Forming Health Care Leaders: A Guide

Catholic Health Alliance of Canada

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Foreword

On behalf of the Joint Associations of Sponsors and the Provincial Associations who, together with CHAC, funded the development and publication of this Guide and the studies that led up to it, we are delighted to present an outline for learning about carrying out the Catholic mission in health care and related social services in Canada.

Leaders in changing times are cognizant of the many challenges being faced each day. It may have seemed easier when the lay people in Catholic organizations could rely on the Sisters to set the tone, to be vigilant about our mission and values, to carry on the ministry of Jesus with clarity and courage. Now others have to shoulder the responsibility.

This document attempts to provide an introduction that also functions as an annotated curriculum. It does not attempt to be definitive; one must look elsewhere for a more thorough treatment of its themes, and Appendices C and E provide starting points for accessing further resources. Just enough content has been included in this Guide to ensure that the nature and rationale of the curriculum suggestions are clear.

Part of that content is quotations from the Catholic health care leaders of today; these have been chosen to help ground the Guide's suggestions in current practice.

The Guide identifies the themes that must be included for developing an adequate grasp of leadership in a Catholic health care or social service environment. These are the minimum; to aim at less than what this Guide sets out is to aim too low; hopefully everyone will be inspired to aim higher. The material in some of the appendices is intended to help with that further reaching.

The Guide responds to an urgent need identified by the Joint Associations of Sponsors and the Provincial Associations in 2004. But this is not the end of the story; rather, the beginning. Their expectation is that leadership development reflecting this curriculum will flourish, for Trustees and CEOs and for others too. Moreover, ecclesiastical authorities—our diocesan Bishops and the Vatican—might refer to this Guide when specifying their expectations of the stewardship exercised by Catholic health care leaders.

We thank our consultants, Robert Czerny and Margot Cameron of Agora Management Associates, Ottawa, for researching and writing the Guide; Brian Cameron for editing and production; and Annita Watkins for design and layout. We also thank our colleagues who participated in interviews and virtual focus group discussions and reviewed the draft text. And a special thanks to the support and assistance of CHAC through the five-year path to this Guide.

We hope that this Guide will enable every reader to understand the Catholic health care mission better and find or create learning activities to further that mission. Please contribute to the Guide's continuing utility by offering criticisms and suggestions.

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Summary

1 Introduction: A Learning Link Between Past and Future

Why this kind of Guide? Why now?

Until recent times, trustee and executive leaders of Canadian Catholic health care and social service organizations could learn about the Catholic aspect of their responsibilities from daily contact with the Sisters who founded the organizations and led them for so many decades, even centuries. This is no longer the case, so other sorts of learning are needed now to help present and future leaders to fulfil their obligations under the sponsorship arrangements that have them acting on behalf of the Church.

What is the purpose of this Guide?

The Guide recognizes that leading, or working in, a Catholic organization requires special theoretical and experiential knowledge and different emphases in addition to those needed in a non-faith-based organization. The Guide is intended to assist the reader to understand and apply these differences to learning about leading Catholic health care organizations. It therefore serves several purposes.

- First, it is intended to help executives and managers of Canadian Catholic health care organizations to identify requirements for learning activities focusing on the Catholic character of these organizations. The Guide identifies the core themes that any curriculum should cover in order to address the learning and development needs of staff, physicians and volunteers in Catholic

health care organizations, with a special emphasis on senior-level leaders.

- Second, it is intended to assist in the design and delivery of these learning services.
- Third, the Guide may be used to stimulate discussion of what it means to be a Gospel-based organization in the Catholic tradition, and how that meaning should be put into action by integrating Catholic values into every aspect of the organization's operation, including governance, administration, and care delivery.
- An additional purpose is to assist dialogue between Catholic organization leaders and other health care leaders by identifying what they have in common and where the Catholic situation is unique.

This Guide is intended to be the beginning of a learning process. The curriculum suggestions are supplemented by the rationale and basic explanation of each element of that curriculum. However, the Guide stops far short of being a full explanation or of mentioning all possible worthwhile topics. The Guide will be successful if individuals and organizations are inspired and assisted in going further; see the appendices for help in this regard.

For whom is it written?

- The main audiences are those who are seeking, and those who want to provide, learning activities about service and leadership in Canadian Catholic health care organizations.

- Anyone who wants to reflect on and discuss the essential characteristics of Canadian Catholic health care—particularly those engaged in health care ministry as volunteers, front-line workers, executives or Trustees—should find the Guide useful.

Is it optional or mandatory?

This is an optional aid to all our Canadian Catholic health care organizations, arising from the desire of the Joint Associations of Sponsors and the Provincial Associations to provide strong support to all involved to address their learning needs.

Where does it apply?

The Guide is written at a general and pan-Canadian level; it is intended as a starting point that can be tailored to the particularities of local situations by those responsible for local learning activities.

Origins and acknowledgements

The Guide is the product of a process that began with a 2004 decision of the Joint Associations of Sponsors and the Provincial Associations. Thank you to the dozens of practitioners and experts who contributed via interviews and virtual focus groups and through earlier studies and reports.

2 Overview of Catholic Health Care Service in Canada

What is distinct about the identity of Canadian Catholic health care organizations?

- The mission of Catholic health care is rooted in the Gospels of Jesus; its identity and values come from this source, from the Church and from the founding Religious Congregations.
- Several key values are the trademark of Catholic health care organizations: human dignity, respect for life, social justice, compassion and spirituality (which includes human wholeness).
- Canadian Catholic health care organizations are expected to pursue and apply these values with extraordinary focus and energy as a matter of policy—it is part of their mandate, not a matter of individual preference.
- In the past the Religious Congregations reached out to care for the sick, the poor and most vulnerable in society without great reserves of resources but with faith that this was God's work. They invited men and women of many backgrounds and walks of life to share in ministering to others and advocating for the common good. Continuing this invitation is one of the tasks of our health care leaders.

Who is responsible for our mission, vision and values? Who puts them into action and who leads?

Our organizations understand "service" in three ways, and each involves dimensions of leadership.

- Inspired by the healing ministry of Jesus and in a particular way by the parable of "The Good Samaritan," we come together in order to *serve those in need.*
- Guided by the example of the life of Jesus and his call to "Love One Another," those who serve those in need must also *serve one another.*
- The action of Jesus in the "Washing of Feet" sets the example of *leading and serving those who serve*. This "servant leadership" applies especially to those who have executive, managerial and supervisory responsibilities.

3 Mission, Vision, Values

What is the significance of "mission, vision and values" for Catholic health care organizations?

They state how the organization intends to continue the healing ministry of Jesus—the essential, unchanging mission—in a particular place and time.

How are the mission and vision kept dynamic?

- Mission and vision should be renewed regularly; the values, history and capacity of the organization, the needs of the community, and what governments and partners contribute should all be taken into account. They should also be reinforced in various ways, such as mission awareness days and inclusion in orientation sessions.
- Stories from the past and about current experience help to make the mission, vision and values real.

What are the key values of Catholic health care?

- The key values are human dignity, respect for life, social justice, compassion and spirituality (including human wholeness).
- Other values of great importance are respect, diversity, personal growth, care, hospitality, generosity, integrity, excellence, and accountability.
- Stewardship is an all-encompassing value, particularly for those in decision-making positions.

What is the practical impact of the values?

The values should influence all the interactions in the organization, resulting in a culture distinguished by their articulation and practice. They should be integrated into human resources processes (including recruitment and performance monitoring), strategy planning, and program and Board decisions.

4 Social Justice

What does "social justice" mean? What is the importance of this value?

- Social justice is grounded in fundamental values of human dignity and human interconnectedness.
- It follows the example of Jesus by engaging on behalf of the less powerful, the marginalized and the dispossessed.
- This requires vigilance, looking beyond the centre to the margins of our society and communities, and managing the organization so that it has the capacity to serve those most in need.

What inspires and informs this focus on social justice?

The life of Christ, the vision of the Sisters who founded our Catholic health care organizations, the ensuing histories of these organizations, and Catholic social teaching all help to shape our understanding of the social justice imperative.

What is the responsibility of leaders regarding social justice?

Leaders need to:

- educate and inspire;
- engage everyone in becoming aware of changing needs and social conditions;
- be a persuasive advocate and social conscience in the public sphere and in dealings with governments;

- create a capacity so that the entire organization can make a positive difference on behalf of the marginalized and voiceless; and
- manage their own resources justly and support social justice initiatives.

5 Spirituality and Human Wholeness

What is the place of spirituality in Catholic health care?

- Spirituality is essential because each unique individual is made up of spirit as well as mind, body and relationships.
- So caring for the whole person would be incomplete without attention to spirit; it would be "cure" but not "care."

Should our spirituality be specifically Catholic?

- Our Catholic spirituality stems ultimately from the passion, death and resurrection of Jesus, which gives meaning and hope to our suffering and dying. Its expression in health care reflects his healing actions and stories.
- At the same time, because of the diverse backgrounds of staff and patients or residents, we respect and accommodate other forms of spirituality (religious and non-religious) too.

Should our spirituality be visibly Catholic?

By maintaining an environment with visible signs of our Catholicism (crucifixes, statues, pictures) and providing Mass and other Catholic practices, we satisfy the needs of our own personnel and of those we serve; and we remain true to the history and culture of our organizations.

How do we apply spirituality and human wholeness in serving others?

- Human wholeness urges us to treat others as having supreme value. Among the values and skills that go into this are courtesy, genuine interest, patience, attentiveness and sincerity.

- Spiritual care can range from a warm, compassionate presence to prayer and pastoral functions. Spiritual care should be given by all, not only by designated pastoral and spiritual care workers. It should be offered, not forced, and respectful of the diversity of the people we serve.

What roles should spirituality and human wholeness play in the workplace?

- A spiritually satisfying workplace encourages staff to bring their whole selves to work, and helps them to reflect, celebrate and grow as full human beings. Prayer helps us to focus on our mission to carry on the healing ministry of Jesus.

- Spirituality needs to address the stresses of workers in health care at all levels.

6 Ethics

What is the relevance of ethics to Catholic health care?

- Ongoing ethical reflection and the promotion and protection of the dignity of all persons from conception until natural death are defining principles of Catholic health care.
- Ethics encompasses organizational, societal and environmental issues as well as the morality of particular medical procedures.
- Our foundations are fundamental belief in all of creation as God's gift and all humans as God's children, and the healing and teaching of Jesus.

How do Catholic health care organizations deal with ethics?

- As Catholic health care organizations, we are expected to use the *Health Ethics Guide* and to follow the moral teachings of the Church.
- The *Health Ethics Guide,* endorsed by the Canadian Conference of Catholic Bishops, serves as an essential tool and resource for all Catholic facilities in the area of ethics, decision strategies and education.
- Establishing a mechanism for ongoing participation of the diocesan Bishop is essential.

How should we ensure that we are well prepared to make proper moral and ethical decisions?

- Ethics touches everyone in the Catholic health care organization and all aspects of the organization. It is important that everyone have an understanding in this area.

- Leaders need to ensure that the organization is equipped to identify, discuss and decide on ethical issues.

7 Canon Law, Stewardship, Accountability, Community

To whom is the Catholic health care organization accountable?

The formal accountability relationships of the Catholic health care organization are from its CEO to the Board of the organization; thence to the Board of the sponsoring group; and from that Board to civil authority (for instance the provincial health ministry) on the one hand and to the Church on the other—either the diocesan Bishop or the Vatican.

What does it mean to be a "steward"?

- Stewards exercise delegated authority and carry out responsibilities that eventually result in accounts being rendered.
- At its broadest, stewardship is "The appreciation of the giftedness of creation and the exercise of responsibility in relationship to creation."

What does canon law bring to accountability and stewardship?

- Canon law specifies the religious and administrative obligations of an organization with a Catholic charter.
- The canonical obligation of a Catholic organization is to carry out the accepted task in accordance with the teachings of the Church, while administering ecclesiastical goods responsibly.

- The principle of subsidiarity tells us to bring decision making as close as possible to those who are directly involved or affected by the decisions.

What about engagement with the wider community?

The Catholic health care organization is also accountable to all whom it serves or may serve in terms of:

- its health services;
- its concern for the environment; and
- as a concrete expression of Catholic identity in the community.

There are many ways to engage with the community, from volunteer opportunities to formal partnerships. This engagement is a responsibility of all members.

8 Modalities of Learning

- The Guide is intended to serve as a curriculum for a variety of learning opportunities, ranging from personal reflection and group discussion to university-type courses.
- These opportunities can occur in the job setting, at other sites including universities, using on-line instructional materials, or with a combination of techniques.
- The Guide's approach is consistent with existing training for Catholic health care leaders.
- Catholic organizations are expected to offer learning opportunities to staff frequently.
- The curriculum themes listed are primarily for leadership development at the senior executive level but are also valuable for learning by others, such as volunteers, other levels of staff, and trustees.
- Recognition, celebration and commissioning events also provide opportunities for learning.

Appendices:

A. Catholic and Secular Leadership Capabilities Frameworks

- The 5C Capability Framework is a recent pan-Canadian guide to the essential characteristics and competencies needed by health care leaders in Canada.
- Frameworks of this sort are important for succession management as well as for recruitment and performance monitoring purposes.
- By showing the points of similarity between what this Guide proposes and the 5C Capability Framework, this Appendix establishes the "common language" for discussions between Catholic leaders and other Canadian health care leaders.

B. Performance Appraisal

Performance management, of which appraisals are one element, is required by modern health care organization standards. This Appendix mentions some aspects and suggests some questions that can bring a Catholic perspective into appraisals.

C. Christian and Catholic Values and Principles

This Appendix provides three useful summaries of the distinct values and principles that should guide the missions and ministries of Catholic health care organizations.

D. Catholic Health Care: Some Historical Background

This is a summary of the development of Catholic health care up to the 18th century.

E. Resources for Reference and Learning

This Appendix provides basic assistance to begin the next steps beyond the Guide itself, whether for personal study or to find or create programs. The entries are current as of March 2009.

The Appendix is not exhaustive; by no means should the reader assume that all worthwhile resources are listed here and that anything not listed has been judged to be inferior. Like the Guide itself, it provides a starting point for further work, rather than a description of everything that could be useful.

