

A Church That Heals Sign of Hope for Appalachia and Beyond

Most Rev. Michael J. Bransfield delivered this talk at Villanova University, Philadelphia, PA on March 26 for a 2008 conference on Catholic Social Teaching and Access to Health Care in the United States. It will be published in a forthcoming issue of the Journal of Catholic Social Thought.

The Crises of Health and Leadership

Every year, Lake Superior State University has issued a list of overused words. The word “crisis” has never made that list even though it occurs 97 million times in a Google search. This is twice as much as one of the overused terms selected this year, --- “surge” and even more than another term selected, --- “perfect storm.” Last year’s winner, “truthiness,” is merely a blip on the screen when compared with the occurrences of crisis. Despite being overlooked, the word crisis has not gone out of style. It means even more since the terrorist attacks of September 11, 2001 and the inundation of New Orleans and the Gulf Coast by Hurricanes Katrina and Rita.

The word crisis has always had companions; none as frequent as health. Crisis appears with “health” and “health care” about one out of nine times. They are not new acquaintances. President Truman in his 1948 State of the Union address spoke of “the lack of adequate provision for the Nation's health” as “the greatest gap in our social security structure.” Sixty years later, many of our candidates for president acknowledge a continuing problem, if not crisis, in health care for Americans.

There seems to be a long standing consensus that health care is in crisis. The unaffordable costs of health care and a lack of financial access to it convey threat and uncertainty—two elements of crisis—for millions of Americans. Those Americans who become seriously ill, without the means to access health care, meet the third element of crisis—urgency.

This acute crisis has broader, social implications. Currently, Americans pay far more for their health care than citizens of other nations but have a lower standard of health as measured by infant mortality, life expectancy, and incidence of chronic disease. While Americans have perhaps the world’s best hospital-based medical care in the world, they have income-tiered access to it; higher costs of care with lower results; and too little

attention to the behaviors that contribute to chronic illness and the need for hospital care. This triumvirate—threat, uncertainty, and urgency—marks our crisis in health care.

There is another, underlying crisis, however, a creeping and less visible crisis; the illness beneath the symptoms. Social scientists distinguish an acute crisis from a creeping one.¹ The acute crises of a bridge collapse or collapse of a sector of the home financing market grab our immediate attention. They appear in plain view with a clear urgency. Creeping crises, such as the deterioration of public infrastructure or a growing volume of unsecured home loans of great risk, occur out of public view. Their threat and urgency are denied or contested until they become certain—acute. In my remarks, I will talk mainly about the less obvious *creeping* crisis of health—as distinct from the more obvious *acute* crisis of health care.

“Crisis” has another companion, “leadership.” Although we associate leadership with acute crisis, the less certain and clear crises present the more daunting leadership challenge. It makes urgent a threat that many do not see; others deny; and still others contest. This leadership expresses the prophetic voice of the Church—its role to explain the signs of the times in terms of universal principles of God’s love and human interdependence. That prophetic role requires speaking truth to power and the courage to speak with the certainty of faith when others waver. Without its prophetic voice about the hidden crisis of health, a Church that heals falls short of its leadership role.

Of course, we must remain a voice crying out for justice regarding the acute crisis of health care, as well. The U.S. Bishops speak of justice annually in its call for political responsibility of faithful citizenship. In this context, they invariably include health care as a moral imperative.²

As good and as important as this advocacy is, however, I speak to you today about seeing another moral imperative. Like prophecy, the leadership of a creeping crisis brings our attention to the underlying causes of acute problems. Like a good physician, the leadership of a creeping crisis finds the unseen cause of the symptoms that we do see. This is the more difficult leadership task that I want to share with you this morning. It is

¹ Arjen Boin, Paul’t Hart, Eric Stern, and Bengt Sundelius, *The Politics of Crisis Management: Public Leadership under Pressure*. New York: Cambridge University Press, 2005, p. 16.

² For the most recent statement on health care as justice see United States Conference of Catholic Bishops, *Forming Consciences for Faithful Citizenship: A Call to Political Responsibility from the Catholic Bishops of the United States*. <http://www.faithfulcitizenship.org/>

the calling of a Church that heals. We must not only minister to the wounded, as the Good Samaritan did, but we must make the road to Jericho safer for all of its travelers.

Our perspectives will also need to shift to see this other moral imperative. They will have to see an expanded vision of health; reaffirm the inherent dignity of each person; and explain the interdependence we have if we are to understand and address the interrelated problems of health.

