Mission and Business: Resolving the Tension

An Awareness of the Process of "Splitting" Can Help Organizations Achieve a Creative Balance

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There is much talk today about the tension between mission and business in Catholic healthcare organizations. Some argue that business must take priority, that without margin there can be no mission. Others believe that if we concentrate on the mission, the business will look after itself. Conversation between people of these differing views becomes difficult, if not impossible. Those who support a mission emphasis think business advocates are too worldly; business advocates think mission supporters are too remote from the realities of life.

To resolve this tension, it is necessary first to discover its source. It is too simplistic to say that mission and business are both important.[1] Questions need to be asked: Why has this tension particularly emerged in recent years? Are cultural factors involved? Are there other significant tensions in healthcare—for example, between CEOs and boards of trustees—that can throw light on the problem?

Healthcare in Chaos

Healthcare in the Western world is in a period of tumultuous change, as it struggles to move from a hospital to a community focus, from an illness to a wellness emphasis, from a biomedical to a holistic health model, from simple to complex technologies, and from patient passivity to collaborative interaction. Costs are rising and populations are aging, bringing difficulties never before experienced so acutely.

In the midst of this turmoil the Catholic healthcare ministry has additional problems of its own. It faces increasingly complex medicomoral challenges, the administrative burden of coping with changes in funding sources, the closing of many once-flourishing hospitals, and uncertainty about how best to continue its ministry in a secularized and fast-changing world.

These shifts and pressures in healthcare are not just technical or structural. Primarily they involve cultural change of such complexity and speed that chaos is the inevitable result. A culture is a system of felt meanings, which usually operates at the subconscious level and provides us with a much-needed sense of order and predictability.[2] When this sense of order is dramatically interfered with, as is happening in healthcare, people feel disoriented and anxious.

This is what "chaos" means: the radical breakdown of cultural predictability, leading to anxiety and a sense of being lost. But the human group, like individuals, cannot live in pure chaos. It must find forms and boundaries to contain it. The process of "splitting" is one common, although ultimately unproductive, method of containing the chaos.

The Splitting Process

Splitting is a cultural and psychodynamic process in which individuals and groups, in an effort to cope with the doubts, anxieties, and conflicting feelings caused by difficult or anxiety-provoking work, isolate different elements of experience, often to protect the perceived good from the bad.[3] For example, people opt for mission *or* business, leadership *or* management. One pole is seen as "good," the other "bad." This division forms a social defense, that is, a system of relationships that people feel protects them from the devastating consequences of cultural disintegration or loss of meaning. They yearn for simple causes for their problems, especially causes outside themselves, in ways that pass the responsibility on to others.

Applications to Healthcare

In healthcare today there is great potential for dangerous splitting. A split between mission and

business is one possibility, but splits can also occur between acute and community care, federal and state government control, management and leadership, public and private facilities, and physicians and nurses. The following case studies illustrate the process of splitting in healthcare facilities.

Illness Versus Patients Isabel M. Lyth, in a pioneering study of nursing staff in hospitals in Britain, illustrated how nurses use the process of splitting as a defense against the emotionally distressing nature of their work. Lyth found in her research that the division of patient care into discrete tasks delegated to different nurses and rotation and charting practices reduced nurses' awareness of or feelings of responsibility toward patients as whole persons. Sick people became "the cancer cases in room three" (the illness itself, or the "good" pole) instead of patients with personal names (people whose suffering might cause nurses emotional distress, or the "bad" pole). Nurses could concentrate on the mechanical problems of illness, the "good" pole, while avoiding involvement with patients' feelings. Thus, while splitting strategies protected nurses from the anxiety-creating issues of life, sickness, and death, they did so at great cost to the healing of the patients.[4]

Accounts Department Versus Executive In another example, a hospital with serious financial problems employed a new director to reform the accounts department after it had been poorly managed for several years. She succeeded in her reform, but she became the object of intense hostility throughout the organization. Comments were made such as "The senior executives are fine. They are human, but not the accounts department—especially its head," and "The accounts department has lost the spirit of the place."

This is an example of splitting. The hospital culture, to survive, must face the anxiety-creating realities of budgeting, cost-cutting, and accountability. Most of the department heads do not want this, so the accounts department is split off from the "good" culture and labeled as "bad."

