

Caring Connections

An Inter-Lutheran Journal for Practitioners and Teachers of Pastoral Care and Counseling



The Future of Faith-based Healthcare

The Purpose of Caring Connections

Caring Connections: An Inter-Lutheran Journal for Practitioners and Teachers of Pastoral Care and Counseling is written by and for Lutheran practitioners and educators in the fields of pastoral care, counseling, and education. Seeking to promote both breadth and depth of reflection on the theology and practice of ministry in the Lutheran tradition, *Caring Connections* intends to be academically informed, yet readable; solidly grounded in the practice of ministry; and theologically probing. *Caring Connections* seeks to reach a broad readership, including chaplains, pastoral counselors, seminary faculty and other teachers in academic settings, clinical educators, synod and district leaders, others in specialized ministries and — not least — concerned congregational pastors and laity.

Caring Connections also provides news and information about activities, events and opportunities of interest to diverse constituencies in specialized ministries.

Scholarships

When the Inter Lutheran Coordinating Committee disbanded a few years ago, the money from the “Give Something Back” Scholarship Fund was divided between the ELCA and the LCMS. The ELCA has retained the name “Give Something Back” for their fund, and the LCMS calls theirs “The SPM Scholarship Endowment Fund.” These endowments make a limited number of financial awards available to individuals seeking ecclesiastical endorsement and certification/credentialing in ministries of chaplaincy, pastoral counseling, and clinical education.

Applicants must:

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- be rostered or eligible for active roster status in the ELCA or the LCMS.
- not already be receiving funds from either the ELCA or LCMS national offices.
- submit an application, along with a financial data form, for committee review.

Applicants must complete the Scholarship Application forms that are available from Judy Simonson [ELCA] or Bob Zagore [LCMS]. Consideration is given to scholarship requests after each application deadline. LCMS deadlines are April 1, July 1 and November 1, with awards generally made by the end of the month. ELCA deadline is December 31. Email items to Judith Simonson at jsimonson@aol.com and to Bob Zagore at Bob.Zagore@lcms.org.

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Call for Articles

Caring Connections seeks to provide Lutheran Pastoral Care Providers the opportunity to share expertise and insight with the wider community. We want to invite anyone interested in writing an article to please contact one of the co-editors, Diane Greve at dkgreve@gmail.com or Lee Joesten at lee.joesten@gmail.com. Please consider writing an article for us. We sincerely want to hear from you! And, as always, if you haven't already done so, we hope you will subscribe online to *Caring Connections*. Remember, a subscription is free! By subscribing, you are assured that you will receive prompt notification when each issue of the journal appears on the *Caring Connections* website. This also helps the editors and the editorial board to get a sense of how much interest is being generated by each issue. We are delighted that the number of those who check in is increasing with each new issue. Please visit www.lutherservices.org/newsletters#cc and click on “Click here to subscribe to the *Caring Connections Journal*.” to receive automatic notification of new issues.

Editorial

Lee Joesten

FOR OVER ONE HUNDRED YEARS Lutheran Medical Center in Brooklyn, New York was a clear and tangible expression of the Lutheran church's healing ministry in that community. That changed in 2016 when Lutheran Health merged with the nonsectarian NYU Langone Medical Center. Don Stiger chronicles the dynamics of that merger and its impact on the legacy of Lutheran Health, its reputation in the community, and the psyches of those who felt privileged to be associated with that mission of the church. According to Stiger, the good feelings that many staff had in being part of the church's healing mission evaporated, seemingly overnight.

Stiger laments the fact that Lutheran's story is not unique. He gives statistics regarding the rapidly declining number of church-sponsored hospitals in the United States. What if anything does this trend portend for the future of faith-based healthcare? That question emerges as a subtext to the broader question about the future of American healthcare in general. Stiger and those who have written responses to his essay don't give simple answers to these questions, but they do offer their reflections on the importance of the church's ongoing role in helping shape American healthcare.

Stephen Bouman provides the first response to Stiger's essay. Representing the ELCA, Stephen had a direct role in the Lutheran Health and NYU Langone Health merger and therefore provides a unique perspective on the issues Stiger raises. He balances his concerns about the future of faith-based health care with optimism by affirming Don's recommendations for structural improvements within the denominations.

Roger Paavola responds out of his experience as a pastor, a leader within The Lutheran—Church Missouri Synod, and a former executive of two different healthcare systems. Among other points, he distinguishes between health services provided by institutions and the health of the recipients of those services. He underscores the responsibility we all have in influencing our own overall health.

Kathie Bender Schwich follows with her perspective as a pastor, a former administrative church leader, and a current member of an executive leadership team of a large health system comprised of both faith-based and non-sectarian institutions. She draws parallels between the challenges facing hospitals and health systems and those facing the church.

Mark Whitsett ministers in a faith-based organization providing services to intellectually and developmentally disabled individuals. He describes how his specialized ministry setting is vulnerable to the same challenges faced by health care institutions and what it needs to effectively meet those challenges.

I am grateful to each of these gifted individuals for contributing to this issue of *Caring Connections*. In an effort to encourage a conversation around the future of faith-based healthcare, Don Stiger gives a response to each of his colleagues in ministry. Regardless of setting, all who feel called to specialized pastoral ministry have a vested interest in the future of faith-based healthcare.

This issue of *Caring Connections* includes a new section titled Letters to the Editor. The Editorial Board invites all our readers to share their comments and reactions to the articles and topics that *Caring Connections* covers. Special thanks go to Nancy Wigdahl for her letter in response to Brian Heller's article in the last issue of *Caring Connections*.

In the News section of this issue we draw attention to the deaths of two beloved colleagues in specialized pastoral ministry, Bryn Carlson and Roy Tribe.

Finally, we hope to see many of our readers at the Zion Conference in September of this year. See the flyer at the end of this issue.

“And Then There Were...None?” The Future of Faith-Based Healthcare

Don Stiger

“We have created new idols. The worship of the ancient golden calf (Exodus 32: 1–35) has returned in...the idolatry of money. In this system...whatever is fragile is defenseless before the interests of a deified market.”

–Pope Francis

“Evangelii Gaudium”

The origins of this essay

Today’s healthcare climate might well be described as a vast array of rigorously competing interests, co-existing in a sea of discontinuous change. It is an environment marked by accelerated mergers, closures, buy-outs, and consolidations. Struggling to serve and survive in such a climate, what is to become of faith-based healthcare providers, particularly those regarded as “safety nets?” Will they continue to matter or make a difference? Will those that have managed to endure reflect the spiritual wellsprings of sacrificial love, vocational calling, and whole-person care that founded and grounded them? Will they be able to “do” mission without being “done in” by mission? As we struggle in this country to find our way through a prolonged healthcare crisis, will they play a constructive role? Some wonder if denominationally-sponsored healthcare organizations will even be around in five, ten, or twenty years. Others question whether major faith bodies have been negligent in their support and sponsorship of these longstanding social ministry organizations — serving, as many do, on the frontlines of mission.

Will those that have managed to endure reflect the spiritual wellsprings of sacrificial love, vocational calling, and whole-person care that founded and grounded them? Will they be able to “do” mission without being “done in” by mission?

These and other issues are addressed in this essay. It’s actually a compilation of reflections and notes I’ve been writing for decades in a rumpled 7x9 notebook and on the backs of meeting agendas and banquet programs. Significant events over the past 4–5 years compelled me to pull many of those observations and reflections together. Paramount among them was the consolidation of an elite, academic-research system with the 133-year-old, church-sponsored healthcare organization I served for nearly 14 years from 2003 to 2016.

Writing from the perspective of both participant and observer, I attempt to address some of the whys, whats, and wherefores relative to the questions cited above. None of these concerns can be adequately addressed or settled within the scope of a limited essay like this. While portions of this piece are anecdotal, interlaced with

some of my own personal lament and catharsis, my ultimate hope is to stimulate a wider conversation amongst colleagues serving in ministries of healthcare chaplaincy and administration.

Setting the stage

In March 2009 Daniel Sulmasy, M.D., Senior Research Scholar at Georgetown University's Kennedy School of Ethics, published an article in *America* titled, "Then There Was One: The Unraveling of Catholic Health Care." In it Dr. Sulmasy lamented the fact that, while in 2007 there had been eight Roman Catholic-sponsored acute care hospitals still operating in the five boroughs of New York City, by the end of 2008, there was only one. At the time, any informed New Yorker would have told you that the "one" to which Dan referred had to be the much-cherished St. Vincent's Hospital, located in lower Manhattan. St. Vincent's was founded in 1849 by the Sisters of Charity. Often identified as "The 9/11 Hospital" and a major teaching institution, this large, faith-based safety net medical center had treated patients from as far back as the cholera epidemic of 1849 and sinking of the Titanic in 1912 to as late as the passengers of US Airways Flight 1549 ("The Miracle on the Hudson") in 2009. For decades, it was also well known as ground zero for AIDS patients and homeless persons in desperate need of health and human services. Unfortunately, hovering on bankruptcy and threatened with corporate takeover, the beloved St. Vincent's abruptly closed its doors in 2010. I will never forget the tragically ironic words of a St. Vincent's nurse and member of the Sisters of Charity: "Don, put in simplest terms, effectually we were defeated by our own mission — devotion to the poor."

The consolidation in 2016 of Brooklyn-based Lutheran HealthCare with Manhattan-based New York University Langone Health has now left many wondering just how long it will be before the phrase, "and then there were none" literally applies to a metropolis the size of New York, a city of over 8 million — a city in which the vast majority of health care institutions were founded by faith-based organizations. Many suggest that, for all intents and purposes, that moment has already arrived. Even more alarming, reference here to "none" pertains to *all* faith groups, not just the Roman Catholic church.

While perhaps occurring in more sudden and dramatic fashion in New York than other cities or regions of the U.S., this gradual, incremental trend has been conspicuous for decades. Citing just one telling statistic from the mainline denomination I serve, Lutheran churches were supporting over 130 hospitals and medical centers in the early 1970's. Today, those maintaining any genuine, organic affiliation with the church can be counted on one hand. Sadly, the extent of

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denominational amnesia and apathy attached to the alarming entropy of faith-based healthcare organizations, many of which have served on the frontlines of mission for 100 plus years, is dismaying. This seems the case particularly among mainline Protestant church bodies. My own denomination, the Evangelical Lutheran Church in America (ELCA), no longer maintains an identifiable Church in Society (social ministry) unit within its structure to officially interface with its affiliated healthcare organizations.

Dr. Sulmasy incisively identified six key social, economic, ecclesial, and political realities tied to the demise of dozens of long-serving, faith-and-values-inspired healthcare ministries. His diagnostic framework is worth repeating:

1. How harsh an environment the marketplace has become for faith-based institutions, particularly those whose healing mission has intentionally focused on serving the poor, underserved, and marginalized;
2. The weakening of Catholic (I quickly add most all) faith-based philanthropy amidst intense secular, market-based competition;
3. Faith-based healthcare systems disregarding cutting-edge administrative competence in favor of operating under outdated, parochial methods and assumptions;
4. Faith groups opting for secular values, no longer prizing their own religiously-grounded core values;
5. The “enervating effects” of ecclesial culture;
6. Poor political connections — loss of the kind of political and governmental clout Catholic and other major faith communities once took for granted.

Taken together, these six developments represent a seismic shift — both moral and cultural — in the worlds of health, healing, and healthcare.

In that same *America* article, Sulmasy posed a yet more prophetic question for sober consideration: Has the time come to humbly abandon denominationally-sponsored “bricks and mortar” social ministries altogether and instead “live the faith by blending like yeast into

Has the time come to humbly abandon denominationally-sponsored “bricks and mortar” social ministries altogether and instead “live the faith by blending like yeast into the secular society.”

the secular society.” Dan’s query is reminiscent of the far-sighted, prophetic notion Dietrich Bonhoeffer scribbled from his Nazi prison cell in 1944 of a “religionless Christianity,” intent on serving “a world come of age.” When it comes to preserving institutional healthcare ministry, many of us continue to relentlessly resist giving up the farm altogether. The tangible bricks-and-mortar, religiously-sponsored, mission-driven healthcare safety nets — particularly those dedicated to faithfully serving the underserved — really do matter! Indeed, they can and do make indispensable differences in today’s healthcare “industry.” In my estimation that industry is

steadily devolving into a predominantly commodified, corporatized, business-and-technology-driven enterprise.

I have some primary claims and hopes underlying this essay:

1. Those resilient faith-and-values-inspired healthcare organizations that have managed to survive are *worth preserving and actively supporting*;
2. Those that have closed are *worth honoring, celebrating, and remembering*;
3. The legacies, values, best practices, and special gifts of those merging with other organizations are *worth actively sustaining* within the complex culture of today's consolidated health systems.

Not least among those enduring gifts and legacies is a distinctive *spirit of care*: faith-rooted, sacrificial, compassionate care of whole persons throughout whole communities, including steadfast commitments to equitable access, charity care, and care of the soul.

The Founding and Grounding of Faith-Based Care

"It may be said that nearly all the great social institutions have been born in religion."

—Emile Durkheim

Where did this distinctive spirit of care and mission come from? How did it inspire the formation of once-thriving safety nets like St. Vincent's Hospital, Lutheran HealthCare, and scores of major healthcare ministries now gone by? How is it possible that so many of these vital, centuries-old healthcare ministries have either closed, merged, or could even be at risk of total extinction?

Krister Stendahl, the late Archbishop of Sweden and former Dean of Harvard Divinity School, once made the bold claim in a 1982 issue of *CrossCurrents* that, "God's agenda is the healing of creation." Since the dawn of history, health and spirituality, medicine and religion, have been inextricably interconnected. The mission of caring for our own and others' health has been deeply lodged in the DNA of all major faith groups. Indeed, religious belief and practice formed the bedrock value system that continues to ground and inspire this distinctive spirit of care — one marked by genuine compassion, distributive justice, community benefit, and welcoming the stranger. Further, it shaped a number of specific callings, vocations and ministries, all centered in the whole-person art of "caring for health." While, in large part, this spirit of care remains intangible, it carries with it a remarkably earthy, "bricks-and-mortar" story.

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As I gratefully learned in one of my earliest conversations with Wendy Z. Goldstein, CEO of Lutheran HealthCare from 2001-2015, the concept of '*tikkun olam*'

— literally, “to repair the world” — dates back to the Mishnaic period of Judaism and goes to the very heart of that tradition’s passionate devotion to ministries of health, healing and healthcare. From the time of Abraham, Jews have been actively living and teaching responsibility for the healing of God’s creation and caring for strangers in need. This biblically-based mandate has inspired the worldwide Jewish community to actively pursue vocations in the healing arts, medical education and research. It has also been a major force in the philanthropic establishment and advancement of healthcare institutions around the world. Indeed, in comparison with other major faith groups, Judaism’s contributions to healthcare reach far beyond its proportionally smaller numerical size.

Perhaps most poignantly illustrated in the Parable of the Good Samaritan (Luke 10) and the prophetic exhortations found in the 25th chapter of Matthew, the historical Jesus relentlessly emphasized the importance of compassionately attending to the needs of the ill, injured, suffering, and vulnerable. With over thirty acts of healing

recorded, the New Testament gospels unanimously witness to the historical Jesus placing healing ministry at the forefront of his central mission — proclaiming and ushering in the Kingdom of God. Recently combing through all four gospels, I discovered that approximately 35–40% of the narrative texts feature references to healing.

In his 2014 informative historical overview, *Medicine and Religion*, Gary B. Ferngren reminds us that, from its earliest beginnings, “Christianity displayed a marked philanthropic imperative that manifested itself in both personal and corporate concern for those in physical need.” Charitable care was motivated by agape, a self-giving love for all human beings as created in the image of God. Such sacrificial love reflects “the incarnational and redemptive love of God in Jesus Christ.” Both in conception and foundation, hospitals were distinctly religious institutions.

Reaching back to the founding of the first hospital, Basileias, by Basil the Great in Cappadocia, Turkey, in 372 C.E., the initial Christian hospitals were created to charitably provide aid to those suffering in body, mind, and/or spirit. As they grew in numbers, these earliest hospitals maintained libraries, medical training programs, and various forms of research. Without doubt, the establishment of these earliest hospitals marks the most significant advance in medicine and medical care to date, particularly with regard to direct care of the indigent poor, disenfranchised, dying, and those most seriously ill.

Health and healing have always been central motifs in Islam, with the first hospital established by Muslims in Baghdad in the early ninth century under the Abbasid Dynasty. Referred to as bimaristans, Islamic hospitals were religiously

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grounded in a moral imperative to treat the ill — regardless of socioeconomic status or ability to pay. Many Islamic-based healthcare ministries followed in cities like Damascus and Cairo, eventually spreading throughout the Muslim world. These early hospitals even had lecture theatres and libraries. One of the hospitals established in Baghdad (982 CE) employed twenty-five staff physicians; among them were accomplished surgeons who were required to obtain diplomas and licensure.