The Leadership of a Church that Heals

Those of you familiar with my 2006 pastoral, *A Church that Heals*, will recognize the elements of this shift of perception. They are among the leadership principles that the pastoral espouses for a Church that heals. I will touch on three of them today.

- Expanded vision of health;
- Respect for the human person; and
- Interdependence

Let us begin by considering an expanded vision of health. A Church that heals will need to continue to address these issues of health care services and the attendant ailments of access, cost, and quality. It must also raise our sights, however. Healing requires more than treatment of disease and illness. A Church that heals works toward the integration of mind, body and spirit as well as the treatment of illness and disease. We must be witnesses of healthy living and wholeness.

The health care system is only one part of healthy living and wholeness. Robert Putnam's study of social capital offered statistical evidence that social connectedness has as many health consequences as cigarette smoking. He judged social connectedness to be "one of the nation's most serious public health challenges."³ Some public health professionals go even further and tie social justice and health together. In a just community, these public health officials assert, the inherent value of human life makes full and equal protection of all persons against preventable disease and disability a human right.

³ Robert D. Putnam. *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon & Schuster, 2000, p. 327.

We have many vantage points from which to see this broader vision of health. Thirty years ago, the World Health Organization expounded its definition of health—all the factors which promote well being. At their first international conference in 1976, their charter document identified peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity as prerequisites for health. The health care sector was only one component of promoting health. The broader social, political, economic, and physical environment were others. All were necessary for the public policies, supportive social and ecological environments, community action, and personal skills required to promote health.

By this time, some of you may be thinking this is pie-in-the-sky rhetoric. Our heads are not in the clouds however. This expanded vision of health matches the views of people whose feet are very much on the ground. As part of the pastoral, my staff held conversations and focus groups on health and well-being with more than 400 men and women, clergy and laity, young and old and people of all races, income levels, educational background and work experiences in all parts of the state. Their views are shaped by their lived experience not the statements of academics, professionals, or moral theologians. We learned the problems that ordinary people see; the visions that they nurture, and the vessel of hope that the Church provides for those visions.

From our conversations, we gained a vision of the impact of the natural, social, and cultural environments on health. Take roads for example. In the mountainous coalfield region of southern West Virginia, focus group participants recounted the challenges to reaching what might be the only healthcare facility in the county. Winding, narrow, and treacherous roads are themselves health risks and require much more time than the flight of a crow. Even before taking to the road, however, they must first try to arrange reliable transportation from family, friends, or social service agencies. Conditions requiring a specialist's care require even more travel, sometimes hours to the major population centers Wheeling, Charleston, or Morgantown. Compounding these stresses are worries about whether health insurance – if they even have it – or Medicaid or other free programs, will cover the costs of treatment.

We learned from the people with whom we spoke how people place the problem of health and health care against a backdrop of personal responsibility for ourselves and for others. We heard disturbing stories of rampant drug abuse and addiction. People with legitimate need for pain-killing drugs, such as OxyContin, are fearful that they and their families will be targets for violence from those seeking to meet their addictive needs. Meanwhile dealers of pilfered or locally made drugs are profiting and setting a frightening example to young people wishing to escape poverty.

We heard also of the continuing stigma of some health problems, such as mental illness and physical disabilities, and the continuing consequence of race, gender, and ethnicity on access to health care. We also could see how individual attitudes of hopelessness, alienation, and loneliness are among those consequences. Shortly after arriving in West Virginia, I visited a diocesan clinic in southern Wyoming County. I met a five-year-old boy whose face spoke of pain and fear; and his parents whose demeanor and words told of the sacrifice required to get him to the clinic and their anxiety about their ability to shoulder the responsibility and cost of navigating the daunting health care system. I felt immensely grateful that the Church was there to partner with those parents on behalf of that child.

We found an expanded vision of health in our people's hope in health education and for social connectedness. They explained to us that empowerment at the local level, collaboration with other advocates and service providers and intergenerational connections are means of strengthening health, in the broadest sense, in our communities.

A Church that heals is called to advocacy on behalf of the poor and to support the poor as advocates for themselves. This is advocacy for health as all the factors which promote well-being as well as deterring disease and illness as the examples above make clear. It is the prophetic role of the Church to interpret these stories as social injustices and to call forth community responses in light of the Gospel.

