Theologians in Catholic Healthcare Ministries: Breaking Beyond the Bond to Ethics

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Catholic healthcare in the United States relies upon and benefits from the contributions of theology. Historically, ethics served as the default locus where theology and medicine intersected in Catholic healthcare ministries (CHMs). Yet, as CHMs face increasingly intricate challenges today, they seek theological expertise on an expanding spectrum of issues. Pairing theologians exclusively with ethics no longer suffices to address the contemporary needs in CHMs.

The first part of this essay reviews historical markers indicating how theologians aligned with ethics in their service to CHMs in the U.S. This association became most clear beginning in the early twentieth century as theologians opined on clinical ethics procedures emerging from advances in medicine. The role of the theologian evolved to include organizational ethics and analysis of cooperation with moral wrongdoing. By the mid and late twentieth century, substantial changes in U.S. healthcare delivery and financing prompted Catholic hospitals and systems to partner with outside organizations, many of which are other-than-Catholic.

The second part of the essay spotlights areas beyond ethics where CHMs need theological expertise. I argue that theologians in CHM must move beyond the historical paradigm of problem-analysis-answer created by its pairing with ethics. Rather, the role of the theologian serves as a bearer of the broader Catholic tradition across multiple areas of a healthcare ministry. While ethics remains an important domain, five additional areas call for the gifts and skills of the theologian.

First, I explain how theologians specializing in social ethics provide an essential body of work that CHMs ought to more fully integrate. Second, CHMs need theologians to guide organizational discernment processes, distinct from the analysis of cooperation with moral wrongdoing. Third, the emergence of formation within CHMs must include sound theological depth. Relatedly, the fourth area features how sponsors increasingly raise questions pertaining to ecclesiology, the nature of ministry, and missiology which call for theologi-
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cal expertise. Finally, the theologian serving in CHM needs partnerships and dialogue with other theologians. The theologians in the academy, in CHMs, and in the chancery need insights from one another to honor and reflect the concrete and complex realities CHMs face.

This work focuses on CHMs in the American context. The scope pertains to a theological response to scientific and technological advancements from the late nineteenth century to the present when medicine and its financial and organizational structures substantially changed. My own professional and social perspective draws from formal academic training, years of experience working in Catholic healthcare systems, teaching theology in an academic setting, and being an active parishioner.

THE THEOLOGIAN AND MEDICINE

For centuries Catholic theologians have engaged matters of life, death, and health. Developments flowing from the Enlightenment dramatically altered the questions considered by theology and other disciplines. By the late nineteenth century, modernity anchored itself firmly in medicine. Therapies advanced from vaccine discoveries. Devices multiplied with inventions like x-ray, and processes accelerated toward standardization and professional licensing. The American Medical Association, founded in 1897, led the way in these and similar efforts, including the development of a code of professional ethics.  

Catholic hospitals responded to the professional and social changes with steadfast commitment to their ministries while welcoming willing physician partners. Catholic researchers like priest psychiatrist Thomas Verner Moore embraced emerging scientific possibilities from the perspective of his Catholic faith.  

Fr. Charles Moulinier, S.J., responded to the need for a unified and standardized Catholic approach to medicine in this time, and he hosted the first Catholic Health Association gathering (CHA; previously ‘Hospital’ association) in 1915.  

Questions surfaced from Catholic hospitals regarding the moral permissibility of new clinical procedures. Catholic theologians used the tradition that preceded them to produce resources giving moral direction on clinical procedures. By 1947, U.S. and Canadian theologians and healthcare professionals, respond-

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1 For an insightful overview of how modernity influenced the evolution of the American healthcare system, see Paul Starr and the American Council of Learned Societies, The Social Transformation of American Medicine (New York: Basic Books, 1982).


3 For a most helpful overview of the historical transition in Catholic healthcare in the U.S., see Christopher J. Kauffman, Ministry and Meaning: A Religious History of Catholic Health Care in the United States (New York: Crossroad, 1995).
ing to the groundswell of standardization, created the document *Ethical and Religious Directives for Catholic Hospitals* (ERDs). Gerald Kelly, S.J., worked with the CHA on a second revision in 1956. Within a few years, he authored *Medico-Moral Problems*. The majority of issues addressed in these publications pertained to matters of human reproduction, pregnancy, and fertility. This focus is unsurprising as Kelly’s theology recycled the methodology of the moral manuals. Kelly and his Jesuit confere, John C. Ford, S.J., maintained close alignment with papal teachings and magisterial writings. Not only did theologians opine on matters of the rapidly emerging technologies and new procedures advanced by the scientific revolution, but even the popes of this era entered into the discourse in the neo-manualist vein, perhaps none more so than Paul VI’s 1968 encyclical *Humanae Vitae*. Theological discourse following the encyclical’s release reflected other methodologies in moral theology that germinated in the twentieth century, yet the manualist imagination like that of Ford and Kelly infiltrated most deeply into the policies and operations of CHMs. While alternative methodologies came from academia, the legacy of a manualist imagination and an emphasis on dogmatic correctness and moral compliance linger today in the discipline of ethics, and theologians in CHM have been formed by these factors.