The middle ages witnessed rapid growth in the founding of healthcare ministries devoted to the care of the sick, rising to 750 at the time of the 16th-century Reformation. In France, hospitals were literally referred to as *hotels Dieu* — “hostels of God,” with care provided primarily by monks and nuns. The 16th – 19th centuries witnessed a literal surge in religiously-sponsored charity care from notable Roman Catholic reformers, including Ignatius Loyola, Vincent DePaul, the Sisters of Charity, and rapidly growing numbers of Catholic “sister nurses.” According to James Carroll in a June 2019 article in *The Atlantic* there are nearly 40,000 Catholic hospitals and healthcare facilities around the world. This one church body alone continues to manage 26% of the world’s healthcare facilities.

The extent of contributions to modern day healthcare attributed to the Protestant Reformers is hard to fathom, including their spirited promotions of scientific inquiry, altruism, and religiously-motivated charity care. Among the many notable Protestant pioneers were Theodore Fliedner (1800–1864), his nurse trainee Florence Nightingale, William A. Passavant and sizable numbers of deaconess nurses from several denominations — Methodist, Presbyterian, Episcopal, Baptist, Lutheran, and others — who inspired, founded, and developed countless hospitals and healthcare ministries throughout Europe and the U.S.

All told, by the turn of the 20th century, approximately 1500 Christian-sponsored hospitals were operated by 15,000 deaconesses, sisters and nurses, representing over 200 religious orders. Whether one turns to the letters and diaries of Loyola, Fliedner, DePaul, Nightingale, Passavant, or other prominent 16th – 20th healthcare pioneers, it’s clear that the vocations of physician, nurse, administrator and health educator were overwhelmingly pursued as religio-vocational *callings* that melded commitment to compassion and clinical expertise with *seelssorge*— literally, “soul care.” Such empathic care of souls consisted in heartfelt, compassionate ministry to/for whole persons — in faithful response to the call of Micah 6:8, “*Do justice, love kindness, and walk humbly with God,*” and the prophetic words of Jesus found in Matthew 25, “*As you do it to one of the least of these, you do it to me.*” Rather than offering culturally-restricted, parochial service, the bulk of those early, faith-



William A. Passavant

rooted healthcare ministries were well known for their egalitarian inclusivity and commitment to serve all of God's people in need.

Awareness of the above history could very well run the risk of becoming redacted into exclusively nonsectarian, nonreligious expressions. Indeed, many of these stories and legacies are at serious risk of becoming altogether lost memories. One wonders how many secondary school students are even exposed to them. Like Scripture itself, if not recounted in intentional, public ways, they could eventually slide into total obscurity. Centered around moral purpose, many of these faith-rooted, institutional stories witness to incredible levels of courage, service, struggle, and sacrifice. For 31 years of my life in pastoral ministry, I had the privilege of serving two of these storied institutions, both of which have Norwegian-Lutheran heritage/identity flowing through their DNA. The first was Lutheran General Hospital in Park Ridge, Illinois where I served from 1980–1997. Lutheran General is currently a member hospital of the Advocate Aurora Health system located in Illinois and Wisconsin. The second and most recent was Lutheran Healthcare, now NYU Langone Hospital-Brooklyn, the healthcare ministry with which I'm most intimately acquainted in terms of heritage and missional story — a narrative that takes its place among hundreds like it.

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Brooklyn's "Borrowed Sister"

During the latter half of the 19th century, massive waves of immigrants struggled to survive on the streets of America's major cities, New York City by far the largest and most diverse among them. Since government-sponsored programs of health and human services were almost nonexistent at that time, several faith groups were among the charitable organizations that stepped forward to create a much-needed healthcare safety net. Norwegian American Lutherans alone sponsored 28 hospitals, 20 hospices, 20 "homes for the aged," 14 children's homes and a home-placement service for orphaned children.

These safety net social ministries were in large part founded and operated by European deaconess nurses who also established motherhouses, training scores of women to serve as nurses and allied healthcare providers. The Norwegian Lutheran churches in America established three such motherhouses in Brooklyn (1883), Minneapolis (1889) and Chicago (1897). As faith-grounded, monastic-like communities centered in nurturing religious vocation and practical training, the motherhouses spawned a wide array of healthcare ministries, reaching inestimable numbers of un-served and underserved immigrants. As moral agents, mission, meaning, and mobilization were all intertwined with a deeply felt commitment to religious calling. In short, they were inspired to serve God by serving others in

need. That was their singular “bottom line,” and it defined both moral purpose and vocational life. We’re not talking here about flamboyant, sentimentalized piousness. Drawing upon a treasured phrase from Parker Palmer’s book *A Hidden Wholeness*, we could say these early healthcare pioneers humbly and genuinely “joined soul and role.”

In south Brooklyn, one particular Norwegian Lutheran deaconess nurse, Sister Elisabeth Fedde, figured prominently among those who tirelessly and selflessly immersed themselves in providing health, healing and social services to first-generation immigrants. Their community-based healthcare ministries extended well beyond immediate medical care to any singular religio-cultural group. Coming directly from Norway and speaking all of eleven words of English when she arrived, Sister Fedde soon became known as “Brooklyn’s Borrowed Sister.” Sister Elisabeth and the deaconess nurses who accompanied her literally became the earliest pioneers of what we now refer to as *population health management*, identifying and actively addressing many of the underlying disparities and social determinants of health they encountered throughout the impoverished, multi-ethnic immigrant communities they served. Unquestionably, one could say that they were inventing the future of healthcare.

In Fedde’s case, The Norwegian Relief Society, a make-shift, three-room clinic founded in 1883 with the active support of local Lutheran congregations, soon became known as a healing mission marked by culturally-inclusive, whole-person care to the growing immigrant community of southwest Brooklyn. That included direct services to people in homes, prisons, and congregations, as well as language education, food assistance, financial relief, spiritual care, and placement services for both orphans and the unemployed. In one of her first missional ventures, Sister Elisabeth attended a severely hemorrhaging adolescent who had been abandoned in a Brooklyn tenement; she had just given birth to twins. That vignette typifies the kind of benevolent care this faith-based safety net provided over the next 133 years of its life and mission. By the turn of the 20th century, Sister Elisabeth’s fledgling mission had evolved into a full-blown, 90-bed hospital, featuring a horse-drawn ambulance service, nursing school, and approval for public funding from the governor of New York. Gradually and incrementally, it would begin evolving into a fully-integrated health system, serving the greater part of southwest Brooklyn.

In 1956, Johnson and Johnson, Inc. named Sister Elisabeth Fedde one of the “12 Most Outstanding Nurses in History.” That same year, the Norwegian Lutheran Deaconess’ Home and Hospital was renamed “Lutheran Medical Center” following a full-asset merger with a sister Lutheran-sponsored hospital in Manhattan. That merger presented an historic fork-in-the-road relative to the hospital’s future



Sister Elisabeth Fedde

missional identity, core values, and faithfulness to its original moral purpose. Move to Manhattan and be virtually assured of a financially stable — even potentially lucrative — future? Or purposely stay planted amidst the urban blight of Sunset Park and serve a predominantly impoverished, underemployed, underserved immigrant population. Soon after re-cementing its affiliation with the newly-formed American Lutheran Church in 1960, Lutheran Medical Center (Lutheran) and its sponsoring denomination made the bold decision to remain in Sunset Park, relocating just blocks away to the abandoned shell of the American Machine and Foundry (AMF Bowling!) factory building — an old, decrepit structure on the Hudson Bay, purchased for one dollar from New York City through Mayor John Lindsey. Committed to making a difference in the public square, Lutheran would soon become the largest employer in southwest Brooklyn and primary catalyst for the revitalization of one of New York City’s most socioeconomically depressed neighborhoods. The die was cast in terms of its continued moral purpose, grounded in a renewal of faith-and-values-inspired identity.

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By the celebration of its 125th anniversary in 2008, Lutheran had become the busiest Level I Trauma Center in Brooklyn (second busiest in all of New York City), a New York State-designated stroke center, home to the largest, most comprehensive network of federally qualified community health centers in the country, and a nationally recognized center of excellence in religio-cultural competence. With the Presiding Bishop of the Evangelical Lutheran Church in America (ELCA) keynoting the event, that 125th anniversary also celebrated the extent to which, under the leadership of President and CEO Wendy Z. Goldstein and its Board, Lutheran had once again strengthened its organic ties with the ELCA, its sole corporate member (legal owner).

The Current Healthcare Climate: Accelerated, Discontinuous Change

Faith-rooted safety nets like St. Vincent’s and Lutheran appear to have peaked in number around the middle of the 20th century. Regrettably, they have been quietly and steadily declining ever since. It’s actually quite difficult to pinpoint their total number today, whether from the perspective of governmental criteria, sponsoring faith bodies or the public identities of the institutions themselves. However assessed or tallied, a considerable number endure, and they continue to be significant stakeholders and players in the overall schema of U.S. healthcare. Each year faith-based health systems directly touch tens of millions of lives while generating billions of dollars in operating revenues.

Today, a wide and complex array of vested interests defines America's healthcare system. Many of them seem brazenly marked by ambitious corporate appetites, rigorous competition, and market-driven self-interest. They co-exist in a Darwinian-like socio-economic atmosphere of accelerated, discontinuous change — regulatory, financial, demographic, corporate and technological. Granted that many contemporary health systems endeavor to retain their religious founders' mission and core values — even to the extent of faith community sponsors retaining the status of sole corporate member — growing numbers of today's consolidated systems have become predominantly driven by strategic business objectives and the attainment of optimal market advantage. Their moral purpose is attenuated by competitive profit-making. Invaluable forms of social capital as defined by Robert Putnam become displaced by preoccupation with monetized capital. While some retain nostalgic-like vestiges and symbols of attachment to their founding faith groups, many have cast off any semblance of meaningful religious identity, whether the result of merger, closure, or complete takeover by financially-advantaged mega systems. In short, scores have become re-conceptualized institutions. "Takeover" and "re-conceptualization" go far in describing the ultimate fate of Lutheran HealthCare and the story of its corporate acquisition by NYU Langone Health.

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Prior to delving into that narrative, there are four, upfront claims/disclaims of vital significance to the balance of this essay:

- I have been privileged to spend the greater part of 41 years of ordained, pastoral ministry serving in the context of contemporary healthcare. Consequently, I do not seek to denigrate the immeasurable blessings and contributions of scientifically-developed, evidence-based, allopathic medical care. In fact I am a living beneficiary — including over twelve years of effective treatment for coronary artery disease.
- Second, regardless of the massive changes the former Lutheran HealthCare underwent in recent years the fact that the original, faith-and-values-founded healthcare system located at 150 55th Street, Brooklyn continues to benefit the health and well-being of countless southwest Brooklyn residents is a good thing. Unequivocally, scores of colleagues and I are grateful to see a fully functioning health system providing reliable clinical services to the community of south Brooklyn rather than being largely boarded up with plywood like St. Vincent's. Most every former Lutheran board member I've spoken with concurs that Sister Elisabeth and the early Deaconesses would have felt the same. The impressive, state-of-the-art acute care available

through NYU Langone Health without a doubt significantly benefits hundreds of thousands of Brooklynites with new, cutting-edge services.

- Third, this paper is not intended to be a sweeping condemnation of democratic capitalism or America’s free market system. I remain supportive of our country’s basic governmental/economic architecture and uphold its continued potential for growing health and human services. However, there is an immense gulf between the kind of morally-grounded, democratic capitalism originally envisioned by Adam Smith and the unbridled, “Pac-man-like” commoditization currently assailing healthcare and other service sectors of our culture. Indeed, there is a striking difference between healthcare being supported and grown by a vigorous market economy and healthcare becoming overwhelmingly commodified. At one time, I assumed that the original vision behind merging an institution like NYU Langone Health with one like Lutheran Healthcare held the exciting prospect of melding the relationship of the market with faith-inspired service in ways both complementary and synergistic. The original promise was to creatively take the age-old tension of “no mission, no margin/no margin, no mission” to new and higher ground, all for the sake of serving the common good.
- Last, truth and justice must finally be rigorously pursued in an arena as vital to that common good as healthcare. For that reason, I feel a critical responsibility — in fact a moral imperative — to openly report and scrutinize that which many of us serving in vocations of health, healing, and healthcare ministry have experienced in recent decades. For me, that moral imperative carries with it a felt sense of pastoral responsibility. Overwhelming, cumulative evidence now beckons me to step up to publicly address the disturbing trend of excessive commoditization that characterizes so many of today’s titanic healthcare consolidations. That same trend might very well serve to eventually put faith-based hospitals and health systems, institutions so many have cherished and benefited from for centuries, at serious risk of losing any type of critical mass, resulting in untold forfeitures to whole-person health and societal well-being.

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Truth and justice must finally be rigorously pursued in an arena as vital to that common good as healthcare.

I hope that the remainder of this paper will be read through the lens of these four claims.

Anatomy of a Takeover

Merriam-Webster notably defines merger as, “a combining of two or more organizations” ...“a union, fusion, or unification.” Bona fide merger does not imply the

disproportionate imposition of one organization over/upon another, or one dominant partner advancing its particular agenda at the expense of another.

At the outset of the affiliating process, NYU Langone's expressed intentions appeared nobly centered on mutually building the kind of union that would synergistically fuse two unique, exceptional organizations. Lots of "value-added" language could be heard in early explorations and negotiations. Besides assurance that a healthy merger would require a gradual, incremental process of cultural integration — one stretching "over a four or five-year period"— the immediate adoption of a new, public moniker, "NYU Lutheran Medical Center," in itself overflowed with positive meaning and good spirit — particularly in the eyes of Lutheran's staff, board members, and longstanding church sponsor. As that fresh, evenhanded name soon appeared on all signage and was broadcast throughout the community via NYU Lutheran's busy ambulances, public retention of the word *Lutheran* — and all that well-known designation had come to mean to the community over the years — demonstrated the kind of balanced partnership and trust so many had been earnestly hoping for.

Within only a few months of entering into formal affiliation, troubling signs of bait-and-switch-like behavior began to surface.

Within only a few months of entering into formal affiliation, troubling signs of bait-and-switch-like behavior began to surface. Just as the initial getting-to-know-you phase had launched, out of nowhere, NYU's leadership abruptly discarded its assurance of a five-year integration plan, insisting instead on completing a full asset merger within only a matter of months. Ostensibly, there were significant economic advantages to be realized in radically accelerating the process. Among them was the re-negotiation of third-party insurance contracts, which would apparently generate increased revenue for NYU's corporate coffers.

Such a cataclysmic change in course caused troubling anxiety and distrust to ripple through Lutheran's staff, leadership, and board. As word of that unforeseen development found its way to local congregations and throughout the neighborhoods, I was personally confronted by growing numbers of community stakeholders who felt bewildered, angry, even betrayed. Ironically, much of that public reaction was displaced onto Lutheran itself. Even at that point, many LHC leaders, myself included, remained public champions of the evolving partnership, pointing to promising benefits yet to be realized, benefits clearly signaled by our new, integrated name.

In the ensuing months, noticeable trivialization and disregard of Lutheran's longstanding missional identity and sponsorship were becoming more and more conspicuous. Overheard at cafeteria and water cooler conversations were remarks like, "Did we miss something? Is it possible we're now somehow being played? Should we still continue extending benefit of the doubt?"

At the same time, the ELCA exhibited increased detachment from the entire merger process. Consistent with one of Dan Sulmasy's elucidations, whether due to enervation or intimidation, the overall behavior of the wider church was captured in a memorable comment made to me from a local church official, "You know, it seems there's really nothing any of us can hope to further influence at this point; it's apparently pretty much a done deal, reaching far beyond anyone's capacity to change." The more important question was whose ecclesial job description included such designated responsibility? Apparently, no one's.

Only two years earlier in Chicago, the ELCA Church Council and its Presiding Bishop had, in all good faith, unanimously voted to surrender formal, legal control of Lutheran HealthCare, opening the door for the Medical Center to become its own sole corporate member. That action in turn enabled Lutheran to responsibly address the ominous financial storm clouds on its horizon and position itself to merge with a new, complementary partner in shared mission. In essence, as frequently occurs in such circumstances, a church body chose to make a magnanimous gift for the sake of the public good, ensuring that a much-needed safety net health system could continue serving an underserved community, its core mission and values remaining essentially intact.

