A *Health Progress* Diversity and Health Equity Discussion Guide

Catholic health care considers its commitment to promote and defend human dignity foundational to the work we do. In 2020, CHA launched "We Are Called" to confront racism and achieve health equity. This discussion guide was created, at the suggestion of *Health Progress*' advisory council, to provide a means in often busy Catholic health care settings to learn, discuss and consider ways to move toward greater understanding of one another and patients and how to work together for improved diversity and health equity in the work of the ministry. As *A Shared Statement of Identity* highlights, "our ministry is an enduring sign of health care rooted in our belief that every person is a treasure, every life a sacred gift, every human being a unity of body, mind, and spirit."

This guide includes an opening and closing prayer from CHA's resources, as well as three *Health Progress* articles for reflection, discussion and as a call to action. (Additional details and updated coverage of the We Are Called work is available at https://www.chausa.org/cha-we-are-called/about.)

CHA
Catholic Health Association of the United States

*We Will Empower Bold Change to Elevate Human Flourishing.*SM

How To Use This Guide

INTRODUCTION BY NATHAN ZIEGLER, PhD, SYSTEM VICE PRESIDENT, DIVERSITY, LEADERSHIP AND PERFORMANCE EXCELLENCE, COMMONSPIRIT HEALTH, CHICAGO AND A MEMBER OF THE *HEALTH PROGRESS* ADVISORY COUNCIL

The following articles provide insight, guidance and resources to support a culture where everyone is treated with dignity and respect. Understanding the history of systemic racism, acknowledging our biases, and taking definitive actions to achieve justice and equity are foundational to our work in the Catholic health care ministry. While engaging with these resources, a simple but effective tool should be applied to help foster an environment where everyone has the opportunity to explore these complex and challenging conversations.

Incorporation of the "three V" framework (value, validate and voice) is a useful process to support inclusive and crucial conversations about topics ranging from racism to global conflicts.

First, as you approach these perhaps difficult discussions, start with a value orientation toward each other. Be proactive in your inclusion of diverse perspectives. Ensure that underrepresented people are acknowledged, given space to share and are heard. Show that you value others through your actions by demonstrating care and support. Avoid making jokes, sarcastic comments or trivial remarks about a person's identity or experiences. Do not make assumptions or biases about a person based on their attributes, such as race, gender, religion or sexual orientation. And finally, respect the importance of another person's identity. Their unique individual attributes do not define them but shape their perspective and experiences.

Second, ensure that you validate each person's existence and experience. Do this by showing compassion for others and their personal histories. Listen actively with compassion and empathy, and accept their experiences as real to them. Ensure that you are holding yourself accountable for your actions, decisions and words. Acknowledge that bias exists and that underrepresented people are among those impacted by it daily. Be sure not to tell other people how to feel or think about their own experiences. Avoid making a person's perspective about you, unless you are directly involved. Do not argue or challenge an individual's experience. When someone is telling their story, do not interrupt or speak over them. Finally, do not tell people that their experiences with bias aren't real or that they are overreacting.

Finally, voice your support and concern. Start by paying close attention to what you say — be impeccable with your word. Speak out when someone does or says something against the ministry's mission, vision and values. Be sure to act with urgency in your response, but be courageous and respectful. Be compassionate to your colleagues and patients when speaking with them about their concerns. However, do not ignore statements or behaviors that don't align with the mission, vision, and values and address them as soon as possible. This will ensure that the issue does not escalate. And finally, do not disrespect others while addressing problematic comments, behaviors or attitudes.

The 3V framework can be applied when you or your teams have formal or informal discussions around this content. If you plan to host conversations about crucial topics, it is best to have a trained facilitator who can maintain a safe and respectful environment through intergroup dialogue. Finally, lean into our values as a Catholic health ministry. As we extend the compassionate healing ministry of Jesus, it is imperative for us to treat everyone with dignity and respect. The tools provided in this guide will help us learn more about these varying issues and how to respond to, discuss and understand the unique perspectives of our patients, communities and employees.

Opening Prayer

We Are Called

God of All People,

You came as one of us to show how we belong to each other.
You served among us to show how we are to serve one another.
You called us to follow you that we might build a better world together.

God of Wisdom and Compassion,

Renew our minds with your call to humble learning and service.
Refresh our hearts with your call to equity and integrity of community.
Reignite our spirits with your call to justice for our brothers and sisters.

God of Righteousness and Justice,

Make us relentless as we examine the structures that perpetuate inequity.
Make us humble as we lean in to listen and learn what we do not know.
Make of us steady allies and advocates, leveraging the strength of our shared ministry for the good of your people.

Amen.