**FROM CLINICAL TO ORGANIZATIONAL ETHICS**

Alongside the exponential growth of questions involving the clinical practice of medicine, the late twentieth and early twenty-first centuries experienced dramatic developments in regulatory, capitalist,
and organizational structures impacting the overall landscape of healthcare delivery in the United States. These shifts pushed the theologian into another realm of ethics, namely organization ethics. The passage of Medicare in 1965 markedly altered the structure of American healthcare. Changes continue today at an accelerating pace fueled by the passage of the Affordable Care Act in 2010, and subsequent attempts by congressional factions to repeal or systematically dismantle the legislation. Fears, uncertainty, and capitalists’ risk-aversion in health insurance markets and financing structures exacerbate the complex commercial and political environments.

Such structural dynamics prompted CHMs to align with other-than-Catholic partner institutions to expand access to basic health services and gain profitability amidst ever-increasing demand for specialty services. A variety of contractual alignments and corporate commingling caused CHMs to question whether they cooperate with morally objectionable actions of doctors, vendors, or institutions with whom they partnered. Theologians drew from the tradition’s long-standing principle of cooperation, although they hesitated since the principle had historically been applied to individuals. No precedent existed for applying it to institutions, such as CHMs. Following a decade of dialogue in the early twenty-first century, American theologians across Catholic healthcare and the academy agreed the principle of cooperation applies to Catholic institutions, although analogously.¹⁰

The emerging need to evaluate cooperation with partners potentially engaged in wrongdoing spurred a notable growth in the role of the theologian in CHMs. Theologians who initially grappled with clinical procedures and actions involving physicians and patients witnessed their scope of inquiry morph to include the relationship between the entire organizational enterprise and society at large.

Determining cooperation with wrongdoing pertains to the integrity of the organization as a ministry of the Church and to theological scandal. To assist theologians in CHMs, the United States Conference of Catholic Bishops (USCCB) substantially revised and expanded the

ERDs in 1994, including the addition of part six, which precisely addressed partnerships. The most recent revision to the ERDs in 2018 pertained solely to part six.

Scrutinizing collaborative ventures against the moral tradition’s principle of cooperation with wrongdoing further pigeonholes theology in ethics, at least primarily if not exclusively. After the 1994 overhaul of the ERDs, the three subsequent revisions impacted only clinical or organizational ethics. The revisions reflect the U.S. bishops acting in their teaching authority. They acted with consultation and advisement from theologians. As I conclude the first part of the essay tracing the general contours of this historical pairing of theology with ethics in American Catholic healthcare, I pause briefly to elaborate on the term theologian, before discussing expanding the theologian’s influence.

**The Theologian in the Catholic Tradition**

As St. Anselm concisely stated in the eleventh century, theology is faith seeking understanding. Principally, a theologian is one possessing deep and broad understanding of doctrine and the Christian faith. Besides those exceptional cases when the Church posthumously recognizes an individual as a doctor of the Church, ordained clergy were historically the most learned in theology. Through their office and ministry, they brought understanding to the Christian faith both formally and practically. The term theologian thus applied largely to priests who pursued higher studies or an ecclesiastical degree, thereby preparing them as seminary instructors.

A different example of theologians applying intellectual expertise in service to the Church occurred with the *periti* at the Second Vatican Council. The world’s bishops brought their trusted advisors who impacted the Council’s enduring works. This example reflects a dynamic between theology and the Church’s teaching authority. Today, for example, the International Theological Commission serves a

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11 O’Rourke, Kopfensteiner, and Hamel, *A Brief History*, 20.
similar purpose. Its members include lay professors, women religious, as well as priests. Lumen Gentium’s universal call to holiness catalyzed the movement toward diversification among theologians (no. 39–42). A broadening of experience and intellect deepens the call from Gaudium et Spes to discern the signs of the times and to apply the tradition to modern developments and discoveries (no. 45).

