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Incarnate Grace:
*Perspectives on the Ministry
of Catholic Health Care*

EDITED BY FR. CHARLES BOUCHARD, OP, S.T.D.



INTRODUCTION: INCARNATING CARITAS

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IF YOU HAVE PICKED UP THIS BOOK, YOU MOST LIKELY serve as one of almost three-quarters of a million people working in Catholic health care in the U.S. It might be worth taking a moment to appreciate the scope of this shared endeavor. In January 2017, The Catholic Health Association paints a vibrant picture of this dynamic ministry:

- + 132 critical access hospitals
- + 258 trauma centers
- + 156 indigent care clinics
- + 527 hospitals providing palliative care
- + 355 hospitals with obstetrics services
- + 1,614 continuing care facilities,
85% of which are in urban areas, and 15% in rural areas
- + 523,040 full-time employees
- + 216,487 part-time employees.

With nearly 5 million admissions annually, these facilities care for approximately 1 in 6 patients nationwide every day, including over 1 million Medicaid discharges. Catholic hospitals host more than 100

million outpatient visits, 20 million emergency room visits, and bring 527,000 babies into the world annually.

Thus, as the nation's largest group of not-for-profit health care providers, the Catholic health ministry cares for people and communities across the United States, giving special attention to those who are poor, underserved and most vulnerable, transforming "hurt into hope."¹ And you are a part of that.

Yet, the landscape of what it means to identify as a religiously affiliated institution in the 21st century is in flux. There are a number of recent legal cases that signal troubling shifts in attitudes toward the role of faith-based organizations. These include the well-known Hobby Lobby case, regarding exemption from regulations on contraception by a closely held corporation;² *Zubik v. Burwell*, brought by a number of organizations, also about the contraceptive mandate;³ and finally, a series of class-action suits filed against Catholic and other faith-based health systems regarding long-standing religious exemptions from ERISA regulations for "church plans."⁴ In addition to these cases, Catholic health care is under constant surveillance by groups such as the American Civil Liberties Union and MergerWatch who worry that religious exemptions infringe on civil rights or the quality of health care itself.⁵

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- 1 Catholic Health Association, "U.S. Catholic Health Care — 2017." Accessed at: https://www.chausa.org/docs/default-source/default-document-library/cha_2017_miniprofile.pdf?sfvrsn=0
 - 2 *Burwell vs. Hobby Lobby Stores, Inc.*: Accessed at: https://www.supremecourt.gov/opinions/13pdf/13-354_olp1.pdf.
 - 3 Timothy Jost, "Zubik v. Burwell Briefs Explore Potential Compromise (Update)," *Health Affairs Blog* (April 13, 2016). Accessed at: <http://healthaffairs.org/blog/2016/04/13/zubik-v-burwell-briefs-explore-potential-compromise/>.
 - 4 Julie Minda, "Dozens of Faith-Based Providers Targeted in Pension Law Suits," *Catholic Health World*, October 1, 2016. Accessed at: <https://www.chausa.org/publications/catholic-health-world/article/october-1-2016/dozens-of-faith-based-providers-targeted-in-pension-lawsuits> and Emma Green, "The Supreme Court Case that Could Bankrupt Religious Schools and Hospitals," *The Atlantic* (December 12, 2016). Accessed at: <https://www.theatlantic.com/politics/archive/2016/12/advocate-health-care-erisa/510218/>. This case was decided in favor of religiously affiliated hospitals by a Supreme Court ruling on June 5, 2015. See *Advocate Health Care Network v. Stapleton*, U.S., Nos. 16 – 74; 16 – 86; 16 – 258, 6/5/17.
 - 5 American Civil Liberties Union, "Health Care Denied." Accessed at: <https://www.aclu.org/feature/health-care-denied>. See response from Catholic Health Association: <https://www.chausa.org/newsroom/news-releases/2016/05/09/catholic-health-association-responds-to-aclu-merger-watch-report>.

