America

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THE JESUIT REVIEW OF FAITH AND CULTURE

CELEBRATING 110 YEARS

Health Care on the Margins

A SPECIAL ISSUE

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JULY 14
15th Sunday Ordinary Time
Luke 10:25-37
The Good Samaritan

SEPTEMBER 29
26th Sunday Ordinary Time
Luke 16:19-31
Lazarus and the Rich Man

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28th Sunday Ordinary Time
Luke 17:11-19
Jesus Cleanses Ten Lepers

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Health Care on the Margins

I remember the size and shape of the ceiling tiles—square, with rows of holes the size of pencil erasers. I lay staring up at them for the better part of an hour, waiting for the two medical residents to arrive and begin work on my leg. I was 12 years old and in the second week of my stay at Boston's Floating Hospital for Children. I had just had surgery on my leg to correct a birth defect; and in order for the leg to heal properly, I needed to have a cast made that bent at the knee.

They told me it would be painful. I braced myself. The residents went about their work, casually chatting with each other about their weekend plans. As they bent my leg, the pain was excruciating and I started to cry out. They ignored me—just kept on chatting. Just as I was about to reach my breaking point, the surgeon, Dr. Zimbler, arrived, took one look at this scene and yelled: "Stop!"

Dr. Zimbler came to me, gently patted my head and asked if I was O.K. I was crying and couldn't speak. He smiled and assured me that things would be alright. But his smile vanished when he looked up at the residents. It was their turn to be scared. "Let's talk," he said. They went to the other side of the room and Doctor Zimbler let them have it. How could they stand there casually chatting and laughing about their weekend when this boy they were treating was scared and in such pain? He couldn't understand their thoughtlessness.

I understand it better now. Residents work long hours and have to maintain an almost inhuman pace. I was probably the fourth or fifth or maybe the 15th patient they'd seen just that morning. It was all a blur to them. I'm sure they were decent guys and they probably went on to be fine doctors. They had just made a mistake: They had forgotten that I was a human being, more than just "the patient"—a person.

"See the person," Pope Francis keeps telling us. The subject of every public policy question is not an abstraction or a statistic or a social construct, but a person, created and redeemed through love. That was the principle at work as we began planning this special issue on health care. But what our authors discovered along the way is that this principle, "see the person," not only frames the question but must be a fundamental component of the answer. "The solution to the current opioid crisis is one that involves the whole person," Bishop Malesic tells John Miller in this issue.

It's hardest to see the person who lives at the margins. That's why Pope Francis keeps telling us to go to the margins as well. From that point of view, it is also clear that our health care system, for all its advances, marvels and miracles, is still marked by structural injustice. I had that surgery on my leg, was fully healed, and within a couple of months I was back on the ball field.

But looking back I see now how lucky I was. I was lucky that my dad had a job with a good health care plan that also covered his family. I was lucky that we lived within two hours of one of the finest hospitals for children in the world. I was lucky that my father knew someone who knew Dr. Zimbler, who was otherwise not taking any new patients but made an exception for me.

Access to the kind of high quality health care that I enjoyed as a kid, not to mention the kind I enjoy as a Jesuit, shouldn't depend on luck. A month or two ago, an older friend described to me how quick and easy it was for him to have his cataract removed. And yet I remember traveling with a doctor in the third world when I was a Jesuit novice. There, a cataract meant almost certain blindness for the rest of one's life. That's not fair.

Life isn't ultimately fair, of course. But where it can be, it should be. Making the world a more just and healthier place begins with listening to people's stories. That's what this issue of **America** is about.

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This special issue of **America** is sponsored by Somos Community Care. We are very grateful for their support. America Media is solely responsible for the editorial content.

The chief executive officer of Somos is Mario J. Paredes, K.G.C.H.S., who is a longtime friend of America Media. It is his vision and generosity that has brought this issue to you. I guess you could say that in Sir Mario, we got lucky. AMDG.

Matt Malone, S.J.
Twitter: @americaeditor.

THE ISSUE

GIVE AND TAKE

DISPATCHES

FEATURES

AP Photo/Ben Curtis

South Africans queue to cast their votes in the mining settlement of Bekkersdal, west of Johannesburg, in South Africa, on May 8. President Cyril Ramaphosa's ruling African National Congress won the election, which took place 25 years after the end of apartheid.
Cover: iStock

FAITH IN FOCUS

FOLEY POETRY WINNER

IDEAS IN REVIEW

THE WORD

LAST TAKE

Should doctors and other medical professionals have a general right to refuse to perform medical procedures based on their conscience?

Nearly 60 percent of respondents believe that the conscience rights of medical practitioners need to be protected; 40 percent do not.

Readers were also presented with a list of 11 medical interventions and asked from which of those interventions doctors and other medical professionals should be allowed to exempt themselves. Euthanasia drew the most votes, with 67 percent of respondents saying that medical professionals should be allowed to exempt themselves. After that, 61 percent indicated doctors should be allowed to exempt themselves from performing abortions.

However, when asked if doctors should be required to refer patients to another physician who will perform a given procedure, 71 percent of respondents said yes.

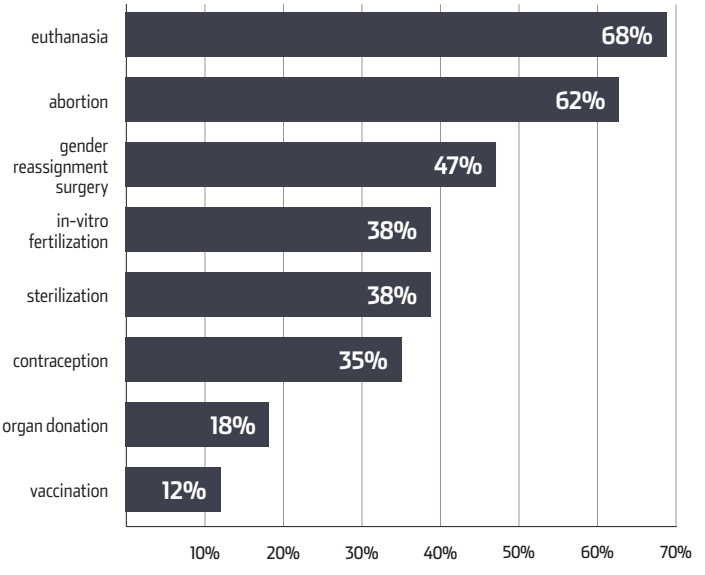
In their written responses, several readers invoked the Hippocratic Oath, from which the phrase "first do no harm" is derived.

Maura Martin, a nurse from Broomfield, Colo., wrote, "I would appreciate laws that protect my call to 'first do no harm' in regards to abortion and euthanasia. I went into this profession to help and heal. I don't know how I would continue in my profession if this becomes a requirement in workplaces."

Norma Kreilein, a physician from Jasper, Ind., believes that medical professionals should not be allowed to exempt themselves from any of the interventions listed.

"Doctors should not have to perform procedures they feel unqualified for, but there has to be a sound reason in their skill set," she wrote. "Each of the procedures listed is a bit different ethically."

From which of these medical interventions should doctors and other medical professionals be allowed to exempt themselves?



Discerning the call to celibacy

Re "Priestly Celibacy Today," by Louis J. Cameli (5/27): This is a respectable presentation of the three dimensions considered. However, not all people are called to the celibate life. Formation itself does not and cannot make up for not being called to celibacy. Yet I do not believe that not being called to celibacy dismisses the call to the priesthood. The church is being called to expand its vision of priesthood today. The early "priests" did not have to deal with this man-made invention.

Mary Collingwood

The need to accompany the wounded

Re "U.S. Catholic leaders welcome new Vatican protocol on sex abuse accountability," by Michael J. O'Loughlin (5/27): As a survivor, I watch and listen with open ears, straining to find positive outcomes to issues that have plagued me for 49 years, since I was 17. I believe with all my heart that survivors need healing centers, safe places to go to be among family, to be together during these explosive times. We need to understand what happened and how to recover from it—our families, too. I think this is a very good development. But we must not forget the walking wounded in our midst. We need a place. We need a healing center. Thank you for listening.

Sheila Gray

These results are based on 146 reader responses to a poll promoted on Facebook and Twitter and in our email newsletter.

SOMOS COMMUNITY CARE

‘Neighborhood-Based Primary Care’ holds key to optimal healthcare for the poor

THIS SPRING will see the beginning of a new chapter in healthcare reform aiming to provide the poorest Medicaid patients in New York City with superior care. On June 11, 2019, the first annual Conference on Neighborhood-Based Primary Care (NBPC) will introduce doctors, healthcare policymakers, and academics to best practices behind what is being billed as an “innovative organizing principle for healthcare delivery.”

NBPC revolves around the rehabilitation, reiteration and renewal of the role of the primary care physician; the NBPC model empowers the neighborhood doctor to, once again, become a trusted community leader who, intimately aware of all the needs of patients and their families, provides them with comprehensive care.

NBPC is a patient-centered, single-stop healthcare model that utilizes enhanced patient engagement; team-based care, involving primary care physicians and specialists as needed; and highly personalized, tailored care management—all in the service of meeting the full spectrum of patients’ medical, behavioral and social needs. In this model, patients are enabled and encouraged to play an active role in the improvement and maintenance of their well-being. Central to the NBPC formula is the quality of the relationship between primary care physicians and their patients.

The concept of NBPC was developed by SOMOS Community Care, the organizer of the NBPC conference. SOMOS is a network of more than 1,000 healthcare providers and 2,500 primary care physicians in New York City, serving a population of close to 1 million of the city’s most vulnerable Medicaid patients. Neighborhood-based primary care physicians have been key to the success of SOMOS.

SOMOS has just entered its fifth year as a so-called Performing Provider System (PPS) mandated by the Delivery System Reform Incentive Payment (DSRIP) program, which was launched in 2015 by the New York State Department of Health (NYSDOH). At the core of DSRIP—as well as of NBPC—is the Value-Based Payment or Pay-for-Performance formula. Value-Based Care (VBC) means that physicians are compensated not on the fee-for-service, transactional basis of the traditional Medicaid formula, but according to the longer-term health outcomes of patients. The healthier the patients, the greater the earnings for physicians who are rewarded for deeply investing themselves in the well-being of the people they serve.

The success of SOMOS after four years of operation is evident in the reduction by 36 percent in the number of preventable hospital readmissions among the patient population, a 34 percent drop in preventable visits to the emergency room, and a 47 percent reduction in the number of preventable behavioral health emergency visits. Those milestones have delivered many millions of dollars in savings for New York State taxpayers; NBPC holds the promise of being able to deliver superior care at manageable, sustainable costs.

Among New York State’s 25 Performing Provider Systems (PPSs) operating under the DSRIP mandate, SOMOS is the only PPS led by independent, neighborhood-based physicians; the other PPSs involve massive hospital-based systems in which care is inevitably more impersonal. SOMOS started out as a definite newcomer in the healthcare universe of New York State, but gradually established itself as an innovator consistently able to meet stringent DSRIP standards and, in the process creating the blueprint for NBPC.

Success for SOMOS—and the NBPC model—depends on putting doctors in an optimal position to succeed. Accordingly, SOMOS ‘practice transformation’ teams help medical practices to become the one-stop nerve center of Patient-Centered Medical Homes (PCMHs) to ensure comprehensive, quality care. The American College of Physicians describes PCMH as a “care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.”

Many SOMOS doctors also share the ethnic, cultural and linguistic background of the largely Hispanic, African American and Chinese American patient population; the bulk of these doctors also work in the neighborhoods where their patients live—all hallmarks of the NBPC model.

SOMOS Community or Neighborhood Health Workers (CHWs) make home visits and inform doctors and their staff about conditions in the home that may affect a patient’s health; CHW’s also ensure that patients keep their appointments. Practice staff are trained to free up physicians from time-consuming electronic health record keeping, which is also a distraction during the one-on-one doctor-patient consultations—precious time when authentic relationships of trust can be established. The foundation of that trust is the doctor’s real knowledge of the patient’s circumstances.

A key dimension in evaluating a patient’s needs is to consider the Social Determinants of Health (SDH), non-medical factors that impinge on individuals’ health. These include housing and environmental issues, employment, safety, education, food, etc. SOMOS experience has clearly shown the importance of the primary care physician being mindful of SDH in the lives of their patients. For example, a low-income patient living in a low-income neighborhood faces challenges to attaining and maintaining good health and overall well-being; there may not be access to healthy foods; and mold and rodents may pose health risks in the home.

A keynote speaker at the NBPC conference, Jason Helgerson, the former Medicaid Director for NYDOH and the main architect of DSRIP, has called on doctors to become genuine community leaders; for SOMOS that has meant the engagement of Community-Based Organizations (CBOs) that tackle SDH to create joint medical-social strategies for the neighborhood. The primary care physician plays a critical role in creating a culture of health in the community. The NBPC model formalizes this structure of leadership and collaboration.

The DSRIP program gave SOMOS the opportunity to both rediscover and reinvent the vital role of the primary care physician, in the process creating the NBPC model. That this model holds tremendous promise is at the heart of the vision of SOMOS Founder and Chairman Dr. Ramon Tallaj, the leader and spokesperson of the NBPC movement.

NBPC and the accompanying Value-Based Care formula will continue to drive SOMOS as the organization is laying the foundation to continue operations—likely in the form of both a non-profit and for-profit entity—beyond the DSRIP mandate, which is slated to conclude at the end of March 2020. The NBPC conference will help set the course for the future of SOMOS, by inspiring its doctors to stay the course, enlisting new physicians, and making the case to policymakers for the adoption of the NBPC model at the state and federal level.

Mario J. Paredes is CEO of SOMOS Community Care, Inc., one of 25 Performing Provider Systems operating under the mandate of New York State’s Delivery System Reform Incentive Payment (DSRIP) program.

Roe v. Wade Has Made Abortion Politics Impossible

The recently passed abortion laws in Georgia and Alabama have raised the temperature of the national debate nearly to the boiling point. The law in Georgia, keyed to the detection of fetal cardiac activity, would restrict abortion after about the sixth week of pregnancy; it also defines human beings in the womb, at any stage of development, as "natural persons." Alabama's law bans abortion at any stage of pregnancy. While these laws allow exceptions for cases where a woman's life would be endangered by carrying the pregnancy to delivery, neither law has exceptions allowing abortion in cases of rape or incest.

Much discussion of these bills has described them as "extreme" while almost universally neglecting the most significant cause of such "extremism." Many commentators recognize that these new laws are designed to mount a legal challenge to Roe v. Wade—but they fail to notice that these laws' blunt restrictions are a mirror image of Roe's broad rejection of any practical or effective limits on abortion. When abortion rights advocates defend Roe in order to reject any proposed restriction of abortion, they are taking an extreme position. That leaves no ground open for any compromise on less extreme laws. Pro-life legislators are going to meet the same tooth-and-nail opposition whether they aim to ban all abortions or, as recently seen in the U.S. Senate, attempt to require that infants born alive during an abortion receive medical care.

Consistently over decades, polls show that a significant majority of Americans support stricter restrictions on abortion than allowed under Roe, yet not as stark as those established by these new laws. American public opinion on the legality of abortion is conflicted and contradictory: According to one poll conducted this month, half of voters believe that the six-week "heartbeat laws" are either "just right" or even "too lenient"; another poll found that two-thirds of U.S. adults oppose overturning Roe. But under Roe and its successor decision, Casey v. Planned Parenthood, the abortion limits many voters want, even while abortion remains legal, are rendered unconstitutional. About 60 percent of Americans support legal abortion during the first three months of pregnancy, but far fewer—less than one-third—support it up to six months. But Casey's "undue burden" standard disallows abortion restrictions anytime before fetal viability (around six months), which is not what most Americans would choose.

There is a large gap between what Roe requires and what Americans believe about abortion. But addressing this gap remains politically unimaginable for pro-choice activists at the same time as they present the possibility of Roe being overturned as an acute political crisis. In reality, the reverse is the case. The ongoing political crisis is a consequence of the persistent failure of Roe and Casey to settle the abortion question and the failure of the Supreme Court to offer any sign that these cases ever will.

In her majority opinion upholding Roe in Casey v. Planned Parenthood, Justice Sandra Day O'Connor wrote that "the Court's interpretation of the Constitution calls the contending sides of a national controversy to end their national division by accepting a common mandate rooted in the Constitution." On the abortion question, this call has manifestly and expressly failed for more than 45 years, while distorting national politics and contributing to national division. The wreckage of these cases needs to be cleared for the country to move forward.

The Alabama and Georgia laws are far from perfect. They should have been accompanied by equally vigorous support for women struggling with pregnancy. They will almost certainly be suspended by injunction before they are implemented; and whenever they eventually reach the Supreme Court, they are unlikely to be upheld in all the details of their current form. If these laws are upheld and Roe is overturned or limited, they will need to be modified in order to be practically and justly enforced. But the legislative work of answering the challenging moral questions about abortion will at least be possible. While that will not end political divisions over abortion, it would allow us to engage them more honestly.

Dental Care Is Health Care

Several articles in this issue address health care "at the margins." One problem that affects almost all marginalized places and demographic groups is poor dental care, despite growing evidence that oral health problems can be symptoms of and even contributors to life-threatening illnesses like diabetes and heart disease.

The lack of access to dental care has two main causes. The first is that even employer-provided health insurance often does not cover dental care as generously as it does other health services. As for Medicaid, each state decides whether to cover dental care past childhood, and most states offer only emergency care. Also, the Medicare program does not cover routine

dental services, and only about one-third of Medicare recipients choose to get supplemental coverage. Not surprisingly, only about half of Medicare recipients visit a dentist annually.

The second factor is that almost 63 million people, or more than one-fifth of the U.S. population, live in "dental deserts" with few or no places to obtain oral care, according to a 2018 report from the U.S. Department of Health and Human Services. Even though the number of dentists practicing in the United States has gone up, there are more and more shortage areas (5,866 communities as of 2017), mostly in rural communities and low-income urban neighborhoods.

These two factors contribute to huge disparities in oral health among demographic groups. The Centers for Disease Control reports that 47 percent of the U.S. population has periodontal disease, but there are much higher rates among blacks and those of Mexican descent and among those with less than a high school education. The same pattern holds true for tooth decay.

Any further decline in oral health would constitute a public health crisis, one that can easily be avoided. Health care remains a top priority for voters, and policy makers should consider new requirements for health insurance to cover dental care, as well as incentives (perhaps loan forgiveness) for dentists to practice in underserved areas. Dental care is inseparable from overall health care, and it should be a priority in any plan to reduce inequities and improve the well-being of all citizens.

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For prison inmates, health care comes slowly and unpredictably

"You will get the health care you need, but not right away. They will delay your care by downplaying your symptoms. They will not adequately respond until your symptoms get worse or critical. They do that because they look down on you."