First of three articles for discussion — from the Summer 2020 issue

'I Don't Want *THAT* Doctor to See Me'

Responding to Bias and Racism from Patients

By NATHAN ZIEGLER, PhD, ODESA STAPLETON, JD, and MUZIET SHATA

On a rainy Thursday afternoon, a middle-aged man came to the hospital for his visit with a specialist. He had many routine procedures to treat his condition, but so far little progress had been made. He was growing tired, frustrated and worn down. That day, the patient became somewhat agitated as the specialist made his rounds through the room. The patient's attitude switched instantly from one of being tired but compliant to being hostile, angry and challenging. The shift in tone was noticeable to his care team, and they started inquiring about his behavior. Moments after his specialist left the room, the chaplain came to provide spiritual care. The chaplain noticed the man's shift in behavior and mood, so she asked him what he needed to feel more comfortable. The patient looked up at her and said, "I want you to get that Arab doctor off my care team!"

For some care providers, this scenario is far too common. People of color or whose first language isn't English, women and LGBTQ+ individuals often experience racist, xenophobic, sexist or homophobic comments regularly. In fact, such comments are increasing as people become more comfortable feeling empowered to express them. Acquiescing to such biased demands may impact underrepresented associates physically, psychologically, emotionally and even professionally.

At Bon Secours Mercy Health, our mission of extending the compassionate ministry of Jesus calls us to provide quality health care to all patients, regardless of race, gender, nationality, sexual orientation or personal beliefs. Even when a patient exhibits racist behaviors and attitudes, we are bound by the Hippocratic Oath to treat them. But are we obliged to meet their requests? And if not, how should we respond?

For our care providers, the frequency of such requests and behaviors has increased over the last few years, causing us to develop a response plan. Across our system, we have seen cases like this unfold, often with chaplains who are tasked with supporting our patients spiritually and emotionally. When patients feel comfortable making biased comments and requests, our chaplains immediately recognize a conflict with their own values. As chaplains have grappled with the issue, our Diversity and Inclusion team worked with them to identify a solution.

At Bon Secours Mercy Health, diversity and inclusion is a ministry-wide priority. As the nation's fifth largest Catholic health system, we serve more than two million patients a year across seven U.S. states and in Ireland. Our 60,000 associates provide health care to patients with a focus on serving the poor, dying and underserved. Based on our mission and core values of human dignity, integrity, compassion, service and stewardship, we see diversity and inclusion as the right thing to do from a mission perspective as

Illustration by Jen Everett

well as a business one.

Our philosophy is that when we live our mission in the way that we care for people and communities, we can also be an embodiment of inclusion. Jesus embraced all people regardless of their attributes, attitudes, status or behaviors. Our commitment as a ministry to our patients and associates is rooted in principles of inclusion, where we treat everyone with dignity and respect. Yet we know it can be challenging to help our associates stand on these principles when patients make racist, sexist or xenophobic requests or comments.

As we considered the issue of patient bias and racist comments, it was necessary to understand the pervasiveness of the problem from scientific and historical perspectives. The first step is to clarify the difference between bias and racism. Bias is a cognitive process that allows the brain to make shortcuts in its decision making about people, things and situations. Cognitive shortcuts evolved to help humans decipher between what is good or bad, safe or dangerous. Evolutionarily speaking, bias became an early defense mechanism to identify danger and make quick, life-saving decisions. Bias is influenced by stereotypes or negative portrayals of people based on certain attributes. Biases can be implicit, that is, occurring without conscious awareness, or explicit, occurring with conscious awareness.

Racism is a systemic structure of injustices that foster inequities for people based on their physical and cultural attributes. In the early parts of U.S. history, the notion of race was deployed to justify racial supremacy and support the enslavement of African people and the genocide of Native people. This was done by making racial distinctions between white, African and Native peoples where African and Native people were considered racially inferior. This framing was later applied to other groups that drew intellectual and behavioral distinctions based on race.[1] Human bias is influenced by such a racial paradigm because these constructs influence our perceptions of behavior from a perspective of race. This deeply rooted systemic structure still influences our social consciousness, which perpetuates social injustices and inequities toward people of color. The mechanism of socially engineering bias to leverage the fear and hatred of people of different races is as pervasive as ever.[2,3]

The history of systemic racism helps us understand what happens when individuals act in accordance with certain stereotypes about people of different racial and ethnic backgrounds. When a person is frightened, vulnerable or sick, bias mechanisms are heightened, so that they are more likely to display biased or racist beliefs and behaviors when in this state. It should not be surprising, then, that patients who hold these biases are more likely to display them in states of duress.

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The response to bias and racism in care settings should be met with the same complexity of thinking. Rather than simply putting together a programmatic response to such issues, we developed and deployed an integrated strategic approach to diversity and inclusion to ensure the advancement of equity for all Bon Secours Mercy Health associates, patients and communities.

Our priority was to establish a structure to support diversity and inclusion in our ministry. To do this, we deployed Leadership Councils for Diversity and Inclusion in each of our markets in 2019. These councils consist of cross-functional leaders who represent different levels in the organization and different attributes in terms of race, ethnicity, gender, sexual orientation, religion, age and ability. The Leadership Councils for Diversity and Inclusion develop strategic plans that support the five key areas of our ministry: a workforce that represents the communities we serve; a workplace culture where everyone is treated with dignity and respect; engagement with all the communities we serve; a patient experience where all patients receive equitable care; and a business strategy that leverages diversity and inclusion to grow the ministry. The Leadership Councils

for Diversity and Inclusion develop market-level plans that they monitor, support and communicate to their market peers.