In taking such responsible action, the ELCA's clear intent was to join with Lutheran and its future partner in a vision of organizational change for the sake of continued healthcare mission, blessing major changes in governance structure, while redefining Lutheran's relationship with the church, NOT ending it. Indeed, a formal, written covenant had been created and mutually affirmed, assuring both the health system and church body of a meaningful degree of continued moral partnership in healthcare ministry. While the integrity and total autonomy of each partner would be fully recognized, at one and the same time a less formal environment of shared mission was to be sustained in which each partner would act upon its rich potential for cooperation. Lutheran would continue drawing heavily upon the ethical and theological tenets of the ELCA's Social Statement, *Caring for Health: Our Shared Endeavor* which was officially adopted by the ELCA in 2003. Other specific intentions were carefully identified, including commitments to whole-person care, religio-cultural inclusivity, spiritual care, clinical pastoral education, social ethics, community faith/health ministry (e.g. faith community nursing), and active preservation of faith-based heritage.

Unfortunately, active, supportive accommodation all too easily runs the risk of quickly degenerating into passive neglect. My expectation had been that, given its own vested interests, the ELCA would be very pro-active in safeguarding those

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key covenantal commitments, thereby preserving meaningful, lasting relationship. Unfortunately, even after encouraging prompts, nothing further was to be heard from the church. After the ELCA's Division for Church in Society was structurally eliminated, the church's involvement with Lutheran became at best incidental, symbolic, and sporadic. In reality, there simply were no designated church structures, offices, or staff persons in place to advocate for sustained relationship. My own enthusiastic expectations for overt, pro-active denominational involvement began to wane, eventually leaving me with a troubling mix of disparagement and anger.

To be clear, throughout their earliest conversations with NYU's leadership, Lutheran's CEO, board chair, and other representatives repeatedly underscored that the fundamental nature of Lutheran's longstanding mission, charity care policy, and other longstanding, faith-values commitments were non-negotiables. Fortunately, a few missional hallmarks did survive. Specific commitments were made to retain Lutheran's liberal charity care policy, along with continuation of a much-diluted, executive-level position for mission and spiritual care. Nonetheless, NYU Langone demonstrated minimal interest in sustaining any semblance of meaningful legacy relative to the church or the covenant document.

To the dismay of many staff, opening interfaith prayers and missional reflections at public gatherings were purged from programs and agendas, as were other overt expressions of public social ministry.

References such as "faith-based" and "religious heritage" would soon be noticeably scrubbed from the operational agenda of cultural integration. To the dismay of many staff, opening interfaith prayers and missional reflections at public gatherings were purged from programs and agendas, as were other overt expressions of public social ministry. Even after initial approval, a day-long chapel prayer vigil, marking a mass shooting in Orlando, FL, was intercepted and curtailed by NYU Langone's executive offices. An annual dinner dance, celebrating Lutheran's mission, values, and distinctive spirit of care was supplanted by more formalized events focused solely on fund-raising. Along with curtailment of the gala came cessation of the annual *Sister Elisabeth Fedde Medal of Service*. For years, this distinguished award had recognized clinicians and other individuals who continued to embody the legacy of compassion and community service Sister Fedde had demonstrated.

Seemingly without any shared consideration or communal discussion, "Mission Week" was discontinued. This weeklong celebration had included blessing the hands of nurses, symposiums, workshops, and a celebration of the Norwegian-Lutheran heritage that had founded and grounded the hospital. Likewise, the annual "Caring for Health Research Award," created to promote the major tenets of the ELCA's social statement on health, was soon discontinued. This longstanding competition had inspired dozens of research/quality improvement projects focused on addressing the social determinants of optimal whole-person health. "Spirituality in Patient Care," an

annual educational series for medical students and residents soon lost the support of medical education. In due course, even the public announcement of National Nurses Week would fail to make mention of the nurse who had originally inspired and founded the institution, Sister Fedde. Only Florence Nightingale would be associated with this public commemoration of nursing. Ironically, history reveals that the two nurses had most likely communicated and collaborated with one another.

Based on numerous comments and observed behaviors, I began getting the sense that key senior leadership within NYU were somehow constrictively caricaturing “faith-based” in terms of parochial, “churchy,” evangelical piety. On occasion, I even found myself needing to intercept crude distortions of “Lutheran” that had begun floating around, attached to images of proselytizing chaplains roaming about the halls, distributing New Testaments and seeking to win patients over to Protestant doctrine. Rather than regarding all caregivers as active agents of spiritual care, pastoral care became more restrictively compartmentalized — limited to a subservice of NYU Langone’s “Patient Experience” arm. It was also not long before inclusion of theological principles seemed to all but evaporate from clinical ethics.

Consistent with this doctor’s observation, many in leadership began getting the impression that just being associated with a faith-based orientation to healthcare signaled being outmoded, uninformed, or Pollyannaish...even downright deficient or incompetent.

One notable feature characterizing this string of rapid changes was the absence of shared, communal conversation, and negotiation. A longstanding LHC physician distressingly shared with me in a hallway conversation, “My God, Don, it’s like 130 years of simply seeking to do God’s healing work here is somehow being stamped out overnight...like a bad case of sepsis!” Consistent with this doctor’s observation, many in leadership began getting the impression that just being associated with a faith-based orientation to healthcare signaled being outmoded, uninformed, or Pollyannaish...even downright deficient or incompetent. Several struggling employees made appointments to see me, sharing instances of experiencing smug condescension, at times bordering on hurtful ridicule. Memorably, one veteran RN shared that, for the first time, she was feeling “like just another cog of human capital in a massive business venture” (my paraphrasing). At the same time I was inspired by physicians, nurses, and other staff that stated their original, faith-inspired motivation to enter into healthcare service was not a matter of naiveté or embarrassment but rather the primary source of meaning and purpose in their vocational lives.

What’s in a Name?

In July of 2017 the process of acquisition truly became a *fait accompli* as the name “Lutheran” was altogether stricken from NYU Lutheran Medical Center’s public moniker. The 133-year-old, faith-based, church-sponsored safety net was henceforth

to be known as, “*NYU Langone Hospital –Brooklyn.*” As is well known throughout the worlds of healthcare and social ministry, once such a denominational name is removed, it can seldom, if ever, be reinstated. Perhaps that’s why, regardless of the many makeovers they have undergone, New York-Presbyterian, Mt. Sinai Beth Israel, New York-Presbyterian Brooklyn Methodist, Interfaith, St. John’s Episcopal, and other religiously-founded New York City healthcare organizations have respectfully made no such changes in nomenclature.

To the dismay of many longstanding faith and community stakeholders, that same summer a single-engine plane flew over the borough of Brooklyn, streaming a banner bearing the commercial message: “NYU Lutheran Medical Center is now NYU Langone Hospital-Brooklyn.”

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Though I had repeatedly assured many in Brooklyn, Chicago, and other parts of the country that I couldn’t imagine such a drastic reversal ever occurring, there it was for all to see. Written across the New York City sky was the message of corporatized, commoditized medicine taking yet another audacious step in its steady march of displacing religiously-sponsored healthcare. For many a Brooklynite (some of whom, in their dismay, soon contacted me), that advertisement-in-the-sky, displaying as it did the extent to which runaway commercialism continues to impose itself on the revered faith-and-values narrative of New York City healthcare, only served to debase the spiritual wellsprings of beneficence, wholism and sacrificial love that had founded and grounded that well-known story in the first place. As shared with family and friends, personally, I could only liken the feeling to my grandparents’ name somehow being abruptly extracted from our family tree. Interestingly, major New York City TV news teams covering a traffic accident or stabbing incident continue to report victims “being taken to Lutheran Medical Center.”

What Might Be Learned?

Had the original vision of patiently and incrementally merging (*a la* Merriam-Webster) two very different — yet altogether complementary — cultures been given even half a chance, the breadth and depth of benefits created from such a shared endeavor might have made for a much different outcome. Along with other colleagues in leadership, that is why I publicly and wholeheartedly supported the originally-intended merger as long as I did. Besides the obvious opportunity of further bridging the artificial firewalls still separating so much of “academy and religion,” “faith-based and evidence-based,” “mission and margin,” the creative melding of faith-grounded beneficence with cutting-edge research, technology, and business savvy could have generated truly groundbreaking results. That prospect shall remain essentially unfulfilled. However, though this once-promising opportunity has fallen by the

wayside, my hope is that it might still be realized through future consolidations now gestating.

I do believe there are some noteworthy lessons that can be learned from Lutheran's experience and applied to institutions considering similar consolidations. First, to be equitable and effective, a true merger process must by nature be a two-way street. It can never be about implementing a leveraged, accelerated strategy designed to expediently erase the identity and name of one or another partner. When the media cosmetics are all removed, such a process constitutes top-heavy, aggressive takeover, not shared, balanced merger.

Second, and fully consistent with the claims of most secular corporate researchers, merger processes are by far most effective and successful when people are encouraged to take meaningful dimensions of their institutional story, identity, meanings, and rituals with them. Linking past and present really matters, no matter who or what one is. It grounds, guides, motivates, and sustains. Measurable assurances that each institution's history will be honored should be built into the due diligence process.

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Third, when in all honesty acquisition/takeover is clearly intended all along, "acquirers" do well to patiently and empathically *listen* to "acquirees" over an extended period of time, particularly understanding and affirming what continues to really matter to them, what continues to motivate and hold lasting meaning for them. This requires both considerable time and space. There is no short-cut way around it. Such a process of cultural transition and transformation cannot be expediently thrust into the fast lane or conveniently truncated. The grief that staff and stakeholders predictably undergo needs to be honored and openly validated, along with the acute anxiety experienced by those swept up in such a process. After all, employees' own *personal* stories are also undergoing massive transition. As William and Susan Bridges remind us in *Managing Transitions: Making the Most of Change* such grief and transitioning require considerable "fallow time" in order to be openly named, processed, and supportively validated. This might very well include public rites and rituals. Moreover, it is critical to invite and take seriously the hopes, expectations and input of the former sponsor, not effectually brush them aside.

Fourth, be cognizant of any disabling role that self-intimidation might play in the process. Regarding my own participation, this is the issue that haunts me more than any other, particularly with regard to my own sporadically gullible complicity. The entire experience now reminds me that the most regretful form of intimidation isn't that which others impose. It's intimidation that is self-imposed. In Lutheran's case, did the ultimate threat of total closure excessively restrain our capacity to confront

and push back when most called for? Those who find themselves the more vulnerable partner in such a merger process might be reminded of Shakespeare's famous words: "Our doubts are traitors and make us lose the good we oft might win by fearing to attempt."

Fifth, perhaps the greatest ethical and organizational imperative is to simply tell the truth about everything of consequence at the very outset. That means more-advantaged organizations being transparent about their principal motivation of gaining additional market-share advantage through acquisition of a geographic or demographic footprint, their intention of stripping away any surviving legacy or name-attachment with an acquired organization, and owning up to the fact that they have no intention of honoring prior covenantal commitments or other meaningful linkages with an acquired organization's former sponsor. Be painfully honest and upfront about all of these matters and all that is really intended.

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Given such lessons, one mystery lingers. If I understand correctly, studies conducted by such leading healthcare foundations as Robert Wood Johnson and the Kaiser Family Foundation do not necessarily confirm the "bigger is better" assumption that seems to justify so many of today's command-and-control consolidations, particularly when expansive, monetized, business-oriented cultures seek to dominate and aggressively take over smaller, more local, communal ones. In fact, much like the NYU Langone-Lutheran consolidation process, many such endeavors only end up ridden with broken promises, stakeholder disillusionment, weakened relationships with community partners, and the heartrending loss of talented, dedicated staff. Over the long haul, many do not even necessarily perform all that well financially. Having already journeyed through the debacle of dissolving a major merger with the Mt. Sinai Health System less than twenty years ago (still referred to on the street as "the great healthcare divorce"), one might have expected a health system as sophisticated as NYU Langone to have integrated some of those earlier lessons, especially given that much of that miscarried merger was also, in large part, attributed to hasty, mismanaged cultural integration.

Peering into the Future of Faith-Based Healthcare

In the remainder of this paper I gaze into the precarious future of faith-and-values-inspired health systems and identify six concerns and issues worth considering. They are theological and sociological, abstract and pragmatic in nature.

Can/Will We “Keep the Faith” in Faith-Based Care?

“Science without religion is lame; religion without science is blind.”

–Albert Einstein

“Science is not only compatible with spirituality; it is a profound source of spirituality.”

–Carl Sagan

This first issue seems to me the most critical, as well as the one meriting most immediate, overdue and extensive attention. Phrases such as “faith-based,” “religiously-sponsored,” and “spiritually-inspired” can be understood in significantly diverse ways...by diverse people...from diverse perspectives. We do well to candidly acknowledge that going forward. A burning issue

will be how such references are interpreted by both sectarian and nonsectarian healthcare providers who may find themselves approaching, or already immersed in, some form of consolidation. What presumptions and associations are tied to faith-grounded orientations, language, and semantics?

Are they transparently named? Openly addressed in C-suites, board rooms, and integration team meetings? It would seem that the word *interpret* is pivotal here, as it applies to *all* participants and stakeholders.

Based upon my own experience — most recently, that of a mission officer assisting in the process of merging an elite, academic health system with a faith-based, social ministry organization — some of the former’s presuppositions regarding anything smacking of religion or religious sponsorship can, at times, almost border on the exotic. Many (certainly *not all*) within the academic-research camp interpret references to religion, theology or even spirituality as primitive.

Many reflexively associate things religious with superstition, moralism, and/or fanaticism. Several have openly confided that religious language elicits imageries long ago cast off from their own personal religious formation. Foremost is an anthropomorphic image of God as a regal, silver-bearded patriarch residing in his otherworldly heaven. This randomly interventionist godhead seemingly plays favorites — doling out special miracles and favors in response to the shopping list prayers of pious believers “below,” while all but ignoring the suffering and plight of the rest of his kingdom. Unfortunately, such visceral associations carry with them a number of other antiquated, pre-scientific notions such as a literal seven-day creation, a prowling devil, sexually-transmitted original sin, uncritical adherence to rigid, outdated creeds, and a punitive understanding of illness (the latter often cited as most distressing of all).

Add to this whole formulary an enduring dose of traditional, hierarchical clericalism, and it’s no wonder that so many scientific-academic types in medicine

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not only squirm in their seats, but quietly and instinctively dismiss so much of this construal as intellectually void and rationally deficient. Such sweeping misrepresentations comprise a bundle of religious/theological distortions which I and countless other contemporary people of faith no longer find credible. It's really no surprise that massive numbers of millennials and "nones" have all but dissociated themselves from the entire pre-scientific package.

From my own observation, there are at least three regretful upshots that result from these negative interpretations:

1. The great faiths are reduced to only their weakest features;
2. Healthcare is alienated from the heart of its vital, faith-and-values-inspired narrative; and,
3. Striving to play things safe and find "politically correct" ground, healthcare leaders evade open dialogue around matters of faith-based identity, mission, and religious sponsorship.

The net result is a trifecta of lose, lose, lose. It's certainly much safer to artfully evade all of this and talk about "market share" and cost-benefit analysis.

Along with many a contemporary faith-based CEO, medical staff, or board member, I favor the words the late Marcus Borg used for himself in his 2001 book *Reading the Bible Again for the First Time* in describing myself as "a non-literalistic, non-exclusivistic Christian" who "affirms the validity of all enduring religious traditions." To that I swiftly add, "non-dualistic, science-embracing Christian." It's long past time that vast numbers of spiritually/religiously-evolving people of faith, many of whom are entrusted with publicly leading faith-based social ministry institutions, venture out of our theological timidity and lay claim to the more forward-thinking spiritual outlook we hold in common. For starters, we see ourselves as both fully "in and of" this world, which straightaway translates into robustly embracing modern science, technology, and academic research. In the timeless words of Henri Nouwen in *Life of the Beloved*, "The spiritual life does not remove us from the world, but leads us deeper into it." Theologically, I'm pointing here to laying claim to a spiritual outlook open to the wonder of continuous revelation, one that is more creation-centered, panentheistic (defined ahead), evolutionary, and process-oriented — both complementary to and compatible with modern science and such enlightening phenomena as quantum theory, genomics, neuroscience, and evolutionary psychology. Drawing heavily on Scripture's abundant interweaving of wisdom, parable, history, allegory, and metaphor, this more progressive-leaning outlook regards the rich library of the Bible with utter seriousness and reverence.

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If there is any final, consistent message from the entirety of that very same Bible, it seems best captured in those resounding words cited earlier from Krister Stendahl: “God’s agenda is the healing of creation.”

I’ve yet to hear a convincing argument as to why an institution’s religious identity must be left behind in the consolidation of healthcare institutions or why it cannot contribute to a fresh vision of quality, compassionate and equitable healthcare for all. After all, faith is a universal, meaning-making activity in which, one way or another, all human beings are engaged. Whether it takes shape in religious or “religionless” terms, faith inevitably shapes our fundamental understandings of reality, truth, belonging, morality, well-being and what ultimately matters. What could be more important in the pursuit of health, healing and healthcare?

