INTEGRATING BUSINESS AND SPIRITUALITY

A Denver-Based System Aims to Make Mission the Principle of Organizational Performance

BY FR. GERARD T. BROCCOLO, STD

We who work in contemporary Catholic health care tend to be nostalgic about the past, when things were simpler. We realize, of course, that times have changed, that today we must behave as good business people. But the more businesslike we become, the more we like to reminisce about the days when the ministry's focus was on the *spirit*. We envy the sisters of an earlier day, who, dedicating themselves to serving the ill and injured, also soothed and inspired the larger society around them with the spirituality they embodied. We sometimes feel like the disciples on the road to Emmaus, walking away from the world we knew, feeling deserted and lost in a harsh new world.

Perhaps the time has come for us to put our heritage—our Catholic imagination—to work. We know that people come to work in Catholic health care because it is a ministry, rather than a business. They feel called to this ministry by what some would call a vocation. And that call to ministry, deeply rooted in our heritage in health care delivery, is about being called to build relationships that heal. We believe that our business is not just about market strategy, cost containment, staffing ratios, the newest technology, building projects, reimbursement, the latest regulations, or even managing disease. We believe that what we are about is helping people come to wholeness.

What if we really took this conviction—that we have been called to a ministry that builds healing relationships—and made it more than just pious words? What if we made it the principle of *organizational* alignment, integration, strategy, and performance? What if we made it the *measure* of organizational performance?

I realize that talk like this makes some people nervous. They feel that spirituality cannot be a measure of performance. They say that spirituality is too soft to put your hands on, too shapeless to measure.

I disagree. I believe that it is possible to understand mission as more than assurance of a legacy, as more than care of the poor or those who are marginalized, as more than just the good intentions or motives we bring to work every day. I believe it is possible for mission to become the principle of organizational alignment, performance, and development.

I believe that the spirituality of a distinctive culture can be assessed and developed, provided that one first finds behavioral indicators that demonstrate the core values underlying the culture. Once you have identified those indicators, you can hold people accountable for their performance in terms of customer relations, staff relationships, community partnerships, and effectiveness of leadership, or whatever other areas you decide are important.

CATHOLIC HEALTH INITIATIVES

Let me offer some examples of what I mean from my own organization, Catholic Health Initiatives (CHI), Denver. I've heard it said that cultures take five years to build. In 2001, CHI celebrated its fifth year as a national health care system, so I guess it is now possible to use CHI as a case study.

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My boss, Sr. Diana Bader, OP, PhD, CHI's senior vice president for mission and ministry, had the foresight several years ago to structure a position—my own—that would address organization development in terms of a culture grounded in spirituality. "You're *actually* called a 'vice president for spirituality?'" people often ask me. "Do you get *paid* for that?" And then, of course, they ask: "Well, what do you *do?*" The truth is, I do a little bit of everything.

Leadership Development At CHI, we conduct leadership orientation programs for the senior managers of each of our facilities. In these programs, we teach managers a style of ethical decision making, a methodology to be used for all major decisions. We have a 360-degree performance evaluation tool for measuring development. With this tool we can evaluate not just leaders' technical competency and performance, but also their behavioral indicators of spirituality. Leadership development is an integrated effort of both our Human Resources and Mission departments. Leadership development at CHI is thus not "either/or"; it's integrated.

Mission Audits Most Catholic health care organizations now have mission audits or assessments. In these audits, a team visits the facility and measures certain indicators to see whether it is indeed "living the mission." Our CHI mission assessment team was expanded last year to represent a variety of disciplines—including people from clinical, legal, finance, and business strategy departments, as well mission people.

Lately we have taken our mission assessment a step further, asking ourselves whether we might integrate it with other culture initiatives—for example, those involving leadership development and customer service excellence. Leaders are often viewed as having responsibility for financial and operational measures. However, we are now trying to make the mission-assessment process an integral part of a larger template for assessing and developing ministry culture, clinical quality, and market measures of strategy *as well as* indicators of financial and operational performance. If we could monitor measures in all these sectors comprehensively, we could produce an integrated assessment to focus a development plan of overall top priorities for a given facility.

Hiring the Right People Above all, we need leaders who take this ministry seriously. We want lay managers who are just as serious about our work being a ministry as were the sisters who used to manage Catholic hospitals. The sisters believed that their call to ministry was also a principle of organizational focus and alignment, and they lived that belief. Today there are many laywomen and laymen who live that same conviction. They have the same ability to make their commitment to ministry the framework for practical work. At CHI, we know that all we have to do is find them.

We want lay managers who are just as serious as the founding sisters about our work being a ministry.