These developments reflect what Richard Gaillardetz identifies in his chapter in this volume as “the contemporary anti-institutionalist impulse,” “a sweeping cultural distrust of public institutions” rooted in an increasingly atomized individualism (252). They also reflect increased animosities toward the public practice of religious identity. On one side, there appears to be a campaign to eliminate the *practice* of religious identity in any venue that interfaces with government, professional, or public spheres. On the other side, strident claims about the violation of religious liberty are made by those committed to practicing religious identity in aggressively visible ways but who reduce religious identity to what amounts to a few issues almost exclusively related to sexuality and reproduction while for all appearances ignoring broad swaths of Christian religious convictions and commitments. Ironically, driving these conflicts is a shared commitment to the severing of any relationship between religion and government. Both sides seek a purity — whether purely secularist or purely religious — that requires faith to be completely siloed or privatized. Both sides create difficulties for those with more traditional understandings of the collaboration for the common good and who seek to advance the vision of the Second Vatican Council of the church *in* the world.

Yet questions of public policy are only one side of the coin. These developments also raise familiar questions for Catholic organizations: What does it mean for us to be a *Catholic* health care institution? What does it mean to be a part of the *ministry* of Catholic health care? What are the differences between a secular, non-profit health system and a Catholic health system? As these cases and the public posture of many religious leaders suggest, is religious identity simply about a few discrete practices that we *do not* do (e.g., contraception, abortion, physician-assisted suicide, and certain reproductive technologies)? Or does our Catholic identity bring anything distinctive to *how* we approach end-of-life care, population health, emergency health services, and behavioral health — perhaps even the entire way we think about promoting health and caring for the sick?

Incarnate Grace: Perspectives on the Ministry of Catholic Health Care, clearly argues the latter. What is more, it pushes the conversation deeper. It seeks to plumb not only what *actions* make (or should make) Catholic

health care distinctive; it seeks to lift up what drives, empowers, and gives shape to those actions, to help us to understand the *why* as well as the *what*. It suggests, following the heart of the Christian tradition, that *action* is rooted in *identity*, that *what we do* should flow from *who we are*. Only once we understand who we are — individually and corporately — can we authentically discern how to respond to the evolving landscape in which we work and whether we are living our identity consistently across all our actions.

As such, it continues the work begun in *Caritas in Communion: Theological Foundations of Catholic Health Care*.⁶ *Caritas in Communion* (hereafter CIC) drew deeply from the lived wisdom of those who work in Catholic health care to sound out key theological convictions that shape, sustain, and motivate the ministry. It is humbling and a great honor to find such an esteemed group of Catholic theologians expanding on the components of the vision outlined there, bringing additional dimensions of the tradition into the conversation, and raising as-yet-unanswered questions.

In doing so, *Incarnate Grace* provides three important resources for people who work in Catholic health care — whether they are Catholic or not — as they embark on the journey of exploring Catholic identity. First, it provides new *resources for deeper reflection* on the theological convictions named in *Caritas in Communion*. Christology, sacramentality, church, sponsorship and more are each fleshed out here in chapter length. These chapters are but introductions to deep wells of theological scholarship, but they bring each topic to life in accessible ways, drawing connections between these theological convictions and the day-to-day realities of Catholic health care. Hopefully, they will pique your interest and draw you to delve further into the topics discussed here.

Second, as I suggested in CIC and as Robin Ryan notes explicitly in his chapter, we all work with *implicit theologies*. We all have implicit understandings of what we mean when we hear the terms Jesus, church, ministry, suffering, God, and more. CIC and *Incarnate Grace* provide

6 M. Therese Lysaught, *Caritas in Communion: Theological Foundations of Catholic Health Care*. Catholic Health Association, 2014. Available at: <https://www.chausa.org/store/products/product?id=2828>.

companions for those in Catholic health who ask themselves: What is my implicit theology? Where does it come from? How does it play out in my day-to-day life, especially in ways that I have not heretofore recognized? What are its limitations and how might I enhance it through greater reflection and shared conversation with my colleagues?

