

**Living our Mission  
Contextualizing Catholic Health Care in Ontario**

**A Reflective Paper  
Prepared by  
Sister Bonnie MacLellan, csj, PhD  
For  
The Catholic Health Association of Ontario**

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## **ASSESSING OUR CURRENT REALITY**

Catholic health care in Ontario stands at the precipice of an exciting time in its history. The Ministry of Health has promised the people of Ontario “transformational change” of the health care system. Change, of its very nature, is a challenge for most humans who struggle to maintain a sense of personal and organization equilibrium. We gravitate towards that which is most familiar – regardless of its dysfunctionality.

Organizational theorists would caution that change, for the sake of change, is fool-hardy at best. The rationale for the government’s desire for transformation of the health care system appears to have a two-fold genesis: financial and political. The publicly funded health system cannot be assumed to offer limitless, affordable health care solutions to meet every need of our ageing population. The Romanow Report suggested the future of the Canadian Health Care system depended on refocusing leadership, governance, system efficiency, accountability, and finally, defined system investment.

*The Commission on the Future of Health Care in Canada was established by the Prime Minister in April 2001. Its mandate was to engage Canadians in a national dialogue on the future of health care and to make recommendations to preserve the long-term sustainability of Canada’s universally accessible, publicly funded health care system.*

*Over the past 18 months, the Commission has completed a rigorous research program and exhaustive consultations, involving tens of thousands of Canadians - health experts and ordinary citizens, Health Ministers and Premiers, researchers and health care workers. The Commission has set a new standard for transparency by releasing, in advance of its final report, all of the submissions it has received, the research it has commissioned, and summaries from all of the consultative activities in which it has been engaged.*

*The Commission's final report comprises 47 detailed, costed recommendations that include implementation time frames. "My recommendations are premised on three overarching themes. First, that we require **strong leadership and improved governance** to keep Medicare a national asset. Second, that we need to **make the system more responsive and efficient as well as more accountable** to Canadians. And third, that we need to **make strategic investments** over the short-term to address priority concerns, as well as over the long-term to place the system on a more sustainable footing." Commissioner Romanow explained.<sup>1</sup>*

Recognizing an inevitable financial Armageddon if changes were not made to the current system of health care in Ontario, Bill 8 was created (and critiqued) to enhance accountability structures and systems for hospitals, Boards, and health administrators.

*Unfortunately, the Bill as drafted simply does not achieve these goals and could seriously undermine the very objectives it seeks to attain. On February 16, 2004, George Smitherman, the Minister of Health and Long-Term Care (MOHLTC) opened the public hearings on Bill 8 by acknowledging that a number of changes must be made to this Bill. Some of these "potential changes" have been shared with stakeholders, however, the actual wording of these proposed amendments has not yet been provided.*

*It is our view that even with the acknowledged changes, certain portions of the Bill, and in particular, Part III (which deals with accountability) and Part II (which deals with physician funding agreements) are so fundamentally flawed as to be unworkable. A full analysis of the legislation is beyond the scope of this Communiqué. However, from a policy perspective, this legislation appears to be directly contrary to the existing principles upon which accountability is enshrined. It fails to recognize the strengths of our system and to enhance and build upon those strengths, and in particular:*

- *The need to preserve and enhance voluntary corporate governance models which have built-in accountability structures and to ensure that the roles of management and governance are separate and distinct. The proposed model seriously undermines long-standing and accepted roles of the governing board and management.*
- *Recognition of the existing oversight mechanism under the Public Hospitals Act that allows the MOHLTC to intervene in the "public*

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<sup>1</sup>Romanow Report Proposes Sweeping Changes to Medicare. Release Date: 28 November 2002. <http://www.hc-sc.gc.ca/english/care/romanow/hcc0403.html>

*interest” in certain circumstances. Bill 8 does not require the MOHLTC to act in the public interest and, in fact, gives the Minister carte blanche authority to direct a health service provider to do or refrain from doing anything.*