But what are the implications of all this for you? What are some practical things you might do to "unleash" a Catholic spirituality that shapes your organizational culture and—if truly allowed to influence processes and measures—a distinctive market niche as well?

PRACTICAL IMPLICATIONS

We Must Integrate the Sacred and the Secular

My first suggestion, and perhaps the most difficult to carry out, is that each of us integrate the sacred and the secular in our worldview and in our daily behaviors. The operative word here is "integrate." Most of the people I know in Catholic health care, regardless of their religious backgrounds, tend to live compartmentalized lives.

We who work in health care are no strangers to compartmentalization. You can go into any hospital cafeteria and, noting how the people there are dressed and who they are sitting with, guess fairly accurately which department they work in—that's how compartmentalized we are. But spirituality can be compartmentalized, too. I know many people who are personally devout, active in their churches, generous in their volunteer work, and absolutely committed to integrating their faith with their family life. But when they get to the office, they're all business, like everybody else.

Many such people work in Catholic health care. They often say, "I don't allow that part of my personal life to affect how I do business. It certainly influences my motivation, *why* I'm in this business, and why I view it as a ministry. But in terms of *what* I do every day and *how* I do it, my faith makes me no different from any other corporate executive." I am amazed that we in the ministry can talk so much about having a "distinctive culture," and, at the same time, every day engage in business processes that are not distinctive, using measures that are common to the industry. In fact, most of the processes and measures we use are not different from those used by other businesses.

The problem, many times, can be found within our own souls. If we truly want to be distinctive, we must integrate the sacred and the secular. The issue is not one about "mission or margin." I don't believe that the issue is mission versus margin. If one really takes the incarnation of Jesus Christ seriously, if one takes seriously the Second Vatican Council message about the church being the leaven of society, mission and margin are no

longer separate. They are integrated; they are intermeshed. They are one because *we* are both sacred and secular. Individuals do not have a secular part and a sacred part. The integration that matters involves the way one views the world.

Not long ago, I visited a Catholic health care facility on a day when its CEO happened to be interviewing a candidate for the mission leader position. I was privileged to sit in for part of the interview. At one point, the CEO described for the candidate what he expected of a mission leader. I have never heard such deep conviction about our ministry as I heard from that CEO. "When I walk the halls in this hospital," he said, "I expect to feel the *soul* of what we are all about in our staff work and our patient relations. If I hire you," he told the candidate, "I'll expect you to make that happen." And I thought, listening to the CEO, that *he* would make a wonderful mission leader himself. This was a person who was very savvy about finance, community relations, operations, and performance improvement. But he was also very savvy in how he had integrated within himself the secular and the sacred.

Can we measure that kind of integration? I believe we can. Arthur Anderson, for example, has a process called Value Dynamics that allows companies to monitor and measure such intangible assets as customer, patient, and staff relations.[1] If we can measure these assets, we can monitor their growth or diminishment in reports to our boards. Equipped with these reports, boards can guide the integration of the sacred and the secular at the institutional level.

I believe that we can measure how well we have integrated the sacred and the secular in our facilities.

We Must Do Business Differently

Catholic health care must do business differently in three different ways:

- We must be *collaborative* and *comprehensive* and deliver *personalized* care.
- We must be *reflective* and *strategic*.
- We must be *magnanimous*.

Collaborative, Comprehensive, and Personalized Now the truth is, most of us know little about *collaboration*. We *do* know how to be competitive. We are used to competing with other providers in the marketplace, and we are also adept at competing within our organizations and among ourselves. So how do we become collaborative instead?

Let me give an example. At St. Vincent Infirmary Medical Center, Little Rock, AR, the senior leadership team has launched a program called "Share the Care," which is intended to strengthen culture and build relationships. Under "Share the Care," at least once a month, each member of the team steps out of his or her usual routine and spends a half-day working in one of the hospital departments. The departments they choose to work in are usually those they know little about, so they often have to ask the regular employees there to show them how to do those jobs. After their half-days are done, the executives go back to their desks and write a one-paragraph e-mail describing what they've learned.

St. Joseph's Area Health Services, a small hospital in Park Rapids, MN, has a CEO who rose to that position after working in every department of the facility. He is able to function in nearly every department. And he continues to spend a part of most days working in one of those departments. People like these, the Arkansas executive team and the Minnesota CEO, show their coworkers that Catholic health care has no room for "we" and "they" categories. They demonstrate what collaboration really means. If the rest of us took collaboration seriously—if we learned about and better appreciated what others are contributing to our daily activities—we would really quickly start to change culture.

What about *comprehensive* services? What does that mean? Hal Ray, MD, CHI's chief medical officer, likes to say that comprehensive health care is what physicians used to call "bedside manner." He's absolutely right. In providing comprehensive care, we are concerned with the whole person.