Finally, from the *Ethical and Religious Directives for Catholic Health Care Services* to the mission statements of most health systems, we know that those who work in Catholic health care continue to advance Jesus' healing ministry. A repeated theme echoes throughout *Incarnate Grace*: that the heart of Catholic identity is, in Sean Martin's phrase, "*the imitation of the divine*." To incarnate grace is to embody in our actions the work of God in the world.

This is no small task. But if undertaken by three-quarters of a million people — that alone would change health care in the U.S.! As a starting point for reflecting on this mission, allow me to outline the ways in which *Incarnate Grace* elaborates on the introduction to the theological foundations of Catholic health care identified in *Caritas in Communion*. I also hope to identify ways in which it expands that vision to incorporate additional theological convictions, and close with further questions elicited by this study and the ongoing ministry of Catholic health care. Along the way, a refrain will be: What is your implicit theology? How are we called to imitate the divine as individuals and, more strangely, as health care *institutions*?

ELABORATING CARITAS IN COMMUNION

CIC was the outcome of a year-long collaborative listening session designed to hear the theology at the heart of the Catholic health care ministry. At the heart of this foundation, it noted, is *caritas*, God's essential nature as love and grace. God's *caritas* is manifest in, with and through Jesus and the Holy Spirit — the Trinitarian communion. From this communion emerges a sacramental *caritas*-shaped church, a communion from which baptized Christians bring *caritas* into the world through institutional ministry and witness to the faith. To reprise:

At the outermost level — the level of visible behaviors — we find the stories of the founders of Catholic health care and the principles of Catholic social thought. These are the tangible manifestations — the mountain ranges, if you will — of the topography of Catholic identity. Immediately undergirding these are the theological concepts of ministry and evangelization, the grounding for both Catholic social thought and the work of religious communities. Undergirding ministry and evangelization, we find the fundamental doctrines of sacramentality and ecclesiology, both of which are necessarily rooted in Christology — the person and work of Christ. And at the center of it all, at the heart of Catholic identity in Catholic health care, is charity or *caritas* — the fundamental theological reality: that God is love, that God so loved the world. . . . God’s essence — revealed in the Trinity, in every action of God toward humanity and the world — is *caritas* in communion. (CIC 45)

In painting the overview of this framework, CIC offered brief snapshots of key theological convictions, noting that they are dynamically interrelated. Each component mutually shapes our understanding of the others. *Incarnate Grace* delves more deeply into many of these components, illuminating these interconnections, and addressing a number of the “questions for further exploration” named in CIC. Specifically, *Incarnate Grace* deepens the conversation on God, Jesus, ministry, church, sacramentality, and sponsorship.

God

Neil Ormerod elaborates on God’s Trinitarian nature, building on the notion of *caritas* or grace-experienced-as-love-and-gift as the starting point for the Christian life. Through a Trinitarian spirituality of the theological virtues — love (charity, *caritas*), faith, and hope — he fleshes out the interrelationships among the Persons of the Trinity, Father, Son and Spirit. In so doing, he suggests practical ways in which understanding God as Trinity shapes the work of Catholic health care. It calls us to *see* God’s grace as potentially present at each and every moment of our journey with patients and families, no matter how dark or difficult those moments might

be. It calls us to *say* “Yes” to this gift of God’s *caritas* when we encounter it. And it calls us to *embody* or imitate God’s *caritas* and a countercultural hope in our encounters with others. Each reader should stop and reflect: “how does this understanding of God articulated in CIC and *Incarnate Grace* interface with my own implicit understanding of who God is?”

Jesus

The Second Person of this Trinitarian God is the Son, God Incarnate as Jesus Christ. CIC noted that Catholic health care explicitly draws its identity from Christology, seeing its reason-for-being as continuing the healing ministry of Jesus represented in the Gospels. CIC made clear that Catholic health care needs to articulate a more balanced Christology, one that understands Jesus both “from below” — the work of the fully human Jesus depicted in the Gospels — but also “from above” — attending to Jesus’ divine nature (CIC 25). Ormerod provides a more in-depth account of Christology from above.