Additionally, we developed diversity and inclusion education and training that is deployed across the system in order to reduce the impact of bias in our care delivery, associate relations and community engagement. In 2019, for example, we were able to train almost 2,000 leaders in diversity and inclusion and 700 associates in bias reduction across the ministry. Our goal is to train all 60,000 associates in anti-racism and cultural sensitivity by the end of 2021.

When our mission leaders raised the issue of patients displaying bias towards our caregivers, we were able to build on our established foundation to provide a multi-faceted response. We started by redesigning our current bias training that only focused on reducing bias at the individual level. This four-hour training, entitled 3Rs: Bias Recognition, Bias Reflection and Bias Reduction, has five key modules aimed at reducing the impact of bias on one's behavior. A sixth element was added to address patient biases.

The first module focuses on building trust and comfort with the group. We have found in past trainings that people are more likely to fully engage in a training seminar when they have established trust in the presenters, as well as the other people in the room. Given the sensitive nature of the topic of bias, trust was crucial, because the participants are expected to open up about their experiences and analyze their own biases.

Inclusion is creating and fostering a trusting environment where all are included, respected and supported in their engagement with the acceleration of the mission, values and vision. Diversity is who we are. Inclusion is what we do.

The second module is designed to help participants gain an understanding of the basics of diversity and inclusion. The Bon Secours Mercy Health understanding of diversity is rooted in the existence of the gifts, talents and attributes of people, processes and functions, characterized by both differences and similarities. This definition is designed to show that diversity is a fundamental part of who we are as people and that it exists in all of us. Inclusion is creating and fostering a trusting environment where all are included, respected and supported in their engagement with the acceleration of the mission, values and vision. Diversity is who we are. Inclusion is what we do. This becomes the focal point of ensuring that all members of our community feel engaged in our mission.

The third module covers the importance of cognitive diversity, which is a person's individual thinking style preference. Using the Whole Brain Thinking model developed by Ned Herrmann, we showcase how different thinking styles influence how we are engaged, how we communicate, what information we see as important and what we focus on when we are thinking.[4] This portion of the training module is designed to give our participants a sense for how they think, how others think, and what they need to do when speaking with someone who has a different thinking style preference.

The fourth module is focused especially on the 3Rs: bias recognition, reflection and reduction. In this portion of the training, we highlight how every person has bias, which is a cognitive process. Thus, intercepting bias and reducing the impact of bias on our behavior becomes the goal instead of ignoring our biases and pretending that they do not exist. Bias recognition is aimed at learning that everyone has biases and trying to determine how they occur in our interactions. The next step in the process is to reflect on the bias by determining the root and intention behind it. After reflecting on our bias, it is critical to take steps to reduce the impact of the bias on our behavior. We use multiple tools to help our participants do this, such as the equity lens. This tool helps a person check their own biases and remove such biases in their decision-making process to remain as objective as possible. It helps ensure that people are making decisions based on consistent criteria instead of bias.

The fifth part of the training module is aimed at putting the 3Rs to work through an application exercise. We divide the room into small groups of three or four people. Together they select a certain

number of people out of a larger list of people to embark on a journey to a Brave New World. Each person on the list has different salient attributes, such as age, race, gender, occupation, parental status, educational background, criminal background and health status. The group establishes certain criteria for deciding who stays and who goes. After each group has determined their short list, they are required to justify their selections, using strict criteria about who they took and why. As facilitators, we challenge their selections and help pull out the implicit biases of the group. By the end of the module, we highlight how to apply the equity lens to change the influence of bias on their behavior going forward.

The last part of the training is focused on having difficult conversations. In this module, we start with the premise that what you permit you promote. That is, if you do not address biased behaviors directly, then you are complicit in their impact on other people. Second, we give a script-template that helps participants learn different responses when addressing requests from patients. With statements such as "I understand that you feel frustrated, but we do not make decisions based on a person's race or ethnicity," our participants have a standard reply that they are able to rely upon in difficult scenarios. The third portion of the module provides protocols to stand behind our mission, vision and values in response to these requests. For example, our participants were instructed to say "At Bon Secours Mercy Health, our mission is to live the compassionate healing ministry of Jesus every day, which requires us to support all of our patients, associates and community members by treating them with dignity and respect at all times. For that reason, I'm not willing or able to make that type of accommodation for you." These standardized responses create messaging that helps respond to these scenarios with integrity, allowing us to stay true to our mission, vision and values.

In summary, the 3R training is designed to take our participants on a diversity and inclusion journey that engages them in the content, breaks down personal barriers and teaches on a deeper level how to mitigate the effects of bias on their behaviors and on others. By starting with trust building, we can help people have open discussions about their beliefs and views. Afterwards, we work to help everyone to see themselves in Bon Secours Mercy Health's definitions of diversity and inclusion. With the incorporation of cognitive diversity, we look deeper at how thinking influences interactions, perspectives and communication. This helps our participants see on a deeper level how people are similar to and different from one another. These first three modules prepare our participants to start looking at their own biases, which will help them more actively and openly reduce the impact of bias on their behavior. The final two modules reinforce their learning by giving them practice at examining their biases and addressing the biases of others.