How we think about God in the context of health, healing and healthcare really matters!

How we think about God in the context of health, healing and healthcare really matters! For starters, I like Barbara Brown Taylor’s uncommon theological wisdom gleaned from a friend and described in her recent book, *Holy Envy* (2019): “Spirituality is the active pursuit of the God you didn’t make up.” What if today’s medical centers and health systems, particularly those still bearing some semblance of faith-based roots and legacies, were fully embraced as laboratories in which that kind of theologizing — that kind of ‘pursuit of God’ — could freely and openly occur?

Abraham and Sarah witnessed and knew well from their own humble faith journeys that God is never restrictively defined. G_d simply and universally IS. As expressed in the language of “panentheism,” God is intimately, vulnerably, and lovingly in all, with all, and for the sake of all, while mysteriously still cosmic, Creator God. Coming from my own faith tradition, we actually do get far more specific and granular about God. Jesus repeatedly taught and demonstrated that God is *first and foremost* to be found in the world — particularly in the face of the neighbor and the stranger in need — a central teaching of Christianity, Judaism, and Islam alike. Bonhoeffer described Jesus in remarkably simple and unambiguous terms: “the one for others.” That means *all* others, not some, are to be inclusively affirmed in their inherent dignity and spiritual freedom. In turn, it means that we need to equitably care for the health of *all* God’s people. Further, it means that love of God, self, others, and all of creation are inextricably interconnected, as are science, religion, healing, mercy, and justice.

Finally and crucially, a humbler, ever-evolving faith posture celebrates how all enduring faith traditions shine a light on truth and what it means to be healthy, whole, and human. Each in its own unique and limited way brings forth wisdom in terms of what it means to seek truth and moral purpose, to love, heal, learn, actualize, and spiritually grow. Ultimately, that means taking religion far more seriously, not less seriously. Might we dare even envision the kind of spiritual

renaissance that will inclusively embrace and celebrate the best and truest within all religious traditions, universally recognizing religion as the pervasive, all-encompassing force it is, grounding humankind in ultimate meaning, purpose, hope and direction? Surely then we would agree that overlooking, denigrating, or condescendingly dismissing faith and “faith-based” out-of-hand is paramount to brushing aside one of the most important dimensions of life and reality, one that, as it “reasons from the heart” (H.R. Niebuhr), penetrates to the very core of health, healing, and healthcare. The diverse religio-cultural crossroads integral to today’s healthcare institutions makes of them unusually rich, pluralistic laboratories in which to learn, practice, and grow such inclusivity.

I pose the question that goes to the heart of this article: When it comes to integrating faith-based institutions into today’s rapidly consolidating health systems, to what extent are such matters of ‘faith-in-relation-to-health’ taken seriously, prominently placed on the agenda of an integration strategy or even named? If identified, do they hold parity with decisions over which brand of electronic medical record or MRI to use, which product lines to pursue for optimal “ROI?” (return-on-investment). They did not receive more than passing attention in the process I and others navigated in south Brooklyn.

In an effort to peel the onion a bit further, a painfully concise historical take on this might be as follows:

Having put most all of reality — including religion — under its rigorously probing microscopes and telescopes, the 18th century Enlightenment and 19th century scientific revolution unfortunately ended up throwing baby out with bathwater. How ironic that Martin Luther, father of the Protestant Reformation, is also often seen as the father of scientific inquiry and secularization. Like two Brooklyn subway cars pulling in different directions, religion and science became de-coupled. Scientific materialism complete with its own god(s) basically replaced one faith system with another. Thus it came to pass that anti-religious, scientific fundamentalism built its own kingdom. In so doing, it found a safe, welcoming base of operation in the academy. When secularist universities became increasingly involved with healthcare, they soon discovered a diverse dance floor, one upon which they began to awkwardly bump into their religiously-oriented counterparts, already waltzing around that floor. Whether due to fear, threat, arrogance, or just plain intellectual laziness on the part of both, there would soon prove to be minimal creative mixing of those dance partners. Regrettably, they began to segregate and split the dance floor, becoming increasingly distanced from one another until an ever-widening gulf ensued.

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To the unfortunate detriment of *all*, that gulf now prevents and frustrates the kind of creative, synergistic merging of values, gifts, strengths, legacies, and best practices that could have potentially marked the outcome of a merger process like that which molded NYU Langone Brooklyn Hospital. In short, one faction remains more oriented to whole-person care of body, mind and spirit, social welfare/justice ministry, and community engagement; it largely serves those who cannot pay. Its counterpart remains more oriented to evidence-based, metricized physiological cure, and research; it largely serves those who can pay. One advances healthcare as a faith-inspired, wholistic ministry, the other as a techno-centric science and savvy business practice. I am aware of the extent to which these depictions reflect a considerable degree of caricaturing; it's done here for effect.

My argument is that health, healing and healthcare need science **and** religion, mission **and** margin, academy **and** faith community, public/governmental **and** private at their noblest and best. All must be welcome on a dance floor that remains open and fluid. When creatively unleashed in complementary ways, all hold abundant gifts and strengths in support of one another. What's sorely needed is for science, religion, government, and business to freely engage one another on that dance floor, stepping to the music of mutually-enhancing conversation and cooperation, rather than stumbling over the dissonant sounds of defensive, competitive, threatening argument. Simply stated, creative dancing can occur that avoids the extremes of religious dogmatism/fundamentalism, scientism, excessive governmental control, or runaway commoditization.

The creative interplay of religion, science, government, and sound economics still presents inviting opportunities through the very kind of prospect the NYU-LHC merger had originally promised. When religious, governmental, and academically-sponsored organizations meet in the public square for the sake of the common good, the outcome need NOT always be something quintessentially "secular." Instead, why not conceive of something far more imaginative, inclusive, and pluralistic? How long before we more fully embrace the resplendent ways in which science, religion, government, and morally-grounded business interconnect in complementary and mutually beneficial ways? How long before we spiritually mature a notch or two and wake up to the kinds of opportunities Diana Butler Bass has creatively named "fluid re-traditioning" in her 2018 book *Grateful: The Subversive Practice of Giving Thanks*?

It's no coincidence that, in recent decades, a number of major research centers and institutes have arisen in prestigious universities and health systems, all exploring the vital intersections of health, faith, ethics, religion, medicine, and economic

My argument is that health, healing and healthcare need science **and** religion, mission **and** margin, academy **and** faith community, public/governmental **and** private at their noblest and best.

justice. This is to be celebrated and fervently promoted. One need only look to the extent of remarkable research conducted by Harold Koenig a physician at Duke University or the ongoing mission of The Templeton Foundation to be enlightened and inspired. My own observation is that this work seldom appears to fruitfully impact processes shaping the consolidation of sectarian/nonsectarian healthcare organizations. Might we imagine more scientists seeking to better appreciate how spiritually-oriented people understand science and scientific inquiry while at the same time more religiously-grounded persons seeking to better understand the world of science and evidence-based medicine? By their very nature and purpose, healthcare institutions continue to provide some of the most fertile ground for this to occur...if and when that ground is intentionally cultivated and seeded.

Even though a Pew Research Center study in 2009 revealed that 69% of Americans favor faith-based social service initiatives, my sense is that the escalating world of commodity-based healthcare now pretty much proprietorially controls today's dance floor, buttressed in large part by stigmatizing religion as anti-intellectual, anti-scientific, and unfriendly to business. Fewer and fewer effective public advocates and activists are either in place, or sufficiently resourced, to challenge and stem that tide. Now caught up in circling their own wagons, fewer and fewer denominational organizations are exhibiting the chutzpah to do so.

Thankfully, by their very nature, such undying faith-inspired blessings as sacrificial love, whole-person care, genuine beneficence, and soul-planted vocation will never become mechanistically-manipulated, metricized commodities. Even as some of my own colleagues seem bent on recasting spiritual care into a thoroughgoing evidence-based, taxonomic, mechanical/technical service, we do well to remember sociologist William Bruce Cameron's enduring statement in his 1963 book *Informal Sociology: A Casual Introduction to Sociological Thinking*, "Not everything that can be counted counts; not everything that counts can be counted."

In the current climate of commercialized self-interest, it's not surprising that, when an opportunity like the complementary merger of NYU Langone/Lutheran HealthCare presents itself, the promise of rich benefits for enhanced, shared healthcare mission is thwarted by the more dominant, proprietary member. I believe that the forfeitures of that once-promising merger, as well as past and future ones like it, are exposed in an insightful observation offered by John B. Cobb Jr. in his 2010 book, *Spiritual Bankruptcy*: "The shift from religion to secularism, while freeing people from one set of evils, has plunged them into another...the widespread victory of secularism in society has fostered developments that most secularists deplore."

Might we imagine more scientists seeking to better appreciate how spiritually-oriented people understand science and scientific inquiry while at the same time more religiously-grounded persons seeking to better understand the world of science and evidence-based medicine?

Finitude and Distributive Justice: Persistent Realities

“The willed-but-not-yet-achieved omnipotence of The Market means that there is no conceivable limit to its inexorable ability to convert creation into commodities...It has begun to shape us in ways that elude our awareness.”

–Harvey Cox

The Market as God

Second, we do well to be reminded that we are created “in the image of God” — not as gods in and of ourselves. One of the most significant contributions religion brings to the increasingly commodified, technologically-saturated world of modern healthcare is acknowledgement of the reality of finitude. Directly tied to that acknowledgement is the spiritual quality of humility. Indeed, finitude and humility are fundamental precepts of all the great religious traditions. The prophet Micah expressed these central tenets of life, faith, and health in simple terms: “Seek justice, love mercy, and walk humbly with God” (Micah 6:8). That means at least three key things:

1. There are inherent limits to all human resources, capacities, and endeavors;
2. More often than not, others have gifts and strengths we don’t; and
3. There are always larger forces at work in our midst — including those of a more ultimate nature.

As business-and-technology-driven providers of healthcare continue to steadily overtake more vulnerable safety net providers, it seems that one of the dogged illusions at play is that somehow more financial prowess, more evidence-based science, research and technology, more and more market share will eventually eliminate the inconvenient reality of human finitude. Granted that much of today’s “purchased-product” care can and does create *some* better efficiencies and enhanced outcomes in the treatment of *some* illnesses, when factoring in glaring inequities and disparities in care for the poor and underserved, such enhancements are, at best, negligible. Meanwhile, other more inequitable tradeoffs *are* quite significant.

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If we acknowledge that *equitable access* to finite resources really is the fundamental *moral* issue at play, sadly, distributive justice in healthcare today in large part seems determined by what finance experts technically refer to as the mechanics of “payer mix” and “cost shifting.” Rather than basing care on the reality that there are limited resources to serve everyone in need, commoditized healthcare appears increasingly bent on the aggressive construction of more and more sleek buildings and luxurious facilities, concierge-like services, bloated executive salaries, exorbitant consultants, accruals of massive endowment, and extravagant advertising campaigns. Much like any other monetized, corporate business, by aggressively

securing such competitive advantages, those amassing large shares of the healthcare market position themselves to demand the largest margins of profit. In some cases, they are even able to receive upwards of 2–3 times more revenue intake from billing and reimbursement formulas (“mix”) in comparison with their poorly-positioned public or safety net counterparts, all the while managing to garner huge tax advantages through preservation of rather dubious “not-for-profit” criteria.

Meanwhile, most struggling public, faith-based and community-based safety net providers — operating out of a very different set of missional objectives — serve far higher numbers of uninsured and underinsured persons, including high numbers of undocumented immigrants. Given their frail payer mixes, they basically struggle to survive. For their revenue intake, they must rely heavily on Medicaid and Medicare — comparably low payers on the block — as well as other sources of government/public funding. For the most part, their payer mix is restrictively pre-set, not allowing them to advantageously “cost shift” and incorporate significant numbers of private payers.

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Lutheran HealthCare’s inpatient hospital typically maintained a payer mix of approximately 50% Medicaid, 30% Medicare, and only 15% private/commercial, with the remaining 5% paying nothing at all. Of greater financial stress was the vast extent of outpatient care a safety net like Lutheran provided to the underprivileged community it served. There the mix was typically 65% Medicaid and 5% Medicare, with the remaining 30% charity care. Such safety net organizations are thus placed in severely disadvantaged positions contrasted with more privileged, business-driven providers who treat relatively few publicly-insured patients. Safety nets are forced to rely on whatever “trickle-down” revenues hopefully come their way, pending the latest whims of state and federal funding sources.

Ironically, healthcare has never been more avariciously prosperous for some. With the advent of Big Pharma and the creation of titanic hospital systems, massive profits are readily available. Viewed from another perspective, whole-person care of mind, body, and spirit — once largely exempt from such calculating motivation — has never been more ruthlessly monetized, competitive, homogenized, and monopolistically-inclined — a sobering reality often deceptively airbrushed out of public eyesight. Consequently, captive to market-driven material gain and competitive commercial status, health and human “care” now flirt with taking their place among the daily menu of advertised consumer products barely distinguishable from others purchased online. Just watch some of the ubiquitous pharmaceutical and healthcare ads on TV. Many predict that some cybernetic form of “Amazon Healthcare” is just around the corner!

In terms of Micah's call to humility and distributive justice, does this scenario sound the least bit fair, equitable, or just? Does it depict a level playing field committed to equitably serving the common good, one that acknowledges the limited resources at our disposal? Further, how is such a public arrangement allowed to occur in the first place? My nearly 40-year vocational tour through the world of healthcare afforded a personal, front-row seat from which to form a conclusive opinion on that: It continues to occur in part because of lack of transparency and the artful business skills of financial officers concealing much of it in complex, leveraged contracts and negotiations. If the goal of equitable care is to be the primary starting point in today's financing, a system of fair healthcare economics, not unfair economism, must be the rule.

Staking a yet more prophetic claim, some of us are now convinced that the drift toward accelerated consolidation and corporatized domination, *in itself*, has become one of the primary *causes*, not just *symptoms*, of inequitable financing and runaway profits. I fear initially harmless merging and consolidating are now degenerating into outright will-to-power and greed. Rather than "mission and margin" being held in creative, constructive tension, the market itself determines and manages the mission of the organization. A kind of economic social Darwinism sets in and seems to offer no foreseeable exit. The result is painfully evident: Healthcare behemoths, comprised as they are of massive concentrations of capital and technology can simply overpower less-advantaged, faith-and-community-based providers. These vulnerable safety nets are left out in the cold with meager bargaining power and dwindling support from their original sponsors or the government. All too often their limited options become: 1) close altogether, abandoning their original mission (a la St. Vincent's), or 2) languish in financially imperiled, at-risk status for a while and eventually "go on the block" for acquisition (a la Lutheran HealthCare).

What might all of this suggest regarding the future of healthcare in America? For one thing, it would seem that my earlier portrayal of a vast, discontinuous array of rigorously competing interests can be expected for some time. Do we wish to remain complacent about such a future and its dire implications?

An intriguing op-ed piece appeared February 25, 2018 in *The New York Times*. In it, Ezekiel J. Emanuel, M.D., vice provost at the University of Pennsylvania and author of *Prescription for the Future*, reminds us that, at \$1.1 trillion, hospitals in the U.S. continue to account for about a third of all medical spending (approaching the size of the entire Spanish economy). Predicting that many of today's hospitals will continue to either close or convert to outpatient services, Dr. Emanuel quickly pointed out how "special interests in the hospital business" aren't going to like that trend one bit. While multihospital systems insist that their ongoing crusade of forming huge

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conglomerates will create cost savings for patients, Emanuel claims that, actually, the very opposite will be the case. Why? “The mergers create local monopolies that raise prices to counter the decreased revenue from fewer occupied beds.”

If, as Walter Brueggemann claims in his 1986 book *To Act Justly, Love Tenderly, Walk Humbly* the heart of the biblical concept of justice is “sorting out what belongs to whom and giving it back to them,” why would we continue to tolerate a healthcare system in which sorting out what is most profitable for a few has become the norm? While I seldom choose to play the cynic, could it be that Nietzsche was all too astute? That our inherent “will to power” appears capable of making its way into *any* human endeavor or enterprise? At my retirement event, a colleague asked me, “Now that you look back on the last few years, what dynamics seemed most at play in the LHC-NYU merger?” My gut-level reply was, “I still feel that, on the part of both institutions, there’s been genuine concern over continued healthcare services for south Brooklyn. But frankly, at the end of the day I think that power, control, and wealth dominated.”

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The Ungainly Elephant in the Room: U.S. Healthcare Policy

“Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.”

–Rev. Dr. Martin Luther King, Jr.