- *The need for two-way, mutual accountability. The legislation contemplates that the health industry will be accountable to the MOHLTC. It does not reflect a collaborative or negotiated process, but rather, allows the MOHLTC to unilaterally direct health service providers to enter into vaguely defined accountability agreements and further, to issue broad compliance directions. Accountability agreements should truly be negotiated, not compelled by legislation.*
- *While the MOHLTC is taking on greater responsibility in directing the performance and actions of the health industry, liabilities of existing organizations continue to exist. In contrast, the MOHLTC is statutorily immune from liability. The net effect is less accountability to the public for decisions and decision-making. Further, with board members continuing to be responsible for matters which are outside their control, the ability of the health industry to attract and retain qualified voluntary directors could be seriously impacted.*
- *CEOs and Executive Directors are directly accountable to their Boards and are increasingly subject to performance reviews on a voluntarily basis. In our view, the unprecedented provisions which allow the government to unilaterally interfere in independent contractual relations with CEOs, including the ability to reduce their compensation is draconian and unnecessarily punitive. Further, these provisions potentially place such individuals in a position of conflict and could undermine the ability of the health industry to recruit and retain qualified executive leadership.<sup>2</sup>*

Sponsors, boards, and senior leaders of Catholic Health Care in Ontario are living within this context. The surety that publicly funded Catholic Health Care will continue into the future, despite government rhetoric and assurances, is no longer clear.

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2 (Health Communiqué - Ontario Newsletter, February 24, 2004: Bill 8: An Illusionary Accountability? Kathryn Frelick; Joshua Liswood; & Catharine Schiller. <http://www.millerthomson.ca/issue.asp?NL=22&Year=2004&Season=131> – Accessed January 4, 2004

Over the years, many in Catholic health care have suggested we are “different,” but a quantitative and qualitative assessment of these differences has been sorely lacking in the literature. While we could historically refer to our religious foundations as the basis and framework for our commitment to the sick in our midst, recent public opinion especially related to Church abuse scandals might suggest Church affiliation could generate greater suspect than assurances for the general public.

*. . . Institutional silence [on allegations of abuse] confused two very different matters: sin and crime. We treated as sin that which was also a crime. A crime is something a democracy handles in the public realm, through the police and the courts. A church has neither the capacity nor the authority to handle the criminal behavior of citizens.*

*So, we move ahead as Catholic people. We move ahead as God’s People. We need to change our silent ways. We need to learn how to be a church . . .*<sup>3</sup>

How will we, as Catholic Health Care health care sponsors and providers, respond to public and political calls for accountability, efficiency, and effectiveness within our organizations? How will we explain our call to this mission of healing and work collaboratively with our public counterparts, without losing our spirit and corporate soul?

This task has, in many ways, been embraced and accomplished through the canonical sponsorship requirements of any Catholic facility, especially as they relate to mission and religious and spiritual care. Advocates of strategic planning suggest that futures – of individuals or corporations – rely less on chance and more on strategy development.

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<sup>3</sup> *Monsignor Frank Kelley. Pastor of the Church of the Sacred Heart, Roslindale, Massachusetts. Editorial, Church Magazine, Summer 2002.*  
<http://www.nplc.org/church/sabuse2.htm>)

Good planning for leaders in Catholic Health Corporations in our current environment must include the following dimensions which will be reviewed in this paper.

- The essential role of mission for all organizations – Research & Best Practice
- The mission of Catholic health care
- Sustaining the mission of Catholic health care
- Our current reality: Assessing the mission and religious and spiritual care in Ontario Catholic Organizations
- Securing the future of Catholic health care: Requirements and Implications

### **THE ESSENTIAL ROLE OF MISSION FOR ALL ORGANIZATIONS: RESEARCH AND BEST PRACTICE**

Most organizations, from McDonalds to Toyota, have developed a mission statement. Despite their front-row profile in for-profit and not-for-profit organizations, limited research had been created on the development and efficacy of mission statements. A mission provides a written, formal document that attempts to capture an organization's unique and enduring purpose and practices (Byars, 1984; Bart, 1996; Glasrud, 2001). A mission statement should find itself central to every firm's strategy. It should be enduring (not have a time frame); passionate (emotionally charged); and lacking in specific quantitative measurements (financial goals). Glasrud (2001) adds to the characteristics of mission statements, suggesting they should invigorate volunteers; catalyze public support, and prepare an organization for the future. He notes some non-profit mission statements focus on the present reality, which can fail to stir much passion for the creation of a better tomorrow.

Many authors have outlined the rationale for the development of mission statements.

