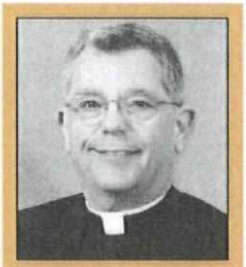
Ministry Leadership Development: A New Pilgrimage

BY FR. MICHAEL D. PLACE, STD

Over the last year, the Catholic health ministry has experienced leadership transitions, or the announcement of impending leadership transitions, in several key executive positions. While transition in key positions is not in itself unusual, the number of changes involving highly visible positions has become a source of conversation and discussion both within and outside the ministry. Some of that discussion has centered on the difficulties and challenges facing any health care executive today, let alone one who has the added responsibilities of stewarding an ecclesial ministry. Other discussion has focused, in one way or another, on questions the ministry has been engaging ever since the movement to lay leadership began: How do we understand and describe what is needed in an effective ministry leader? And how do we ensure that there will be a "critical mass" of such leaders available for the future?

Such an environment makes it opportune that this issue of *Health Progress* has as its theme ministry leadership. In what follows, I will share some reflections on that topic. They will build on previous columns in *Health Progress.*

Let me begin by reflecting briefly on what we have accomplished in recent years. Clearly, we have come a long way. For example, we have identified core competencies associated with effective leadership, competencies that are recognized across the ministry as having relevancy, in a variety of ways, to local recruitment, hiring, ongoing development, and retention. We have developed resources based on that work, such as the "360-degree" assessment tool, that can be utilized or adapted. We also have paid a great deal of attention to agreeing on what the "foundational" elements of the Catholic tradition—elements important in being successful as a ministry leader—are. These elements can be experienced through the program, "Foundations of Catholic Health Care Leadership," presented annually by CHA staff and others or through local adaptations such as those conducted in some systems.



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In mentioning the above, I realize that they are but the visible, national tips of what is, fortunately, an ever-growing iceberg of leadership activities in the ministry. Clearly, across the ministry, there is heightened concern, energy, and intentionality about leadership, all of which are reflected in the articles in this issue's special section. In addition, there are expanding efforts, where appropriate, not only to share "leading practices" but also to jointly develop mutually beneficial programs (e.g., the "Collaborative Formation Program for Public Juridic Persons" created by Trinity Health, Covenant Health System, Catholic Health East, and Catholic Health Initiatives; and the Ministry Leadership Formation Center, developed by five systems with facilities on the West Coast*). Clearly, at the national, system, and local levels much has been done and much is being accomplished.

Reasons for Concern

That being the case, why does the recent spate of senior transitions elicit so much discussion and, I dare say, concern? As in most things, it could be that there are multiple reasons for this concern.

First of all, there is within the ministry a passion for a vision that comes from the Lord and that has been conveyed to us by generations of religious women and men; and, flowing from that passion, there is also a profound sense of responsibility—whether one is religious, lay, or cleric—for the future. In the context of that passion and responsibility, it is clear to many that one of the most critical issues is effective leadership for the future at three levels: executive, governance, and sponsorship. Attending to any one of the three would be a daunting task. Addressing all three simultaneously raises understandable anxiety.

Secondly, there is a clear recognition that the business, as well as the practice, of health care is increasingly complex. In other words, the "howness" of the ministry, as distinguished from its

*See William J. Cox, "Nurturing the Ministry's Soul," p. 38.

"whyness," has changed and will continue to change dramatically.

On "Howness" and "Whyness"

Lest I leave all my readers lost in this flight into philosophical rhetoric, I will make a brief digression to explain my categories.

We know that Jesus left to his community of disciples the charge to proclaim the good news that the Reign of God is at hand, and that, as an expression of that presence, he urged them to heal the sick. Bringing healing to the world is our mission, our purpose, our "why." The church's response to this mission is both individual and collective. (We used to be more focused on the collective, but the Second Vatican Council called us to attend to the personal responsibility of all the baptized as well.) The collective or organized response is what today we speak of as "ecclesial ministry." As we know, the root meaning of "ministry" is associated with the concept of service. Consequently, we can say that across the centuries the community of disciples, the church, serves the mission of proclaiming the Reign of God by being about healing. The healing ministry is, in a sense, a constitutive element of ecclesial life.

By turning to the Gospel stories of Jesus' healing, we can get a general sense of some of the essential elements of being in service, in ministry to the mission of Jesus Christ. They include witnessing to God's active presence, demonstrating a sense of inclusiveness, providing both care and cure, and restoring broken relationships.