As such and at its core, theology reflects upon human life in light of the existence and love of God. Christian theology serves the Church and the lives of the faithful to respond to the unfolding of God’s reign of love, justice, and peace amid the world’s trials and blessings. The Church insightfully asserts that in times of great spiritual and cultural change an acute need arises for the role of theology (Donum Veritatis, no. 1).

Thus, in this present essay the term theologian refers to an individual with extensive, in-depth formal training in Catholic theology and doctrine and experience in the study and life of the Christian faith. This working definition pairs intellectual knowledge of the Christian tradition with individual practice. This means that the theologian actively cultivates a life of faith through personal prayer and active participation in a faith community (Donum Veritatis, nos. 8–9). As Hans Urs von Balthasar famously said, he prefers a kneeling theology. The remark connotes active, contemplative, and liturgical dimensions, rather than a mere academic, intellectual exercise.

As the ranks of theologians expanded since the Council to include lay faithful, new areas of inquiry, expertise, methodologies, and insights for CHMs arose. The second part of this essay illuminates how parallel shifts in the role of the theologian and the changing pressures on CHMs warrant a recognition and repositioning of the role of the

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15 See Pope Paul VI’s letter to Prefect Franjo Cardinal Seper of the Congregation for the Doctrine of the Faith, 11 April 1969; later formalized by Pope John Paul II’s Apostolic Letter Tredecim Anni.

16 Formal academic credentials typically attest to levels of successful completion of formal training. Master of Arts degrees represent a foundational understanding of a particular discipline, like theology, religious studies, or spirituality. Yet most masters’ degrees lack a depth and expertise, particularly as compared to other advanced degrees. Master of Divinity programs generally require almost triple the hours of other master-level programs. Pontifical or Ecclesiastical degrees, such as the Licentiate in Sacred Theology (STL), enables the individual to function as a theological resource to Catholic seminaries, dioceses, or other Catholic institutions. Terminal degrees, such as a Doctorate in Sacred Theology (STD) or a secular Doctor of Philosophy (PhD) in theology or religious studies, most clearly designate an expert and in-depth knowledge referenced in the working definition for the purposes of this article.

theologian to far exceed clinical and organizational ethics. I will suggest five areas where the theologian provides an important and unique contribution.

**Social Ethics and Healthcare**

The breadth and depth of theological social ethics expanded in the decades since the Council. While a part of the ethics wheelhouse, social ethics breaks the methodological mode of problem-analysis-answer, largely a manualist mode of inquiry. Rather, social ethics raises important questions pertaining to human dignity, solidarity, the common good, and justice.\(^{18}\) The methodological mode for Catholic social ethics often is summarized as see-judge-act (*Mater et Magistra*, no. 236).\(^{19}\) These and other related themes from the social tradition intimately relate to many facets of a CHM. For example, Pope Saint John XXIII declared a fundamental human right to medical care, rest, and to be cared for in times of ill health, disability, unemployment, widowerhood, and old age in his 1963 encyclical *Pacem in Terris* (no. 11). Two decades later Cardinal Joseph Bernardin advanced similar thoughts by promoting a consistent ethics of life.\(^{20}\) Both the Pontiff and the Chicago Cardinal point toward holistic care. Addressing the root causes of abortion, for example, cannot occur without looking at the structures of sin and injustices in the U.S. health care system and the modern world.

In recent years theologians spurred this connection between social ethics and the tarnished structures of American healthcare.\(^{21}\) Some in CHMs have incorporated aspects of Catholic social thought and teaching into their work, yet their treatment of it often remains couched in clinical terms and confined to public policy and health reform.\(^{22}\) An

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\(^{21}\) A good example is Lisa Sowel Cahill’s Père Marquette Lecture in Theology published as *Bioethics and the Common Good* (Milwaukee: Marquette University Press, 2004). See also her larger work *Theological Bioethics: Participation, Justice and Change* (Washington, DC: Georgetown University Press, 2005).

An integrated approach would identify a medical issue and the moral dilemma, and amply includes themes from the wider theological and social tradition. However, three factors contribute to the meager application of the social tradition in CHMs. One reason entails training. Some responsible for ethics in CHMs studied at institutions emphasizing bioethics and philosophy. Others may have studied with professors schooled in the manualist or neo-manualist methodology. Training begets areas of comfort and expertise, and theologians may be most comfortable providing moral analyses to discrete and delineated questions. A second reason is that social justice is implied in the charitable acts and structures of the CHM itself. This presumption seemingly absolves CHMs of the need for explicit theological reflection. Third, CHMs, like all contemporary medicine, are unavoidably marked by the effects of modernity. Efficiency, effectiveness, immediate applicability, and even monetization, insuppressibly drive much of the culture. The theologian in a CHM does not enjoy the freedom and protected time to research and write, let alone a paid sabbatical, like those afforded to some colleagues in the academy. There is little perceived value or incentive from the organization for the theologian in a CHM to dream of the impact Catholic social teaching could have on community programs, strategy, advocacy and wider operations.