1. Providing a more focused basis for allocation of resources (Ireland, 1992; King & Cleland, 1979; Gibson et al, 1990)
2. Motivating and inspiring members throughout the organization to achieve a common goal or purpose (Campbell, 1989; Campbell, 1993)
3. Creating a balance among the competing interests of different stakeholders (i.e., customers, society, shareholders, and employees) (Klemm et al, 1991)
4. Refocusing an organization during a crisis (Campbell & Yeung, 1991)
5. Creating behavioural standards, (Bart,1996)
6. Providing a common purpose or direction (Campbell & Yeung, 1991)
7. Defining the scope of the business (Campbell & Yeung, 1991)
8. Allowing the CEO to assert control over the organization (Klemm et al, 1991)
9. Developing shared values or cultures within the organization (Campbell & Yeung, 1991)

Pearce (1991) and David Pearce II & F. David, (1987) demonstrated a significant relationship existed between selected mission statement components (the organization's philosophy, self concept, and public image) and "high" versus "low" performing Fortune 500 companies. Despite the many endorsements for creating organizational mission statements, Gibson, Newton & Cochrane (1990) examined quantitatively the use of mission statements in hospitals. They measured seven components of mission statements: customers, product, technology, organizational goals, organizational philosophy, self-concept and public image, and found "customers" and "organizational

philosophy were components most frequently used by hospital managers. Concepts such as “self-concept” and “technology” were least used items. The study did not examine the inclusion of mission items suggested by other researchers. Ginter et al (1998) noted “a great deal of disagreement remains regarding [the] value of mission statements and the influence these statements actually have on behaviour within the organization.”

Bart & Tabone, (1998) studied the process of development and use of mission statements in not-for-profit health care organizations, suggesting mission statements and the processes by which they are formulated should be substantially different in the not-for-profit sector because mission statements appear to serve a different set of ends in not-for-profits versus other types of organization. There should be a “fit” between the organizational mission statement and processes (i.e., job design, strategic planning systems, budgeting system, performance evaluation criteria, leadership styles, etc.). The mission statement should help to keep not-for-profit organizations focused, and in so doing, act as a surrogate bottom line. (p. 56-57) Of interest in this study of 496 executives of English-speaking, Canadian health care organizations with a budget in excess of \$2 million (response rate of 20.8%), was that very few managers perceived their mission statements to be “totally aligned” with any of their hospital’s formal organization’s arrangement. The majority indicated their mission statements were only moderately attuned to their organization’s structural components. The more an organization’s component was aligned with the mission, the more the managers expressed satisfaction with how that component was set up and managed (and vice versa).

Subsequent research by Bart & Tabone (2000) noted hospital mission statements that were intended to guide and focus decision-making, motivate and inspire employees behaviour toward a common purpose, and create a balance between the competing interest of various stakeholders, usually also lacked specific quantitative measurements, lacked time frames, and yet were passionate and inspiring.

Bart & Baetz (1998) found a connection between selected mission content items (i.e., financial objectives, values, purpose, business strategy, length) and performance measure such as return on sales, return on assets, percentage of change in sales and percentage change in profits. They also examined the impact of mission statement processes quality (who is involved in developing the organization's mission statements and making the mission statement "live" in the organization) on organizational performance, and found that satisfaction with the mission statement process correlated fairly strongly with organizational performance. There was a significant and positive correlation between the number of internal stakeholder groups involved in the mission statement development and two outcome measures: return on sales and influence on employee behaviour. In a 1997 study, Bart found the involvement of five stakeholder groups (CEO, senior management, middle management, non-managers, and customers) correlated positively with satisfaction with the mission statement process. Bailey noted, "A diverse group of individuals can improve the final product because each sees the ultimate mission of the organization in a different way. By combining perspectives, the various groups will be able to focus on the elements that most would agree are the critical ones." (Bart & Tabone, 1999)

The connection between mission and human intellectual capital was noted by Bart (2001). Various intangibles that make up the difference between market and book value are being identified, dissected and analyzed. Old notions that have been traditionally ascribed to goodwill among staff (e.g., intellectual property rights, such as patents, trademarks, and the like) are no longer considered sufficient. What has emerged is a robust new concept called intellectual capital which now appears to be challenging (and intent on replacing) the monolithic notion of goodwill. (p. 320) The organization's intellectual capital is best described in three main components (Bontis, 1999; Bart, 2001, p. 320-321)

1. Human capital, including the collective knowledge, education, skills, attitudes, and experience of employees
2. Structural capital, including the collective (and often proprietary) routines, systems, processes, and information within an organization (*including its culture*) that help – or hinder – employees in the pursuit of organizational performance excellence.
3. ***Relationship capital***, including the value of relationships with those stakeholders external to the organization, such as customers, suppliers, and regulatory agencies.