Third, closely related to and flowing from number 2 is the persistent belief that the free enterprise system is the most effective vehicle for providing comprehensive, equitable healthcare services in this country. Stubborn arguments for and against that ideology keep us locked in a never-ending debate over whether this society should: a) try to incrementally build upon the 2010 Affordable Care Act (“Obamacare”), b) adopt some form of total “repeal and replace,” or c) opt for as equitable a model as possible through an entirely new system of universal, single-payer healthcare (i.e. “Medicare for All”). At the time of this writing, many in Congress and the current administration seem intent on keeping us dysfunctionally suspended between options “a” and “b”. Meanwhile, over the past three consecutive years, average life expectancy in the U.S. has actually been decreasing while healthcare insurance premiums for middle-class families continue to skyrocket. And the leading causes of our declining health and longevity? They are consistently identified as rooted in *despair and depression* — disorders of the human spirit — directly connected with stress, addiction, loneliness, and hopelessness.

Thanks to a mutually beneficial partnership Lutheran HealthCare shared with “Diakonie Neuendettelsau” (a Lutheran-sponsored integrated health system based in Bavaria), I was able to study firsthand Germany’s uncontestedly successful execution

of a modified version of option “c.” A forewarning: never refer to the Germans’ system as “socialized medicine” in their presence!) Clearly motivating and grounding that system is a set of broadly held core values. Foremost among them is a passionate commitment to serve the common good through a universally-held, communal principle of “solidarity.” Solidarity is coupled with a healthy respect for the realities of finitude and limited resources. And the bottom-line result? In terms of overall quality of health and healthcare, their comparable outcomes soar beyond ours, *all at a little over half the percentage of GDP expended*. Throughout a number of presentations I offered at German hospitals (both faith and academic-based) regarding the current status of U.S. healthcare, I found myself both sheepish and embarrassed.

Why can't we pursue **quality and equality** in the kind of more balanced ways I just witnessed in Germany?

About midway through a return flight home, I entered in the abovementioned ruffled notebook: “At its core, our increasingly-monetized, broken healthcare system is no less than immoral, let alone a deplorable demonstration of economic stewardship. Why can't we pursue **quality and equality** in the kind of more balanced ways I just witnessed in Germany?” While we waste enormous amounts of GDP on our competitive, technocratic, business-driven system — with all of its unnecessary bureaucratic, competitive, and commercial waste — Germany spends far, far less per person while benefitting from far, far better outcomes. That is simply a verifiable fact. We've run out of 'wonkish' ways of denying, spinning or burying it. Of course, this is also the case when we compare the U.S. to Japan, Norway, France, Canada, Great Britain, Sweden, and others that have successfully implemented various models of option “c.” Each of these countries demonstrates that there are creative ways to effectively do option “c,” tailored to particular needs, resources, and demographics.

Last survey I checked, approximately 60% of U.S. citizens would much prefer a system in which government guarantees universal, equitable health care coverage. And yet, the more U.S. healthcare becomes increasingly corporatized and monetized — through its wasteful, competitive, market-driven business model — the more ineffective, inequitable, diffuse, and unjust it seems to become. Only two metaphors would seem to possibly describe our current scenario: we're either chasing our own tail or getting in our own way. Actually, it appears that we are managing to do both simultaneously. Most regrettable is the price so many in serious need continue to pay for such chronic, societal dysfunction. Like Sister Elisabeth Fedde and the early deaconess nurses, it's time we step out and take a far more prophetic stand on behalf of the underserved in our midst.

What is the plight of faith-based safety nets in all of this? While it is obviously too late for a St. Vincent's, a Lutheran HealthCare, or countless others, many faith and community-based safety net providers like them, both small and large, are still

positioned to fulfill the very missions for which they were created in the first place — providing equitable access to compassionate, quality healthcare services for vast numbers of underserved people. Why not simply provide the relatively modest public funding they need to continue offering the disproportionate levels of charity care they are obviously still willing and wanting to provide? In the words of the RN Sister at St. Vincent's, why not help them *do* mission, rather than be *done in* by mission?

The Ever-Enduring Value of Whole-Person Care

“Healing is about more than a well-functioning body...”

—Norman Wirzba

Fourth, as the great hymn rings out: “There is a balm in Gilead, to make the wounded **whole**.” Understanding and practicing health as **wholeness** — health as a fundamental unity of body, mind, spirit, and relationship — is another of the indispensable gifts credited to faith-based healing and healthcare. The essence of such multidimensional wholeness was incisively expressed by Norman Wirzba in his article, “Love Goes to Work,” published in the March 2, 2016 issue of *The Christian Century*:

“Healing is about more than a well-functioning body. As important as it is, an individual, functioning body is only the visible tip of the much deeper phenomenon of health.

The full realization of health encompasses bodies, souls, and the relationships that join us to communities and places. In order to appreciate those far-reaching dimensions of health, we must attend to the heart — the animating core of our lives...As the power of love increases, so does the capacity to live...Jesus is proclaimed to be the savior of the world not because he plucks people out of this world as if to relocate them in some ethereal, disembodied heaven, but because he enables them to experience life abundantly here and now...He sees what their lives can be if their suffering is healed...to experience the wholeness of life.”

In the July 2017 issue of the *Journal of the American Medical Association* (JAMA), Tyler J. VanderWeele, M.D., et. al., Harvard T.H. Chan School of Public Health, remind us of the dangers inherent in neglecting “the substantial history linking health, religion and spirituality within most cultures.” This same article extensively cites a 2016 Gallup Poll, reconfirming that “89% of American adults believe in God or a universal spirit and 75% consider religion of considerable importance.” These physician authors conclude, “Recent studies suggest a broad protective relationship between religious participation and population health...More explicit focus on spirituality, often considered outside the realm of modern medicine,

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could improve patient-centered approaches to well-being long sought by patients and clinicians.”

Subsequently, a *New York Times* article dated February 24, 2018 featured Rich Joseph, M.D., Resident Physician at Brigham and Women’s Hospital, recounting his unforeseen encounter with a frustrated, 96-year-old patient with pneumonia. Little did he know that his patient was none other than Bernard Lown, M.D., emeritus professor of cardiology at Harvard. Dr. Lown is well known for pioneering the use of the direct-current defibrillator for cardiac resuscitation and an implant called the cardioverter for correcting errant heart rhythms. In 1996, Lown published *The Lost Art of Healing* in which he warned that “healing is (being) replaced with treating, caring is supplanted by managing, and the art of listening is taken over by technological procedures.” Regarding the escalating industrialization of healthcare and its preoccupation with metrics and market share, Dr. Lown shared with Rich Joseph that today’s hospital can actually be likened to a factory — “it tests every ache and treats every laboratory abnormality, but it does little to heal its patients... doctors of conscience have to resist the industrialization of their profession.” In his earlier book, Dr. Lown claims, “Doctors no longer minister to a distinctive person, but concern themselves with fragmented, malfunctioning body parts.”

Without question, a culture of religiously-grounded, spiritually-inspired compassion goes to the heart of caring for whole persons, an orientation to healthcare which strives to comprehensively embrace “the meaning of the whole of life” (James Fowler). Faith groups distinctively got that and continue to get it. It is an age-old, indispensable contribution nurtured through centuries of faith-and-values-inspired healthcare. Its providers remain the key guardians of the spiritual wellsprings, stories and rituals that have motivated and sustained it.

Losing or diluting any of that seems to me both unthinkable and inexcusable. Disregarding it in any way constitutes a dreadful loss to the human condition and human care giving.

Today’s increasingly metricized, techno-centric focus on improving the “patient experience,” while commendable, is no substitute for the kind of care that emanates from a sense of vocational calling, firmly planted in the soul. An art form as exquisitely person-centered as caring for another’s well-being simply cannot afford to lose that. Whether considered historically or spiritually, such soul-grounded, vocational calling has inspired and safeguarded compassionate wholistic care for centuries. We put our trust in caregivers based not so much on techniques, metrics, or clinical trials, but on the genuine, heartfelt empathy and sacrificial love we experience emanating from them. Such care cannot be artificially scripted, metricized, forced, or technically replicated. Attempts at doing so are symptomatic of healthcare becoming increasingly *soulless*.

Today’s increasingly metricized, techno-centric focus on improving the “patient experience,” while commendable, is no substitute for the kind of care that emanates from a sense of vocational calling, firmly planted in the soul.

“De-Enervating” the Indispensable Role of Faith Bodies

Fifth, while much of today’s healthcare evolved through a series of phases entrenched in a faith-and-values-based storyline, quite sadly it has seriously wandered from that central missional narrative. Drawing again on Dr. Sulmasy’s diagnostic model, we must find ways of addressing the prolonged “enervation” (in many cases, “hibernation”) plaguing major faith groups when it comes to revitalizing organic connections with the major healthcare ministries they once founded and continue to officially sponsor. The missional embers of affiliation and shared mission that have lost their glow call for immediate re-fanning if we are to reverse the apathy and amnesia that have set in on the part of both denominations and the healthcare organizations they have sponsored. I’m more than convinced that those missional fires can still be rekindled, if there is a collective will to do so.

Going forward, just how should faith bodies react to the continued usurpation of their role in sponsoring healthcare ministry throughout the world? I am *not* suggesting the unrealistic expectation of major funding, a former luxury no longer possible for most denominations. However, there are other ways of maintaining meaningful, organic relationships which can transcend provision of an annual check.

As the leadership and bureaucracies of most religious bodies continue to find themselves dealing with the crippling stress of steep declines in both membership and revenue, many seem to have almost forgotten that they do indeed still carry the mantle of scripturally-mandated, faith-rooted healthcare ministry. The fact that these same healthcare institutions are major expressions of social ministry, social justice, and social action seems to have fallen off their radar, while active sponsorship of everything from liturgical institutes to outdoor camping have not. In recent decades it has become all too convenient and self-justifying for denominations to restrict their peripheral involvements in healthcare to chaplaincy or faith community nursing, while circumventing more direct involvement in the kinds of acute, primary, preventative, palliative/hospice, long term, behavioral health, and addictions services they founded, shaped, and actively sponsored.

Illustrative of such faith group enervation, in recent years a self-organized group of ELCA healthcare mission leaders arranged for a series of consultations with denominational leaders and bishops regarding the plight of the ELCA’s church-sponsored health systems, imploring renewed programming, shared part-time staffing, and other resourcing that could strengthen organic relationship. On each occasion, that group was met with respectful expressions of concern; however, our requests and intentions were, for the most part, deferred or deflected. Thankfully,

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that group survives, continuing to provide inter-institutional support and resourcing within its own ranks.

As cited earlier, some years ago the ELCA chose to dismantle its internal, structural capacity for actively sponsoring and relating to its social ministry organizations. My own assessment continues to be that doing so literally set our church body back decades. As a default measure, support for social ministry organizations has largely been entrusted to a pan-Lutheran coalition, Lutheran Services in America (LSA). While we indeed thank God for LSA's faithful, dedicated work and the support services it provides, it can hardly be expected to attend to substantive matters of direct, organic ecclesial/legal relationship involving large, complex healthcare systems — particularly with regard to missional, legal, economic, and consolidation issues. Nor can it be expected to serve as a kind of all-purpose surrogate for full-blown, corporate, denominational relationship.

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It's just as unrealistic to expect local judicatories (synods, districts, conferences, etc.) to assume such responsibility; they are a fraction of the size of today's major health systems and cannot be expected to keep pace with the complex, ever-changing dynamics of contemporary corporate healthcare. In the midst of our heightening anxiety over aging clergy and congregations, the mission drift of church-sponsored colleges and closures of seminaries, strategically, a more effective course of action would seem the formation of a shared, collaborative "Office for Faith and Health" among several mainline denominational partners — a cooperative structure that could augment capacity for direct, organic relationship, shared mission, consultation, intervention, and support. In the case of the ELCA, such a structure could have/still could be readily formed among those church bodies with which it holds relationships of "full-communion." The creation of such infrastructure could also serve to effectively/efficiently support and grow ministries in chaplaincy, pastoral counseling, clinical education, congregational health ministries, faith community nursing, and other shared faith-health endeavors. It's not too late for such a creative measure to be taken.

While the Roman Catholic Church continues to demonstrate far more committed public sponsorship of its healthcare systems, it too has experienced serious challenges in navigating the current landscape of closure and consolidation. Yet, by maintaining a robust, centralized, programmatic structure — the Catholic Health Association (CHA) — Catholic-sponsored healthcare ministries are far better positioned to survive. With more than 600 hospitals and 1,600 long term care and other health facilities, CHA represents the largest group of nonprofit health care providers in the

United States. One of CHA's most creative strategies has been that of pro-actively facilitating consolidations of its own church-sponsored healthcare institutions with other providers, employing imaginative organizational engineering while remaining committed to keeping mission, values and faith-based identity alive and flourishing. The same can be said for some distinctively Lutheran-sponsored systems like Advocate Aurora Health and Fairview (Minneapolis), Adventist systems like Loma Linda, as well as Wake Forest University Baptist, Methodist Memphis, Baylor, and other large, resilient, faith-based systems committed to maintaining respectable levels of organic denominational affiliation. One can only hope that, given their expanding corporate prowess and capacity for growth, these faith-based systems are not lured into compromising their faith-rooted heritage, identity, mission or core values, thereby finding themselves on the ever-slippery slope of runaway commoditization.

If major faith bodies choose not to fan the embers of healthcare mission and ministry, we will no doubt need to increasingly look to the kinds of parareligious organizations now endeavoring to pick up and carry the baton.

Noteworthy examples are Stakeholder Health, the Institute for Healthcare Improvement, the Robert Wood Johnson and Templeton Foundations, 100 Million Healthier Lives, and likeminded organizations centered around preserving and supporting faith-health mission and service. However, to be effective, they too will need the renewed support, resourcing and public participation of denominational partners.

If major faith bodies choose not to fan the embers of healthcare mission and ministry, we will no doubt need to increasingly look to the kinds of parareligious organizations now endeavoring to pick up and carry the baton.

Shared Endeavor: A Way Out of Our Prolonged Healthcare Crisis

"In a sane society, common pain should lead to common purpose. And common purpose should lead to common projects and solutions."

—Van Jones, *Beyond the Messy Truth*

Last, Dietrich Bonhoeffer, cited earlier in this paper, penned the following words in a 1943 letter to his closest comrades about three months before his arrest and imprisonment by the Gestapo: "I believe that God can and will generate good out of everything..."

Whatever now evolves in the U.S. healthcare equation, there are always grounds for hope. I'm aware of the extent of lament embedded in this essay. However, rather than wallow in a prolonged state of grief, rage, or paralysis, I'm convinced that current alarm over the onslaught of commoditized, inequitable healthcare can serve to motivate and mobilize us. The question is whether the spiritually-inspired energies, values, and best practices of faith-based healthcare will continue to be included in that equation. Hopefully, whatever their plight, faith-and-values-inspired safety

nets will find creative ways of bringing their unique, indispensable contributions to the table. As Scripture attests, faithful remnant communities carry the capacity for remarkable resilience and creative impact.

Like many denominations, the ELCA created a major social statement on health, healing and healthcare for the 21st century entitled *Caring for Health: Our Shared Endeavor*. I referred to this statement earlier in this paper. I consider having served on the task force entrusted with developing that statement a rare privilege and learning experience. Besides its strong emphases on whole-person care, sound enduring values, equitable access, and limitations to resources, much of the statement's impact has come through a set of claims embedded in its very title, "shared endeavor." Quoting from the statement:

"Regardless of the means used to provide health care and ensure access to it, we must diligently preserve the nature of health care as a shared endeavor.

This means that we recognize our mutual responsibilities and guard against the ways in which motivation to maximize profit and to market health care like a commodity jeopardizes health and the quality of health care for all...

Patients and caregivers are more than consumers or providers; they are whole persons working together in healing relationships that depend on and preserve community."

Caring for Health makes clear that governmental, academic, faith-based, for-profit or other agents of delivery acting on their own will not be able to provide the kind of quality and equitable access we long to achieve. None should seek to build its own exclusive kingdom to the detriment or elimination of others, nor purposely suppress others' constructive contributions. Inclusive, pluralistic and shared endeavor is the way forward. Thus, existing faith-and-values-inspired healthcare providers are indeed *worth saving and actively supporting*. Those that have closed are *worthy of intentional study and remembrance*. And the legacies, values, best practices, and special gifts of those merging with other organizations are *well worth vigorously sustaining* within the cultures of today's consolidated systems.

As Scripture attests, faithful remnant communities carry the capacity for remarkable resilience and creative impact.

