Catholic hospital to extend services to that non-traditional population. In that geography, this population is part of what constitutes community. Further, the network actively promotes best practices and capacity building dialogue between community organizations by convening grantees regionally over the course of the year.

Moreover, CPH recognizes that its financial equity can be leveraged to extend the scope of mission even beyond cash grants. The system sponsors a community investment program that makes no- or low-interest loans to non-profit housing developers and similar community organizations, often building relations with other Catholic social ministries like Mercy Housing. Since the hospital system was incorporated in the mid-eighties, it has lent over $45 million and made guarantees totaling another $23 million. In FY 2002 alone, it made 9 new loans of $4.8 million to create low-income housing in its service areas. The new standards for mission integration successfully required that one of the evaluation criteria for each hospital facility seeking access to capital is the annual initiation of three loans to organizations in each hospital's local service area.

Catholic Pacific Healthsystem engages in prophetic witness for the larger society but also looks to the future in its own efforts to be a social actor. Some groups of sisters have been instrumental in redefining a religious identity that explicitly articulates an environmental ethic within the terms of their particular charism, practice and Catholic theology. For example, sisters from one congregation founded Genesis Farm that has become a leading example of an American Catholic ecology.[26] St. Catherine-by-Sea Medical Center is at the forefront of ecologically-sound healthcare within CPH and has been recognized nationally for its efforts. In 1996, sister-sponsor leadership originating at this hospital was responsible for driving CPH to become the first healthcare organization to ratify the Coalition for Environmentally Responsible Economies principles. As a signatory to the CERES, CPH pledged to monitor and improve their environmental impact and endeavor to do so beyond the letters of the law where possible.

Every hospital within CPH tracks its waste stream and recycling volume on a quarterly basis. As a system, CPH entered into dialogue with Stericycle, the sole national medical waste management company in the US and obtained commitments to phase out incineration of medical waste wherever feasible, and to develop a format for a public environmental report. Working with CPH and representatives of Health Care Without Harm (an organization that campaigns for environmentally responsible health care), the waste management company is seeking to expand and enhance the waste audit tool that the company uses with all clients in order to reduce the volume and toxicity of medical waste.

As a system, CPH aspires to be more than just a corporation that offers healthcare services, access to physicians and procedures. The sister-sponsors and their colleagues want CPH to be an agent for social change in the communities they serve, and they want those communities to collaborate with them in embodying their organizational core values of stewardship and excellence:

> [As not-for-profit organizations], we gave equal to or more in charity service, right? And it is true that it has in recent years - we've had to *quantify* that. It's not so bad, because that kind of *keeps your feet to the fire*, too, you know, because you can lapse into this: "Oh, we're

> doing such lovely work," you know? So - but maybe it just is short-sighted. I think that it made not-for-profits stronger, 'cause they've had to dig deep. Now, it is true, you probably could contrive and fake, or try to come up with numbers that would mask that you are really not giving, I mean - but that's - there's always those - somebody may always look, you know, see this as an opportunity for some kind of a fake report but - well, I don't know. And that's all... I mean, you know, it keeps - *accountability* is a good thing.

Several months into my fieldwork in individual facilities, at one of the hospitals late in the afternoon, I joined a group of sisters for their meeting to introduce my project. As a the sisters' council came to an end, I asked what really marked the difference between themselves and other committed people who "walked the walk," and I suggested a larger comparison between Catholic healthcare and other nonprofit hospitals. One of the more robust personalities who had only minutes earlier opined enthusiastically about system reorganization, suddenly drew quiet and looked at me. She drew a deep breath and said, "Well, that is the question we have always asked ourselves and continue to ask. We are always looking for what makes us different from the folks over at [Coastal Med-Center, a competing medical center]. And if the day ever comes..."At this point, she paused. She sighed, leaned back in her chair and looked up and away to the ceiling. Then she leaned forward, and moved her hand to her chest and said, "I, you can't..." Her eyes reddened and began to water. She reached out to the sister across the table from her, and looked back at me and said, "if the day ever comes when we can't see what's different about what we're doing here [breath] then we have to quit." She pulled her hand back and rubbed at her cheek with the back of her wrist. There was quiet from the other sisters. She blinked, straightened up and looked me in the eye and said "then we have to quit, you know. Just close our doors and move on."

Towards the end of fieldwork, I sat in on a governance meeting. One of the Corporate Members despaired of a future where the distinctiveness of the system and its collaborative ministry lost its prophetic vision. As she had earlier insisted, "We will not become catholic-lite." I have argued that such a dilution would depend anyway on a social projection, an imagined construct of what real, authentic Catholicity might be. Collaboration in an ethos of pluralization is

not without its challenges. Even with an aggressive ethic of articulation, the road that the sponsors of Catholic Pacific Healthsystem have chosen for the organization has often been uphill.

Recall the system's identity statement that concludes by describing the work of CPH as "furthering the healing ministry of Jesus" rather than "of Jesus Christ." The adoption of that mission statement ruffled feathers among some sister-sponsors. There was extensive debate among the Corporate Members at the time, and not all parties were willing to concede to such a gesture of accommodation. Furthering the ministry of a historical figure is different from acknowledging that such a historical individual is the messiah and the source of indentity behind a given hospital. This stance was intended to accommodate pluralism. It also reflects one aspect within a range of issues that fed a difference of opinions on the nature of governance the ramifications of which contributed to substantial changes in organizational structure for CPH in the period just preceding my fieldwork. After several years, one of the sponsoring congregations rejected the cosponsorship model and made the decision to withdraw its hospitals from Catholic Pacific Healthsystem. Those sister-sponsors subscribed to a model of governance drawn along the lines of what the Sponsors Relations document called "control and ownership." Consequently, the disagreeing congregation believed their experience of hospital ministry was better served without the accommodations that they felt co-sponsorship foisted on their facilities.

The politics of identity lie at the heart of the efforts of Catholic Pacific Healthsystem to bring a new form of catholicity into being through collaboration with secular community hospitals and other partners. The balance between strong and weak ontologies, between the history and traditions of the doctrinal Church and those of the congregations of women religious, seems to lie in the determination to be Catholic-in-the-world through a mission of *caritas* and *communitas*. I have tried to document examples where the system continues to struggle in its self-fashioning together with the characteristics that the Catholic Pacific Healthsystem would consider a success. In both cases, it is the attention to reflection and articulation that suggest an ongoing process in which the collective entity is always and already coming into being.

[1] (Anderson 1995: 83)
[2] *New York Times,* Sunday April 7, 2002.
[3] *Heralds of the Gospel.* June 2, 1951.
[4] See http://www.religionandsocialpolicy.org/docs/events/2003_spring_research_conference/lee.pdf (September 2003) or (Lee 2003).
[5] As laid out in (Griese 1987), the principle of dignity includes recognizing the priority of spiritual needs of all people (p.27) and the principle of religious freedom, that "which relates to the ministering to the needs of non-Catholic patients is the impropriety of efforts to 'make converts' of adult non-Catholic patients during their stay in a Catholic hospital. Non-Catholic patients should be made to feel that their stay in a Catholic hospital will in no way expose them to the enticements of proselytism" (p.141).
[6] Personal communication by email, Carole Patterson, Deputy Director, Joint Commission Department of Standards, 2002.
[7] This will be addressed in greater detail when this chapter turns to the prophetic role of the sisters, see below. It is certainly true of the sister-sponsors involved in CPH. But it is not universally so; substantial political diversity exists within Catholic women religious as in any other population. For documentation of more conservative groups of women religious (both sisters and nuns), see for example, (Caterine 2001) and (Weaver and Appleby 1995) as well as (Weaver 1995, loc.cit.). For the most part, social issues are uniformly championed; the distinctions often lie more with different attitudes and stances toward the authority of the magisterium and the reforms of Vatican II. See also Appendix A.
[8] The withdrawal of sponsorship involved in the closing and sometimes selling of a facility invokes the canonical process of "alienation." Believing he was assuaging anxiety about the process, one staff member suggested to a Corporate Member that this was not a difficult task and shouldn't be a cause for concern. To his surprise, the sister made it very clear that alienation was not the issue. She was succinct in her desire to know "how community needs would be addressed and mission served if *my hospital* is closed."
[9] *The Constitution in Conflict*, Belknap Press 1992: 346-7. See also, for example, *Hostage to fortune: The letters of Joseph P. Kennedy*, Amanda Smith, Ed. Viking Press, 2001.
[10] See http://www.sistersofmercy.org/qanda/voc_chart.html. June 2003.
[11] Elsa Brenner, "$150 Million Continuing-Care Unit in Sleepy Hollow," *New York Times*, June 15, 2003.
[12] In greater deatil, the merger demonstrates the pragmatic approach to ministry – go where the need is, when the need changes, revise: In 1894, five former Sisters of St. Mary, led by Sister Mary Augustine Giesen, organized themselves as a separate religious congregation, named the Sisters of St. Francis of Maryville, Missouri. They gave special attention to health care in rural areas and established the first hospital in the Oklahoma Territory in 1898. In 1987, the two congregations reunited and refounded to form one religious congregation: the Franciscan Sisters of St. Mary and together sponsor as a single entity their amalgamated healthcare ministries as SSMHC.
[13] Olive Bordelon, CCVI, "The Cosponsorship model" in *Health Progress*, July-August 2001, p.2,3.
[14] Rev. Michael D. Place, STD "Elements of the theological foundation of sponsorship," in *Health Progress*, Nov-December 2000, p.6-10, italics in original.
[15] As in the statement of philosophy and mission, the order of women before men was a deliberate decision by the sister-sponsors to recognize social disparities in serving the needs of women.
[16] (Weber 1958, p. 333)
[17] Championed by the late Cardinal Bernardin, see (Bernardin 1999). The volume brings together reflections on healthcare written and presented while Archbishop of Chicago, 1983 until his death in 1996. Four different essays address the consistent ethic of life in the context of healthcare systems, witnesses of Catholic healthcare, and healthcare reform. See also *Consistent Ethic of Life*, Sheed & Ward, Kansas City Missouri, 1988.
[18] See (Risse, p.560, fn 39). Risse, in turn, cites editorials in the Catholic Health Association monthly *Hospital Progress* 31 (January 1950), "Does new epoch call for new planning?"
[19] On the bulletin boards and waiting room tables are fliers for: Buddhist AIDS project organization, marginal housing, career planning, job counselling; Cantonese bible study; Vietnamese meals-on-wheels, a new neuro-psych testing at two different sites; MOVE: Men overcoming violence, gay and bisexual abuser help project; drug trials, support groups; women's only services, support group and trials. Heterosexual groups, Hepatitis C partners group. The HIV+ smokers study, return to work program, and a University medical center study on viral loads each had fliers on which all the "call here for more information" tags had been taken by patients.

[20] One point of entry is (Higgins and Bole 1993).
[21] This fear was probably further nurtured by lay administrators seeking to avoid having to negotiate as management with union shops.
[22] Patricia Talone, RSM PhD, "Church teachings on Labor" Catholic Health Association, May 30, 2002.
[23] Historically, California government is a democratic stronghold and organized labor very much has the ear of the administration during this time.
[24] Burns and Oates, *Followers of Christ: The religious life and the Church*, Exeter Press 1978, p.12.
[25] Mission Integration, Annual Report 2002, Catholic Pacific Healthsystem.
[26] See http://www.caldwellop.org/genesis.htm, as well as (Taylor and Kaplan).

Ethical scrutiny: Culture and the institution

In documenting the emerging framework of (co)sponsorship that Catholic Pacific Healthsystem generates, I have suggested that the system models an ethico-moral engagement that opens itself to the contingencies of contemporary pluralization. In the classically Catholic tradition of reason informed by faith, the sister-sponsors and their colleagues brought into being a "post-conciliar" organization that retains a central religious identity that can function in the changing world of contemporary US healthcare.

> I think there is a big difference between the Church and sect. And I think that when focus on the "Capital C" [Catholic] and doing the distancing thing, and saying, okay, well, if this is the way you have to be, I can hold my nose and work here, but, you know, I disagree with it. That's the Catholic Church acting as a sect. I think a whole lot of people have a lot more comfort with the Catholic Church acting as a church, which is, I mean, it's-dirty-get-in-there, roll-up-your-sleeves. But your worldview is people are good, God loves them. Compassion is an important human thing, you know. There are people who wouldn't buy that, either. But they're on every street corner. There is a way that the Church has, you know, that the Christian worldview has sort of saturated people's secular understanding. And that's the part that is actually kind of more, that's in the rest of the box that actually could draw people, that you can kind of engage with without having to call it Catholic. But knowing that, at least for us, that's, that's what it is. That's where [organizational identity] comes from.