Conor Kelly’s study complements Ormerod’s by enriching the traditional understanding of Christology from below. Gesturing toward the social, political and economic dimensions of Jesus’ context, he shifts standard understandings of Jesus as healer — one who physically touched those considered religious and social outcasts and one who attended primarily to those who were poor — into language drawn from liberation theology. Liberation theology helps us to understand more clearly the *how* of Jesus’ healing — that this work was rooted first in the practice of *accompaniment* that reflects the deeper theological reality of God’s solidarity with us, especially in our suffering and brokenness, incarnated in Jesus. As such, Christology provides a non-negotiable model for the practice of Catholic health care that we are called to imitate and embody.

Ministry and Church

CIC drew on important work done by Fr. Charles Bouchard and Zeni Fox to begin to clarify the question: What does it mean to refer to Catholic health care as a ministry? In *Incarnate Grace*, we hear directly from

Bouchard and Fox, as they reprise that material and take it to the next step. Bouchard takes up a question posed in CIC: In what sense can *institutions* be considered as ministries? This is not just a hypothetical question — it is at the heart of the legal cases outlined earlier. But as Bouchard makes clear, the answer is still evolving, complicated by ecclesiastical reservations about lay ministry and pragmatic aspects of Catholic health care, from financing to collaborative endeavors.

Fox looks at this issue from the angle of history. She highlights the stories of St. Vincent’s Hospital in New York City and St. Michael’s Hospital in Newark, New Jersey. Her history demonstrates what the richness of an ecclesial, institutional ministry looked like in an earlier era — a ministry that comprised a rich collaboration of religious, lay persons, and non-Catholic collaborators. These stories, read through the lens of the Second Vatican Council, provide a framework for self-reflection for both bishops and leaders of health systems to enrich their own vision of Catholic health care as a ministry.

Fox’s inductive description of the church-in-action is nicely complemented by Richard Gaillardetz’s nuanced discussion of what comprises an institution or organization and the complex attitudes toward institutions in the U.S. context, even among Catholics. He challenges those in leadership to ask themselves: What do we visualize when we hear the word institution or organization? What are the “interlocking systems” that structure our organizations? Which systems are invisible to us? Where do they come from? Who do they benefit and who do they exclude or oppress? What fundamental visions or narratives do they embody?

Sacramentality

Catholic institutions ought to differ from other institutions in a key way. Using a historical narrative similar to Fox’s, but focusing on the Sisters of Charity of the Incarnate Word, David Gentry-Akin shows how the work of these sisters is sacramental. According to Gaillardetz, sacramentality is the foundational “interlocking system” for Catholic institutions. The church itself, he notes, is understood to be a sacrament, the ongoing embodiment in the world of the Body, presence and work of Jesus Christ. Catholic health

care, as a ministry of the church, shares in that sacramental identity. As I noted in CIC:

Daily, the sacraments renew the church. They ground the ministerial vocations of the faithful, seeking to transform us into the likeness of Christ so we can bear that likeness into the world. Both Catholic persons and Catholic institutions — specifically Catholic health care — have a vocation to embody this incarnational and participatory sacramentality. Catholics hold that the sacraments truly make Christ present. Therefore, Catholic persons and institutions are called to incarnate, embody, truly make Christ present in the world, enabled by the grace that comes through their participation in the sacramental life of the church. (CIC 40)

Incarnate Grace immerses readers in this dimension of Catholic health care in three essays. The chapters by Catherine Vincie, Darren Henson, and Jim Schellman, together with Gaillardetz, elaborate the recursive relationship between Eucharist, Viaticum, liturgy, and the church's sacramental nature. These chapters outline the theoretical and theological vision behind the understandings of ministry discussed by Fox and Bouchard. And they make clear why Christology (our understanding of who Jesus is) matters. For in the transformative power of the liturgy we meet the foundation of the claim that our work is to imitate the divine.