These were thoughts shared by an inmate—I will call him Frank—who has been incarcerated for over 20 years. He was attending a spiritual retreat, held by the Thrive for Life Prison Project behind prison walls. I was there as a volunteer minister, and we talked about health care between retreat activities that included group meditation, prayer and faith sharing. After the retreat, I kept thinking of his words: "They look down on you." Is it that simple?

I am mindful that the paramount concern of all prisons and jails is the safety of inmates, staff and volunteers. Most other issues, including health care, are secondary. This is understandable, but it still seems unfair when security eclipses health and well-being.

For nonemergency care, an inmate must first submit a form requesting medical attention. Depending on the security level of the facility, the inmate might be required to have a correctional officer escort him or her to the in-house medical unit. Because of staffing and officer shortages, the wait for medical attention will be counted in days, not hours.

Many inmates complain that the medical staff does not take their concerns or symptoms seriously, or that staff members wait until their symptoms get worse before approving surgery. A study in 2017 by the Pew Charitable Trusts found that health care accounted for about one-fifth of all prison expenditures, though annual spending levels varied widely by states (from $2,173 per inmate in Louisiana to $19,796 in California). Do financial considerations impede adequate medical care?

Before getting approval for a significant medical procedure, like a colonoscopy or surgery, an inmate must visit a specialist off the grounds of the jail or prison. If approval is granted, the inmate must again be transported offsite on the day of the procedure. In transit, all inmates are shackled; they are generally given a bologna sandwich for the excursion, which can take all day as other inmates are dropped off and picked up.

If a security issue within the jail or prison arises, like a fight between prisoners, on the day of a surgery, the medical trip might be suddenly canceled, even if the inmate in need of medical attention is not involved in the fight. The inmate may have been waiting months for that day, and more months may pass before the procedure can be rescheduled. Similar delays may occur with post-procedure care for anything from a routine colonoscopy to cancer surgery, causing unnecessary health and financial complications.

Frank shared with me the experience of his hernia operation. He was in so much pain after the surgery that he could not stand up straight. A corrections officer had to put on Frank's pants for him. He was subsequently shackled and placed in the van for the jolt-filled ride back to the prison.

One issue Frank did not mention was vulnerability caused by physical pain. If infirmity makes an inmate weaker, he or she can be at greater risk of violence from other inmates when trying to perform basic tasks like showering or going to the cafeteria.

Given the constellation of challenges surrounding inmates' medical needs, it is no wonder that many of them will forgo medical attention for as long as possible, perhaps too long.

And what if an inmate is in need of emergency care? There are many horror tales. One infamous example is that of Carlos Mercado, whose story is recounted by Dr. Homer Venters, the former head of New York City's correctional health services, in his book *Life and Death in Rikers Island*. During his initial 24 hours of "processing" in Rikers Island, Mercado died of diabetic ketoacidosis due to a lack of insulin. He kept telling the corrections officers that he needed insulin, but the officers told him he was suffering from narcotic or alcohol withdrawal and gave him a barf bag.

Behind the wall, inmates have no choice. Their general well-being and health care are dependent upon others. This includes issues like mental health, substance abuse, dental care and unhealthy prison food that can cause short- and long-term ailments—which also increase the cost of inmate health care.

One inmate told me: "There is no accountability on the [prison] medical staff. I continue to live with pain and anxiety about my health." He fears his unaddressed medical issues "may be life threatening." Sometimes, all an inmate can do is pray for the patience to endure and survive a system of inadequate care.

John T. Booth *is a trial attorney with the New Jersey Office of the Public Defender, a volunteer prison minister with the Thrive for Life Prison Project in New York and a spiritual director at St. Francis Xavier parish in Manhattan. He lives in Jersey City, N.J.*

U.S. health care at the margins

Reaching the underserved is a familiar role for Catholic health institutions

By Kevin Clarke

Where are the margins in U.S. health care? They can be tracked by race and ethnicity, highlighted on a map or charted along an income graph. In rural America life and death may be a matter of how far an injured farmworker has to be transported to reach emergency care. In a Rust Belt city where rates of depression and anxiety are reaching unprecedented levels, the opioid epidemic has been taking a shocking toll on white, blue-collar workers.

Income is perhaps the unifying indicator of health care in crisis across all the margins of America—a reliable predictor of lapses in insurance coverage, diminished access to health specialists and poor health outcomes from inadequate treatment for common illnesses—leading to the final measure of all: substantially lower life expectancy.

Mary Haddad, R.S.M., is the incoming president and chief executive officer of the Catholic Health Association. In July, Sister Haddad will succeed Carol Keehan, D.C., who has led the C.H.A. for 14 years.

Going to the margins is something that Catholic health care has always done, Sister Haddad said. "That's where we started in Catholic health care in this country; it's what we have given to this country," she said, pointing to the association's 19th-century origins in the work of religious communities in underserved immigrant communities in both rural and urban settings across the country. She affirms that her network's membership is ready to do the same today.

Spiking rates of income inequality have been accompanied by poorer rates of general health among vulnerable populations, and differences in life expectancy according to income quintiles have followed. The Health Inequality Project reports that the richest men in the United States live 15 years longer than its poorest, and the richest women live 10 years longer than the nation's poorest women.

The chronically under-resourced Indian Health Service struggles to live up to treaty obligations that guarantee health care to Native American and Native Alaskan communities where health outcomes are among the worst in the nation.

America's indigenous communities suffer rates of acute illnesses that are substantially higher than those of other U.S. communities, and life expectancy in Native American communities is almost six years less than in the overall population—73.0 years instead of 78.5 years. Rates of accidental death and death because of influenza are more than double the general population; diabetes-related mortality is three times the national rate; and mortality related

CNS photo/Lisa Johnston, St. Louis Review

A woman plays with her 1-year-old son at Our Lady's Inn maternity home in St. Louis. African-American women suffer rates of maternity-related mortality more than three times higher than white women.

to alcohol abuse is almost seven times higher.

Globally, maternal mortality fell 44 percent between 1990 and 2015, according to the World Health Organization. But in the United States the trend has been moving in the opposite direction. Mothers die in 17 out of every 100,000 U.S. births each year, up from 12 per 100,000 25 years ago.

"An American mom today is 50 percent more likely to die in childbirth than her own mother was," Neel Shah, an obstetrician at the Harvard Medical School, told the Associated Press.

Possible factors driving that unfortunate trend include the high C-section rates in the United States and soaring rates of obesity, which raises the risk of heart disease, diabetes and other complications during pregnancy. But race has also become a consistent risk factor.

African-American women suffer a rate of maternal mortality that is more than three times that of white women, and mortality among Native American and Native Alaskan women is 2.5 times the rate experienced by white women. More than half of the maternal deaths among African-American and Native American women are preventable, according to a report released in May by the Centers for Disease Control and Prevention.

Dr. Lisa Hollier, president of the American College of Obstetricians and Gynecologists, told The Associated Press the high mortality rate among African-American women may be partly attributable to racial bias they experience in receiving prenatal and delivery care—for example, doctors not appreciating risk factors more common in African-American women, like high blood pressure.

Health care in the United States finds itself at a crossroads, according to Sister Haddad, reorienting itself from acute care, which now claims the lion's share of the system's resources, toward community health services focused on prevention and lifestyle modifications that prevent health crises in the first place.

Adjusting reimbursement structures from private and public payers that will finance that realignment will be critical, according to Sister Haddad. Despite the exorbitant cost of the nation's health care delivery system, many not-for-profit institutions struggle to keep their doors open. Sister Haddad said that reimagining health delivery will mean turning fresh eyes to the true contributors of health problems. Acknowledging and responding to the social determinants of poor health must be integrated into contemporary health care, she said.

"We're finally reckoning with the value of addressing social issues as well as clinical issues," Sister Haddad said. It is a paradigm shift for C.H.A. members, who are now proactively "looking into how to incorporate that social component into health care."

People seeking treatment today cannot be sent home with a prescription and vague instructions to address their illnesses, she explained. "You may not have a home," Sister Haddad said. "And if you do, you may not have a refrigerator in your home to keep your medication cold."

Catholic health services have begun to team up with social service providers to respond to patients' total needs. "What pleases me to no end is to see that collaboration beginning...[for example,] Catholic Charities housing working with Catholic health care."

Individual counseling has become a key component of complete health care, and not just in terms of wellness and treatment. Many of the people C.H.A. tries to serve on the margins are not aware that they qualify for Medicaid or social assistance, or they are intimidated or confused by the health care and social service bureaucracy, a problem that is especially prevalent in the immigrant and refugee communities where Sister Haddad began her career in health care.

Going, as Pope Francis might suggest, to the margins of health service today, she said, indeed means responding to the racial and economic disparities that persist in the United States despite decades of awareness of this problem. But in the end, she said, "there probably isn't a single person who isn't on the margins in one way, shape or form.... You could be living on the edge and not know it."

She explained that as surely as geography, race and income are factors in producing marginalized care, other patients are pressed to the margin because of the nature of the care they need—people seeking assistance from the nation's poorly resourced mental health system, for example, or families who discover holes in their insurance coverage during a medical crisis or when specialized care is needed. And many others find how close to the margins they have

been living when they find themselves unexpectedly out of work and abruptly bereft of health insurance.

That ongoing effort to broaden health insurance coverage had been an extraordinarily personal fight of her predecessor—Sister Keehan had been credited with saving the Affordable Care Act as it bogged down in Congress in 2010—and it is one she will continue, Sister Haddad said. "We know the importance of Medicaid expansion, but we are in a volatile state just now, given our political situation."

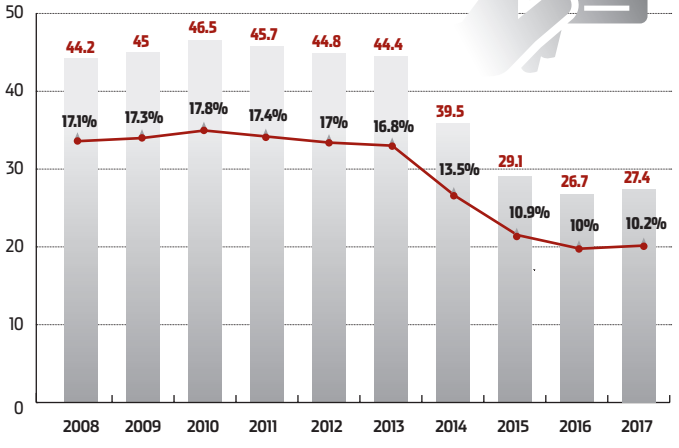
Sister Haddad said that the C.H.A. under her direction would continue its efforts "to rally advocates and to work with this administration to expand Medicaid and protect and enhance the A.C.A.," referring to the unfinished work of moving uninsured Americans, now 27.4 million of them, from the margins to the mainstream.

Kevin Clarke, *chief correspondent.*
Twitter: @ClarkeAtAmerica.

UNINSURED POPULATION FALLS...FOR A TIME

After a steep decline between 2013 and 2016, the number of Americans without medical insurance rose in 2017 for the first time since implementation of the Affordable Care Act, to 27.4 million.

Number of uninsured (in millions) and uninsured share (%) of nonelderly population



People of color make up **42% OF THE OVERALL NONELDERLY U.S. POPULATION** but account for more than 50% of the uninsured population.

FEW OPTIONS IN SMALL TOWNS

Physicians per 100,000 people		Specialists per 100,000 people	
Urban communities	31	Urban communities	263
Rural communities	13	Rural communities	30

FAMILY DOCTORS make up **15% OF THE OUTPATIENT PHYSICIAN WORKFORCE NATIONALLY,** but they provide **42% OF THE CARE** in rural areas.

NATIVE AMERICANS

U.S. overall life expectancy, at 78.5 years, is nearly six years more than life expectancy for Native Americans, at 73.0 years.

In 2017, Indian Health Service spending for patient health services was $4,078 per person, compared with $9,726 for per-capita health care spending nationally.

MATERNAL MORTALITY A WARNING SIGN?

A new federal report finds that pregnancy-related deaths are rising in the U.S., especially among black women.

RACE	DEATHS	RATE PER 100,000 LIVE BIRTHS
White	1,385	13
Black	1,252	42.8
American Indian, Alaskan	62	32.5
Asian, Pacific Isl.	182	14.2
Hispanic	519	11.4

A CONTINUING CRISIS

Drug overdose deaths per 100,000 (2016)

All	19.8	Northeast	26.6
Ages 35-44	35	Male	26.2
		White non-Hispanic	25.3

AMERICA'S INVISIBLE WORKFORCE

Up to 3,000 farmworkers are victims of acute pesticide poisoning incidents every year. More than 300 California public water systems serve unsafe drinking water, affecting more than 1 million, primarily in agricultural communities in the San Joaquin and Central Valleys.

GoCureMe

Roughly one-third of the $5 billion raised by GoFundMe since the website was founded in 2010 has been for medical expenses, with an average of 250,000 new "medical campaigns" begun each year.

Sources: uninsured data from Kaiser Family Foundation, based on U.S. Census data; rural health data from National Rural Health Association and the U.S. Centers for Disease Control and Prevention; Native American data from Indian Health Service, U.S. Department of Health and Human Resources; maternity and drug overdose data from the U.S. Centers for Disease Control and Prevention; FarmworkerJustice.org; "They Grow the Nation's Food, but They Can't Drink the Water," New York Times, May 21, 2019; "GoFundMe CEO: 'Gigantic Gaps' In Health System Showing Up In Crowdfunding," Kaiser Health News, Jan. 16, 2019.

CNS photo/Barbara Fraser

In Canada, a toothless watchdog?

Critics say Canada's new oversight office lacks power to stop abuses by mining corporations abroad

Workers collect oil from a stream below the site of an oil pipeline break in 2016 in Wachapea, Peru.

Sheri Meyerhoffer, a former lobbyist for the Canadian Association of Petroleum Producers, has been given the task of overseeing the activities of Canadian companies abroad—most notably, extractive industries like gold mining and oil drilling—and many environmental and human rights advocates are not pleased.

The Canadian international trade minister, Jim Carr, announced in April that Ms. Meyerhoffer would become the first ombudsperson of Canadian companies doing business in other nations but declined to say what powers the ombudsperson would have. Critics are disappointed that Ms. Meyerhoffer's office will not be independent but accountable to Mr. Carr's office.

The new office, which was announced in January 2018, was created following years of petitions, letter-writing campaigns and grassroots organizing across the globe. Canada is home to the majority of the world's mining companies, and most of them operate in Latin America, where harrowing stories of abuse of workers and local ecosystems are widespread.

But activists say the new office pales in comparison with what they hoped for and what they thought the government was committed to implementing.

"Fifteen months ago, we were celebrating," said Elana Wright, advocacy officer at Development and Peace, the international development organization of the Catholic Church in Canada. "Canadian Catholics across the country, hundreds of civil society organizations around the world, people we work with and who are part of our networks—we were all celebrating the creation of an ombudsperson."

Proponents of an ombudsperson had called for an independent office with the power to assemble evidence, compel companies to turn over documents and conduct thorough investigations regarding allegations of environmental and human rights abuses by Canadian companies. Mining watchdogs say the apparently lackluster power given to the office instead may be the result of extensive lobbying by the Mining Association of Canada.

Ms. Wright said Development and Peace is willing to see what powers are available to the new ombudsperson's office before making a final judgment. "But at this point," she asked, "will this ombudsperson really be able to provide justice for a community in Guatemala, who has really experienced crimes, including rape, the forced displacement of their community and murder?"

The reference to Guatemala is significant in Canada, where three high-profile legal battles between Canadian mining giant Hudbay Minerals and several indigenous plaintiffs from Guatemala have been continuing for nearly a decade. The lawsuits all involve the Fenix nickel mine, acquired by Hudbay in 2008 and sold in 2011.

In one suit, Angélica Choc alleges the company's security forces murdered her husband, Adolfo Ich, a respected community leader known for opposing the mining operations. In another, 11 women allege they were raped by men, including uniformed members of Fenix's private security force; and in the third, a man named German Chub alleges the chief of security shot him at close range, leaving him paralyzed.

"Canadian Catholics are motivated to respect what Pope Francis is proposing, working to put people before profit," said Ms. Wright. "Our government is really not respecting that approach, even if they say they're committed to confront climate change and to protecting the environment.

"I fear that this is a David and Goliath battle, where the Canadian voters don't have as much of a say as Canadian corporations," said Ms. Wright. But, she added, "we're people of hope. We just have to keep trying."

Dean Dettloff, *Toronto correspondent.*
Twitter: @DeanDettloff.

GOODNEWS
Jesuits West scores a win against for-profit detention corporation

The GEO Group, a for-profit provider of "diversified correctional and community re-entry services" for local and state governments, faced a rare challenge from its own shareholders on May 7 when they approved a resolution proposed by the Jesuits West Province of the Society of Jesus. The province requested that GEO, which runs 134 facilities around the world, including 69 detention centers in the United States, "report annually...on how it implements" its human rights policy.

For years GEO facilities have been the subject of a litany of horror stories. Multiple suits have been filed by detainees in different facilities, who contend that they are forced to work for food and sometimes are placed in solitary confinement if they refuse; that detention facilities for undocumented migrants are structured as though detainees were criminals, with metal detectors, jumpsuits and no access to telephones; and that fights among detainees at a GEO youth facility were orchestrated by guards.

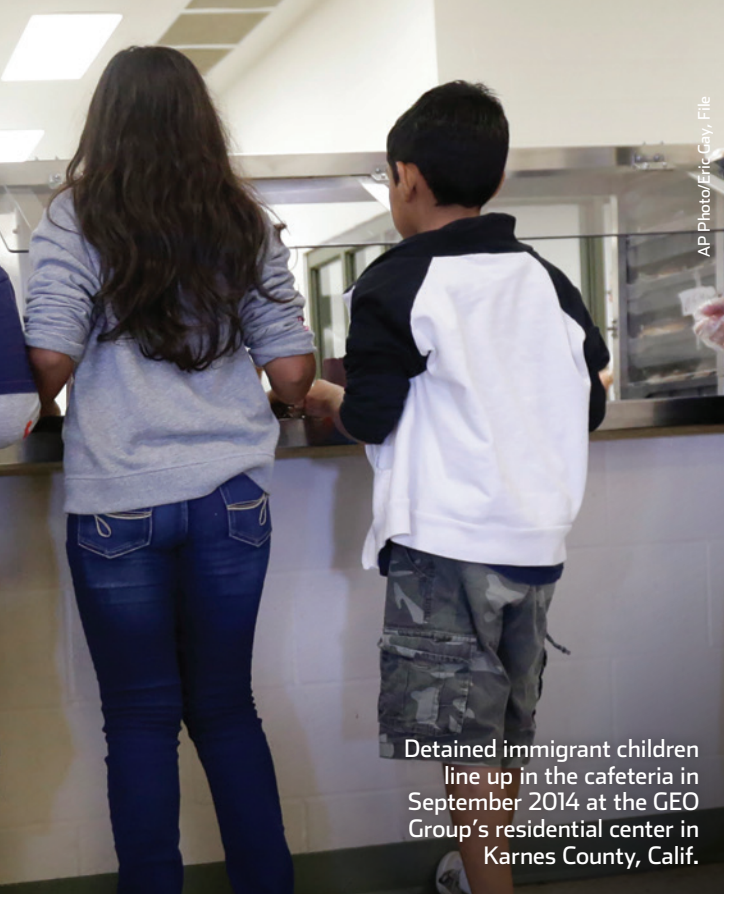
GEO's Immigration and Customs Enforcement processing facility in Adelanto, Calif., which can house 1,940 detainees, was named the "deadliest ICE detention center" in 2017 by the Detention Watch Network and other organizations after three men died and at least five other detainees attempted suicide. In 2015 the facility was forced to turn over its medical care to an outside organization after a government investigation found its care substandard—an evaluation the U.S. Department of Justice has also leveled against other GEO facilities.