Bart (p. 322) also noted that one of the essential keys to mission fulfillment appears to be the degree to which the organizational members know, understand, and are committed to their organization's mission. When employees share an awareness, knowledge and

understanding of their organization's mission (and passionately support its stated course), they should achieve the mission's goals and objectives much more rapidly, and with greater boldness and confidence, than those organizations which do not. The mission statements, through the effect they hold over the organization's human intellectual capital, can have either a positive or negative impact on performance, depending on whether the mission is remembered or not; understood or not, engenders commitment or not; and either promotes shared values or not. To the extent that a mission statement has a positive effect on an organizations' human intellectual capital, the evidence is unequivocal in its conclusion that positive performance consequences will follow. To the extent that organizational members support their organization's mission with fervent conviction, this should make it more likely to be achieved and less a situation of "mission impossible."

Brown & Yoshioka (2003) noted the mission statement helps define an organization, expressing its values and envisioning its future simply and clearly. Often, the mission statement attracts clients, donors, funders, employees, and volunteers to an organization. (p. 5) Staff will stay with their organization if they believe in the mission of the organization and have a desire to help people; are satisfied with the organization and their co-workers; and are satisfied with their jobs and opportunities for personal and professional growth (p. 13).

Aspects of non-profit organizations compel them to keep the mission central in decision-making. The mission is the bottom line for non-profit organizations. (Sawhill and

Williamson, 2001). Non-profit organizations must use the mission as a management tool that sets their agenda (Garner, 1989). The nature of non-profit organizations places an expectation on employees to work for the cause, not for the paycheques, as non-profit organizations are unable to compete with for-profit organizations in providing pay and incentives (Brandel, 2001).

At least three basic principles influence employee attitudes towards the mission: awareness, agreement and alignment (Brown & Yoshioka, 2003, p. 8). Employees must agree with the expressed purpose and values of the organization. If employees are going to work for what may be lower compensation, they need to perceive agreement between their values and those of the organization (Kristom, 1996). Employees need to perceive a connection between their work and the fulfillment of the mission.

Researchers have identified several predictable indicators of performance that can be used to assess an organization's vital signs (Perrone, 2001). These indicators relate to whether people feel empowered to act, identify with the organization as a whole, manage conflict, and engage in continual learning. Organizations must ensure that every individual understands where the organization is going and is deeply committed to its success (embracing the mission). Improvement must become a daily discipline and continual learning a way of being. Even experienced managers cannot survive on past know-how. The collective intelligence of people at all levels of the organization is needed to solve problems with no easy solution. (Laabs, 1998 p. 170; Forum, 2000)

Does this kind of invitation to living the mission at all levels of the organization really work when it is brought into the typical work situation? People are extremely reluctant to experiment with new ways of being. If you think of yourself as a circus high-wire performer struggling to get across a swaying tightrope, the last thing you need when you cannot afford to make a mistake is someone yelling at you to try a new move. That is what it feels like to organizational survivors when managers exhort them to challenge the status quo and find new ways of living the mission. If organizations want people to step out onto tightropes, they must first provide safety nets in the form of leaders who will support people in taking risks and experimenting with new ways of bringing the mission to life. In many organizations today, there are no safety nets. People will be self-motivated when they are doing something they believe in. When people share a commitment to the achievement of a compelling goal (mission), extraordinary things happen.

### **THE MISSION OF CATHOLIC HEALTH CARE**

Father Frank Morrissey is recognized as a “fountain of wisdom” in the area of defining the key determinants of a ministry of the Catholic Church.<sup>4</sup> Sponsorship of health care by the Catholic Church requires that the Board, leadership, staff, and community we serve are aware of the connection between the organization’s mission and the mission of Jesus. The ministry of health care is not initiated from a purely business perspective. Rather, it reflects the Church’s response in love through the compassionate action of health care as we meet the needs of the community in which they serve.

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<sup>4</sup> Notes from presentation by Fr. Frank Morrissey to the Catholic Health Corporation of Ontario and its sponsored agencies – Sept 24, 2003.

We have noted the concept of “co-responsibility” between the Catholic health sponsors and the Boards for the health care ministry offered on behalf of the Catholic Church. Specifics which for with sponsors and boards of Catholic institutions are responsible include the following:

1. Ensuring the **mission is animated** throughout the organization.
  - a. The ministry of health care is a direct mandate of the gospels, evident in Jesus’ invitation to us to feed the hungry, clothe the naked, and heal the sick (Luke 9:2).
  - b. It is the responsibility of the Sponsors to ensure the mission of the organization is “lived and breathed” at every level of the organization.
  - c. This assumes the mission forms the foundation for leadership and policy decisions.
2. **Promoting** the mission
  - a. Resources are made available to ensure the mission is supported in the organization’s culture
3. Assuring the **mission is carried out**
  - a. The sponsors have a responsibility to ensure the mission is lived throughout the organization. Various activities can be incorporated to measure the effectiveness of mission dissemination in the organization
4. **Stewardship**
  - a. Sponsors are responsible for ensuring the organization makes wise and prudent decisions regarding fiscal allocations