The comments of this CPH administrator offer a distinction between perceptions of "Catholic" that he makes in terms of Church and sect. He further points to a conception of the Church as a social entity of humanity, drawing on the sense of catholic as comprehensive and universal. His observation that the Christian worldview has "saturated people's secular understanding" invokes an idea of values that are broad in sympathies of interest to the general human condition and thus can draw or engage others to a collective undertaking "without having to call it Catholic." At the same time, the explicit knowledge of the origins of *those* values does matter in *this* organization "at least for us, that's what it is."

In earlier chapters, the treatment of various documents such as the philosophy statement, or the mission and core values, indicates the kind of collective discernment inherent to the social

processes that produce policy and procedure within Catholic Pacific Healthsystem. The commitment to creating a common mission that sustains not-for-profit healthcare emphasizes a collaboration with non-Catholic partners and is reflected in documents that are largely oriented towards an external public audience, though I treat the documents because they reflect an organizational self-configuration and create an ethical awareness of a specifically constructed collective identity. The explicit process of collective discernment that has now been codified at CPH in "A process for ethical decision-making" is a fundamental dimension of how the system constitutes itself as an ethico-moral collective. As a management strategy, such a process creates a greater sense of "buy-in" among stakeholders, but it also uses the dynamics of group process as a vehicle for identity formation and maintenance. And, as Connolly reminds us, sustaining an identity of "who we are" can be most productively accomplished in the context of making distinctions on the basis of "who we are not," that is, constituting identity through difference (Connolly 1991).

This is perhaps most clear when the system was considering opportunities to affiliate with non-Catholic facilities and sister-sponsors and their colleagues have undertook a deliberate dialogue with those bishops responsible for the dioceses in which CPH hospitals operate. Over the years, every proposed affiliation with non-Catholic providers was discussed with the appropriate bishop to explore the rationale for affiliation, the nature of the affiliation and the specific arrangements that would govern the partnership. Those dialogues engage the religious cultural context of their Catholic interlocutors, just as CPH identity documents endeavor to communicate clearly to their external secular audiences engaged in an affiliation. In one instane, when the system sought the guidance of a bishop with regard to the possibility of an affiliation, the dialogue was based on explicit articulations that were first developed within CPH as the organization, in the words of one internal memo, attempted to:

> negotiate for itself the questions involved in [this proposed affiliation] with a potential partner, [a secular community hospital]. The language is theological language and is intended for our own use in thinking through the identity and cooperation questions that

> arise for us in pursuing a particular strategy for carrying out our mission. Because we are a Catholic organization, with certain moral commitments as well as certain traditional tools for upholding those commitments in an imperfect world, we need to be able to justify to ourselves why we would embrace collaboration with a non-Catholic partner who does not share all of our moral commitments.

Some bishops invited a broader engagement with the issues by consulting other theologian advisors. In each case, CPH governance itself solicited a theologian outside the system for his or her independent, academic moral perspective on the appropriateness of the affiliation, with express reference to the Church's expectations as laid out in the *Ethical and Religious Directives for Catholic Health Care Facilities*. The comments of one such consultant neatly sums up in more theological terms the argument I have advanced in the earlier discussion of sponsorship:

> In many communities in the United States, Catholic health care facilities are present in communities with a very small Catholic population (in some instances 1%-2%). Catholic presence is essential to witnessing to Catholic social teaching and to the Sacredness of Human Life and the Dignity of the Human Person. In particular, providing for the health care of all persons and witnessing to the Catholic teaching concerning abortion and euthanasia is critical in these communities. Catholic theology has recognized the Principle of Gradualism in evangelizing societies. The Church often evangelizes concerning the central truths of the Gospel before it can teach concerning the finer points of Catholic theology. It is imperative that Catholic health care continues to have a presence in these local communities in order to witness to the central truths rather than leaving these communities because of issues like sterilization.
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> The current lack of universal health care in the United States is scandalous. The United States is the only industrialized nation in the world that does not provide universal access. It is essential that the Catholic Church have a strong institutional presence in the provision of health care services in order to participate and have leverage in this important public policy issue. In addition, our nation is going to debate many ethical issues related to genomics and reproductive technology in the next two decades. It would be remiss for the Catholic Church to withdraw its institutional health care presence in many communities because of the inability to partner with those who provide sterilization.

The CPH hospital system is an organization of collective catholicities gathered together under a greater Catholic identity and designed to facilitate collaboration with external non-Catholic partners. The comments of the theologian above affirm a prioritization of values (sanctity of life, human dignity, universal care) that balances the signifying role of a continued institutional and public Catholic identity that witnesses to a given set of beliefs (Catholic

teachings concerning certain medical interventions) in communities that are largely non-Catholic. The theologian calls out the experience of the greater Church in evangelization as a guiding model for how to think through the Catholic presence in healthcare. In the second paragraph, the theologian echoes the prophetic dimension that sister-sponsors recognize in their ministry and sponsorship when he invokes the flawed state of US healthcare. The greater goal of advancing universal access in this society depends on the continued ability of Catholic ministries to be a participant in healthcare services and a voice in public policy in the US. Collaborating with secular community facilities, even those that provide sterilization services, strengthens the continuation of not-for-profit care in that community and furthers Catholic participation in the social discourse around the future of healthcare generally.

Individuals within

During fieldwork, other conversations with managers and other executives lent further perspective to how people thought about the system through the lens of their own involvement.

> It actually helps that it's an institutionalized ministry. Because there's a clear difference between what individuals will choose to do and what institutions who stand for something, who have the stamp on their forehead, must look like. And in my job, I can say that we're doing the second thing. This is the institutional part. I think it would be harder if I were a nun, looking like I had made my personal choice to be with this other institution called the Church, in addition to the institutions of the Catholic hospitals... It would be not just harder, it would be more awkward, and more, you know, I'm defending something I don't believe in. I'd be looking like I personally defend something that I personally don't believe in. And that's a, that's a hard place to stand...

Earlier reference to Mary Douglas and George Cheney grounded the description of the ethical effects of articulation (Douglas 1986; Cheney 1990). Both struggle with the interaction between individual agent and "group think" or organizational identity. Here, I want to engage personal perspectives of CPH agents to highlight how individual level differences are worked through within the bounds of organizational identity, even in the context of issues fraught with meaning and compounded by larger, polarizing public discourses.

When I spoke to Marie about some of the more distinctly "bioethical" aspects of her work with the system, she imagined for me a set of hypothetical situations in order to illustrate distinctions she understood to lie between individual and organizational morality. Marie is a rare blend of healthcare professional, both highly educated and particularly gifted in her ability to engage her colleagues in the real ethical complications of hospital practices in the contemporary world. Her training, as well as her official role in the system and within the Mission Integration team mean that Marie is significantly more predisposed than her colleagues to speak to the issues I have tried to undertake here.[1] The two cases she imagines for me are exemplars of exactly the sort of "ethics cases" that rarely manifest in reality, but Marie uses the extremes to preface an interpretation of how the politics of identity can play out in an organization like CPH, even in the context of an ethos of pluralization.

> For example, the question about whether termination of pregnancy can happen in a Catholic hospital. And let's say, you know, we have two cases. It's the, the bikini abortion, meaning, she wants to go to the Bahamas, she's a college girl, she got pregnant, she doesn't really want to be pregnant, she hates abortion clinics, and her mother works in the hospital, so she wants to have... She wants to be out. She doesn't want to be aware. "Just knock me out, and do whatever you do." So she wants to have it in the hospital. I mean, it's not realistic, but let's just say - Case One. And then Case Two, you know, a woman with two kids looking forward to this third baby, finds out it's anencephalic or Potter's Syndrome or a second trimester baby with trisomy-9 -- some horrible, awful thing. It's easy for me to say that I personally believe that the first woman is making a choice that's not a moral choice, I personally believe, and that I personally believe that the second woman is making a choice that could be a moral choice, but that neither one can appropriately happen in a Catholic hospital. And I can stand behind that. And I could even say it to that second mom. I could even say to her, you know what, you have every moral voice to listen to, and you should do what you're committed to doing. And I'll help you think about it and weigh the pros and cons, and there's nothing to feel guilty about.... But that's different from what can happen in this hospital. And it's not because this hospital is somehow more pure than you are. It's just because this hospital has a sign on its forehead that says, we stand for the other choice. We stand for a place where fetuses that are going to have no other life besides the life that they have in the womb can be treated respectfully and [so on]. And I have no problem in saying that institutional morality is different from personal morality. And I think there is such a thing as institutional morality that is made up of something different from, is not just the sum total of the moral choices that people make who work in institutions. I don't know how I defend that. I don't really know how that works. It's not in the bricks and mortar. But it does seem to me that there is an identity in Catholic hospitals, that they stand for something more black and white. As much as I think that, if those were the only choices, it would be a hard place to work. But we don't have any of those. We don't have any remote sites: you know, the nearest hospital is three hundred miles way, second trimester trisomy 9, what are

you going to do? And if that were the case, I would say institutional morality can take a hike for those thirty-six hours it takes just to take care of that lady.

Marie corrected me when I made a comment about efforts to sustain a particular set of values amidst multiple other identities active in society that held to different, even opposing values. Like the sister-sponsors that articulated the prophetic dimension of their work, Marie called out the larger political culture of the United States itself that contributes to how the ethics of catholicity are structured even as CPH works to engage a greater pluralism than simply the Church or the secular non-profit community of providers.

> You know, even though I know it's not pinned to this, and this will seem somewhat reductionist, but I do think that *that* identity, when you say, "in the context that we find ourselves," it's not just the historical context of the nuns coming to build a school and then so they build a hospital, because that's what they need, and, you know, growing up [as part of] an institutionalized [religion]. It's definitely an American phenomenon.
> And that's important, I think. There's a First Amendment reflection here that the identity connects to. Definitely. Because Catholic hospitals in other countries don't have anything remotely like the issues that we're talking about. Partly because the context for health care is so different. All health care is a social good, not just Catholic health care. In a way, all the health care in a Germany or a Canada is more Catholic than Catholic health care is in the United States. So it's, it's partly the, the social good aspect of hospitals in the United States. And it's partly ... the other side of the First Amendment stuff, which is – "don't do abortion, don't do ..." you know....

Marie suggests that the moral voice of Catholic healthcare ministry exists in relationship to its larger social context. As I have said earlier, healthcare is a moral experiment in the United States and Catholic hospitals exist as ethico-moral collectives in the way that they do because that is what the originating faith and values calls them to be in this world.

When I first introduced the hospital system, I sought to set aside the misperception that the ethics and social values of Catholic healthcare would necessarily entail a detailed exegesis of abortion politics and the rhetoric of both sides that has dogged the mergers and affiliations of Catholic hospitals. However, the socially contested moral status of reproductive healthcare procedures provide a useful heuristic device precisely because one can set aside the objections most known for causing conflict, in order to focus on value dimensions adhering to healthcare otherwise overshadowed. In the first quote of this chapter, the speaker makes reference to the part

"that's in the rest of the box that actually could draw people" in. The "box" refers to an illustrative analogy used by a well-respected system ethicist working with another Catholic hospital system, based in Southern California. Jack Glaser is a former Jesuit and ethical scholar known for championing the social justice dimensions of Catholic healthcare that are often eclipsed by what he characterizes as the Church's persistent preoccupation with reproductive health. To explain the misguided emphasis, Glaser draws a large box on the page, and in one corner, he fills in a tiny square. With a smile, he says this box represents the "pelvic stuff," what the magisterium sets up as the most significant site of Catholic values. This, he says, pointing with his pen to the rest of the page, is the breadth of what Catholic social teachings *actually* address: the whole host of moral issues in the social world spanning the human life course. Those few principles that speak to reproductive health have made their mark on the secular world because of the vocal disagreement they engender in public discourse to the detriment of society as a whole. The magisterium's insistence on reproductive services debate means that society as a whole equates Catholic values with one stance on abortion and turns a deaf ear to the larger social conditions of injustice against which Catholic social teachings also inveigh. *This*, he says, circling the rest of the page, is what our tradition tell us to be concerned about: social and environmental justice, universal access, poverty, exploitation, but these things are lost in the reductivist politics of abortion. Glaser's professional ethical agenda operationalizes Cardinal Bernardin's consistent ethic of life: "what we need is to spend half as much energy on the rest of the box as we do on the "pelvic stuff."