Closing thoughts

One of my favorite public expressions of pluralistic, shared endeavor, one that embodies the major tenets of the ELCA social statement while also serving as an inspiring beacon of hope, can be found at The Johns Hopkins Hospital in Baltimore, Maryland. Prominently positioned in the centermost rotunda area of the entrance to the hospital's administration building is a 10.5-foot marble statue of the Healing Christ. It's a replica of the famous "Christus Consolator" statue that Danish sculptor Bertel Thorvaldsen created in 1821 for Copenhagen's Frue Kirke. Until recently, a similar "Healing Christ" statue, dating back to the motherhouse of the early Lutheran

Deaconess nurses in Brooklyn, had prominently adorned the main entrance to the hospital of the former Lutheran HealthCare. Unfortunately, the acquiring organization saw fit to physically remove that statue, placing it in a remote corner of the hospital's second-floor heritage gallery, essentially relegating it to the status of museum-like nostalgia.

Ever since it was first dedicated in 1896, countless patients, families, visitors and staff continue to be welcomed to Johns Hopkins — a world-renowned, prestigious center of clinical excellence — by its “Christus Consolator” sculpture. I personally observed the toes of the statue worn smooth by the touch of patients, families, visitors, and staff for over 125 years of visits. It provides a special place for daily prayer, meditation, and reflection. Others can even be seen “high-fiving” it! For them, it is an enduring symbol of compassion, hope, inspiration, whole-person healing, and spiritual care. It continues to have universal, nonsectarian appeal and meaning for Jews, Christians, Muslims, and countless others of diverse faith orientations who interpret the meaning of the statue in ways appropriate for them. This same statue serves as the focal point of important traditions and commemorative events, setting the tenor for Hopkins’ continued values-inspired healing mission.

Founder and Quaker, Johns Hopkins was clearly devoted to establishing a nonsectarian university hospital and medical school. But he also intended the integration of faith, religion, and spirituality with health, healing, and healthcare. He understood that statue represented healthcare as an indispensable expression of sacrificial, whole-person ministry to/with a community. Thus, when that statue was first unveiled in 1896, the president of Johns Hopkins publicly likened the entire hospital to a *hotel-Dieu*, “hostel of God,” openly blessing the essential faith-and-values-grounded dimension of all medical care.

As we continue to search for ways to provide equitable, compassionate, whole-person healthcare for all — as a shared endeavor by/for all — may we remember and support the many faith-based safety nets still striving to preserve their values-inspired missions, identities, and indispensable contributions to health and healing. Perhaps we can take our best cue from Michael A. Williams, M.D., a former neurologist at Johns Hopkins, and his timeless reflection on the beloved statue cited in the July 1982 issue of *The Johns Hopkins Medical Journal*: “When you see how many people come to that statue, it tells you the value of faith and spirituality that people hold may speak louder than any spreadsheet could for enhancing our ability to give not only through a beautiful, silent statue but through the services we provide here.”

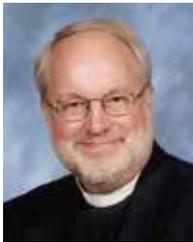


The Christus Consolator at Johns Hopkins Hospital

Afterword and Acknowledgements

One final note: All of the observations and claims in this essay are mine. Prior to starting this project, I was aware of the extent to which various readers within the healthcare “industry” (particularly within NYU Langone Health) might very well view my observations and interpretations as uninformed, inaccurate, or unfair. Similar reactions might hold true for some denominational representatives as well. Such is the inherent risk when venturing to candidly speak out of one’s experience. For the sake of furthering this important conversation I welcome any and all feedback at the following email address: *dastiger@msn.com*.

In creating this article, I am deeply indebted to the following for their review and helpful suggestions: Dan Sulmasy, Rich Novak, Teresa Cutts, and Gary Gunderson. Very special thanks to Lee Joesten and Chris Stiger for their invaluable editing, re-editing and personal support.



Prior to retirement in 2016, Don Stiger served as Senior Vice President for Mission and Spiritual Care at NYU Lutheran Medical Center, Brooklyn, NY. He is an ordained pastor in the ELCA, board-certified chaplain in the Association of Professional Chaplains, and certified supervisor in the Association for Clinical Pastoral Education. Don served for six years as Director for Ministries in Chaplaincy, Pastoral Counseling and Clinical Education at the ELCA Churchwide Office and is both a co-founder and past co-editor of Caring Connections.

Response from Stephen Bouman

Crossing the Brooklyn Rubicon

DON STIGER HAS WRITTEN A CRUCIAL ESSAY, on many different levels, about the public health care ministries of the church. His grasp of the history, theological issues, the interplay between religion and science and sacred and secular, and of health care ministries is profound. In tracing the saga of the merger between Lutheran Health Care (Lutheran) in Brooklyn and New York University Langone Health (NYU Langone) in Manhattan, Don helps us see what is at stake when a merger becomes a takeover, when business and commodification of health care overwhelms a priority to serve the poor, when sacred and secular are polarized (and the sacred caricatured, belittled, and sidelined). As the number of faith-based hospitals and health care institutions continues to dwindle Don has an important and cautionary word to say to national church bodies of all denominations. It is a hard word to hear, tinged with the hurt and disappointment of someone who truly loves the church he has served so faithfully. It is a word we must hear before it is too late.

I have been part of Don's story, as bishop in New York, denomination executive in Chicago, and as friend and partner in ministry. Let me say right at the beginning here that I agree with Don's analysis of the issues, his critique of the wider church, and his proposal for moving forward. What is everybody's responsibility is no one's responsibility. I fully support Don's call for a shared, collaborative "Office for Faith and Health" among several mainline denominations, perhaps starting with those in full communion with the Evangelical Lutheran Church in America (ELCA).

Shortly after being elected bishop in the Metropolitan New York Synod in 1996 I attended a meeting of executives and board members of three Brooklyn hospitals seeking to merge: Downstate Medical Center, Maimonides, and Lutheran. The meeting was about planning the business and structure of the deal, setting up a holding company and a path to move forward. I listened for over an hour, then spoke. I asked if the hospitals had spent any time sharing core values and history. I noted that Downstate was ardently secular, Maimonides was deeply religious (Orthodox Jewish), and Lutheran was casually, but historically faith based. I gave a brief view of Lutheran's faith based DNA: South Brooklyn was the motherhouse of Nordic Lutheran immigration, the churches wanted to care for the health and well being of immigrants, that Lutheran provided primary health care for more people in poverty and immigrants than almost any other institution in the country. I asked if there

As the number of faith-based hospitals and health care institutions continues to dwindle Don has an important and cautionary word to say to national church bodies of all denominations.

were some core, spiritual values we all shared, such as accessibility to health care for everyone in South Brooklyn, highest quality health care, supporting vocations of all involved in health care, a wholistic view of health care including the spiritual dimension. The comments changed the meeting. A task force was formed to explore “the bishop’s proposal.”

My point here is the one Don makes throughout his essay. Faith and religion bring a lot to the party, and a seat at the table can be a powerful witness and influence as decisions are made which shape the future of health care, one merger and neighborhood at a time. The corporate member of Lutheran was the ELCA, the national church body. I was the local bishop and spoke for that national governance with great support from the ELCA.

Over time Downstate dropped from the picture and Maimonides proposed a full asset merger. As details emerged it looked more like a takeover more than a merger. I was courted by the board chair and also the CEO of Maimonides who would become the CEO of the merged hospital. He had previously been the Director of the Port Authority of New York and New Jersey. Several of the board members of Lutheran were nervous about the emerging details and asked me to intervene with the national church. What looked like a way out of continuing fiscal crisis, and broadly supported by the board, was beginning to look like a hostile takeover by some. I was way in over my head: wined and dined by Maimonides, encouraged to support the merger by the Lutheran board chair and most of the board, listening to board members who were troubled by what they discovered as the merger moved forward.

Which brings me to Don’s point. There was a “there there” at ELCA headquarters, the Division for Church and Society, and a person dedicated to health care institutions like Lutheran, working in partnership with the ELCA’s lawyers. They had my back and gave me cover to bring things to a head. The board chairs and CEOs of the two hospitals (Judge Dominick Lodato, who presided at the Son of Sam trial was Lutheran’s interim CEO) flew with me to Chicago where we were able to put all the cards on the table. In the next months the deal fell apart. There were hard feelings internally on the Lutheran board and also out in the community (we were accused of anti-semitism). But I felt that we had dodged a bullet.

Lutheran continued to serve its immigrant community and those in poverty while continuing to manage an increasingly difficult fiscal and regulatory landscape. When Wendy Goldstein arrived as the new CEO and shortly thereafter appointed Don Stiger as Vice President for church relationships and spiritual care, Lutheran entered into an era of deepening relations with the church, deepening spiritual care for an interfaith public, and resilience and ingenuity in addressing the many issues facing

Faith and religion bring a lot to the party, and a seat at the table can be a powerful witness and influence as decisions are made which shape the future of health care, one merger and neighborhood at a time.

Lutheran. The board, though still anchored by faithful local Lutheran leaders, also had a growing cadre of other high powered and philanthropic leaders, including H. George Anderson, the former presiding bishop of the ELCA. Church leaders, hospital executives, doctors and staff engaged each other in studying the ELCA's new Social Statement on Health Care. Don and Wendy were two of my closest allies as we formed an alliance of the ten Lutheran Social Ministry Organizations in New York with David Benke, my counterpart in The Lutheran Church—Missouri Synod (LCMS). That alliance contributed to the programs and services of Lutheran Disaster Response New York in the wake of the September 11 attacks. Wendy served on the board of Lutheran Services in America (LSA), the umbrella organization for Lutheran Social Service ministries and their church bodies. Lutheran Health Services, including their nursing home and senior housing and neighborhood clinics were an integral part of the area mission planning for Lutheran churches in South Brooklyn.

In 2008 I moved from New York to Chicago to be the new executive director of the Evangelical Outreach and Congregational Mission Unit of the ELCA, a merger of two former units. Two years later came another shake up in the structure of the ELCA. The Domestic Mission Unit was formed from seven prior units, including Church and Society. What was formerly a unit, with several staff dedicated to Lutheran Social Ministries, became a stripped-down team with one person dedicated to this work, who was also Team Leader. The Poverty and Justice Team included social ministry organizations, disaster response, HIV and AIDS ministry, Domestic Hunger program, and liaison to LSA and Lutheran Immigration and Refugee Services. From that point on the ELCA had two program Units: Domestic Mission and Global Mission and a new Mission Advancement unit.

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Don Stiger is correct. That reorganization left a weakness in the structure, compounded by the retirement of Ruth Reko, who had so ably provided leadership for the ELCA's Social Ministry Organizations for many years. I will say that over the years this new structure did knock down some silos, provided new opportunities for fresh missional engagement across the unit, and enabled us to heighten impact. And it did reset the churchwide organization with a financial model the church could afford and support.

Don has already described the process of the merger between Lutheran and NYU Langone. The process had integrity, and there were many spaces in which the faith based DNA could flourish in the structure. It was a choice between survival — continuing to serve the poor and the immigrant on a large scale or going out of business. The vetting process was stellar. Our Poverty and Justice team, the office of Presiding Bishop (and our attorneys), and church council were all part of the process. As the unit inheriting the constitutional responsibilities of the former

Church and Society Unit I was the one who ultimately signed off on the merger on behalf of the ELCA.

I also signed off on the merger between the Advocate Health Care and Aurora Health Care systems in Illinois and Wisconsin. That merger appears to have a more hopeful future. For one, Advocate is powerful and not vulnerable to a hostile takeover. The local bishops of the ELCA and the United Church of Christ (UCC) were actively involved with their synod councils. I had several opportunities to review the structure drafts that were shared with counsel, our Poverty and Justice Team, and the Presiding Bishop and Secretary of the ELCA. The governance structure included the presence of a bishop and mandated ELCA or full communion board members. Spiritual care and program boards for the Advocate system were in place (as they were with Lutheran and NYU Langone). Kathie Bender Schwich, Advocate Aurora Health's Chief Spiritual Officer, is part of the new structure moving forward.

I agree with Don that there needs to be national staff dedicated to these institutions. I would love to see this be a full communion effort.

Here are some things I have learned.

- 1.** The local judicatory has to be alert and involved. That means the bishop, but also careful attention needs to be given to board members and governance. These hospitals and health care systems are gems for the church and their competence in leadership development, demographic knowledge of the community, public and private relationships, expertise in planning, experience with a large scale of activity, measuring impact, and more, are gifts the church should utilize.
- 2.** I agree with Don that there needs to be national staff dedicated to these institutions. I would love to see this be a full communion effort. I would love to see the ELCA take the lead and contract with someone like Don or Kathie or another long distance runner to work with these organizations to develop a structure for this. This staff could then be proactive, especially in the run-up to these mergers, which will continue. I think it would have made a difference had there been a dedicated person working with the bishop and staff in NY, with Don and the folks at Lutheran, reaching out to others in the Lutheran system that have gone through this.
- 3.** Once you lose your faith-based identity you almost never get it back. Wagner College in New York is a Lutheran College. As it slipped away from a relationship with the church its history and spiritual DNA were almost lost. I got on the board and worked hard to bring it back. The jury is still out. But when the dust settled after the restructuring in the ELCA churchwide ministry, Mark Wilhelm was still there, working on the relationships with our colleges and universities. Our unit, with Mark's leadership and the attention of the presiding bishop, was able to form an organization of ELCA college presidents, and to

produce and organize around a President's Statement lifting up the Lutheran and vocational and spiritual core values of these schools. The Presidents formed their organization and hired Mark Wilhelm as the first Director. Mark gives them leadership while officed at ELCA Headquarters as part of the Domestic Mission structure. Could a similar structure emerge to support ELCA health care institutions?

4. The dynamic engagement between good business and spiritual, wholistic health care; the symbiosis between science and religion; the mutuality between mission which gives access to health care to the poorest, most vulnerable and the financial margin which supports that mission; these are powerful fusions and possibilities which I believe may be a form of evangelism in these latter days. Perhaps a humane and compassionate engagement by the church through it's healing institutions would give a weary world a reason to give the life of faith and the Gospel another hearing.



Stephen Bouman served as a parish pastor for twenty years in New York City and New Jersey. He served two terms as bishop of the Metropolitan New York Synod of the ELCA. For the past eleven years Pastor Bouman served as Executive Director of the Domestic Mission Unit of the ELCA. He retired from that position in 2019 and is currently a consultant and interim pastor. He has authored many articles and books, including From the Parish For the Life of the World, The Mission Table, Baptized

For This Moment, and They Are Us: Lutherans and Immigration.

Response from Roger Paavola

I READ WITH GREAT INTEREST the article written by Don Stiger, “And Then There were... None?” Using an abundance of adjectives and adverbs, he explains the difficult reality of what seems to be happening to faith-based healthcare facilities in our United States. His concern is of deep significance for the historical presence of religious organizations that support healthcare ministries and facilities. The decline of faith-based healthcare is remarkable and concerning. The history of faith-based healthcare pre-dates secularly based healthcare facilities, as Stiger notes. In one year’s time, seven faith-based healthcare facilities disappeared, leaving him to ponder, “Will they be able to ‘do’ mission without being ‘done in’ by mission?”

The closing of St Vincent Hospital and the merger of Lutheran HealthCare are stunning examples of what Stiger characterizes as a “predominantly commodified, corporatized, business-and-technology driven enterprise” in which he later suggests “...strategic business objectives and the attainment of optimal market advantage attenuate the fundamental mission of the original institutions. He supports his assumptions with several examples of indigent care offered by faith-based healthcare providers when compared to secular organizations.

Having worked in the healthcare field as a CEO in the United States and experiences in the Canadian healthcare systems, I share Stiger’s deep concern over the decline of faith-based healthcare services. There are two large faith-based systems where I worked. One operates as a hospital with a faith-based name, but in name only, having been “merged” with a “corporatized, optimal market and competitive profit-making enterprise,” to use Stiger’s words. On the other hand, the second provider expanded its service and ministries to all segments of the population in the many locations of its healthcare ministry. What is the difference? The corporate conviction to “Be what we say we can be” is based squarely on its undeniable and unwavering dedication to its mission and ministry.

Its commitment to the founding principles of the healthcare ministry that would otherwise lead to abandonment or modification of its founding principles is undeniable.

There is a more fundamental issue that is inferred in Stiger’s article that begs for greater detail. On July 30, 1965, President Lyndon Johnson signed into law the bill that introduced Medicare and Medicaid. It provided for hospital insurance and physician visits. *Healthcare* (not *health*) was declared to be a “right” for every American citizen. Over the years, Congress changed Medicare, making more people eligible for

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government-payer coverage. The Social Security Trust Fund became the stretched-out funding source for Medicare. Medicaid, administered by each State, gave medical insurance to people from low-income families, people of all ages with disabilities, and people who need long-term care. States molded their Medicaid programs to serve their people, thus leading to a wide variation in the services offered from state to state.