Jesuits West was one of a number of religious organizations that bought a small number of shares in GEO nine years ago with the intention of influencing corporate policy and standards. Their ongoing dialogue with GEO Group management led the company to institute a human rights policy for the first time in 2013.

But when Jesuits West recently requested that GEO offer a yearly report on the implementation of its human rights policy, GEO management initially balked, arguing that answering these questions might violate the company's contracts with state and federal governments. Bryan Pham, S.J., became the point person for Jesuits West on the matter in the fall of 2018.

The Jesuit province proposed a resolution on the matter for the annual shareholders meeting. GEO executives appealed to the Securities and Exchange Commission in an attempt to prevent the resolution from reaching shareholders, but ultimately the S.E.C. overruled GEO's concerns and allowed the resolution to be considered.

Father Pham explained that just getting that far had already been a win for those backing the resolution because it gave them a platform to publicly express their concerns.



AP Photo/Eric Gay, File

Detained immigrant children line up in the cafeteria in September 2014 at the GEO Group's residential center in Karnes County, Calif.

Roughly 1,000 shareholders participated in a conference call on the resolution on May 7. "GEO hasn't told us the numbers yet; they've said those who support the resolution outweigh those who oppose it."

In the end the GEO Group agreed to an accelerated timeline for the report, which will be published in September 2019. A spokesperson said the self-evaluation "will help our stakeholders better understand our long-standing commitment to respecting human rights and will over time incorporate appropriate metrics to measure our performance."

Father Pham will no doubt be among its most interested readers. "The information in the press about how inmates are being treated, the violence, the sexual assaults, the suicide attempts...are indications that there's something not right in these institutions," he said. "And I think when shareholders choose to support our resolution, they're saying essentially that making money is important but so is the dignity of the person, the care of the person.

"It's a sign that what happens [inside] our prisons and detention centers is important."

Jim McDermott, S.J., *Los Angeles correspondent.*
Twitter: @PopCulturPriest.

Cardinal Konrad Krajewski, the papal almoner, visits refugees on the Greek island of Lesbos on May 8.

CNS photo/Vatican Media

In 'act of humanity,' Pope Francis' almsgiver turns on the lights

Cardinal Konrad Krajewski, the pope's almsgiver, climbed down a manhole in Rome on May 11 to restore electric power to a building occupied by some 450 homeless people, including more than 100 children. They had been without electricity and hot water for almost a week.

The municipal electric company cut off the power supply because the occupants—who had lived in the state-owned property as squatters since 2013—had run up a substantial electric bill that they could not pay. Once the electricity was cut off, residents were left without light or power to run refrigerators or to heat water. Some of the children were afraid in the dark, and some residents fell and hurt themselves.

Breaking the seals that prevented the building from having power, the papal almoner also broke the law. "If a fine should arrive, I will pay it," he told Italian media.

It was, the 55-year-old Polish priest said, a situation that called for "an act of humanity," given that on the weekend he could find no one with the authority to restore power.

"Don Konrad," as he is popularly known, is the man Pope Francis chose in 2013 to be his right hand for assisting the poor and vulnerable of Rome. Pope Francis made him a cardinal last year to emphasize that "the poor are a priority in this pontificate."

The pope's almsgiver said he would pay for the electricity for the squatting families until the situation stabilizes, but he emphasized that "money is not the first problem. There are children here, and the first question is: 'Why are they in this situation?'"

Gerard O'Connell, *Vatican correspondent.*
Twitter: @gerryorome.

Labor of Love

Lauren Gilger

Nicolle Gonzales, a midwife, with 4-week-old Isla Cadiente.

How one midwife is helping Native mothers connect to their childbirth traditions

By Lauren Gilger

It was 2:30 in the morning when Nicolle Gonzales walked in the door of Leah Kolakowski's house in Santa Fe, N.M., one night in April. Ms. Kolakowski was in labor with her first baby, a boy, and Ms. Gonzales, a midwife, was there to help deliver him.

Ms. Gonzales went directly to the fireplace to make an offering of cedar, a tree sacred in her Navajo culture.

A homemade altar was set up on the brick fireplace mantel, filled with herbal medicines, sage for smudging and small clay pots to collect the ashes after the dried bundles had been burned.

Ms. Kolakowski, a 29-year-old photographer who is half Ojibwe, had been laboring for about six hours, and Ms. Gonzales could tell something was not right. The pain was all in her back.

"I already knew," Ms. Gonzales said. The baby was occiput posterior, what is often called "sunny side up." His head was facing the wrong way—toward the sky. And the back of his head was pushing against Ms. Kolakowski's spine.

"I felt like I was going to pass out, I was so tired and exhausted, and I couldn't eat or drink anything," Ms. Kolakowski said. "It was just excruciating pain."

She was surrounded by her family—her partner,

American Indian and Alaska Native mothers are 4.5 times more likely to die from pregnancy and childbirth-related causes than white women.

her sister and mother, as well as a doula from a group called Tewa Women United, which trains indigenous women to assist and support women in labor.

Ms. Gonzales, 39, is a certified nurse midwife who has worked in the field for about 15 years. And she is the founder of the Changing Woman Initiative, a women's health collective in Santa Fe that aims to renew cultural birth knowledge for a new generation of indigenous women like Ms. Kolakowski.

That night, she and the doula put their skills to work. They tried to turn the baby, maneuvering Ms. Kolakowski onto her side and placing pillows under her knees and behind her back. They got her into a birthing tub set up in the middle of the living room. Ms. Gonzales pressed on her back until her hands cramped. She burned dried sage, the smoke wafting around Ms. Kolakowski as she labored.

Nothing worked.

"He was just determined to be the way he was," Ms. Kolakowski said.

After 24 hours of laboring at home, surrounded by family and employing traditional, indigenous practices, she went to a nearby hospital, desperate for relief from the pain.

Ms. Gonzales went with her, carrying out the contingency plan that is always in place for every home birth she attends. She called ahead to the midwives she knew at the hospital, and when they got there she explained to Ms. Kolakowski how the epidural would be administered and how long it would take to work.

"I don't know if you heard all of that," Ms. Gonzales told her a week later at her postpartum visit.

Ms. Kolakowski laughed. All she could think about at the time, she said, was, "When is it going to work? When is it going to work?"

The two women were sitting on Ms. Kolakowski's couch in the same living room where she labored the night of her son's birth. There were vestiges of the homemade altar still on the fireplace, the ashes from the burned sage now cold. Her baby boy was in her arms.

His name is Waya Ode. The first name means wolf in Cheyenne, her partner's ancestry. The second means heart in Ojibwe, her own.

Ms. Gonzales was there to check the baby's height and weight, to make sure he was eating enough and that he was growing. She felt Ms. Kolakowski's abdomen and asked a stream of questions about her sleep and her bleeding and her breastfeeding and if she was getting out of the house yet.

"You just make it look so easy," Ms. Gonzales said as she finished taking notes on her laptop.

But for many Native women it is not. According to 2016 data from the Urban Indian Health Institute, American Indian and Alaska Native mothers are 4.5 times more likely to die from pregnancy and childbirth-related causes than white women. And the U.S. Department of Health and Human Services reports they are 2.5 times more likely to receive either no or late prenatal care. As for their children, the infant mortality rate among American Indian and Alaska Native infants is nearly twice as high as for white infants, according to the Centers for Disease Control and Prevention.

Ms. Kolakowski is striking even a week after giving birth—a week in which she cannot have slept much. She has olive skin, high cheekbones and two thick braids that reach nearly to her elbows. Her arms and legs are decorated with intricate tattoos—a buffalo skull, a crescent moon, constellations and her favorite, her tribe's emblem, a Thunderbird, on her back. She is wearing a flowing, bright red dress. She is in a good place, but the process of getting there was not simple.

Reconnecting to Tradition

Ms. Kolakowski decided to give birth at home after she passed out at work early in her pregnancy. A coworker rushed her to the hospital, where she was treated for dehydration.

"I didn't like being confined in bed and had all these

Nicolle Gonzales, left, encourages Native childbirth traditions that help mothers like Leah Kolakowski reconnect with their Native roots. Ms. Kolakowski holds her son, Waya Ode. Waya means wolf in Cheyenne, the ancestral language of Ms. Kolakowski's partner. Ode means heart in Ojibwe, her own Native language.

IV's in me," she said. "I was just like, 'I hate this.'"

For her prenatal care, she turned to the Santa Fe Indian Hospital; but even that, she said, was nothing like what she felt she would experience under the care of Ms. Gonzales. With her, she felt empowered in a very different way.

"It didn't feel like something was happening to me," she said. At the hospital, it was all about the baby. "I mean, that's important, don't get me wrong," she said. "But [becoming a mother] is also a huge transformation."

And that transformation, for Ms. Gonzales, is a sacred one.

"Those changes in your body are happening, like you're growing a baby and your breasts are changing. Yes, those things are happening, but there's also this spiritual and emotional thing that's happening at the same time," she said. "That's never really addressed in the Western medical way because they don't understand those connections the way we do as Native people."

Early in her career, Ms. Gonzales worked for the Indian Health Service as a nurse, then spent a decade working in private hospitals, and eventually earned her master's degree in nursing midwifery from the University of New Mexico while working. In 2015 she launched the Changing Woman Initiative, envisioning a birthing center for indigenous women. A few years later, she left her job as a midwife to devote all her time to it.

While she has yet to raise the funds to open a birthing center, Ms. Gonzales's practice is growing. At the Changing Woman Initiative's office, there is a women's health clinic that provides free, easy access to care, as well as a healer who offers everything from massage and cupping therapy to acupuncture and herbal medicine consultations.

And Ms. Gonzales attends home births in the region for mothers who receive pre- and post-natal care and doula support in addition to healthy groceries from a local co-op.

Changing Woman, or Asdzáá Naadleehi, the center's namesake, is a sacred creator in the Navajo culture who represents, as Ms. Gonzales put it, transformation. Ms. Gonzales's goal is to offer women the space to bring back ancient tribal birthing practices and, at the same time, provide much-needed care and information to women who might not otherwise be able to get it.

As she drove from one new mother's home to the next, Black Belt Eagle Scout's album "Mother of My Children"

These traditional, indigenous birth practices should never have been erased in the first place.

played on the stereo and bags full of Ms. Gonzales's midwifery gear—laptop, thermometer, stethoscope and a baby-sized scale—jiggled in the back of her big S.U.V.

Ms. Gonzales is slight and powerful at once. Her long, black hair hangs straight and her movements —especially when she's holding a baby—are gentle, like her voice. Black tattoos mark both of her forearms—a cedar leaf on one and the Navajo tree of life, a corn stalk, on the other.

She is a mother of three and says her own experience is what led her to this work.

Despite her mother's wish that she put her education and career before marriage and a family, she met and fell in love with her husband during college. They married, and by the time she was 20, she was pregnant with their first daughter.

"It wasn't something that was really supported by my family," she said. "They were kind of disappointed and thought maybe that, you know, you kind of failed us." In fact, she said, in Native communities, young motherhood is often not encouraged.

"It's kind of like 'Oh, we have many baby daddies and we're not going to do anything with our lives and we're just going to have babies,'" Ms. Gonzales said. "And when I was pregnant with my kids, that's kind of also how I felt."

People assumed she did not have a husband, and even doctors treated her accordingly. Through their eyes, she said, "I was just this kind of single, brown woman having a baby that I didn't know what to do [with]."

During that first birth, little went as planned. She was diagnosed with pre-eclampsia, doctors told her her blood pressure was too high; and, when she finally delivered, they had to use forceps to get the baby out. She tore badly and hemorrhaged afterward.

When Ms. Gonzales was pushing, she asked the doctor if she was doing it the right way, but he did not talk to her. "I had to get feedback from the nurse," she said.

After her first daughter, she had three miscarriages and two more children, and her understanding of her Navajo culture grew.

"With each of my miscarriages, I went to see a medicine man. He helped restore things and restore balance in my body," she said. As she learned more about the deity Changing Woman and what it means to become a Navajo woman, she felt more connected to her community and its teachings.

"The world is telling you you're not important, or, if you're a brown person, that you're a burden or that you're worthless, or you're not good enough, or even that you're just property," Ms. Gonzales said. "I feel like that is constantly reinforced in our Native communities."

She sees her work as a midwife as a way of reclaiming the beauty of her culture.

When she worked in a hospital, she said she tried to make sure that Native families knew they had the power to advocate for themselves.

"You can tell me and the nurses to be quiet when the baby comes so that the first thing they hear is you," she would tell them. "Or that maybe the first thing the baby should hear is the native language of their community and not a nurse talking to them in English."

"To me that's reclaiming," she said. "That's reclaiming that space for tradition and culture and language."

'Different Forms of Trauma'

According to Christina Novoa, senior policy analyst with the Center for American Progress, that work is especially necessary right now.

"There is a serious crisis in maternal and infant mortality going on in [Native] communities," she said. "But we're not hearing as much about them." In fact, in the last few years, Native women are the only demographic that have not seen a decline in infant mortality, Ms. Novoa said.

Last year, Ms. Novoa released a report that documented the connection between this grim reality for indigenous women and children in this country and the institutional racism they face.

"The United States just has a really fraught and a really long and difficult history dealing with Native Americans," she said. "The United States was founded on genocide of indigenous populations, forced migration, cultural erasure."

Just a few generations ago, Native American children were taken from their families and put into boarding schools. And as recently as the 1970s, the Indian Health Service pushed sterilization of Native American women through force, coercion and misinformation.

Lauren Gilger

A homemade altar was set up on the brick fireplace in Leah Kolakowski's home. It was filled with herbal medicines, sage for smudging and small clay pots to collect the ashes after the dried bundles had been burned.

"They are different forms of trauma," Ms. Novoa observed.

Child development experts like Ms. Novoa call these adverse experiences. If they are not addressed in children, they can embed themselves in a person's psyche, she said, and affect their long-term health and development.

"So all of these things that we've seen historically in the United States, all of these assaults, frankly, on indigenous women really can get under the skin," Ms. Novoa said, "and that has serious implications for their long-term health—including their reproductive potential and their ability to have healthy infants and have a healthy pregnancy."

For long-time Navajo health care worker Olivia Muskett, the challenges for Navajo women and infants begin long before they are in labor.

Ms. Muskett is community outreach manager for C.O.P.E., or Community Outreach and Empowering Patients, a partnership with the Navajo Nation's Community Health Representative Outreach Program. The way she describes it, trying to track down the women who need pre- and post-natal care can be like a game of hide and seek.

Despite efforts by I.H.S. and health care workers like the ones she trains, "they'll come in, they'll take a pregnancy test and then won't come back until they're ready to have their baby," she said. There are many reasons for that.

The Navajo Nation is largely rural. Many women have to drive hours to prenatal appointments, which are usually

Olivia Muskett, a long-time Navajo health care worker, is community outreach manager for Community Outreach and Empowering Patients, a partnership with the Navajo Nation's Community Health Representative Outreach Program. She advocates for better care for Native women and infants and says the challenges for many pregnant women begin long before they are in labor.

monthly. When a woman is close to term, those appointments are weekly.

In addition, it can take a long time to get in to see a specialist like an obstetrician or gynecologist, Ms. Muskett said, especially for the growing number of women of the Navajo Nation who are being diagnosed with gestational diabetes.

"The clinics are having a hard time trying to make sure they're reaching out to everyone. They're having evening clinics, they're trying to extend their hours, but it's really difficult," she said. "You'll see some of the women, they'll just leave because they don't want to just stay and wait for their appointments."

There are other challenges: There are not enough doctors, especially specialists, and people move and can be difficult to find. "There's a lot of Yazzies; there's a lot of Begays," Ms. Muskett said, referring to some of the most common last names for Navajos.

There is an entire system of providers, which C.O.P.E. supports, who take prenatal care to women living on reservations, and even some hospitals on Navajo land that are bringing traditional Navajo practices into birthing. But building trust has been difficult.

Most doctors who work with Native populations are not from Native communities, Ms. Muskett pointed out. "And the other thing is, I think, they're not here for the long term. They're not here to build those relationships."

And when it comes to I.H.S. facilities, the problem is compounded by memories of the forced sterilizations performed on Native American women.

Ms. Muskett thinks that, for the most part, I.H.S. is doing good work for the Navajo people. But she also remembers something that happened earlier in her career, when she worked as an environmental research specialist, surveying pregnant women about contamination from uranium mining.

"People were so angry at the uranium companies for coming in, for polluting the area, for having the mines," she said. At one community meeting, someone said, "You know, if we could just get the companies or the president of the United States to apologize to us, we can let this go. And, thinking about that, you know, maybe that's something that I.H.S. needs to do."

"They need to publicly come out and say, 'We're sorry


Lauren Gilger

for what happened in the past; we're sorry we did all of these things to you as a community, but we want to change now.'"

The Legacy of a Social Sin

The roots of these challenges for Native American mothers go far beyond recent history, according to Jeannine Hill Fletcher, a Catholic theologian at Fordham University.

Her work has focused on motherhood and racism, and more recently she has begun looking at the intersection of those topics. In her current work, she is asking more specific questions about women of color and their acts of resistance in the face of white Christian supremacy.

And just as Christina Novoa discovered in her research, Ms. Fletcher said none of this is happenstance.

"The maternal mortality rate and the infant mortality rate for indigenous women in this country isn't by accident," Ms. Fletcher said. "It is an economic reality that is directly traceable to legislation and historical dispossession of indigenous peoples in the U.S."

Moreover, she does not see the problem as being a strictly secular one. What is happening to Native women is, at least in part, the result of a social sin that Christian theology played a part in creating, she said.

Ms. Fletcher points as far back as the Doctrine of Discovery, which, for centuries, by papal decree, allowed Europeans to seize Native peoples' lands in the name of discovery. It was enshrined into law by the U.S. Supreme Court in 1823, and it still affects indigenous nations in the United States today, Ms. Fletcher said.

"Part of witnessing the struggle of these women is that it's an economic struggle," she said, "and that economic struggle has legislative roots in Christian theology, Christian ideology and Christian practice."