F. Reflection and Discussion

This provides some quotations from early Biblical times to the present to stimulate personal and group reflection and discussion.

G. Acknowledgements

This lists the people who are quoted in the Guide and who contributed to it in other ways.

1 Introduction: A Learning Link Between Past and Future

Why this kind of Guide? Why now?

Catholic health care in Canada has been undergoing a transition for several decades. Originally founded and led by devoted Religious Congregations, the sponsorship of organizations that have retained their Catholic identity has been passing from the Sisters to new arrangements that answer either to the diocesan Bishop or directly to the Vatican. The leaders are lay, not religious; the Catholics among them have varying levels of familiarity with Catholicism; and some leaders are non-Catholic.

We no longer have the conditions in which lay staff learned what it meant to carry out the Catholic mission of these organizations from daily contact with the Sisters. Some say that we are now two generations away from that pattern by which leaders were formed.

In the past, many Sisters served as role models who mentored new staff with one-to-one feedback that taught "the way" of doing things. They passed the torch of accumulated wisdom and practicalities to the next generation. (Steve Hill) [See Appendix F for information on individuals who are quoted.]

As a CEO of a long-term care facility, I often struggle with my limited knowledge of Catholic tradition, social teachings, etc. and what parts are important for leaders to understand for them to succeed in their leadership role. We need to capture that "je ne sais quoi" of our founders—the importance of values, mission and servant leadership (to name only a few). From my experience, the leader who "gets it" understands what it is we are trying to accomplish and how we best respond to unmet needs, to those who are vulnerable, etc. From my point of view this is what often needs to be learned though experience and leadership development. "The practical level of accountability for how we treat people" and the "permission to discuss values and behaviours" become the "vocation" some of us lay people discover from within, once we begin working for a faith-based organization. (Charles Gagné)

Now, with laymen and women not only providing almost all the staff but also leading our Catholic health care organizations, other means are needed to ensure that the leaders have the capacity to direct and inspire their organizations as *Catholic organizations.* This is essential to their role—as stipulated by *sponsorship,* they are acting on behalf of the Church. A different sort of learning needs to take place.

And it has taken place. Fine leadership development programs, for example, began as early as the mid-1990s; more have been devised and continue to be offered, some very successfully. However, the results were limited because they did not reach the majority of persons involved in leadership roles. Many more leaders, and others who may become leaders—the succession planning challenge—ought to benefit from training in what is essential to a proper understanding of Catholic health and social care.

The ministry of Catholic health and social service organizations is one of the visible expressions of the ministry of Christ. The Church—either a diocesan Bishop or the Holy See (the Vatican)—establishes and authorizes particular bodies to carry out particular ministries on its behalf. Two terms are important in this relationship: **Public Juridic Person**, and **Sponsorship.**

When the Church establishes a group as a **Public Juridic Person** (PJP), that group is authorized to perform functions, on behalf of the Church and in its name, that have legal implications—for example, signing contracts, owning property, and acting in court proceedings. The PJP is accountable to the Church. This accountability can take two routes. PJPs "of diocesan right" answer to the diocesan Bishop, whereas those "of pontifical right" answer directly to the Vatican (except on matters that pertain to the diocesan Bishop). In both types of PJP, there is a Board of Governors or Trustees that includes lay persons. The diocesan Bishop or his representative may be on the Board too, as may other religious (often from the founding Congregation).

The PJP is set up and acts on behalf of the Church in order to **sponsor** one or more organizations that are carrying out a Church ministry such as health care or social service delivery. The PJP delegates powers to the leaders of the organization so that they can carry out day-to-day operations. (According to the Church's principle of subsidiarity, policies and actions should be as decentralized as possible, bringing them as close as possible to the human realities that are being served, unless a more centralized approach is clearly required. The most "grass-roots" form of subsidiarity is for the free and competent individual to take responsibility for his or her own health care needs.) At the same time,

it monitors how the organization and its leaders are carrying out their mission. It must ensure that the organization is being true to its Catholic values and identity. In effect, sponsorship is a link in the chain between the Church which establishes the PJP and the PJP which sponsors the Catholic health care or social service organization.

For more on these terms, on canon law and related topics, see *Sponsorship of Catholic Health Care Organizations* by Rev. Dr. Michael McGowan; the link to this document is provided in Appendix E.

What is the purpose of this Guide?

The Guide recognizes that leading, or working in, a Catholic organization requires special knowledge and different emphases in addition to what is needed in a non-faith-based organization. It identifies the core, specifically Catholic themes needed to meet the learning and development needs of senior leaders and other personnel in Catholic health care organizations.

First, it is intended to help trustees, executives and managers of Canadian Catholic health care organizations to identify requirements for learning activities focusing on the Catholic character of these organizations.

Such requirements could be met by:

- identifying existing learning programs to which to send personnel;
- having new programs developed by outside providers to meet their unique needs; or
- developing and conducting learning activities in-house.

Key Terms

"Health" in this Guide should be understood as having the same breadth of meaning described in the *Health Ethics Guide* (Catholic Health Association of Canada, 2000, p. 20): "Health arises from the dynamic balance and harmony of a person's biological, psychological and spiritual energies within a physical, social, cultural and economic environment. Health is no longer understood merely in medical terms as the absence of illness. Increasingly, consideration is given to the person as an integrated whole and to a perspective on health that includes wide-ranging determinants of health."

It follows that **healing** "is more than simply curing a disease. Healing takes into account the wholeness of the person, recognizing the interrelationship of body, mind and spirit. It involves the restoration of balance and acknowledges the role spirituality and/or religious belief can play in the healing process." (Ibid.)

The **organizations** addressed by this Guide, accordingly, are social service providers and the wide range of health service providers such as hospitals, long-term care homes and community health outreach agencies. Consistent with the wide range of health and healing sketched above, this Guide will use the phrases "Catholic health care organization" in an encompassing fashion for Catholic health and social services programs, services, arrangements, organizations and facilities.

Catholic health care facilities have the right to expect that all involved be informed, and formed, in the requirements of Catholic identity. Without this reflective formation, there is no guarantee that our identity will be maintained. (Gerald A. Arbuckle, SM)

Second, it is intended to assist in the design and delivery of these learning services.

The Guide offers basic underpinnings for other purposes too.

For example, it can:

- Serve as a resource for personal study and reflection, including assessment of one's own understanding and commitment.
- Help set learning objectives and develop learning plans for individuals or groups.
- Help enculturate the Catholic identity of Catholic health care, especially for those with limited knowledge of Catholic tradition, and introduce it to prospective trustees and staff as an essential element of their professional service and an expectation of their professional responsibility and performance.
- Assist in human resource management, including:
    - o hiring employees, engaging volunteers, and providing orientation; and
    - o supervising, appraising and coaching staff with respect to the behaviours expected in light of the organization's mission, vision and values.

- Articulate and communicate the Catholic identity of Catholic health care in Canada and help individual organizations to articulate and communicate their mission.

- Act as a common point of reference for dialogue within the organization and with other parties.

- Help all who serve, from Board members, executives, senior managers and directors of mission to physicians, front-line staff and volunteers, to recognize their responsibilities respecting the Catholic character of their organization.

- Assist in mission renewal and adaptation, as well as strategic planning.

- Inspire research and knowledge development.

An additional broad purpose is to support mutual understanding of leaders of Catholic health care organizations and their colleagues elsewhere, in secular settings as well as those based in other faiths. There are far more similarities than differences between the languages, preoccupations and responsibilities of executive leaders and senior managers in these different settings.

This Guide is intended to be the beginning of a learning process—indeed, of a larger process of leadership formation. The curriculum suggestions are supplemented by the rationale and basic explanation of each element of that curriculum. However, the Guide stops far short of being a full explanation or of mentioning all possible worthwhile topics. For example, this text is not intended to replace others with different aims and greater depth in their own area, such as the *Health Ethics Guide,* published by the Catholic Health Alliance (formerly Association) of Canada (CHAC). (A third edition is in preparation as of

early 2009; the quotations in this document are from the second edition, published in 2000.)The present Guide will be successful if individuals and organizations are inspired and assisted in going further in leadership development.

Within Catholic organizations or thinking one often hears the word “formation” used when describing the process that is used to introduce and prepare individuals for leadership. This speaks to something very broad and deep in the development of individuals. For religious congregations the term referred to the process used to introduce a candidate into a particular way of life, vision and ministry. It also was the process used to prepare a person for leadership. (James Roche)

For whom is it written?

Anyone who wants to think about and discuss the essential characteristics of Canadian Catholic health care (including social service) and its leadership should find the Guide useful. And anyone can be a leader by inspiring others, contributing insights to plans, or helping outside one's specific role. That being said, the main audiences are those who are seeking, and those who want to provide, learning activities about service and leadership in Canadian Catholic health care organizations, including:

- All who provide and lead Catholic health care services, from Board members, executives, senior managers and directors of mission to physicians, front-line staff and volunteers.
- Educators who design continuous learning and development; coordinate learning services; or act as instructors, learning facilitators, mentors.
- Other stakeholders who influence Catholic health care.
- Those who wish to apply Catholic values in non-Catholic health care organizations.

In my view the most important message we can give to our communities is that we are committed to maintaining and celebrating the Sisters' legacy through our programs and services to the community. While we need to continually reference the healing ministry of Jesus and Catholic values and ethics (that's why we exist in the first place) we must strive to "translate" our good works in an inclusive and non-threatening manner. (Brian Guest)

Is it optional or mandatory?

Of itself, the Guide is not mandatory, although it reflects the Church's requirement that Canadian Catholic health care organizations have Boards that are aware of and capable of promoting and defending their Catholic character. However, a diocesan bishop can make it binding in his own diocese. Whether or not the Bishop does so, Board members must all be able to meet the requirements of a Catholic-sponsored ministry of the Church, as derived from canon law.

Rather, the sponsors of this publication—CHAC and the Joint Associations of Sponsors and the Provincial Associations—offer it as an aid to all our Canadian Catholic health care organizations to reflect on their identity and communicate it, and to provide strong support to all involved to address their learning needs.

Appendix E listing references and resources is not a prescription or endorsement. It is offered as a convenience.

Please regard this as a living document. We hope to receive suggestions for additional resources, including innovations in educational technologies, as well as for the text itself. The Guide will be as authoritative as the successful use that's made of it.

Where does it apply?

The Guide is particular to Canada, with its many Catholic initiatives in health and social services, and the context of our national public health care system. It addresses the challenges of developing leaders for Canadian Catholic health care organizations.

On the other hand, it is written at a general, pan-Canadian level; it is intended as a starting point to be tailored to the actual local situation by those responsible for local learning activities.

Origins and acknowledgements

The Guide is sponsored by eight Public Juridic Person sponsors/ owners of Canadian Catholic health care organizations; by six provincial Catholic health care associations; and by the CHAC. It is the product of a process that began with a 2004 decision of Joint Associations of Sponsors and the Provincial Associations to take a new look at leadership development, which had been a concern since at least the early 1990s. It builds on two important previous steps in that process: *Report on the CHAC Health Care Leadership Program 1999 to 2006* by Dr. Maureen Duffy; and *A Strategic Review of Catholic Health Care Leadership Development* by Rev. Dr. Michael McGowan (2007). Thanks are due to them and to the dozens of practitioners and experts who contributed via interviews and virtual focus groups.

Quotations from various practitioners and experts are intended to expand on the text and ground it in the reflections of those who know the topic through experience, teaching and research. Of course, many other individuals could have added other interesting and pertinent remarks, had there been time and budget to seek more input.

2 Overview of Catholic Health Care Service in Canada

What is distinct about the identity of Canadian Catholic health care organizations?

Our distinct identity as Catholic health care organizations arises from the Gospels, a testament to God's enduring love for humanity; the Church; and the Religious Congregations that founded our health care organizations. Each of these shapes values essential to our mission to be a healing presence.

Our mission, based on the healing ministry of Jesus, is to act in an ethical manner, reaching out to the whole person, to the marginalized in society, valuing life and wholeness in the way we act. Essential to doing this is recognizing the innate strength and goodness of those with whom we serve and empowering them to be a sign of hope and compassion to those whom they meet each day. (Sr. Sarah Quackenbush)

- The **values** of human dignity, respect for life, social justice, compassion and spirituality (which includes human wholeness) are key for the mission of a Canadian Catholic health care organization. Other values are vital too, such as hospitality, stewardship and excellence.
- Although others may also highlight these values, Catholic organizations are distinctive in the high **priority** they assign to them, and in the consistent energy they devote to them.

We do not take these values for granted; we do not leave them to chance. We aspire to be recognized for our explicit, intense dedication to these values.

Last year we had a system-wide retreat for our Sister leaders, Bishops, Board and senior managers on our commitment to the poor and marginalized. A statement to this effect is in all our Mission/Values statements but we challenged ourselves with "Do we walk the talk?" … "How are we doing to date and how do we integrate this commitment in a formal manner into both operational and strategic planning?" The bottom line is that we are doing a good job (we need to lose the humility approach and celebrate more) but we need to formally integrate them into our policies and decision making processes. (Brian Guest)

- Moreover, these values are **mandated.** It is not up to individual employees whether or not to subscribe to these values. It is not up to individual Trustees whether or not to consider them essential.

- We know the original **source** of these values—the Gospels, especially the healing ministry of Jesus. They have been interpreted and enriched for us through the teachings of the Catholic Church. Further, these values have been brought to concrete realization in the actual organizations we now enjoy, as a product of the charism and acts of their founding Congregations, in the context of Canadian social and political conditions. In other words, the three sources of our values are the Gospels, the Church, and founding congregations whose legacy we preserve and whose culture we are challenged to regenerate.

The core values include (1) compassion based on the Gospels, (2) respect for each person's worth as a creature of God (others say "respect" too but the basis is different), and (3) spirituality as recognition of the totality of the person; note that spirituality is not the same as religion. (Sr. Kateri Ghesquiere)

From the earliest years of health care in Canada our history is filled with stories of the various Religious Congregations who reached out to care for the sick, the poor and most vulnerable in society. Their resounding "yes" was not based on strategic plans, government approvals or available cash, but rather on their strong faith that this was God's work based on the healing ministry of Jesus and therefore part of the work of the Church.