Now, let us turn to the second leadership principle, respect for the whole human person. We are compelled to this broader vision of health because of what Christ taught us to see. Jesus of Nazareth teaches that all the law and prophets are caught up in the two commandments of love: love of God and love of neighbor. Compassion and love of neighbor are central principles of a Church that heals. Jesus makes clear, innumerable

times that we cannot love a God we do not see unless we love the people we do. Our compassion comes from our respect for the human dignity of each person and our awareness that the Spirit resides in each of us. This presence determines the dignity of a human person and not what they have or can do. As with so many paradoxes of our faith, our own dignity in the eyes of God relates directly to our awareness of the Spirit's presence in others.

Compassion requires the transformation of many unjust social arrangements and attention to their symptomatic consequences. Again, Good Samaritans show compassion to victims. However, we must also work to prevent similar harm that might befall our other brothers and sisters on the road. Compassion must be accompanied by a demand to end the injustices that make some people victims. This prevents us from the smug satisfaction of being compassionate towards those poorly served by our social arrangements without recognizing their violent assault on the dignity of those whom they serve too poorly.

The labor history of West Virginia tells the sad story of what happens when we lose respect for the human person. As long as health care remains part of the social capital overhead of economic activity, the health needs of people are measured by their value to work. When that economic activity falters and the demand for workers declines, so will the health care, and other forms of social capital overhead, invested in them. We can see this presently in West Virginia in the post- industrial and cybernetic revolutions. As the people of West Virginia become less needed as workers, its people become more vulnerable to poor health, including lack of access to health care. West Virginia's incidence of high blood pressure, arthritis, and total tooth loss by age 65 are the highest in the nation. We rank second among all states in high cholesterol; third in obesity; fourth in diabetes; and forty-sixth in life expectancy. It is particularly disturbing to see how our children suffer. We experience more low birth weight infants; more infant mortality and child death, more child abuse and neglect, and more teen births than the national average.

The vision of the Church has always looked beyond the market and into the inherent dignity and value of all people. The Church from *Rerum Novarum* through *Pacem in Terris* and *Centesimus Annus* has made clear that human needs, such as health, are not commodities. John Paul II explained:

There are *many human needs which find no place on the market*. It is a strict duty of justice and truth not to allow fundamental human needs to remain unsatisfied, and not to allow those burdened by such needs to perish.⁴

West Virginia tells the tragic story of what happens when the market decides human needs. Many other parts of life become merely a factor of production. Strip mining and mountain top removal became the coal industry's competitive edge. They demanded more of the earth, a far smaller work force, and environmental degradation that eroded the very ground upon which people lived. The rusted remnants of urban industrial areas demanded that working age adults and their families move to areas of higher employment or into lower wage employment, without benefits. Strip malls of bedroom communities became venues of individual consumption. The creeping crisis of health comes from treating our land, our water, our air, and each other as economic tools, primarily if not exclusively. West Virginia represents the stark consequence of ignoring the moral premises of a Church that heals—respect for the whole human person: body, mind, and spirit.

The third leadership principle is interdependence. West Virginia instructs us that the loss of respect for one another comes from and contributes to the failure to see and recognize our interdependence and our community bonds. The mountains, the urban areas, and the bedroom communities of W.Va. hold ecological, economic, and social lessons of interdependence and the adverse consequences of avoiding them.

We find another story in West Virginia, however. It is a story of social capital—the social goods and moral resources that people invest in one another as members of a community, regardless of the labor market. Social capital addresses common needs and reduces social and economic inequalities.

The first occurrence of the term “social capital” comes in the work of a school official in West Virginia, almost 100 years ago. Lyda J. Hanifan, state supervisor of rural schools in West Virginia, was interested in how poor conditions in rural areas may be made better; just as we are today. He answers that question with social capital. He speaks

⁴ *Centesimus Annus*, para. 34.

of social capital as “good will, fellowship, sympathy, and social intercourse” that may come from contact with neighbors and networks.⁵

Hanifan describes how a small coal-mining community took a survey of local needs and assets. That survey became community meetings that turned into evening classes and a lecture series for adults. Community meetings raised \$282 for school libraries and school athletics—including a baseball league. The community undertook a local history project. In Hanifan’s estimation, “The crowning event of this notable year’s work was the voting of bonds in the sum of \$250,000 to improve the roads—a very large dividend paid on the social capital developed during the year.”⁶

In this very early American story of social capital, set in West Virginia, we find two essential components of social capital. First, we have increased amounts and improved forms of social goods that we invest in each other as members of a community—the local history project, funds for the library and school athletics, and improved roads. Second we find moral resources—good will fellowship, sympathy, and social interaction that may come from contact with neighbors and networks of neighbors.