- b. Sponsors are fully aware that receipt of public money requires public accountability, ensuring appropriate utilization of scarce resources and budget decisions consider the impact on the mission and values of the facility

5. **Fidelity to a tradition and heritage** found in the Catholic Church

6. **Shared responsibility** between the sponsors and the local board

- a. Defining how operational decisions are carried out on behalf of the Catholic Church.
- b. Ensure decisions support the moral and social teachings of the Catholic Church.

7. **Accountability**

- a. Ensuring the ministry of the institution is in keeping with Catholic tradition
- b. Ensuring Church requirements, both local and central, are supported by the institution

Sponsors provide a formal relationship that links the Catholic Church to the apostolic work of the institute, working to sustain the mission of the Church. This work does not need to be connected to a building. Institutional sponsorship identifies a ministry or institution to the Catholic Church. We are no longer *only* good people who come together to meet the health and social service needs of the people in our community. We are marked by the sign of the cross as those people who have been *called* to serve in

direct response to Jesus' and the Church's mandate to respond out of love and compassion to the needs of people in our midst.

Our commitment, as Catholic health care providers, must answer questions related to these four foundational elements.

1. Mission

- a. What is our mission as a sponsor or Board of a Catholic Health Care institution? How is this mission lived out in our organizations?
- b. Is the meaning of life always defined in relationship to God?
- c. Do we regularly evaluate our decisions and services based on our mission and values?

2. Sponsorship

- a. What is the institutions relationship to the Church?

3. Holistic Care

- a. Does our ministry in health care focus on the whole person (staff and patients/residents/families) – not only on a disease or on particular system, but including care for the spiritual, physical, social and emotional aspects of every person we serve?

4. Ethics

- a. Do we as sponsors, struggle with questions of what is good for individuals and society, evaluating how we relate to ourselves, others, and our society at large?

## SUSTAINGING THE MISSION OF CATHOLIC HEALTH CARE

Cox (2004) suggests that future Catholic health care organizations will not be able to justify and claim the name “Catholic” if an understanding of mission does not exist at every level of the organization. The mission cannot survive if Catholic Health care organizations do not find a way to retrieve it, renew it, maintain it, and pass it on. Cox, speaking at the Sept 18<sup>th</sup> Catholic Health Initiatives 2004 National Leadership Conference in Vancouver, British Columbia, noted one initiative – the Ministry Leadership Centre – which was designed by five Catholic health systems in the western US to address the strategic challenge of finding ways to persevere and transmit the understanding of the Catholic health care mission today.

*“The center’s goal [Ministry Leadership Centre] is to develop in each participating health care system a critical mass of committed leaders who sense a personal calling and are in fact called to a vocation in Catholic health care; who are confident and competent in their ability to integrate an understanding of mission into the operations and governance of the ministries for which they are responsible; and who are able and willing to mentor the next generation of health ministry leaders.”*

When examining the nature of the Catholic mission in health care and what would be lost if it ceased to exist, he suggested:

*“For patients, the Catholic approach to health care can mean the difference between an experience of hope and healing, and an experience of isolating, mechanistic cure. Most people value a spiritual dimension to their care. They don’t want to be proselytized or converted, but when they are sick and vulnerable, they want their entire being respected and attended to . . . Catholic health care’s transformative presence is necessary to keep respect for human dignity at the centre of medicine and healing.”*

To be faithful, Cox suggests it is essential that ways be found “*of renewing the religious character of our health care institutions and enabling the next generation of leaders to both own it and transmit it.*” He noted that many observers do not believe that Catholic health care institutions will close, but rather that they will lose their religious character. Some observers, like the regarded Jesuit theologian Richard McCormick, believe that dissipation of the Catholic mission in institutional health care is well under way and may not be reversible.

While Cox notes the critical elements inherent to the mission of Catholic health care, he also provides a list of distinct threats to this ministry.

1. Health care has been transformed from centres of care and comfort to centres of high tech interventions and cure. For Catholic health care providers, there is a need to balance our capacity to provide high tech care with our spiritual capacity to provide these benefits in an atmosphere permeated by human warmth and compassion.
2. Our cultural values have shifted from a basic respect for human life to a sense that human life is expendable if the personal or financial costs appear to be excessive.