Sponsorship

This responsibility is personal and corporate, exercised in communion as church. What are some of the parameters of this communion? *Incarnate Grace* provides a helpful primer on the complicated and evolving canonical notion of sponsorship. Starting from the Second Vatican Council's re-grounding of lay ministry in Baptism, Barbara Anne Cusack, Fr. Francis Morrisey and Sr. Sharon Holland complement the chapters by Bouchard, Fox, and Gaillardetz, tracing the ministry of the laity from its individual starting point through public (or ministerial) juridic persons, in communion with diocesan bishops. They also distill for readers the essential components of canon law for Catholic health care.

EXPANDING THE THEOLOGICAL VISION

In these ways, *Incarnate Grace* elaborates on the theological foundations of Catholic *identity* outlined in *Caritas in Communion*. But it goes beyond that framework, introducing additional theological topics relevant to the *work* of Catholic health care — Scripture, the human person, suffering, and death.

Scripture

One of these is the foundational role of Scripture which infuses the day-to-day work of Catholic health care — a reflection on a lectionary reading opening a meeting, a psalm being read by a chaplain at a patient’s bedside, a scripture passage artistically gracing a visitor waiting room. What is more, historically, Catholic health care has been catalyzed and shaped by the Scriptures, either in the way it formed the sisters and other religious who cared for the sick via their daily prayer of the Liturgy of the Hours or by the way the Gospel witness of Jesus’ life and ministry informed their mission.

Although prayerful engagement with scripture is necessary, Fr. Sean Martin reminds us that more is required, that “the hard work of exegesis is...essential to the task of constructing a theology of health care.” He demonstrates how exegesis — going deeper into the texts using the tools of scripture scholars — illuminates deeper meanings of foundational narratives of healing from the Hebrew Scriptures and the New Testament. He lifts up key scriptural themes from across the entire corpus that should help shape our understanding what it means to imitate the divine in Catholic health care. His addendum on “Varieties of Biblical Interpretation” is a helpful aid for a more critical and constructive engagement with the Word of God. It will help both Catholic and non-Catholic leaders understand how their approaches to Scripture differ and complement one another.

The Human Person

Incarnate Grace also extends the CIC framework with a rich theological reflection on the human person. The triad of essays by Daniel Daly, Fr. Robin Ryan, and Fr. Thomas O'Meara introduces the topic of *theological anthropology* which is jargon for “the understanding of the human person.” Daly shows how our understanding of the human person is informed by our prior understandings of who God is, who Jesus is, and what the church is. Consequently, a Catholic or Christian understanding of the human person differs in important ways from the anthropology that shapes much of U.S. culture, particularly around issues in medicine. Those who serve on ethics committees should reflect on the extent to which their thinking is shaped by these culturally dominant anthropologies and how a theological understanding of the human person might change how we think about clinical ethics. It might change how clinical staff think about and deliver patient care, e.g., am I treating a body or a person? For senior leaders, it might change how we think about our various “markets”: Are they only customers, a payer mix or a revenue source, or human persons in need? Daly also demonstrates how Christian thinking about the human person evolves over time, as the work and life of Christians in the world encounters new ideas, philosophies and cultures, bringing these into conversation with central theological convictions. Yet in the end, we find that at the heart of our understanding of the human person is *caritas*. Made in the image and likeness of God, we are called to honor that in others and to embody it ourselves.

Suffering

A central challenge to the whole theological edifice, though, is the pain, loss and suffering that bring people into our health care facilities. How can this God of *caritas* and solidarity also be the God of so much tragedy, diminishment and death? In these situations, Fr. Robin Ryan asks how we should speak about God in light of suffering and evil. He notes that we all carry around implicit theologies of suffering — some helpful, some unhelpful, some inconsistent or muddled. A key task for those of us who work in health care is to reflect on our own implicit theologies, to make

them explicit, to understand where they come from and how they are informed by other theological commitments. Ryan opens a conversation about that process — a process which is not easy and cannot be completed in a single session but rather must extend over time. The scriptural witness points to a God of compassion who accompanies us in our suffering. As such, we find a model for those who work in Catholic health care — a response of compassionate accompaniment.