In Ms. Fletcher's view, what Ms. Gonzales and others like her are doing is an act of resistance. Women are finding strength and power in their historically marginalized traditions, she said, "which should say something to Christian theologians. And say something to Christians."

Ms. Fletcher calls such resistance "the empowerment, the nearness of the divine."

There is a word for this in Christianity, too: grace.

And that raises another question for Catholics and Christians, Ms. Fletcher argued. "If Christians see this as a practice that brings people in touch with the sacred reality, the divine reality, how might we mobilize resources to empower that practice?"

These traditional, indigenous birth practices should never have been erased in the first place, she said, and indigenous women should never have had to suffer the consequences.

"There should have been no need to rediscover this," she said.

Seeking Closure

About five weeks after the mothers she has cared for have given birth, Ms. Gonzales assists the healer who works in her practice in performing a ceremony called the Closing of the Bones.

They boil medicinal herbs in a pot for a new mother to sit over. "It soaks into her pores; it causes her to sweat," Ms. Gonzales said.

Then the mother is wrapped in a blanket, and the midwife uses her hands to massage muscles stretched out from months of carrying a child. It is a physical closure as well as an emotional one.

"We talk about the birth and things you were happy with, things you weren't happy with," she said. "It's really more for you to release whatever feelings that you're harboring—even if it's crying or whatever. You just let it go."

The herbs are meant to make the mother rest, and maybe sleep, a welcome respite for any new mom. "And then we feed you after," she said.

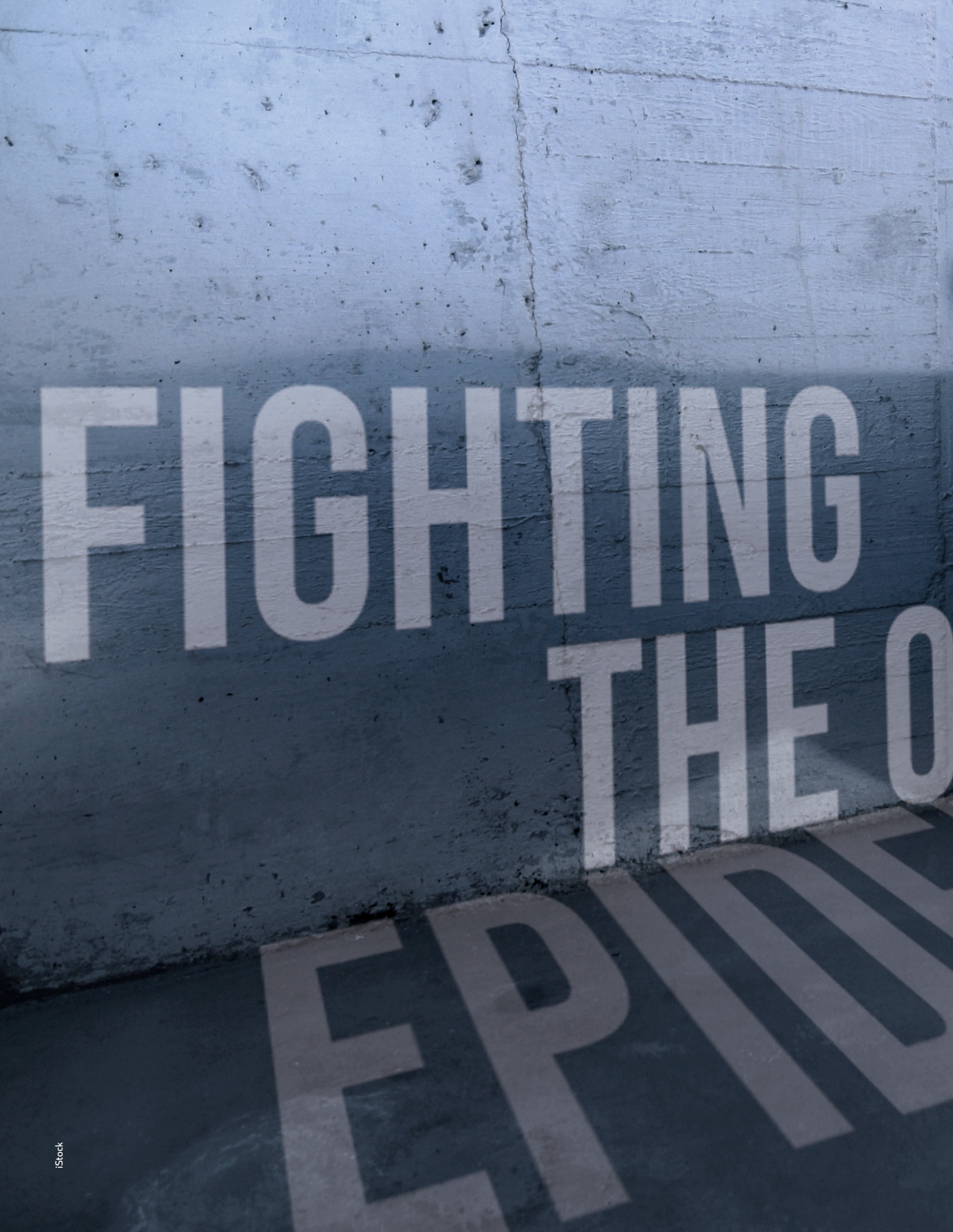
Ms. Gonzales said it is mostly young women who seem to be interested in home birthing.

"They're 30, they're 25; I have somebody who's 18," she said. Their mothers and aunts are often skeptical. But these young women on the brink of motherhood see it differently, Ms. Gonzales said.

"They're really seeing this reclaiming of birth as a way for them to be activists of their own bodies."

Editor's note: ***America*** *reached out to the Indian Health Service multiple times for comment on this story but received no response in time for publication.*

Lauren Gilger is *a multimedia journalist, host and producer at KJZZ News, the National Public Radio station in Phoenix. In 2013 she was the recipient of the prestigious George Foster Peabody Award and an Edward R. Murrow Award.*



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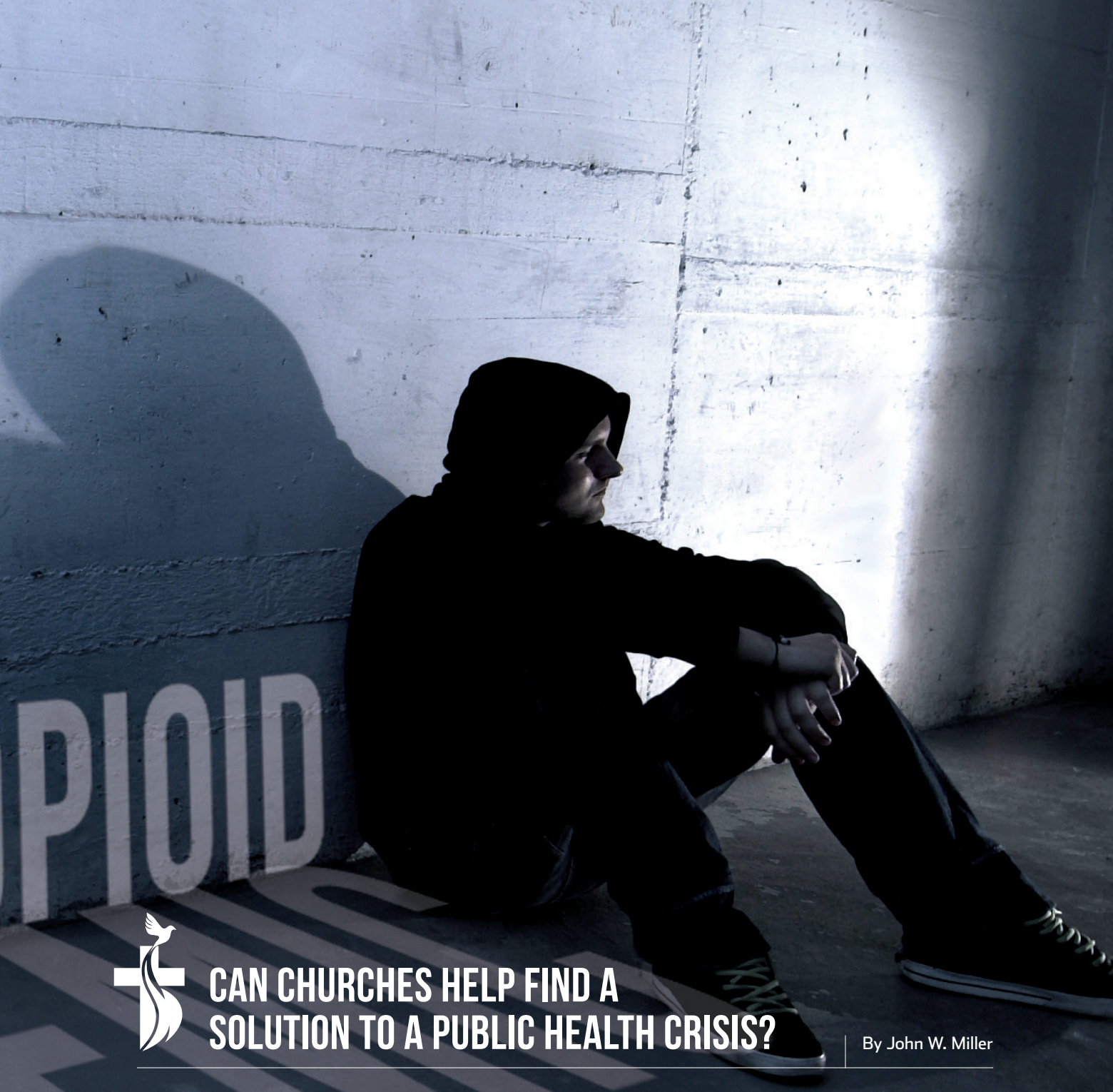

CAN CHURCHES HELP FIND A SOLUTION TO A PUBLIC HEALTH CRISIS?

By John W. Miller

In 2009, Eryn Jobe of Huntington, W.Va., then 21, gave birth to a girl. For postpartum pain her doctor prescribed Percocet, a legal opioid. "It was like somebody had lit a candle," says Ms. Jobe. She got addicted to pills, and then to a cheaper fix, heroin.

For years, Ms. Jobe got high, paying for her addiction with petty thefts and other hustles. "I hated the person that I was, but with addiction comes a different mindset; it becomes not a choice anymore," she says. "I lost friendships, I lost my family, I lost my jobs."

It was not until her boyfriend, a "full-blown addict," overdosed in the passenger seat of her car as she was driving during the summer of 2017 that she woke up. "There was no compassion," she says describing her feelings following the incident, which ended with the man being revived with Narcan, an overdose reversal drug. "And when I realized I'm not having normal human emotions, I started to contemplate my whole situation."

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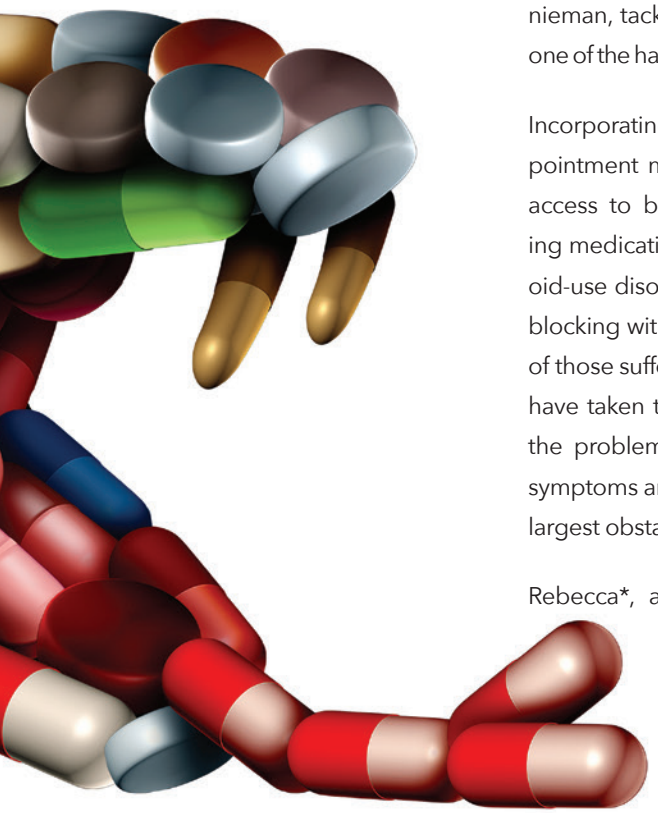
SOMOS

HOW SOMOS IS FIGHTING THE OPIOID BEAST

Across the United States, Opioid Use Disorder has become a public health crisis, devastating communities across the country affecting both young and old, rich and poor, and those from all racial and ethnic backgrounds.

In West Harlem to address the epidemic's effects in New York City, SOMOS Chief Medical Officer Dr. Diego Ponieman launched the "BUPE Group" in 2017 at Metropolis Medical Office to provide patients battling addiction with options for treatment within their primary care. This program uses a Shared Medical Appointment (SMA) approach, which allows primary care physicians to treat patients with Substance Use Disorder (SUD) and offer wrap-around SUD services such as substance abuse education, peer support, and counseling in a safe and confidential environment.

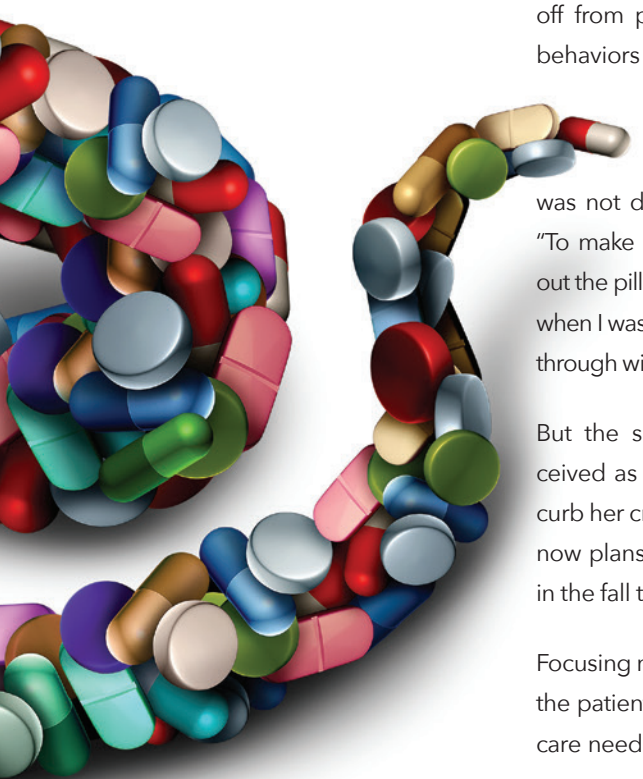
SOMOS – a nonprofit, physician-led network of over 2,500 physicians serving over 700,000 patients in lower income, immigrant-rich communities – works in the most underserved parts of New York City with culturally competent care that reflects the diverse backgrounds of their patients and doctors. Through the program, Dr. Po-



nieman, tackles the addiction problem in one of the hardest-hit areas in New York City.

Incorporating the shared medical appointment model, the initiative increases access to buprenorphine, a non-addicting medication which is used to treat opioid-use disorder by curbing cravings and blocking withdrawal symptoms. For many of those suffering from addiction and who have taken the first step to acknowledge the problem and seek help, withdrawal symptoms and cravings can be one of the largest obstacles in their path to recovery.

Rebecca*, a 23-year-old student found her way to the BUPE Group to help combat just this issue while enrolled in university. Having begun taking pain killers recreationally, Rebecca reached a turning point, recognizing a dependence to the dangerous drugs and decided to make a change. She cut herself off from people who encouraged these behaviors and sought help.



" I realized it was messing with my life; I failed two classes and was not doing well in school," she said. "To make matters worse, I felt awful without the pills; my anxiety increased so much when I wasn't on them or when I was going through withdrawals."

But the suboxone prescription she received as a BUPE Group patient helped curb her cravings while in school, and she now plans to go back to school full-time in the fall to complete her degree.

Focusing not only on addiction issues but the patient's overall medical and primary care needs, the BUPE Group offers more than just medical examinations, but also education and social and psychological support. To reduce the likelihood of overdose and decrease the probability that patients will re-engage in risky behaviors, the program also promotes proper self-management and treatment, encouraging patients to make informed healthcare decisions and supporting them to be set up for success.

Through the group appointments, patients with similar substance abuse issues become peers and support each other through their recovery. Martin*, a 59-year-old BUPE Group patient, said receiving care through the group helped to eliminate cravings that plagued him for decades and to get other health conditions, including high blood pressure and diabetes, under control.

"It helped me to change everything in my body," he said. The shared medical appointments, he said, helped him to realize he wasn't alone.

As a result, patients have reported their satisfaction with the program. Patients like Rebecca have been able to rehabilitate and return to school, find employment and support their recovery efforts while managing their medical conditions.

So far, Martin and Rebecca are among dozens of patients who have successfully received treatment through the program, and SOMOS is dedicated to recruiting additional providers to expand care to those who need it most.

For more information about the BUPE program, contact Nathel Hernandez at nhernandez@somoscommunitycare.org.

**Name changed to preserve the patient's privacy.*

www.SomosNYHealth.org

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She decided to seek treatment.

How to help people like Ms. Jobe in that pivotal moment of enlightenment and openness is one of the most important health questions in the United States today. An estimated 11.4 million Americans abused prescription pain drugs in 2017, according to government data. Almost one million used heroin, and 75 percent of those people started by abusing prescription drugs.

Doctors, counselors, politicians, prosecutors and pastors are converging on new approaches that combine medicine, law enforcement, drug counseling and spiritual direction. "At first, I thought drugs were a law enforcement issue," says Steve Williams, the mayor of Huntington, which has been ravaged by addiction. "But it's way more complicated; you need to look at everything."

What makes opioids different is that long after any crime related to the drug has been committed, the people who ingested the opioides are still living with their addictions. Opioids, which are derived from, or mimic, opium, a drug made from the poppy plant, block the brain's perception of pain, an almost irresistible lure once it has been experienced. Yes, there is some choice involved in taking that first pill, but the rest of the addict's journey is often without capacity for choice or restraint, experts say. That makes it a public health issue, and when people like Ms. Jobe are ready to get better, it is essential that society respond to their moments of clarity.

THERAPY VERSUS MEDICATION

Huntington recently developed "quick response teams" to respond to any report of an overdose. These teams include a police officer, an emergency medical technician and either a recovery coach or a clinician. That kind of holistic approach, which is becoming more common, knits together two approaches that have often been at odds.

On one side is a kind of therapy broadly known as a 12-step program that follows the guiding principles of Alcoholics Anonymous, or AA, a popular self-help group founded in Akron, Ohio, in the 1930s. AA and other sister organizations preach abstinence, surrender to a higher power and the creation of a supportive network of friends and fellow addicts.