The question arises: Are institutions that profess a specific religious affiliation and those inherent values entitled to the same government support granted to institutions founded on purely secular principles?<sup>5</sup> In March 2003, the California Supreme Court affirmed a state law that puts California in the position of determining which entities of the Catholic Church are or are not ministries for the purpose of requiring them to provide state-mandated birth control benefits in their employee health plans. The

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<sup>5</sup> Avery Dulles, “Continuing the Conversation: A Pluralistic Society Has Room for Various Religious Traditions,” *Health Progress*, Jan/Feb. 1995.

state's highest court concluded that Catholic Charities is a secular agency unrelated to the church's religious mission and is not entitled to protection under the First Amendment. It would take only a small leap of logic for other US states (and some in Canada) to conclude that Catholic hospitals are also secular entities and are therefore required to provide abortion or other services antithetical to their religious beliefs.

3. In an effort to accommodate partnerships, mergers between Catholic/non-catholic organizations can erode fundamental Catholic values and responsibilities.
4. The government's role in financing health care can at times, limit Catholic health care's mission to serve the poor. State and federal budget politics have resulted in reduced public program payments to providers.
5. Unlike our American Catholic health care contemporaries, Canadian health care continues to be seen as a social good, not being treated as a commodity. However, today's price-driven markets have increased financial pressures for all health care facilities. Market values are often in fundamental conflict with the values that shape the religious character of Catholic health care. The threat, as Cox notes, is two-fold. Market forces by themselves, do not recognize and honour the demands of justice. In addition, market forces foster a commercialized culture that can be corrosive of the moral and spiritual foundations of Catholic health care.
6. In today's health care environments, where the non-insured and chronically ill too often represent economic risks to be avoided, the demands of financial survival can seduce a Catholic health care organization into embracing the culture of the market and behaving as if health care is simply another market commodity, not a service necessary to the achievement of human dignity. In doing so, Catholic health care

organizations may begin to look less like ministries and more like highly competitive businesses; instead of being a transformational presence in the marketplace, they may be transformed by the market.

The most significant concern about the future of Catholic health care is that these hard realities are occurring at a time when there are fewer women religious available to help the system and facilities develop effective ministerial responses. Those “culture bearers” (Cox, 272) are largely absent from the administration of Catholic health care organizations and less available for their governance. That culture, anchored in the healing mission of Jesus, is Catholic health care’s *raison d’être* – its meaning and purpose. Catholic health care has been losing its religious distinctiveness in many subtle and not so subtle ways for a very long time. Retrieving Catholic health care’s identity in the present context will demand more resources than its leaders can reasonably command. Should we, as Catholic health care providers, work diligently to preserve our capacity to serve in this ministry into the future?

Reverend Martin Marty<sup>6</sup> has identified the qualities that animate the Catholic approach to health care. Engaging in the mission of Catholic health care means that *all* dimensions of being are penetrated by the call. Catholic health care ministry rejects “chopping up” the elements of personhood to fit into bureaucratic pigeonholes. Our mission is to be concerned for the soul, or what Marty calls “*the integrated vital power of any organic body.*” He reminds us that we all hunger to be seen for the totality of who we are, not just a diseased heart or billing opportunity. At times of sickness and vulnerability,

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<sup>6</sup> Marty, Martin E. (1995). Can we Still Hear the Call? *Health Progress*. Jan-Feb

Catholic health care is called to be a visible sign of God's healing presence in a world that is often harsh and can appear to lack meaning. The concept of human dignity, considered by some to be the lost child of the medical and health care delivery system is central to our mission. This multi-faceted foundation for our mission is enhanced by our belief in the value of ritual, recognizing that rites of passage are essential to transforming life transitions from "matter of fact" experiences to embraces of the Divine in our lives. In addition, Cox adds to Marty's list suggesting the mission of Catholic Health care must include a preferential option for the poor. (The definition of "poor" extends beyond the definition of poverty offered by economists, and includes the emotionally, relationally, and spiritually poor as well.) When decisions are made, as stewards of the mission of Catholic health care, we must ask the question, "What is happening to the poor as a result of this action?"