Death

The companion of much of the pain, illness, and suffering encountered in Catholic health care is death. But while it is a constant in our work, it often becomes a reality which-shall-not-be-named in our culture, parish congregations and even our hospitals. Fr. Thomas O'Meara provides an *eschatological* perspective as a way to help us explore our implicit theologies of death and the afterlife. Such reflection is crucial for those who work in Catholic health care because too often our care for the patient ends abruptly the moment life ceases. All our patients will die — not necessarily while immediately in our care, but they will. As will we. We accompany many who suffer into the mystery that lies beyond the moment of death. What then? What happens to the human person? What happens to the care provider? How do we carry out our task of compassionate accompaniment in light of the ultimate reality of eternal life?

ELICITING FURTHER QUESTIONS

Incarnate Grace also elicits several questions for further exploration around spiritual formation, evolving ecclesiology, and Catholic social thought.

Spiritual Formation

How does Catholic health care as church attend to the spiritual formation of all of its associates, both Catholic and non-Catholic? As noted in CIC, “The Christian life is understood as a pilgrimage, a journey in which we grow in virtue and holiness. Such growth necessarily emerges in response to particular persons and situations” (CIC 21). How does Catholic health care nurture growth in holiness?

The sisters and brothers who founded and grew Catholic health care were not, for the most part, trained theologians. They were activists and practitioners. They did not necessarily bring to Catholic health care a robust, explicit and carefully detailed understanding of the theological foundations of the work as articulated above. But they did bring a deep immersion in ongoing practices of spiritual formation, practices in which they continued to engage while they worked in Catholic health care. Practices such as daily prayer, regular worship (perhaps even daily), retreats and spiritual direction informed their day-to-day lives and work. They sought to live the Gospel, to care for the poorest and most marginalized, to witness to the work of Jesus and the church in the world.

The workforce and leadership in Catholic health care have shifted from those in religious life to lay persons — both Catholic and non-Catholic. They often come to the work of Catholic health care with much passion but with little experience of spiritual formation. As Celeste Mueller notes in her chapter, this has given rise to a variety of approaches to ministry leadership formation over the past 20 years. She provides a helpful overview from her experience with one such program, demonstrating how it incorporates many of the topics detailed in *Incarnate Grace* — how “theology” becomes practical. How do we extend formation beyond the limited number of persons in formal programs? How do we blend spiritual formation with effective business leadership? How do we share our theological tradition and our spirituality with associates who do not share our religious beliefs?

A key question to ask within our systems is this: In what ways do Catholic hospitals and systems encourage, nurture and reward the *daily, ongoing, spiritual* formation of its members *as part of the work of health care*? Is this something recommended for associates but on their own time? What would it look like to encourage, nurture and incentivize associates to attend to their own spiritual formation *on work time* — given that it’s not something that is directly reimbursable? I am confident that that question gives many readers of this book pause. Does it reveal the ways we prioritize finances over faith or the ways in which we share a discomfort with the public practice of faith beyond carefully circumscribed houses of worship? Surely our founders did not see it that way.

Evolving Ecclesiology

It has often been said that praxis precedes theory or, in our case, theology. Historically, the lived realities and experience of the faithful (what some refer to as “first order practice”) provide the material upon which theologians reflect. Theology, therefore, is a “second order” activity, reflectively bringing the resources of the tradition to bear on practice of the church in the world, providing insight and guidance to that practice but also gleaned new insights about God and theological realities based on the activity of God among God’s people. Practice, then, is the leading edge. It might be true, as Bouchard notes, that “practice and language [have] gotten ahead of theology” (201).

My work in and study of Catholic health care suggests that Catholic health care is — or could be — leading the development of new insights into ecclesiology. Those in the ministry of Catholic health care, catalyzed by the Second Vatican Council, have boldly lived the reality of this mission, identifying problems in our practice of the faith and creating new ecclesiological questions, many of which have yet to be answered.

For example, if we understand Catholic health care as part of a communion as church, we are led to ask: How do our health care institutions interface with other components of the church, particularly parishes? When we speak of “the church,” do we mean only the bishops? There seems to be little substantive structural interaction between hospitals and parishes, save sacramental or pastoral visits by priests or a few commissioned parishioners who bring communion to the sick. This has not always been the case, as Zeni Fox makes clear in her history.