The lacuna between social ethics and healthcare structures and operations opens avenues for all theologians to grow in partnership. The theologian in CHM encounters unique situations scantily attended to by theological discourse. Burgeoning aspects of the social tradition span a vast range and present opportunities to intersect with CHM. For

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24 See John M. Travalone and Louise A. Mitchell, ed., *Catholic Witness in Health Care: Practicing Medicine in Truth and Love* (Washington, DC: The Catholic University of America Press, 2017). The final chapter laudably highlights a medical clinic for the poor in Appalachia in Kentucky modeled after a “casa” or a place for the sick and suffering founded by St. Pio of Pietrelcina in Italy. Yet the text lacks engagement with the social tradition. An authentic Catholic witness in health care, as the title asserts, must seriously engage the depths of Catholic social teaching and tradition and not merely medical ethics.
example, the environment (Laudato Si’, no. 20, 21, 44), immigration, and racism, all connect to health, as does international financing and foreign labor, foreign mission, global health, artificial intelligence, and more. These issues cause theologians in CHMs to break free of the problem-analysis-solution paradigm and delve more deeply into a pursuit of broader implications of social ethics. No singular response suffices for these complex social and operational topics. This reality, therefore, reveals the need for organizational discernment to guide ministry leaders as health resources move outward beyond hospital rooms and walls to meet God’s people on the margins.

Discernment

Discernment is careful attention to the presence or absence of God in making decisions and enacting them. It is particularly necessary at critical junctures in an individual’s or organization’s life. While the distinction may not be immediately self-evident, it differs from organizational ethics and is broader. The latter originated from and continues to entail moral analysis related to cooperation with wrongdoing. Discernment stretches beyond, questioning where God may be calling the organization to expand the healing ministry of Christ Jesus. For example, a discernment process would guide a CHM considering joining another CHM—a situation presumably absent of moral wrongdoing or scandal. Discernment questions how ought the organization as a ministry act in this particular situation with these particular constraints. A discernment process operationalizes the Church’s vision of seeing, hearing, and judging strategic options in light of ministerial identity. It provides a structure for senior leaders, board and sponsor members to tackle complex issues and incorporate pertinent aspects of the Catholic tradition to the matters at hand.

Because discernment processes include relevant aspects of the Catholic tradition and the honing of virtues, they necessarily call for the gifts and the role of the theologian. Service to discernment is integral to the vocation of the theologian, whose task is to foster dialogue with the culture. At the same time, “It is important to emphasize that when theology employs the elements and conceptual tools of...other disciplines, discernment is needed” (Donum Veritatis, no. 10). Synthesizing and making sense of the truths revealed by reason and by faith is the very work of theology.

The Council articulated a role for the theologian in the Church’s dialogue with the modern world. With the Holy Spirit, theologians must “hear, distinguish, and interpret the many voices of our age and judge them in light of the divine word, so revealed truth may be more deeply penetrated, better understood, and set forth to greater advantage” (Gaudium et Spes, no. 44). Discernment, conducted with participants open to the Spirit, enables the organization to act with integrity. The process also serves to scrutinize the organizational conscience to then act out of that conscience. Like that of the individual, conscience needs to be formed. Formation, in CHM, emerged when sponsors and leaders saw more clearly the growing need to educate executives and clinical associates alike on foundational matters of Catholic identity and spirituality, and they turned to the Church’s tradition of formation.

**Formation in CHMs**

Amidst the exponentially increasing complexities in healthcare today, CHMs have developed formation programs within mission departments. One of the many aims of formation entails sharpening not merely the knowledge but also the consciousness of leaders and decision-makers in the organization. The development of formation programs opens up an entirely new organizational geography that calls for the gifts and resources of theology. Charles Bouchard, OP, asserts:

> It is clear that there can be no meaningful appropriation of the term ‘ministry’ to describe Catholic healthcare unless it is nourished with serious theology and spirituality at a number of levels. Senior leaders, board members and sponsors must acquire fluency in theological questions that impact healthcare just as they have fluency in organizational development, finance and strategic planning. They must also see that formation extends across the organization so that all leaders, employees and volunteers grasp the mission and are able to participate actively in it. 