In our conversation, Marie offered another "bioethical case" this time extending a radical imaginary technology to the entire country. Her imaginary case does away with the limitations on procedures demanded by the *Ethical and Religious Directives* by rendering the medical mechanism irrelevant to the moral person receiving care. In this scenario, Marie imagines a future where the orientation of particular religious values that initiate and mobilize Catholic healthcare

today would lose its distinctiveness because the structural conditions in the social and political world against which Catholic healthcare today stands in resistance had been removed.

> Let's imagine, way out into the future... Let's just say after a woman has sex, within twenty-four hours, if she gargles, she will not be pregnant. Period. No question. And let's even further say that the gargling works at any point. So when she's had amniocentesis and she discovers that she's carrying trisomy-9, she can go home and gargle. And the pregnancy will not, you know, she won't go through labor and... it'll just absorb into her body, let's say. So let's say this way how we're doing abortion is really irrelevant. I think that the ideology that makes a Catholic hospital would still be there. And let's say the same was true for euthanasia and whatever other, you know, whatever other procedures are the sticking points right now for Catholic hospitals. They're just not issues, let's say. I think there would still be an ideology left to make a Catholic hospital a Catholic hospital. But I think they'd look a whole lot different.
>
> [In the future] there aren't going to be nuns. That's the other thing about Catholic hospitals in other countries. There are still nuns walking around, and they still wear outfits that make them look like beings that are supposed to remind you of God, you know. I mean there's something nice to that. But it's not the case in American hospitals anymore. So I think there would still be a sort of an ideology that formed a Catholic hospital. But I don't know if the identity would still be there in the same way. Maybe it would. Maybe it would. Let's just imagine for a minute... I'm thinking out loud here.
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> Let's say that at the same time as the gargling change [in technology] happened, the hospital [environment] changed, and you can't do business in Massachusetts. So they only have not-for-profit hospitals. So let's say that all the United States went that way, and there were only not-for-profits, and you could gargle and get rid of a pregnancy or not ever need a sterilization or euthanasia or any of that. Then I wonder what would be the difference between a Catholic hospital system and a Sutter or a Kaiser or any of the surviving not-for-profits. And I think the difference would be historical.... I don't mean only historical. I mean that people who had gone through nurse's training in a Catholic hospital, learning about the reverence for an individual person, or...You know, that that kind of ideology was really part of their training, part of doctors' training, part of a person's upbringing. That that hospital work was seen as some sort of an expression of your ministry, just the same as somebody who becomes a priest. Well, somebody becomes a doctor, maybe. I, I think it would be historical, though. I think that there would be probably half the nurses that could go either to the Sutter equivalent or to the Incarnation Hospital equivalent and feel like they weren't too different.

With this heuristic, Marie suggests that the identity and nature of Catholic healthcare has evolved through time, in part, in reaction or in a productive tension with the world context in which it operates. If those elements of the external world were not there, Catholic healthcare ministry would be very different. Then, Marie suggests, the identity behind the mission would

only be anchored in a social values-acculturation tied to the idea of formation, especially the calling to serve and understanding of healthcare provision as a sacred vocation.

The social and political environment in the US is such that universal access to healthcare remains a goal and not-for-profit healthcare continues to resist the incursions of commodification, however imperfectly. In this world, Catholic healthcare sustains a prophetic vision and a remedial practice in the face of what the Church perceives to be a culture of injustices. In CPH, the politics of identity are negotiated between Catholic and community, to articulate together by means of a common mission a collaborative values orientation that permits a continued healthcare ministry for a modern and pluralizing world.

Institutions without

> **Scandal**: n [LL *scandulum* stumbling block, offense] 1. In religious use. a) discredit to religion occasioned by the conduct of a religious person; conduct, on the part of a religious person, which brings discredit on religion. Also, perplexity of conscience occasioned by the conduct of one who is looked up to as an example. b) Something that hinders reception of the faith or obedience to the Divine law; an occasion of unbelief or moral lapse; a stumbling block.
>
> -- Oxford English Dictionary

> 1a) a discredit brought upon religion by unseemly conduct in a religious person b) conduct that causes or encourages a lapse of faith or of religious obedience in another; 2a) loss of or damage to reputation caused by actual or apparent violation of morality or propriety: disgrace; 3a) a circumstance or action that offends propriety or established moral conceptions or disgraces those associated with it; 4a) malicious or defamatory gossip; 5) indignation, chagrin, or bewilderment brought about by a flagrant violation of morality, propriety, or religious opinion
>
> -- Webster's New Collegiate Dictionary

In the early years of Catholic Pacific Healthsystem, the concept of a Catholic affiliation with a non-Catholic facility was an innovation for national ministry. Catholic bishops were understandably wary of what such an affiliation might portend. CPH undertook the deliberate social process I have documented both to clarify their own organizational stance as a new ethico-moral entity and to work with Church leaders to identify the implications of proceeding with this kind of alliance.

In the midst of the hospital system's phase of rapid growth through affiliations, the organization outlined in one document the particular elements involved in a proposed affiliation with a non-Catholic community hospital. In this particular instance, the facility in question was a district hospital created by political decree to serve a particular geographical community that had historically lacked access to hospital services in either the public or private form. As a result, when it considered affiliation with a larger hospital system, the district hospital board maintained that the array of services, including sterilization procedures, were part of its historical commitment and responsibility to serve that particular district community. Thus, in considering affiliation, all the parties moved to think through how CPH organizational collaboration with a non-Catholic provider that condoned sterilization could proceed. Preparatory documentation was produced within CPH to delineate the benefits and challenges, carefully laying out, in the tradition of Catholic methodological reasoning, a range of considerations for use in the dialogues between the system, consulting theologians and the responsible bishop. The chief document concluded with the following reasoning:

> Unlike the abortion controversy in the United States, about which most of the population is clearly conflicted and about which Catholic teaching has taken a clear, unequivocal and forceful stand, contraception, including the permanent contraception of sterilization, does not raise the same possibility of scandal. The level of scandal is greatest when a known evil is being tolerated, encouraged or enabled. To a great degree, the public at large does not share the view that birth control and sterilization are evil; therefore the likelihood of *scandal* is remote. Some, in fact, are more confused by the teaching itself. The danger of *scandal* over the perception that [Catholic Pacific Healthsystem] is fixated on a reproductive issue at the expense of a sound collaboration to provide quality health care in a compassionate environment is undoubtedly greater. [italics mine]

In the introduction to this project, I laid out the orientation of the dissertation that provided a rationale for why the scope of analysis did not engage the politics surrounding abortion provision. In the contemporary American context, many people have assumed that a diagnosis of ethical and social values of Catholic healthcare must necessarily revolve around reproductive politics. The public discourse, however reactionary, concerning hospital mergers and varying claims of (limiting) access to reproductive health services over-determine the

analysis (Bucar 1998; Dinsmore 1998; Baumgardner 1999; RCRC 1999). This assumption was often expressed as an expectation that participant-observation in such a hospital system would result in an anthropology of denunciation. I have tried to go beyond this single issue to the broader elements of contemporary identity operating within Catholic Pacific Healthsystem because the concept of sponsorship speaks to so much more in healthcare ministry, as earlier chapters have described, and the very real anthropological dimensions of ethical formation amidst pluralization.

In an age of prolific communications media, a general public understanding of the idea of scandal is more likely to reflect its usage as a verb to defame or slander, the connotation conveyed by newspaper coverage of a given controversy.[2] In many cases, the public experience of Catholic healthcare organizations reflects this sense, especially when reproductive health access is portrayed in terms of conflicting moral values (CBS News 2000). The discourse of access to reproductive health services was an anticipated backdrop during my research. At the same time that I undertook full-time fieldwork for this dissertation, however, other concerns arose to eclipse that discourse in the news and in many people's lives. The charges of pedophilia that have wracked the Roman Catholic Church are alleged to be the greatest scandal in the history of the Church in America. This issue is at once distant and disconnected from the works of Catholic Pacific Healthsystem yet also uncomfortably close and personal for individual people within the organization, identified as it is in variable ways with the Church proper and engaged in a mission to champion society's most vulnerable.[3]

> Traditionally, church authorities interpreted the scriptural injunction against 'giving scandal' (Matthew 18:6-7) to mean that the worst effect of clerical "improprieties' was their public broadcast, which could erode people's faith in God and in the Catholic Church. And so, traditionally, whenever church authorities were confronted with priestly concupiscence....the best moral course of action was seen as a deft, quick, and quiet internal 'management' of the potential scandal.... The traditional ecclesiastical response to preventing scandal- or what cynics might call institutional 'damage control'- is clearly apparent in Pope John Paul II's letter to the Roman Catholic bishops of the United States concerning then recent revelations of child molesters in the ranks of the priesthood...As excerpted in the *New York Times*, 6 June 1993, the letter defined the problem of clerical sex

> abuse as one pertaining to the 'particular situation of the United States.' The letter denounced...the news media for 'treating moral evil as an occasion for sensationalism.'
> -- (Scheper-Hughes and Sargent 1998: 310-1)

In making this narrative leap, it is not my intention to suggest that any of the practices of Catholic Pacific Healthsystem are cause for "scandal." The events of the world during fieldwork made this word a common place in public commentary and even casual conversation in and out of the system. Finding reference to the term in the documentation prepared for a secular community affiliation suggested a way of thinking about the politics of social values and I asked about "scandal" in the course of my structured conversations with sister-sponsors and mission integration team members:

> What does scandal mean to you? That's a deliberately loaded question.
>
> R: Yeah. I, it means two things to me. It means the traditional causing confusion among the faithful about Church teaching, on the one hand. On the other hand, it also means, for me, causing distress at the perception of hypocrisy. And it can mean both of those things to me, depending on the context. And I think sometimes when we're supposed to be worried about the first one, we have no idea how damaging the second one can be. So something that we do so as not to cause the first kind of scandal actually does in fact cause the second kind of scandal. And the damage is big. Well, I think back to, I mean, the one that comes to mind is the Immaculata example. [That hospital is] not part of us now. But it was, I mean, when they were here, it was us. There were two hospitals in a relatively geographically isolated place. One was not a Catholic hospital, and one was a Catholic hospital. And because the non-Catholic hospital was going to go out of business, we had an opportunity, CPH had an opportunity to be present in that community in a different way. And we chose to be present in that community. But there were two choices. One was to continue being a Catholic hospital in that community. And the other was to have CPH be present in that hospital—in that community—as CPH, and not have it be a Catholic hospital. Have it be a hospital like a Denomination North or a City Physicians' or an Eastbend. And because of [that hospital's historical sponsoring congregation], we chose the first way, which was to continue a Catholic hospital there. On a different campus. So we moved into an old community hospital. What we could have done is close the Catholic hospital and keep the community hospital running. But what we did was get rid of the community hospital, and keep the Catholic hospital running in the community hospital's shell. Now, on the one hand, that—and in doing that, we, the only relative difference is the sterilization stuff. Because abortion would have been not done in either case. But in doing that, we did not permit scandal of the first kind, causing confusion among the faithful about what the Church teaches, because we held fast to the view that you don't do sterilizations. Sterilizations are morally wrong. So we didn't do that kind of scandal. But we did cause distress about hypocrisy of our action in a lot of the public. So we—and yet, the decision making structure didn't admit to that kind of tradeoff.
>
> I: What was the perception of hypocrisy?

R: That we were, in a pluralistic society, visiting our narrow Catholic views on people needing health care. And that wasn't, that was unfair, and it was wrong, and we were responsible for it. What the point that I'm making now is that CPH at that time, because of the personalities, but also because of the corporate structure, we didn't have a way to evaluate the one kind of scandal against the other. We just refused to do that. The people in the trenches were doing it. The [regional executives] and the people in the regional office, were aware of it. But they did not make it, they didn't give it any moral voice at all at the management level or the Corporate Members. And I was kind of a voice in the wilderness. I was one of the only ones that did give it a kind of a moral voice. But the [historical group of sister-sponsors] won. Yeah. So that's an example. And actually, I'm trying to think if there's a non-sterilization example of scandal. It might be—well, no. Because the first definition is causing confusion about what the Church teaches. And the only thing that the public is even remotely confused about in Church teaching—it's pretty straightforward what the Church teaches otherwise—but the only remotely difficult stuff has to do with women's reproductive [procedures], contraception, sterilization "stuff."