We find something else as well; the story becomes God's story. We can imagine and re-imagine the social capital of a Church that heals through the economy of the Trinity—the perfect model of community, as witnessed by the early Church:

“Now the company of those who believed were of one heart and soul, and no one said that any of the things which he had possessed was his own, but they had everything in common...there was not a needy person among them, for as many were possessors of lands or houses sold them, and brought the proceeds of what was sold and laid it at the apostles' feet, and distribution was made to each as any had need” (Acts 4:32, 34-35).

The early Christian ethic of love, mutuality and shared life—moral resources—in community provides a model for interdependence. It can become a transformative historical model for the sharing of resources to meet human and community needs—social goods. This ethic should shape the church that heals. Our efforts will strengthen and nurture social goods by bringing people together and creating links across

⁵ Lyda J. Hanifar in Putnam, *Bowling Alone*, pp. 445-46 note 12

⁶ Lyda J. Hanifan “The Rural School Community Center” *Annals of the American Academy of Political and Social Sciences* 67 (1916):130-38.

communities where resources, assets, power and knowledge can be invested in one another as members of a community.

Our models of the Trinity and the early Church transcend time. So do our efforts to increase and improve the social goods that we invest in one another as members of a community and the moral resources we use to do so. They borrow from the supply left to us and provide those who follow us a replenished amount. Our hope that our efforts will mean the enhanced dignity of others and ourselves, keeps faith with the hope of those whose efforts brought us the possibilities that we enjoy.

The Action of a Church that Heals

These three principles of leadership—an expanded vision of health; respect for the human person; and interdependence—are closely interrelated. Our efforts to invest social capital in each other as members of a community demonstrate our respect for the human person. Our vision of health must be expanded to include the moral resources that express the bonds of community. Our interdependence moves us to increase and improve social and public goods for all members of the community. It also makes clear that the moral resources that we have we owe to others who preceded us and that we owe it those who follow us to replenish and improve the store of them that we received.

These principles are not a substitute for action but our call to action. But what action? My first action was to listen to those closest to the problems. I heard that

- A Church that heals testifies to healthy living by the example of clergy, religious and other church ministers and by their healthy behaviors.
- A Church that heals preaches, teaches and provides programs that encourage healthy living and practices making connections between faith and health;
- A Church that heals continues or develops practices that assist members and employees in living healthy lifestyles including a living wage and adequate health insurance for employees;
- A Church that heals uses its colleges and universities to train health professionals to serve in areas with too few resources; health professionals as agents of health as well as health care; and local people for professional and paraprofessional roles;

- A Church that heals creates the habit of contemplative living; the discipline of going apart, so that we take time to be touched by ordinary moments.

Precisely because the crisis of health is related to so many other problems, addressing it requires many partners. Leadership of a Church that heals promotes networks of sharing, learning, and collaboration.

- A Church that heals recognizes and acts upon the connectedness that we have with each other and in the places where we live.
- A Church that heals encourages its members to partner with others to identify key health issues in a town, county or region; to collect information on how other communities have solved similar problems; and to devise and implement responses appropriate to the locale.
- A Church that heals supports and sustains existing exemplary programs of services and participation.

Faithful to living a Trinitarian life, a Church that heals will comfort the afflicted by its own actions and its collaboration with others. A Church that heals also speaks truth to power and afflicts the comfortable.

- A Church that heals addresses the irony, if not the hoax, of public policies that give with one hand and take, most often from the most vulnerable, with the other.
- A Church that heals presses to make provisions for the promises we make. We are bound by the public promises we make as much as those we make to one another.
- A Church that heals looks beyond the easy path of balancing budgets and cutting costs at the expense of the poor and the most vulnerable.
- A Church that heals removes the boundaries that mark “us” and “them,” not only between those with more needs than others but among and between those who address those needs.

What I learned when I listened to the people is that a Church that heals acts as if we have a stake in the health of one another—because we do. We all have less justice when we ignore the injustices that beset others and less health when others and our environment fall ill. We are more vulnerable when others are not provided for; and less democratic when all interests involved in policies and programs are not represented in their formation, design and implementation.