These women had a long history of inviting men and women to share in their spiritual ministry of caring for others. They saw this work as a special call to service in caring for the most vulnerable in their time of need. They welcomed people of all walks of life, of different faiths and traditions to share in this very important work of ministering to others and advocating for the common good.

Preparing our leaders to carry on this rich legacy today requires that we call forth that goodness in others, help them to recognize that their contribution to Catholic health care ministry is not just a job but rather a privileged opportunity to reach out and embrace those we meet and care for each day. This invitation welcomes people of various faith traditions and cultures in a spirit of respect, dignity and hospitality.

For the founding sponsors, the Religious Orders, the "Catholic Optic" was present almost by intuition and by daily, visible example. They prayed every day, celebrated daily Mass (usually in the hospital chapel), tried to render the compassionate attitude of Jesus to all and sundry, and gave their whole lives, without individual pay, to an apostolate that lives to this day.

Now, our new generation of leaders need to do this without many of these deeply spiritual and visible aids. In spite of that, what I observe is a deep desire to protect confessional health care institutions in a world becoming more and more secular. They are literally on the firin g lines from people who want to remove all public signs of religion and to water down our cultural values to the lowest common denomin ator in the interests of tolerating everyone's value, no matter how opposed these "values" might be to the true ones of human beings. (Fr. Michael Prieur)

The Introduction (pages 1 to 15) of the *Health Ethics Guide* provides a very helpful overview of the main characteristics of Catholic health care.

Who is responsible for our mission, vision and values? Who puts them into action and who leads?

Our organizations are places of mission-driven service. The service can be characterized in three ways, and each involves dimensions of leadership.

First, inspired by the healing ministry of Jesus, and especially by the parable of "The Good Samaritan" (Luke 10: 25-37), our organizations exist to *serve those in need.* This is the fundamental reason why all staff, volunteers, trustees and stakeholders are involved—to make sure that the afflicted, the wounded, the lonely, the needy, wherever they may be in our communities, are served in order to bring healing into their whole being. Leadership in

this context can be shown by everyone who serves. Indeed, even patients and residents and their families can take part in this ministry, bringing healing to others and to staff and volunteers as well. How a patient/resident or a family approaches suffering can bring grace to a staff member or volunteer, as much as the other way around. Moreover, as health care organization personnel become increasingly diverse, our organizations can tap into a growing range of strengths arising from varied cultural backgrounds.

Second, guided by the example of the life of Jesus and his call to "Love One Another" (John 13:31-35), those serving in Canadian Catholic health care organizations must also *serve one another.* No one serves alone; all serve with others. This imperative must apply (and appeal) to all who serve, from front-line workers and volunteers through to every level of supervisor, manager and executive and to trustees too.

Third, the action of Jesus in the "Washing of Feet" (John 13:1-15) sets the example of *leading and serving those who serve.* The core responsibility of those who "wash the feet" is to make it possible for everyone in the Catholic health care organization to "love one another" while acting as "Good Samaritans."

This Guide has a special concern for leadership in the usual formal sense, where the chief executive holds ultimate accountability for the actions of the organization. The CEO leads the entire staff, carrying out the policies and directions set by the Board; answers for the organization to the principal stakeholders (the Board of Trustees, the Sponsors and the government); and represents the organization to the surrounding community.

As a "servant leader," the CEO possesses humility and has the interests and welfare of others at heart. This leader comes "not to be served but to serve" (Mt. 20:28).

The concept of Servant Leader goes back to the Old Testament, and is found in the understanding of the King who is protector, judge, guide, etc. The King was seen as being the instrument of God and God's love for his people. There are numerous references to servant leadership in the New Testament, of which the washing of the disciples' feet would be an example. On that occasion what Jesus says to the disciples is important: "If I, your Lord and Master have washed your feet, so also you should do." (Fr. Vince Herner)

In the first instance, the formal leader at the top of the organizational hierarchy should always be directing and inspiring. In the final analysis, everyone is responsible for leadership. Everyone—home visitors, surgeons, I.T. workers on their way to fix office computers, administrators, nurses and so on—will encounter occasions of suffering, dying and bereavement; whatever their job description, their vocation should call them to help those who suffer to be in touch with God.

I think the challenge in all this is to have organizational systems in place which ensure that the tradition of compassion and respect can be maintained. Emphasis must be on the concrete living of an organization's core values such as compassionate service, human dignity and social justice. This is done by integrating the values and mission into all aspects of the organization: the initial hiring process; performance reviews which incorporate questions that focus on the employee's behaviour; and recognition based on the living of the values. What I try to emphasize with new staff is that our values come from the philosophy of our founders and that they are invited today to live these values no matter what, if any, faith tradition they come from. The key is to have persons who are in leadership positions who are convinced of the worth of the mission and values and who are committed to seeing that those whose behaviours are not consistent with treating people with respect and dignity are held accountable for their actions. (Sr. Mary Anne McCarthy)

Questions for Reflection and Learning

Questions for individual reflection and group discussion also suggest themes for other, more formal learning activities.

Do I understand: the evolution of health care in Canada; the role played by the Church; the legacy of the Sisters in health and social services; the relationship of Catholic health care organizations to public health care, especially in my province or region?

What do I know of the social teachings of the Church? Which teachings have been most important to me so far?

How well do I know the history of my organization: the vision of our Founders; their achievements over the years; the relations between this organization and the community it serves?

What does this history inspire us to do in current conditions? What does it suggest for future directions?

How well do we empower everyone in our organization—front-line staff, volunteers, executives and managers—to take the initiative to lead where appropriate?

Do we truly serve in all the important dimensions—our patients and residents and their families, each other, those whom we supervise or manage, and the surrounding community?

Do we seek ways to enrich our capacities to serve and to lead?

Are we maintaining and celebrating the Sisters' legacy through our programs and services to the community?

3 Mission, Vision, Values

What is the significance of "mission, vision and values" for Catholic health care organizations?

What Catholic health care organizations do and how they do it are expressed in their mission, vision and values.

The mission, vision and values express the fact that each organization exists to continue the healing ministry of Jesus—this is the essential, unchanging mission—in a particular place and time. They will be open to constant monitoring and periodic renewal, because needs and circumstances change over time. They will admit of a range of approaches in response to different local circumstances. The vibrant, distinct character of that response over time can be thought of as the "charism" of the organization.

There is a need to consider the organizational expression of "Catholic" as well as its traditional sense (i.e. based on the very fluid, rich, and dynamic traditions within Catholic circles over the past 2,000 years). From this fluidity flows Catholic mission. This does not mean the mission is insensitive to organizational goals, values, and standards, but it is not limited to current understandings that may, for some reason or other, be limited and not allow forays into new expressions of mission from a Catholic perspective. (Dr. David Perrin)

How are the mission and vision kept dynamic?

The mission and vision at a particular juncture stem from a combination of unchanging values, the history and present capacity of the organization, the needs of the community, and the agreements that can be secured with government authorities and with partner organizations.

The organization (particularly through its leaders) will be attentive to its history. Being conscious of the aims and achievements of the founding Congregation and of those who carried out its mission over the years will help anchor the organization and help it articulate the mission for today and tomorrow. It should add its own stories of recent achievements and celebrate the good work of staff and volunteers.

I went to High School with the Grey Nuns, that's how I learned the message and the culture of hope and caring. My training for leadership in a health care organization added formal teachings to that intuitive understanding. I believe it was a very important part of my development. We can give hope to people through our understanding of healing as making whole – not just the body but also spirituality and hope. We achieve this through our compassionate care and by following the teachings of Jesus on loving our neighbour. This affects how we treat the people we work with and those we are called to care for. These are non-negotiable beliefs. (Claudette Savard)

The marks are a conscious awareness of the healing ministry of Jesus, which people can relate to the actual circumstances of health care today. This encompasses the good of the whole person and a concern for social justice. Of course, secular organizations want to be caring and compassionate, too, but they may find it difficult to make these values explicit and vibrant. (Archbishop Brendan O'Brien)

Story telling is the most powerful tool to reinforce values, mission and Catholic identity. There was lots of story-telling on the leadership course, and I have practiced this in the organizations where I served. It is especially in evidence in Aboriginal cultures where story-telling is central to all communications. So you should start discussions with "Here is how our caring began…" (Bernie Blais)

The organization should review and renew its mission, vision and values regularly. It might ask: "What is the history of our organization? What difference did its founding Congregation make to the surrounding community? How has their mission, vision and values been continued to the present? What do they suggest for the future? What does our mission call us to do in the current environment?"

In addition, on an ongoing (not periodic) basis, the organization should keep the mission alive by practices such as mission awareness days, values integration assessment, the focus on mission in orientation sessions for volunteers and staff, and commissioning ceremonies for new personnel.

The commissioning ceremony when I became CEO, with the Bishop and others taking part, made a big impression on me: it said "you are more than a CEO, you are a model, your mission is larger." (Cliff Nordal)

What are the key values of Catholic health care?

The essential values are human dignity, respect for life, social justice, compassion and spirituality (which includes human wholeness), because these are the values of the healing ministry of Jesus and of the Judeo-Christian understanding of human nature. Other values of great importance are respect, diversity, personal growth, care, hospitality, generosity, integrity, excellence, and accountability. Stewardship is an all-encompassing value of appreciation and responsibility for creation that applies particularly to those in decision-making positions. The next four chapters of this Guide explore various of these values in greater detail.

This is not an exhaustive list; some organizations and writers use different words for similar values or add other values. Appendix C expands on the values and principles that should be reflected in all aspects of Catholic health care, with statements on (i) Christian moral values, set out in the Health Ethics Guide; (ii) distinctive values of Catholic health care, from the CHAO publication on Mission Driven Organizations; and (iii) ten principles of Catholic social teaching.

The mission and vision tend to be similar among many hospitals, and even the wording of the values is similar. What you see though is that the Catholic hospitals are more focussed on the kinds of patients whom others prefer to ignore, the very marginal, the poor, those with serious and persistent health needs. What's distinct is how Catholic hospitals embed and practice those values, how we live out our values day to day in strategic thinking and in operational care-giving. We really live our values. And we talk about them; my staff challenge me on how we are living up to our ideals. (John King)

What is the practical impact of the values?

These three elements—mission, vision, the various values—are not compartmentalized. They work together in practice to create an organizational culture. Successful Catholic health care organizations have a distinctive atmosphere, a recognizable organizational culture. It is one in which members not only hold important values. They can also name them, tell stories about them, know how to think and learn more about them. Most importantly, they know that these values are endorsed by the organization and its Sponsors; acting on them is expected, and they are committed to put them into action constantly.

In our leadership orientation we say that the Scriptures are the lens through which leaders of the Ministry look at the world and plan the work they do. Others have used the expression "Impelled (compelled) by the Gospel" —to seek out the lost and those who are marginalized and to restore them to wellbeing, by extending not only the medical and social care but also the compassionate love of God. Of course we are attentive to industry standards too, but we look first to our mission via that scriptural and gospel lens. (Fr. Vince Herner)

How we are living the mission has a qualitative rather than a quantitative sense and is a standing agenda item for our management team meetings. Our sponsors expect us to track it, and in so doing, we become more aware of its living dynamic presence in our daily lives. (Linda Chaplin)

All key decisions we make must reflect on our mission and values. (Sr. Sarah Quackenbush)

The practical consequences of the mission, vision and values are seen in such areas as how personnel are recruited; the "contract" between new personnel and the organization; behaviour expectations; monitoring of performance; mentoring, coaching and training to help personnel bring their behaviour into line with the values. To be values-driven, we must know our values and match our actions to them.

After clarifying values important to our organization, we created four core questions related to values fit for all candidate interviews and have implemented them across our organization:
1. Please describe a situation when you promoted and/or participated in an open, honest exchange of diverse ideas. What did you do specifically to contribute to this outcome?
2. Describe a particularly challenging situation in which there seemed to be a values conflict that involved you and a patient/resident or family (or colleague). What specifically was the values conflict? What did you learn from this situation?
3. Describe a time when you initiated a process or patient care improvement in your work. Why did you feel this change was important? How did you go about making it happen? What was the impact of the change? Is it still in use?
4. How would your peers describe you as living out the values of your organization? (Those of our organization are respect, excellence and compassion.) (Deb Miller)

The way things evolved in Canada, with Tommy Douglas and others, there is a strong Christian presence in public hospitals. Catholic identity needs to situate within the general health care context and be excellent; otherwise why would patients come to us if more competent hospitals are available, and why would donors continue to support an inferior service? We should not use "Catholic" to be isolationist or to excuse inferior service! Be a place of excellence. The Sisters were relentless in doing everything as well as possible. The standards we have to meet are derived from our faith; thus the expectations are extra-high. (Conversely, our performance reflects not just on ourselves as health professionals and on our hospital but also on the Church.) For instance, compassion towards those in crisis is demanded in the first instance by our faith. (Cliff Nordal)

The key values also lead the Church to take a firm stand on medical decisions regarding human reproduction; organ and tissue donation and transplantation; care of the dying person; and research on human subjects. (See Ch. 3 to 6 of the *Health Ethics Guide*.)

Humanity has a deep abiding need for our perspective on human life in its total context; the absolute interdiction against anyone having dominance over the life of another; the responsibility that each has for their own decisions including their mistakes; the commitment to serve the outcasts, those on the highways and byways, the poor and unwanted. (Dr. Maureen Duffy)

Questions for Reflection and Learning

Questions for individual reflection and group discussion also suggest themes for other, more formal learning activities.

Does our organization "walk the talk" on its values? Are they integrated into the mission and vision? (See the next four chapters for questions on specific key values.)

How do we make our mission, vision and values relevant throughout the organization, in all its services at all levels?

Does the community think we are living up to our ideals? Do those whom we serve and their families think so? How do we know?

How do we keep our mission and vision up to date?

Do our human resources processes such as recruitment, hiring, and performance management incorporate the mission and values as a key expectation of staff who choose to work in our facilities?

