

FORMATION AND GOVERNANCE

Do not cling to events of the past or dwell on what happened long ago; watch for the new thing I am going to do, it is happening already, can you not see it?

—Isaiah 43:18-19

“What makes a Catholic hospital Catholic?” a student in my ecclesiology course recently asked. We were in the middle of a lively conversation about the catholicity of the church, and the students expanded the conversation to include two other major institutions that demarcate themselves as Catholic: health care and education, particularly Catholic higher education. If the church has identifying marks, my student reasoned, should not other Catholic institutions have them as well?

What makes an institution Catholic? Who makes an institution Catholic? Clarke E. Cochran, who has made a lifework of studying Catholic identity, particularly that of Catholic health care, contends that the aspects most characteristic of Catholic institutions are their incarnational and sacramental dimensions.¹ If this is so, who is responsible for bearing and transmitting these sacramental and incarnational dimensions? Governance, I suggest, has a substantive role to play in this respect for Catholic health care organizations. How well equipped are our boards

Catholic Organizations Should Institute Theological and Spiritual Formation Programs for Their Trustees

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of trustees to play this role?

It used to be that the ministry of the sponsoring congregation manifested these sacramental and incarnational aspects. However, that reality has changed with the reconfiguration of diverse models of sponsorship and the increasing involvement of laypersons, some of whom may not be Catholic and whose identity is primarily formed by business values.

Most Catholic hospitals anchor their ministry in “continuing the healing mission and ministry of Jesus,” a phrase that is not exclusively Catholic. Catholic health care typically employs some combination of three strategies to maintain its Catholic identity.

Sympathetic Administrators One strategy involves hiring administrators (Catholic or otherwise) who are sympathetic to the charism of the founding congregation and are respectful toward the tradition of Catholic health care. How theologically and spiritually fluent should such leaders be? Is it sufficient that a leader exhibit the operative values attached to the charism, even if he or she cannot articulate the theology undergirding the charism?

Mission Leader The second strategy designates a mission person who has some degree of authority concerning charism and catholicity. Of course, this strategy risks creating a ghetto for mission. A mission person raises the mission-and-identity question as a matter of duty. He or she becomes the conscience of the organization. One consequence is that, to the degree the mission person functions as organizational conscience, others are relieved of this fundamental responsibility.

In-House Formation The third strategy establishes a type of in-house formation program that fosters foundation and growth in Catholic health care identity and mission. The person in charge of mission frequently oversees this in-house formation program.



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However, I would like to explore still another way of perpetuating mission: through governance. How might Catholic health care change if trustees were formed as leavening leaders?

THE MISSION OF GOVERNANCE

Sr. Jean deBlois, CSJ, PhD, argues, "Our capacity to sustain Catholic health care as a ministry of the Church depends on our realization that all our activities must flow from the core of who we are, that is, from our spirituality."² She goes on to say that, "as ministry, we must provide witness as well as service because the call to be MISSION in the world is also the call to build up the kingdom of God within."

But much of health care is caught up in the flurry of service delivery. Governance is uniquely postured to give witness and to establish accountability for witness. Governance, I suggest, is best positioned to be an agent of witness because it is not involved in direct health care service.

Governance's task is to hold the common good of mission as a value in itself and to create a mission "horizon" toward which policies and procedures move. Too often, mission and identity are seen as negative boundaries that the organization must not violate ("That would be contrary to our mission"). Unfortunately, governance, identity, and sponsorship tend to be seen as forms of oversight, often expressed by the principle: "Don't do anything that will upset the sisters."

If mission were articulated as a *positive* horizon, governance's role would be different. As a positive horizon, mission would serve a higher, transcendent purpose that prompts and invites others to share in the higher purpose of Catholic health care, witnessing to the love and the healing presence of God, while delivering excellent services. Trustees would be, not watchdogs, but *leaven*, animating the culture of Catholic health care.³ They would then remind Catholic health care of its sense of purpose and help keep the ministry focused on its fundamental, orienting values.⁴ In a negative-boundary model, governance functions as a shepherd who seeks the safety and survival of the flock; the shepherd trains the flock to go where the shepherd wants the flock to go. Leavening governance, on the other hand, remembers that the ultimate task of health care ministry is to witness to and to serve the realm of God. Leavening governance would be open to discerning new ministry.