These are not merely West Virginian or Appalachian insights, however. The pastoral *This Land is Home to Me* pointed out that Appalachia is a portent and a symbol for our nation and the world.

The suffering of Appalachia's poor
is a symbol
of so much other suffering
- in our land,
- in our world.
It is also a symbol
of the suffering which awaits
the majority of plain people
in our society
- if they are laid off,
- if major illness occurs,
- if a wage earner dies,
- or if anything else goes wrong.⁷

The poverty and plight of West Virginia's children is not unique either. It is not an issue for the Church alone to solve. But we must be leaders in advocating for that which promotes the dignity of human life. Last month acting U.S. Surgeon General Dr. Steven Galson met with West Virginia Gov. Joe Manchin to address the obesity rate of children in our state. Kentucky and West Virginia currently tie for the highest rate in the nation, and these governmental leaders are looking for solutions. Education, of course, is an important first step. West Virginia Office for Healthy Lifestyles and the West Virginia Center for Civic Life have designed a program called *Weighing the Options: How Can We Encourage Healthy Weight among West Virginia's Youth*. Using a community discussion format, this program will raise the awareness and the ability of our people to

⁷ Appalachian Catholic Bishops. *This Land is Home to Me: A Pastoral Letter on Powerlessness in Appalachia*. Catholic Committee on Appalachia, 1975.

respond to this significant problem. So I am encouraging diocesan staff across the state to host discussion forums in our parishes and in collaboration with other organizations. More recently, West Virginia lawmakers passed a bill allowing dental hygienist to practice in schools, nursing homes, hospitals and health clinics without a dentist standing over their shoulder. We supported this measure because it is designed to offer relief to a people whose dental health ranks the worst in the nation.

Martha Farah, of the University of Pennsylvania, and others recently garnered news coverage with her findings of children in poverty. The stress of childhood poverty may do pervasive harm to the brain, especially from six months to three years of age, and adversely affect the development of language and memory.⁸ But the question remains, what is the cause of that stress? What is the invisible crisis behind this condition? Paul Krugman, New York Times columnist, offered one explanation of the stress of poverty. “Living in or near poverty has always been a form of exile, of being cut off from the larger society. But the distance between the poor and the rest of us is much greater than it was 40 years ago... To be poor in America today, even more than in the past, is to be an outcast in your own country.”⁹

That is the pain and fear I saw in the face of that five-year old boy in Wyoming County and in the worried demeanor of his parents. I was grateful that a Church that heals was there to meet his needs that day. I speak today of the hope that the Church that heals will do more to address all of the factors that contribute to the well-being of that child and his parents and the myriad like them in all corners of the country and the globe.

Conclusion

In conclusion, let me suggest that the hope emitting from Appalachia springs not from a new set of principles but a renewed commitment to existing ones. That commitment calls us to inject values into the public debate and action on health care as the public expression of our moral understanding of the sacred and social nature of human beings.

⁸ Clive Cookson, “Poverty Mars Formation of Infant Brains.” *Financial Times* (February 16, 2008).

⁹ Paul Krugman, “Poverty is Poison,” *New York Times* (February 18, 2008).

In addition however, a Church that heals must also underscore the urgency of the crisis of health. As I stated earlier, it falls within the prophetic role of the Church to explain the signs of the times in terms of universal principles of God's love and human interdependence. We see clearly in Appalachia the truth that we must speak to power: The acute crisis of health care is a symptom of the less visible crisis of health.

Those values must also find expression in action. By our actions, we can make sure that the phrase "crisis" of leadership" is never applied to a Church that heals. Those actions must continue the quiet ministry of the Good Samaritan as well as small steps or giant strides to promote the health and well-being of all of those who travel the road to Jericho.

We are in the Easter Season when the road to Emmaus looms larger than the road to Jericho. The road to Jericho was the site where a man near death discovered a wounded healer, the Good Samaritan, but the road continued to be a dangerous place for future travelers. The road to Emmaus is the road journeyed by past and present disciples who discover healing for themselves and others in the word proclaimed, bread broken and a community gathered around the risen Lord. The Emmaus response is, "Were not our hearts on fire within us" (Luke 24:32). A church that heals continues to live with hearts on fire, proclaiming the healing presence in word and action of a risen Lord who works in our midst this day and all days.

Thank you and God bless you.

