Baltimore Hospital Is "Staying in the Struggle"

An Interview with Sr. Helen Amos, RSM

For an inner-city hospital, Baltimore's Mercy Medical Center (MMC) is prospering these days. Although it was ranked only seventh for women's care in a 1987 regional telephone poll, a similar survey in 1998 named it the best in the region. And in 1997 a national magazine said that for women's care MMC was one of the 10 best hospitals in the United States.

MMC is a 125-year-old, 285-bed facility sponsored by the Sisters of Mercy Regional Community of Baltimore. Sr. Helen Amos, RSM, has been its president and CEO since 1991. She spoke with Health Progress *about MMC's turnaround, healthcare leadership, women's health, sponsorship, and other issues.*

In an article you wrote for *Health Progress* a few years ago ("A Moral Quandary for Sponsors," January-February 1996, pp. 20-22 and 42), you said that religious congregations should continue to sponsor healthcare organizations, despite all the difficulties involved. Do you still feel that way?

Yes, in fact I feel it even more strongly now. Of course, the debate is still going on. Religious orders, which used to comprise many more sisters than they do now, are finding it increasingly difficult to administer big, complex institutions like hospitals, or even to find a proper niche in them. So some sisters are saying that we need to find another way of serving our communities.

I don't agree. Sponsorship is a way of holding a congregation's feet to the fire, so to speak. It's good for the congregation to witness a modern city's problems. Those problems are part of reality. And it's *not* good for a hospital to run away to the suburbs just because times are tough in the inner city. Hospitals need to stand fast and serve the people who need them, and sponsoring congregations can encourage their hospitals to do that.

Did you come to MMC from a career in healthcare?

No, I had no healthcare experience when I came here. I taught mathematics in high schools and colleges for 10 or 12 years. Then I kind of drifted into administration, serving as an assistant principal and dean in those schools.

Then I was elected an officer of the Sisters of Mercy Regional Community of Baltimore. I began to be put on boards, including MMC's. The hospital's board approached me about the CEO job, but I put them off for some time because I thought I wasn't prepared for it.

In fact, even after I did agree to become CEO I expected to get some sort of training for it. But I never did. There simply was never time for it.

You seem to have thrived in it nevertheless.

For me the key was having the opportunity to recruit MMC's senior management team members. They are excellent in terms of both skills and character. I guess I deserve some credit for picking them, but they really run the place, not me.

Did you, when you first came to MMC, have any trouble picking up medical terms or medical ways of thinking?

In the early months I thought about taking a course in medical terminology. But I never really had time for that either because I was immediately swept into the work.

I learned about healthcare mainly through a kind of osmosis. And it turned out that medical terminology wasn't all that relevant to the job. What a hospital CEO really needs to learn is the organization's various pieces—the clinics, departments, physicians, and so on. The CEO must

learn how these pieces fit together, about the common ground beneath them and the tensions among them.

This is especially tricky in the 1990s because these pieces and relationships are constantly shifting. Payers, providers—it's all in flux.

MMC seems to specialize in women's health issues. How did that come about?

Soon after I arrived here in late 1991, I realized that we needed to convene a strategic planning process. Because MMC was then in a financial crunch, the process had to be "quick and dirty," as the saying goes. We did it very rapidly, over a few months.

We looked at three or four possible focuses and wound up choosing women's health. That was partly the result of my naivete, my lack of knowledge about healthcare. But if I had come to MMC knowing little about healthcare, I *did* know something about women's issues. My congregation, the Sisters of Mercy, had been founded out of a special concern for women. And in 1991 we Mercy sisters were talking about the fact—it was just breaking in the news then—that medical research had traditionally focused more on men's health problems than on women's.

Also, MMC had once been known in the Baltimore area for its obstetrical services. But that had changed—it had slipped to seventh place in the local ratings. We talked about this and decided we would reclaim our former lead position in women's health.

We knew almost immediately that this was a good decision. It gave us an underdog kind of feeling—and the energy that goes with it.

How did you go about rebuilding MMC's reputation as a leader in women's healthcare?

We considered a combination of factors. We decided, for example, that although talk about mergers and partnerships was very strong, we would not partner with another organization. We thought that the key for us was internal partnerships, rather than external ones, and especially partnerships with physicians.

MMC had traditionally emphasized educating medical students. We knew that, because of this emphasis, there were many MMC-trained physicians in the Baltimore area and that many of them seemed to have fond memories of and warm feelings for the hospital.