FORMATION FOR GOVERNANCE

Forming trustees theologically, spiritually, and developmentally is fundamental if they are to be

equipped to accomplish this leavening function. Many board members are professionals; they have been formed in the name of and in service to their particular professions.⁵ If professional people are formed to convey their professional identity, should not governance leaders be formed for their understanding of and participation in continuing the healing mission and ministry of Jesus? Taking responsibility for governance in Catholic health care requires the trustee to undergo theological formation so that he or she can participate in the discourse of Catholic health care. He or she should undergo spiritual formation to participate in the witness of Catholic health care as it journeys toward the realm of God.

Two major challenges facing Catholic health care are changes in its understanding of sponsorship and the theological and spiritual formation of its lay leaders. These challenges come together as religious congregations strive to foster continuing leadership in the ministry and, in communion with the laity, discern new and important ways of continuing the healing mission of Jesus in a pluralistic context. Catholic health care today has new opportunities for exploring the charism of the laity, which is rooted in baptism and lived in witness and service to the world.

One writer has claimed that the greatest crisis facing religiously founded Catholic institutions today is the decline of professed religious and their concomitantly diminished ability to continue their charism in the world.⁶ Most Catholic health care leaders today are not professed religious. As laypeople, they have not shared a common formation in the sponsoring congregation's vocation, charism, and perspective on health care. Lay leaders often locate their identities differently than do religious, which naturally alters their priorities and purpose. Lay leaders and trustees, some of whom are not Catholic (and may not even be Christian), bring to the institutions they serve their own sense of professional vocation and identity.⁷ A leader or trustee who has not undergone deep theological and spiritual formation may be tempted to focus on developing his or her skill sets exclusively, ignoring the need for formation, above all virtue and character formation.

In attempting to meet these challenges, contemporary Catholic health care bases its identity on four factors:

- The historical religious identity and mission of the health care facility or system, continuing under a predominantly lay staff and board of trustees
- The professionalism of the staff

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- Identity and mission, rooted in and flowing from baptism

- The goals of Catholic health care and the articulation of those goals in a pluralistic world

In this confluence of factors, one factor will be dominant because it is the one in which we have placed most of our identity and resources. It is where we find most of our meaning and where we derive our sense of purpose for what we do: vocation.

That to which we give the highest priority becomes the norm for our health care activities. The questions, "What is my identity?" and "What do I profess, and why?" flow from and form how we "vision" and "revision" our vocational identities, from which our health care purposes develop. The question for Catholic health care is not only *what* is its mission but also, perhaps more forcefully, for *whom* is its mission and *why*. What is the ministry's vocation? Is its primary mission in service of the Roman Catholic tradition? Is Catholic health care's mission to serve its own ends and its continuation in history? Is it for a people of a particular region? Is its mission focused on particular populations, such as the poor, the wealthy, the blue-collar mainstream, and the marginalized? One immediate consequence of this train of thought is the realization that we need to shift the conversation from *what* and *whom* to *why*. Why is our mission? The "why" of mission has been woefully underaddressed.

Shifting to the why of mission challenges us to go back to basics and examine anew the foundation of identity and mission, vocation. Reflection on vocation is a fundamental revisioning process that prophetically invites us to contemplate and articulate the relationship between our proximate mission (the focus of which is the recent past through the present to the near future) and our ultimate mission (which focuses on being cocreators of the Realm of God). Shifting to the "why" of mission challenges Catholic health care's various constituencies to reflect on how they are formed and transformed by such foundational values and virtues as maintaining baptismal identity, protecting and enhancing the dignity of the human person, promoting human flourishing, restoring members to the community, and caring for the vulnerable members of the community (particularly the poor and the marginalized).

