EFFECTIVE GOVERNANCE IN COMPLEX SYSTEMS

With Sponsorship at a Crossroads, Navigating Change Becomes Vital

BY DAVID J. NYGREN, CM, PhD

Sponsorship of church ministry refers to the unique relationship of oversight, endorsement, or support by a group that commits itself to advancing the ministry of Jesus. Sponsorship is a call and a response to advance the love of God manifest in Jesus and in a ministry of the church. The response, born in profound trust and confidence in providence, implies that the person or group entrusted with the ministry can attest to its worthiness. The sponsor is responsible for interpreting institutional fidelity to its founding intent and for suggesting modification to its form or configuration to ensure its continued vitality, relevance to those served, and worthiness of public trust.

When we say that religious congregations sponsor health care ministries, we assume a common understanding of the term. Catholic health care has used the term "sponsorship" to define the unique relationship between the founding congregation and its works. Hospitals, systems, and other corporations founded and endorsed by the congregation often carry the name of the congregation. The congregation sponsors the ministry. The evolution of sponsorship, however, has not kept up with reality and has led to considerable heartache within the health care ministry.

Not so long ago, sponsorship of an institution implied a direct relationship between the congregation and the ministry. Often the name carried the brand, so to speak. Mercy Health System, the Daughters of Charity National Health System, and Alexian Brothers Hospital triggered a firm image in any church member's mind. At the very least, the name implied the organization's founder or religious character, even to people who were total strangers to Catholicism. To those involved in the work of health care, moral connotations such as respectability, legal control, and values may have been evident. Employees often understood the importance of the congregation's tradition on the type and quality of service provided, special care given to spiritual needs, or care for the poor. Insiders referred to that special gift of the order's tradition to the institution as the *charism*.

In recent years, systems aggregated hospitals by markets, incorporated Catholic and community hospitals, and rapidly created large faith-based enterprises that looked as much like big business as ministry. Obligated groups convened, assets were commingled, and system names were changed. Congregations quickly determined that alternatives to this rapid evolution were limited. Ironically, however, many Catholic sponsors continued to compete or isolate their ministries rather than combine charisms and "lose their identity." Some did so at their own peril. Others survived this wave of consolidation and have generally held on to a sole sponsorship model.

Sponsorship describes reasonably well the unique relationship between a congregation and its ministry. Does it continue to hold when describing the relationship of a congregation in either multisponsored ministries or within the public juridic person construct of ministerial oversight? Less so, I believe. But even in these configurations the local ministry retains much of the character, identification, and values of the founding congregation.

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Multisponsored Hospital Systems

For all their great intent and actual success in delivering on their promise, cosponsorship of ministry takes time, trust, and constant renewal of conviction. Congregations making a commitment to one another to share in the sponsorship of ministry think in evolutionary terms. They generally believe that their charism will be sustained through the transition into the new organizational form. Even when individual group dynamics have already been formed, new group dynamics emerge while the ink is drying on the contract. The old structure is disrupted, and theological assumptions get challenged. Each congregation has its own rituals, celebrated heroes, and special places that embody the congregation's spirit that they expect to continue. The friendly interchange that may have accompanied the courting phase may devolve into unpleasant conflict and misunderstanding. The experience for congregation members can be bewildering.

Why does this degeneration seem to happen so repeatedly and rapidly? Each congregation experiences God in highly nuanced ways. Employees and staff assume that sisters coming together share the same mission of healing, and in many ways this is true. Too often, however, the core of congregational identity is presumed to be clear. In fact, charisms are intricate experiences of faith, group consciousness, and mission. If convictions and differences are not explored thoroughly before entering a cosponsorship of ministry, chances are high for post-merger frustration and, often enough, failure. Consider a congregation whose primary identity is service of the poor. It desires to merge ministries with a congregation whose primary emphasis is the corporal works of mercy. Assumptions about the core combined mission may vary despite the seeming similarity of intent. Congregations may differ on populations served, how resources are allocated, which ministry will close, how governance is exercised, and who should lead the organization. What began as an evolutionary journey is experienced as disruptive, if not totally *revolutionary.* When the inevitable downsizing, closures, or clinical consolidations occur, each sponsoring group has a natural bias to protect its own and cosponsorship becomes further challenged.

Deciding to cosponsor is the beginning of the process, not the end. Although incredible energy is required to begin the transaction, even greater energy is required to sustain consolidation. The building of a new, shared culture requires a new theological anthropology. Expanding congregational awareness and behavior that demonstrates a broader intent by a congregation to embrace the duty of care, the duty of loyalty, and the duty of oversight over hospitals that have heretofore been, at best, only a name is an immense challenge.

