The current political debate regarding immigration is at the forefront of our country's public agenda. It has brought out some of the best and some of the worst in our citizens and in our public discourse. It is appropriate that we take a portion of our reflection today to examine the role of Catholic Health Care in this and other timely issues – to assess these issues through the focused lens of our faith and the mission of Catholic Health Care.

In the fifth chapter of Saint Mark's Gospel (Mark 5: 21-43), we find the account of Jesus' return from the district of Gerasenes after a dramatic, healing miracle. The welcoming crowd was exuberant. Jairus, the president of the local synagogue, approached Jesus seeking the Lord's intervention to heal his dying daughter. Jairus was obviously a prominent member of his community. The crowd was huge and closed in on Jesus as He walked with Jairus to his home.

A sick woman in the crowd reached out in the hope of touching the tassel of Jesus' cloak. She had suffered for 12 years from hemorrhaging. This affliction made her ritually unclean according to the norms of the Mosaic Law. In Jewish law she was marginalized and disregarded by the local community. Because of her condition, she was not even supposed to be mingling with other people. She was unclean, isolated, and unwelcome according to her status under the law.

The woman touched the hem of Jesus' garment and was immediately healed of her chronic sickness. She might have slipped back undetected into the crowd and gone on her way, anonymously cured. Jesus, however, did not let this miracle go unnoticed. The Lord turned and asked his disciples, "Who touched me?"

They were confused by his question. Peter said, "Master, the crowds are pressing in upon you." The implication of Peter's observation is obvious: dozens of people have come into contact with you, why this strange question? The disciples were too focused on Jairus' dying daughter to be sidetracked by Jesus' unanswerable query. However, the woman herself came forward admitting that it was she who had touched him and attesting to the healing that had occurred.

The story stresses the limits of mere physical contact with Jesus. On one level, we recognize that doctors who use physical strategies to effect physical cures had not been able to help the afflicted woman. In fact, they have made things worse, adding financial collapse to her physical malady. Mark mentions that she had spent all the money that she had without any relief. On a more important level, we recognize that the crowd's physical contact with Jesus – pressing in on Him - is constant. But just touching Jesus does not lead to experiencing Divine Love or Divine Life.

When Jesus asks "Who touched me?" he does not mean it in the sense of skin against skin or clothes against clothes, although His disciples take it in that sense. But this type of touching is not spiritually significant. The desperate woman touched Jesus

in a different way. She had a distinctive inner disposition, one that allowed her to receive the flow of divine power from Jesus. Her interior openness to Divine Love is what was necessary. And so it must be for us.

Love never thinks of people in terms of human importance or social status – documented or undocumented. A central commission of our faith is to "love one another as Jesus has loved us." This woman experienced the healing power of Divine Love and was restored to health and to solidarity with the community.

In our 2003 pastoral letter, *Strangers No Longer*, the Bishops of Mexico and the United States wrote: "Our common faith in Jesus Christ moves us to search for ways that favor a spirit of solidarity. It is a faith that transcends borders and bids us to overcome all forms of discrimination and violence so that we may build relationships that are just and loving."

How relevant this is when we consider the responsibilities of Catholic Health Care Administrators. Health care ministry, because it is ministry, must always be motivated by Christ's love and healing power. The Catholic health care institutions represented by you here today makes this so obvious. Most of the institutions that now characterize the Catholic Church in the United States - parishes, schools, hospitals and Catholic Charities – were created or greatly expanded because of our nation's immigration experience.

In an address earlier this month (October 8, 2007) at the University of Notre Dame Forum on Immigration, Cardinal Roger Mahony commented: "Immigration is one of the most important social issues facing our country today. It impacts not only a few States along the border or our big cities – it impacts virtually every community in our nation. … Some of you may ask why the Catholic Church would speak out on the issue of immigration. It is primarily because of the Gospel mandate, with strong roots in the Old Testament, in which Jesus instructs us to "welcome the stranger" for "what you do to the least of my brothers, you do to me" (Matthew 25: 31 – 46). In the face of the immigrant we see the face of Christ."