This is where governance plays a central role, for trustees are in a position to see more of the terrain than others can. Governance must be formed in the "why" of mission if it is to be an effective force in the culture of Catholic health care. The "why" of mission is the transcendent purpose, the greater good of God's love and

God's healing presence that motivates and amplifies Catholic health care culture. When trustees fail to understand the why of mission—their institutions' greater and more durable good—lesser and more proximate goods will drive the engine of Catholic health care.

Catholic health care has thus far exercised good stewardship by working with religious and congregational leadership to develop lay leaders who, having been formed theologically and spiritually, will advance the ministry.⁸ Catholic health care systems have developed lay leaders who continue to bring moral and theological voices to the conversation and, at the same time, serve with professional acumen in a pluralistic context.⁹ For the most part, these activities have been focused on administrators and managers; few have been intended for trustees.* Governance is an area in dramatic need of development and formation, so that those who exercise it will more fully understand, appreciate, and advocate the theological heritage, the centrality of spirituality, the foundational values, and the generous ecumenism of Catholic health care. In this sense, governance is leadership, and leadership stands in need of formation. The type of theological and spiritual formation proposed here is reflective of the board and trustee development work of Katherine Tyler Scott. Scott advocates "depth education" that leads board members to actively appreciate and understand the organization's fundamental beliefs, values, and culture.¹⁰

TWO APPROACHES

There are two general approaches to the leadership challenge in Catholic health care: the "critical mass" approach and the leavening approach. At one time, critical mass signified the presence of professed religious in Catholic health care. Because the number of professed religious in the ministry has dwindled, this form of critical mass no longer exists. Critical mass was intended to put enough Catholics in key leadership positions to perpetuate Catholic identity and mission. Having a significant number of Catholics among an institution's leaders would, it was hoped, ensure that the institution's policies and procedures were Catholic as well.

Critical mass dynamics are not to be ignored. As one researcher has shown, a critical mass of Catholic personnel does indeed promote an insti-

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*St. Joseph Health System, Orange, CA, and Ascension Health, St. Louis, have in-house formation programs. More fully developed is the master's of arts in health care program administered by Aquinas Institute of Theology, St. Louis.

tution's religious character.¹¹ A critical mass, however, cannot be about numbers alone. It does not necessarily follow that, just because an institution includes a number of Catholics, it also will have a culture rooted in the spirit of Catholicism and policies and procedures consonant with Catholic theology. Roger Finke, an eminent sociologist of religion, endorses the need for a critical mass, but adds that how well the critical mass anchors itself in core teachings and adapts these teachings to new cultures and contexts is also vital.¹² Religious groups that can articulate and hold true to their core teachings in innovative responses to new cultures and contexts will sustain themselves and grow. Religious groups and institutions that overly accommodate to changing cultures and contexts compromise their core teachings and are diminished and die off in time. Finke's insights reflect those seen in recent corporate analyses. In *Built to Last: Successful Habits of Visionary Companies*, for example, James Collins and Jerry Porras describe three interactive factors that influence the life and adaptability of corporate culture more significantly than sheer numbers:

- Core values with sufficient power and richness to both drive and temper innovation
- A purpose beyond profits
- A dedicated workforce¹³

The critical mass model too often depends on serendipity. The "leavening model," in contrast, builds in complementarity with the critical mass model. The leavening model is intentional in its theological foundations and in equipping leaders with the theological and spiritual knowledge and resources, as well as the skills, to lead and suffuse Catholic health care organizations—and their partners—with core values and behaviors that reflect Catholic identity in dialogue in a complex, pluralistic world. Because leaders in a leavening model work out of various areas in the organization, ministry is not reserved to, or pigeonholed in, mission and ministry.

Leavening leadership formation brings a distinct perspective to governance formation. A leavening leadership model departs from the strict oversight model of governance, in which tension (if not near hostility concerning "meddlesome boards") exists between governance and management. Leavening leadership reimagines the board-management relationships so that governance, rightly formed theologically and spiritually, serves as part of Catholic health care's socio-theological capital.