With the incorporation of cognitive diversity, we look deeper at how thinking influences interactions, perspectives and communication. This helps our participants see on a deeper level how people are similar to and different from one another.

CONCLUSION

The response to the training has been overwhelmingly positive. Participants feel empowered to address patient bias in real time, while also discovering they still have work to do on their own. In follow up debriefs, our chaplains said they were able to respond with integrity to challenging patients, and that has empowered the chaplains to stay true to our mission, vision and values in continuing the good work of extending the compassionate healing ministry of Jesus.

For diversity and inclusion, our work is far from done. We know that we must continue to develop ways for patients and associates to better understand our embrace of diversity and our practice of inclusion. With our ministry-wide commitment to infusing diversity and inclusion into everything we do, we know we can make real strides towards ending systemic structures of inequity that plague our associates, patients and communities, making us better able to support everyone in mind, body and spirt.

For Bon Secours Mercy Health, **NATHAN ZIEGLER** is vice president of culture and inclusion; **ODESA STAPLETON** is chief diversity and inclusion officer, and **MUZIET SHATA** is director of language services.

NOTES

1. Audrey Smedley and Brian Smedley, "Race as Biology Is Fiction, Racism as a Social Problem Is Real: Anthropological and Historical Perspectives on the Social Constructs of Race," *American Psychologist* 60, no. 1 (2005): 16-26, doi: 10.1037/0003-066X.60.1.16.
2. Combating Bias and Stigma related to COVID-19," American Psychological Association, March 25, 2020, http://www.apa.org/topics/covid-19-bias.
3. Ying Liu and Brian Karl Finch, "Discrimination against Asian, Black Americans More Likely amid Coronavirus Pandemic," *The Evidence Base*, USC Schaeffer, March 23, 2020, https://healthpolicy.usc.edu/evidence-base/discrimination-against-asian-black-americans-more-likely-amid-coronavirus-pandemic/?utm_source=sfmc&utm_medium=email&utm_campaign=covidexternal&utm_content=newsletter.
4. Whole Brain Thinking website: https://www.herrmann.com.au/what-is-whole-brain-thinking/.

chausa.org/publications/health-progress/archive/article/summer-2020/'i-don't-want-that-doctor-to-see-me

QUESTIONS FOR DISCUSSION

The decline in civil discourse and heightened levels of fear, anger and anxiety have resulted in situations of bias and racism directed at clinicians and other health care professionals. Bon Secours Mercy Health has developed a systemwide approach to dealing with bias and racism directly and consistently. Authors Nathan Ziegler, Odesa Stapleton and Muziet Shata describe the process they developed and the commitment that makes it work.

1. How has your ministry dealt with difficult patients who acted or spoke inappropriately in ways that express racist or other prejudicial biases? Since many of these instances happen in the ED or ICU, when anxiety is at its highest, what has been done to defuse and rectify the situation?

2. How can entire hospitals and long-term care facilities, much less large health systems, enact policies and procedures that carry out real diversity and inclusion? What has to become actionable? What needs to happen to make it a systemwide priority rather than a department with the right name?

3. How would you rate your organization's approach to diversity and inclusion? Does your ministry have a process in place to provide training and reflection opportunities for all associates whether in new associate orientation, formation experiences or other leadership development opportunities? Are the values of diversity and inclusion clearly articulated in your recruitment, retention and promotion practices? What work still needs to be done?

4. This article mentions the difficult role chaplains have in responding to racist situations or leading difficult conversations. What mechanism does your system have in place so that difficult conversations have all the right people at the table, from intake receptionist to board member? Do you have any suggestions for your ministry's approach to this subject?

Second of three articles for discussion — from the Winter 2023 issue

Maintaining Identity and Inclusivity in Catholic Health Care

JOHN O. MUDD, JD, JSD, and JOHN SHEA, STD
Consultants on Catholic Leadership Formation Programs

In Catholic health care, an ever-changing workforce can present new opportunities to enhance and preserve its identity and culture. This endeavor — to tie one's calling with the ministry's mission — can, however, invite new challenges, especially when welcoming staff with increasingly diverse backgrounds that are both religious and nonreligious. Those who regularly encounter this dynamic know it has no easy resolution.

For the last 20 years, we have grappled with this issue in formation and administrative settings, working with hundreds of Catholic health care leaders. From our experiences, we offer lessons learned on some areas of concern. It is our hope that by continuing this vital conversation, Catholic health care can find new ways to carry on the healing ministry of Jesus.

TWO WRONG APPROACHES

Before offering our suggestions on how to respond to a changing workforce and its beliefs, while still remaining faithful to Catholic health care's mission and identity, we first want to rule out two approaches that have been proven not to work — based on our time in Catholic health care. The first is trying not to offend those with different beliefs by avoiding language or engaging in practices that might be considered "religious" or "spiritual." For example, recently a mission leader was asked to give a short reflection to a gathering of donors, but to not say "Jesus."