I frequently hear physicians complain of patients being "noncompliant." In my experience, noncompliance usually means a failure to communicate. A "noncompliant" patient may simply be one with psychiatric symptoms the physician has failed to note. Or one who has no capable caregiver at home. Or one who lacks the money to pay for the medication the doctor prescribes. I don't suggest that the physician should step out of his or her realm of expertise in such cases. But the physician can certainly ask questions concerning the different areas of the patient's life, and, if it seems appropriate, make a referral to a psychiatrist, social worker, chaplain, or other specialist.

Are our physicians trained to ask patients about their relationships? Do they ask to see patients' behavioral indicators? Do chaplains chart on the patient record? Do our facilities have single, unified care plans? Is the care we provide truly comprehensive?

And is it *personalized?* Not long ago, I stayed at a hotel in Lincoln, NE, where the service was absolutely wonderful. A colleague and I were so impressed that we went to the front desk and asked to see the manager. The desk clerk phoned the manager and told her that a guest wanted to speak to her. We expected the clerk to put down

the phone and tell us, "I'm sorry, but the manager is in a meeting and can't see you." No. The manager immediately came out to see what we wanted.

We told her that we had been highly impressed by the hotel's service and asked her what business philosophy she followed. In response, she took us into the hotel's back areas and began introducing us to her employees. She greeted every single environmental services person by name. She knew everyone in dietary services by name. And the way the hotel manager treated her staff was the way that the staff treated the hotel's guests.

The patient care we provide in our hospitals should be personalized in the same way. To ensure that, we must give all staff members customer service training.

Reflective and Strategic The second way we need to do business differently is by being reflective and strategic. Most of us who work in Catholic health care are good at operations, and, being good at it, we tend to focus on it and to shy away from reflective and strategic thinking.

Strategic thinking, of course, is thinking about long-range goals: Where do we want to go? What about this new business opportunity? Should we merge with another organization? Reflective thinking is thinking about the values and ethics of a proposed strategic initiative.

The Catholic Church has a long tradition of balancing action with contemplation. Contemplation, incidentally, does not mean going off to a monastery. It means finding equilibrium in what you do by balancing reflective processes with active involvement. Many companies in the for-profit sector do this nowadays; they call themselves "learning organizations." Anyone who has ever served on a continuous quality improvement (CQI) committee knows what it means to be reflective: It means analyzing what you're doing so that you can do it better. But CQI is just the beginning of being reflective on the job.

Catholic organizations should make theological reflection, perhaps led by a mission leader or chaplain, an element of weekly staff meetings. Once this becomes part of the senior management team's routine, team members will begin thinking reflectively about strategy. The team should also make time for annual retreats at which it does *not* discuss business. Such retreats help build a sense of community, and, perhaps more importantly, give participants an opportunity to restore balance to their lives.

Magnanimous The third way we must do business differently is by being magnanimous. I think, for example, of Seton Cove, the retreat house that St. Vincent Hospitals and Health Services created in Indianapolis several years ago for its staff.[2] St. Vincent is, in effect, paying for its employees to get away from their jobs and spend some time in peaceful reflection. Penrose-St. Francis Medical Center, Colorado Springs, CO, gives its employee of the month a paid day off for a personal day of retreat. Those are two good examples of corporate magnanimity.

We who are leaders in Catholic health care should ask ourselves how magnanimous we are. Are we magnanimous about staffing, for example, or do we follow the same staffing ratios used by our competitors? Are we magnanimous in our personal relations with employees? Patricia A. Cahill, JD, CHI's president and chief executive officer, always takes the time, when she's walking around the building, to stop and ask people how they're doing. She may have 50 things on her mind, but she takes an interest in people. Some executives, when they see you, automatically think of some agenda item. Not Pat—she's interested in people as people. That's also a kind of magnanimity, and I think that Catholic health care leaders should display more of it.

> **C**ontemplation, incidentally, means finding equilibrium in whatever you're doing.

WE MUST DEVELOP AN AFFILIATIVE STYLE

In the early 1990s, the Catholic Health Association sponsored original research on the competencies of Catholic health care leaders. The report, in summing up those studies, had a good deal to say about what it called "the affiliative management style."[3] A leader who possesses the affiliative style is basically a "people person." My personal mantra of advice for leaders: Ask, listen, and affirm. If you're a leader who wants to have a strategic market niche, then all you have to do is ask, listen, and affirm. Ask people how they're doing. Ask their opinion on some project your organization is planning. Then listen to the responses and find something in those responses that you can affirm.