On the other side is weaning patients off dangerous substances with a range of milder drugs, like methadone or Suboxone, opiates that are not as strong or addictive. Without these drugs, many doctors say, patients are at risk of overdosing when they relapse, consuming an amount of opioides their bodies are not prepared for. But these drugs can also prolong addiction or be abused and trafficked.

A new consensus, driven by a desperate search for new solutions to a vicious and unexpected public health crisis, is emerging that the best approach to treating people like Ms. Jobe involves combining different approaches from both ends of the drugs-or-abstinence spectrum. We need to stop "pitting one treatment modality against another," says G. Caleb Alexander, M.D., the co-director of the Johns Hopkins Center for Drug Safety and Effectiveness. The upshot: Clinics are hiring pastors; faith-based groups like Catholic Charities are prescribing pills; and you hear people on both sides of science and religion saying basically the same thing.

The solution to the "current opioid crisis is one that involves the whole person," says the Most Rev. Edward Malesic, the bishop of the Diocese of Greensburg in western Pennsylvania, a region hit hard by opioids. "The use of opiates changes the chemistry of the brain. It's a sticky disease. Our brain is wired to want air and water. If you're addicted, your brain is wired to want opiates; and it's a strong addiction, so you need both a medical and pastoral response."

The stakes are high. Developing better treatment could save tens of thousands of lives. According to the Centers for Disease Control, in 2017 there were 70,237 deaths by drug overdose in the United States, at a rate 10 percent higher than the year before. Around 50,000 of those involved opioids.

'GETTING AHEAD OF YOUR PAIN'

The opioid crisis mushroomed in the 1990s, when doctors in the United States started treating pain more aggressively, adding it as a fifth vital sign, along with temperature, pulse, respiration and blood pressure. They even talked about "getting ahead of your pain," prescribing opioids pre-emptively. Also, in a health care system that often chases profits, it made more sense to quickly prescribe a pill than to work with somebody in pain on a longer treatment plan involving healthier alternatives, like diet or exercise.

Around that time, Purdue Pharma started aggressively marketing OxyContin, a mass-market opiate painkiller that promised a slow release of opiates, which would make it less addictive. Still, millions got hooked, building a market for the heroin from Mexico that was then flooding the United States, and in this decade, synthetic opioids fentanyl and Carfentanil, which are much stronger and more dangerous.

Purdue did not return a request for comment. It is in the process of paying out hundreds of millions of dollars in compensation, recently settling with the State of Oklahoma for $270 million. In addition, museums are starting to

Photo: John W. Miller

The solution to the "current opioid crisis is one that involves the whole person," says the Most Rev. Edward Malesic, bishop of the Diocese of Greensburg in western Pennsylvania.

reject donations from the company's owners, the Sackler family, who are among the world's leading philanthropists.

As those battles get settled, policymakers say the focus now should be on treatment.

The natural alliance of public officials has often been with the medical community. Medical treatment involving drugs "is especially valuable early in a recovery," says Dr. Alexander, the Johns Hopkins doctor. He says treatment drugs have been unfairly stigmatized as a fraudulent form of getting clean. "We don't talk about 'medication assisted treatment' for asthma and diabetes," he points out. "There are medications for addiction like there are medications for other chronic diseases, and anyone who wants treatment with medicine should have access to them on demand."

The fiercest opponents of that point of view are recovery coaches in the 12-step community, many of whom are recovered addicts themselves.

People who are taking Suboxone and methadone "are running around telling people they're in recovery, but my definition of recovery is abstinence, plus change," says the recovery coach Justin Patton, 37, who has been clean for over three years, thanks, he says, to a 12-step program. "The meetings are a reminder you're not alone," he says. "I can go to a meeting and see one person doing better than me, and 10 people who aren't."

Mr. Patton admits that heroin haunts him. After I ask a couple of questions about the drug, he replies, "You know, if we talk about heroin, that's going to give me a thought, and the thought could turn into a craving, and that craving could become an obsession, and that could make me want to use again." Putting words on those feelings helps control impulses, he says. Spooked, I change the subject.

The frequency and pain of relapse is a tough and demoralizing fact for families of people with addictions and the people who treat them. They say one needs to learn to treasure any day without drugs, even if a relapse follows.

In November 2017, Terry Allebaugh, an activist for the homeless in North Carolina, took his 37-year-old son Eli to a meeting at the White House about addiction, which was chaired by Chris Christie, the former governor of New Jersey. It was a hard decision. For over a decade, Mr. Allebaugh had fought to help his son get off heroin. "For a teenager who was smart, artistic, engaging and athletic, I could not have imagined such a path for my son," Mr. Allebaugh told Mr. Christie. "It's a path that's included arrest and incarceration, multiple stays in numerous detoxification programs."

One problem, he said, was a lack of connection among social services. "The elements of response to his situation never seemed to be connected in a comprehensive way that would lead to an integrated life of employment and independent living," he said. People with addictions get lost in the system. Once, Eli had to wait 15 hours in an emergency room.

Mr. Allebaugh then revealed that it was Eli's birthday, and that he was in the room. "It's truly a celebration for us not only to have your testimony but to have your son here," said Mr. Christie, according to a recording of the event. "I'm hoping that today provides him encouragement to keep staying the course," Mr. Allebaugh responded.

In February 2018, Eli died of an overdose of fentanyl and heroin.

The trip to Washington in 2017 "was a good day for Eli," Mr. Allebaugh says. "I think you have to maintain that perspective, that every day is precious."

Mr. Allebaugh is one of many parents who wish their child had been given more options. "He was active in 12-step programs, and I think medical treatments could have helped," he says.

"There's so much stigma about medical treatment within the 12-step community," says Carmon Capozzi, whose son overdosed in 2012. "My son went to rehab a few times, and was never prescribed" treatment drugs. "I think that could have helped him," he says.

> I HATED THE PERSON THAT I WAS, BUT WITH ADDICTION COMES A DIFFERENT MINDSET; IT BECOMES NOT A CHOICE ANYMORE.

A COLLECTIVE ADDICTION

One reason for the stigma is politics. In the 1980s and 1990s, religious and conservative political leaders coalesced around their opposition to abortion, predisposing churches to preach in support of personal responsibility for one's actions, says Jason King, a professor of theology at St. Vincent's College in Latrobe, Pa. This campaign, combined with Ronald Reagan's War on Drugs, reinforced the notion of addiction as a weakness or sin.

That way of thinking is misplaced, says the Franciscan writer Richard Rohr. "Healing should be our primary mission, not sin management," he says in an interview. "Most of what Jesus did for three years was heal." He adds: "Our real addiction is collective, to comfort and consumerism. Our society has lost its tolerance for pain, and that enables addiction."

The scorn that many have for people who are addicted to opioids reflects "our culture's obsession with other people's sin," says Father Rohr. "Jesus' message was to not throw the stone."

The thinking of churches and their spiritual allies is evolving, with the growing realization that previous efforts at battling addiction only in a spiritual way—like 12-step programs—are poorly designed to cope with monsters like heroin and fentanyl.

When Nina Corona's teenage daughter became addicted to heroin at 17, Ms. Corona had just quit a career managing a food company to study theology. She is currently finishing a doctorate at Fordham University. After learning of her daughter's addiction, she started a ministry called We Thirst, which runs workshops to educate people about addiction. Out of that grew a nonprofit called Afire (Active Faith Implementing Relief in the Epidemic) that helps parishes fight addiction with counseling, education and other actions. "There is a spiritual component," says Ms. Corona. "But this is more than about mastery of the self. Addiction to opiates is very powerful, and you need to understand the biology, physiology and sociology. That's why 12-steps may not always be enough anymore."

One big shift, she says, is that pastoral workers need to understand that addiction is a lifelong condition, and that some people need to take methadone and other proxy drugs for years before getting clean.

Another new group, Medication Assisted Recovery Anonymous, has combined the 12-step program with an acknowledgment that medication is necessary. Members can still participate even if they are taking recovery drugs. They are still considered "clean."

More and more of the programs run by Catholic Charities in Baltimore include "substance use counselling, including medical treatment," says Rowena Daly, a spokeswoman. The city suffered 607 opioid-related deaths in the first nine months of 2018, up from 354 over the same period in 2015; and the problem has become so widespread that Catholic Charities has made an extra effort to connect services better across departments, says Ms. Daly. "For example, if a parent in Head Start has an addiction issue, we can offer them treatment services and therapy."

'WE CAN COME BACK FROM THIS'

There are few places where the question of treatment is more urgent than Huntington, a proud college town of 50,000—home to Marshall University—at the intersection of the Ohio, Kentucky and West Virginia state borders. In 1970, a plane carrying the university football team crashed, killing all 75 people onboard. The memory of that team is invoked as inspiration for overcoming the opioid crisis. "We came back from that, and we can come back from this," says Mr. Williams, the mayor, who played football at Marshall and keeps a picture of the team that died behind his desk. "We want to be known as the epicenter of the solution to the opioid crisis."

Nonfatal overdoses in the county were down over 40 percent in 2018, and the mayor credits a new initiative called the Provider Response Organization for Addiction Care and Treatment, or Proact. Housed in an old CVS pharmacy building and launched by a coalition of hospitals and smaller medical providers, the clinic, which has a capacity of 700, offers a range of services covering abstinence and medication-based treatment, including drugs, individual therapy, career placement and monitoring, and even spiritual counseling—all in one place.

Doctors and analysts say the approach is innovative and a harbinger of new approaches being developed elsewhere as well. Recent visitors to the program included top C.D.C. officials and the British ambassador.

"There's not one solution that fits everybody," says Dr. Stephen Petrany, left, of the Marshall University School of Medicine. Eryn Jobe, right, has emerged from opioid addiction through a combination of medication and therapy.

Photos by John W. Miller

After patients come in, they are assessed by a drug treatment counselor and prescribed a course of treatment. "There's not one solution that fits everybody," says Dr. Stephen Petrany, a board member who is the public face of Proact and chair of the Department of Family and Community Health at Marshall's School of Medicine.

A tall, wiry, 64-year-old Brooklynite who moved to Huntington in 1989 to care for underserved people in Appalachia, Dr. Petrany says the medical community regrets its embrace of opioids in the 1990s. "We all thought it was safer than it actually was," he says. "But that's over now, and it's important to look to the future."

Dr. Petrany is a trained family physician, which he says, "taught me how important personal relationships are when you're trying to heal from anything." It also taught him that one size does not fit all. Also, he says, he learned that the human body is mysterious.

Working with people with addiction is a job full of heartbreak. Dr. Petrany describes the overdose of a 21-year-old woman he had known when she was a child. "The family called me and said 'fix this,'" he said. "Now she's at home, taking meds, struggling, but that's a victory," he says. "It's hard for me to judge negatively somebody that I've taken care of since she was a kid."

There are changes in the brain "that happen that you can't wish or pray away," says Dr. Petrany. "I'm a serious Catholic, but there are issues where you don't just appeal to a higher power."

Another point on which medical and spiritual leaders agree is that this country needs to rethink its attitude toward pain. "There's this idea that medicine should be able to relieve any suffering you have, and that's wrong," says Dr. Petrany.

At Proact, staffers are trained to tailor their treatment. "If it's somebody who's just dabbled in opiates and they have a good support system, then abstinence is probably best," says Michael Haney, director of the center. "If it's somebody who's really hooked, then they're probably going to need medication."

After an assessment by a counselor, the Rev. Noha Khoury, a Presbyterian pastor, often gives them a "spiritual assessment." There is no proselytizing. "We try to determine each person's specific spiritual needs, what gives their life meaning," says Rev. Khoury. "It's about helping people find out their authentic desires, what makes them happy." The idea is to reorient people's hearts toward something healthy they can love instead of drugs, and that can help them rebuild community. That is often through a church, but it can also be through other shared activities, like crocheting or basketball.

It was on a recent visit to Proact that I met Ms. Jobe. It was her first day there. After deciding to try to get clean, she had problems finding a treatment program. This is not uncommon. People who overdose and end up in emergency rooms often do not know where to seek treatment. But many hospitals do not see it as their job to treat people after they come back from overdosing.

Through a friend, she found a local hospital that is participating in Proact. Her doctor there has put her on one strip of Suboxone, which she takes sublingually every day. "It's completely changed my life," she says. She has a good job and custody of her daughter.

The emphasis on human connection is healing, too. "I adore my group therapy family," she says. "We know each other, we support each other." She talks to her counselor every two weeks.

Her dad is a minister, she grew up in a church, and even though she is on medication, she also credits faith for recovery. "I found God through addiction, as strange as that sounds," she says. "You have to realize there's a higher power. After I accepted that, everything fell into place."

She describes the treatment drugs she takes as medicine. "People think you're trading one addiction for another," she says. "but if that's what it takes to not lose your kids and not lose your family, then it's worth it."

John W. Miller *is a Pittsburgh-based writer and former staff reporter and foreign correspondent for The Wall Street Journal.*

Archives, Sisters of Charity of New York

Quiet Courage

The secret history of Catholics caregivers and the AIDS epidemic

By Michael J. O'Loughlin

A mother of five needed help navigating multiple medical appointments, sorting her medications, arranging transportation and completing the many other day-to-day challenges that confronted people with H.I.V. and AIDS in the early years of the epidemic. Julie Driscoll, a Sister of Charity of Nazareth, remembers this particular woman because even in the face of the fear and uncertainty that accompanied a diagnosis then, she learned a lesson about gratitude.

"Toward the end, when we would say, 'Winnie, how are you?' she would always say, 'I'm blessed,'" Sister Driscoll recalled recently. "Can you imagine?"

For the past few years, I have researched how the Catholic Church, both the institution and individual believers, responded to the intense suffering of the most marginalized during the AIDS crisis in the United States. For those of us who are too young to remember, the scope of that suffering can be difficult to comprehend. According to the AIDS research group amfAR, more than 319,000 people in the United States died of complications related to H.I.V. and AIDS between 1981 and 1995.

Many of them felt abandoned by their friends and family and by the institutions that should have responded with both compassion and bold action.

"People were desperate. Your friends were just dying every week," recalled Andy Humm, a gay rights activist and journalist.

More than a few Catholic priests, sisters and brothers, and laypeople confronted the stigma perpetuated by nearly every sector of society, including the church, by responding pastorally to the H.I.V. and AIDS epidemic in the early years. Sister Driscoll was among them.

From 1993 to 2003 she was the executive director of the House of Ruth, a social services center in Louisville, Ky., founded by a handful of other sisters and their friends in 1992.

In its earliest days, the House of Ruth was not so much a "house" as it was two rooms nestled inside a parish rectory. People managing H.I.V. and AIDS, mostly women and their children, stopped by the House of Ruth for assis-

Nursing students treat a patient in the
AIDS ward of Saint Vincent's Hospital in New York in the 1980s.

tance. Sometimes they needed help finding a doctor willing to treat them—this was a time when even some health care professionals would not touch patients with H.I.V. or AIDS—or needed just for few dollars for bus fare so they could run errands. They also sought assurances that they were not alone.

"People often asked me, what should I do if I know someone who has H.I.V.?" Sister Driscoll recalled of her efforts at community education. Her response was: "Touch them, please. Hug them if you can."

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Today, the House of Ruth is a multi-site housing and social services center that serves more than 600 people annually. (It is estimated that about 6,600 people in Kentucky live with H.I.V.) It is one of the largest resources of its kind in the state, which has experienced a surge of new H.I.V. diagnoses in recent years.

Challenges remain in eradicating H.I.V., but a diagnosis is no longer a death sentence. Medications are available both to decrease the transmission of H.I.V. and to slow or eliminate the progression of H.I.V. to AIDS.

So why am I interviewing dozens of people about events 30 years ago, asking them to describe moments marked by sadness, fear and anxiety? It has been decades since many of them thought about those experiences. I have noticed that often when I wrap up these conversations, the person I am interviewing will say something like: "I hope that was useful. There's just so much I don't remember."

And sometimes they will reach out a few weeks later.

They might have rummaged through their personal files or reached out to a friend or former colleague. They now have more to tell me. In follow-up conversations, they make the lives of their lost friends more vivid, recounting quirky personality traits or memorable dinners. They also articulate more clearly their sadness and remember their feelings of helplessness.

These encounters are always moving, but I seek them out for more important reasons than simply wanting to learn about the past.

First, many of these stories of ordinary people responding to suffering in an extraordinary fashion have not yet been captured in forms that will last. Given that the first case of what would become known as AIDS was reported in 1981, nearly four decades ago, many of the people who were on the front lines then are now in old age. Time is not on our side.

Second, the institutional church's relationship to L.G.B.T. people today is fraught. But there are historical examples of kindness between Catholics and L.G.B.T. people during the epidemic that can be helpful as we navigate major societal shifts.

Many people in my generation—I am in my 30s—have left the church because of the perceived hostility of some church leaders toward those with non-normative sexualities. People younger than me often look past the church entirely when trying to order their lives for similar reasons.

H.I.V. and AIDS affected more than the gay community. But I focus on the relationship between the gay community and the church at that time because it provides previously unknown stories of Catholics overcoming social bias. I am eager to listen, and I seek to help share their stories of quiet courage.

Take Michael Carnevale, O.F.M., a Franciscan friar who for many years ministered at the Church of Saint Francis of Assisi, a large parish just across from Pennsylvania Station in New York City.

During a sabbatical in the early 1980s, Father Carnevale lived in San Francisco's Bay Area. He befriended a man named Michael and his partner, Donald. Michael, an artist whose love for life manifested itself in the epic costume parties he hosted, became sick. He lived with H.I.V. for about three years. During this time, Father Carnevale spent weekends with his friends, helping out as Michael grew weaker.

On Halloween night 1983, Michael died. He was surrounded by about 30 friends, each in costume for one last party. Father Carnevale was among them. Moved by his friend's suffering, Father Carnevale decided to do more. He volunteered as a chaplain at San Francisco General Hospital, visiting the mostly gay men who were spending their final days in a ward for people with H.I.V. and AIDS. He quickly came to understand that these men needed more than medical care. They needed to know people cared about them.

"At that time, the church was really not that involved," Father Carnevale recalled in an interview in 2017. He knew there was a need, but he was not sure who could help. His mind turned to a group of "old Italian ladies" who met regularly at Mission Dolores Parish in San Francisco. He asked if he could address the group, and they agreed.

> Many stories of ordinary people responding to suffering in an extraordinary fashion have not yet been captured in forms that will last.

"I told them of the need that we had, that young men and young women [with H.I.V. and AIDS] were [alone] in their apartments and they really didn't have anybody to take care of them," he said.

He asked if some the women would consider volunteering.

"I didn't know what kind of response I would get, but it was amazing," he said. "They would go and they'd clean and they'd cook. Some of them would even take some of the guys and the girls to the doctor's appointments because they didn't have anybody."

Homemade meals, clean apartments and rides to appointments may seem insufficient at a time when the communities most affected by H.I.V. and AIDS required systemic change—in health care, government, religious institutions and nearly every other sector of society. The church is hardly without blame when it came to creating a culture of fear and judgment around H.I.V. and AIDS. But for those who felt abandoned and alone, those acts of kindness were more than gestures. They were lifelines to the outside world.