Cardinal Mahony referenced the fact that the Catholic Church in this country is itself an immigrant church that has always grown by the newcomers who have arrived on our shores. With a word play on the name of the well-known toy store, the Cardinal stated that we, US Catholics, could describe ourselves as "Immigrants R Us". For this reason pastors, educators, health care and social service providers are painfully aware of the plight of immigrants.

At this time in our political and social history, we are often confronted with strange and contradictory pressures. The debates over the status of immigrants, the continued assault against the unborn, the ever increasing technologies that present moral challenges to human dignity, and a frightening increase in the tolerance of

euthanasia, challenge our fidelity to the sacredness and dignity of human life as we exercise our ministry of caring and healing.

In these times, we must never, *never* lose sight of our fundamental commitment to the dignity of all human persons in their uniqueness as creatures, made in the Divine image and likeness. Catholic hospitals and health care facilities must be sanctuaries where all persons are valued for their innate dignity, loved and served without regard to these conflicting pressures.

In the homily of his inauguration Mass (April 24, 2005), Pope Benedict XVI noted: "We are not some casual and meaningless product of evolution. Each of us is the result of a thought of God. Each of us is willed, each of us is loved, each of us is necessary." Again in his first encyclical, *God Is Love*, the Holy Father firmly placed the Church's works for social justice and social service in the context of God's love for us and our duty to love in practical ways the poorest of our sisters and brothers.

The sponsorship of Catholic health care involves animating, promoting, and ensuring Jesus' healing ministry. This mission imperative challenges us to a dynamic leadership, publicly representing and sustaining an authentic fidelity to the Gospel values of life expressed and embodied in the teachings and traditions of the Roman Catholic Church.

As Catholic health care and Church leaders, we are expected to represent a higher social consciousness and responsibility. The sponsorship of Catholic health care institutions infuses in them the threefold ministry of the Church: to teach, to sanctify, and to serve God's people (Fr Morrisey, 2007).

In the business of health care, moral and business imperatives will confront us with alternatives, sometimes false alternatives. We must always choose the alternative with the higher moral and ethical standard of the Gospel. This must be our brand identity and brand differentiation. The well-known axiom, "*no margin, no mission,*" must never be the dictum for the choice of false alternatives that distract us from our ministry – preserving and caring for the health and well-being of all our brothers and sisters. Our panel of health care leaders who spoke earlier gave clear testimony that the ongoing challenge of margin versus mission is met with the proper balance and care in the delivery of Catholic health care here in Kentucky.

In a culture dominated by utilitarianism, relativism and materialism, there are a plethora of false alternatives offered in today's health care market. One of these false alternatives is the assessment of one's "*quality of life*." This false alternative is being offered as the pivotal criteria determining resource allocations and appropriateness in clinical care.

Our society is rich in many ways but our spiritual poverty is evident when we entertain choices between these false alternatives. Position statements are crafted to

be attractive by deliberately using non-offensive images. Reconstructive language speaks of "death with dignity" when referring to the deliberate killing of a human person. Suicide-murder is named "assisted death". Euthanasia is "administering mercy", and mercy killing is classified as "terminal care" (Wakefield, 2007). Too often, we are tempted to fall under the spell of human cognitive powers which have abandoned traditional principles based on revealed truths and the transcendent providence of God.

Sam Schulman, in an Op-Ed for the *Wall Street Journal* (January 5, 2007), warned of an emerging social strategy that wants us to be ashamed to profess our faith. Proponents of this strategy are described as methodological atheists, lamenting the effects of religion as a threat to their political and social agenda. The proponents of this strategy strive to persuade American Christians to give up their "*infantile*" attachment to God; to detach themselves from their faith in matters of public debate and common good. The greatest error is the belief that the individual is a sovereign moral agent sufficient unto herself or himself. The Catholic Church has never shied away from defending against these assaults on the truth.

A consequence of the skewed reasoning of methodological atheism is that the voice of Christian conscience becomes silent in the Public Square, placing the very dignity of the human person in jeopardy, making the human person the prey of the self-serving interests of the powerful.

Richard John Neuhaus (2007) has described politics as free persons deliberating the question: ***How ought we to order our life together***. Political vocabulary is inescapably a moral vocabulary – what is just or unjust, what is fair or unfair, and what serves the common good and what offends it.