Governance becomes an asset when it is formed theologically and spiritually. With other leaders, it creates a partnership that animates culture and calls the whole to deeper purpose as a

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culture of the whole.¹⁴ As such, formed governance becomes part of the collaborative core that leavens the internal culture of Catholic health care. Additionally, given their roles in multiple publics, trustees leaven the external culture.¹⁵ Governance participates in these internal and external leavening activities in the degree that it is equipped to do so.

GOVERNANCE AS LEAVENING LEADERSHIP

I suggest that Catholic health care begin to view trustees as leaven, especially vis-à-vis executive leadership. In baking, leaven suffuses dough and causes it to rise. In organizational life, it is the element that catalyzes other elements, causing the whole organization to rise. Leaders cannot help their organizations to rise through simple acts of will. Reflecting what has been called a "relational model of leadership,"¹⁶ leavening leadership amplifies the idea that leaders are part of a greater whole and that the whole is transformed in communion. The whole, moreover, is at any given moment in time part of ever-enlargening interwoven partial wholes:

- The whole of governance leadership is part of the whole of the system.
- The whole of the system intersects with the whole of the various entities.
- The whole of the entity intersects with the whole of other departments in that same entity.
- At the same time these units, departments, entities, and system are part of the whole of a larger community.

Leavening leaders recognize these "partial wholes"¹⁷ and will develop the vision and skills to bring the individual chemistries of the partial wholes together for the common good. Governance, in collaboration with senior leadership, has the perspective needed to see the whole, but it always must strive to see things in light of the common good.

The common good is the unifying framework through which the interrelationships of the diverse elements of Catholic health care should be viewed. It is the framework for developing transformational strategies that can enlarge both personal and social goods in these interconnected communities. The social ethics understanding of the common good is a time-honored rubric for understanding persons and communities in relationship.* The concept of the common good evokes a principled vision of relationship. The

* Problems arise, of course, when a community tries to determine which goods it holds in common and which cannot be held in common.

common good serves as a lens through which one can see whether relationships are just or unjust. Finally, the notion of the common good emphasizes the dignity of the human person and encourages the creation of societal conditions that allow the person to flourish in community. In general, the social ethics understanding of the common good seeks to:

- Enhance and protect human dignity
- Promote human flourishing
- Restore members to the community and care for its vulnerable members, thereby reflecting the power of solidarity
 - Underscore the social good
 - Create conditions in which people can participate in decision making, particularly when they are most directly affected by those decisions, thereby reflecting the principle of subsidiarity
 - Emphasize people's role as citizens, thereby encouraging them to resist the temptations of vested self-interest
 - Shape an awareness of the person's capacity to have an impact on his or her society

Given this understanding of the common good, we can suggest some forms of leadership for governance. At a minimum, leadership theories concerning governance in Catholic health care should seek to protect the common good.

THEORIES OF LEADERSHIP

Definitions of leadership are abundant.¹⁷ "Leadership" is a term that flirts with banality because it is used in so many ways. Here I want to focus on representative theories of leadership and critique their compatibility with the theologies that underscore governance leadership in Catholic health care.¹⁹ Most theories of leadership arise out of business and industry and are driven by particular sets of values, each of which encourages identification with that set. One should analyze these theories with a critical theological eye to see how applicable they might be to the theological domain. For example, in a profound article on leadership, Fr. James Heft, SM, argues that Stephen Covey's understanding of leadership is incongruous with Catholic theology.²⁰

Those who are interested in forming governance leadership will find especially fruitful two books I have already cited: Ronald A. Heifetz's *Leadership without Easy Answers* and Susan R. Komives, Nance Lucas, and Timothy R. McMahon's *Exploring Leadership: For College Students Who Want to Make a Difference*. The authors of both books recognize the need not only to clarify the values operative in leadership but also to develop social values consciously. Both

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attend to the character and role of power, particularly as it is expressed in collaborative terms. In both cases, the approaches to leadership and leadership formation seek the common good.