Later, Medicare added prescription drugs as an expanded service to the American public. Still later, the Children's Health Insurance Program (CHIP) was created to give health insurance and preventive care to uninsured children. Then in 2010 Congress passed the Affordable Care Act (ACA) that brought basic health insurance coverage, in a single place, where consumers applied for enrollment in government-approved health insurance plans. Provisions in the ACA made new ways for Congress to design and test how to pay for and deliver healthcare. But the provision of dollars to pay for healthcare came with strings — Congress must hold accountability for what way and how many dollars are going to contribute to the rising cost of healthcare — so aptly pointed out in Stiger's article.

Unfortunately, Stiger's significant premise where governmental dollars are affixed to healthcare delivery, will not necessarily translate into healthiness of the American public. Consider the empirical studies. Inherited genetic factors are not the principle factors that determine the quality of life or how long a person will live. Our health (*not healthcare*) is primarily dependent on two other factors: 1) what we put into our bodies, and 2) what things our bodies are exposed to. The word "lifestyle" encapsulates both of these concepts. We cannot change our genetics, but we can change our lifestyle. Those lifestyle choices can prevent or forestall the development of diseases for which we are genetically predisposed. Dr. Lamont Murdoch of Loma Linda University School of Medicine stated, "Faulty genetics loads the gun, lifestyle pulls the trigger [on bad health]." (Dr. Lamont Murdoch, Nedley Health Solutions, "Proof Positive," Ardmore, OK, 1999, p. 1.)

The impact of lifestyle factors was documented by Dr. Nedra Belloc and Dr. Lester Breslow in an epic study of nearly 7000 people living in Alameda County, California and compared to comparable populations in Nevada and Utah. (Belloc, N.B. and Breslow, L. (1972) "Relationship of Physical Health Status and Health Practices." *Preventive Medicine*, 1, 409–421.) They found seven lifestyle factors that influenced healthier lives and how long people lived. These factors are:

1. seven to eight hours of sleep daily,
2. no eating between meals,

Unfortunately, Stiger's significant premise where governmental dollars are affixed to healthcare delivery, will not necessarily translate into healthiness of the American public.

3. eating breakfast regularly,
4. maintaining a proper height/weight ratio,
5. regular aerobic exercise,
6. moderate or no use of alcohol, and
7. no smoking.

Only about 5% of the study group who followed all seven health habits died within the nine year study period, compared to a 20% of the comparison group who followed three habits or fewer and did die within the same period. A person's health age can be lower or higher than the actual chronological age, depending on the number of lifestyle factors practiced.

Healthcare inequities along social classes have also been the subject of several epidemiological studies. When plotted against an array of socio-economic determinants, the 19th century Edwin Chadwick's mortality tables indicated child

RELATION OF LONGEVITY TO HEALTH HABITS



Neil Nedley, Nedley Publishing, www.cps.org.rs/Innerpeace/Health/principles.html

mortality is correlated with paternal occupation, especially in the case of cancer and heart disease. Better health status was more closely related to socio-economic variables than the availability of healthcare services.

The article "Why Are Some People Healthy and Others Not?" used epidemiological evidence to explain how different factors influence health, and concluded that socio-economic conditions have a

Average age of death for occupation group by location (after Chadwick, 1842).			
Location	Professional Trades	Tradesmen	Labourers
Rutland	52	41	38
Leeds	44	27	19
Liverpool	35	22	15
Manchester	38	20	17
Bolton	34	23	18

(Chadwick E. W., Clowes and sons; London: 1842. *Report on the Sanitary Conditions of the Labouring Population of Great Britain.*

stronger impact on health than individual behaviors. The Canadian Whitehall Study concluded that individual decision-making and self-control are important mediators of health inequalities. (*Improving the Health of Canadians*, Canadian Institute of Health Information, September, 2004.) For the Bicentennial of the United States in 1976, the Norwegian government gifted the University of Minnesota's School of Public Health for Dr. Tor Dahl to study the factors that contributed to US health. Assisting in the research, I was astonished to discover that the availability of healthcare did *not* contribute to one's health. In fact, the research found that people on government subsidized healthcare were less healthy than people who either paid

for their healthcare or purchased insurance — suggesting the importance of personal responsibility in health outcomes.

Psalm 90:9–10 (ESV) states, “*For all our days pass away under your wrath; we bring our years to an end like a sigh. The years of our life are seventy, or even by reason of strength eighty; yet their span is but toil and trouble; they are soon gone, and we fly away.*” For the thousands of years of historic healthcare services since the time of King David, the ultimate measure of health (chronological age) has not changed all that much. Economics, technology, finances, strategic initiatives, or a single-payer system will not change the health of a single person. Stiger states, “For me, the moral imperative carries with it a felt sense of pastoral responsibility. Overwhelming, cumulative evidence beckons me to step up to publicly address the disturbing trend of excessive commoditization that characterizes so many of today’s titanic healthcare consolidations... resulting in untold forfeitures to whole-person health and societal well-being.”

I totally empathize with Mr. Stiger’s lament about the decline of faith-based healthcare services. His litany of what was lost in his experience is truly saddening and alarming. Yet the contrast of the two institutions where I served and my experience in the Canadian healthcare system lead me to a different conclusion. As the government increased its financial interest in the healthcare system of these governments, the tighter its fiscal control became. The single-payer system of the provincially operated healthcare systems in Canada produced longer waiting lines for services and denied technological improvements that could have contributed to better diagnosis and treatment. That system created a situation in which a US hospital ninety miles south of the Canadian border built hotels and larger treatment facilities to accommodate the Manitobans who were encouraged to cross the border for healthcare services that were not readily available in Manitoba — all at the expense of the Manitoba Province, but not counted in the Manitoba healthcare budget expenditures!

Stiger references Matthew 25, where Jesus listed the various disadvantaged and needy segments of a people in need of our care. Christ’s encouragement to the faithful was the basis for their mission — the *seelsorge* ministry that points to Christ’s ultimate healing — the forgiveness of sins that leads to eternal life. Martin Luther concluded this thought in his Small Catechism on the Lord’s Supper, saying, “What is the benefit of this eating and drinking? These words “Given and shed for you for the forgiveness of sins” show us that in the Sacrament forgiveness of sins, life, and salvation are given us through these words, for where there is forgiveness of sins, there is also life and salvation.” May God grant us the wisdom and guidance to keep

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faith-based healthcare ministries going and growing, as we stand on doing what we say we are doing for the sake of the Gospel.



Rev. Dr. Roger Paavola is a second-career pastor, who received his BA in Public Administration from the University of Minnesota-Duluth; an MBA from the University of Minnesota, Minneapolis and spent 23 years as a hospital chief executive officer in metropolitan medical centers. He served as an examiner for the American College of Healthcare Executives, a surveyor for the American Hospital Association and a preceptor and adjunct instructor in healthcare administration at the University of

Minnesota, Bemidji State University and Moorhead State University.

He is a graduate from Concordia Lutheran Theological Seminary, St Catharine's, Ontario, receiving his Masters in Divinity in 1997. He completed his doctorate in pastoral care and counseling from Concordia Theological Seminary, in Fort Wayne, IN in 2009. His first Call was to Grace Lutheran Church, Beausejour, Manitoba. He accepted a Call to Heavenly Host Lutheran Church, Cookeville, TN, in 2000.

Pastor Paavola was elected as District President/Bishop of the Mid-South District in 2012, and continues to serve in that capacity. He has published two books; Upon the Rock, (Northwestern Publishing Company, 1989) as history of the Presentation Healthcare System; Pastoral Care for the Victims of Parental Deficit Syndrome. (Brock University Press, 1997).

He is married to his wife, Pat of 49 years. They have three grown children and eleven grandchildren.

Response

from Kathie Bender Schwich

I AM GRATEFUL TO DON for so carefully chronicling the history of how faith-based health care organizations first came to be as well as the challenges they have faced and will continue to face in the future. As one who currently serves under call in this type of setting, I resonated with much of what Don says. While this response will not come close to doing justice to Don's months and years of careful thought, nor address all the key points that he makes, his article did raise for me two key issues that spiritual care leaders of faith-based organizations face today.

At the "macro" level (and as Don points out), our faith-based healthcare organizations were literally birthed by the church. The church funded these institutions and those who served in them, creating a ministry to care for the sick and underserved in their respective communities. As healthcare institutions grew in size and complexity, funding became ever more dependent on government contracts and commercial payers, with minimal to no dependence on the church for financial support. Now as health systems face challenges of decreasing reimbursements, changing patient and consumer expectations, and new types of competitors vying for the same business, denominations also struggle with decreasing membership and resources, and leaders with too many priorities demanding their attention. This doesn't mean that the strong relationships faith-based healthcare institutions once valued with their denominational sponsors can't continue. But it does call for creativity in finding new ways for those relationships to thrive in meaningful ways.

To that end, my spiritual care and faith outreach teams and I have become increasingly proactive in connecting with our church sponsors, both to assure them that Advocate Health Care is committed to remaining faith-based amid a new merger with a partner that is not, as well as finding ways that we can work together in carrying out the ministry to which each of us is called. Through Advocate's Office for Faith Outreach and our Faith Community Nursing program, as well as our Community Health efforts, we are partnering with congregations to explore ways to care for those we are privileged to serve in wholistic ways within their local communities.

While I agree with Don's vision that an "Office for Faith and Health" would be a helpful addition to the ELCA's churchwide staff, I also realize that the national expression of the church itself struggles with decreasing income and the need to carefully discern what it can no longer do. Since Advocate has the benefit of sharing

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geography with the ELCA's national office, we regularly communicate with national leaders, exploring opportunities for partnership and reminding new churchwide leaders of our historical connection. My colleagues and I who are part of the Mission Leaders Group of Lutheran Services in America strive to do the same thing on an even broader level.

At the "micro" level, faith-based healthcare organizations have, throughout the years, built the profound impact that faith has on one's "fundamental understandings of reality, truth, belonging, morality, well-being, and what ultimately matters" (Stiger's words) into the very culture, the DNA of the organization. This is a wholistic difference that is felt, not only by the patients and family members who seek care from us, but also by those who serve within our institutions as environmental services staff, nurses, physicians, administrators, and volunteers. Staff and leaders affirm and embrace the profound impact that faith and spirituality have on the healing process as well as their impact on one's call to serve in the healthcare setting with all the challenges, struggles, and tragedies it presents.

As leaders and staff change, it is imperative that we find ways to ensure that (as Stiger says) "matters of 'faith-in-relation-to-health' are taken seriously" and included in agendas for which the connection isn't obvious.

While leaders of faith-based healthcare organizations have never had the luxury of resting on our laurels, assuming everyone "gets it," the need for ongoing education and enculturation is even more crucial today as mergers of organizations that are increasingly diverse in the services they provide are happening with increasing rapidity. As leaders and staff change, it is imperative that we find ways to ensure that (as Stiger says) "matters of 'faith-in-relation-to-health' are taken seriously" and included in agendas for which the connection isn't obvious. I remember being at an operations meeting several years ago where I was asked "what does God have to do with xxx?!" This was an educational opportunity for me and the motivation to find additional ways to make connections with my colleagues in other disciplines.

Going forward, it is important for leaders who oversee the mission and spiritual care functions of faith-based healthcare organizations to explore with their respective leaders ways to expand their areas of oversight within the organization to give further expression to the church's mission and values. I am privileged to oversee within Advocate Aurora Health the chaplaincy, clinical pastoral education and faith outreach functions as well as clinical, social, and organizational ethics. The organizational ethics oversight allows my spiritual care team to articulate the organization's philosophy and puts us at tables where decisions are made about everything from charity care policies to socially responsible investing to business development and growth. I also have oversight of our organization's Environmental Sustainability work, where we regularly connect decisions concerning recycling, constructing green

buildings, and our commitment to use 100% renewable energy by 2030 to how we care for God's creation.

Do we have it all figured out? Absolutely not. But we continue to explore ways to keep the faith-based values alive in ways that fit our changing context and inform our organization's culture, care, and actions going forward. I personally find comfort, challenge, and encouragement in Peter C. Brinkerhoff's words in *Faith-Based Management*¹ where he writes, "It doesn't matter if the faith behind the mission is obvious from the name or not. What matters is that the faith was there at the beginning of the organization, has been there throughout its growth and development, and most importantly, is evident in the actions and policies of the organization today."

May God grant us courage, conviction and compassion in these efforts.



Kathie is an ordained pastor in the ELCA. She serves on the Nominating Committee of the ELCA nationally and is convener of the Senior Mission Leaders Group of Lutheran Services in America. Kathie is the Chief Spiritual Officer of Advocate Aurora Health which has healthcare sites in both Illinois and Wisconsin. She has been with Advocate Health Care for over a decade and has more than 30 years of experience in spiritual care and executive leadership. Previously she served as Assistant to the Presiding Bishop of the ELCA and Executive for Synodical Relations. She received undergraduate degrees from the University of Michigan and Saginaw Valley State University and a Master of Divinity degree from Luther Seminary in St. Paul, Minnesota. She is a graduate of the Harvard Kennedy School's Women in Leadership program, holds graduate certificates in Healthcare Management and Patient Experience Leadership, and is a fellow in the American College of Healthcare Executives. Kathie lives with her husband, Rev. Daniel Schwich in Park Ridge, Illinois.

¹ Peter C. Brinkerhoff, *Faith-Based Management*, John Wiley & Sons, Inc., 1999, p.4.

Response from Mark Whitsett

*Will There Continue to Be a Faith-Base for People with Intellectual and Developmental Disabilities?—
The Challenge of Forgetting and Remembering*

IN THE “FUTURE OF FAITH-BASED HEALTHCARE,” Don Stiger describes the experience of faith-based health providers in central New York City. His story impacted me personally because 40 years ago I started my pastoral ministry as a parish pastor in NYC. I remember tending to the personal and spiritual needs of my parishioners in the very hospitals that Don names and whose accounts he narrates. I also felt the normal and real grief that comes with change and that communicates the sense of loss of meaningful, hopeful confession and care among those who need and want to know God’s assuring grace and help in such circumstances and places.

The question of faith-based healthcare for the present and future is also relevant for Cedar Lake, a Recognized Service Organization (RSO) of The Lutheran Church—Missouri Synod (LCMS) and Affiliate of the Evangelical Lutheran Church in America (ELCA), where I currently serve as Director of Pastoral Care. Cedar Lake, located in the greater Louisville Kentucky region, will celebrate its 50th Anniversary in 2020. In any given year we support 230–250 individuals with intellectual and developmental disabilities (IDD) in 38 locations with a staff approaching 450. We support medically fragile people in intermediate care facilities (ICF) and those who cognitively function in the severe to profound range. We have individuals in staffed residences who attend adult day programming or supported employment. Still others live in quasi-independent, supported apartment settings. In addition, Cedar Lake provides adult day programming, community access and a number of other services interfacing between the supported individuals and the communities of which they are a part.

I have had the privilege of participating for 12 years in the day to day lives of the individuals we support and their families as “Pastor Mark.” In addition, I also serve in various administrative roles and functions, working with senior management in the complexities of a diverse organization. My primary calling is to represent to management and our general staff the best practices in terms of a Christ-centered faith, ethical and moral considerations, human rights for the people we support, employee assistance, organizational cultural concerns, strategic planning for organizational spiritual life as well as pastoral presence, spiritual guide and fellow-traveler.

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This “sounds” like Cedar Lake is solidly situated as a faith-based health provider. Today, Cedar Lake does articulate a clear, conscious commitment to its Christian

history and confession. However a number of elements Don identifies could and do certainly impact Cedar Lake. I suspect that this is happening or will likely happen for other faith-based providers in the IDD field. In what follows, I key off Don's reflections and discuss how Cedar Lake "fits" with the challenges he identifies. In the end, I ask what if Cedar Lake forgets its faith base? Then what?

Market Forces and Faith

Cedar Lake is a not-for-profit that supports what is really a small "market." People with IDD are about 1.5% of the general population. Their needs tend to be expensive to support. As a result, funding is from Medicaid and to a much lesser extent Medicare or private pay. Most federal dollars are funneled to the States which prioritize the funding distribution through programs and described eligibility for individuals with IDD. Dollars are limited or capped. Regulations or processes for eligibility are subject to interpretation and make it difficult for service recipients and service providers to receive supports. In addition, service providers can find themselves competing for available resources rather than cooperating on behalf of the people they both support.

Cedar Lake started as a private pay agency in its early years. It was committed to supporting the faith the people they served and funded for this. As they moved into government funding, the problem was not the support of an individual's faith, since faith can be reflective of the "whole person" in their life of well-being. Rather, the problem is when available dollars per person must be spread across an array of services. Even though the organization has a faith-based commitment, the practicality of limited funds challenges the concept of funding faith-programing in light of "more critical" human care needs. For example, Cedar Lake's In-Community Spiritual Life Director has been integrated into the Community Access program. In this way, individuals who have chosen activities in the community that are spiritual in nature and need direct staff support in those activities can be assisted in such a way that units of times are billable.