Does the organization build a strong orientation component and ongoing education and formation about living the mission and integrating this into the day to day operations and decision making in the organization? How are these evaluated and communicated?

Do our organization's values influence our decisions about programs and activities?

Do we safeguard our mission and values in our arrangements with partners and with our funding sources such as government, donors, research clients and research granting agencies?

Inspired by the efficient manner in which the Sisters ran Mount Hope, a home for the aged and orphans, the government inspector of hospitals and charitable institutions encouraged Mother Ignatia to take on hospital work. For $7,500, the Reverend Mother obtained an old home across from Mount Hope on Judge Street near the corner of Richmond and Grosvenor streets and the Sisters set about extensive alterations to make it suitable for hospital purposes. (From the History of the Sisters of St. Joseph of London, 2007)

Our ideals call us to put our own house in order, and to make our organization a place of peace, love and compassion in the midst of the pressures, conflicts—chaos—often unavoidable in life/death situations. (Dr. Maureen Duffy)

Everybody has values, but I sense that we put more emphasis on dignity, compassion, respect. People say that something is different in a Catholic organization but can't put their finger on it. The Sisters made it obvious; all of their care was faith-based. (Robert Stewart)

Our distinguishing characteristic is that with our tradition, mission, vision and values we are able to create a culture of trust and respect where people have the ability to take the initiative to be creative and innovative. Because of this, as a leader in St. Michael's Centre, I was able to spend more time outside the Centre once the organization was running smoothly. I personally walked the talk and the management team was completely faithful to mission, vision and values. The unions were on side. Employees of other faiths such as the Sikhs and Muslims understood and shared our values. (Gerry Herkel)

The Sisters modeled values-based leadership, the respect for employees, the care and compassion; these will be lost if there is no explicit discussion of the values, or if the profit motive is present. Risk management decisions easily forget the patient, the resident and the family in favour of economy and of service integration; we must put the patient and family back in the centre of decisions. (Bernie Blais)

What is most significant is also what is least likely to be measured empirically: the commitment to mission where that mission is the care of the whole person; the emotional and spiritual as well as the physical. When we make our practical, financial choices, we take the extra step of asking the ethical question about the consequences of our choices for the people we serve.

What resonates is a standard of care that derives from our faith tradition; like other faiths, ours is an expression of how to be in a right relationship with God, with oneself and with our neighbours. So it may also be correct to say that our health-care mission derives from our faith-community mission. In doing our work, we are thinking through a lens and via a vision that has evolved over centuries, concerning God, self and other.

In this we face a big challenge of branding, because society at large is fixated on an ethos of individualism and what is often considered evil and dangerous in religion (e.g. culture of death). Few reflect on the good that faith communities bring to society in various ways, including a health-care mission grounded in a faith-community mission. (Dianne Moser)

After learning the tradition, the key step is cultural integration: integrate it in the milieu, for all levels in the organization, from vision exercises in the boardroom to staff holding the hand of a dying patient or resident; live it, help everyone to live it. It helps to have someone on staff who focuses on this (such as our Vice President of Mission, Ethics and Spirituality), but it's easy to slip with all the pressures and frantic pace; so we need opportunities to refresh, renew and inspire. (Dianne Doyle)

If the effect of becoming HIV positive is that you are thrown out of your family, excluded from your community, you lose your job and are no longer welcome at church, then you're going to die. If you're brought in, you're going to live. If an HIV positive mother can actually earn her living and take care of her child, she's much more likely to stay alive than if she is treated like a pariah and cannot make ends meet anymore and can't send her children to school… The curing model, if I may use it this way, is to remedy the biochemical, electronic or mechanical problem: stop the cells from multiplying or stop the gland from overproducing. To me the paradigm for healing is Jesus touching the leper. First he said, Of course I want to heal you; then he reached out and touched him. For me, that is God in the time of AIDS. He really wants to heal and reaches out to touch. Healing is to be touched, therefore to be treated humanly, to be included and able to feel that you're okay. We are God's way of reaching and touching. He can't do it without us. (Fr. Michael Czerny, SJ, in an interview in America, 197:11, 15 October 2007, www.americamagazine.org. Canadian Jesuit Fr. Czerny is serving in Africa.)

4 Social Justice

St. Michael's Hospital in Toronto describes itself as an "Urban Angel." Those who work at St. Michael's are proud of a history that began when the Sisters of St. Joseph stepped forward to help with a diphtheria epidemic in 1892. Despite huge growth and diversification, the hospital never forgets its mission to reach out to those in need in their surrounding community. Its Centre for Research on Inner City Health (CRICH) is Canada's first and only trans-disciplinary and hospital-based research centre dedicated to reducing health disparities and improving the health of socially and economically disadvantaged urban populations. "My job is to do research on the problems I see every day in my clinical practice with homeless men and women, to ensure that our health care system is responsive to the needs of poor and disadvantaged urban populations," says Dr. Stephen Hwang, one of the world's most influential researchers on the severe health risks faced by homeless people. (An interview for this Guide.)

What does "social justice" mean? What is the importance of this value?

Social justice is the active side of human dignity and human interconnection. It means engagement on behalf of the less powerful, the marginalized and the dispossessed. The *Health Ethics Guide* defines it as "The concern to root out social habits, institutions or structures that harm the common good of society, and to establish structures, ways of acting and attitudes that promote the common good" (p. 101). It links the common good (including a just and compassionate social order) and charity or solidarity (including response to the needs of others) back to two fundamental values—the dignity of every human

person, and the interconnectedness of every human being. (See Appendix C (i).)

Social justice becomes a reality when an organization's Trustees, managers and employees identify the needs of the marginalized and the dispossessed and initiate a proactive response to them. There are several components to this response:

- The organization needs to maintain a constant vigilance to see who or what is at the margin, and a capacity to re-orient and adapt its services to emerging needs.
- The organization maintains this vigilance through its staff, at all levels, keeping social justice in their minds and hearts and recognizing as a consequence the needs of those not being served. They all share the ability to look beyond the centre to the margin, and ask themselves all the time: What is beyond the pale? What is not making it into town? Who is being by-passed?

Gerald A. Arbuckle SM, retold the story of the Good Samaritan at the 2008 CHAC Conference in Quebec City (a DVD is available from CHAC). He emphasized that by stopping to deal with the victim the Samaritan allowed himself to become vulnerable to danger from all sides: by robbers, who could now more easily get at him since he was off his horse and moving slowly; by his fellow Samaritans, who would ostracise him subsequently for having touched a non- Samaritan; and financially, since he paid for the victim's treatment with no guarantee of repayment. The Samaritan accepted increased personal danger, social rejection, and financial burden to help this person rejected by others who just passed by.

- Social justice concepts and practical applications need to be integrated into all the management systems of the organization (appraisals, training, intelligence gathering and dissemination).
- The organization's finances need to be managed so that it remains viable while offering justice to all.

Social justice is a dimension of the internal life of an organization as well—do we "Love One Another" in the ways we work together?

Following a re-organization that resulted in her reporting to several people rather than one, a mentally challenged employee became very difficult to manage. The CEO talked with her and her supervisors. It became clear that her inability to prioritize the requests was frustrating and frightening her, and causing her to behave inappropriately. Once this was rectified and her tasks and priorities clarified, all returned to normal. There was no question in the mind of the CEO who dealt with this issue that the organization's mission required going as far as possible to ensure that this employee was treated justly. (An interview for this Guide.)

What inspires and informs this focus on social justice?

The Sisters have handed down and entrusted a proud heritage to modern-day Catholic health care organizations. Historically, the driving mission of the founders was to respond to unmet needs and go where they were needed most. From the beginning, they looked for the marginalized and dispossessed and sought to help them. Requests came from Bishops as well as from provincial and local governments (for example, resulting in Sisters opening hospitals in London in 1888 and in Sarnia, where the petrochemical boom had started, in 1946).

Time and again, they brought comfort to those ignored or rejected by the rest of society, adapting their services to the changing needs of the marginalized.

At the request of the Bishop, the Sisters of St. Joseph arrived in Prince Arthur's Landing (now known as Thunder Bay) in 1881. The object of their mission was to respond to the needs of the people. Education seemed to be the greatest need. While planning for construction of a new school, the Sisters opened their first class in the basement of the Catholic Church two weeks after their arrival. At the same time, Canada was constructing a rail system that would connect our vast country from coast to coast. Construction in remote areas like Prince Arthur's Landing meant accidents—with nowhere to care for injured workers. One rail worker lost both legs in an explosion. His co-workers approached the Sisters to care for him, so they took this man into their convent and gave him the only room that was not occupied by Sisters—their chapel, where they nursed him back to health. When word of this spread through the community, more and more came to the convent seeking nursing and medical support. Health care needs of the new settlement, especially because of influenza and typhoid epidemics, soon exceeded the capacity of the Sisters to accommodate patients in their convent, so they converted the recently constructed school into the first hospital in the community, and began planning for the construction of a hospital which would be opened in 1884. (Sr. Bonnie MacLellan)

This attention is at the core of the healing ministry of Jesus. It is there in word and deed: the words of parables such as the Good Samaritan; the deeds of healing the blind and the lepers, and of communing with the socially despised (tax collectors, prostitutes).

The example of Jesus, who cared without judgment and loved the sinner, is interpreted and amplified for us by the teaching of the Church. For instance, in the 1980s, the late Cardinal Joseph

Bernardin articulated a “Consistent Ethic of Life” that has become a centerpiece of the U.S. Catholic Bishops’ moral teaching. It holds that we are to have a respect for life from its inception in the mother to other areas of life including capital punishment, war and the end of life. This is a truly Catholic theme. It includes what threatens life as well as what diminishes life (such as poor housing, health care, etc.).

This Consistent Ethic of Life flows from the life of Jesus who was sensitive to the vulnerable at all stages and from every walk of life. In being so, he often was at odds with society’s standards, associating with religious and social outcasts. This is the Jesus of the Sermon on the Mount who proclaims as blessed not the leaders of society but the mourning and the meek, the poor and the pure, the persecuted and the peacemaker (Mt 5:1-12). This is the Jesus who praises not power but reconciliation in the story about the forgiving father of the prodigal son (Lk 15:11-32). This is the Jesus of faithful ministry, of suffering and death, of new life (Mk 14:3—16:8). This is the Jesus who says, “I came so that they might have life and have it more abundantly” (Jn 10:10). Who Jesus is and what Jesus means by abundant life, then, are surely different from what the consumerism and individualism of our culture tell us about life. (From an article by Kenneth R. Overberg, S.J., www.americancatholic.org/Newsletters/CU/ac0798.asp)

More recently, in his encyclical *Deus Caritas Est (God is Love)*, Pope Benedict XVI briefly sketches the linkages between politics, justice and ethic, and then poses the challenge that deciding what is just “can never be free of the danger of a certain ethical blindness caused by the dazzling effect of power and special interests. Here politics and faith meet… From God’s standpoint, faith liberates reason from its blind spots and therefore helps it to be ever more fully itself… [The Church] has to reawaken the spiritual energy without which justice, which always demands

sacrifice, cannot prevail and prosper" *(God is Love,* 2005, §28a). (For a summary of Catholic social teaching, see Appendix C (iii).)

What is the responsibility of leaders regarding social justice?

The experience of senior leaders suggests the need for the following capabilities:

- Education, inspiration, commitment: ensuring that the social justice mission is thoroughly understood and receives attention throughout the organization; ensuring that employees treat each other with respect and that the workplace is free from harassment or bullying.

Bearing the name Catholic would imply that the social teachings of the Church inform the actions taken by the organization. It would mean being attentive to the changing needs of the population; looking at the source of illness, not just treating it. A case in point may apply to jurisdictions where economic upheaval creates massive unemployment. It could be argued that this is not a health issue; however, if it is left unaddressed, the mental and physical health of the population will suffer. Addressing the issue by utilizing mental health resources fosters health and well-being and circumventing further, more extensive and expensive treatment. (Fr. Vince Herner)

- Awareness: capacity to identify needs of those on the margin, for example by providing forums for dialogue about changing needs in the society we serve, with special emphasis on the marginalized, poor and voiceless in our midst. This empowers the whole organization to think about the social justice issues implied or encountered in daily activities.

We serve several Reserves. We will soon be meeting regularly with counsellors from the Aboriginal communities to see how we can best serve them. Five of us—the Chairman of the Board of Directors, the CEO, the director of nursing and myself for the Hospital and the director of resident care for the Personal Care Home—will drive to the communities to meet with the counsellors to discuss their needs. I also participate in a weekly multidisciplinary meeting here where we discuss needs of Aboriginal patients and their communities. We have found that the needs are quite distinct, both culturally and because the distances to travel are so great. For instance, with help from community partners, we have built family units so relatives can stay with patients in palliative care. And often there will be several dozen community members along to support an individual or family. (Angèle Delaurier)

- Advocacy: capacity to be an articulate, persuasive social conscience, able to lead public discussion of the needs of the marginalized, to develop the case for funds for social justice initiatives, and to press for wider action as well as responses by one's own organization.

Be there for all, especially the most vulnerable; advocate for justice and betterment of the system. Then the Bishops will recognize you as Catholic (their opinion, not that of government, is essential in this matter). Avoid both meekness and self-promotion. In our everyday living, we should both challenge and mentor by our presence. (Canadian health care in general is good, but by no means are all facilities caring or values-based.) Our Catholic organizations still exist in Canada because people want us, sometimes without even knowing we're Catholic. (Sr. Elizabeth Davis)

- Sound organizational information management: capacity to ensure that the necessary organizational systems are in place to collect the right intelligence about who needs what care. This includes training for all staff, multilateral communication, and frequent analysis of the situation. (For instance, home visitors, paramedics and ambulance workers out in the community who see the everyday circumstances of patients, need to bring that information to where it can inspire new responses.)

We are enabled to create a culture of trust and respect where people have the ability to take initiative and to be creative and innovative. We can bring hope to people, particularly to the marginalized, reaching out to those in need. For example, when AIDS first came to light to the health care community in British Columbia, the Sisters came forward with a bold and compassionate decision that they would welcome AIDS patients at St. Paul's when other hospitals were turning them away. Today, St. Paul's continues this attitude in its care for all patients, in particular those with mental health and addiction issues or other marginalized populations. (Dianne Doyle)

- Sound financial management: capacity to ensure the continued viability of the organization while still meeting newly-identified needs.