Marie's answer lays out the communicative dimension of values-in-action in which the politics of identity constitute a practical paradox for the ethics of the organization. An identity established in relation to a set of differences is susceptible to allowing the drive towards distinctions to regulate, fix or exclude certain differences as otherness. It becomes apparent that "to be ethical is often to put identity, to some degree, at risk" (Connolly 1991: xix). In the case of Immaculata Hospital, the moral voice of critical responsiveness to the non-Catholic community lost out to the stronger drive inherent to avoiding scandal of the first type, as well as the need by a particular group of sponsors to assert their congregational charism in the form of institutional witness. The non-Catholic hospital closed and CPH assumed the building and campus, expanding their original Catholic hospital into the former secular site. Consequently, the CPH hospital system decided to sustain its presence as a Catholic facility, a worthy values-based choice, but one that missed the more complex dimensions of operating in the deep contingency of contemporary pluralism. To push it further, "agonistic respect is a reciprocal virtue appropriate to a world in which partisans find themselves in intensive relations of political interdependence" (Connolly 1991: xxvi). Stand-alone not-for-profit hospitals have not survived in California, and even the expansive leverage of a major system like CPH is still challenged to sustain break-even

operations; continuing to perpetuate not-for-profit healthcare in today's healthcare marketplace requires interdependence.

Beyond the bounds of Catholic Pacific Healthsystem, the discourse of scandal in the larger Church continued. As the number of alleged cases of child abuse rose, mounting evidence suggested that American prelates had been aware of allegations and, in some cases, diocesan authorities had not initiated investigations but instead had quietly transferred accused priests to other regions.[4] Organized American Catholics expressed increasing frustration and anger toward the US bishops, and alarm at Rome's reluctance to address the crisis directly.[5] Several bishops in the US and elsewhere cast the situation as a result of persecution of the Church by international media. As a Mexican cardinal wrote:

> The issue of pedophilia among ministers of the Church, came into prominence in the media in countries of the First World, for the benefit of lawyers who profit from the accusations, and as a means to discredit the Church and deprive her prophetic voice of authority, which is opposed to the powers of this world when she condemns abortion, contraception, sexual libertinage and injustice in economic matters, which impoverishes millions of human beings.[6]

The attitude linking scandal to public perception of the institution is reflected in comments made by Father Richard John Neuhaus, a leading Catholic intellectual and editor of First Things magazine. In an interview with Zenit News Service, Neuhaus stressed that "the crisis has a clear consequence." He remarked, "The moral role of Catholicism has been very weakened in the eyes of public opinion. We will regain prestige, but it is a process that might take years," he said.[7]

Though the real-time challenges of navigating the financial turn-around and operational restructuring in Catholic Pacific Healthsystem were paramount, they failed to completely eclipse the larger problems of the Church proper. During fieldwork, the media coverage of the charges against the Church and the reactions by various bishops met with a great deal of consternation among the sister-sponsors and their colleagues. Their dismay and concern for the suffering of victims and their families struggled with on-going puzzlement over how to make sense of the

Vatican's apparent reluctance to engage with the issues already so paramount in the United States. One sister tried to set the abuse in a larger context of institutions dealing with changes in the external world, but her frustration with the apparent betrayal of the faithful interrupted her efforts at contextualization.

> You know, sometimes I think when we're - within the Catholic Church, we kind of - certainly has its problems, there's no question about that. But I have found that my years - my few years, and they're not that long, twelve years, with working with the Methodists, gave me an opportunity to view organizations from a Christian perspective, but in a different denomination. And look at the Catholic Church from their point of view, you know, and come to appreciate - in fact, - Trotter was his name, he used an initial - he used to be on the faculty at Berkeley. The theological school. And he and I used to - and he wasn't my boss, but he liked to talk stuff. And he had a great interest in the Benedictines in the Catholic church, you know, as the great preservers of Roman law, that whole concept of law, you know, which is part of western civilization. But you know, it was kind of interesting, because sometimes I think - not feeling superior, but those who have never viewed - or seen organizations - church organizations, except from within the Catholic Church, think that - say, problems, say, dealing with a priest or something, is peculiar only to the Catholic church. Oh, let me tell you, lady, you are wrong. (laughs) I've seen it on the other side, you know. I mean, it's the same - it's human nature functioning in an organization, you know, whether it was with - in the Methodist system at the time I was working, the big problem was, they - had these women going to theological schools, and then when they got to be - you know, they were ready, they were ordained and they were ready to be assigned to a ministry, either the people weren't prepared to take them, or the ministers - you know what I mean? And really, it's the same thing. There are different time lines. And of course, the Methodists have this great approach, its - I tell you, method, is really right. They have stratified their population so in their boards and agencies, it's by gender and by age. I tell you, everybody's represented. Which - the Catholic church, you know, has started to try to do this... So they used to worry about - you don't feel quite as up-tight about it, as though there's some major secret that has escaped, that nobody knew about the Catholic church. We've all got dirty laundry. It's the human dimension, and it's unfortunate, especially unfortunate in recent events, that this whole pedophilia [situation] because of the - the violation and the deceit, that just, I think, harms everybody.

She explained that her thoughts were not about trying to explain away the fundamental violations reflected in the abuse charges. Drawing my attention to recent letters to the editors that had appeared in various newspapers, she expressed her frustration with some commentators who seemed to miss the point of the allegations. One such letter read: "Modern perceptions of clergy abuse also need to be placed in the much longer historical context of anti-Catholic and anti-clerical imagery and rhetoric." Her own opinions were more in keeping with a second letter that read: "In the midst of a skepticism that undercuts faith and hope, naming the truth is the only

place to begin. All priests should be thankful that any clerical evil be unmasked for what it is. For only truth makes possible love. And truth alone yields forgiveness."[8] This perspective echoes what Foucault has bequeathed to us as the speaker's benefit, the right and duty, despite the ambivalence that can adhere to such truth games, "to announce to a resistant and philistine world a difficult truth." This stance shares a common aspect of prophetic witness that the sister-sponsors call out in their sponsorship of CPH, and it echoes the broader Catholic tradition of speaking truth to power. [9]

On June 16, 2003, former Oklahoma governor, Frank Keating (a lay Catholic and the president of the American Council of Life Insurers) resigned his position as chairman of the national review board charged with enforcing the zero-tolerance charter against child sexual abuse that had been adopted by the US Conference of Catholic Bishops. In an editorial he wrote several days later, titled "Finding Hope in My Faith," the former governor "remained optimistic that the church – my church – will ultimately protect the innocent and hold the guilty accountable."[10] I cite Keating to close the reference to the pedophilia scandal emphasizing the personal note of continuing ownership, membership, affiliation that the editorial sounds even as the former governor protests the obstruction by certain prelates of the workings of the national review board. Throughout his term chairing the board, Keating spoke of his faith and hope in the institution of the church as he undertook its reform. Similarly, during my fieldwork, I was struck that even as the women religious or lay Catholics of CPH spoke of their varying and individual frustrations with the larger institution of the Church proper, they struggled to understand while holding firm to the ultimate worth of a Christian morality. Some were clear that their belief lay in the theological holiness of Church as a vehicle for God's Kingdom on Earth while others were more articulate that their faith lay in the redemptive capacities of its social ministries. One sister was acutely conscious of the all too evident flaws inherent in human leadership and in human organizations:

> But the humanness and the weakness, to me, makes the whole thing of the church surviving absolutely remarkable. I mean, you know, I mean, there's absolutely nothing that would show you it was because it was good leaders and ... always right. Nothing in the history will give you any reason why the Catholic church is still around, except in - those of us who believe, that the Holy Spirit is guiding this - this whole thing, and we just seem to be able to walk through it. And that's true of other churches also, so it's a human - it's the human endeavor in a kind of cooperative mold with divine. We're so totally reliant on the other.

The spectre of the pedophilia allegations and the resulting perception by American Catholics of scandal in the Church are enormously complex. The problems they raise have direct application to thinking about social ethics and values as well as the relationship of identity to ethico-political processes at both the individual and group level. I have earlier raised the concept of a Catholic "culture" as a heuristic that is useful for thinking through. The notion of scandal also has heuristic utility because the "culture" of that larger institution's engagement with the world provides an analogy for thinking about the hospital system as a (c)atholic organization. I have earlier tried to draw out the dynamics between individual and institution at play in the practice of ethics and identity. I want to continue that argument here to come full circle back to the initial dynamics of power and influence within CPH after having developed the ideas of pluralization and (co)sponsorship in the two chapters preceding this one.

Enduring change

The hierarchical structure of the Roman Catholic Church as a social and political organization lends itself to resisting change. The extensive documentary history of encyclicals and other pronouncements demonstrate the careful engagement of the Church with the "signs of the times."[11] As I have suggested in the earlier discussions of culture, the history of the problematization of "Americanism" also suggests that the Church perceives "culture" as other (McAvoy 1945; Yuhaus 1990). I have earlier suggested an institutional perspective that follows a trajectory more in keeping with the *longue durée* than other forms of social time (Wallerstein and Braudel, loc.cit.). In such an interpretation, the Roman Catholic Church's first charge is to

perpetuate and propagate the gospel Truths. Thus, *as a political bureaucracy*, as a social organization, the Church is designed for long-term survival and contrasts its own stability with the vicissitudes of culture, cast as change and human fallibility as opposed to the enduring Truth of Catholic witness.[12] After two thousand years, the enduring power of that theological legacy is substantial. However, the organizational attunement to that internal stance, from wherever it may originate, today falls short of the expectations of many Catholics for a responsive institution that can act rapidly to the challenges of the modern world.[13]

The historical and political context of Catholic Pacific Healthsystem follows the wake of larger American social narratives. Earlier discussion set out for the organization the implications of the rise and decline of the demographics of women religious, and the resulting transformation of Catholic hospitals through lay control. The significance of Vatican II and – though less explicit to my analysis – the possibilities that emerged from American civil rights and feminism, including the "sexual revolution," all contribute to the politics of identity and the diversity of agents within Catholic Pacific Healthsystem today, embodied in particular in the former women religious who guide mission integration for the system.

Beginning in the discussion of power and influence, I called out the significance of charism for the collective personality of decision-makers within the CPH system. As I have documented, substantial changes to the senior system management team and the arrival of the new president and CEO made Catherine the senior executive with the longest tenure in the system. As the new team came together, she was increasingly recognized as an organizational ("cultural" if you will) resource for her newer colleagues. In subtle ways, Catherine was increasingly perceived as a vector of power and authority that stemmed from her extensive experience within the system as well as Catherine's proximity to Corporate Members through her responsibilities in mission and sponsorship and, more distantly, her personal history with a religious congregation.

The system president and CEO took the system senior management on a team-building retreat. This event seemed to mark a new understanding among Catherine's peers of her centrality to the system's functions and their own work. On his return from Rome, Luke turned to Catherine to affirm his new perspective on his role as a lay leader in Catholic ministry. His new awareness led him to engage Catherine's participation in explicitly operations management, where Luke actively solicited Catherine's expertise and judgment to integrate the mission and values dimension into the processes that he oversaw as chief operating officer. She was routinely invited to participate in Luke's operations group, where vice presidents of group operations found they were expected to speak to how their operations facilitated mission integration. Because they were held to this expectation, so the vice presidents, in turn, held their respective groups of hospital presidents to this standard. I noted that Catherine began by calling these meetings "Luke's operations group," a term that slowly gave way to "*our* operations group." Catherine's authority and legitimacy extended across the new executive management team, and as a result, the work in her purview gained new significance that set her staff and their mission integration standards in a new light. The new administration, that brought structural centralization to the hospital and an emphasis on rationalization in the form of care management reporting and accountability, also opened an avenue for mission integration made possible by a long-term strategy of endurance.