The goal of this strategy — what might be called a "watered-down" approach — is to be sensitive. However, this tactic can result in excluding conversations on topics and traditional practices that are central to the Catholic ministry's identity.

A second approach is trying to blend the ministry's mission and values with the dominant secular culture, perhaps even implying that the Catholic and secular cultures are virtually the same.

History is filled with examples of health care and educational organizations that are secular today but were founded within a religious tradition. Their transition from religious to secular was usually not the result of an intentional decision to drop their religious heritage, but rather the cumulative effect of small decisions and shifts in practice that eroded that tradition over time. Ultimately, the decision to become secular became merely a recognition of what had already occurred.

The result of either watering down the Catholic heritage or trying to blend it with secular culture is inevitably the loss of Catholic identity. Over time, the ministry becomes Catholic in name only — an organization that may still deliver quality health care, but is no longer connected with or defined by the Catholic tradition.

Instead of these fruitless approaches, we offer

Illustration by Anna Godeassi

three principles to guide how the ministry can be faithful to its Catholic identity while still welcoming into the ministry people from diverse backgrounds.

Principle One: Values Alignment

Everyone who chooses to serve in a Catholic ministry must demonstrate their commitment to the ministry's values. This is not optional. Only when the ministry holds staff accountable for living up to its values is the ministry itself being faithful to its identity. If a staff member fails to show respect for patients and colleagues, for example, that person does not belong in a ministry that professes the value of respect. Demonstrating a commitment to the ministry's values does not mean being perfect, but it does mean that the everyday speech and behavior of those who work in the ministry must be in line with the values the ministry professes.

The source of the Catholic ministry's values is its theological understanding of God, Jesus and the human person. Those with different religious or philosophical backgrounds are free to ground the values in their own traditions. For example, while everyone in the ministry must demonstrate respect for others and excellence in their work, they may base those values on their own philosophical or religious understanding. A Buddhist and a secular humanist will ground the values of compassion and respect differently. What is essential is that they demonstrate the values in their words and actions.

Demonstrating a commitment to the ministry's values does not mean being perfect, but it does mean that the everyday speech and behavior of those who work in the ministry must be in line with the values the ministry professes.

To ensure that all are committed to the ministry's values, its hiring processes should include a focus on them and help those who are hiring determine if candidates have demonstrated values like respect, integrity, compassion and excellence. They should ask themselves: Is there evidence of those values shown in the person's life and experience? Similarly, the ministry's performance evaluation process should assess whether employees' words and actions are consistent with its values, and, if they fall short, it should have effective improvement plans and respectful ways to separate those who fail to improve.

It can be challenging to deal with a person who is failing to uphold the ministry's values but who otherwise has valuable skills. The temptation is to overlook where the person exhibits deficits in the values of the ministry to retain their other contributions. Yet, if some staff get away with unacceptable behavior, that tells others the ministry doesn't really care, and a "staff infection" spreads. On the other hand, when the ministry makes clear that everyone, even high-profile people, must demonstrate the values, the message also spreads that this ministry walks its talk and is faithful to its identity.

Principle Two: Respect

Those who choose to work in the Catholic ministry must show respect for its Catholic tradition and heritage, regardless of their own beliefs. When a person with different beliefs accepts the invitation to work in a Catholic ministry, it is like visiting the home of someone from a different culture. If the invitation is accepted, the guest is expected to respect the host's culture. The same would be expected of Catholics who choose to work in a Jewish or Adventist hospital. For those working in a Catholic ministry, respect for its tradition includes participating in practices like reflections before meetings, celebrations of milestones in the ministry's history, and orientation and educational programs that explain its heritage. Respect extends in a special way to the ministry's organizational and ethical principles. One does not need to personally agree with the ministry's principles and positions, but must show respect for them, and, consistent with their responsibilities, must follow them.[1]

Principle Three: Welcoming Diverse Traditions

The third principle is the reciprocal of the first two — the ministry must demonstrate respect for the diverse backgrounds of its staff. The model is Jesus welcoming everyone, including outsiders. Welcoming all who work in the ministry means at the outset not suggesting any effort to convert

them. While it is essential to explain the tradition and heritage of the ministry in which they work, it must also be made clear that the ministry respects their beliefs and does not intend to proselytize or indoctrinate them.

In a formation program for senior executives, a question was asked of every group: "What do you not want to happen in this program?" The number one response in every cohort was, "No proselytizing." The deep-seated fear was that the Catholic faith-based organization would try, in one way or another, to make converts. The prevalence of this suspicion suggests it has to be explicitly rejected.

A welcoming attitude can be demonstrated in many ways. One way is to show how the Catholic tradition, its stories, language and practices share elements with other traditions. When describing the value of compassion, for example, the ministry's stories of compassion may be complemented with stories from other traditions. Jewish, Sufi and Buddhist traditions — to name a few — are rich with spiritual teachings and stories. Incorporating them shows a welcoming attitude and how the Catholic tradition shares values with others.