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Public Juridic Persons

The decision by a congregation to incorporate ministerial assets into a new public juridic person (PJP) alters the nature of sponsorship of that ministry. The PJP is, by definition, a change in control and sponsorship from one group to another body legally recognized by the church and society. For various reasons, even with full knowledge of the shift, founding sponsors continue to feel some abiding obligation to the work and its employees (rightly so) even though their fiduciary control has been shifted to a new entity. Catholic Health Initiatives, Trinity Health, and others systems sponsored by PJPs face unique dynamics with former sponsors (see **Box,** p. X, for a description of the four existing PJPs of pontifical right). Sponsors face similar upheaval in their role definition.

Merger of assets and the accompanying shifts in canonical and civil control require relationships to realign. Although a member construct may continue in the new enterprise, the reserved powers are usually limited to appointment of congregational members to serve as members of the board of the new PJP. Some have slightly more power, but these powers are restricted.

Although sponsors understand the rudiments of the shift, the emotional costs of alienation are high and the resistance or hesitation to implement the terms agreed upon can be intense. Congregational leadership transitions may compound the challenges. The leadership that combined a few sponsored hospitals into a system will differ from the leadership that merged the singular sponsored system into a cosponsored ministry. In addition, the decision to move from a cosponsored construct into a new PJP model is often made by yet another leadership team. Congregational members may not understand or agree with the rapid evolution often born of market necessity.

Congregational leaders themselves may not support, appreciate, or communicate the restructuring clearly, often because the choices are limiting and resistance within the congregation may be emerging. Conversely, leaders who once embraced the new PJP model may not be entirely satisfied with the direction set by the leadership of the new PJP once they have ceded their assets into the new construct. This dissatisfaction may result in an attempt to influence the direction of the PJP.

Once the myriad challenges are understood,

what can we do to make an effective transition and advance Catholic health care? Whatever the decision by the congregation relative to sole sponsorship, cosponsorship, or migration to a new PJP model, several actions are worthy of consideration. Recalling that any organizational form is a social construction is helpful. Organizational forms merely provide the architecture for a set of relationships. The term "sponsorship" cannot carry the full range of relationships embedded in either cosponsorship or the new PJP models of ministry. Using the term continues to set expectations between a congregation and its institution—expectations that the new structure needs to redefine.

Remembering Our Purpose

Charisms are gifts graciously given by God for the building of the church. Their proclamation is ultimately about the love of God, not about the charism itself. The founding inspirations of each congregation are in very mysterious and beautiful ways about the kingdom, the eternal, and incarnate love of God. Charisms also evolve in unexpected ways, including diminishment or transformation to a new life and membership form. Furthermore, believers—lay, religious, and clergy—embrace the healing ministry of Jesus. The proclamation of the love of God in Jesus is the center of personal and collective religious identities. Although religious life is clearly a strong mediator of God's grace and love, it is a channel of healing instrumentality, a conduit of hope, and a framework of continuity and stability. The healing ministry is rooted in the love of God manifest in Jesus.

The PJP structure of ministry should find its purpose and identity in this unmediated love of God. Many of us have believed that health systems are about the preservation of sponsorship. Although this may have been a secret hope, preservation of a charism alone is not sufficiently compelling. What matters to those who must govern these ministries is not that they were or are Dominican, Daughter of Charity, Franciscan, or Alexian. The health system must be focused on the immediate love of God manifest in these works. The board and congregational leadership must discuss this point. The issue is not preservation of a charism or congregational identity, but living the sacrament of the immediate love of God.

Who holds the trust of the traditions? All the traditions, while uniquely important in a local context of ministry, publicly and collectively express the healing ministry of Jesus. A board commits itself to advancing the healing mission of Jesus, advancing the faith of the church, and building healing environments and services. A board must develop the heart of a sponsor if it is to:

- Attest to the worthiness of a ministry in the eyes of the church and the community
- Interpret the fidelity of the ministry to its purpose and for its constituents
- Be the public face of the church, for the church, and to the church in collaboration with the president

Directors or trustees are not called to a vocation in any congregation, but they do experience the call to service in the church by promoting the healing ministry of Jesus through a church ministry. Therefore, they oversee and support the development of a culture and environment that is faithful to the Gospel life of Jesus. The charisms of the religious congregations indeed have significance and importance historically and in an ongoing fashion, but only the congregation is capable of interpreting the specific charism.