A small group of physicians helped us create new forms of partnership with both primary care doctors and specialists. For example, we invested in a primary care physicians' group that has become one of the hospital's strategic partners. Other doctors, especially among the specialists, joined MMC on a salaried basis. We focused on attracting high-caliber physicians, and they in turn attracted other high-caliber professionals—nurse practitioners, nurses, and others. We put a great deal of time, energy, and resources into renewing the hospital's medical staff.

Sr. Helen Amos, RSM

We also focused on making the hospital atmosphere friendlier to patients and visitors. I once read somewhere that you have 90 seconds to make a good first impression on another person. At MMC we have a huge lobby full of comfortable furniture, with a player piano at one end of the room. Our lobby makes a wonderful first impression. It starts filling up at about 8 o'clock in the morning, with those people who like music sitting around the piano and those who prefer quiet sitting at the other end.

Our information desk, near the lobby's entrance, is operated by a "hospitality team" that includes both staff members and volunteers. Hospitality is one of our core values. Just last week I talked to a visitor who said that although she had had her children at other hospitals, she was so impressed by MMC's friendly atmosphere she thought she would come here next time.

A reputation for hospitality and a top-quality medical staff—those, I think, are the two main reasons we've done so well.

On one hand, you've argued that sponsorship is important for Catholic hospitals. On the other, you've noted that religious congregations, the traditional sponsors, no longer have enough members to do the job. That seems to bring us to lay sponsorship. What qualities should the ministry seek in laypeople in sponsorship roles?

Well, first, you have to remember that laypeople have a different mix of motivations than sisters have. They *have* to. My congregation takes care of my material needs: It feeds me, houses me, and will do so even after I retire. That's not true for laypeople, who have to think about feeding and educating their children and saving enough for retirement. Laypeople need money, and they need to figure out how to get it.

Continued on page 21

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Sponsorship and Mission

As new forms of healthcare sponsorship emerge, the relationship between sponsorship and mission is growing critical. Sponsorship is the faithful administration of a healthcare ministry. Although mission is the tangible expression of and support for sponsorship, it is not sponsorship itself.

It is becoming clearer that these functions, while integrally related, have different responsibilities. Consequently, it may not be desirable—or even feasible—for one person to be in charge of both functions. (Another complication is that healthcare systems generally locate the sponsorship function in the corporate office while the mission services function usually resides at both the corporate office and local facilities.) Healthcare organizations of the future may prefer to group mission services and human resources in one department and sponsorship and strategic planning in another. Saying this may oversimplify the issues, but it does suggest a way of sorting out the functions involved, and it may also clarify the competencies required for each function.

No single model of mission leadership can be appropriate for all Catholic healthcare organizations. But we have reason to hope that, as we seek new communities of persons committed to the Catholic health ministry, greater cooperation in delineating new roles will emerge and we will create the mission leadership the new millennium requires. □

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INTERVIEW

Continued from page 17

Those of us seeking candidates for sponsorship work must remember that laypeople differ from us in important ways. But good lay sponsorship candidates come into the ministry for essentially the same reasons we did. They're in healthcare for *more* than the money. They respect those they serve and honor religious direction. We religious sponsors simply must succeed in recruiting and retaining such people.

Will lay sponsorship be as effective as traditional sponsorship has been?

That's a question only the future can answer. I can only talk about the present. I spend a lot of my time these days mentoring lay colleagues. Most of them, incidentally, are a generation younger than I am. I don't talk to them so much about mission or theological matters. I focus, instead, on building their confidence. It's such a big job, you know. They tend to be doubtful. So I try to persuade them that they *can* be lay sponsors. I try to make them comfortable with their responsibilities.

Healthcare in the United States is in an unsettled state, and Catholic sponsorship of healthcare is vital. Catholic healthcare should stay in the struggle. Managed care is here to stay, and we've got to learn to live with it. In 1997 the state of Maryland mandated managed care for Medicaid patients. As a result, MMC has become a business partner of Maryland Blue Cross/Blue Shield, along with some other organizations. This experience has taught us that insurance companies aren't completely villainous; to some extent, we've had to learn to think like payers too.

But managed care doesn't solve everything. In fact, since it tends to focus on cutting costs rather than on providing care, it provokes new problems. So it's critically important that the Church stay in healthcare. It's important for healthcare and for us, too. To heal as Jesus did is an essential part of the mandate for our Church.

—*Gordon Burnside*