As helpful as these core elements are in providing depth to an appreciation of our purposefulness, the question remains: "*How* do we bring this purposefulness into existence?" Over the centuries, our collective or ecclesial response has taken on different forms of "howness." Today, around the world, the "how" of the healing ministry varies from one place to another. The hospices of Mother Teresa, the dispensaries of Asia, the clinics of Latin America, and the tertiary and quaternary acute care centers in the United States all represent various "hows" of today's ecclesial healing ministry. This same variety is also present in our own country. As we have grown in our appreciation of the fact that Jesus' healing is of body, mind, and spirit, the "how" of the healing ministry has evolved. This evolution was reflected in the 1979 decision to change our name from the Catholic Hospital Association to the Catholic *Health* Association. Utilizing the word "health" provided a framework for the evolving complexity of the ecclesial healing ministry. Our "howness" includes large and small acute care centers of varying forms and shapes in urban, semi-urban, and rural communities; clinics and community-based health services; and elder and senior services of various modalities; as well as emerging efforts related to community wellness, such as affordable housing and environmental advocacy. Individually and collectively, these institutions constitute the "howness" of the ecclesial healing ministry. Whereas the ministry's purpose, its "why," is noted by a sense of transcendence, the "how" is quite incarnational.

A Dualistic Approach Will Not Work

Having established the distinction between why and how, let me return to my reflections on leadership. We were speaking of the recognition that the "howness" of the ecclesial healing ministry is increasingly complex and, consequently, the demands on leadership are more challenging, too. It is understandable that some might wonder whether there is, at various levels in the ministry, the "bench strength" needed to manage, govern, and sponsor its current and future "howness." (While admitting that this is a reasonable concern, I must also offer the editorial observation that our predecessors did not let their own concerns stop them from building today's remarkable ministry.)

I would propose, however, that there is another reason for our concern—namely, the recognition that, in fact, the very complexity of which we speak makes the distinction between the "why" and "how" of the ministry more intellectual than real. In other words, we cannot run the "why" and "how" of the ministry as if they exist in isolation. There is no "why" without a "how"; and a "how" of acute care, senior care, or community service that lacked the essential "why" would not really be an incarnation of the healing mission. Perhaps it is *this* growing recognition that fuels anxiety in the ministry as to whether we have leaders who can effectively serve the "how" of

contemporary health care in a way that makes it an apt vehicle of the "why" of an ecclesial healing ministry that advances Jesus' and the church's healing mission of service and transformation.

Recently, I was privileged to participate in a discussion with some of those in the ministry who share the responsibility in various ways of serving Catholic health care leadership efforts. It was that discussion that catalyzed what I have just written. As I listened, the meeting's participants asked themselves whether the ministry might not need more explicit efforts to assist all who share responsibility for its leadership to be effective leaders of both the "why" and the "how," the transcendent and the incarnational, the mission and the margin. In posing this question, the participants recognized that, although not everyone needs to know everything, a dualistic approach that simplistically gives the sponsor responsibility for the "why" and administrators responsibility for the "how" will not work. It will not work because, in fact, "how" and "why" cannot be easily separated. Obviously, the hard part is in figuring out how much of each is needed at each level.

A New Pilgrimage

Let me turn now to ministerial leadership at the executive level. What is needed, at this level, to be effective at integrated leadership of both the "why" and the "how"? Clearly, if this line of reasoning is found to have merit, we might need to explore new opportunities or be more intentional with existing efforts. As I reflect on these issues, it seems to me that we will have to engage a tension that could exist between the ethos of the "why" and that of the "how."

Allow me to explain. If we approach the "why" (or purposefulness) that is mission, we immediately are drawn into the world of depth and meaning as experienced in the Roman Catholic faith tradition. To use a secular phrase, we enter into a distinctive culture. And, as we know, culture is passed on not so much by words as by experience. To get somewhat technical, in cultural transmission the rational cannot exist apart from the imaginative, the affective.

I would suggest this recognition is not something new to the ministry. All one needs to do is talk to an executive who has participated in a system- or institution-sponsored retreat to Assisi or Montreal. Participants come back with a new energy (with, dare we say, an experience of purposefulness?) and often say something like, "I get it now" or "The parts came together." (Dare we say an experience of "whyness"?) In many cases, those on these pilgrimages are veterans in the ministry. They have read about and understand the charism of the sponsoring community. However, experiences such as these pilgrimages—which often are described as "transforming" events—provide something more. Perhaps it is that "more" to which we must pay more attention.

One must move beyond the tyranny of doing *and* producing *to experience meaning.*

I have been thinking about what I have heard from those who have participated in these pilgrimages and from those who have been on our annual program of Ecclesiology and Spiritual Renewal for System Leaders. I have heard some common themes, themes that might provide some insight into what facilitates an encounter with purposefulness, an entry into the nonrational dimensions of the Roman Catholic culture.