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Bouchard’s astute observations and deep experience in both theology and Catholic healthcare articulate how formation, as a theological activity, directly and intimately impacts the organization beyond ethics. The latter tends to emerge in times of conflict. Conversely, formation endeavors occur within the ordinary life of the CHM.

Celeste Mueller advances a formation model that comprises both theological foundations and spiritual practices. These twin pillars of theology and spirituality gesture toward von Balthasar’s kneeling theology. They represent a post-conciliar motif that formation entails more than knowledge, and Mueller’s methodology reflects the Church’s view that “theology requires a spiritual effort to grow in virtue and holiness” (Donum Veritatis, no. 9). Thus, spiritual practices belong alongside theologically grounded formation.

What exactly ought to constitute formation, theologically and spiritually, remains an open question. Determining a formation program’s content and method will involve many voices. Theological expertise ought to be among them. The theologian can contribute in various ways to the creation of formation programs. I highlight two aspects: to foster virtue and to ensure the formation program is consonant with the tradition.

First, formation in CHMs entails individual growth, if not holiness, which in the Christian tradition includes virtue or the practice of benevolent habits. As individuals grow in virtue, so too might the organization act more virtuously. Pope Francis expanded the Council’s call to universal holiness in Gaudete et Exsultate. The theologian brings knowledge of the depth of the virtue tradition and the role that virtues play in healing and the unfolding of the reign of God. Relatedly, the theologian as one steeped in the tradition can ensure that formation avoids distortions of authentic Christian witness.

Second, formation must bear resonance with the tradition. The Council and official documents since then reimagined religious and priestly formation in light of its call to embrace the modern world,

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35 Pope Francis, here and in other writings, identifies modern reiterations of Gnosticism and Pelagianism. Both find fertile ground in medicine and the corporate milieu. The former prizes the intellect to the detriment of the body. Though medicine treats the body, the physicians who lead it and the structures that deliver it prize the mind. Contemporary Pelagianism relies on the human will and personal effort. It is especially prevalent in American corporate culture, and ongoing formation ought to provide practices and structures to transcend these tendencies. See Gaudete et Exsultate, no. 35–46, and Evangelii Gaudium, no. 94, 233.
cognizant of worldly pitfalls. The theologian possesses the expertise and is uniquely adept to interpret and bring such documents’ vision to leaders for incorporation into the formative experience. The USCCB’s expectation for priestly formation includes four dimensions: human, spiritual, intellectual, and pastoral. As increasing numbers of lay persons entered pastoral ministry, the USCCB issued guidelines for their development, and, quite interestingly, they articulated the same four areas noted for priestly formation.

I am not arguing that CHMs necessarily adopt these aims. Formation must effectively respond to the needs of the ministry. Bouchard, Mueller and others pinpoint unique challenges and requirements of formation in CHMs whose leaders include Catholics and non-Catholics, and whose healing ministry extends far beyond the institutional walls into the fabric of a highly pluralistic society. Just as Bouchard calls for renewed theologies of ministry in light of emerging iterations arising in Catholic healthcare, it is equally important to reimagine formation within the tradition. Formation does not and will not mirror seminary formation, for example, but it must be recognizably Catholic—meaning it clearly relates to and draws from the tradition that speak to formation.

The transition from religious communities to separately constituted public juridic persons that can and do include laypersons precipitated, in part, the request from sponsors themselves for formation. It expressed a desire to entrust essential aspects of the original charism, ethos, and zeal that ultimately arose out of the healing stories of Jesus and have been relived by leading religious women and men throughout the centuries.

Sponsorship

All of the aforementioned areas of a CHM meriting the gifts of the theologian ultimately stand to support and strengthen the work of the governance and sponsorship. Currently, theological expertise may commonly intersect with sponsors through formation to these bodies, and it may additionally entail direct service on particular matters. One could view the early medico-moral analysis by Gerald Kelly as service to the individual congregations sponsoring local hospitals. The religious communities looked to trained theologians to render moral judgments that in turn strengthened the congregation’s integrity as ministries enacted in the name of the Catholic Church. In a sense, a renewed


focus on theologically supporting sponsors represents a retrieval of an earlier function. At the same time, organizational, clinical, and social ethics, discernment, and formation all serve the sponsors as they forge ahead into new endeavors to heal in complex social and individual realities.