Our dominant Canadian culture has become secular. We, as faith-based health care providers, sometimes feel we are placed in a position of defending our role in the ministry of health care. The question which is asked of faith-based providers in health care, as in education, is why have a faith-based system at all? Does anyone really care who delivers health care as long as there are those who will care for me when I am sick? Why should public money go to faith-based providers? Probably a more fundamental question we must ask ourselves is, "Are we, as Catholic health care providers, any different than our secular counterparts? If we are different, how is this difference expressed, and does anyone recognize the difference?" Have we told the public we serve, exactly who we are, why we provide health care, and how they can expect to be cared for

because we are faith-based? If the communities in which we serve are not standing up in revolt at the thought of losing Catholic health care providers, than perhaps it is time we strategically defined the distinctiveness of Catholic health care in the Province of Ontario. There is a word of caution here that must be raised: If we articulate our differences, we must be willing to be judged by those with whom we work and those we are called to minister to.

**OUR CURRENT REALITY  
ASSESSING THE MISSION AND RELIGIOUS & SPIRITUSL CARE IN  
ONTARIO’S CATHOLIC HEALTH CARE ORGANIZATIONS**

In 2002, O’Hara consultants were contracted by the Catholic Health Association of Ontario (CHAO) to review mission and religious & spiritual care services offered in member health care agencies. Two questionnaires were developed by Sister Mary Buckler (Grey Sisters of the Immaculate Conception, Pembroke) and distributed to 34 health care organizations (CHAO members). The goal of the surveys are noted below.

1. To assess the manner in which Catholic mission-driven health care institutions operationalize and embrace their mission.
2. To assess the status of spiritual services currently being offered in these facilities to patients, residents, visitors, volunteers, and staff.

Both questionnaires relied heavily on open-ended questions that would not bias or constrain respondents.

**Reviewing the Data**

Twenty-six organizations (80%), completed the mission services questionnaire, and the spiritual and religious care questionnaire.

Mission Data:

- Staffing:
  - 47% identified a Mission Director or committee with responsibility for mission
  - 37% described someone with combined responsibilities for Pastoral Care and Mission
- Responsibilities
  - Defining the mission (which may include other key stakeholders in the mission statement development)
  - Promotion, communication, and education re mission
  - Integration of mission into all systems within the organization
  - Evaluation of mission promotion, communication, education, and education effectiveness
- Funding - Director of Mission position
  - Internal sources – e.g., global funding.
  - Two facilities received external funding
- Role of Sponsor in Selection & Hiring
  - 53% - nil
  - 10% - limited
  - 37% - very active
- Mission Program Development

- Overall, mission effectiveness has existed in responding facilities for an average of 22.3 years, with the most recent reporting 2.5 years and the longest mission effectiveness program of 115 years.

➤ Organization

- Mission effectiveness is a full-time position (6 organizations) or a position shared between 2 people (1 organization)
- Those responsible for mission dedicated, on average, 42% of their time to mission
  - 62% have a dedicated department or program for Mission services
  - 68% organized mission services as a committee or team
  - 10 facilities noted mission is covered during vacation periods (either by a member of senior management or pastoral/spiritual care)

➤ Qualifications

- Education in theology was identified by almost half of responding facilities. Facilities sponsored by CHCO were more likely to stress education in theology, specific qualifications such as CAPPE (Canadian Association for Pastoral Practice and Education) and experience in pastoral ministry. Facilities sponsored by RHSJ Health system were more likely to stress interpersonal qualities e.g., the ability to inspire and educate; effective communicator, etc.

➤ Continuing Education

- 78% identified ongoing education related to conference attendance (CHAO, CHAC, CAH US, and ethics workshops), reading journals, and establishment of a “report card” identifying key indicators. Two respondents noted limited access to professional development opportunities secondary to workload and resourcing
- Participation in Senior Management
  - 76% (19/25) Mission Directors are full members of Senior Management. If Mission Directors are not part of senior management, the majority report directly to the CEO, an administrator or other member of senior management
  - 72% attend all Board meetings.

### Religious & Spiritual Care

- Staffing
  - All but one (community health care provider) indicated a distinct department or program for the provision of spiritual and religious care
  - Full-time staff (88%); part time (68%) staff; both full-time and part-time staff (52%)
- Qualifications
  - Director Spiritual & Religious Care
    - 68% - theology; pastoral ministry; CAPPE certification
      - Graduate degree (CHCO sponsored facilities; St. Joseph’s Health System, Hamilton)