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It is impossible for anyone who was not alive at the time to feel viscerally the fear that permeated communities ravaged by H.I.V. and AIDS in the early days or to understand the abandonment and isolation many individuals experienced in their final days. But I have sat quietly with men who, decades later, tear up as they recount all the friends they lost in just a few years. I have looked in awe at Catholic sisters, now in their 70s and 80s, who wince at my suggestion that their work was extraordinary, if not heroic.

"This is not a bunch of martyrs in that period. It really isn't" is how Pascal Conforti, an Ursuline sister, put it. Sister Conforti was the director of pastoral services at the former St. Clare's Hospital in New York's Hell's Kitchen neighborhood. Before it closed in 2007, St. Clare's served a large number of patients with H.I.V. and AIDS. "We did what we did because that was where [we were] at the moment."

Though most of the people I have interviewed resist praise, a thoughtful look at this time in history shows that each kind response to the H.I.V. and AIDS epidemic during the early years was, in fact, extraordinary.

Some people, Catholics included, made life more difficult for the vulnerable. The vast majority of Americans did nothing at all. But more than a few people provided a gentle touch, free of judgment and scorn. These are just a few stories. Many other people have shared their stories with me, and I am seeking to hear more, because embedded in these histories are lasting witnesses to the power of Jesus' call to love one another.

If you have stories from the early days of the H.I.V. and AIDS epidemic that you would like to share, please email the author at oloughlin@americamedia.org. Anna Marchese, a former intern at ***America****, contributed to the research in this essay.*

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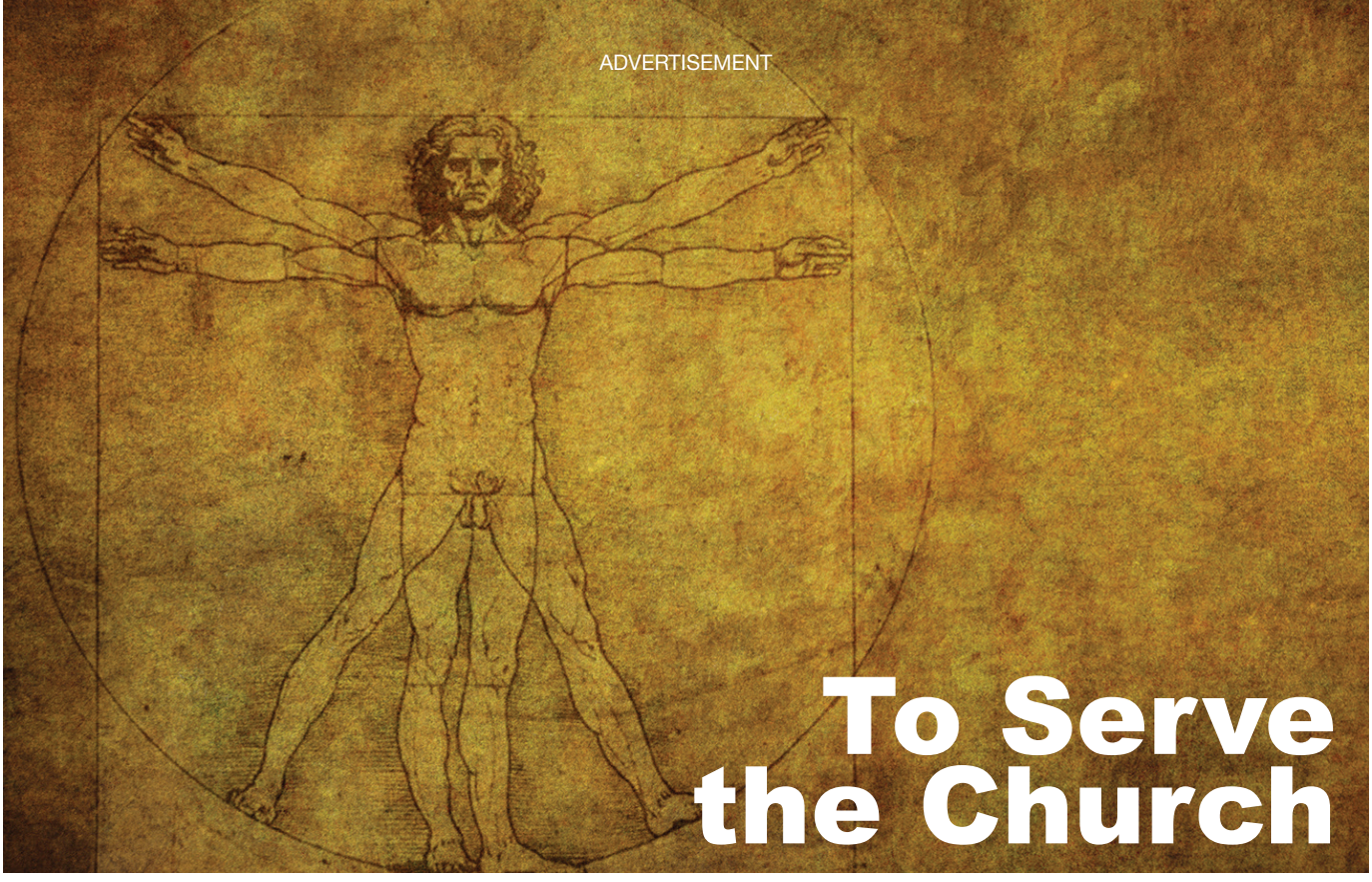


To Serve the Church

As Pope Francis has repeatedly said, what the Church needs are old people with dreams the youth can put into action. Ten years ago I literally had a dream of people moving to music beneath an egg shaped dome, at whose apex was a woman with wings. Beginning with a year of discernment in a Trappist Monastery where I ended up studying Greek and Medieval philosophies of harmony while being mentored in Trinitarian theology; and followed by nine years of independent contemplative study; I came to realize that the Trinity can more accurately be described as not just the three persons of the Father and the Son and the Holy Spirit, but as the perfect harmony of the three. By perfect harmony I mean: 'two' that are so perfectly disposed toward each other that they are indistinguishably 'one'. If we can think of the Father and Son as 'two' indistinguishable 'ones' then the Holy Spirit is their disposition toward each other – 2:1. This same disposition of 2:1 is perceived as the interval of an octave in music where the 'two' tones are felt to be 'one'.

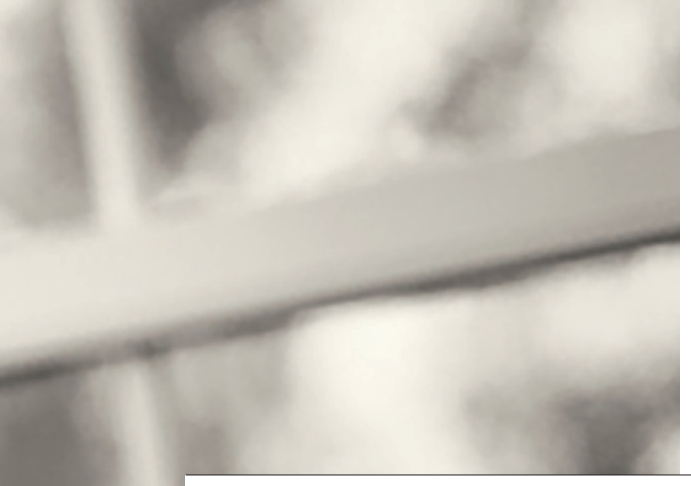
We also know God as truth and beauty and love. Since truth proceeds from beauty and the love we feel for them intensifies when they are more completely in accord, we have to ask ourselves, as a Church, why we have never developed a preK-12 graded course of study of music as truth and beauty as a supplementary component of the religious curricula. It would need to be very specific forms of music; and since the proportions defining musical harmony are not limited to sound but extend into movement it would need to incorporate dance as well. Although it would be a side benefit, the purpose is not to have a singing and dancing Church but for our children to grow up with a more heartfelt understanding of the Holy Trinity.

Something like this will not be an initiative from Rome that works its way down. That would be relying on our works rather than God's grace. This needs to be a groundswell where the grace of God touches the laity so that the hierarchy can take notice, give it form and incorporate it into its institutions. This is my dream and while I can write and speak about it and coordinate activities, it will not become a reality unless other people contribute their time and talent. And so, what I need to find are

- Spiritually minded young adults already advanced in studies of ballet, classical music, modern dance, and Jazz to (a): develop a new aesthetic based on a refined understanding of harmonic form and (b): create the movement and musical exercises to be employed in the graded course of study.
- Students of theology and those pursuing the priesthood or religious life who have either studied music or dance or have more than a passing interest in these arts to scrutinize the above statements and consider its impact on our other doctrines.
- Pastors who can see the potential benefits for invigorating and growing their flock by becoming involved with the incubation of this movement.

If I had a fixed agenda I could easily promote it on the internet and ask people to subscribe to it, but what I am looking for is people to work with in putting that agenda together for the benefit of the Church. Anyone in the above categories who would like to contact me to learn more and enter into a dialog can contact **Ralph Karow** at **ralphk@yandex.com** or call **718-690-1351.**

"I have just given up on what happens after I pray," says Kate Bowler. "I just pray boldly for healing and for others. But I will not measure effectiveness, because I think I can't."



Kate Bowler on Cancer and Christianity

The idea that we earn or even deserve the good things that happen to us seems, on the face of it, harmless. But what does it mean if, like Kate Bowler, you receive a diagnosis of Stage 4 cancer at 35? Is the cancer a sign you have done something wrong? Is God punishing you?

Those are questions Bowler takes on in her book, Everything Happens for a Reason: And Other Lies I've Loved, *for which she just won a Christopher Award. Her book points out the harmful implications of the "prosperity gospel," the theological idea that if we pray enough, if we are good enough, then God will send blessings our way. Bowler is a professor of Christianity in North America at Duke Divinity School, and she speaks from both an academic and personal perspective about common spiritual myths about health. Here she talks with the hosts of* ***America****'s podcast, "Jesuitical," Ashley McKinless, Olga Segura and Zac Davis. She explains what her cancer diagnosis taught her about American Christianity and more. The interview has been edited for length and clarity.*

Photo courtesy of Kate Bowler

When did that saying "Everything happens for a reason" start to ring hollow for you? Did something change for you when you were diagnosed with Stage 4 cancer at 35?

I would probably like to imagine that I was so sophisticated that I didn't need that phrase. But I spent so long studying the prosperity gospel—the idea that God wants to bless you with health and wealth and happiness—that I think I had really gotten used to it as this sort of synthetic explanation for the good and the bad stuff that comes up in your life. And maybe I used it a little bit as a motivation. Like, when something good happened, it just proved to everyone how insanely hardworking I was. I was probably a secret believer in that for quite a while.... And then the second I got sick, I started to realize how cruel it felt to hear someone say that when I was really struggling to understand why something so terrible could happen to me.

You've mentioned that even health care professionals—and you have interacted with lots of people in the field—can say problematic things. Is it somehow worse coming from people who should know better?

Last week, I was being wheeled into a procedure. I was in the gurney, in the sad medical gown and looking really scared. The nurse looked down at my chart and was like: "Oh, colon cancer at 35. Man. It really must be the stuff you guys are eating."

I would like to say it is bizarre, but I think it is probably the most human thing on earth. It is just to want to look at something hard and then just see a little bit past it, because it's too painful. It is all a pivot to control.

What would you say to someone who says that these efforts to gain control over a situation are actually harmless. Maybe these "reasons" work, as a placebo at the very least.

I think maybe one of the most beautiful things about what the prosperity gospel does is that it helps people set their horizons. I have seen it have a tremendous effect on people, their self-esteem and their joyful expectation that life can give you more. And so in those cases, I am always kind of happy for people.

I think the tricky part is when you have to hold a little more ambiguity about the good things and the bad things. Did you really deserve every wonderful surprise

> This is an entire country that does not believe in luck.

that came your way? And I find the prosperity gospel can be a little overly reductive and make people a bit cruel toward those of us who are not always so lucky.

It is just total audaciousness that we get to pray to God and we expect God to listen and sometimes we expect God to even change his mind. So I love the boldness of it. I have just given up on what happens after I pray. So I just pray boldly for healing and for others, and I think God gives us that dignity in prayer. But I will not measure effectiveness, because I think I can't.

You have spent most of your career studying the history of Christianity. What did you learn about American Christianity once you got sick?

This is just the country of individualists, endless triumphalists. I did not realize how much the prosperity gospel is just an American theology of divine bootstraps. This is an entire country that does not believe in luck as a fundamental concept. It just assumes that people eventually get what they deserve. And I am really hoping that is not true.

I think the way we talk about illness, cancer, in particular, it's like you are in a battle. You beat it. That has always struck me as really problematic.

I have tried to embrace it—like, I am a loser; I am absolutely on the losing team. But now I just kind of think, you know, Christianity is on the losing team. Jesus' life was certainly a bummer. All the "kingdom come" and "not yet" usually focuses on the "not yet," that we are waiting till God's reign comes. And in the meantime, we're going to be on the losing side. So come join me.

Have any of the responses you have gotten from readers surprised you at all?

Maybe the most confirming is that there is absolutely nothing special about a 35-year-old getting cancer. I think the deep tragedy, which I was grateful to be able to share with others, is that it is so bizarre how hard it is to suffer in this country without other people always trying to explain it away. And it felt so good to get those emails and letters that just said: "I'm in it with you. Life came apart for me, too."

What group of people do you think needs to hear this message about the prosperity gospel?

I am so grateful for nurses. They are usually on the front lines. If I could create love and community and a little more theological language for a certain profession, I would definitely pick nurses because I love some very much.

Is there a specific nurse that you are especially grateful for?

Oh, my Meg. She looks like a beautiful Anne Hathaway who just sort of floated into the oncology ward.

What does she do well?

She was my age, and Meg just made it seem like it was totally normal that we were in there together and that she was going to be fun and kind and cool. But then in this one little moment, she sat down next to me—and it was in the middle of treatment—and she said it in the lightest way, "I just want you to know I lost a child." And the way she said it, it was not like she was trying to dump on me. She was just building that bridge; she was communicating that she knew what it was like when everything falls apart and that we were on the same side. I could not be more grateful for the Megs of the world.

Do you think you have become more vulnerable like that in your own interactions?

Yeah, I'm a mess! Absolutely. I picked a profession, academia, where I could study for 15 years and then sort of climb, just keep climbing the career ladder. And my diagnosis knocked me so far down that ladder that it made me realize that this life can only be done together. And we are all going to be trading places in our misery. So you may as well just accept that and open your little heart, or else it is going to be a rougher road.

Metaphors so simple and clear

By Joe Hoover

iStock

In her Foley poetry contest submission, "Myself, the Almost Infinite (A ghazal)," Rainey Sierra writes about "My mother's eyes—bloodshot boondocks—Chicago sprouting from Tennessee soil, everything soaked in unanswered prayers." D. E. Kern's "The Weight of Fools" is set in "a town that breathes ore and exhales coke." Among the list of 21 phrases in Dagmawe Berhanu's "Different Ways to Say Thug" are: "Jesus in Hiding," "Unintentional Vaudeville Show," "It's just my phone" and "Mom alone in the chapel."

"Dilution" by Lydia Weinberger begins: "In which if my father had been my mother I had been Jewish,/ But my father was not my mother,/ And so I am not Jewish,/ Except for when I was seventeen/ Ecstatic at finishing my first school musical as a wife/ gogo dancer/ in 'Joseph and the Amazing Technicolor Dreamcoat.'"

The high-schooler Tara Pattilachan starts off her poem "The Auspicious Color of Joy": "I'm what they call a 'people-watcher.'/ Certainly, an ironic statement, because I'm actually blind."

Lewis Leone's "On the nature of feeling" drops in a metaphor so simple and clear you can see it exactly. Galaxies, he writes, were formed "gently/ the way honey falls from/ a spoon, silent in empty/ space."

Entrants to this year's contest included poems about the issues of the day, including sexual assault, human trafficking, walls, abortion, the Mueller Report, priestly abuse and screen addiction ("A Cry Against Cell Phones.")

Cover letters occasionally prove to be as notable as the poems: one poet wrote, honestly enough, "I am a twenty-three-year-old corporate sellout who has an affinity for creative writing." Another entrant described herself as "a 12-year-old trying to find her way in this confusing world, through her poems." One letter was moving in its plain and simple query: "I often wonder what God is thinking. I mean did he know that we would destroy ourselves?"

All told we received roughly 1,200 submissions, which I whittled down to 31 to share with the two other contest judges—Emma Winters, a Joseph A. O'Hare fellow here at **America**, and the 2014 Foley prize winner, Dan MacIsaac.

For the first time in my six years as poetry editor, a student poem made the final round. Among the many evocative lines in "What Helps Me Sleep at Night," by 18-year-old Thaili Barrios: "All my life I've been loud and incoherent/ because silence feels like there's a dead body in the room/ and that dead body is always me." The poem ends: "More of me will melt the sun and less of me/ would make the world go quiet./ Listen,/ There is light in all this noise."

The final round was filled, for some reason, with many poems about animals and historical figures: a cormorant ("Great Cormorant's Blessing,") a shrike ("Shrike"), Ralph Waldo Emerson ("Outside Concord, Massachusetts"), Ruth ("Ruth"—Bible, not baseball), a lamb ("Agnus Dei"), five birds on a utility wire ("Or"), St. Francis ("Francisco's Flight to San Lorenzo"), birds in general ("Night to Her Birds"), Walt Whitman ("Searching Out Walt Whitman") and a poem that included both saint and bird: "Saint Agnes Meets a Hawk on the River's Edge."

The three runners-up we selected—to be published in subsequent issues—continued the theme: "St. Perpetua/St. Felicity," by Bryce Emley; "Ghost Sounds," by Robert Jackson, which features a host of animals now extinct; and another poem that featured both man and fowl: "Thanks a Lot, Shakespeare, for the Starling," by Jonathan Greenhause.

The winner of this year's Foley Poetry Contest is "Arise," by Marjorie Maddox. The poem is—well, I'm not a fan of taking a piece of art and telling people how or why it is so good. People just have to experience it. We hope you like it as much as we did.

Joe Hoover, S.J., *is* ***America****'s poetry editor.*

The editors of ***America*** *are pleased to present the winner of the 2019 Foley Poetry Award, given in honor of William T. Foley, M.D.*

Arise

By Marjorie Maddox

July 2018, during the Thailand cave rescue

This is the prayer of all parents
in whispers, in screams, in the near-silent
gasp sinking to groan outside the dark cave
of the dead and the maybe-gone (who can tell
what the gruesome air is chewing), the unknown
hovering its blind hope too high,

too high. This is your language; this
mine, lament swirling the undercurrent
of belly, twisting the tunnels' neck
into blind holes, dead ends,
while the now-maimed but still
living parents beg, "Arise, come forth!"