If politics is the art of free people answering the question: *How ought we to order our life together*? Then the key to this question is: Who belongs to "we" – who is IN this community for which we accept responsibility? Political solutions that establish policies identifying some human persons as NOT warranting the protections associated with their innate and God-given dignity deserves our faith-based rejection! The Church and Catholic health institutional leaders by virtue of our positions and our faith convictions are desperately essential to infuse authentic human values and truths into political debate and public policy decisions.

Surveys tell us that 80 percent of the American population professes to be Christian. If this is true, then why does the public and political debate seem to be running counter to the moral and ethical principles of the Gospel? Are we swept up in a crowd without recognizing where we are or where we are going? The majority of US citizens might claim to be part of the crowd touching Jesus but that is clearly not enough. Are we touching him in a way that is open and receptive to His Divine Love and transforming power? It is time – it is past time - for us to touch Christ in a way that transforms us in order to be attentive to all those in the crowd – those who are

marginalized, without legal status, outcasts, especially in the area of health care policies and decisions.

According to the Ethical and Religious Directives for Catholic Health Care Services (4th Edition, 2001), "Catholic health care expresses the healing ministry of Christ in a specific way within the local church. Here the diocesan bishop exercises responsibilities that are rooted in his office as pastor, teacher, and priest." Catholic health care and its leaders participate in the threefold ministry of the Church: to teach, to sanctify, and to serve God's people (Fr Morrisey, 2007). We need to do everything we can to reinforce our unity of purpose under these shared responsibilities.

Catholic health care entities are entrusted with great responsibilities and leadership expectations in the health care industry and in the fora of advocacy and public policy formulation. Your ministry is fundamentally rooted in the Gospel and the commitment to promote and defend human life (USCCB ERD, 2001). Animating this responsibility requires vigilance in leadership and authentic stewardship (Wakefield, 2007). It also requires and deserves the active support and engaged involvement of Church leadership.

Your Catholic identity offers a purpose and a meaning that transcends business and public understandings. Together we need to develop shared dialogue, programs, and initiatives to promote a better understanding of Catholic health care's identity. This involves engaging our parishes and parishioners as participants in the Catholic health care ministries. The Catholic Conference of Kentucky is actively working to promote and expand the parish nurse ministries. Parish nurses help address issues of access, care management, and navigation through the complexities of our health care processes and procedures.

Communities of Women Religious and Catholic health care entities were in the vanguard in the 1970's debate regarding the rights of the unborn. It was their vision and leadership that formulated the public policy of honoring the sanctity of life from the moment of conception in our Catholic hospitals. That same visionary leadership is needed today in a plethora of public policies: the plight of the uninsured, the increasing tolerance of euthanasia, the access and costs of care for the immigrants, and many more. The Catholic health care industry can lend its marketing expertise and public relations acumen to disseminate the moral and ethical messages so vitally needed in our public debates. As pastors and teachers, we bishops need to develop and communicate messages that will help the faithful and all the public to understand the complexities of health care issues. Close and effective collaboration between the bishops and the leadership of Catholic health care is essential for the good of our people in the pews and the public we serve.

It is good for us to gather in this Summit. Here we share a day of reflection and insights, a time to reconnect and to understand and appreciate each other more fully.

But we need also to consider what could be done to better integrate our dialogue and actions? We need to honor and recognize the balances and the tensions between public policies, business governance, sponsorship, and our Catholic values and directives. CCK provides a venue for us to pursue our shared responsibility. What more might our Catholic Conference offer to assist us all?

In the name of all our Kentucky bishops I salute your ministry of healing and offer you my personal gratitude for your leadership, professionalism, vigilance, fidelity, and faithfulness to Jesus' ministry of healing and caring for the most vulnerable among us. May God strengthen and embolden your resolve to face the challenges of today's health care ministry with faith, courage and hope. May you live with that interior disposition that is necessary to receive Christ's healing power and love and to communicate those gifts to all whom you serve. Thank you.

Ronald W. Gainer
Bishop of Lexington