Heifetz, who is considered a leading leadership theorist, characterizes leadership as drawing forth talent from within the community in the service of a common goal as the community seeks to face its problems.²¹ Heifetz is most interested in viewing leadership in terms of what he calls "adaptive work." "Adaptive work," he writes, "consists of the learning required to address conflicts in the values people hold, or to diminish the gap between the values people stand for and the reality they face. Adaptive work requires a change in values, beliefs, or behavior. The exposure and orchestration of conflict—internal contradictions—within individuals and constituencies provide the leverage for mobilizing people to learn new ways."²²

Heifetz has developed a model of leadership that, rather than striving to bring everyone to agreement, is based on the idea that "the inclusion of competing value perspectives may be essential to adaptive success."²³ According to Heifetz, adaptive work creates "a guide to goal formation and strategy" that articulates the values the goal represents and tests "the goal's ability to mobilize people to face, rather than avoid, tough realities and conflicts. The hardest and most valuable task of leadership may be advancing goals and designing strategies that promote adaptive work"²⁴

For example, a gap frequently exists between the ideal values a community espouses and the actual or operative values that it lives. The ideal values arise from the community's aspirations whereas actual values are driven by perceived pragmatic realities, often perceived realities involving the marketplace. This gap represents an adaptive challenge that can lead to conflict and distress. Trustees who are trying to consider the common good would find valuable Heifetz's understanding of adaptive work and the role of conflict. Trustees often find it difficult to articulate the common good, not to speak of the specific goods that constitute the common good. Competing visions, values, and interests sometimes derail pursuit of the common good. Heifetz's model attends to these dynamics. Governance would be enriched if it were informed both by Heifetz's approach and a theological understanding of prudence, one in which prudence exercises justice for the common good.²⁵

The theory of leadership developed by Komives and her colleagues is especially apropos in this connection.²⁶ The authors define leadership as "a relational process of people together

attempting to accomplish change or make a difference to benefit the common good."²⁷ Is this not the very task of governance as we have described it?

"Relational leadership" is the goal here. Relational leaders place a premium on being inclusive, empowering, purposeful, ethical, and process-oriented while acting as responsible citizens in community. Relational models of leadership differ from those involving "positional leadership." Positional leaders exercise leadership as a function of their position of authority. They hold formal leadership roles, believe that values should not drive leadership, and make clear distinctions between leaders and followers.²⁸ Unlike positional leadership, which focuses on the immediate situation, relational leadership is long-range, aiming at effecting positive change on behalf of others and society. Komives and her colleagues recognize leadership as a collective effort. Leadership "involves collaborative relationships that lead to collective action grounded in the shared values of people who work together to effect positive change."²⁹

Any model of leadership that focuses on effecting social change must attend to the values found at the core of that model. Relational leadership asks, "What values form, invite, guide, foster, and foment social change?" Trustees who are theologically equipped and spiritually formed will be prepared to ask these questions, both as critique and as witness in Catholic health care. Relational, social-change models of leadership must attend to larger societal values, as well as to the personal values of the participants. Komives and her colleagues' understanding of relational leadership is thoroughly congruent with Catholic understanding of the common good.

Their formulation is consonant with an articulation of an incarnational sacramental theology. An incarnational perspective is based in the incarnation of Jesus as fully and completely human. Created in the image and likeness of God, people have fundamental dignity and worth. They have fundamental dignity and worth simply because they are, not because of who they are or what they have done. An incarnational understanding calls for the active respect of self and others. People should act in such a way that they serve to enhance and protect fundamental human dignity and worth. They should not act in ways that deny, diminish, or distort fundamental human dignity and worth.