"Come forth!" the doctor-priest I don't know
commands my child, who has barricaded
herself behind boulders of her own making—
too large. "Too large," she cries when the divers
swim under, around; instruct her to breathe
more deeply the length of her labyrinth

that turns now into stones not thrown
but shouldered by the belief of swimmers,
by the petitions of ancients, by the precise
calculations of strangers marking the thin space
between supplications rising daily
in a common language of grief

or relief swallowed again and again in the narrow
cavern of waiting, someone else's words
bobbing steadily in the dark night of the cold,
the faithful ritual of rescue ready to begin
again for this child, and this one, and even
mine, miles below belief and barely breathing.

Marjorie Maddox *has published 11 collections of poetry, a short story collection and children's books. She was co-editor of* Common Wealth: Contemporary Poets on Pennsylvania *and is an assistant editor of* Presence: A Journal of Catholic Poetry. *She is a professor of English and creative writing at Lock Haven University in Pennsylvania. Website: www.marjoriemaddox.com.*

The Foley Poetry Award is underwritten by a grant from the William T. Foley Foundation.

Unhealthy Care

By Tobias Winright

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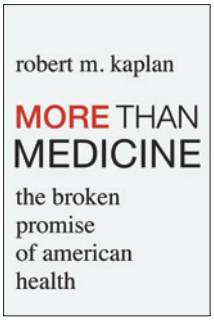
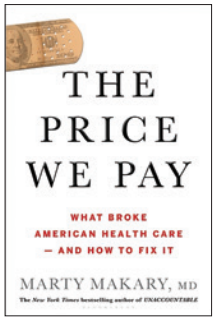




Several years ago, I slipped in a hotel bathroom, hitting my head on the sink and then on the floor. My skull was fractured from the left parietal through the sagittal suture and on to the right parietal bone, with a subarachnoid hemorrhage and a small epidural hematoma under my left frontal region.

Prior to this accident, I had never spent more than one night in a hospital. This was a new experience, full of unknowns, as well as fear. Not only did I have my middle-of-the-night talks with God, in case I wouldn't wake up in the morning; I felt tremendous concern for my spouse and two daughters, who were only 7 and 2 years old.

I worried, too, about the bills. Although as a tenured professor at a university, I had health insurance, I had never used it before for anything so serious. Would it cover all the CT scans and MRIs? Would it pay for the couple of weeks in two different hospitals? Would it take care of my transport in an ambulance? Would my deductibles be astronomical? What if I needed neurosurgery? What would happen financially if I were disabled, or if lingering cognitive impairments prevented me from returning to work? I even anguished over possibly becoming addicted to my pain medication, an opioid.

Such matters regarding the costs of medicine are addressed in different, though complementary, ways in two books on broken U.S. health care: *More Than Medicine: The Broken Promise of American Health,* by Robert M. Kaplan (Harvard University Press 240p, $29.95), and *The Price We Pay* by Marty Makary (Bloomsbury Publishing, 228p, $28). They are written accessibly in a journalistic key by senior research scholars and professional health practitioners with distinguished careers. Kaplan, a psychologist, is Director of Research at the Stanford School of Medicine Clinical Excellence Research Center. Makary is a surgeon and professor of Health Policy at Johns Hopkins University.

Predatory Practices

According to Makary, about one in five Americans currently has unpaid medical debt. He refers to a study by the Kaiser Family Foundation that reveals 70 percent of Americans have had to cut back on food, clothing or other basic needs to pay medical bills, with 58 percent taking an extra job or working additional hours and 41 percent borrowing money from friends or family to pay these bills. "Gouging" is one of Makary's most-used words to describe the business model that has come to dominate health care.

At one point he quotes the muckraking writer Upton Sinclair, an appropriate genre in which to consider Makary's biting book, which opens with a health fair held at an urban African American church just 15 minutes

According to the Kaiser Family Foundation, 70 percent of Americans have had to cut back on food, clothing or other basic needs to pay medical bills.

from the U.S. Capitol building. Medical professionals there "weren't serving; they were prospecting." Through "predatory screening," congregants are being told that the blood flow in their legs is lower than in their arms, suggesting that something might be wrong and that further testing is necessary. According to Makary, "This test should not be performed unless a patient has serious symptoms, like crippling leg pain."

Nevertheless, further tests then are "nudged" upon the patients, along with unnecessary ballooning, stenting and lasering of nonthreatening plaques in leg arteries—all of which costs these patients, Medicare, insurance and the rest of us.

Similarly, Makary scrutinizes the cost of a heart bypass operation. Hospitals rarely, if ever, give a price quote in advance. In addition, insurance companies compete and negotiate discounts. In a study conducted by the University of Iowa, the average price was $151,271. The range was from $44,000 to $448,000, and there was no correlation between price and quality. He also devotes attention to other examples of such gouging, including unnecessary C-sections and Mohs surgeries for skin cancer.

For those who cannot afford such hyperinflated prices, lawsuits and garnished wages are often in store. Particularly troubling was Carlsbad Medical Center in New Mexico, which one of the town's court clerks said accounted for "like 95 percent of the lawsuits" there. Indeed, as Makary and his research team discovered, it had successfully sued and garnished the wages of one in five people in that small town.

Thirty-seven percent of hospitals in the United States filed over 20,000 lawsuits in 2017 alone. It is especially unsettling that nonprofit hospitals were more likely to sue, and even faith-based hospitals are implicated. One Catholic hospital executive said, "We don't sue patients" and "We forgive patients who can't pay." Markary's investigation of the court records sadly showed otherwise.

'Find It and Fix It'

For his part, Kaplan is critical of a "cure narrative" that has captured American health care. Specifically, he focuses on how much health care consumes of the U.S. gross domestic product ($3.2 trillion, or 18 percent of the G.D.P. in 2017), in particular because of "the most expensive variety of that care: biomedicine." But are these monetary investments producing better health outcomes? He thinks not.

Americans "have shorter life expectancies and higher infant mortality rates than the people of most other developed nations, and the gaps are widening." The life expectancy of men in the United States is 75.65 years (last among 17 peer nations); for women it is 80.78 years, which ranks in 16th place.

For Kaplan, the main problem is that in the United States, attention is diverted from studying and addressing the numerous social and behavioral determinants for health and health problems, even though health determinants like violence, poverty, racism, workplace policy and stress, and poor education are viewed as crucial. Medicine does not address these problems.

U.S. universities are perpetuating the problem, as they have become "research-intensive institutions heavily focused on biomedicine," receiving large sums of money from the federal government. Too much money is devoted to research on Alzheimer's disease, cancer, genomics and the like, but very little is targeted at the social, behavioral and environmental determinants that actually account for most premature deaths in the United States.

Biomedicine, Kaplan says, views people "like auto garages treat cars"—a "find it and fix it" philosophy that, while it is effective for some problems, does not work for most. The money spent on genomics, with its assumption of biological determinism (i.e., genes determine health), reflects this view.

Both Kaplan and Makary are critical of over-testing, over-treating and over-prescribing, all of which are costly to Americans. Echoing Makary's criticism of the business-centered approach to health care, Kaplan adds that the drug industry spends "billions of dollars tweaking older, effective drugs in order to re-release them before patent monopolies run out."

Both authors bring to our attention many moral problems than have traditionally been evaluated in Catholic bioethics. While the Catholic Health Association and some theological ethicists, like Lisa Sowle Cahill at Boston College, have done so, integrating Catholic social teaching and health care ethics is still just beginning.

Tobias Winright *teaches theological ethics and health care ethics at Saint Louis University, and he is associate editor of Health Care Ethics USA, published by the Catholic Health Association.*

Incarnate Grace
Perspectives on the Ministry of Catholic Health Care
Edited by Charles Bouchard, O.P.
Catholic Health Association of the United States
296p $25

Effective and ethical

We all struggle with health and long for healing. Our faith is profoundly concerned with well-being and flourishing. And since its beginning, Christianity has made a special ministry of caring for the sick. In insightful ways, *Incarnate Grace* enriches our understanding of the ministry of Catholic health care practiced in the United States today.

The book articulates a theological approach to health care ministry, focuses on the person in health care contexts, explores the sacramental and liturgical aspects of this ministry and lays out its ecclesiological vision. I foresee *Incarnate Grace* becoming an important book for practitioners, staff, administrators, students and faculty, and interested believers, both in Catholic health care and elsewhere.

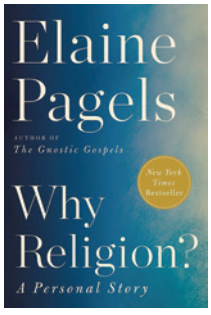
Readers will appreciate, first, the foundational theological contributions on the Trinity in light of grace, charity, faith and hope; second, on Christology, by revisiting Jesus' healing ministry and our "solidarity Christology" that promotes justice and aims at holistic liberation; and third on Scripture, by interpreting the healing stories of Jesus within the context of rituals in ancient Israel.

Daniel Daly reaffirms the centrality of personhood and the dignity of the individual person that informs Catholic theology and care. Robin Ryan, C.P., discusses biblical perspectives on suffering, while other essays turn to eschatology and situate health care practice within the larger framework of the history of humankind. Readers will also gain much from essays on the transformative power of liturgy and sacraments, particularly on the Eucharist and on the (underappreciated and underused) sacraments for the sick and dying.

The collection also includes an essay on the ecclesial character of health care ministry, rooted in the ministry of Jesus. Two other contributions study the canonical implications of this ministry by discussing the role and responsibilities of the diocesan bishop and of institutions as "juridical persons" in terms of canon law.

Rounding out the volume are profound reflections on the role of the laity in the church and the institutional dimension of Catholic health care organizations, both of which further develop the ministerial dimension. In another contribution, Celeste DeSchryver-Muller notes how essential personal and institutional formation are to effective and ethical health care.

Andrea Vicini, S.J., *is an associate professor of moral theology at the Boston College School of Theology and Ministry.*



Why Religion?
By Elaine Pagels
Ecco Press
256p $27.99

Plumbing the depths

The religion scholar Elaine Pagels has spent much of her life answering questions about her interest in issues of faith and ritual. She boils these inquiries down to one question, one she makes the title of her new memoir: *Why Religion?*

Professor Pagels's 1989 book *The Gnostic Gospels* was the first to offer a thorough and widely accessible account of a set of writings found in Egypt in 1945 that date back as far as the second century and present a different understanding of traditional Christian belief. In the wake of that book, Pagels, a professor at Princeton, became one of the world's most influential religion scholars. But those scholarly quests play only a supporting role in *Why Religion?*, yielding the spotlight to Pagels's own journey of faith, which includes a teenage conversion as an act of rebellion against her secular upbringing, an encounter with what she likens to demonic forces, and the role that religion and ritual played in her life following the deaths of both her young child and, just a short time later, her husband, the physicist Heinz Pagels.

As for the publication of *The Gnostic Gospels*, Pagels wrote, "I knew that the book would be con-

troversial—and it was." But she writes that she also received "letters of intense appreciation" and ultimately learned from the experience that "neither the praise nor blame mattered as much as I had imagined they would—and mattered far less than finding my own voice."

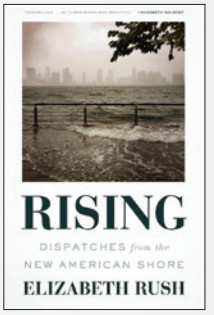
Much of Pagels's book deals with the death of her son Mark, who died at age 6 from a congenital heart condition. When her husband died following a hiking accident several months later, Pagels again needed to try to make sense of grief and suffering.

It was during a visit to a Trappist monastery, in the silence of prayer, that Pagels says she was given space to confront her grief. Following the funeral of her husband, she returned to the monastery, where the monks offered to say a Mass for Heinz. It was a gesture that touched Pagels, as the monks knew her late husband was not Catholic.

"After," Pagels writes, she hugged the monks and felt "hugely grateful that their monastic practice allowed for such open-hearted grace."

The pages of *Why Religion*? plumb some of the deepest questions about what it means to be human. They explore how ritual and faith can help make sense of the unfathomable, and may serve as an invitation to take a second look at how scholars of religion can provide valuable insights that go beyond the classroom walls.

Michael J. O'Loughlin, *national correspondent.*
Twitter: @MikeOLoughlin.



Rising
Dispatches From the New American Shore
By Elizabeth Rush
Milkweed Editions
320p $26

Before the flood

Books on sea-level rise and the coastal United States often have the dry tone of academics or city planners writing for others in their circles. That dryness is ironic, given the very wet future looming for cities like New York and New Orleans and smaller communities, like Isle de Jean Charles, La.

Written with warmth and close attention to the details of nature, *Rising*, by Elizabeth Rush, is a welcome addition to the small but growing canon on what the changing climate means for U.S. residents. *Rising* takes readers to communities from Staten Island and Miami to coastal Rhode Island and San Francisco.

One of the author's first examples is Isle de Jean Charles in Louisiana. In January 2016, the U.S. Department of Housing and Urban Development began a $48 million program to relocate the island's inhabitants inland, away from rising seas that intensify hurricane storm surges. Somewhere between 65 and 100 residents—most of them members of the Biloxi-Chitimacha-Choctaw tribe—were offered federal rent support for apartments in the nearby city of Houma while awaiting the construction of a new community about 40 miles north of Isle de Jean Charles. They are being called the nation's first climate refugees. And some are refusing to leave their homes, come hell or—literally—high water.

On Isle de Jean Charles, Rush introduces Chris Brunet, one of the few residents who have decided to remain rather than accept federal aid. Sitting in the house his grandfather built, which was gutted but never completely rebuilt after Hurricane Lili in 2002, Brunet shares cake and soda and tells Rush what it is like to see the community he grew up in gradually disappear as the water inches ever higher.

Rush's writing is much more subtle than Jeff Goodell's in his 2017 book *The Water Will Come,* which drew accusations of sensationalism for its portrayal of Miami in 2037 following a devastating hurricane and 20 feet of storm surge. Where Goodell writes of condoms and tampons strewing the beaches and a foot of sand in the lobby of Miami Beach's Fontainebleau Hotel, Rush evokes Henry David Thoreau's *Walden,* wandering through Maine tidal marshes and South Florida swamps.

Rising is about resilience—both resilience as adaptation to rising seas and resilience in the sense of people retaining their identities as they confront a future of flooding, hurricanes, economic pressures and relocation. As uncertain as that future is, the stories in *Rising* provide hope as more and more people find themselves experiencing the impacts of the rising sea.

Kate Stein *is a writer and multimedia journalist based in Miami.*

In "Beautiful Boy," Steve Carell plays a successful writer and a devoted father who struggles to know how to support his suffering child.

Art and Addiction

By Ciaran Freeman

How are artists to address the signs of the times? How are they to do so when those signs are tragic, scary and painful? With surging rates of opioid addiction and overdoses, we are experiencing one of the greatest public health crises our nation has ever faced. In this issue, John W. Miller reports from the front lines of this crisis and explores how churches might play a role in finding a solution. But I am curious: How might artists play a role?

Should filmmakers make the pain of addiction bearable to watch? Should they render the horrendous beautiful? Since the opioid crisis began to emerge in the mid 1990s, there have been many compelling character arcs involving addiction in acclaimed movies and television shows.

Think of Christopher Moltisanti sticking a needle between his toes on "The Sopranos" or Nurse Jackie popping pills on the job. In the aughts we saw the complexities of the war on drugs play out on "The Wire"; then we watched Walter White cooking meth on "Breaking Bad." Reese Witherspoon ("Wild"), Christian Bale ("The Fighter") and Anne Hathaway ("Rachel Getting Married") were all nominated for awards in the past decade for their portrayals of addiction in film.

Last year, two of Hollywood's most in-demand young actors—Timothée Chalamet and Lucas Hedges—took on similar roles as addicts in well-received performances. Felix Van Groeningen's "Beautiful Boy" tells the true life story of David Scheff (Steve Carell) and his son, Nic (Chalamet), who became addicted to drugs, including crystal meth. And Hedges stars as an addict to painkillers in "Ben Is Back," a film written and directed by his real-life father, Peter Hedges. Neither film is perfect, but both show us ways in which our culture grapples with the wider drug crisis.

Van Groeningen's film is based a pair of memoirs: *Beautiful Boy: A Father's Journey Through His Son's Addiction,* by David Scheff, and *Tweak: Growing Up on Methamphetamines,* by Nic Scheff, published simultaneously in 2008. The method of adaptation resulted in a film that at times feels disjointed, cramming two distinct stories into one neatly packaged product.

David Scheff is a successful writer and a devoted father who struggles to know how to love and support his suffering child. He is on a journey to understand what is going on with his son. We want to empathize with him but find it difficult. He is detached and melancholic, and there is not enough for the viewer to grab onto.

David is a stark contrast to the reclusive Nic, who comes of age reading Charles Bukowski, sketching in his notebooks and listening to "Territorial Pissings" by Nirvana. When shifting to Nic's perspective, the film becomes


CNS photo/Amazon Studios

darker and more erratic. He is on a seemingly endless loop of relapse and recovery. Because of the nonlinear plot, his cycles are hard to follow and grow tiresome.

The direction of the film is weak and excessively sentimental. Van Groeningen cuts back and forth through time, using heart-stirring music over montages of a young Nic growing up. The director recreates the feeling of watching home videos. But the viewer is acutely aware that her emotions are being manipulated.

The movie begins to sing only at a pivotal moment about 45 minutes in, when the two viewpoints finally cohere. The father and son sit in a booth at a diner and confront Nic's addiction.

"You're just embarrassed because I was, like, this amazing thing. Like, your special creation or something, and you don't like who I am now" said Nic, looking up at his dad.

"Yeah?" David ask with desperation, "Well who are you, Nic?"

"This is me dad, here. This is who I am."

We return to this diner at the film's climax, when we have just about given up. David has turned to tough love on the phone with Nic's mother, telling her, "He's going to die even if we do [help].... I'm done." The film cuts to Nic in the same booth in the diner, writing. He walks into the bathroom, unpacks his paraphernalia and shoots up into his arm. His body is then sprawled across the tiled bathroom floor, wracked by convulsions before going limp. His pain and suffering are rendered like a painting: a 21st-century version of Jacque-Louis David's "The Death of Marat."

"Ben Is Back" has an art-historical moment of its own. On Christmas Eve, a recovering Ben (Lucas Hedges) arrives back at home on his mother's doorstep. The film is told over the course of about 24 hours, a narrative structure that keeps the audience engaged. We don't know if we trust him or not, whether he is clean or not.

In the film's best moments, we connect deeply with the characters. Ben's mother, Beth (Julia Roberts), is a stand-in for the audience; she doesn't know if she can trust her son, and neither do we. She wants to, she has hope—we do, too—but she is frustrated with the system. More than that, she is angry. In one scene she confronts her family's pediatrician, Dr. Crane, after running into him at the mall: "When Ben was 14 he had a small snowboarding injury and you prescribed painkillers. When I asked, you told me they weren't addictive and kept upping his dose and he got hooked and it f— up his life. You can pretend you don't remember, but I won't forget. I hope you die a horrible death. Merry Christmas."