A similar approach can be used in explaining the centrality of the Catholic social tradition. The newcomer may never have heard of any "social tradition," much less one that is Catholic. It can help to start the explanation with what is familiar: all clinical professions share the humanitarian tradition of providing excellent, compassionate care and respecting patients, regardless of their personal or economic status. This humanitarian tradition includes working for the common good, or, as expressed in the U.S. Constitution, promoting "the general Welfare." Religious traditions of the East and West also foster respect and care for others, especially those who are vulnerable. When explained in the context of humanitarian or other religious traditions, the Catholic social tradition becomes less mysterious and more like the Catholic dialect of a language newcomers have already heard. Starting with what is familiar also makes it easier to highlight the Catholic social tradition's areas of emphasis and why it is central to the ministry's work.

Another way to show respect for those with different backgrounds is to avoid using "insider" language. Like others in the health care world — for example, clinicians, information technology specialists and accountants — Catholics have their own specialized terms. But using insider terms leaves some outside of the conversation and can generate confusion and misunderstanding. In explaining the Catholic tradition, it is essential to use language that is understandable and tailored to the role of the listener. A floor nurse may need to understand only a few Catholic terms, whereas an executive will need to understand and be able to use many.[2]

While it is essential to explain the tradition and heritage of the ministry in which they work, it must also be made clear that the ministry respects their beliefs and does not intend to proselytize or indoctrinate them.

A number of words Catholics commonly use need explaining to those new to the ministry. Some examples include: What is a sister? (Few entering Catholic health care today have known, much less worked with, a Catholic sister.) What is a congregation, religious order, superior, province, provincial council or a charism? What is a layperson, bishop, archbishop, diocese or a hierarchy? What is a ministry, sponsorship or sponsor? What is canon law, the Vatican, a dicastery, a public juridic person, an ecumenical council or Vatican II? What are encyclicals or the ERDs, and what does preferential option for the poor, subsidiarity, and, more recently, synodality mean?

Words like these can be translated into more familiar terms. For example, an order of sisters' "province" or a church "diocese" might be translated as a "region" or "geographic territory"; "canon law" as "church law"; a "public juridic person" as a "church corporation"; or a "dicastery" as a "Vatican department." As with any translation, nuances from the original may be lost, but the listener will better understand the concept and will appreciate being welcomed into the conversation, not left wondering what is being said.

Some of the ministry's practices will also be unfamiliar to a newcomer. The practice of starting meetings with a reflection may be seen at first as a formality, something like singing the national

anthem before a ballgame. Explaining that the reflection is a time to pause, be fully present, and connect the meeting with the mission and values can overcome the misinterpretation. The newcomer can learn to appreciate that the reflection should not be simply listening to a few pious words or a management quotation, but a time to consider the "why" of the work before diving into the "who, what, where and when."

Catholic ministries have found creative ways to welcome those with different traditions. For example, when a Catholic system assumed ownership of a hospital serving a predominantly Jewish community, the hospital's dedication ceremony included local rabbis placing mezuzahs at the entrances to patient rooms along with chaplains placing the traditional crosses. Another Catholic hospital set aside a special room where its Muslim staff and visitors could pray. Catholic hospitals have found ways to connect regularly with local religious leaders by inviting them to engage with the ministry and to teach hospital staff about cultural sensitivities of patients and ways to honor their healing and end-of-life customs. These are all ways the ministry maintains the interfaith openness of its Catholic identity.

The challenge of maintaining Catholic identity while being welcoming also arises when a Catholic ministry enters a close relationship with an organization that is not Catholic. While this complex topic is beyond the scope here, there is a parallel challenge of ensuring that the partner organization is committed to the values of the Catholic ministry and, if the Catholic identity is intended to remain, that the ministry's practices are not diluted or lost because of the relationship.

CONCLUSION

When the founding communities of sisters began to transfer the leadership of their ministries to laypersons more than a generation ago, some doubted that the ministries could remain Catholic without sisters at the helm. The widespread development of orientation and formation programs, along with maintaining cultural practices, have proven effective in keeping Catholic identity and heritage alive. An ongoing challenge is to engage Catholic health care's increasingly diverse leaders and staff so they feel ownership of their ministry's Catholic heritage and share the commitment to pass it on.

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NOTES

1. Chad Raith, "How to Strengthen Catholic Identity in a Diverse Workforce," *Health Progress* 102, no. 2 (Spring 2021): 63-68, https://www.chausa.org/publications/health-progress/archives/issues/spring-2021/how-to-strengthen-catholic-identity-in-a-diverse-workforce.
2. *Framework for Ministry Formation* (St. Louis: Catholic Health Association, 2020), https://www.chausa.org/store/products/product?id=4363.

chausa.org/publications/health-progress/archive/article/winter-2023/maintaining-identity-and-inclusivity-in-catholic-health-care

QUESTIONS FOR DISCUSSION

1. Reflect on what it means to you to be a member of Catholic health care and to extend the healing ministry of Jesus.

2. What examples do you have of demonstrating or respecting Catholic identity while accepting perspectives of those of other faiths or of no faith tradition?