When I offered this interpretation to Catherine, she was amused that I had focused on her role, but she did agree that the changes of administration had effected her political location with regard to her peers in senior system management. In return, she related an anecdote from a trust and communication exercise involving blindfolds during the senior management team retreat. Each person in the group had been asked to take hold of a section of a long rope, and then form a single circle without relying on their vision. Catherine had recounted how the CEO had interjected to calm another executive down when he started barking suggestions, at the same time the CEO frankly pointed out that the other was acting without thinking. Catherine suggested this was indicative of distinct differences in modes of leadership. Further, in contrast to her

colleagues, Catherine had simply taken a firm hold of the rope and, true to her own style, stood her ground to listen to the emerging strategy. As the CEO began to walk the group through it, Catherine needed neither to follow nor to lead as the rope circle took its shape around her stable point.

In thinking through the organizational transformations that Catholic Pacific Healthsystem has attempted and continues to undergo, hospital operations are slowly engaging with the mission and core values in an explicit way. In terms of procedure, this integration is made possible by the implementation of the "mission integration standards" that the Corporate Members, Catherine and her mission team colleagues have advanced. At another level, this implementation represents the tactical aspects of a larger long-term strategy that finds its focus in Catherine's personal leadership. As a Catholic organization, even given the multiple contributing identities this analysis has suggested, Catholic Pacific Healthsystem reflects its origins in the Roman Catholic Church in the way that mission and core values, and the meaning of sponsorship, engage with the continual change pressed upon the system by its entanglements with the rest of American healthcare, the secular communities it operates in and the collaborations it undertakes to sustain those operations.

Like its institutional parent, CPH as an ethico-moral collective is committed to the long-term survival of the system, in order to sustain a witness to human suffering, an advocacy for holistic care and a vision for prophetic change. The system's determination to champion collaboration with secular community partners reflects a dimension of the core value of stewardship, where the system nurtures and in some cases reinvigorates not-for-profit healthcare in places where the market threatens to impose its values entirely. However, the demands of the rapid growth strategy of the previous management era did not permit substantive values integration. The ramifications of that growth strategy took the system into financial crisis, and only when operations brought it out of a successful turn-around was Catherine in a position to advance mission integration as a comprehensive agenda for the future of the system.

Forming futures

Anthropology has engaged time as an object of social analysis and cultural inquiry in many ways.[14] Analyses of religion have distinguished sacred time from secular (Eliade 1959); indeed, Turner's concept of *communitas* hinges on this distinction (Turner 1967). When Luke returned from Rome, he latched onto the concept of formation as a trope for organizational development and leadership training. When I raised this idea with Marie, she had a very visceral reaction. She argued that while the term might carry some linguistic power because "formation" was marked with signifying meanings in a Catholic context that evoked mission and vocation, Marie questioned the accuracy of the label in light of larger healthcare industry trends:

> Here's the reason that I think formation is important, or the lack of formation is important. Health care, you know ... the world come from organizational development into a work force that's changing. So the way the [OD director] does her job to make you a CPH manager is to put you through a training where you learn management skills. Fully expecting that you will be with us three years, four years, probably not seven or eight years, and for sure not ten years. The thing about, that's different about formation is that it's, it's like the rock, it's like a rock formation or a river or something. It's slow and deliberate and little by little by little. And that slow, deliberate, little by little, we don't have that in health care. We have so much turnover that we don't have the opportunity for formation. And I actually don't think formation goes with high turnover.
>
> So if you have senior executives who are going to be with you a long time, and are kind of in it for the long haul, then I do think that there's a way... I think Luke [the COO] had begun to be formed. He was in a Catholic health system somewhere, and then somewhere else, and then in Denver, and now here. And I think he kind of plans to be here. He doesn't have a career trajectory where he's not classified with what he's doing. [As for the CEO] if things go according to his plan, he's at the top of a very interesting heap right now. And I think he's, I have heard it said of him that he plans to retire from here. That kind of stability means that you could actually have formation at a certain level.
>
> But I think at another level, I think the turnover just mitigates against it. It doesn't mean you can't have good managers. You just don't have formation. It also means that, I think, the same as we got Luke, hiring is much more important than orientation: you, you, you, you. I don't think you can teach the stuff that I think is important in terms of making CPH have the character that we want it to have. You can't teach that. Certainly not in the first three months or year that somebody is with you. You've got to hire that person already like that. And then they get the flavor and the dynamic, once they're here. But I don't really think you teach that stuff.

Marie suggests that there is a temporal dimension to the inculcation of mission and values that seems to resonate with the Catholic experience. It echoes the Church's institutional concern with longevity and is embodied in the analogy of Catherine's strategic patience that brings about new opportunity for real mission integration across the CPH system. The ethical constitution and self-fashioning that have been formalized in Catholic Pacific Healthsystem emerge from the unique constellation of catholicities within the system, finding their roots in the sister-sponsors but sprouting in the hybridity of various collaborations with secular community partners. However, the system is still undergoing formation, still in the process of transformation. It remains to be seen how the power and influence of the current meanings of (co)sponsorship may shift and how the sponsors, former sisters, and their colleagues move the system forward.

* * *

At the time of this writing, the Roman Catholic Church in the US is engaging the scandals of its priesthood in new ways. The tide seems to be turning with the announcement of a major settlement by the Archdiocese of Boston. The break-through agreement has been represented as the result of a radical change in orientation initiated by the new archbishop, Sean P. O'Malley, a Capuchin Franciscan friar.[15] Shortly after he was installed, the archbishop moved out of the episcopal mansion to live in the rectory with diocesan staff.[16] Archbishop O'Malley replaced the diocese's former legal counsel that reportedly had relied on stonewalling tactics in dealing with abuse cases and the archdiocese has moved rapidly to a significant settlement agreement.[17] In newspaper coverage, both the legal firm representing the plaintiffs and a professor of Church history agreed that the archbishop's Franciscan formation informs his "clarity of vision." "Wearing that brown robe, giving up the fancy residence and being willing to spend the church's money to help people all fit as core values for Franciscans," said Rev. John O'Malley of the Weston Jesuit School of Theology.[18]

[1] For this reason, as well as our long association, I had delayed the intensive semi-structured interview until after I had completed fieldwork and had begun the full-time project of analyzing data.
[2] Think of the Mayflower Madam, Watergate, Michael Milken, Whitewater, Lewinsky, Enron.
[3] As explained earlier, the finances of Catholic hospitals are completely independent of diocesan finances because the healthcare ministries are operations and assets of congregations of women religious, not Church dioceses. The resolution of the pedophilia scandals by financial settlement would not directly impact Catholic healthcare. However, public anger and declines in charitable contributions to Catholic organizations could extend to Catholic hospitals and other organizations. Potential donors might feel insecure about giving to Catholic charities and Catholic contributors could remain so offended by the actions of the Church proper that tithing and gifts to Catholic service organizations could be at risk.
[4] For example, see Frank Bruni, "U.S. Catholics See Priest Scandal Testing Faith and Vatican," *New York Times*, April 8, 2002. "Church in US is working to combat abuse, says Archbishop," Zenit, June 4, 2002.
[5] For example, see Melinda Henneberger, "Pope Offers Apology to Victims of Sex Abuse by Priests," *New York Times*, April 24, 2002. James Sterngold, "Four Sue Cardinal Mahony, Using Racketeering Laws," *New York Times*, April 30, 2002.
[6] Juan Cardinal Sandoval Íñiguez, Archbishop of Guadalajara, published on the web page of the Mexican Bishops' Conference: www.cem.org.mx and reported by Zenit, June 10, 2002.
[7] "Editors of First Things and Commonweal comment on U.S. Scandals," Zenit- Avennire, June 12, 2002.
[8] Issues of the *New York Times*, the *San Francisco Chronicle*, and the *Los Angeles Times* were available in various departments of the hospital and read by staff and employees as well as patients and their families.
[9] The earlier discussion of the prophetic dimension of sponsorship aligns well with some veins of critical medical anthropology, though they are not pursued here.
[10] *New York Times*, June 19, 2003.
[11] John XXIII, *Pacem in terris*, 1963.
[12] See for example, "Cardinal Poupard on the divorce between Faith and Culture," Zenit, June 5, 2002, and "Guadalajara Cardinal's comments on scandals involving priests," Zenit, June 10, 2002.
[13] I want to be clear that I recognize that Vatican II signaled a doctrinal shift that sought to respond to this need. I am not offering a critique of developments in ecclesiology here. I am suggesting an analogy between the organizational behavior of the larger Church and of CPH in the form of a common relationship to change where the mission/values remain constant despite shifts in worldly culture.
[14] See, for example, (Fabian).
[15] Fox Butterfield, "Catholic Church installs new Boston Archbishop," *New York Times*, July 31, 2003.
[16] "New bishop turns down big house," *New York Times*, August 9, 2003.
[17] "Boston Archbishop replaces lawyers in sexual abuse suits," *New York Times*, August 1, 2003.
[18] (John O'Malley is not related to the archbishop.) Fox Butterfield, "Deal reflects Archbishop and his Franciscan roots," *New York Times*, September 11, 2003.

Apocrypha: Signs of the Time

> The increasing intellectualization and rationalization do not, therefore indicate an increased and general knowledge of the conditions under which one lives. It means something else....
>
> – Max Weber, *Science as Vocation*

> In the sphere of meaning, the mark of modernity is fracture and pluralism. The gradual institutionalization of science [medicine] applied the fracturous blow to older worldviews, not forceably destroying them, only decentering them, placing them in a relational position.
>
> – Paul Rabinow, *American Moderns*,
> – Essays on the Anthropology of Reason

> Will you be bitter or banausic?
>
> – Max Weber, *Politics as Vocation*

I have, following pedantic custom, begun this account with external conditions. I have endeavored to develop a description of a circumscribed social phenomena and provide a diagnosis of a contemporary problematization for which anthropology might account. I describe the labors of a group that may be unique in its particularities, to represent something other than the norm, a singularity, no representative of Catholic healthcare in any statistical sense and, against the grain of science practice, without regard to replicability. Catholic Pacific Healthsystem and its actors are a unique social constellation that I have attempted to historicize rather than reify. I wanted to recognize or call out the social context, the economic and political circumstances in the broader sense, that shaped the formation of CPH to show the evolving practices of this organization as a collective entity-in-the-world.

In the interest of circumstantial integration, my account could be positioned in relation to the analytic discourses of social suffering (Kleinman, Das et al. 1997; Bourgois 1998; Bourgois 1999) and/or evolving meaning tied to biopolitics or now biosociality (Downey and Dumit 1998; Rabinow 1998; Rabinow 1999) that sees its antecedents in more social anthropology. Drawing back to society and its contexts, the secular rationalization that now drives medicine – like evidence-based protocol and treatment guidelines, outcomes measures, the fixation on

quantification for quality and other various metrics – has still not enabled society to resolve what "health" is.[1] As we know, medicine is based on a conceptual framework of pathology, the absence of which creates the norm(al) as Canguilhem explained well before this academic attempt at problematization (Canguilhem 1989). Similarly, one might argue that we cannot take for granted the nature of the object, "religion." Thus in this analysis, the ethical life of Catholic Pacific Healthsystem is brought into being through the daily and systemic engagements with both the lineage of Roman Catholic identity and the moral trajectory of not-for-profit, often understood as secular, healthcare provision in the United States and the pragmatics that result from such efforts of ethical articulation in the dynamics of pluralization.

This is not a salvage ethnography that makes visible under-recognized identities in order to rescue from assumption and generalization the particularity of an organization, its actors and collective works. Salvage anthropology always connotes impending dissolution and the preservation of some "authenticity" (Clifford 1986, p.112; Marcus and Fischer 1986). The sister-sponsors and their colleagues with whom I have worked would more clearly claim transformation, certainly change, but always a hope for transformation, and necessarily in accord with the signs of the times.

The case of CPH demonstrates a re-conceptualization of the often concretized idea, easily presumed, of a single monolithic Catholicity. The account I present remains true but in the sense of the particular aspiring to the universal. The story of CPH (of caring and advocating for our sisters and brothers who are poor, sick and disenfranchised) continues to have meaning in the contemporary world. As the ranks of the overlooked and uninsured grow, and more of the working poor are unable to manage the cost of healthcare for their families, Catholic not-for-profit healthcare has a purpose in providing charity care and community benefit. Further, there is a place even a need, in an increasingly "polar night of icy darkness and hardness, no matter which group may triumph externally now," to hold tight to our capacity for ethical reflection and organizational self-fashioning for political action in the world.