Bouchard observes how sponsorship entails unique canonical and theological roles. It may behoove sponsors to have members who themselves bring a substantial depth of theological training and expertise, as well as search out other voices from the theological community. The theologian’s role with sponsorship in turn relates to church relations. Theologians serve the sponsor and senior leaders in their dialogue with bishops and diocesan personnel. Often this may take the form of gradually educating bishops and their representatives on economic, scientific, organizational, and technological matters that press upon a ministry aimed at working within social and cultural confines to tend to the needs of the poor and marginalized. It might also include advising sponsors and leaders on difficult matters. It could even include offering theological reflection on the nature of sponsorship in CHM, a very new theological concept.

**Theological Collaboration – CHMs, Academics, and Bishops**

Collaboration among theologians entails three spheres—those in CHMs, in diocesan roles, and in the academy. Fruitful collaboration involves a generosity of spirit, which begins with the recognition that each brings unique gifts and insights that can be mutually enriching. Generously listening and understanding the perspective of the other fosters mutual good will. Bouchard witnesses to the type of theological collaboration needed. He noted how practice and language operative in CHMs are ahead of the theology and thus assembled new scholarship for a contemporary Catholic theology of the healing ministry by inviting theologians from the academy and CHM to dialogue via video conference and correspondence. The result was *Incarnate Grace* with a foreword notably penned by a bishop.

Bishops are no strangers to theological quandaries and, as previously noted, their advisors—particularly those designated as liaisons for healthcare—are themselves theologically trained. Dialogue cannot overlook theologians in seminaries, particularly locations preparing students for diocesan ministry. Decades later these seminarians will be priests influencing and advising bishops. The wider the dialogue with an accurate and ongoing articulation of the many challenges of

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healing ministries entrenched in the world, and yet not fully of it, will more authentically redound to its benefit and to the work of theology itself.

Also previously noted, a need exists for a more astute sensitivity between CHMs and the academy. On the one hand, the academy can grow in appreciation for the monumental challenges that stymie practical implementation of a broader theological vision for CHMs. One scholar contributor to *Incarnate Grace* remarked how much he learns whenever he interacts with those inside CHM. A spirit of mutual learning and enrichment is helpful in this ongoing dialogue. Academics and chancery personnel alike can underappreciate the difficulties of doing theology in an environment where most are not Catholic, have limited experience with the Catholic world and imagination, and yet have good hearts and a passion for the healing ministry, and seek to do what is best in difficult circumstances and in an environment and industry that scarcely harnesses modernity’s forces.

On the other hand, if theologians in CHMs are the ones entrenched in the missionary-like environment of modernity-laden medicine practiced within the unforgiving confines of the American political and regulatory environment, then we need to articulate our reality more accurately and loudly so that those in different settings can better assist us. For example, in recent years both CHMs and universities have called for greater access to fellowships. Training and preparing young theologians for work in CHM must remain a priority for both. Advisors to these students must be acutely cognizant that students’ own formation cannot be exclusively intellectual.

Theology is always a response to God’s action. It happens after the Spirit of God has swept by us. As CHMs and the multiple gears that operate the structure of health care in the U.S. evolve, theologians have much work and contemplation. With prayer, an active life of faith, and scholarship rooted deeply in the riches of the Church and a post-conciliar theology, theologians can make meaningful and lasting contributions to CHMs especially for its sponsors, the people and communities served, and for the whole of the Church itself.

**CONCLUSION**

Moving more fully into a wider landscape where theologians in CHM have the freedom to contribute across disciplines requires embracing a full vision of the Council—one of continual *ressourcement* along with the continual *aggiornamento* present in medicine. No longer can mission leaders, senior leaders, and sponsors typecast theologians as ethicists or even moral theologians. The serious and contemporary challenges of CHMs call out for the very best across a broader theological spectrum ranging from social ethics and pastoral theology to ecclesiology, missiology, sacramental-liturgical theology, spirituality, anthropology, canon law, biblical studies, and more. An
authentic ressourcement to advance CHMs necessitates more than mere exposure to theology. It requires advanced degrees and commitments from theologians for life-long learning. Lastly, it will require the virtue of humility. No one person and no one discipline holds the single solution to these vexing issues of fostering a Catholic healing ministry in a contemporary, pluralistic society. It calls for community and a kneeling theology, where the theologian is nourished by the living presence of God encountered in the people, word, and sacrament at the eucharistic celebration, to then embrace aggiornamento—sent out again to be God’s very presence in word, thought, and deed.