By entering into a covenant with a new PJP, congregations entrust their unique gift as lived through their healing ministries to people of faith in the corporation. Theologically their charism remains with the congregation. A health system composed of many traditions cannot be a blend of charisms; neither can it describe itself as a charism in the church. It may have a culture, an operating environment, and be in the lineage of charismatic traditions. A PJP is fundamentally a ministry of the church. Its end and inspiration is Jesus, not the founders of congregations, however important they may be to the spiritual history.

The more we continue to debate internally among ourselves how we will advance multiple charisms in complex health systems, the more time, focus, and commitment to the real task of spreading the love of God manifest in Jesus and the healing ministry will be lost.

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The Differences between Governance and Sponsorship

There is little that the term "sponsorship" adds to the full notion of governance if governance is properly understood. Governance of a church organization has all the aspects of sponsorship embedded in its self-definition. If we accept that governance is the process of establishing the mission, philosophy, direction, and strategy of the organization to ensure its long-term viability, all responsibilities of sponsorship are included in the obligations of governance.

What more does the term sponsorship imply that is not also covered in the word governance, particularly for a PJP? By dichotomizing sponsorship and governance, we assume that the full

moral, fiduciary, and spiritual authority does not reside with the board, but with sponsors. Yet, if we consider that governance, properly understood, incorporates potentially all that sponsorship implies, might shifting the burden of obligation to those governing be worth considering? If we were to do this, what would become of sponsor influence? Would the relationship between the congregation and the institution or system end?

What Can We Do?

Congregations entering into cosponsorship, a new PJP construct, or even expanding their own sponsored ministries will benefit by clarifying their intentions and hopes early in the process. Never assume that sponsorship means the same thing to all sponsors.

The first challenge is to open the conversation. Test assumptions about the charism and perspectives about faith, the church, and the healing ministry. As noted before, inferences about such key principles will not necessarily hold. Second, understand the deep structure of belief beyond the operating style of the organization with whom you intend to partner. Determine how, if at all, the members of the congregation hope to remain involved and how they expect that the congregation's charism will influence the cosponsored works or the PJP. Expect to write a new theological anthropology that specifies the new entity's theological framework, the social and culture norms and behavior that will characterize it, the inductive ecclesiology that it embodies, and how the new enterprise operates in its environment as a healing ministry. Be explicit about congregational views of the church and what collectively advancing the healing ministry of Jesus means in a practical sense. Finally, adopt new patterns and rituals to celebrate conversion and conviction for the new organization. These seemingly obvious steps are, in my experience, the most overlooked aspects of the due diligence process.

Lay leaders within these health ministries are often perplexed by the lack of precision in the rationale for a merger among sponsors. When the core identity and values evolve into a new identity, everyone is curious about the practical and personal consequences. Congregations must conduct a dialogue with each other about the fundamentals of their culture, value system, operating environments, and views of the church in order to partner effectively in a structure that is inherently complicated. In addition, engaging lay partners in the dialogue at the outset will help support the change process and codify the congregation's intent over time.

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Moving the Agenda

With or without the term "sponsorship" in our vocabulary, the traditional duties of oversight, care, and loyalty for ministries of the church will be ongoing. The emphasis here has been to suggest that sponsorship does still apply in some form to the unique relationship a religious congregation has with its works. Sponsorship can be changed into something as rich and enduring as charisms, but to do so requires sticking to the conversation and being open to new models.

Pope John XXIII spoke in the *Dogmatic Constitution on the Church in the Modern World* of initiating a new order of human relationships in which all people are called to holiness of life and discipleship. Catholic health care is rapidly adopting new disciples to the healing ministries of the church. Believers embrace the healing ministry of Jesus, and the proclamation of the love of God in Jesus is the center of identity. Sponsored ministries, cosponsored ministries, and new PJPs are moving toward a new ecclesiology that has yet to be claimed. The charismatic lineage from whence these systems emerged historically will influence those responsible for governing and leading these new systems by pointing the way to Jesus. Although folding their charism into a broader ecclesial identity to advance the healing ministry of Jesus is difficult for religious congregations, they understand at some level that this is the future. Religious sponsors need to be ready and willing to trust and invest in the new ecclesiology. Former sponsors must continue to endorse the work given over to the new entity without their trademark being obvious.