As we move toward population health models, strengthening the relationships between hospitals and parishes seems a natural move. It is here that many of our associates receive their spiritual formation and sustenance. Equally, parishes and local congregations include many who will find their ways into our emergency rooms, outpatient clinics, physician’s offices, and in-patient beds. As such, parishes can and should serve as key partners for education around ethical issues that plague so many hospitals,

especially end-of-life care. And, as systems begin to re-envisage community transformation in ways informed by findings on the social determinants of health, parishes will again be necessary partners in implementing structural social changes designed to promote the wellness and flourishing of all in our communities.

The realities of Catholic health care institutions themselves raises new ecclesiological questions. Unlike parishes and even many other Catholic ministries, health care institutions are religiously pluralistic — in staff, in leadership, in clientele. Many who work in Catholic health care are not baptized, though they may be deeply committed to the mission. Many within health care do understand their work as a ministry, yet they have no official ecclesial standing (CIC 33). Or, as Gaillardetz asks, “How can Catholic health care institutions participate in the sacramentality of the church when they are both led and staffed by many who are themselves not Catholic?” (264). How do we think theologically about non-Catholic — and perhaps, non-baptized — members of sponsor boards, as also discussed in this volume by Bouchard and Cusack, Morrissey and Holland? Such practices raise for the church new and important questions that might push us to come to see new dimensions of the church and to expand our theological understanding of what it means to be involved in this ministry.

Catholic Social Thought

Catholic health care is deeply committed to the principles of Catholic social thought and has been a major force in helping the church articulate the principles and put them into practice. Threads of this run through the essays in *Incarnate Grace*, and Conor Kelly helpfully brings into the conversation insights from liberation theology.

Important questions remain, however, about how thoroughly Catholic health care is willing to recognize the powerful economic critique voiced in liberation theology. Jesus did not simply accompany the poor; reading the Gospels in the light of liberation theology would also recognize the political and economic context of Jesus’ healing practices and reveal the Gospels’ critique of these structures. If we read the Gospels through 21st century

eyes, we can miss important subtleties that would have been obvious to the original readers. Exegesis is crucially important for unleashing the powerful critique that permeates the Judeo-Christian Scriptures. Scripture scholar Ched Meyers offers such a reading in his book *Binding the Strong Man: A Political Reading of Mark's Story of Jesus* (Orbis, 2008). Meyers makes clear that much of the illness experienced by those in Mark's Gospel results from what we could call today the social determinants of health or what liberation theologians and St. John Paul II would call the structures of sin.

Accompanying patients — especially the poor and marginalized — is an important embodiment of the Gospel and Catholic social thought. But liberation theology also presses us to ask: In what ways does the contemporary infrastructure of Catholic health care participate in the structures of sin, the structures of oppression, and invisible structures of violence? Are there ways in which business ventures and market models — with economies of scale, efficiencies, outsourcing, financing and more — are informed more by economic theories that exacerbate racism and income inequality than by the Gospel? What would it look like for Catholic health care to drink deeply from the well of liberation theology? Is Catholic social teaching practiced equally in our system offices as well as in our community clinics?

GO FORTH TO LOVE AND SERVE THE LORD

I hope this roadmap highlights connections between the chapters that follow and gives you a sense of the dynamic and progressive interplay between theology, Catholic health care and the life of the church. I hope it launches you on a powerful and grace-filled journey of personal and communal reflection and conversation in which you wrestle with yourselves and colleagues about your understandings of who God is, what it means to be engaged in the 2,000-year-long healing ministry of Jesus, and to witness to the presence of God in our world of brokenness and hope. Whether that witness calls you to be a prophetic voice in the public sphere, a sacramental presence at the bedside, or a liberating companion for the poor, our solidarity is empowered by the God who is in solidarity with us and who we are called to imitate as we sojourn in communion as church in the 21st century.