The relationality model of Komives and her colleagues, which is compatible with a theology of the Trinity (in which the persons of the Trinity

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are each unique and distinct but fully in relationship with each other), emphasizes living with committed fidelity and integrity in the midst of multiple relationships. The theological focus for Catholic governance is on living with responsibility in relation to God, self, others, and the larger community. One lives in critical awareness of his or her multiple relationships. The accent is not on the independent, individual self, as in popular culture. Rather, it is on the social self who lives in community. The decisions one makes and the actions one takes grow out of the experience of community and affect the community. The moral stance is to live with committed, faithful response to the good of self, neighbor, community, and, ultimately, God in relationship.

The virtues that these writers prize in leaders (being inclusive, empowering, purposeful, ethical, and process-oriented while acting as responsible citizens in community) lend themselves particularly well to the understanding of the common good I have been discussing here. These virtues are, moreover, sufficiently elastic to be applied with integrity to most theologies of governance leadership while making accommodation for specifics of mission and identity in particular local contexts.

READY FOR PROPHETIC WITNESS

With its focus on the common good, the relational model of leadership is particularly suited to Catholic health care. The model allows governance leaders to address theological realities without necessarily using explicit theological language. If trustees were to couple the ideas of Komives and her colleagues with Heifetz's ideas, they would be theologically informed in a way that enabled them to address the adaptive work evidenced in the dynamic tensions involving the reality of the marketplace, on one hand, and the incarnational and sacramental realities that shore up Catholic health care, on the other. Theological formation would give trustees the grammar necessary for participation in the discourse of Catholic health ministry. Spiritual formation would equip them for prophetic witness intramurally and extramurally.

Lay leaders need theological education and spiritual formation in order to:

- Know, understand, and appreciate the faith and theological heritage of the Roman Catholic tradition
- Understand and appreciate the theological foundations of Catholic health care as a continuing ministry that participates in the healing mission of Jesus in the modern world

• Articulate to multiple publics the core beliefs and practices of the Roman Catholic tradition as they relate to health care

• Respond to the call of *Gaudium et Spes*, from Vatican Council II, to be ecumenically aware and equipped to carry out dialogues with the world and its other great faith traditions. □