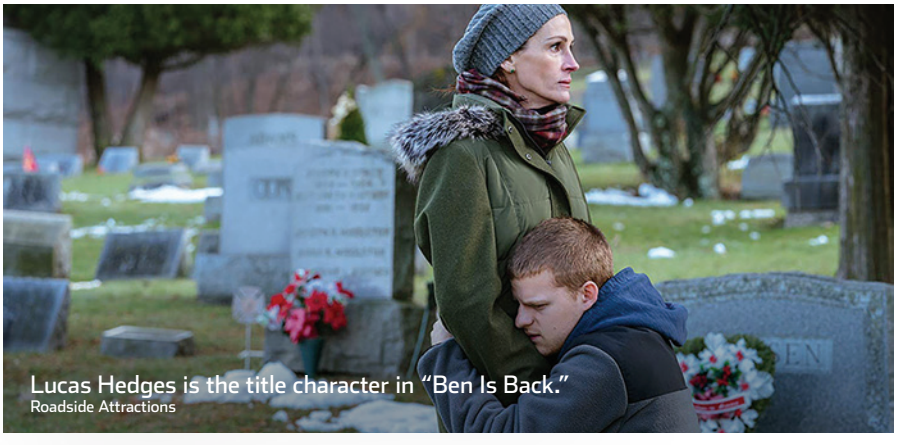
She is furious with the injustice of the crisis, and we connect to her anger. The filmmaker Hedges cuts to the core of the epidemic. He does not look at Ben's situation as a random phenomenon or a personal trial to be overcome, but instead holds doctors, pharmaceutical companies and the health care industry accountable for criminal negligence. He does so without compromising the emotional integrity of the film, folding this critique into Beth's character arc.

In the film's final scene, Beth finds Ben's stiff, cold body on the floor after an overdose. Just as she seems to be overcome by grief, about to give up trying to resuscitate him, Ben inhales and the screen fades to black.

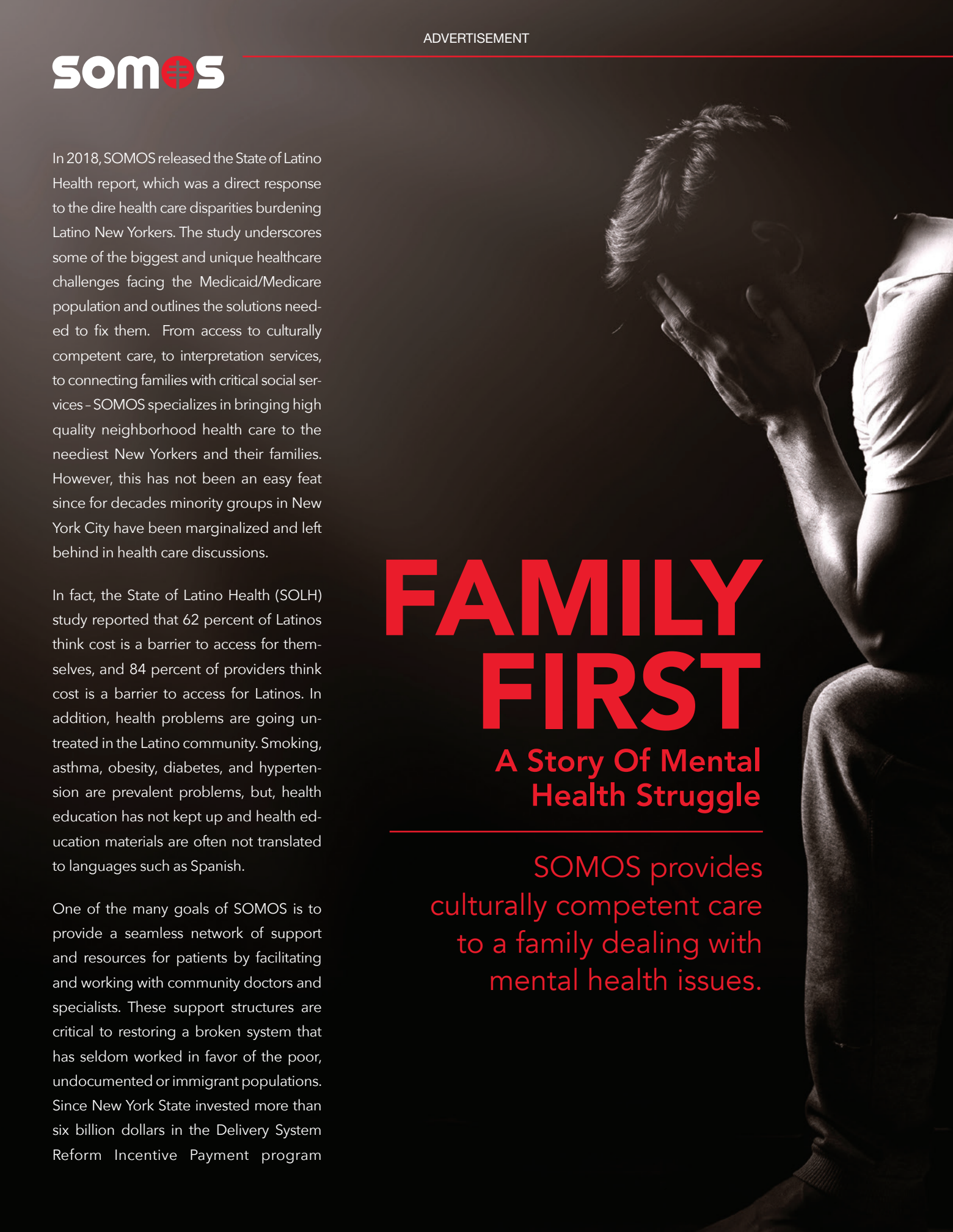
Here suffering is rendered in a way that is familiar. As in Michelangelo's "Pietà," a body is draped in his mother's arms. This is an image Catholics are familiar with, one most of us have meditated on. We empathize with her grief and her pain. The grieving mother is an archetype in Western art, perennially relevant because of humanity's predisposition to suffering.

The role of the artist is to grapple with the human condition. The choreographer Martha Graham understood this, as she demonstrated in "Lamentation." The German printmaker, painter and sculptor Käthe Kollwitz achieved this with her self-portraits, including "The Grieving Parents," a memorial to her son Peter. In "Ben Is Back," Peter Hedges takes the universality of this archetype and applies it to the opioid crisis.

Ciaran Freeman, *Joseph A. O'Hare fellow.*


Lucas Hedges is the title character in "Ben Is Back."
Roadside Attractions

SOMOS



FAMILY FIRST

A Story Of Mental Health Struggle

SOMOS provides culturally competent care to a family dealing with mental health issues.

In 2018, SOMOS released the State of Latino Health report, which was a direct response to the dire health care disparities burdening Latino New Yorkers. The study underscores some of the biggest and unique healthcare challenges facing the Medicaid/Medicare population and outlines the solutions needed to fix them. From access to culturally competent care, to interpretation services, to connecting families with critical social services – SOMOS specializes in bringing high quality neighborhood health care to the neediest New Yorkers and their families. However, this has not been an easy feat since for decades minority groups in New York City have been marginalized and left behind in health care discussions.

In fact, the State of Latino Health (SOLH) study reported that 62 percent of Latinos think cost is a barrier to access for themselves, and 84 percent of providers think cost is a barrier to access for Latinos. In addition, health problems are going untreated in the Latino community. Smoking, asthma, obesity, diabetes, and hypertension are prevalent problems, but, health education has not kept up and health education materials are often not translated to languages such as Spanish.

One of the many goals of SOMOS is to provide a seamless network of support and resources for patients by facilitating and working with community doctors and specialists. These support structures are critical to restoring a broken system that has seldom worked in favor of the poor, undocumented or immigrant populations. Since New York State invested more than six billion dollars in the Delivery System Reform Incentive Payment program

SOMOS

(DSRIP), SOMOS, which is the only multi-cultural physician-led group participating in DSRIP, has been in the forefront of reforming health care into a value-based system.

Family is key to countless immigrant and first-generation American families, which is why Yolanda Sanchez* sought help when her 16-year-old son Jose* began to show signs of depression. He became aloof, reclusive and his grades took a downturn. Yolanda was referred to Centro Medico Dominicano, a staple in the Washington Heights community and beacon of hope for tens and thousands of Latinos for nearly 40 years.

After months of psychiatric treatment involving therapeutic conversations with a child psychologist from Centro Medico, Jose was feeling better. "It wasn't easy, but his doctor was patient and kind with him and now he is a happier child and his grades are improving," said Yolanda. "I would never have been able to get through this difficult time if I didn't feel comfortable with the doctors at Centro Medico. Being able to discuss my son's ongoing rehabilitation in Spanish was a relief," she added.

During this time, Yolanda was able to make health improvements of her own as well. Centro Medico reached out to her about participating in a nutrition program to help her control her diabetes and hypertension. The program included a guide to preparing healthier meals that incorporates plant-based food that are low in sodium, sugar and calories. Yolanda was able to lose weight and adopt a healthier lifestyle.

The Sanchez family's story is one of many examples that proves why neighborhood primary care works. The SOMOS network brings high quality primary and specialty care that is culturally competent and whose doctors often speak the native tongue of their patients. SOMOS doctors are leaders in their field and community, incredibly committed to delivering the best care possible to the families they serve.

Although Yolanda sought help for her son's mental health issues, many Latino and African American families do not. Mental health and substance abuse challenges remain taboo. As a result, mental health illnesses among communities of color are undertreated or even untreated. In fact, the SOLH report found that 32 percent of health care providers think that Latino mental health is unhealthy compared to the general population.

SOMOS is a non-profit, physician-led network of over 2,500 health care providers serving over 700,000 Medicaid beneficiaries in New York City. Launched in 2015 by its Chairman Dr. Ramon Tallaj, SOMOS is the largest and only physician-led performance provider system participating in the New York State Delivery System Reform Incentive Payment Program (DSRIP). The SOMOS network includes providers delivering culturally competent care to patients in some of New York City's most vulnerable populations, particularly Latino, Asian, African-American and immigrant communities throughout the Bronx, Brooklyn, Manhattan and Queens.

**Name changed to preserve the patient's privacy.*

www.SomosNYHealth.org

The Love That Makes God Present

Readings: Prv 8:22-31, Ps 8, Rom 5:1-5, Jn 16:12-15

A matter that perplexed ancient thinkers was the question of divine transcendence. How could a deity who had existence in a supernatural realm be available to believers in the human realm? Israelite thinkers experimented with different answers to this question, which eventually coalesced into the priestly, prophetic, wisdom and legal traditions of the Hebrew Bible.

The doctrine of the Trinity is Christianity's answer to that ancient question. Inheriting Israel's insights on transcendence, Christianity recognized Jesus' Father to be the deity who existed in the supernatural realm. The apparent gap between God and humanity was bridged by the incarnate Christ. In the Spirit that the Father had shared with him, Jesus knew the fullness of divine love; this love made God present in the human realm. In that same Spirit, the disciples also encountered divine love, and the church they founded continues to make the divine presence available to anyone who seeks it out.

Put plainly, love is the answer to the question of divine transcendence. When Christians follow Jesus' example and teaching, they make God present on earth. The readings this week give different perspectives on this task. The first reading tells the story of divine wisdom. Speaking in allegories, the author of Proverbs imagined God's wisdom to be something with a personality of its own. Wisdom was the artisan through which God brought all creation into being. Early Christians took this allegory as a description of Jesus Christ, who embodied divine wisdom and who was at God's side before all time. These Christians saw in their own work a continuation of the Son's role. Just so, Christ's disciples today have a part to play in the healing and sanctification of the earth.

In this Sunday's second reading, Paul describes divine love from a different perspective. He speaks of the struggles he has faced in order to serve God's mission, but these are inconsequential in the light of divine grace. "Hope does not disappoint, because the love of God has been poured out into our hearts through the Holy Spirit that has been given to us." Belief in Christ gave Paul an experience of the same divine love that had led Jesus through his mission.

In today's Gospel story, Jesus helps his followers understand both the gift they have been given and the mission attached to it. In the Spirit, Jesus possessed the fullness of divine wisdom and strength. The Father gave these gifts for a specific reason: because he loved the world and wished that it might not perish but have eternal life. This mission of divine love came to the disciples along with the Spirit. It remains our mission today. Christians who work to restore creation make divine wisdom present anew. Christians who speak God's words keep divine hope alive in the hearts of many. Christians who continue Christ's mission make the divine presence felt in even the most hostile of places. In each of these acts of love, Christ's disciples make God present anew in every corner of the human realm.

'Then was I beside him as his craftsman, and I was his delight day by day, playing before him all the while.' (Prv 8:30)

PRAYING WITH SCRIPTURE

How does the Trinity inspire you to care for creation?

What message does the Trinity give you to share?

Hoe does the Trinity draw you into the experience of divine love?

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Blessed Are You!

Readings: Gn 14:18-20, Ps 110, 1 Cor 11:23-26, Lk 9:11-17

People in the ancient world thought blessings had concrete effects. Such belief is not common today, when people treat blessings as symbolic activities. A blessing today might express concern after a sneeze, approval for a marriage or thanksgiving before a meal, but the words of the blessing manifest only an unseen, interior reality. Biblical people thought a blessing had a detectable effect on the material world. When Jacob "stole" Isaac's blessing from his brother, for example, Isaac mourned that the blessing would now go to the wrong son. Although Isaac's intent was to bless Esau, his eldest, once the words were uttered over Jacob, they transformed reality for both sons in a permanent way.

This gives context to the blessing that appears in this Sunday's first reading. Melchizedek blesses Abram in a ritual that includes bread and wine. The implied effect of this blessing appears in the following chapter, when God offers a covenant to Abram (Gn 15:1-21). Though the two passages may have come from distinct traditions, the compilers of Genesis juxtaposed them to make it clear that the covenant God offered to Abram was, at least in part, the result of Melchizedek's blessing.

'Then taking the five loaves and the two fish, he said the blessing over them and gave them to the disciples to set before the crowd.' (Lk 9:16)

PRAYING WITH SCRIPTURE

How have the words of Christ in the Eucharist transformed your life?

How can your own words of blessing transform the life of another?

About Melchizedek Scripture preserves only this narrative in Gn 14:18-20. He was a priest of God but lived long before Aaron, and his life and ministry were a matter of increased speculation around Jesus' time. If the priesthood that Moses and Aaron established represented the "normal" priesthood established by God's own law, then Melchizedek's priesthood represented an act of God's sovereign freedom to work outside the law. The writers of the Dead Sea Scrolls, believing that the Aaronide priests of the temple had become irrevocably corrupt, seized on this. They saw in Melchizedek a supernatural character who could come and purify Israel's religious establishment. Early Christians, recognizing something similar in Jesus, noted the connections between Melchizedek's offering of bread and wine and Jesus' actions at the Last Supper. At least some saw in him a new Melchizedek, who had come from God to restore Israel's lost sanctity (Heb 6:20-7:3).

The belief that Jesus was continuing the work of Melchizedek reveals a covenantal meaning to his blessing in this Sunday's Gospel. The abundance it produced symbolized the new life offered under the reign of God. Luke uses similar language to link Jesus' blessing over the bread and fish to the blessing over the bread and cup at the Last Supper. Through these actions, Jesus continues the ministry of Melchizedek, offering a covenantal blessing to anyone who participates in the Eucharist.

Eucharistic abundance is real, but not always clear. How often do we, like the apostles, face situations of vast need with resources seemingly as meager as stale bread and a few anchovies? We can trust Jesus' blessing to have a real effect. With a faith like that of our biblical ancestors, we can find in Christ's body, blessed and broken for us, the source of everything we need.

Michael Simone, S.J., *teaches Scripture at Boston College School of Theology and Ministry.*

Service in Sudan

Following Christ in the Nuba Mountains

By Tom Catena

In June 2011, violence erupted in Sudan's remote Nuba Mountains, an area where I had lived and worked as the sole doctor and surgeon for three years. As our situation became increasingly precarious, I was advised by my sponsoring mission to evacuate and return to the United States.

The few religious sisters and priests serving in the region and I did not leave, however, and eight years later, we are still here, despite the violence.

These past eight years have been tremendously difficult. We have taken in thousands of wounded soldiers and civilians, sometimes more than 100 at a time; our hospital has been bombed twice; and the surrounding villages have been bombed on several occasions. Along with the usual seasonal outbreaks of malaria, pneumonia and diarrheal diseases, a major measles epidemic resulted in the death of 30 small children. For months, our wards have housed 450 to 500 patients at a time, all of whom required a high level of care. We tend to our patients mostly with staff who have been trained on the job.

My decision to stay and take care of these people was a very simple one: If I left, many men, women and children would certainly die. This decision was my "come to Jesus" moment. I felt that if I left, that would mean that I valued my life over the lives of the people I came to serve. Why do the sisters, priests and I stay and continue to work and live in this difficult environment? We stay simply because we are missionaries and are there to show the love of Christ to his beleaguered children. We stay because we take Christ at his word when he commands us to take care of the "least of these." These are not mere niceties but actual marching orders.

In our line of work, we witness daily a good share of suffering and pain. It is difficult to keep our spirits up when children are maimed, burned and killed by the effects of an aerial assault by a genocidal regime. On one such occasion, we had to watch three children die because of extensive burns from artillery shelling. On another, we had to amputate both the arms of a boy who was hit by a barrel bomb dropped from 20,000 feet. Another boy had his right arm and leg amputated after a separate bombardment. Many young soldiers have died after we perform prolonged and seemingly successful operations.

How can we continue? How do we avoid becoming paralyzed by grief?

Our Catholic faith teaches us that we are not the authors of life and death and that in humility we have to accept that it is not us but our good Lord who gives and sustains life. The people in the Nuba Mountains have an innate sense of the divine that we who live in peaceful, prosperous countries seem to have lost because of our reliance on our own erudition and technology. We are called to a life of humble service and radical reliance on God but not to perfection. We are to allow the immense grace of God to work in our lives. This can be accomplished only when we align our wills with the will of our loving Father.

I recently returned to the United States for a brief visit. I found this trip home unsettling and bewildering: the noise, traffic, Uber, Facebook, Twitter, too much food, spectacular wealth alongside homelessness. I felt the need to get back to the Nuba Mountains and my simple life of service. While in the United States, I talked to students who asked me how to find meaning in life and to live life to its fullest. Jesus gave the best answer to this question: "Go and sell all you own, pick up your cross, and follow me."

Tom Catena *has been a Catholic Medical Mission Board volunteer in the Nuba Mountains of Sudan since 2008. He is the medical director and sole doctor at Mother of Mercy Hospital, which serves nearly 750,000 people.*

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