(Dis)enchantment

Spiritual care as a dimension of care for the whole patient-person is a perspective that increasingly seems to resonate with people, patients, and their physicians. It remains to be seen how much that is a predictable counterpoint to the growing *disenchantment* with the structures and effects of market-driven healthcare in the US. Holism itself can easily become commodified, witness Deepak Chopra or Andrew Weill, for the currents of commerce run strong no matter the shoal, ironically even the ground once reserved for religiosity. For some actors, holism and the larger realm of mission and core values are no longer simply esoteric marginalia but can be part of adaptive "rationalization" strategies that provide justifiable investment, demonstrate adept specialization and consequently train-ability. As this account has described, these developments contribute to the diffusion and dissemination of those things that most concern the sister-sponsors. But, "no genuine religion of salvation has overcome the tension between their religiosity and a rational economy" (Weber 1958). Sustaining mission through that diffusion involves designing accommodations for the contingencies of pluralization, not only of protestantism (sic), but of efficiency and expediency and other marked forms of rational functionalism. The disenchantment of the world that Weber asserted seems to extend into, rather than over, the value sphere that was understood as religion.

What might this suggest for accounts of modernity, modernities, even counter-modernities that we construct through varied social or anthropological lenses? Huntington's "clash of civilizations," frequently cited in recent days in policy discussions too often cast as the "Islamic problem," might also prove useful to think here if in a very different vein.[2] Can we recognize the echo of a common rhetoric mobilized by protestantized secular voices against Catholic healthcare? Are there resonances between a civilizing, humanitarian discourse and the reductive presumption of a uniform Catholic sectarian threat to the public space, the agora, that resists Catholic sectarianism even while turning a blind eye to its own Protestant origins? Scholar

Sherene Razack troubles her own invocation of the figure of the imperiled Islamic woman within the feminist bind, asking if evoking the figure necessarily reinscribes the very stereotypes embedded in the structural relations one seeks to critique.[3] Similarly, my own project to demonstrate multiple catholicities at work in contemporary California is vexed by an *a priori* societal understanding of Catholicism as uniform and hegemonic identity, equally instantiated by the rhetorics of power of the institutional Roman Catholic Church and those very voices that resist its social, political and ethical incursions into pluralizing social life. Representations are social facts. These are only concluding remarks because the process of ethical reflection that produces the organizational life I have ascribed to Catholic Pacific Healthsystem continues; so too must the effort of real description.

* * *

The challenge of anthropology lies in representation. Lived experience rarely presents a clean-cut case of the good and the bad, despite the continual drive for stories of human history to do so. Sister-sponsors and other actors working in the name of that tradition were not always progressive champions. This analysis is not a heroic organizational *bildungsroman*. A history of US Catholic philanthropy tells of times when sisters were very much less than progressive, and it is important to identify those transitions and to recognize the social formations that accompany them (Oates 1995: 75). Irony suggests the gap between expectation and observation. That is not my goal in the writing of this work. There is the expectation that the Roman Catholic Church is necessarily a restrictive force. Anthropology should ask who holds that expectation and how does it color our ability to perceive the lived experience of being-in-the-world? Nonetheless, for some – perhaps many – the forms of life that religion embues are not liberatory or redemptive, but constraining, oppressive even dominating. It is not clear to me why this would or would not be expected but regardless for them, for us, *ressentiment* is that much harder to set in abeyance. The

call of anthropological integrity is real precisely because it resists easy politics. The rhetoric of values conflicts is stable but that is not the ground of this project not has it ever been.

Extensive fieldwork and years of association means that a good-enough anthropologist will care about the lives she documents. On the page, that sensitivity can lend itself to charges of over-simplification or even subjective narrative/analysis that leans to heroism. I have tried to observe such limits but perhaps apologia is unavoidable. In a sense, in a rhetorically secular world, unless framed within a denunciatory politics, any account of Christian beliefs and conduct seem to always be marked. Sadly, it is an altogether different kind of politics of suspicion that reigns today.

Earlier accounts of fieldwork have mapped the terrain before mine: complicity (Marcus 1998; Rabinow 1999), even earlier deep play are terms that signal it (Geertz 2000). The path plotted by Max Weber continues to be important here. In the later passages of his two lectures, "Science as vocation" and "Politics as vocation," he reminds us that vocational integrity involves what he considers a type of ascetism. Rarely stable, his language parallels Nietzsche's mode of curiosity,[4] though Weber lends himself less to flippant usage in academic treatises.

Catholicism has, on occasion, been condemned by other worldviews for all that is implied in a theology that asserts "there will always be the poor." The theology argues human nature is flawed, and we are all subject to weakness, thus there will always be people who are disenfranchised; alternately, the apparent human condition of finitude means there will always be people who are sick or dying. Catholic healthcare ministry responds by taking the tack of longevity and preparing an institutional religious response to provide for their care in the times to come.

But I could pose the situation differently. For all the gestures to the sick and those who are poor, this project has been more an anthropology of the "elite," of studying-up if you will. This project seeks to resist the banalization of injustice embedded in healthcare structures in the US with its accounting of the ethical life of CPH, its sister-sponsors and allies, engaged in a

politics of compassion.[5] Though their organization parallels a non-sectarian humanitarianism, within Catholic Pacific Healthsystem the common ground of collaboration is made possible by an adherence to a moral economy informed by Catholic traditions. In some ways, it remains the incorporation of bare life in the the pursuit of the good life (Arendt 1958; Agamben 1998), but in the case of CPH, the ethical formation of an institution coalesces over the bodies of the poor and the sick through the provision of healthcare services and a prophetic witness to the creation of a present future: communitas through caritas, perhaps. For the religious believer, the example of CPH illustrates an attempt to constitute a Kingdom of God on earth without renouncing plurality. Thus, contrary to the reigning discourse of secularization, such a modern ethical life is not dependent on the containment of religion or the evacuation of religion from the social as a result of increasing technical rationalization. The religious persists, but perhaps in new forms that may or may not be marked by a defining counter-modern aspect.

The religious worldview seemed to precede a science worldview, it may also present a doubling of experience that only appears to take a linear form. In people's lives, as I have documented in the account of CPH, values (read religion) inform an ethics, creating both intentions and ends. Science and technology constitute a means, instrumental in nature, to approaching those ends. Thus, medicine and healthcare are techniques for ontological realization that permit of a flexibility or accommodation in their use. The telos remains and retains its religious valuation. As "catholic" suggests, one cannot step outside of other worldly influence.

* * *

Posing questions of surplus health in the face of social inequalities that result in significant disparities of disease burden among social groups in the US, some forms of healthcare deal in what Margaret Lock has termed promissory capital, for that is the nature of prophetic witness. And perhaps that promise continues to have dangers for those who seek comfort or find

strength in it. But I would suggest that it is not an entirely transcendental holism that is promised; the pragmatics of healthcare ministry that I have documented undertake to bring that world into being in the here and now as best the system and its ethical actors can. High-tech heroics may enable cost-shifting but the balance can always be questioned. Too dominant a focus on technological advancement in healthcare and access for the underserved may be demoted or forgotten. The sister-sponsors and their agents implement a criteria and ethics of reflection to question the appropriateness of investment over the possibilities of prevention and public health. They ask, how are high tech innovations transferable to the context of the poor and underserved? They ask, how can we pose the question of limits? When is enough is enough? Where is the place of restraint, the core value of stewardship, that informs the efforts at re-distributive justice? Perhaps it lies not only cost-shifting but in the recognition that some technologies only alleviate suffering after the fact rather than intervene at the level of prevention of disease and illness as might vaccination and innoculation, prenatal care and other less glamorous technologies of science but just as evasive technologies of the social. As Foucault and others might have us ask, what form the public health? Do the laws of a secular rational world construct another doctrinal norm that constrains the nature of not-for-profit care much as the Church seeks to define the parameters of "appropriate Catholic" ministry? The late Cardinal Bernardin would ask, how does this complicate the simple binaries of pro-choice/pro-life, progressive/conservative? How might this shape both ethical and political enactment of persons and organizations in communities and in the agora of public policy and legislation?

In another tradition, what is critique? As I have said elsewhere, it need not always be denunciatory. Some gesture to seven arts of science, now two, rhetoric and casuistry. If anthropology aspires to a diagnosis of the contemporary, what language can lend clarity and delineate complexity? I stand adjacent to my informants and their practices that create the ethics of Catholic Pacific Healthsystem and its organizational truth claims, in order to describe, to diagnose within the definition of critique. Any denunciation comes only in the form of troubling

the presumption of uniformity when actual social practices demonstrate complexity and diversity in the production and organization of ethical life. Mindful of the terms of yet another worldview, in the second Christian millenium, I present starting points not end points (Haraway 1997).

Aufklarung

The anthropology to which I aspire reflects an engagement with the lives of people who manifest a passion and motivation for being-in-the-world and an awareness of the continuum that is ethics and politics, in the Aristotelian sense.[6] As an anthropologist, my work is to describe a contemporary constellation, a complexity in the forms of life that lived experience entails. To take their lives as wholly serious is inherent to the practice. After that work, after we have made our attempts to engage with that complexity, then one may take up ethics and politics, in the policy sense. To do otherwise would be premature; to do otherwise here disregards the *conscientious*-ness of my informants to support a human solidarity in and against the easy identity politics to which they could capitulate but endeavor to resist. If the purpose is to increase understanding, however unremarkable, then my mode of work itself must be subject to the same concepts – ethical effects of articulation, ethos of pluralization – with which I bind my object. "Here I stand; I can do no other" (Weber 1958).

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[1] Seven years ago, when I began the program in public health at UC Berkeley, Jamie Robinson drew a simple plateau curve on axes of expenditure and health. Just yesterday, the New York Times still thinks it news fit to print: "More medicine is not better medicine," Elliott S. Fisher, op-ed contributor, December 1, 2003.
[2] Samuel P. Huntington, Foreign Affairs, Summer 1993, v72, #3 p22-8.
[3] "Human Rights, the Muslim's woman's body and the making of a family of civilized nations", American Anthropological Association meetings, November 2003.
[4] See also (Blumenberg 1983).
[5] Didier Fassin, American Anthropological Association meetings, November 2003.
[6] See *Politics* in (McKeon 1941).

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Appendix A

[The following is the public Statement of Principles from one of the sponsoring congregations of Catholic Pacific Healthsystem. It has been edited only to remove the identifying names or characteristics. It is included as an appendix to demonstrate the juxtaposition of the sisters' particular orientation with the Christian gospel and the social teachings of the Roman Catholic Church as three distinct but interwoven sources for direction.]

Statement of Principles

How we treat the poorest and most vulnerable among us is the measure of the greatness of any nation. We have gazed into the eyes of our sisters and brothers as they struggle daily for survival. We acknowledge that the present distribution of the world's wealth and resources prevents them from living a fully human life. We recognize that full human growth and global security will only be acutalized when justice extends to all people. It can only be realized when women's power and dignity have been unleashed. Our care and concern also extend to Earth and its protection as a major part of God's creation.

The Gospel Message of Jesus

The underlying principle for all our justice work is the Gospel call:

Whatever you did to the least of these you did to me.

The spirit of the Lord has been given to me, for he has anointed me. He has sent me to bring the good news to the poor, to proclaim liberty to captives, and to the blind new sight, to set the downtrodden free and to proclaim the Lord's year of favor.

(Luke 4:18-19)

These are but two brief examples of the call and life of Jesus, that leads us in the way of justice.

Catholic Social Teaching

The Catholic Church has developed a tradition of social teachings and analysis. This teaching emphasizes the following principles:

Respect for the life and dignity of the human person

Human life is sacred and the dignity of each person is the foundation of a moral vision of society.

Fundamental question: What is happening to people?

Fundamental question: Is the life and dignity of every human person affirmed?

All persons are called to family, community and participation

Being a person has a social dimension. People have a right and duty to participate in society, seeking together the common good, and well-being of all. This includes participation in the political, and economic aspects of the society.

Fundamental question: How are people included in or excluded from participating in the life and benefits of family and society?

Option for the poor and vulnerable

The needs and rights of those who are economically poor and disadvantaged have a special claim on the concern and care of persons and societies.

