Mission Statements: Politically Correct or Countercultural?

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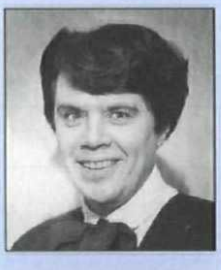
In institutions as diverse as inner-city hospitals serving the urban poor and Fortune 500 companies catering to stockholders, we observe the development of a host of educational programs—guest relations, continuous quality improvement (CQI), and total quality management (TQM). The reasons for this phenomenon vary (e.g., to motivate staff to improve quality, to market services, and to improve employee morale). As Catholic healthcare institutions adopt many of these staff training and development programs, they face the danger that their religious identity and spiritual mission could become so eclipsed that Catholic facilities will become simply clones of their secular counterparts.

In this article we examine how the concept of "mission" has become secularized, delineate the components of a mission statement, discuss the subtle shifts that have taken place in the mission statements of religious organizations, and offer some guidelines for ensuring the integrity of these vital documents.



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Meaning of Mission

Before we discuss the function and role that these vital documents play within organizational culture, we must first reflect on the meaning of the word "mission." *Webster's Collegiate Dictionary* defines mission as "an activity that was essentially religious in nature; an activity divinely inspired by God: an act or an instance of sending; a ministry commissioned by a religious organization to propagate its faith or carry on humanitarian work." We find the desacralization of this religious concept in contemporary news reports related to the successful bombing missions of U.S. pilots who report that the enemy has been totally destroyed and that their "mission" has been accomplished. Such contemporary uses of religious imagery reveal how easily the sacred is secularized in today's society.

In a sociological context, the term "mission" implies an experience so profound that an individual has no choice but to respond to a divine commission. Inherent in the concept of mission is an intense religious experience; the individual believes that God has personally asked her or him to perform a task. The sense of urgency to fulfill this sacred duty is so intense that the individual has no choice but to respond to God's invitation.

After time, commitment to the mission grows and eventually others come to join the movement. What appeared to be an isolated individual experience thus becomes a social movement, which, in turn, often leads to the development of institutions built on the divine mandate to perform some specific task, such as caring for the sick, orphaned, or marginalized.

Components of a Mission Statement

Ideally, a mission statement describes a group's identity—its purpose, beliefs, values, and direction. However, a Catholic organization's mission statement should also articulate the values and mission that set the institution apart from others and give rise to the unique identity of a Church-sponsored institution (e.g., preferential option for the poor, reverence for the unborn, commitment to those dying of AIDS, or sacramental presence).

In addition, a Catholic organization's mission statement should always include the philosophical and theological tenets on which the institution was built (e.g., participating in the healing mission of Jesus, or continuing the tradition of Catherine McAuley, Vincent de Paul, or Francis of Assisi). Thus a well-written mission statement should always contain a clear reference to the spirituality that provides the *transcendental meaning* behind the act of caring for the sick. This grounding in a spiritual tradition identifies the institution as having both a medical and spiritual mission and thus separates a Church-sponsored facility from a purely humanistic endeavor.

Mission Statements and Catholic Institutions

Mission statements are not new to Catholic organizations. Long before mission statements were

in vogue in the corporate world, religious institutes used founders' values, vision, and writings as the rationale for building hospitals, nursing homes, and hostels to care for persons who were sick and destitute. In the 1970s changes in the healthcare environment led congregations to realize that, with fewer members, structural changes would be needed to ensure that healthcare organizations' and sponsors' missions would continue. Catholic hospitals throughout the United States thus established mission effectiveness departments. One of the primary tasks of directors of mission effectiveness was to guide staff as they reflected on their part in fulfilling the organization's mission.

In the course of this reflection process, a diverse staff sometimes found problematic the religious imagery contained in mission statements. Some employees objected to the term "Christlike compassion," stating that it was offensive to non-Christian staff members; others felt that imagery, such as "all persons are made in the image and likeness of God," did not reflect their personal philosophy. These experiences, coupled with the movement toward CQI and TQM, convinced many healthcare institutions that it was time to revise or rewrite their mission statements.

Revised mission statements were often shortened versions of the originals. These revised mission statements deleted much of the religious imagery and focused on values that most employees could accept, such as compassion, charity, and quality. Although we recognize that it is difficult to convey religious values to a diverse staff, Catholic facilities must retain certain religious values if they are to remain true to the reasons for their foundation.

We believe that different members of our staff bring different meaning and commitment to the daily task of working in a hospital or nursing home. For example, most employees would agree that they come to work each day because they want to provide high-quality care to the sick and elderly. We seldom reflect on the transcendental meaning behind the act, which is carrying on the mission of Christ or ministering to Christ himself. Most employees can identify with a mission statement that includes values that are politically acceptable (e.g., compassion and commitment to the sick), but many institutions omit specific religious references such as Christlike compassion or commitment to social justice or the economically poor.