- First, there is the opportunity to be "apart" from the regular, the ordinary.
- Second, there is a sense of permission not to be about the "how."
- Third, there is the new place to which the participants go, a place that is rich with history, symbols, and mystery.
- Fourth, there is an opportunity to experience a sense of community that is bigger than self.
- Fifth, there is an explicit prayerfulness that oftentimes is nurtured by the ritual and Liturgy of the Roman Catholic Church, even while its honors the distinctive faith experience of those participating.
- Sixth, there is an opportunity—provided through reading, input, and discussion—to "connect the dots" both intellectually and emotionally.
- Seventh, there is an invitation, extended through various venues, to the participant to begin a "so what?" journey—to ask himself or herself, "What does all of this mean for the manner in which I live as a leader in the world of the "how"?
- Finally, there is the possibility of experiencing a sense of celebration that makes God's unlimited gracefulness tangible and invites a prayer of thankfulness for the gift of being able to share in this ministry.

Beyond the Tyranny of Doing

As I reflect on the above, I see that to experience purposefulness one must move beyond the tyranny of *doing* and *producing* in order to experience meaning. Individualism needs to embrace community, and control needs to give way to call. There is, then, as noted earlier, a certain countercultural dimension to the world of purposefulness. Within the Catholic imagination, however, that countercultural dimension does not require us to leave the world; rather, it calls us to embrace the world within the tension that is created by these countercultural realities. In other words, in the Catholic experience we go on pilgrimage not to escape the home we leave but in

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COMMUNICATION STRATEGIES

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Some board members in California are campaigning in a referendum.

engineers redesigned department procedures in a way that cut waiting time from several hours to 30 minutes.

To improve an organization's functioning, some board members lend it the expertise of their own business staffs. The trustees of Children's Mercy Hospital, Kansas City, MO, for example, teamed up with the hospital's physicians not long ago to make personal calls on the city's top business executives.* In a typical meeting, a two-person team—a trustee and a physician—would explain to the executive Children's Mercy's values, services, and capabilities, and urge him or her to include the hospital among the preferred providers in his or her company's insurance plan.

Campaigning in California

Board members can also use their influence to further health care reform. In California, for example, board members of children's hospitals currently are campaigning to pass a referendum measure that, if successful, will provide millions of dollars for the much-needed upgrading of pediatric facilities throughout the state. The Children's Hospital Bond Act, known as Proposition 61, would authorize the sale of $750 million in bonds, the money from which would be used to expand children's health care facilities and equip them for the treatment of seriously injured and ill children.

If the measure is approved, its immediate beneficiaries will be eight private children's hospitals and five children's facilities affiliated with branches of the University of California. Together, the 13 institutions treat more than one million children a year, regardless of their parents' ability to pay.

Trustees of the 13 facilities are traveling around the state, urging community organizations, newspaper editorial boards, and business groups to support the measure. They especially want to reassure Californians that passage of Proposition 61 will not mean raising taxes.

Strategic Importance

In some parts of the country, board members are involved in creating healthier communities. Speaking to businesses groups, chambers of commerce, service organizations, churches, synagogues, they seek to encourage incremental changes in lifestyle that add up to improved health.

These new boards can be enormously helpful both in strengthening health care organizations and in improving community health. Because this is so, the selection of board members has become a much more important part of an organization's strategic development than it used to be.

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*Children's Mercy Hospital is a secular not-for-profit organization unaffiliated with the Sisters of Mercy of the Americas.

NOTE

1. Jan Greene, "What Every Board Needs to Know," *Trustee*, June 1, 2004.

REFLECTIONS

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order that we can return to a better home. So, too, when, as ministry leaders, we address the purposefulness of the "how" of Catholic health care, we embark on pilgrimages that will allow us to more faithfully lead the "how," whatever form that might take.

In drawing these reflections to a close, I will propose some tentative conclusions:

- Ensuring a critical mass of effective ministry leaders for the future ought to be one of our highest priorities.
- Although the "how" of the ministry has and will change, the "why" remains constant.
- Though the "how" and "why" can be separated intellectually, in experience they are essentially intertwined.
- Ministry leadership development efforts must address both the "why" and "how" dimensions of leadership in an integrated manner.
- In addressing development in the arena of the "why," we must experience the imaginative and rational dimensions of the Roman Catholic culture.
- The metaphor of pilgrimage might be helpful in understanding how to approach this aspect of development of ministerial leaders.

Each year, during CHA's program in Italy for system leaders, we visit sacred sites in Rome and Assisi, including the humble—yet profoundly beautiful— Portiuncola, the tiny medieval chapel of St. Francis, which is now contained within the great basilica of St. Mary of the Angels. It was here, in this intimate chapel, that Francis responded "yes" to God's call to rebuild the church. If today's ministry leader is to integrate the "why" and the "how," he or she, in that same spirit, should be able to move beyond producing to experience meaning. The leader should be able to embrace a sense of community and say "yes" to a call that will profoundly affect the way he or she approaches the "how" of Catholic health care. □