3. The authors highlight ways of engaging diverse and interfaith perspectives in Catholic health care. What are additional ways to support an inclusive environment while adhering to the foundations of Catholic teachings? The exercise on the next page can be used to understand further the needs of patients, employees and communities of diverse faith traditions.

EXERCISE

Host an intergroup dialogue between employees, leaders or community partners from diverse faith backgrounds, ensuring that you have not only practicing Catholic participants but also those from different faiths such as Judaism, Islam, Buddhism and Hinduism. Together, share key tenets of each person's faith. Then, identify similarities and shared values amongst the different faiths and map these similarities on a board. Then, identify any possible differences between the faiths and map these on the board. Finally, discuss how to honor the traditions of each faith in the Catholic health care setting.

Tips: Ensure that you have a trained facilitator who encourages contributions from all participants, maintains an environment where everyone is treated with dignity and respect, and has a deep understanding of the diversity of faiths. Be sure to limit participation to no more than 15 participants as a larger group makes it difficult to have full participation. Take notes on the talking points and ideas generated in the discussion to inform how we care for patients, communities and employees of diverse faith traditions while recognizing our Catholic identity.

Third of three articles for discussion — from the Spring 2022 issue

'PLAN' FOR BUILDING RIGHT AND JUST RELATIONSHIPS

A pillar of CHA's commitment to equity, the We Are Called initiative, is for Catholic health care organizations to find ways to build and strengthen trust with communities of color that have suffered from the health and economic impacts of structural racism.

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CHA's Confronting Racism by Achieving Health Equity statement describes our commitment to build right and just relationships with communities: "This includes fostering and sustaining authentic relationships based on mutually agreed upon goals; 'leaning in' to listen; learning about and understanding the needs of the community; determining how we can best partner together to bring about sustainable change; measuring the impact of our efforts; and making adjustments as called for by the community and as our combined work and relationships evolve."

Over the past year, CHA members and staff have studied how to accomplish this important goal. We have learned that as we begin this work, we must "PLAN" as follows: to be a "Presence" in our communities; to "Listen" to our communities; to "Actively" recruit community members; and "Never" assume we have the answers.

Presence

Last June, CHA Assembly speaker Bryan Stevenson, founder and executive director of the Equal Justice Initiative, said, "We cannot advance justice if we isolate ourselves in spaces where we are shielded from the problems of the poor and the most vulnerable. Justice only comes when we actually situate ourselves in spaces where there's often injustice."

We can act on these words by being present, working in our communities and holding internal meetings such as board and staff events within local facilities and with area vendors. We cannot just occasionally visit — we need to also build long-term relationships by encountering community members where they work and live and collaborating with local organizations on programs in schools, housing programs and other community spaces.

To achieve this sustained presence requires an honest assessment of how the organization currently engages and works in the community. The Praxis Project offers an organizational self-assessment, "Working Principles for Health Justice and Racial Equity," that can be used to understand the changes that need to occur in the organization's daily activities, polices and strategies to build authentic community relationships.[1]

Listen

Michelle Hinton, the former director of impact, population health and well-being for the Alliance for Strong Families and Communities, urges health care organizations to listen to their communities and learn about the history of structural racism and community priorities. In the Spring 2021 issue of Health Progress she wrote, "Historical examples have left indelible scars and resulted in deep and lasting distrust among people of color toward the medical professions. Rebuilding and restoring that trust requires an approach that engages communities and those with lived experience in both identifying the problem and offering solutions."[2]

Hinton said that when health care staff understand the perspective of community members, they build trust that will help them work collaboratively to improve community health and address social determinants of health. Start with the community needs assessment, she suggested.

"Who are the stakeholders that participate in the assessment?" she asked. As she further added, "Partnering with community, through shared influence in the solutions, is essential in develop-

ing trusting relationships and strengthening the health and well-being of communities." She noted that it is important to involve community members, not just their representatives or executives of their organizations. Involve those "with lived experience," she wrote.

Actively Recruit Community Health Workers

Perhaps the most effective way to build bridges between health care organizations and communities is working with community health workers. The American Public Health Association defines a community health worker as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."[3]

During the 2021 Catholic Health Assembly, Maria Lemus, executive director of Visión y Compromiso, an organization created and led by promotores and community health workers, explained that because these workers share the same language, culture, ethnicity, status and experiences of their communities, they are able to reduce the barriers to working with native-born and immigrant communities.