If, as a leader, you make a practice of asking, listening, and affirming in your interactions with people, you will start to develop what Pat Cahill calls "a territory of trust." This territory of trust allows for constructive feedback.

I have been in Catholic health care for some time. My observation is that a key problem in Catholic health care leaders is that we are conflict adverse. As a result, we tend to avoid disagreement, tensions, or contentions and to create avoidance cultures. Unfortunately, however, an avoidance culture is the antithesis of what we need to produce a strategic market niche. In an avoidance culture, people never get to the real

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providers, why are we here?" This question, in turn, raises the issue of sustainability. Like other Canadian health care organizations, Catholic organizations must continue to change and restructure to be responsive to needs, advances, and cost pressures. For me, the question is: What can we leaders do to change Catholic health care so that it, first, truly responds to the health needs of the communities we serve and, second, continues to provide the value-added aspects that differentiate us from other-than-Catholic care?

If we are not part of the solution, we may not have the opportunity to offer ongoing service with our distinctive voice. The Catholic health care tradition encourages us to constantly reshape, renew, and reform the way we do our work so that we keep the body-mind-spirit connection intact as the best approach to health and well-being. I'm confident that holistic care of this type can still be found at the patient's bedside. But is it alive and well in our ministry's leadership?

A character in Joseph Conrad's *Heart of Darkness* says, "I don't like work—no man does—but I like what is in the work—the chance to find yourself. Your own reality ... what no other man can ever know."[6] What have you found in your work?

In the Canadian context, our health system is our most valued social program. I am privileged to be able to lead a Catholic health system that provides services at all points in the continuum of care and serves people at the time of their greatest vulnerability. I'm conscious of the profound opportunity we have both to be instruments of change *and* to be changed through this vulnerability. I've experienced the power that comes from embracing my own vulnerability and emerging from it with a clear sense of the things that are important to me and of the contribution I can make. As a leader, I want others on my team and in my organization to know that power and the opportunities afforded us.

Hope lives at the core of faith-based leadership. How can you go about increasing hope in your organization?

Hope grows if the leader provides direction and vision for the organization, places a high priority on genuine relationships, builds personal and organizational confidence, facilitates innovation and creativity, encourages people to use all their talents and skills, celebrates accomplishments, explores new possibilities to extend the mission, and helps unify the community. Hope is embodied in every core value that underpins the Catholic health ministry. Leadership grounded in ministry integrity and personal authenticity builds hope in our world. □

NOTES

1. Quoted in Phil Cousineau, *Once and Future Myths: The Power of Ancient Stories in Modern Times*, Conari Press, Berkeley, CA, 2001, p. 7.
2. Jean Shinoda Bolen, *The Ring of Power: The Abandoned Child, the Authoritarian Father, and the Disempowered Feminine in Wagner's Ring Cycle*, Harper, San Francisco, 1992, p. 12.
3. Parker J. Palmer, *Let Your Life Speak: Listening for the Voice of Vocation*, Jossey-Bass, San Francisco, 2000, p. 31.
4. See Helen Palmer, *The Enneagram in Love and Work: Understanding Yourself and Others in Your Life*, Harper, San Francisco, 1990.
5. Rachel Remen, *Kitchen Table Wisdom*, Riverhead Publishers, New York City, 1996, p. 220.
6. Joseph Conrad, *Three Short Novels*, Bantam, New York City, 1960, p. 33.

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issues that they must work through if they are to grow.

But if we ask, listen, and affirm, we make it okay to disagree, okay to have a difference of opinion. An outdated style of leadership would react to differences of opinion by saying, "No discussion! This is the will of the sponsors, the trustees, the CEO!" But show me leaders who go around asking, listening, and affirming—establishing a territory of trust that allows for constructive feedback—and I will show you an affiliative leadership style that encourages honest feedback and an atmosphere of mutual trust.

THE CHALLENGE TODAY

The challenge today for the Catholic sector of U.S. health care is the same as it was for Jesus' disciples on the road to Emmaus. Like them, we need to restructure our imaginations. We need to imagine what this ministry *could* be like—what our workplaces would be like if only we were to recognize the power and the presence of the risen Lord among us in a new way, according to a new game plan. If each of us is faithful to our calling to bring healing and wholeness to those we serve by making their lives better, and if this shows in how we do what we do every day, we will indeed have struck gold! □

NOTES

1. See Teresa A. Maltby and John F. Tiscornia, "The Dynamics of Value," *Health Progress*, September-October 2001, pp. 46-51.
2. See Sharon Richardt, "A Clearing in the Woods," *Health Progress*, March-April 2000, pp. 20-21.
3. See John Larrere and David McClelland, "Leadership for the Catholic Health Ministry," *Health Progress*, June 1994, pp. 28-33.