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The market reality? If the position cannot in some measure help contribute financially to a program, it is simply not practical to have a position for spiritual life even though it has recognized value. While this is not the picture of a faith-based organization being swallowed up by a larger non-faith entity, it is a type of prioritization that places spiritual life in perceived hierarchy of needs. In addition, Cedar Lake has at various points, funded faith positions and programing with donated dollars, but these are hard to maintain in the long run, when there are limits to donor dollars or when other strategic plans take priority. Of course, a

funded position or program is not the only way to support spiritual life, but this takes initiative both on the part of the faith communities and/or individuals in the community and on the part of Cedar Lake in some formal way.

So the question remains: Will market forces override good intentions and faith objectives? We do see market-forces pushing at the IDD faith-based world. Cedar Lake in fact anticipates that the status quo in funding will change within the next decade. This will make any and all commitments to support a faith-base even harder to fulfill.

Relationships with the Church at Large

It is not a secret. The Lutheran church is aging and leaving the planet! This is also true for other mainline churches. But the needs of people in the world continue and grow. Philanthropy is not just about dollars but more about presence. Cedar Lake has been blessed with a strong development agency in its Foundation. The Foundation has generously funded many aspects of spiritual life at Cedar Lake as well as many other services to the people at Cedar Lake. The prioritization of funds is the difference between assuring that people have food, clothing, shelter, health care, and the like. The philanthropy that may be needed in terms of faith may be more about volunteered time, energy, and presence.

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The Role of Leadership

In 50 years of operation Cedar Lake has had a remarkable amount of stability in terms of leadership and commitment to a faith-base. Part of this is attributable to remaining connected to some of our original founding families. Part of the stability is tied to our RSO and Affiliate relationship with the LCMS and ELCA, that have actively required our boards to have members that represent the faith of the Gospel with a Lutheran Christian confession. Also, living in the “Bible Belt” helps in that many of our staff and managing leadership reflect Christian values and commitments. However, the impact of current culture, the changing of generations, and the distancing from our history are a challenge to our faith base.

It is not unusual to hear questions like, “What does Cedar Lake gets out of our RSO and Affiliate relationship with the Lutheran church?” Can’t we keep our faith-base “on our own?” Of course, the challenge here is where does the accountability come from? Who will lead in keeping the faith and what will that faith look like? Our CEO has a strong Christian faith commitment, but on a day to day basis his focus

understandably is on different aspects of the operations. There is also the reality that in the twelve years that I have been with Cedar Lake only one senior manager remains from the original team that I began with. The point? Things change. People change. Priorities and philosophies and leadership change. Will faith remain in spite of that change? So far, yes but the pressures are there that make the faith-base less certain.

Final Reflections on Faith-Forgetting and Remembering

The history of Cedar Lake is a history, where out of necessity, hope and faith “found a way” to meet the needs of loved ones. People remembered their reliance on the God of grace revealed in Christ, even as the immediate need was a place of safety and compassion for their loved ones after parents/family were no longer able to care for their family member. Cedar Lake was an answer to prayer but still required a lot of hard work over many years of faithful labor. Faith was the foundation for a long-term journey that has proved to be multigenerational.

Will there come a time and place when the foundation of faith is less recognized or even forgotten in the shuffle of market forces, an organizational leadership that “doesn’t remember Joseph,” or weakened relationships and support among church communities? Certainly, forgetting is a real aspect of being human! It is descriptive of the nature of people as they generationally struggle to relate to God and each other. But remembering is just as certain, not because it is human but because it is divinely promised and energized. God does not forget! God remembers the cries of broken people. God continues to call and people hear, follow, remember, labor, and renew the covenant.

I know that sounds very pious or like “pie in the sky,” but Cedar Lake and most faith-based health organizations have their roots in people who counted on a God who remembers them in their deepest needs. They called on that God; they labored; they invited others to participate; they did not give up. They didn’t say, “See what we did!” but “Thanks be to God!!!”

The shape of faith in healthcare or in the IDD world will likely not look like it does now. It does not look today like it did even ten years ago! People of faith and faith communities will need to consciously and intentionally change how and where they will engage and with whom they will interact in these contexts. The partnerships and the contexts of mission and care will need creativity, perseverance, and prayer on the part of the people of God. It is once again a time to cast about and to recast how the church in the world meets and will meet the realities of the market, the culture of the day, the scales of economy, the sense of self as member and partner in the body of Christ.

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Change is inevitable. Perhaps forgetting is also. Nevertheless, God is still here, and we are too; just like others before us who understood the need and faithfully labored over lifetimes and generations. We, like they, need to prayerfully figure out what needs doing and begin the task and do it. Who knows, maybe in the future, there will be those remembering the works that God did in and through us in a new and different way that brought faith and hope to those in need, even when market forces, culture, leadership and a church seemed to have forgotten.



Rev. Dr. Mark Whitsett is the Director of Pastoral Care for Cedar Lake in Louisville, Kentucky and also serves as online adjunct faculty for Concordia University Wisconsin. In addition, he was a parish pastor in the New York City metro area in cross-cultural and bilingual ministry and in Central Indiana. He and his Deaconess wife, Margy, have shared in ministry for over 44 years.

My Response to Responders from Don Stiger

I WANT TO THANK Lee Joesten and the *Caring Connections* Editorial Board for soliciting not just one but four thoughtful, insightful responses to “*And Then there Were... None?*” I am indeed grateful to all four responders, not only for enduring the extent of my, at times, longwinded lament, but for making such enlightening contributions to the conversation. As I wrote in the introductory section of my essay, a primary motivation for writing this piece was “to stimulate a wider conversation amongst colleagues serving in ministries of healthcare chaplaincy and administration.” My four responders have begun that process.

- **Stephen Bouman:** Yes Stephen, it’s been a blessing to have been part of one another’s stories in endeavoring to promote and preserve the church’s vital social ministry organizations, particularly our shared journey in New York City. From your initial reference to Brooklyn as “Rubicon” to your concluding expression of hope — that, through its healing institutions, the church might still “give a weary world a reason to give the life of faith and the Gospel another hearing” — I thank you for corroborating and validating the major tenets of my essay. Given the positions you have held within the official hierarchy of our sometimes-energating church body, our journey has included times of both creative tension and synergistic partnership. Please know that your endorsement of hope for a shared, multi-denominational “Office for Faith and Health” means much to many. In light of our church’s current operative priorities, and absent our beloved Ruth Reko and defunct Division for Church in Society, I wish I could be as hopeful that it will ever see the light of day. I welcome your ideas as to how it might garner support and actually materialize.
- **Roger Paavola:** Roger, I wish we had met earlier (hopefully, we might still have that opportunity). It’s particularly gratifying to get the perspective of a former medical center CEO, one also familiar with another country’s healthcare system. I love the missional mantra you cite, “*Be what we say we can be,*” since it expresses the hope many of us still have for those at-risk, church-sponsored healthcare ministries struggling to maintain their missional integrity. I did have one question: In pushing back on the preference many of us now express for some form of universal/single-payer coverage in the U.S., I’m curious as to why you chose to compare our

A primary motivation for writing this piece was “to stimulate a wider conversation amongst colleagues serving in ministries of healthcare chaplaincy and administration.”

poor-performing, inequitable system with that of our neighbor to the north? In its most recent study of the 11 wealthiest nations, the highly-esteemed Commonwealth Fund ranked the U.S. #11 and Canada #9 (based on % of GDP and comparable clinical outcomes). *You're right* about the deplorable wait times in Canada and its other weak features. Why would we not want to raise the bar and compare ourselves to the kind of efficient and equitable systems found in Germany or the UK (ranked #1)?

- **Kathie Bender Schwich:** Kathie, you and Advocate Aurora Health (my *'alma mater'*) continue to inspire me. I am thankful that you convene the Healthcare Mission Leaders Network peer group of LSA — itself an enduring beacon of hope and invaluable resource for strengthening the organic ties of the ELCA with its affiliated healthcare organizations. Thank you for highlighting some of the intentional ways Advocate Aurora aligns with the dwindling numbers of faith-and-values inspired providers who remain “proactive in connecting with our church sponsors.” That is a living reminder that large healthcare systems can still “*keep the faith in faith-based care.*” At the same time, I will not shroud the creeping nervousness I and others experience in watching Advocate Aurora (UCC/ELCA), Loma Linda (Adventist) and others swell in size, acquisitions, and economic prowess. As I endeavored to name in the paper, what is initially intended as mission-driven expansion of healthcare ministry through merger/consolidation can all too easily devolve into market domination eventually determining and managing mission. Going forward, I hope that is carefully assessed and monitored.
- **Mark Whitsett:** Mark, as you openly and perceptively apply the principal claims of the article to your organization and faith-based care of the intellectually and developmentally disabled, I am reminded how the same lamentable dynamics affecting large, faith-based healthcare systems apply just as much today to countless other church-sponsored social ministry organizations. Thank you for your candor and care in transparently identifying the various flash points of vulnerability an organization like Cedar Lake faces in the current climate, particularly such an indispensable service as pastoral/spiritual care. I'm sure LSA “has your back.” I also hope that the LCMS and ELCA, at local and national levels, will step up in whatever supportive ways they can. My question, are they doing so? If so, how?

News, Announcements, Events

In Memoriam

The *Caring Connections* community is saddened to learn of the deaths of two respected colleagues and friends. Both of these mentors spent their days ministering in places most of us never want to find ourselves. May they rest in God's everlasting peace. Our heartfelt sympathies go out to their families.

Bryn Carlson died July 31, 2019. He was born October 17, 1937. Bryn served as a parish pastor until he began a career in prison ministry at Green Bay State Reformatory in Wisconsin. He ministered in other state penitentiaries before going to the Bureau of Prisons in Washington, DC where he was chief of chaplains. Bryn also served in the National Guard and the Army Reserves for 35 years.

Roy Martin Tribe died June 30, 2019. He was born November 7, 1931. After graduating from Trinity Lutheran College he served in the Army Air Corp as a paratrooper. Roy started his career at Lutheran General Hospital in Chicago, then as a parish pastor in Pasadena, California for four years. He went on to spend 20 of his years in ministry as a chaplain in the Federal Bureau of Prisons in Illinois, Colorado, and Oregon. He retired in 1993.

Letters to the Editors

The *Caring Connections* editorial board welcomes comments from all our readers. We ask that Letters not exceed 500 words. Submissions may be edited for length but not for content. All Letters will be responded to but may not appear in a *Caring Connections* issue. Letters should be submitted electronically to either Diane Greve (dkgreve@gmail.com) or Lee Joesten (lee.joesten@gmail.com).

I want to express my appreciation and affinity for Brian Heller's reflections in the recent issue (Vol. 16, No. 2) regarding CPE in the parish. I had two units of CPE before entering the parish as a pastor in 1979. However, I did not fully realize the impact that CPE had on my ministry until 1994 following a couple of year-long residencies and certification as a CPE educator. In 1993–94 I spent several months as an interim before being called to a position as a full-time educator. In those months, the response of parishioners to my preaching and my leadership ability was notable. Something within me had significantly changed between that first call and my interim. I can only attribute the difference to my personal development to CPE. I was significantly more aware of my intrapersonal and interpersonal dynamics and thus a much more effective pastor. I became a better listener, a better responder, and a

better servant. CPE is good preparation for ministry as well as a tune-up throughout one's life of service. I look forward to Rev. Heller's research discoveries.

Nancy Wigdahl, *Retired ACPE Educator*
Rosemount, MN

In Times Such As These...

We find ourselves in troubling and uncertain times.

The national healthcare system does not work well and is extraordinarily expensive with reimbursement uncertain. Healthcare corporations are realigning in anticipation of an uncertain future, leaving their employees anxious about their roles, responsibilities, accountability, and job security.

Our society has been shaken by the dramatic demise of the myth of a post-racial America. We are newly aware of two Americas – one black and one white. We have experienced greater suspicion toward the “other” among us and greater hostility toward the “stranger” outside our borders.

The open secret of sexual abuse, exploitation, and devaluation has exploded with shock waves reverberating in all aspects of society.

The many issues which impact us *in times such as these* are compounded by loss of safe space for, and civility in, our public discourse. Families, friendships, and even congregations are divided as people are no longer able to dialogue with one another.

It is *in times such as these* that we as chaplains, pastoral counselors, and clinical educators are called to serve. We are “front-line Church” impacted through the people to whom we minister, through the institutions we serve, and personally as members of this society. How shall we understand the issues which trouble us? Where do we see Christ at work in these uncertain times? Are there unique insights we might gain from our own Reformation tradition, born and nurtured in equally troubling and uncertain times? How might we best serve clients, patients, students, and families in this context? What can we teach the Church about the world we are encountering on the front-line?

Zion XVII Faculty

Bible Study Leader

The Rev. Peter Nafzger
Concordia Seminary, St. Louis MO

Keynote Speakers

The Rev. Kathie Bender Schwich
Advocate Aurora Health

The Rev. Darryl Thompson Powell
Wicker Park L. C., Chicago IL

Worship Leaders

Liturgists

The Rev. Joel Hempel
Specialized Pastoral Care, LCMS

The Rev. Leroy Joesten
ALGH, Park Ridge IL (retired)

Homilists

The Rev. Paul Erickson
Bishop, Greater Milwaukee Synod

The Rev. Elizabeth Palmer
Books Editor, The Christian Century

Musician

Anne Krentz Organ
St. Luke's L. C. of Park Ridge

Morning & Evening Prayer

The Rev. Donald Stiger
LMC, Brooklyn NY (retired)

Host

The Rev. Thomas Bauma
University of Saint Mary of the Lake

*“In Times
Such As
These”*

Zion XVII



September 26-29,
2019

The University of Saint
Mary of the Lake
1000 East Maple Avenue
Mundelein, IL

SCHEDULE HIGHLIGHTS:

Thursday, September 26

Registration begins at 3:00. Gathering Dinner is followed by the first Keynote Address, "Healthcare in Times Such as These" by Kathie Bender Schwich. The evening concludes with the Gathering Worship.

Friday, September 27

Following breakfast and Morning Prayer, there will be a second Keynote Address, "Women and Justice in Times Such as These." Peter Nafzger offers the first of a two-part Bible Study.

Following lunch there will be opportunity for Judicatory Meetings, a guided walking tour of campus and free time. After dinner there will be the office of Evening Prayer and planned Fellowship Time.

Saturday, September 28

The day again begins with breakfast and Morning Prayer. The third Keynote Address, "Racism in Times Such as These," will be offered by Darryl Thompson Powell. Peter Nafzger concludes the Bible Study. After lunch transportation will be provided for an afternoon visit to The Illinois Holocaust Museum. A celebratory Banquet and Christus in Mundo award presentations fill the evening. The day concludes with a Service of Affirmation of Baptism.

Sunday, September 29

This Zion Conference concludes with breakfast and Morning Prayer.

The University of Saint Mary of the Lake, arguably one of the most beautiful campuses to host a Zion Conference, is the fulfillment of Cardinal George Mundelein's vision of a center for theological education in the Midwest. The University, first chartered in 1844, includes Mundelein Seminary, centers for clergy continuing education, diaconal and lay formation as well as a conference center.

The 600 acre campus includes St. Mary's Lake, extensive forests, walking trails, and an array of historically significant neo-Georgian red brick architecture. The University provides a lovely, peaceful, and hospitable setting for conferences and retreats. Located in the northern Chicago suburb of Mundelein near Interstate 94, it provides ready access to Chicago O'Hare Airport and Milwaukee Mitchell Field.

The Illinois Holocaust Museum began in the 1970's as a response to the threatened March by Neo-Nazis through Skokie, a community which included many Holocaust survivors among its residents. The Museum's mission is to "Remember the Past" and "Transform The Future." Its current building, designed by award-winning architect Stanley Tigerman, was dedicated in April 2009. Thanks to the generosity of an anonymous donor who is underwriting the event, Zion participants can spend Saturday afternoon at the Illinois Holocaust Museum.

Central to the Zion tradition, the **Christus in Mundo** award recognizes individuals who have made a significant, sustained contribution in the fields of chaplaincy, pastoral counseling, and/or clinical education within the Church and the World the Church serves. Awards will be presented to two ELCA candidates and two LCMS candidates at the Saturday evening Banquet. If you wish to make a nomination, please use the form enclosed with this mailing.

To register please fill out this page and mail it, with your check for \$250 payable to Zion XVII, to The Rev. David Killo, 10 Deerfield Road, Deerfield, IL 60015.

Name _____

Address _____

Phone _____ Alt. phone _____ email _____

Judicatory: LCMS _____ ELCA _____ Other (specify) _____ Ministry Site: _____

Will you join the field trip to the Illinois Holocaust Museum? Yes _____ No _____

Dietary restrictions (specify)? _____

Accessibility needs (specify)? _____