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Toward a Hierarchy of Values

Both Catholic and non-Catholic healthcare providers share many values related to care of the sick. However, some values are held only by Catholic institutions. A mission statement for a Catholic healthcare facility should reflect values from four different philosophical and ideological levels:

- Core values
- Professional values
- Humanistic-ethical values
- Religious-transcendental values

These value levels build on one another. Professional values thus incorporate core values. In turn, humanistic-ethical values build on and encompass both core and professional values. Religious-transcendental values (which give our organizations their unique identity) can only be credibly proclaimed if the institution has demonstrated its commitment to the values and behaviors articulated in other strata. For example, it would be impossible for an institution or administrator to speak credibly about the importance of witnessing to religious values (e.g., Christlike compassion) without already having in place a humanistic-ethical structure such as a due process committee to handle employee grievances in a fair and equitable manner. To publicly proclaim one set of ideals and practice another is the basis for the credibility gap that exists in so many Church-sponsored institutions. By incorporating values from each of the different levels, we will be able to challenge each person to deepen his or her commitment to the overall mission of the institution.

Core Values Core values are those values which we share with other healthcare institutions (e.g., serving all those in need regardless of race, color, or creed; alleviating suffering; striving for patient satisfaction and comfort).

Professional Values Professional values demonstrate our commitment to the professional dimensions of our ministry (e.g., delivering high-quality care; striving for excellence; being responsible administrators of our resources).

Humanistic-Ethical Values Humanistic-ethical values reflect our humanity and the institution's belief that care of the sick is not an industry concerned only with the bottom line. Thus the statement refers to the institution's commitment to helping those who are poor, alienated, aged, or vulnerable. This value level also incorporates a concern with questions of justice (e.g., the allocation of

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resources and treatment of staff).

Religious-Transcendental Values Religious-transcendental values ground us in our identity and give purpose to our care of the sick (e.g., Christlike compassion, commitment to Gospel values, special reverence for the dying and the unborn, commitment to patients' spiritual needs, sacramental presence). Articulation of these values is essential, for they publicly proclaim that care of the sick is not merely a work of charity that we perform from nine to five. Rather, care of the sick and the poor is a constitutive element of the Gospel, and participation in this sacred ministry affords each person an opportunity to work out his or her own salvation. To delete this essential component of Catholic healthcare because it makes others uncomfortable or because it is not politically correct is to deny the essence of our identity and to reject our founders' intent.

Maintaining a Ministry Model of Care

We believe that the values articulated in a Catholic healthcare facility's mission statement should contain components from each of the four value strata. If the values in the facility's mission statement merely reflect the first three levels, then our institutions may provide high-quality healthcare. However, they may become so homogenized that they will not only lose their identity but will become additional victims of the profound sociological forces that are moving Catholic healthcare from a ministry to an industry model of care.

Two thousand years ago, Jesus asked Peter a question of identity: "Who do you say that I am?" Likewise, his followers are confronted with questions of identity: What makes a Catholic hospital Catholic? One can only point to the vision from which all mission statements must flow—the vision of Jesus, which challenges individuals and institutions to adopt values that are countercultural and which, if lived, will give rise to a clear sense of identity and purpose. Being politically correct is in vogue these days, but being countercultural is the essence of the Gospel call. □

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situations, reconciling oneself to one's enemies, or making peace with God are not unreasonable. It might well be, however, that such requests need not be honored because they conflict with other goods.

This narrow interpretation of autonomy within the medical context acknowledges that reasonableness and subjectivity are to some degree related. What is reasonable for one patient in part depends on that person's subjective values. But rational medicine demands that patients' requests be reasonable from a clinical perspective, as well as from a subjective one. The practice of informed consent can be implemented as a balance between these two interests.

Providers and Patients Are Responsible

If we understand "autonomy" as self-determination, and "informed consent" as the practice that protects autonomy in a medical context, informed consent applies narrowly to the balance of the subjective interests of patients and the practice of rational medicine. Informed consent refers to the supremacy of patient desires and requests when the benefits of a proposed treatment are balanced against the risks.

Clinicians must take due account of the nonmedical benefits of certain treatments and credit those in descriptions of benefit-burden ratios. Both patients and providers, however, must acknowledge that benefit-burden ratios may include the good of families and communities, as well as the subjective interests of the patient. This means that patient desires and requests cannot obligate healthcare providers to comply with requests for futile treatment or with requests that would render treatments futile, and that treatment which is futile need not be offered to patients for consideration under the practice of informed consent. □

NOTES

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7. I am grateful to Robert M. Veatch, PhD, director and professor of ethics, Kennedy Institute of Ethics, Georgetown University, Washington, DC, for his comments on this article, particularly this section.
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12. See Robert M. Veatch, "Voluntary Risks to Health: The Ethical Issues," *JAMA*, January 4, 1980, pp. 50-55.
13. Jane Mary Trau, "Relational Ethics in a Medical Context," *Cambridge Quarterly of Healthcare Ethics* (in press).