These capabilities, without the special focus on social justice we see in Catholic organizations, mirror elements of the 5C Capabilities Framework (see Appendix A), which suggests the competencies that are required by health care leaders generally.

Questions for Reflection and Learning

Questions for individual reflection and group discussion also suggest themes for other, more formal learning activities.

Does our organization "walk the talk" about social justice? Do we take note of unmet needs? Do we devote attention and resources to addressing the needs of the marginalized? Do we have the courage to "go out on a limb" for the sake of social justice?

Do we treat colleagues and coworkers with respect?

Does social justice dominate our strategic thinking, or is it an occasional extra?

How do we refresh our thinking about social justice? Do we refer back to the healing ministry of Jesus? to Catholic social teaching? to the legacy of our founders? Is social justice covered effectively in our orientation programs? Is social justice a regular topic of discussion throughout our organization? How do we use our mobile teams and outreach workers to serve the marginalized and to become aware of unmet needs?

Do we look for partnership opportunities in order to achieve social justice goals?

Do we advocate for changes in public policy and programs in order to make health care more inclusive and effective for the marginalized?

5 Spirituality and Human Wholeness

What is the place of spirituality in Catholic health care?

Spirituality is an essential element, and Catholic spirituality is a distinct sign, of Catholic health care in Canada.

Spirituality is grounded in a fundamental conception of what it is to be a human being. Humans are composed of spirit, mind and body. The spiritual constituent of human nature is that which seeks for the transcendent, longs for the divine. The *Health Ethics Guide* defines spirituality as "The search for the sacred. A conscious striving to move beyond isolation and self-absorption to a deeper awareness of interconnectedness with the self, other human beings and the transcendent" (p. 102).

Human beings are also essentially social; human wholeness is realized through the community of the human family, so personal history is also essential to being human, and each person is unique. Thus attention to "human wholeness" integrates all these elements—spirit, mind, body, and specific personal history.

Everyone is on a spiritual journey, a seeking that continues throughout earthly life and comes to fullness in the moment of transition into God's heart—into eternal life. The spiritual side, along with the emotional and social, is never absent. Therefore, we must treat the whole person, holistically, all the time. Our job is health care, not just health cure. Because every human person is inherently spiritual, spirituality is an intrinsic and critical aspect of all decisions and services offered by Catholic health care providers.

This orientation—not merely curing the illness or injury but caring for the whole person—permeates the entire organization. It gives a special feeling, an atmosphere, that can be detected clearly although it may be hard to define precisely.

Should our spirituality be specifically Catholic?

Spirituality is not amorphous; we encounter it in the distinct histories and features of specific philosophies and religions. The spirituality of Catholic organizations will reflect the Catholic religious tradition within Christianity. At the same time, because of the diverse backgrounds of staff and patients or residents, other forms of spirituality (religious and non-religious) must be respected as well.

We aren't simply one option among several equivalent options for delivering health services. We aren't interchangeable. We are Catholic, specifically so. Let's not adopt a watered-down vocabulary that is so accommodating that we forget to say who we are—no one benefits from that. Being who we are stretches from praying and celebrating joyfully as Catholics to embracing the whole gamut of Church teachings that apply to health and human dignity, including on bioethical issues. (Archbishop Michael Miller)

Our spirituality is specifically Judeo-Christian in its sources and development. (The field of Christian anthropology explores these ideas.) The fundamental inspiration for how we apply it comes from the healing actions and stories of Jesus, who recognized the faith and trust shown by those in distress and showed compassion for their afflictions.

As the Church has taught since Saint Paul, at the very centre of our faith is the passion, death and resurrection of Jesus. Jesus is a healer because he vanquished death by being obedient to it.

This grounds us in being honest and unafraid, open to the suffering and death of the other; capable of daily sacrifices for the sick and the dying; ready to comfort the perplexed, accompany the suffering and the dying, and embrace the bereaved. The death and resurrection of Christ gives ultimate meaning to all suffering, dying, death and hope for eternal life for us. It is the ultimate hope of our human existence.

Within our Catholic spirituality are beliefs about God's mercy and compassion; in order for it to be active in the world, we give ourselves to the mission of being the meeting ground of human need and God's grace.

Should our spirituality be visibly Catholic?

Catholic health care facilities have a "living spirituality" and are "in union with the Church" as matters of principle. (See Appendix C (ii).) The ways in which this can be manifest include familiar Catholic religious symbols in their environment—crucifixes, statues of Our Lord, our Blessed Mother with the Christ Child, the saints—and the celebration of Mass; other regular and special rituals and ceremonies; and prayer services.

This serves the needs of patients or residents and their families. Although this is primarily for the Catholics among them, non-Catholics often also express positive feelings about the symbols and ceremonies, recognizing that these support the compassionate care that they appreciate. Religious pictures, statues of the saints and other faith-inspired décor tell our clients and community members about us as Catholics and the ideals that we pursue.

We should never be afraid to let people know who we are and what motivates us to do what we do. Our religious symbols and pictures are a testament to that. Such things are not meant to proselytize, but simply to indicate to those who enter our facilities that we are a faith-based organization. We care for everyone and we employ all kinds of people, regardless of their religious beliefs or lack of, and we are motivated to do that out of a love of Christ. (Susan House)

The Catholic "look" and religious practices are authentic to the histories of our organizations, hence they link our current organizational culture with the past. This reinforces the identity and renews the inspiration of all who work in our organizations.

Every Catholic facility should have a sacred space dedicated to religious services for all faith traditions.

At the same time, no one should feel pressured about religion; it is not the job of Catholic health care to gain converts to Catholicism.

How do we apply spirituality and human wholeness in serving others?

People sense if they have not been treated as "a whole person." They might say something like "I felt like a number, not a real person," or "When we talked I thought she wasn't really listening," or "He seemed to be looking past me all the time."

Human wholeness urges us to treat those whom we serve with real regard for them in all dimensions—emotional, physical, spiritual and social. It shows that we consider all people as having unique, intrinsic value and dignity. The people we serve and the people we work with are more important to us than the building and the budget. Many values and skills make up the human wholeness attitude. Among them are courtesy, genuine interest, patience, attentiveness, sincerity, forgiveness, concern, trust, mercy.

Our great calling is to follow the example of Jesus, in particular when he responded to the needs of the sick and the marginal in his ministry. When Jesus wanted to make a difference in someone's life, he would first of all listen to their needs; then he would touch them; his "healing touch" would allow the person to be restored to community. This, in essence, gives us our fundamental vision of caring in the Church's ministry of health and social care. It is a vision of attending to the needs of the whole person and of restoring a person in his wholeness which goes far beyond hospital care or the actual curing of ailments. (Marc Beaudry)

The Catholic health care organization provides spiritual care. It may be the special responsibility of spiritual and pastoral care workers. ("Spiritual care" is usually an encompassing term, while "pastoral care" responds to the needs of members of particular faiths.) Indeed, it is inconceivable that a Catholic health care organization would not provide pastoral care to its Catholic patients or residents. Likewise, as warranted and feasible, it would provide pastoral care in other faith traditions to all other patients or residents.

The responsibility for spiritual care need not rest with designated staff alone. All humans, we believe, are made in the image and likeness of God (the starting point of Christian anthropology), and this anchors the potential of every person to be spiritually

present and supportive to any other person. This applies to all staff. It is also possible for those whom we serve and their families to provide spiritual support; they can be profound inspirations of dignity and grace-filled suffering to others.

Spirituality addresses the distress that arises in the lives of those who are in need—what Fr. Arbuckle refers to as “the sickness of the heart” of residents isolated from family and friends, of patients anxious about death and the future. We need to recognize the integrity of mind, body, spirit; the importance of promoting respect and upholding the wholeness of persons when they feel un-whole, broken, cast aside.

The personal situation and background of each person is unique. Spiritual support must be offered tactfully. One individual may desire an earnest religious discussion with a priest, rabbi, imam or other minister; what works for another may be silent companionship, a warm, compassionate presence. Further, as mentioned above, because Catholic health care organizations are open to all, the patient and resident populations can be extremely diverse. The spiritual care capability should be correspondingly sensitive to diverse client needs. It is important that organizations familiarize themselves with the various faith traditions and make every effort to ensure that the spiritual needs of other faiths are met if at all possible. Interfaith prayer and other religious services are one option that can have a profound effect.

We put up a nicely framed poster of the "Golden Rule Among the World Religions" just outside the chapel and the Spiritual Care office. At the time all the symbols throughout the hospital were not only Christian, they were Catholic, which leaves many other Christians with mixed feelings, let alone members from all the other world religions. The responses were so positive that the Board purchased another 35 framed posters and placed one in every waiting room and outside every elevator on all floors. Those posters quietly did so much healing work, setting a tone and atmosphere of respect for the dignity of all. We also held a multi-faith panel discussion on "Spirituality and Health" where a Buddhist monk, a Unitarian minister, a Muslim Imam and an orthodox Jewish Rabbi joined the Catholic speakers. There was standing room only during the lunch hour. The interfaith community expressed a deep appreciation for their shared values with Catholic health care. If the wisdom of the Sisters in their day was their staying very close to the heart-beat and the needs and concerns of the local community, multi-faith respect is a key for us to do the same in today's culturally diverse society. (Steve Hill)

What roles should spirituality and human wholeness play in the workplace?

There has been a growing movement among modern organizations in general—not only those that are faith-based—to welcome spirituality into the workplace, because values-driven or values-based organizations have an enhanced capacity to excel. Staff and volunteers feel spiritually affirmed when they have a sense of meaningfulness and joy in their work, when they see the importance of their contribution; when they can be "truly themselves" and not set their personal life aside.

Senior leaders support this by striving to allow employees to have a well-balanced life, including the spiritual aspect. They provide time for reflection and prayer. They promote discussion of values and spiritual matters within the organization. They celebrate good work. They keep alive the vision and mission of the organization. Programs designed to address the inner wellbeing of staff, and addressing concerns related to the personal impact of serving others, are also important.

Over the years, I have been impressed by the great effort on the part of CEOs to ensure that there is a truly Catholic vision and that staff embrace it and celebrate it. (Archbishop Brendan O'Brien)

Senior leaders are in particular need of spiritual grounding and sustenance because of the enormous pressures they face. Their challenge is to continue the healing ministry of Jesus with dozens or hundreds of staff and volunteers within the diverse community being served, in constant need of new dimensions of compassionate care—and balance the books at the same time. It is important to have a confident sense of personal worth in pursuit of ultimate values, in order to cope with the stress and avoid burn-out.

Spirituality is a key component of finding inner peace and calm from within. Prayer, however we define it, allows us to find the nourishment and calm to recognize that we all have a greater power, a strength beyond ourselves, an ability to become refreshed with an inner strength when needing time to move away and become peaceful when making choices and decisions and carrying on our daily work. (Sr. Sarah Quackenbush)

Spirituality sustained the Sisters in their ministry: it gave meaning to their work. Their focus was charity (love of others), stewardship (not being wasteful), and humility (seeing Christ in each person). Constant prayer and daily examination of conscience kept them focused on "how they were doing" spiritually and ethically.

Prayer and self-examination should still be part of personal life and of group activities such as meetings. Indeed, senior decision-makers and trustees have a special need to develop their capacity for reflection, meditation and prayer. They find themselves in a complex personal journey where they need to be conscious of how they are thinking and what they feel. Decisions are not made by a machine or a set of formulae. They are made by human beings, the CEOs and others, who should be as aware as possible of their calling (or vocation) of bringing the healing ministry of Jesus to reality in a particular set of circumstances.

I believe that to be effective Catholic leaders today, such individuals must first of all have a deep faith in God. (This is not to suggest that they must be Catholic or practicing members of any particular religion but that their personal lives must reflect the love of God within). Secondly, their personal lives must be motivated by key values such as respect, trust, integrity, honesty, caring and compassion. Thirdly, they must be committed to Catholic health care. And for me leadership in Catholic health care is not a job but a ministry and a vocation. (Gerry Herkel)

In the special workplace of Catholic health care and social services, everyone has the opportunity to grow in holiness, in the likeness of God, by fostering behaviours such as reverence, hospitality, service, forgiveness, and non-violence (respectful workplace). We welcome Christ when we welcome the person in need: “Insomuch as you did this to the least of these, you did it to me” (Matthew 25:40).

Questions for Reflection and Learning

Questions for individual reflection and group discussion also suggest themes for other, more formal learning activities.

How well do we understand human wholeness and spirituality throughout our organization? How do we refresh our thinking about this subject? Is spirituality and human wholeness a regular topic of discussion throughout our organization? Do we refer back to the actions and teachings of Jesus? to Catholic social teaching? to the legacy of our founders?

Does our organization "walk the talk" about human wholeness and spirituality? For example, is spiritual / pastoral care treated as an essential function? Do all staff know what is expected of them in this regard? How is behaviour in this domain monitored? How do we celebrate exemplary performance in this area and what is done to make improvements?

Do we provide the sacraments, other Catholic services and a Catholic physical environment at a level that suits our patients or residents? How do we accommodate and encourage the spiritual expression of patients or residents and staff of other faiths and of no particular faith?

Is the way our organization expresses its Catholic identity supportive of the surrounding Catholic community? Do Catholics in our region feel welcome and nurtured when they come as volunteers, patients, residents, visitors or worshipers?

Is our workplace guided by prayer? Is it a place of spirituality and full human growth for all staff?

How do we encourage a nurturing attitude towards spirituality and human wholeness in our community, in other health care settings and in public policy?

6 Ethics

What is the relevance of ethics to Catholic health care?

Ongoing ethical reflection and the promotion and protection of the dignity of all persons from conception until natural death are defining principles of Catholic health care. (See Appendix C (ii).)

Ethics in health care touches on several areas. Medical ethics—whether or not a particular medical procedure is morally acceptable—is key but far from the only concern. There is also the organizational and business side of ethics, including employer-employee relations, proper workplace behaviour, dealing with finances and material goods, and so on. Ethical issues also arise in connection with social justice and environmental stewardship both within and outside the boundaries of the organization.