Fundamental question: How are persons who are poor or vulnerable affected by personal and societal decisions, structures and processes?

The common good is inseparable from the good of persons

Individual rights are always experienced within the context of the common good. All persons have responsibilities to promote the common good.

Fundamental question: What are my responsibilities to the good of all?

The common good is the sum total of all those conditions of social living - economic, political and cultural - which make it possible for persons to live fully and well.

Respect for the dignity of work and the rights of workers

Work is more than a way to make a living. It is a form of participation in the ongoing work of creation. People have a right and a responsibility to work, a right to receive a just wage and a right to form unions.

Fundamental question: Are persons able to adequately support themselves and their families through meaningful work?

Solidarity of the human family

We are one human family, whatever our national, racial, ethnic, economic and ideological differences. It is imperative that we work for justice and peace among all peoples and nations.

Fundamental question: What divides persons from one another, and what promotes the recognition of our unity?

Care for God's creation

We are called to protect people and the planet, to show respect for all that God has created, and to do what we can to assure that creation continues to thrive into the future. This stewardship is part of our call enter into the continuing work of creation.

Fundamental question: How can we assure creation and our planet will thrive into the future?

Part of this teaching tradition are statements of the Second Vatican Council which speak of the responsiblity of Christians to work for structures to make a more just and peaceful world, basing political and economic decisions on human dignity.

[This Order's] Tradition and Founding Principles

[Our foundress] responded to poverty and injustice in her establishment of her work of mercy and the foundation of the [this order]. [The members of this order] continue this response to need and injustice in the traditions and principles which have guided their lives and work.

Today, the Direction Statement and Action Plan of the [this particular Institute of women religious] continues this commitment to principles of Mercy and Justice in all that we do.

Appendix B

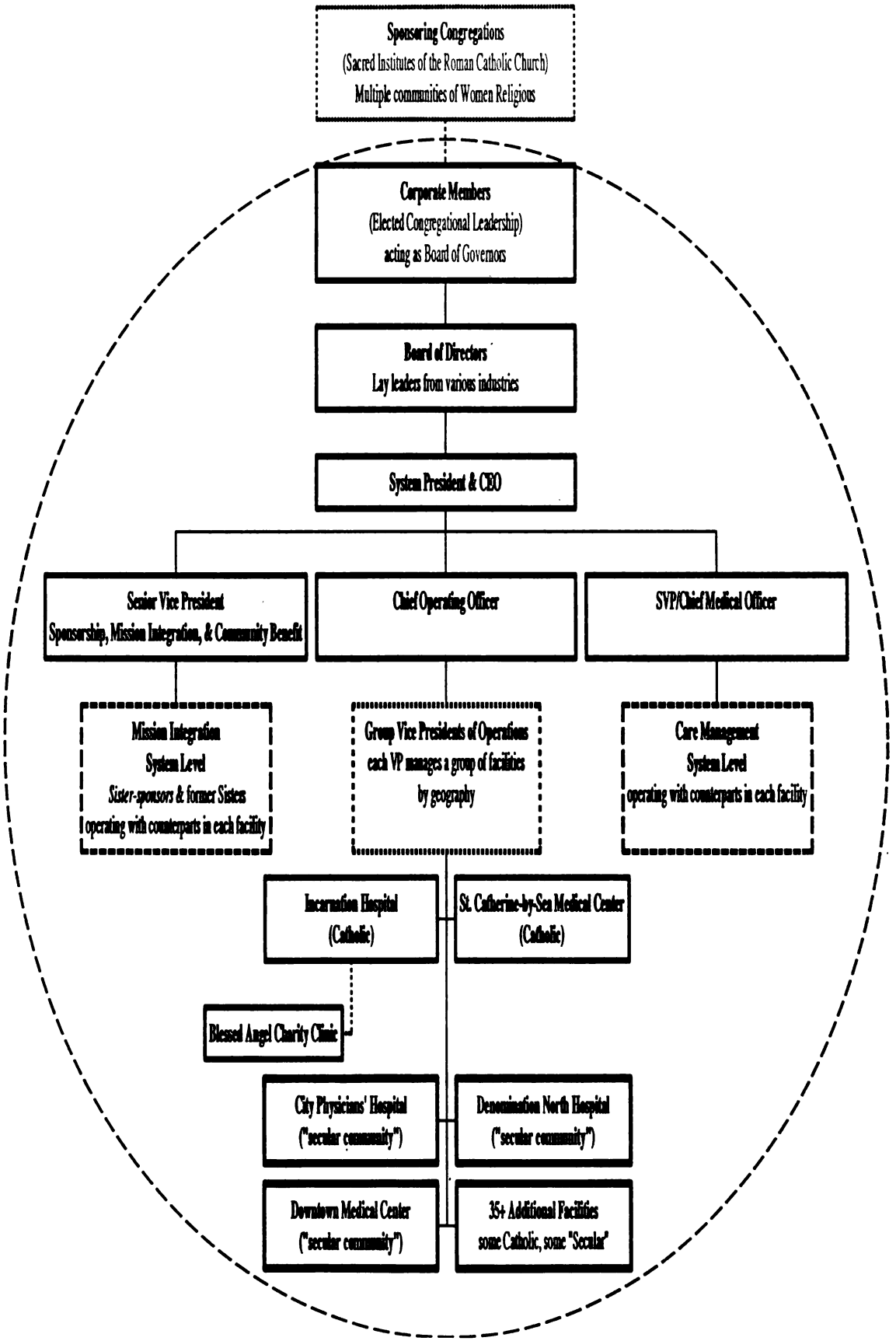
Timetable: Data Collection Plan and Methods			
	Step One Activities		
Estimated Start Date (Total time)	Setting	Activities Planned/Data Collected	Purpose of Activity/ Research Questions Addressed
August 2001 (3 mos.)	Blessed Angel Charity Clinic	Clinic observation and related service provision.	Observe direct care provision. Identify themes, develop codes. How do providers conceptualize relationship with people they serve? What is influence on practice of care?
December 2001 (1 mos.)	CPH System Office	General meetings, systems operations, Mission Services overview.	Integrate into general system administration. Meet additional contacts, identify values agents. What conflicts are recognized and engaged? How are economic drivers reconciled with theological mission?
August 2001 (continue entire length of study)	Media sources	Monitoring and collection of media accounts of Catholic healthcare, not-for-profit hospital, diocesan and national religious coverage.	Understand external forces, conflict between secular and ecclesiastical authorities. Evaluate public meaning of "religious facility" and "non-profit." How is identity managed? How do Catholic administrators navigate secular world-view of biomedicine? What is the nature of collaboration and cooperation between system and non-Catholic agents?

Step Two Activities			
Estimated Start Date (Total time)	Setting	Activities Planned/Data Collected	Purpose of Activity/ Research Questions Addressed
Sept. 2001 (3 mos.)	Incarnation Medical Center City Physicians' Hospital (administration)	Participant-observation. Focus on administrative leaders, operations, finance, planning, mission services.	Establish rapport with specific study subjects. Reassess codes and themes. How are differences between Church doctrine and the practice of healthcare negotiated? What are the supports and obstacles to maintaining religious identity in California? What is the nature of collaboration and cooperation among the different congregations?
Dec 2001 (8 mos.)	CPH System Office	Participant observation. Focus on administrative leaders, operations, finance, planning, mission services.	
September – December 2002 January 2003	Individual Facilities	Problem-focused participant observation and interviews. Developed out of Step II.	Explore situations, suggest scenarios, and initiate more directed inquiry. How do administrators understand their practice within "religious organization"? How is identity managed? How do Catholic administrators navigate secular world-view of biomedicine? What is the nature of collaboration and cooperation between system and non-Catholic agents?

Step Three Activities			
Estimated Start Date (Total time)	Setting	Activities Planned/Data Collected	Purpose of Activity/ Research Questions Addressed
August 2002 (as needed)	Motherhouse of A Sponsoring Congregation	Modified life history interviews.	Explore history and social change, determine context. Explore personal meaning of career/vocation in healthcare. How is Catholic identity constituted at the individual level? Within a group? How is knowledge different from belief? What are the supports and obstacles to maintaining religious identity? How do informants conceptualize and realize "community," "care," "self" and "Other"?
August 2002- January 2003	CPH System Office, Various individual facilities	Modified life history interviews.	
Dec. 2002 – Dec. 2003	Follow-up visits, as necessary	Additional data analysis, leading to writing, corroboration and validation.	Elaborate thesis: data analysis, thematic consolidation. Apply: framework of ideal types to qualitative data, model of countervailing powers. Write: drafting the dissertation, structural analysis, problem and case-based argument and construction. Confer with research subjects and external informants through follow-up visits.

Catholic Pacific Healthsystem

Simplified Organizational Chart



Appendix D

CPH Statement of Common Values

Preamble

Catholic Pacific Healthsystem is a health system structured to foster collaborative efforts among the religious congregations that are its sponsors, [list of sponsoring congregations]. The sponsors collaborate with their lay partners in a spirit of ecumenism to direct the mission inherent in the corporate ministry of CPH.

Throughout its many years of health care ministry, CPH and its sponsors have recognized the importance of partnerships. We believe the social fabric must be woven in partnership with all who have a call to serve the community and we champion collaboration among those partners. Our ability to carry out our mission of healing rests largely on the formation of linkages with others -- health care providers, community organizations, physician organizations, government agencies, employers, health plans, and individuals. By forming partnerships, we can respond to the community's need in a manner that is holistic and comprehensive, rather than fragmented or duplicative.

CPH's respect for values including the dignity of persons, care for the poor, the common good and responsible stewardship are essential in our ministry of healing. We invite our partners to understand and participate in realizing our values, many of which we believe we hold in common with our partners.

Social Responsibility of Health Care Providers

Health care is a ministry that serves the needs of individuals and communities -- it is a social good and a community service. The ministry of health care promotes healthy individuals

and a healthy community that advances the social, economic and environmental well-being of its Community. Most importantly, access to health care is a fundamental right of all persons.

CPH champions the dignity and well-being of all persons without regard to age, gender,sexual orientation, culture, race, ethnicity, economic, immigration or employment status. As a community, we have a moral responsibility to care for the poor and powerless, those of low socioeconomic status, individuals who have had catastrophic illnesses and those needing chronic care services.

Special concern is shown for the poor, helping them through direct service and acting as an advocate to change structures that keep them in poverty. We also have a special responsibility to those individuals at the beginning of life's journey as well as those who have shared so much of their wisdom throughout their years -- children and elderly.

As an employer, CPH treats its employees respectfully and justly, fostering a meaningful and humanizing work environment. Such an environment involves giving people a voice in matters affecting their work; respecting and promoting people's personal and professional growth; and providing a just wage. We try to promote trust, fairness, and mutual communication in all aspects of employment.

Through our health care ministry, we seek to contribute to the common good, which is realized when economic, political and social conditions protect and promote the fundamental rights of all persons and enable them to reach their common goals. Health care resources belong to the community and as providers we are stewards of those resources with the responsibility to use them in a way that advances the health care status of the community. In addition, CPH acknowledges its responsibility as a steward of the earth and recognizes that these resources are limited. CPH is committed to an equitable and ecologically sound use of the earth's resources.

Pastoral and Spiritual Responsibility of Health Care Providers

It is our goal that health care be provided in a holistic way, respecting all dimensions of a person. At a time of extraordinary technological advancement developed to cure disease -- one that focuses on the physical dimension of person -- we need to emphasize and embrace the psychological, social and spiritual dimensions of persons.

Care should not be limited to the treatment of disease. We express our compassion and spirituality by easing the pain and suffering of our patients. Spiritual care is integral to health care and should support the religious and spiritual needs of all those it serves. Care encompasses the full range of spiritual services, including a listening presence as well as help in dealing with powerlessness, pain and alienation Close collaboration with spiritual leaders, caring ministries and communities of faith is essential.

The Professional-Patient Relationship

We respect the privacy of the physician-patient relationship. A person in need of health care and the professional health care provider who accepts that person as a patient enter into a relationship that requires, among other things, mutual respect, trust, honesty and appropriate confidentiality. The resulting free exchange of information must avoid manipulation, intimidation, condescension or judgment. Such a relationship enables the patient to disclose personal information needed for effective care and permits the health care provider to use his or her professional competence most effectively to maintain or restore the patient's health. Neither the health care professional nor the patient acts independently of the other -- both participate in the healing process.