CEO Versus Management Board In my third example, tensions developed between a CEO and the board of trustees of a major acute care hospital. The board had appointed the CEO with a mandate to develop strategies for the hospital's survival and growth, but after several months members began to complain among themselves and to the sponsors about the CEO and his plans. Most of the board members had been selected at a time when healthcare in the region was relatively stable; they had been chosen to maintain the status quo, not to develop policies for a time of turbulence. Eventually the CEO was dismissed and a successor chosen to "get things back to normal."

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In this case, board members branded the CEO as "bad" and the board itself as "good." Most of the board members were personally frightened of change; they projected their fears onto the CEO, who was perceived as a dangerous disturber of the status quo. In theory they wanted change, but in practice they feared it so much they could not implement their own decisions. The hospital eventually sold out to a rival organization because these board members could not cope with their fears of change and the new CEO was incapable of working around those fears.

Laity Versus Religious I still frequently hear a process of splitting involving laypeople and the religious sponsors of a healthcare facility. This splitting is revealed in comments such as "If only we had the sisters back, things would again be normal," and "We religious have nothing left to offer. Our numbers are down. The laypeople have the skills to take over." The first statement, by a layperson, idealizes religious; the second statement, by a religious, overexalts the laity.

Mission Versus Business In this case, a management board of a Catholic hospital selected a CEO candidate because she said in her interview, "I believe that only if we get the margin right can we think of the mission." Most of the board's members, feeling overwhelmed by the grave financial problems they confronted, agreed with this assumption. As one member said:

> Mission is something for the sisters in the past. They had little business sense, just trusting in providence. But times have changed. We must get real. Only sound business acumen will get us through the present crises. We can come back to the

mission later, when we have the hospital on sound financial foundations.

Some board members strongly objected to this logic, but they were branded as "being out of touch" and "traitors to the cause of progress" in Catholic healthcare.

In this incident economic rationalism triumphs. The mission is seen as unimportant, something "soft" or unworldly, a "harmless thing for the sisters." Compared with business acumen the mission is "bad," but the world of financial planning and implementation is seen as "good."

> Recognizing one's temptation to scapegoat others is a sign of maturity.

On the other hand, people can use the mission of healing as an escape from reality. It becomes the "good," and business becomes an evil of the profane world. The mission is spoken about and praised for its beauty, but it is not used to measure reality. This is as destructive as an overemphasis on business management. Anne Schaef and Diane Fassel have shown that the exaltation of the mission and the downplaying of business realities can be a form of addiction for a group. Administrators and employees can "become hooked on the promise of the mission and choose not to look at how the system is operating." The failings of the healthcare facility are dismissed "because [the latter] has a lofty mission."[5] When this happens, the mission is isolated from the real world, contrary to its incarnational imperative.

Resolving the Tension

It is an indication of maturity when a culture or people in a group recognize why they are tempted to scapegoat others individually or collectively. To be aware of this deeply rooted dynamic is the beginning of a creative solution that will keep the perceived "good" and "bad" poles in balance. The documents that emerged from the Second Vatican Council illustrate this need to keep polar opposites in a creative balance, although the task is difficult. For example, they remind us that priesthood is a sacrament established by Christ, but at the same time all who are baptized are priests. They also say that heaven is our final destiny, but for our salvation we must struggle for justice in the workplace and the world at large. Nowhere in the documents did the council spell out precisely *how* these poles are to be balanced in real life, and in fact it simply could not do so. Rather, it challenged Catholics to struggle in faith to develop a living balance between these particular polar emphases.[6]

Mission and Leadership: Senior Partners

Contemporary management literature often distinguishes between management and leadership, using terms such as "transactional" and "transformational," "implementors" and "pathfinders," or "renewal persons" and "refounding persons." But an organization cannot function or survive unless *both* roles are kept in a creative tension. Unless a leader has systems and structures in place under the direction of a gifted manager, he or she does not have the necessary freedom and time to clarify a vision for the group.

In practice a split often develops between the two roles and one role is exalted over the other. Leadership may be depicted as charismatic while management is seen as the evil destroyer of leadership, or vice versa. An inability to accept the need for both leaders and managers is a sure recipe for catastrophe, since to be overled and undermanaged in healthcare is just as dangerous as being underled and overmanaged.

However, although the struggle to achieve a balance between the two poles leads to a creative organization, both poles in a particular dynamic do not necessarily have equal importance. For example, in a rapidly changing healthcare environment, visionary leadership, not management of the status quo, is the senior partner.

So also with mission and business. Mission is the senior partner and must drive or permeate all decisions in business. Mission is not something to be considered from time to time; it must dynamically influence all activities of a healthcare facility.