All of these areas, from perinatology to environmental concern, fit within a consistent ethic of life, a respect for all life, that accepts all of creation as God's gift and all humans as God's children.

There are moral choices to be made—choices based on values and principles—when dealing with individual cases; for instance, "This patient needs care more urgently than that one," or "Let's not buy from this supplier because of their environmental record." Moral choice also applies when setting policy; for instance, "We need to shift more attention to outreach services because

there are too many very needy people who still find it difficult to come to us in our main location."

Decision making cannot be made routine; rules and procedures (without which large scale activities would be hopelessly inefficient) must always be susceptible to further reflection and questioning. By example and through parables—curing the man blind from birth even though it was the Sabbath, suggesting that compassion should over-ride rules against religious contamination (in the Good Samaritan story)—Jesus showed the importance of making "the person" more important than "the system," especially when the needs of the most vulnerable are at stake.

How do Catholic health care organizations deal with ethics?

Catholic health care organizations are required to be consistent with the Church with respect to ethics. To assist them, Canada's Bishops endorse the authoritative *Health Ethics Guide*, published by CHAC. In fact, some organizations mention the *Health Ethics Guide* explicitly in their governance documents.

The CHAC *Health Ethics Guide* is a unique publication. Both Catholic and non-Catholic health care organizations have found it to be well-written, practical, comprehensive, and enlightened in its fundamental appreciation of human dignity and the "whole person." It also provides guidance for dialogue and decision making.

The Health Ethics Guide has been a very successful document. It helped us to go beyond medical morals to a more holistic approach about making decisions about people at their most vulnerable moments. It's also great for Catholic pastoral and other workers in public organizations. It has a sense of Canadian culture and can be read by administrators without philosophical training. It has helped in developing public regional health care corporations in Newfoundland-Labrador and Nova Scotia and their ethics functions. (Sr. Elizabeth Davis)

The Health Ethics Guide sets a standard; even if people disagree with it, it provides a basis around which to work; no other health organizations have such a touchstone. (Sr. Kateri Ghesquiere)

In addition, of particular interest to decision-makers in Catholic contexts, it spells out the position of Catholic moral theology in certain areas such as protection of the unborn, reproduction, artificial nutrition and hydration, and end-of-life issues.

Typically, Catholic health care organizations assign a medical ethicist, a lawyer or other designated official to supervise examination of ethical issues that come up. Because the Bishop is responsible for the life of the Church in the diocese, he must be assured that the Catholic health care organizations are applying the *Health Ethics Guide* in making ethics-related decisions.

To this end, the organization is expected to establish processes whereby the diocesan Bishop is informed about its work and about how the teaching of the Church is reflected faithfully in its ethical reflection and decision-making.

This may occur in various ways. The Bishop should indicate how frequently and in what manner he wishes to be involved. Some Bishops might opt to be a member of an organization's ethics committee; others might assign a representative. Bishops might schedule annual or more frequent discussions of ethics with the CEO, and expect to be informed when an unusual ethical challenge arises.

How should we ensure that we are well prepared to make proper moral and ethical decisions?

Executives need to ensure that the organization has the necessary expertise available for ethical reflection, and that procedures are in place to identify and deal with ethical issues. Any health care organization in Canada seeking formal accreditation faces several ethics-related requirements woven through various sets of standards. For instance, an ethics committee is required, with a written framework to guide behaviour. Processes need to be in place to handle ethics-related issues and concerns raised by staff or by those who are served by the organization. Overall, there is a clear requirement of the governing body and executive group to guide or set the direction.

The Ethics Guide is very much part of who we are; we are required to follow it. So I make clear to people who want to join our organization that they need to be able to support it while working here. (Michael Pontus)

The further challenge is to make ethics a wider topic that informs behaviour throughout the workings of the organization. Practitioners and experts interviewed for this Guide advocate that everyone in the organization learn about ethics and about the resources available to support them in making decisions.

This could be done by private reading or by formal orientation or learning activities. It is particularly beneficial to have staff discussions of moral dilemmas that arise in the workplace. Ongoing ethical reflection not only strengthens the abilities of personnel to perceive and discuss ethical issues; it also helps all to keep in mind the vision, mission and fundamental values of the organization.

Ethics is a way of acting responsibly and justly amidst the challenges we face each day. Organizational ethics is a key component in the work we do. Sound ethical decision-making keeps us grounded and focused; it also brings us to a point of clarity in the decisions we make, calls for accountability and responsibility in our role of service. The provision of on-going education, opportunities for dialogue and ethics rounds, and available consultation are some of the ways we involve staff, clinicians and boards to be aware of the importance of being an ethical organization. (Sr. Sarah Quackenbush)

What we learned in our program helped us think more broadly about organizational ethics and how best to use governance structures for consultation around key issues of principle. We were able to get direction from our Health Ethics Committee about issues related to medical marijuana usage in practice. (Deb Miller)

Questions for Reflection and Learning

Questions for individual reflection and group discussion also suggest themes for other, more formal learning activities.

Have I read the Health Ethics Guide sufficiently for my duties?

Do I encourage, arrange or participate in discussions of moral/ethical issues that are relevant to our organization?

Do I know how to raise such issues? Do I have the courage to do so?

Is our organization well equipped to identify and deal with moral issues quickly, honestly and with respect and protection for the persons involved?

Is our organization continuously learning about ethical issues and moral behaviour? Do we learn from others?

Do we communicate appropriately with the Bishop when dealing with exceptional ethical matters?

Are our organizational policies consistent with our ethical principles? Do the day-to-day practical applications of these policies (for instance in purchasing, investments, accepting donations, staff supervision etc.) hold up to ethical scrutiny?

7 Canon Law, Stewardship, Accountability, Community

To whom is the Catholic health care organization accountable?

Catholic health care organizations are formally and directly accountable both to the Church and to government. They are also accountable to the communities that they serve.

In earlier days Catholic health care organizations were typically "owned and operated" by Religious Congregations. Today, this is true of only a few of these organizations. In most cases now, they are "owned and operated" by other entities established by the Church to carry out functions on its behalf. As Chapter 1 explained, these entities are called "Public Juridic Persons"—PJPs. PJPs of diocesan right answer to the diocesan Bishop, whereas those of pontifical right answer directly to the Vatican (except on matters that pertain to the diocesan Bishop).

The formal accountability relationships of the Catholic health care organization are from its CEO to the Board of the organization; thence to the Board of the sponsoring entity (the PJP) that is its legal owner and operator; and from that Board to civil authority (for instance the provincial health ministry) on the one hand and to the Church on the other—either the diocesan Bishop or the Vatican.

Bishops often feel that medicine has become so specialized that it is difficult for them to follow its development. However, it is important for the Bishop to be represented on the Board and on the Ethics Committee by people with a certain competency in theology and in health care. I consider it my role to promote the Catholic vision of health care and to ensure that the provisions of the Health Ethics Guide are respected. (Archbishop Brendan O'Brien)

In practical terms, the implications of the Catholic accountability relationship vary for a Catholic health care CEO depending on the particular history and style or orientation of the organization's ministry—its charism—and of the surrounding Catholic community, and the wishes and style of operation of the Bishop. This is because the Bishop is the Church superior in his diocese, its leader and chief teacher, and is responsible for all the pastoral work of the Church in his diocese. Health care is part of that pastoral work.

What does it mean to be a "steward"?

Stewardship is directly related to accountability. The steward exercises delegated authority and fulfils responsibilities. From time to time, the steward renders account of what has been done.

Catholic health care stewards are responsible for providing an environment where healing of mind, body and spirit occurs. Speaking of the healing relationship, the *Health Ethics Guide* says that "Those in positions of leadership must recognize their role is, first of all, a ministry of loving service and stewardship" (p. 6). It provides this definition of stewardship: "The appreciation of the giftedness of creation and the exercise of responsibility in relationship to creation" (p. 102).

Senior leaders of Catholic health care organizations, especially CEOs, are stewards over the resources in their care—the physical and financial resources as well as the time, effort and commitment of employees and volunteers. They are stewards as well in relation to the environment and the surrounding community. The following paragraphs spell out the implications of that stewardship with particular reference to canon law.

What does canon law bring to accountability and stewardship?

The Catholic Church's *Code of Canon Law states,* in comprehensive and exhaustive legal detail, what "Catholic" means. It provides a foundation and essential starting point for Catholic organizations by defining relationships and how things should be done. The Church's goal in canon law is to develop good relationships that provide the fruitful context within which the faithful can further the ministry of Jesus. The provisions of canon law touch on both faith and administrative obligations; thus they tell an organization what is involved in being in harmony with the Church and in being true to the designation "Catholic".

The principal canonical responsibilities of the Directors of a Catholic organization fit under three headings:

- Carry out the accepted task…

Those who act on behalf of a Public Juridic Person are to make certain that they fulfil the specific task entrusted to them in view of the public good. The entrusted task is usually stated by the mission of the PJP, and spelled out in its statutes and operating by-laws. For instance, if the mission commits an organization to delivering a wide range of quality health services in order to meet the physical, emotional, and spiritual needs of those it serves, it would be only reasonable to expect that the directors

of this organization would want to make certain that these ideals are upheld.

- …in accordance with the teachings of the Church…

Does the organization carry out its responsibilities in accordance with the teachings of the Church, particularly in matters relating to ethics and moral theology? This implies knowledge of the teachings to be applied, and skills at discussing and applying them in what can be extremely difficult challenges.

The leader in a Catholic organization needs to know the actual Church position (or needs to know whom to ask) on a specific issue. After all, the leader is accountable to the Church for the designation "Catholic." (Dr. Mimi Marrocco)

- …while administering ecclesiastical goods responsibly.

Since the goods of a Public Juridic Person are ecclesiastical goods (that is, belonging ultimately to the Church), and not the personal goods of the members or of the organization, it will be important to observe the prescriptions of the *Code of Canon Law* relating to their administration. (There are civil law implications as well.) In addition to canons on how material assets are managed—inventory, norms for disposal or "alienation" of property, norms for contracting long-term debts, annual accounting—there are also canons on respecting the intentions of donors and benefactors, and on observance of the Church's social teachings in regard to employees.

(The explanation above is taken with slight modification from a presentation by Fr. Francis Morrisey, OMI, a canon law expert at Saint Paul University in Ottawa, to the Catholic Health Corporation of Ontario in April 2004.)

Canon law also supports the idea of subsidiarity—allowing decisions to be made as close to the grass roots, the persons directly affected, as possible, unless there are serious reasons to make the decision at a different level. This principle is based on the over-arching value of the dignity of the human person. Its application would vary with the context:

- In treatment arrangements, is this patient or resident competent to make decisions on his or her treatment, or must someone else be the decision-maker?
- In leadership style, is there appropriate delegation and empowerment so that staff and volunteers are respected and fully engaged?
- In governance and administration, does the authority given to the different levels of managers match their responsibilities?

What about engagement with the wider community?

The Catholic health care organization is dynamically related to the wider community. It provides its services to people of many backgrounds in the community. And it is a beacon of Catholicism, highly visible to all and of special interest to Catholics in the community. Thus, in a fundamental sense, the organization is accountable to all whom it serves or may serve, both in terms of its health services and as a concrete expression of Catholic identity in the community.

The most important external stakeholder is always the local community that we are privileged to serve. (Brian Guest)

Typically, the most senior leaders are expected to be the key spokespersons representing the organization to the community. But engagement with the surrounding community is far more than speaking for the organization; it can happen in myriad ways. All staff and volunteers can contribute; conversely, all staff and volunteers should be careful to avoid actions or relationships that could harm the organization. At the same time, they can encourage opportunities for the local Catholic population to share in their ministry.

Another facet of community engagement is partnerships—informal and formal, simple and complex, limited or broad. Partnerships can extend the reach of the organization's ministry, but they can also divert the organization from its mission and its Catholic identity. They are legitimate as well as valuable if they meet the canonical standard summarized above—to carry out the accepted task, in accordance with the teachings of the Church, while administering ecclesiastical goods responsibly.

Because of the populations we serve and our community outreach, we find that supporters react positively to our social justice emphasis. They want to partner with us by paying for new services that extend our social justice side. (John King)

Finally, it is increasingly important that CEOs, Trustees and others act as careful environmental stewards. This requirement is both ancient—God's creation is entrusted to all humans to care for, use wisely and share—and of critical current importance with global warming, environmental degradation, and the accompanying threats to current health and future survival.

Questions for Reflection and Learning

Questions for individual reflection and group discussion also suggest themes for other, more formal learning activities.

*Do I understand our formal status in relation to the official Church hierarchy, such as the Bishop of our diocese?**

*Do I understand our mission, statutes and by-laws, and the Corporate Objects in our Letters Patent, so as to plan and manage activities that accord with them?**

*Does our organization have a constructive relationship with the Bishop in support of carrying out our mission as part of the Church's pastoral presence in this community?**

*Is accountability to Church and to government carried out in a manner that encourages learning, growth, and furtherance of our mission? Do we take time to evaluate our actions in light of canon law, for instance as stewards of the resources entrusted to us? **

Do we relate positively to the surrounding community? Is this a shared responsibility involving everyone in our organization?

Does our organization practice the principle of subsidiarity in our internal workings and in its dealings with those whom we serve?

Do I represent our organization appropriately to the wider community? Am I a constructive point of contact between the community and the organization?

*Do our partnerships further our mission in a prudent manner and consistently with Church teachings?**

**These questions are for senior leaders in particular.*

8 Modalities of Learning

The guidance in this chapter is based on past and existing leadership development programs and on views expressed by CEOs, educators and others in interviews for this Guide.

8.1 Learning styles and opportunities

The Guide is intended to serve as a curriculum outline for a variety of learning opportunities, ranging from personal reflection and group discussion to university-style courses. These opportunities can occur in private reading, at work, at other sites including universities, or in on-line learning. The Guide's approach is consistent with existing training for Catholic health care leaders.