Never Assume We Have the Answers

The Association of American Medical Colleges (AAMC), in its 10 Principles of Trustworthiness, tells health care leaders, "You are not the only experts. People closest to injustice are also those closest to the solutions to that injustice. ... Listen to people in your community. They have deployed survival tactics and strategies for decades — centuries, even. Take notes. Co-develop. Co-lead. Share power."[4]

Building right and just relationships requires humility, says Fr. Michael Rozier, SJ, the president of SSM Health Ministries and assistant professor of health management and policy with Saint Louis University College for Public Health and Social Justice. In CHA's document on the social determinants of health, he wrote that heath care organization leaders should acknowledge the wisdom and talents in communities and be willing to follow the lead of others.[5] In his guiding principles for global activities, Fr. Rozier wrote that meaningful partnership should be marked by mutuality and respect where both partners take away relevant lessons.[6]

There is no easy way to build right and just relationships with communities that have long endured intentional acts to disenfranchise and marginalize them. It will take time, trust, patience and resources. But the steps of being present, listening and learning about history and priorities of community organizations and the people they serve, actively recruiting community members — especially community health workers — and never assuming we have the answers are a good start.

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NOTES

1. "Working Principles for Health Justice and Racial Equity Organizational Self-Assessment," the Praxis Project, https://www.thepraxisproject.org/resource/2020/principles-self-assessment.
2. Michelle Hinton, "Community Benefit – To Reduce Disparities, Be Mindful of History and Reform Systems," *Health Progress* 102, no. 2 (Spring 2021): 83-84, https://www.chausa.org/publications/health-progress/article/spring-2021/community-benefit—-to-reduce-disparities-be-mindful-of-history-and-reform-systems.
3. "Community Health Workers," American Public Health Association, https://www.apha.org/apha-communities/member-sections/community-health-workers.
4. "The Principles of Trustworthiness," Association of American Medical Colleges, https://www.aamchealthjustice.org/resources/trustworthiness-toolkit.
5. *Healing the Multitudes: Catholic Health Care's Commitment to Community Health* (St. Louis: Catholic Health Association, 2018): https://www.chausa.org/store/products/product?id=3723.
6. *Guiding Principles for Conducting International Health Activities* (St. Louis: Catholic Health Association, 2020): https://www.chausa.org/store/products/product?id=4423.

chausa.org/publications/health-progress/archive/article/spring-2022/community-benefit---plan-for-building-right-and-just-relationships

After reading the third article, please read this reflection while contemplating and talking about how those who work in Catholic health care can "put their own houses in order" in working for diversity, equity and inclusion. What can you do first at work to enact larger change in the world?

REFLECTION: PUTTING OUR OWN HOUSE IN ORDER

A reading from the Book of Joshua 24:15

> But as for me and my household,
> We will serve the Lord.

REFLECTION:

From the last chapter of the Hebrew Scriptures' Book of Joshua, this verse can be seen on coffee mugs, decorative wall hangings, clocks and needlepoint pillows. But what does it mean to serve the Lord? Joshua led the people of Israel after Moses died. Joshua brought his people into the Promised Land. The passage comes from his last speech to the community where they renewed their covenant with God, the same God that called them, led them out of slavery and gave them the land on which they stood.

The feel-good saying comes with a pointed call. First, Joshua reminds the people of all that God has done for them and that God has high expectations of their faithfulness, "You are not able to serve the Lord. He is a holy God; he is a jealous God. He will not forgive your rebellion and your sins." (Joshua 24:19) The people protest and shout assurances that they will be faithful. Then, as a sign of their commitment, Joshua tells them to "throw away the foreign gods that are among you and yield your hearts to the Lord, the God of Israel." (Joshua 24:23)

To serve God and follow the call requires us to look into our hearts and homes and unearth our idols. It is one thing to say that we will follow God's law to care for the weak, the outcast and the voiceless. It is quite another when doing so requires us to carefully assess where we are amiss.

Our shared work to achieve health equity and root out the causes of health disparities in our communities requires us to look inward at ourselves. Do our ministries truly serve God by serving all of God's people? What idols remain within our budgets? What sacred calves cannot be touched? What systems have we built that create inequity?

[You may build in some time for those gathered to reflect on the strengths and opportunities within their department, facility and system when it comes to inclusion, belonging and equity.]

INTERCESSIONS:

Jesus said, "Let the one who is without sin throw the first stone." (John 8:7) No person or organization is perfect in the work of inclusion and anti-racism. Let us pray for open hearts and a willingness to change. Please respond: For me and my house, we will serve the Lord.

For a renewed spirit of curiosity to educate ourselves about the structures of racism and inequality, which limit the challenges of some, while creating greater barriers for others. We pray: For me and my house, we will serve the Lord.

For a renewed spirit of self-reflection to recognize the times we consciously and unconsciously contributed to racism, exclusion and injustice. We pray: For me and my house, we will serve the Lord.

For a renewed commitment to examine all aspects of our organizations, from how we conduct clinical care to business operations and to then make the changes necessary to create a more just future. We pray: For me and my house, we will serve the Lord.

Closing Prayer

God of All People,

You call us to serve you through our service of others.

You call us to work for a just society — a world that values the health and well-being of all people.

Give us the wisdom to consider our shortcomings before indicting at others.

Give us the courage to make the changes necessary for your justice to take root.

Fashion our facilities, systems and entire health care ministry into a house that truly reflects and mirrors your goodness.

We pray in your holy name,

Amen.

This version of the guide was renamed in Feb. 2025 to reflect its focus on health equity.