- Reporting Relationship
  - Directly to the CEO or VP (58%) – particularly true of CHCO sponsored organizations
  - Ecclesial Involvement
    - Approval of personnel appointment (88%)
- Sources of Professional Support
  - CQI or Spiritual Care Committee (47%)
  - Ethics Committee (41%)
  - Other sources of support
    - Senior management, VP, CEO, Board
    - Administrative/member facility
    - Archdiocese and/or local parish
    - Director of Mission and/or Mission Committee
    - Pastoral services team
    - Pembroke Ministry Association
- Availability
  - 7 days/week (60%)
  - 5 days/week Monday to Friday (40%)
    - One facility had no “on-call services”
  - Statistical data available related to referrals, workload measurement, etc was available
- Programming offered
  - Sacramental ministry

- Paid service (71%)
  - Daily or weekly Protestant services
  - Bereavement/grief support/counselling
  - Palliative support
  - Special feast day services
  - Inter-denominational or non-denominational services
  - Pastoral care visits
  - Counselling for patients/staff
  - Education in religious & spiritual programs
  - Crisis intervention
- Standards of Excellence
  - Department-specific standards created (91%) based on:
    - CHHC, CHAO, CAPPE/CAPE (71%)
    - MOH; multi-faith guidelines; in-house standards
  - Standards monitored by
    - Director/Coordinator
    - CEO and/or Board
    - Manager or supervisor
    - Mission Effectiveness
    - Ethics Committee
    - Sponsor (one facility)
- Funding

- Global funding (70%); Donations (13%); Sponsors (4%); from other programs (13%)
  - Departmental budget increases over the past 5 years secondary to salary or funding envelope increases
    - .08% to 41% (St. Joseph's Health Centre, Toronto)
  - Departmental budget decreases over the last 5 years secondary to overall funding reductions
    - St. Joseph's Health Centre, Sarnia (-30%)
    - St. Michael's Hospital, Toronto (-12%)

### **SECURING THE FUTURE OF CATHOLIC HEALTH CARE: REQUIREMENTS & IMPLICATIONS**

Catholic health care providers have a number of “balancing acts” which must be accomplished in every aspect of its ministry. Along with civil and canonical responsibilities, the Board is responsible for ensuring the organization attains and maintains “cutting edge” ministry which is research-based, reflects the board’s commitment to quality, accountability, and transparency while recruiting/supporting the Board’s only employee – the CEO. This mandate is a tall order for any organization – and an absolute requirement for Catholic health care organizations.

The critical role of mission as well as spiritual and religious care within Catholic health care facilities must be recognized and supported by all who called to leadership in this ministry. Kammer (2001) notes *although today's Catholic hospitals still possess religious*

*names and religious ornamentation, they often seem more technological than ministerial, more bureaucratic than blessed. This reality underscores the importance of mission, charism, and sacred stories in our ministry. We need to find new ways of highlighting the ministerial nature of the institutions, the specialities, and the staff of all types.”*

As those who are called to the **ministry** of Catholic health care leadership, we are accountable to our sponsors, boards, patients/residents, staff, and the communities we serve for identifying why we exist as distinct entities and what really makes Catholic health care different from other publicly funded health care organizations. While integration of mission within all levels of organizations is now considered rudimentary in the development of business acumen, focus of mission through identification of dedicated mission director staffing positions, as well as spiritual and religious care staff can set Catholic health care providers in a “different league” and in a sense, “brand” Catholic health care as distinct from public counter-parts. The question which sponsors, boards, and staff must grapple with is if the personal experience of “value added” which we ascribe to both mission integration and spiritual & religious care, is sufficient to support autonomy within the broader political agenda of fiscal constraint and government control. If the general public in communities where we serve in Catholic health care ministry would not stand up in protest at the thought of losing the Catholic health care provider, we have some serious reflection and work to establish ourselves as the “leaders of the pack” or “preferred providers” in our communities.

Traditionally, Catholic health care providers have worked diligently to blend in with the crowd. These days of political agendas and fiscal realities call us to proactively respond to public demands for accountability, which inherently requires standards' identification, monitoring, and evaluations which is publicly disclosed. We may have unconsciously shied away from overt discussions of the unique role of Catholic health care secondary to our own confusion of how we could quantify what is often viewed as enhanced qualitative experiences of services offered or work-life environments.

As the song says, "The times, they are a changein.'" Despite this ever-changing environment, may we continue to touch into our commitment to be gospel people, to be a healing presence in the communities in which we serve, and to be a voice for the poor and marginalized whom we are privileged to serve. Like the apostles, we are called and sent out to proclaim the good news. May we do so with passion, with great love - - and finally with strategies and data which will assuage the critics who see this ministry as a duplication of our secular norm. The for-profit business sector suggests that competition generates quality. May we in Catholic health care ministry continue to offer an alternative service, which promises and delivers care for the body as well as the soul.

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