Modern organizations are expected to offer frequent learning opportunities to staff, and our interviews showed that this expectation applies equally to Catholic health care. Learning is part of meeting standards of service and quality, as well as ensuring a focus on mission.

Learning opportunities should be varied because adults have various learning styles. Moreover, our health care staffs are increasingly diverse. Some people may be far more comfortable with text than others; some may be more comfortable engaging in discussion while others feel that learning means respectful listening to an instructor. The following options may have something for everyone:

- Personal reading of this Guide; reflection on the questions and on relevant short passages such as those in Appendix F.
- Further personal study, with the Guide as starting point, using library and other resources.
- Personal study guided by a mentor.
- Discussion in a work group or a seminar based on a case study or readings (such as the short readings in Appendix F).
- A presentation by a speaker followed by discussion in a work group or a seminar.
- Enrolment in formal learning opportunities without face-to-face encounter, for example correspondence or on-line courses.
- Group learning that includes personal encounter with instructor/facilitators and fellow learners; there are many variations (university courses and seminars, workshops at conferences, on-line courses that include group discussion by teleconference, etc.).
- In-house versions of seminars and courses where circumstances warrant; keeping in mind that this lacks the advantage of sharing views with learners from other locations and organizations.

A key finding from Catholic health care leadership development of the past decade is that *personal interaction is essential:* interaction with an instructor who understands what it means to live Catholic leadership in the health care environment; and preferably, interaction with other senior leaders too. It is not facts

that are being learned; it is the capacity to engage in one's own life journey in imitation of the healing ministry of Jesus, and to facilitate that journey for all others in the organization and those served by it. This capacity in turn requires a capacity for personal reflection; leaders who do not know how to reflect on their own beliefs, values and turmoil will not be able to help others to deepen their analysis and decisions. Meeting leaders from other organizations has the added advantage of immediate sharing of best practices in different localities, and of future networking among mutually supportive peers. If possible, involving past participants allows them to share what they learned and how it has assisted them in their subsequent responsibilities.

It is important to engage practitioners as facilitators who provide authentic information and real mentoring. (Sr. Elizabeth Davis)

Learners experienced personal conversion and communal bonds. It's the mediation by loving humans that permits the cut-and-dried, hard-edged dogmatic material to come alive and connect for the learners. (Dr. Maureen Duffy)

The former CHAC Leadership Course exposed me to a community in which I experienced a very real conversion and lasting ties. What I gained there inspires me to work on this project in order to ensure that educational, formational and leadership opportunities are provided to as many trustees and employees in Catholic health care as possible. And the bonds I gained with my classmates continue to drive me; they are among my models of leadership. (John Callaghan)

Opinion concerning written assignments is mixed among those who pursued Catholic health care leadership development programs in the past decade. The time needed to complete them can be an overwhelming impediment, but they nevertheless tended to be valued. If they are designed to encourage reflection, not just mastery of subject matter, then assignments can help to promote personal integration or appropriation, and drive the learning to a more profound level.

The shared experience, dialogue, networking and fellow-feeling are essential. We need to be exposed to other leaders. Note that MBA programs generally include a practicum where students see and experience what it is to be a leader. Also, assignments that demand reflection and linking of ideas are more valuable than those aimed at knowledge by summarizing or by comparing and contrasting various positions. With the Internet, people can get “expert opinion” very easily; what they cannot get is the human dynamics of emotions, spirituality and ethical issues as one does one’s technical job. (Ken Tremblay)

8.2 Subjects

This section itemizes what the curriculum for leadership development at the senior executive level should contain. (Most of the same topics are valid for learning by others, such as volunteers, other levels of staff, and trustees; see the table that follows this section.)

An over-riding concern is to assist senior leaders to bear up under almost impossible pressure. On the one hand, the modern health care CEO has an extremely complex job, considering all the technical aspects and the public policy environment (government funding and accountability, service standards and so on). On the other hand, as the CEO in a Catholic organization, the leader's model is Jesus as healer and Jesus as servant leader. Accordingly, whatever the other specific subjects for learning and development and whatever the specific arrangements, there needs to be provision to help senior leaders with their own spiritual journey so that they are leading from a personal core of convictions and values.

Any leadership course in these times must address the isolation and embattlement of leaders, which can cause cynicism, or hardening, or burnout. (Sr. Elizabeth Davis)

Include a discussion of coping with radical change (as we have in the present era of extreme centralization): how do we retain identity and values in the midst of such radical change? How do we influence the changes? It is easy to feel lost or dislodged; navigating change requires a return to one's roots. The leadership program gave me back what I'd had years ago, and tools and confidence to apply my values and principles. It helped me to refocus my leadership life. (Bernie Blais)

These are the specific subjects for learning and development:

Foundations of the mission of Catholic health care

- Catholic health care mission and vision. Its foundation in the healing ministry of Jesus.
- Christian anthropology: the understanding of human nature and of the meaning of life that arises from the Judeo-Christian tradition.
- The meaning of suffering and death.

History and current organization

- History of Catholic health care in Canada.
- History of the particular organization, its founding, the vision and achievements of the founding Congregation.
- Relationship between Catholic health care and the political environment; how to defend Catholic health care and make its value apparent to the community and to public officials.
- Canon law, stewardship of resources, accountability.
- PJP status in relation to Rome or diocese; relations between the organization and the Bishop and the surrounding Catholic community.
- The leader as educator and model in the organization and the community.
- Best practices in other organizations.

Values and their application

- How to be a values-based organization in which prayer plays a part and where faith and values influence decisions.
- The values of human dignity and social justice; the three dimensions of social justice (towards clients, within the organization, and in regard to society/systemic issues).
- Other values, especially compassion, respect, diversity.
- Ethics and ethical discernment in the spheres of personal behaviour, leadership behaviour, corporate governance and health care generally; familiarity with the *Health Ethics Guide;* Catholic teaching and dogma on specific medical practices; how to structure and nurture ethical reflection in the organization.
- Values for the work environment, such as work-life balance, fairness, dignity; how to affirm staff; the importance of celebration.
- The culture of service, servant/leadership relationship, dispersed leadership.

Spirituality

- Spirituality and human wholeness in Catholic and other faiths; secular forms of spirituality.
- Catholic symbols, religious observances and celebrations; accommodating the religious needs of patients or residents and staff of Catholic and other faiths.
- Personal spiritual journey, personal reflection and prayer.

This list of subjects should be taken as a starting point only; by no means should it be thought of as restrictive. Other worthwhile subjects may be added for those who wish to continue further and to address special needs of particular localities and situations.

8.3 Recommended Curriculum Choices

This table suggests the subject matter that should be covered, in an "orientation" context, in other learning opportunities (discussions, courses etc.), or in both, by different populations in the Catholic health care organization. "Senior orientation" is orientation given to new Trustees, CEOs and other senior executives. "Feeder" refers to those who report to the CEO and should be considered in terms of succession planning.

Subject	Chapter reference	Senior orientation	Trustee development	CEO & feeder development	Other orientation	Mission, pastoral	Directors (general)	Staff (general)	Volunteers
Catholic health care mission and vision; common points and differences for long term care, community services, hospitals	2	X	X	X					
Health care in Canada: history, recent era, public policy choices	2	X	X	X	X	X	X		
History of the organization; who the founders were, their objectives and experience	2	X	X	X	X	X	X	X	X
Christian anthropology; human nature; suffering and death	2		X	X		X	X	X	X
Values-based organization including prayer, faith and their influence on decisions	3		X	X		X	X		

Subject	Chapter reference	Senior orientation	Trustee development	CEO & feeder development	Other orientation	Mission, pastoral	Directors (general)	Staff (general)	Volunteers
Hiring for the right fit	3		X	X			X		
Human dignity and social justice	4	X	X	X	X	X	X	X	X
The leader as educator and model in the organization and the community	4, 7	X		X		X			
Catholic spirituality; other spirituality; human wholeness	5	X	X	X	X	X	X	X	X
Work environment and work-life values	5	X		X	X		X		
Other values, especially compassion, respect, diversity	3	X	X	X	X	X	X	X	X
The leader's own spiritual journey, vocation; leading from core of convictions and values; avoiding isolation, burnout	5	X		X		X	X		
Religious symbols, observances and celebrations (Catholic, other)	5	X		X	X	X			
Ethical discernment	6			X		X	X		
Discussion of ethical dilemmas; paths for raising and resolving issues	6		X	X		X	X	X	X
Ethics obligations, key issues, use of Health Ethics Guide, organization's ethics structure	6		X	X		X	X		
Past and current status of the organization; relationship to religious authority (Vatican, Bishop) and civil authority	7		X	X		X	X		
Canon law, stewardship, accountability; subsidiarity; partnerships in the community	7	X	X	X	X	X	X		
Culture of service, servant/leader relationship, dispersed leadership	2, 7	X	X	X	X	X	X	X	X

8.4 Privileged Moments

There are key moments in the life of an organization that can have a significant impact on expanding and integrating learning. They can anchor the culture of the organization.

Interview subjects pointed out the great impact of commissioning ceremonies for new members of the organization. They are crucial for engagement of individuals and for integration of the culture of the organization. These can be wonderful occasions of learning and of renewal.

Following an orientation, new staff participate in a commissioning ceremony. They are sent into the work environment knowing their role and the values of the organization. (Margaret Love)

Recognition through public awards ceremonies is vital not only to morale in an organization but also to demonstrating what the organization values most. Organizations should show their concern for learning by recognizing progress in learning.

There should have been a graduation ceremony! Along with the quality of the program and the quality of faculty who balance academic expertise with pertinent health care experience, some recognition of graduates would be a strong motivator to take the program. (Cliff Nordal)

More broadly, wherever staff and volunteers make a noteworthy effort to live the organization's values and fulfil its mission, there is the opportunity for celebration, to provide the recognition that reinforces those individuals' sense of worth and tells everyone else what is truly important.

Many organizations celebrate people who come up with cost-saving ideas; we celebrate those who live the mission. (Bruce Antonello, former chair of CHAO and CEO of St. Mary's General Hospital, Kitchener, ON; quoted in Michael W. Higgins & Douglas R. Letson, Power and Peril: the Catholic Church at the Crossroads, Harper Collins, 2002.)

Privileged moments like these are important stopovers in a constant, continuing process of formation that ought to engage everyone who is privileged to serve in Catholic health care organizations in Canada. Nourished by the Gospel Jesus, Church teachings and the charism nurtured and passed on by the founding Religious Congregations, may we pursue our growth for the sake of greater service of others, and thereby achieve our own greater wholeness.

Appendix A. Catholic and Secular Leadership Capabilities Frameworks

This Appendix addresses the question of whether the leadership capabilities described in this Guide are so specific to Catholic health care that they can be understood only in that context.

There are several practical reasons to be concerned about the ease of understanding these capabilities outside of a Catholic health care setting. Some of the questions that may arise are:

- For some CEOs who lead both Catholic and secular organizations—"Must I switch vocabularies as I move from one to the other?"
- For aspirants to a senior leadership position in Catholic organizations—"How much will my secular education and experience apply to this prospective role?"
- For individuals in Catholic settings planning their careers—"Will I need to re-train if I opt for opportunities outside the Catholic setting?"
- For CEOs of Catholic organizations engaged in discussions with senior leaders from secular organizations, and with government, politicians and the general public—"Will I be misunderstood if I speak as a Catholic leader?"

To answer these questions, it is useful to compare the messages of this Guide with the 20 capabilities of the "5C Capability Framework" in *The Pan-Canadian Health Leadership Capability Framework Project: A collaborative research initiative to develop a leadership capability framework for healthcare in Canada* (October 2007). This document was produced by Graham Dixon et al., of the Centre for Health Leadership

and Research at Royal Roads University (Victoria BC), and commissioned by the Canadian Health Leadership Network (CHLNet), a coalition of Canadian health organizations. See www.chsrf.ca/pdf/Health_Leadership_Framework

This secular framework has been chosen among the myriad available guides to executive leadership and senior management because it is current, Canadian, specific to health care, and supported by ongoing research, teaching and consulting efforts—it's an element of the wider environment of health care leadership in Canada.

The present Guide purposely does not speak of the elements of executive (and other) leadership that do not require a Catholic colouring. In that way, it is incomplete, and some readers may wish to be reminded of the elements that have been left out. This Appendix fills in the rest of the picture. The 5C Capability Framework (or any well-researched competency profile describing leadership behaviours) provides a common framework that defines what modern leadership in a complex health system is and establishes a common language for individuals across organizational boundaries or professions. When a framework like this is used as a platform for the human resources management system, the various components of human resources management, such as training, development, selection, appraisal, and succession planning, are all designed using the competency profile or the capability framework.

The 5C Capability Framework

Research with health leaders across Canada led to a framework of capabilities built on three components. The first component is who the leaders are, their individual values and beliefs (being). The second is the dedication of the leaders to health (caring).

The third is what the leaders do (doing). These three components form the basis for five domains of exceptional leadership capabilities, captured in the headings of the five groupings below.

What do health care leaders do? According to the 5C Capability Framework, they…

A. CHAMPION caring

1. Inspire and encourage a commitment to health.
2. Show respect for the dignity of all persons.
3. Act with compassion.
4. Exhibit fairness and a sense of justice.

B. CULTIVATE self and others

5. Demonstrate self-awareness and self-management.
6. Exhibit character: honesty, integrity, optimism, confidence and resiliency.
7. Enable others to grow.
8. Create engaging environments where people have meaningful opportunities to contribute.

C. CONNECT with others

9. Communicate effectively with a wide variety of stakeholders.
10. Build effective multi-disciplinary teams.
11. Develop networks, coalitions and partnerships.
12. Navigate socio-political environments successfully.

D. CREATE results

13. Develop a shared vision and translate it into action.
14. Hold themselves and others accountable for results.
15. Integrate quality improvement and evidence into decision making.
16. Manage resources responsibly and creatively.

E. CHANGE systems

17. Build personal and organizational understanding of the complexity of health systems.
18. Mobilize knowledge to challenge processes and guide change.
19. Lead changes consistent with vision, values and a commitment to health.
20. Orchestrate changes to improve health service delivery.

How does Catholic health care leadership fit with the 5C Framework?