Health care is patient-centered. Patients have the right to make medical treatment decisions (including accepting or rejecting treatment), which includes free and informed consent,

access to medical and other information regarding their care, the right to make an advance directive and to name a surrogate decisionmaker.

Medical treatment decisions may generate ethical dilemmas for health care providers, patients and their families or surrogate decisionmakers. An ethics committee or some alternative form of ethical consultation will be available to assist by advising on particular ethical situations, by offering educational opportunities and by reviewing and recommending policies.

Issues in Care for the Dying

The practice of medicine is a delicate weaving of art and science, and of ethics and philosophy. Now that medical technology offers so many more ways of keeping us alive, dying can be a prolonged process. Death is not the ultimate defeat; rather it is a natural part of the living and aging process. Health care must be a community of respect, love and support to patients and their families as they face the reality of death. One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it. Effective pain management in all its forms is critical in the appropriate care of the dying.

There is no obligation for the patient to begin or continue life-sustaining treatment if, from the patient's perspective, it is an excessive burden or offers no reasonable hope of benefit. The patient, in these circumstances, may decide to forgo medical treatment to allow the natural process of dying. An individual's decision to refrain from aggressive or curative treatment will be respected even when such a decision may result in the person's death. In addition, pain management of the highest quality is critical in allowing a person to die comfortably and with dignity. Medicines capable of alleviating or suppressing pain may be given to a person even if this therapy may indirectly shorten the person's life, so long as the intent is not to hasten death.

Procedures That Are Not Performed

We are committed to human dignity and the sanctity of life from the moment of conception until death. Therefore, the following procedures will not be performed at our affiliated facilities:

1) Direct abortion is not performed. Indirect abortion is performed in certain medically indicated cases. An indirect abortion is a termination of pregnancy that is not directly intended and in which the sole purpose is the cure of a proportionately serious pathological condition of the mother, when the treatment cannot be safely postponed until the fetus is viable.

2) Assisted suicide, physician aid-in-dying or euthanasia is not performed. These are to be distinguished from allowing the natural process of dying to occur by withholding or withdrawing treatment because the treatment is too burdensome or does not provide proportionate benefit. Assisted suicide, physician-aid-in-dying or euthanasia also should be distinguished from appropriate decisions regarding pain management that have been addressed in this document.

3) Artificial reproductive procedures, including donor insemination and In Vitro Fertilization, are not performed.

Resolution of Unforeseen Issues

In any affiliation between partners of differing histories and cultures, there may be situations in which the appropriate application of values we hold in common has not been anticipated. In such situations, we agree that a collaborative dialogue is necessary to come to an adequate resolution. In these situations, we will engage in a structured decision-making process (called A Process for Ethical Decision Making follows) by gathering all the stakeholders and reflecting deliberatively on the values at stake in the decision. (Revised March 2002)

A PROCESS FOR ETHICAL DECISION-MAKING

We witness to Mercy and Truth when we pursue integrity of word and action in our life and in our decision-making.

INTRODUCTION

Decision-making is more than a rational process. It is always influenced consciously or unconsciously by the values of individuals or groups.

Many decisions are obvious, routine and automatic, while others are more complex and require more thought and effort.

Some decisions clearly touch the heart of what we are about, affect many people and shape our future because of the critical choices that are being considered. In these instances we want to be as clear as possible about our values, our multiple responsibilities and our Mission.

The following process may be useful as a way to explicitly review options in the light of the values of our Philosophy Statement. The process may be adapted to specific decisions by adding or deleting questions as appropriate. This is a group process with six steps. The composition of the recommending or decision-making group is determined by the nature of the decision and represents the key stakeholders. The use of a facilitator will enhance the process.

I. State the issue in the form of a question ("Shall we.....?").
II. Present the options with supporting rationale.
III. Discuss the relevant value questions relating to the issue.
IV. Identify value conflicts and how they can be resolved.
V. Provide reflective time to bring all factors into the light of religious beliefs, traditions and personal conviction.
VI. Discuss the options for action and agree on a recommendation, and action plan for final decision.

PRACTICAL STEPS

Preparation and Time Requirements

A commitment to adequate preparation and process time is needed for the process to be most effective.

Preparation is required to:

- allow facilitator familiarization with the decision being considered;
- involve the facilitator in preparing for the process;
- prepare an accurate statement of the issue;
- identify the stakeholders to be included in the process;
- prepare questions for Section III adapted to the specifics of the decision being considered;
- provide materials to participants in time to prepare for the process.

Time for the process:

- usual minimum will be 2 2 - 3 hours;
- may vary with the complexity of the decision, the number of persons participating and the number of values significantly affected by the decisions;
- time included so that Sections IV, V and VI are not rushed, as reflections, sharing and discussion are important elements of the process.

Cycles of Decision-Making

It may be appropriate to use this decision-making process more than one time in the development of a decision on an issue, project or program.

Example:

Cycle One: A decision might be needed at one point to pursue preliminary study of a possible project.

Cycle Two: When that investigation is complete, another use of the decision process might be appropriate to determine whether to initiate more specific planning of the project, perhaps including feasibility studies.

Cycle Three: Yet another application of the process might be appropriate in making a final decision.

A PROCESS FOR ETHICAL DECISION-MAKING

I. State the issue in the form of a question ("Shall we...? How do we...?").

- Clarify the purpose and expected outcome of the meeting.
- Identify who will make the final decision.
- Identify groups that may be making recommendations regarding this question (Division Board to CPH Board).

II. Briefly list the options with supporting data.

Review the history and context in which the discussion is taking place.

III. Discuss the following questions --based on key value concepts in the CPH Philosophy Statement --to the extent that they are relevant to the decision.

The Sponsoring Congregation's philosophy and traditions may surface additional questions.

A. Quality Health Care

1. By means of this decision, how can we promote healing?
2. Does this involve the appropriate application of medical science and technology?
3. How are we enhancing the quality of life; as well as continuation of life?
4. What safeguards from harm can we provide?
5. Can we provide an environment that is welcoming and caring?

B. Response to Need

1. What are the relevant needs in the community?
2. What are the organization's needs?
3. What are the broader societal needs related to this decision?

C. Recognition of Dignity

1. What groups of people -- within and outside of our organization will be affected by this decision?
2. Which of these groups have direct influence in our decision-making process?
3. How can we provide for direct input and influence by groups in the community who will be most affected?

D. Rights of All to Health Care

1. How does this decision promote our long-range goal of universal access to basic health care?
2. What particular groups of people would be served (men/women, elders/adults/children, affluent/middle class/poor, whites/blacks/Hispanics/Asians)?

E. Advocacy for the Poor and People with Special Needs

1. Does this decision directly affect people who are poor or disadvantaged? If so, how?
2. Can we speak to other influential groups (local, state or national governments, other providers, community groups) on behalf of people who are poor or who have special needs related to this decision?
3. Would the decision affect current advocacy priorities?

F. Stewardship

1. What organizational resources --funds, personnel, space technology, management time -- are involved?

2. How does the decision benefit our organization financially (directly or indirectly, short or long term)?

3. Who would benefit from the various options in these decisions?

4. Who would bear the burden?

5. Would resources be diverted from some other use?

6. Have we ensured compliance with the law?

G. Collaboration

1. Who are the stakeholders and how will they be involved?

   - Sponsors?
   - Church leaders?
   - Relevant boards?
   - Other institutions or groups?
   - Physicians and employees?
   - Government agencies and third-party payers?

2. How would our institution be perceived by the community under various options?

IV. Difficult decisions involve choices among several good things, and affirming one value sometimes means neglecting another.

- Which values are most relevant in this decision?
- Which values are affirmed?
- Which values are not affirmed?
- Are any values denied?

How can we safeguard the values that would not be directly affirmed (by placing conditions on the proposed action, by taking another action at the same time to express those values, by influencing other relevant groups...)?

What really motivates us as we consider this decision?

When scarce resources are being allocated, various approaches may be taken. Which of the following ethical principles seem most appropriate in making this decision:

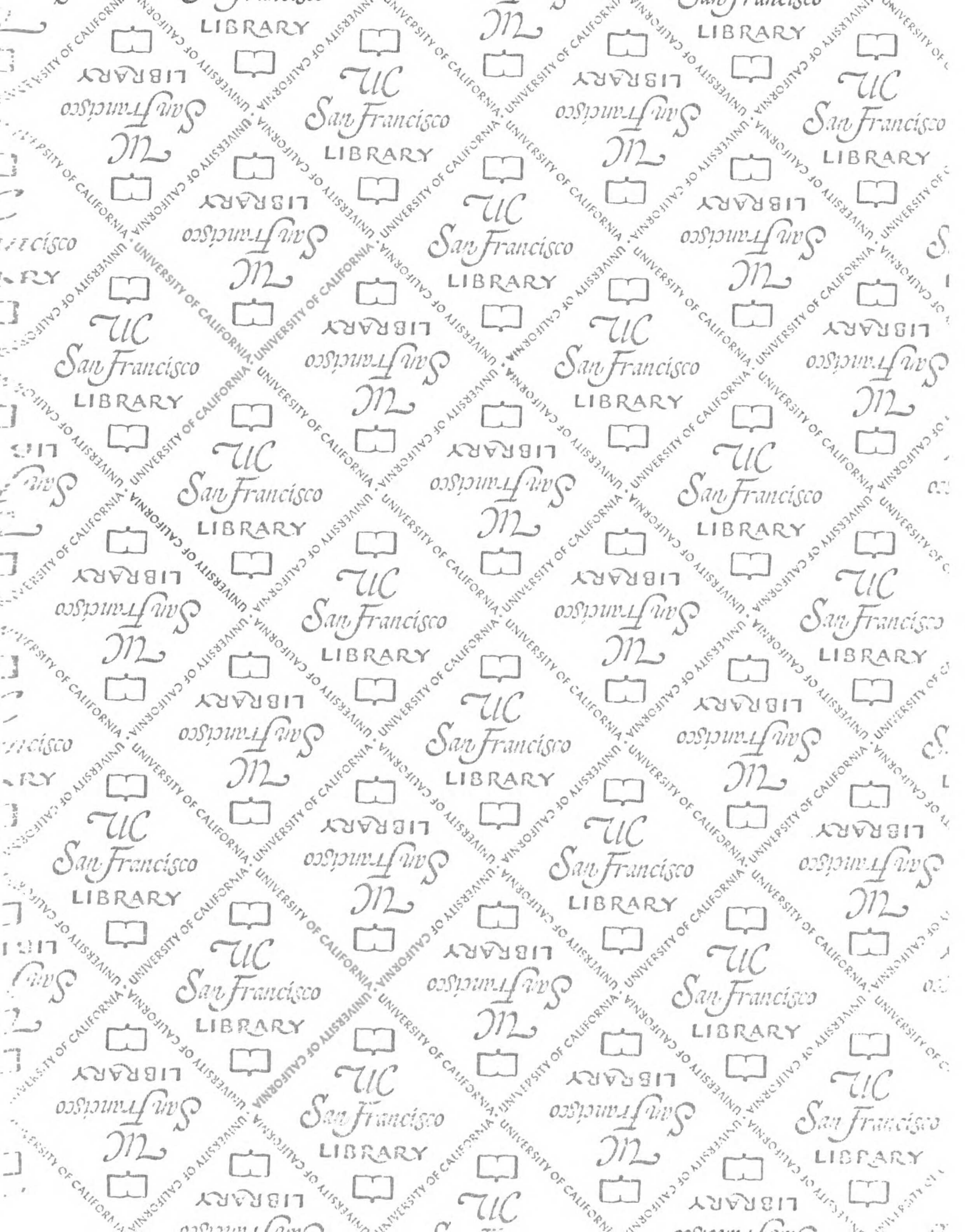
a) the greatest good for the greatest number?

b) distribution of goods according to the specified criteria -- such as ability to pay for services, social usefulness according to the status, making up for previous neglect or injustice?
c) equal opportunity (by lottery or random selection)?
d) greatest need?

V. Provide for a period of reflective silence during which group members can bring all these factors into the light of their religious beliefs, traditions and personal convictions.

Invite each group member to express his or her opinion as to what should be done, with brief supporting reasons and beliefs (no discussion).

VI. Discuss the options for action and agree on a recommendation, an action plan or final decision.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