NOTES

- Clarke E. Cochran, "Another Identity Crisis: Catholic Hospitals Face Hard Choices," *Commonweal*, February 25, 2000, pp. 12-16.
- Jean deBlois, "The Mission Imperative: Our Foundation and Market Advantage," *Health Progress*, March-April 1997, pp. 24-27.
- See Gerald A. Arbuckle, *Healthcare Ministry: Refounding the Mission in Tumultuous Times*, Liturgical Press, Collegeville, MN, 2000. Fr. Arbuckle's book is conceptually rich on Catholic health care culture.
- Ronald A. Heifetz, *Leadership without Easy Answers*, Belknap Press, Cambridge, MA, 1994. Heifetz defines sense of purpose as "the capacity to find values that make risk taking meaningful" (p. 274).
- Gilbert Rendle, "Reclaiming Professional Jurisdiction: The Re-Emergence of the Theological Task of Ministry," *Theology Today*, vol. 59, no. 3, 2002, pp. 408-420. See also S.M. Homan, M.R. Domahidy, J.F. Gilsinan, et al., "Formation for Love and Justice in Graduate and Professional Education," *Current Issues in Catholic Higher Education*, vol. 23, 2003, pp. 55-71.
- Maryanne Stevens, "Revitalizing Charisms Inspiring Religious Life," *Review for Religious*, vol. 53, no. 6, 1994, pp. 847-859.
- "Lay Leaders of Catholic Colleges and Universities," *CARA Report*, Fall 2003, p. 6. See also Melanie Morey and Dennis Holtschneider, "Keeping the Faith on Campus," *Commonweal*, April 1, 2001, pp. 20-23; and Melanie Morey, "The Way We Are: The Present Relationship of Religious Congregations of Women to the Colleges They Founded," in Cynthia Russett and Tracy Schier, eds., *Catholic Women's Colleges in America*, Johns Hopkins University Press, Baltimore, 2002, pp. 277-324.
- The approach advocated here is similar to that described in Mary Kathryn Grant and Margaret Mary Kopish, "Sponsor Leadership Formation," *Health Progress*, July-August 2001, pp. 24-26.
- I don't mean to suggest that the moral and/or theological voice is the exclusive property of congregational leaders—only that examining things in a moral or theological light is what congregational leaders are trained to do. On this point, see Stanley Hauerwas and William H. Willimon, *Resident Aliens: Life in the Christian Colony*, Abingdon Press, Nashville, TN, 1989. Of course, one must take care not to slip into sectarianism, operating solely out of a narrow theological framework and discounting all other perspectives. In this connection, see Richard G. Cote, *Re-Visioning Mission: The Catholic Church and Culture in Postmodern America*, Paulist Press, Paramus, NJ, 1996. The classic text on this issue is H. Richard Niebuhr, *Christ and Culture*, HarperCollins, San Francisco, 1986.
- Katherine Tyler Scott, *Creating Caring and Capable Boards: Reclaiming the Passion for Active Trusteeship*, Jossey-Bass, San Francisco, 2000.
- D. Paul Sullins, "The Difference Catholic Makes: Catholic Faculty and Catholic Identity," *Journal for the Scientific Study of Religion*, vol. 43, no. 1, 2004, pp. 83-101.
- Roger Finke, "Innovative Returns to Tradition: Using Core Teachings as the Foundation for Innovative Accommodation," *Journal for the Scientific Study of Religion*, vol. 43, no. 1, 2004, p. 1934.
- James Collins and Jerry Porras, *Built to Last: Successful Habits of Visionary Companies*, HarperBusiness, San Francisco, 2002.
- Rosabeth Moss Kanter, "The Enduring Skills of Change Leaders," *Leader to Leader*, Summer 1999, available at <http://leadertoleader.org/leaderbooks/L2L/Summer99/kanter.html>.
- Kevin D. O'Rourke, "Catholic Healthcare as 'Leaven,'" *Health Progress*, March-April 1997, pp. 34-38, 43. See also Pope Paul VI, "Apostolicam Actuositatem," para.3: "Since the laity, in accordance with their state of life, live in the midst of the world and its concerns, they are called by God to exercise their apostolate in the world like leaven, with the ardor of the spirit of Christ."
- See Susan R. Komives, Nance Lucas, and Timothy R. McMahon, *Exploring Leadership: For College Students Who Want to Make a Difference*, Jossey-Bass, San Francisco, 1998, especially pp. 20-23. The authors define leadership as a "relational process of people together attempting to accomplish change or make a difference to benefit the common good" (p. 21). Relational leadership places a premium on being inclusive, empowering, purposeful, ethical, and process-oriented while acting as responsible citizens in community.
- "Partial wholes" is an idea, shared by quantum theory and chaos theory, signifying the organic, evolutionary nature of organisms. The whole, because of the interactivity of the parts that constitute it, is always coming into being. For example, an organization will evolve over time even if its membership (the whole) remains static, because the lives of individual members (the partial whole) cannot help but change. See Komives, pp. 51, 73-77.
- Jim Wind, of the Alban Institute, has found more than 130 different definitions of leadership. See James P. Wind, "A Leadership Story," *Congregations*, September-October 2001, which is available at www.alban.org/ShowArticle.asp?ID=81.
- Helen J. Alford and Michael J. Naughton, *Managing as if Faith Mattered: Christian Social Principles in the Modern Organization*, University of Notre Dame Press, Notre Dame, IN, 2001.
- James Heft, "The Courage to Lead," *Catholic Education*, vol. 7, no. 3, 2004, pp. 294-307.
- Heifetz, p. 15.
- Heifetz, p. 22.
- Heifetz, p. 23.
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- Heft.
- Komives, especially pp. 20-23.
- Komives, p. 21.
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- Komives, p. 10.

Theological formation would give trustees the grammar they need for discourse of Catholic health ministry.