Most congregations understand at some profound level the action of God shifting the sands of history beneath them. The challenge is to trust that lay and other leaders within the church can and will steward the patrimony. Yes, the new leaders and governing bodies will never be formed with the same intensity that initially created the congregation's ministry. Similarly, the formation process for health leadership and governance will have to be rapid and systematic if this transition is to occur. The church has myriad resources that it can and will put to the task once the common work is acknowledged and we collectively understand where we are headed.

Health care systems of the size and scale constructed over the last five years make sponsorship influence difficult to achieve. In cosponsored ministries and in the new PJP structures, leadership must be concerned about the evolution of Catholic culture and values. Sponsors at the local level still serve a powerful role in a practical and symbolic sense. In many ways they *are* the church

to the local community. In many contexts, what is known of Catholicism is known by virtue of the deep and abiding presence of the individual religious women. The danger exists of negating the roots of inspiration in individual religious in favor of only a programmatic approach to mission and ministry at the system level. Systematic approaches are required in our complex health systems, but some things can be learned from the living incarnations before us. For instance, we see that public trust is earned over decades; our employees still tend to go to the trusted sister advisor despite the fact she may have no formal role, and if the sisters are not aligned with leadership, the leader will likely fail before the sisters do. The deeper issue is about forming and sustaining a culture without eradicating its foundation.

The adage "driving by the rear view mirror is a hazard" comes to mind when thinking about the way in which we anticipate the future of Catholic health care. We keep looking to the road behind us to explain how things will be. Yet we simultaneously recognize that the old ways will no longer prepare us for the future ministry of health care.

In summary, a few action steps are worth considering:

- Reduce the bifurcation of sponsorship and governance. Fold the historic duties of sponsorship into the duty of Catholic governance and expect alignment of governance systems so that the religious and theological questions are at the heart of a board's work. Let the spirit soar and loosen the proprietary hold on God's grace; it is not known only by a chosen few. The deep structure of the Catholic imagination is more resilient than all the charisms combined. This is the historic wellspring of grace and new foundations in the church.
- Structure educational opportunities, partner with Catholic universities, and outsource training for health care governance to those who can deliver value to adult instruction that is both theological and industry specific. In other words, deliver a market to an educational institution that has demonstrated the drive to support Catholic ministry. Catholic health care education has become fragmented and is ready for some focused consolidation.
- Write a theological anthropology that moves beyond the bifurcation of formation as either a religious or lay spirituality. Focus our theological reflection and discourse on the ministry of Jesus. Preparing leaders and governing bodies to carry on the sponsor's tradition is of limited impact. If we believe, as most individuals do, that the sisters are irreplaceable, we create that reality. However, as believers and healers, we understand that Jesus heals through many channels of grace. We must trust those we think of as partners in ministry and journey with them into a new ecclesiology, particularly physician healers.
- Prepare boards for their emerging canonical and civil legal work so they can assume stewardship of the public trust of these ministries.
- Redefine and understand the moral agency of congregations. For instance, some congregations are moving out of institutional ministry to direct service, but their intent may not be explicit.
- Set the standard for effective leadership in Catholic health care by using CHA's Mission Centered Leadership Model and let the respective boards implement the standards through systematic evaluation.
- Adopt new patterns and rituals to celebrate conversion and conviction to a loving and healing God that is not simply an interpretation of a saint's calling hundreds of years back. In other words, reveal the call to all believers to participate in building the kingdom now.
- Ask ourselves why we are still aggregating by congregations rather than by sustainable natural markets. We have much work to do to strengthen our presence as church ministries. In some cities we are letting church ministries die rather than partner with those with whom we have competed for years. In other circumstances, we are partnering with other faith and community traditions to remain viable. Essentially, Catholic health care continues to fragment when congregations cannot see the greater good of the community being served by natural market combinations.
- Congregational leaders have a choice and opportunity to be heroically generative and to transition their legacy to new forms. The time to rethink national systems in this market-driven industry is now. Imagine new organizational forms to achieve even greater ends.
- CHA should encourage ministry and civic leaders to gather with the intent of interpreting next-stage market evolution for health care in our communities and congregations and help to design the way forward.
- Align ministries within markets, reduce redundancies quickly, and partner with other ministries of the church, such as education and social service, to build healthy communities more effectively. Ready the church and our communities for the work ahead. One helpful activity would be to write the theological anthropology of building community, defining the role of faith-based health care in the equation.
- Start this hard work easily; open the conversation by talking about the role of Jesus in the work of healing. □

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