Biblical Reflections

The Scriptures offer no simple answer to polar tensions. In fact the tension between divine mercy and justice is one of the most profound dilemmas of our belief in God. Yahweh is the "God of tenderness and compassion . . . forgiving fault . . . yet letting nothing go unchecked,

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in activism use this approach.

2. Sponsoring or cosponsoring shareholder resolutions. Approximately a third use this technique.

3. Letter writing and conversations with companies. Approximately a third take this approach.

A Look Ahead

Although the sample size was relatively small, the response rate was significant enough for us to draw some general conclusions about behaviors of Catholic health entities' MBI/SRI preferences and activities. Overall, the survey indicated that the respondents believe MBI/SRI is an expression of mission and are therefore very much committed to implementing MBI/SRI as part of their investment strategies. However, many of the respondents are focused on "basic" MBI/SRI activities, such as the use of screens and have not begun to engage in more advanced approaches, such as alternative investing. Many respondents may be limiting the social effect of their MBI/SRI activities by not being more proactive in communicating their success stories.

Future articles planned in this series will discuss some of the techniques being applied by organizations within the Catholic health ministry. The articles will relate to the survey findings, explore applications of techniques by participants in the Catholic health ministry, and provide observations by MBI/SRI experts. □

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NOTES

1. Peter D. Kinder, Steven D. Lydenberg, and Amy L. Domini, eds., *The Social Investment Almanac: A Comprehensive Guide to Socially Responsible Investing*, Henry

LEADERS' INVOLVEMENT IN MBI/SRI*

Type of Organization	Encourages Use of MBI/SRI	Makes Decisions Related to MBI/SRI	Implements MBI/SRI Strategies
Sponsors	1. Mission leader 2. Congregational leader 3. Board	1. Board 2. Investment committee 3. Congregational leader	1. Investment committee 2. Finance committee 3. Board
System Offices	1. Board 2. Mission leader 3. Chief financial officer, finance committee	1. Board 2. Investment committee 3. Chief financial officer	1. Chief financial officer 2. Investment committee 3. Mission leader
Facilities	1. Board 2. Finance/ investment committee 3. Mission leader	1. Board 2. Financial staff/financial committee 3. Mission leader	1. Chief financial officer 2. Investment and finance committees 3. Mission leader

*Leaders are listed in order according to degree of involvement.

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and punishing the parent's fault in the children" (Ex 34:6). The paradox of a merciful and forgiving God who is at the same time ultimately just remains unresolved.

Biblical writers return to the dilemma many times, especially in prayer. "If you kept a record of our sins, Lord, who would stand their ground? But with you is forgiveness" (Ps 130:3-4). The story of Job confronts the paradox in the form of a dialogue. Job comes to grips with the mystery of suffering because in the interaction between him and God each aims to give himself as he is and seeks also to know the other as he is (Jb 40:15).

So also in healthcare. People need to feel free to ponder and discuss the contradictory tensions. When people have this opportunity in a trusting atmosphere, they begin to form a balance between the poles—for example, between mission and business—and creative action results.

Scriptural reflections, such as the examples above, can provide the atmosphere of faith in which tensions can be resolved. Without this environment the pondering is apt to turn into an intellectual debate, and people retreat further into the isolation of one or another pole, to the detriment of the healing mission of Christ. □

NOTES

1. The tension between mission and business is considered more fully in my forthcoming book, *Healthcare Ministry: Refounding the Mission in Tumultuous Times*, Liturgical Press, Collegeville, MN (pub. date February 2000).
2. See Gerald A. Arbuckle, "Culture, Chaos, and Refounding," *Health Progress*, March 1995, pp. 25-29, 48.
3. See Isabel Menzies Lyth, *Containing Anxieties in Institutions: Selected Essays*, Free Press, London, 1998, pp. 43-85; Gareth Morgan, *Images of Organization*, Sage, Newbury Park, CA, 1986, p. 206; Edgar H. Schein, *Organizational Culture and Leadership*, Jossey-Bass, San Francisco, 1992, pp. 177-179.
4. Lyth, pp. 43-85.
5. Anne W. Schaef and Diane Fassel, *The Addictive Organization*, Harper & Row, San Francisco, 1990, p. 123.
6. See Gerald A. Arbuckle, *Refounding the Church*, Orbis Books, Maryknoll, NY, 1993, pp. 39-43.