Simply put, the capabilities described in this Guide supplement the 5C Framework. That is:

- nothing in the 5C Framework is contrary to what a Catholic leader ought to do; but
- the 5C Framework is silent on some things that are needed in a Catholic context—thus the value of this Guide to anyone interested in the healing ministry carried out under the banner of "Catholic."

With the following adjustments, the 5C Framework can accommodate “Catholic” as a “sixth C.”

I. The “caring” that is championed in (A) mentions “health” (1) and “persons” (2) without elaboration. A Catholic approach interprets health and persons from a Christian anthropology viewpoint that emphasizes human wholeness, of which spirituality is an essential part; therefore health is spiritual, psychological, social and physical together, and provisions must be made to provide care holistically. Spiritual and pastoral care is essential to this; so is the opportunity for self-expression and celebration of a specifically religious nature. The “compassion” (3) shown in a Catholic health care organization requires all of these hallmarks.

II. “Justice” (4) in the Catholic context will speak explicitly of social justice—concern for the poor and marginalized is essential to mission.

III. The special connotation of “Enable others to grow” (7) is that every person—patient, resident, community member, organization members—is on a journey of spiritual growth, growth as a whole person. In addition, growth has the connotation of learning. For Catholic organizations, this hearkens to learning from the healing ministry of Jesus, the social teaching of the Church, and the stories of the Founders and their health care experience.

IV. Communication with stakeholders (9) has the added unique facet of relationships with the diocesan Bishop, the surrounding Catholic community, and the Vatican in some cases. The same complexity arises with respect to accountability (14)—Catholic health care leaders are accountable both to secular authorities and to the Church.

V. For Catholic organizations, coalitions and partnerships (11) need to be formed with an eye to legitimate cooperation with partners that do not share all of the same values.

VI. Managing resources "responsibly and creatively" (16) is informed by a strong canon law emphasis on proper stewardship.

VII. When it comes to "change systems" (E), Catholic health care leaders will be especially attentive to the mission and core values (19) of social justice, human dignity, respect for life, spirituality and human wholeness, and compassion. The knowledge (18) and inspiration mobilized arise from Old and New Testament sources, interpreted through Catholic social teaching and the examples of the Founders.

VIII. While ethics may be implicit through the 5C Framework, ethical awareness, discernment and decision-making capabilities are explicit requirements for Catholic health care leaders.

The above observations should help readers, both Catholic and non-Catholic, to appreciate that leadership in the Catholic context does not require learning a "foreign language." It does have special features that all can readily discuss and, it is hoped, thereby derive enrichment.

Appendix B. Performance Appraisal

Performance management, of which appraisals are one element, is required by modern health care organization standards. The purpose of this Appendix is not to address general organizational mechanics, such as appraisal systems to evaluate and give feedback to employees regularly on their performance. Rather, it describes some aspects, arising from this Guide and other sources, that highlight a Catholic perspective.

There are two basic approaches to appraisal standards. One is to set quantitative objectives and measure if they are met. The other is to articulate expected behaviours and then determine whether the employee is meeting these behavioural expectations. (Appraisals frequently combine them, particularly for senior managers.)

In general, when reflecting specifically faith-based or Catholic expectations in performance appraisal, it is easier to begin with the behavioural expectation linked to a particular value—for instance, "exhibits commitment to social justice." In some cases, a second step would be to add a measurable element—for instance, "Represents the organization at meetings of the Community Anti-Poverty XYZ Coalition."

This applies to appraisals of performance for employees at any level, although some will be more applicable to the CEO or the Trustee than to the middle manager.

It would be important, for example, to evaluate if the employee being appraised has appropriately played his or her part in:

- Understanding the culture and the history of the organization and demonstrating what it means for the present day.

- Creating and participating in the ceremonies supporting the culture while respecting the diversity of faiths among patients or residents and personnel.

- Seeking social justice. Did the individual take actions or make observations demonstrating an active attention to operationalizing this value?

- Attending to human wholeness and the spiritual aspects of health care. Did the individual take actions or make observations demonstrating a commitment to implementing this value?

- Understanding and applying the ethical norms of the organization.

- Respecting the implications of canon law for stewardship and other specified areas.

Simply asking these questions will raise the awareness of members of the organization. Giving them feedback on their observable demonstration of these behaviours will emphasize the message and increase the integration of the values.

Besides the present Guide, there are two further sources (cited in Appendix E) for statements that can be adapted to articulate behavioural expectations for Catholic health care leaders.

- The document on *Responsibility in Ministry* (CCCB 1996) articulates “commitments” expected of religious and lay catholic leaders.

- The CHAO document on *Mission Driven Organizations: A Board and Senior Leadership Guide to Identity, Mission, Values, Evaluation and Selection* (2001) bases the criteria for recruiting and evaluating senior leaders in identity, mission and values, and suggests questions for evaluating organizational performance.

Appendix C. Christian and Catholic Values and Principles

(i) Christian Moral Values

The following articulation of Christian moral values, from the Introduction of the Health Ethics Guide (pp. 11-12), complements the perspective on Catholic health care values articulated in the present Guide.

Christian ethical reasoning is based upon a world view contained in the gospel as interpreted by the church. This world view gives rise to values and principles that direct ethical decision-making and that enable us to respond to the call to respect dignity, promote justice and foster trust.

Two fundamental values underlie the discussion of values in this guide.

1. Dignity of every human person - All persons possess an intrinsic dignity and worth that is independent of what any other person thinks or says about them. (Pastoral Constitution of the Church in the Modern World, Vatican Council II: Constitutions, Decrees, Declarations, Austin Flannery (ed.), New York, American Press, 1996, nos. 27, 29.) The basis for this dignity, in the Judeo-Christian tradition, is the belief that every human being is made in the image of God.

2. The interconnectedness of every human being - Human persons are social beings and cannot live or develop their potential outside of human relationships and community. (Ibid., nos. 12, 25.) This fundamental value affirms the interconnectedness of every human being with all persons, with all of creation, and with God.

From these two fundamental values flow a number of related values.

3. Stewardship and creativity - The scriptures present a view of creation as both gift and responsibility. We share a responsibility to respect, protect and care for all of creation and for ourselves. We are to use our own free and intelligent creativity to fashion a better world while respecting its true nature, appreciating its benefits and accepting its limitations.

4. Respect for human life - Human life is sacred and inviolable in all of its phases and in every situation. (Pontificia Academia Pro Vita, Final Declaration, 5th General Assembly (February 24-27) 1999, no. 1.) Human life is a gift of God's love and the basis for all other human goods. Nevertheless, human bodily life is not an absolute good but is subordinated to the good of the whole person.

5. The common good - Every individual has a duty to share in promoting the well-being of the community as well as a right to benefit from being a member of the community. Respect for human freedom necessitates that society seeks to enable men and women to assume responsibility for their own lives, and to encourage them to cooperate with each other in pursuit of the common good - the building of a just and compassionate social order in which true

human growth for all persons is encouraged. By extension, the common good includes environmental concerns that have a direct relationship to the good of individuals and of society.

6. Charity or solidarity - Charity is the Christian virtue urging us to respond to the needs of others. Solidarity (which includes empathy and compassion for others) is a contemporary way to express our interconnectedness to all human beings and our obligation to respond with love to their needs. This response is even more explicitly articulated in church teaching which exhorts individuals, organizations and those who develop public policy to a preferential option for the poor and marginalized.

Appendix C (ii). Distinctive Nature of Catholic Health Care

The CHAO document Mission Driven Organizations: A Board and Senior Leadership Guide to Identity, Mission, Values, Evaluation and Selection (2001) sets out the essence of Catholic health care in the following manner (pp. 5, 7-9).

Nurtured in a tradition of service of almost 2,000 years, the distinctive nature of Catholic health care reveals itself in its intimate relationship with the Church's mission of healing and service as well as a series of defining principles that has guided its development over the years. The dignity of all people as bearers of the image of God provide the framework for decision-making and standards of care that promotes and protects life at all stages from conception until natural death. Building upon the inherent dignity of all people, spirituality nurtures the belief that God lives and moves among and through us. Spirituality also provides the hidden energy grounding Catholic health care

providers as individuals and as organizations as a source of ongoing call, purpose and meaning.

From the foundational principles of the dignity of the person and spirituality, springs an ethical perspective that focuses upon the common good of all through its clinical and organizational decision-making. As informed decision makers, responsible stewardship urges us to honour the resources of people, goods, natural environment and the healing mission of Jesus. As the continuation of the healing ministry of Jesus, Catholic health providers reach out to all people in a manner marked by excellence, inclusiveness, and compassionate caring especially towards the voiceless and powerless people in our midst.

Defining Principles of Catholic Health

Throughout the history of Catholic health delivery, people and organizations have consistently sought to make tangible the healing mission of Jesus through the following defining principles:

- **The promotion and protection of the dignity of all persons from conception until natural death.**

Grounded in the dignity of all people, we believe that all are created in the image and likeness of God. Our commitment reaches out to protect and foster human life in all stages of life as a gift of God.

- **Union with the Catholic Church**

Our identity as a Catholic health organization flows from our recognition as a Catholic organization by the local Bishop and our willingness to live in communion with the local Bishop.

- **A living spirituality**

Grounded in the experience that God dwells among and within us, we celebrate God's presence in our lives as individuals and as organizations. Through prayer, personal and public, celebrations and rituals we seek to deepen our trust in God's Providence and nurture our lives as we participate in the healing mission of Jesus.

- **On-going ethical reflection**

The *Health Ethics Guide* as approved by the Conference of Catholic Bishops provides a framework for ethical decision-making as well as insight and guidance for decision-making regarding the organizational, social and clinical aspects of health delivery.

- **Responsible stewardship**

The respect and care of people, organizational goods, the mission and values of the sponsor and financial resources demands prudence, creativity and fidelity from all.

- **Excellence**

As organizations devoted to the care of people, teaching and the common good of all, people expect a very high quality of service. Without a dedication to excellence rooted in compassion, the healing mission of Jesus suffers.

- **Compassionate care**

People seek our care and services at moments of vulnerability. Like Jesus, we reach out to all people with kindness, attentiveness and thoughtfulness.

- **Advocacy for the poor, marginalized and powerless**

Like Jesus, who reached out to people who often found themselves abandoned, misunderstood and powerless and in need of comfort, healing and touch, we seek to bring our rich tradition of care and advocacy to those people most in need.

Appendix C (iii). Ten Principles of Catholic Social Teaching

The following summary of major themes of Catholic social teaching is taken from Responses to 101 Questions on Catholic Social Teaching by Kenneth R. Himes O.F.M. (Paulist Press: New York, 2001).

1. The Principle of Human Dignity.

The human person is the crowning glory of God's creation and all rights flow from the fact that the human person is a Child of God. One's rights, therefore, do not depend on an act of bestowal by one person or from the State to the individual. The following principles of Catholic Social Teaching are personal and social rights, responsibilities, and duties that come from being a Child of God.

2. The Principle of Respect for Human Life.

We must honor life from the point of conception to the moment of natural death; a good society is built upon this principle. We cannot interfere with this cycle by shortening, compromising the quality of life or by destroying life. Issues of respecting human rights include topics such as abortion, assisted suicide (euthanasia), death penalty, etc.

3. The Principle of Association.

We are social creatures and our sense of identity and being comes from the fact that we "grow in community." Families, therefore, must be honored and protected. People should be allowed to associate themselves with other families and other social institutions in order to reach their fulfillment in building a society that is founded in the Common Good.

4. The Principle of Participation.

The human person has a right to participate in social associations that are necessary for human fulfillment, which is found in participation in creating a society built in the interest of the Common Good. The Principle of Participation is associated with the conditions of employment and work: the individual has rights that must be respected. Such rights are: the right to productive work, the right to fair wages, to organize and join unions, to private property, and to economic initiative.

5. The Principle of Preferential Option for the Poor.

Matthew 25, 31-46 makes it clear, "Whatsoever you do to the least of these, you do unto me…" If the Common Good in society is to prevail (that which is our human fulfillment), then laws, social policies and government actions must reflect a concern for those who are economically and politically poor and vulnerable.

6. The Principle of Solidarity.

Jesus taught that we are obligated to "Love our neighbor." This means that our neighbor is not limited by geographic location; in fact, all human persons are interdependent upon one another. The Principle of Solidarity serves as a moral category that promotes and protects the promotion of the Common Good.

7. The Principle of Stewardship of Creation.

A steward is not an owner but only a caretaker of something that has been entrusted to the steward by the rightful owner: God is the owner of creation and we are merely the stewards. Property can be deeded to private individuals; however, the resources taken from "private property" are not only for immediate consumption or the exclusive use of the steward. Resources taken from the earth must benefit the Common Good of the present as well as the Common Good of future generations.

8. The Principle of Subsidiarity.

Government has a limited role in the life of society. Government cannot interfere with the social interaction of human persons nor should government do things that cannot be handled effectively at lower levels of society. People working at the grass-roots level are closer to the problems and solutions that promote social growth and the Common Good. The State should enact laws that promote grass-roots democracy rather than pass laws that shield the powerful, well-funded special interests.

9. The Principle of Human Equality.

The equality of all human persons comes from the essential dignity of our identity as being Children of God. Because all persons are created fundamentally equal with equal rights, responsibilities and duties, and an equal share in the resources of creation, each person should be treated with fairness and equity and everyone should receive his or her due.

10. The Principle of the Common Good.

Catholic Social Teaching holds that the fulfillment of each person is found in our promotion of a society in which the care and protection of all human beings is promoted above all things. The Common Good gives birth to a communitarian concern that overrides tendencies toward a society in which unbridled individualism alienates the poor from access to resources and upward mobility. The Common Good in our society today stresses the need for global interdependence and for holding in check nationalism and the self-interest of one nation above another.

Appendix D. Catholic Health Care: Some Historical Background

This brief account is abridged from a history by Fr. Michael McGowan. It is largely in his words.

Pre-Biblical

Throughout the Greek and Roman Empires, numerous temples were dedicated to the gods of health. Facilities to treat the sick were usually associated with these places of worship. The healing arts (what we now know as medicine) were also practised in the ancient cultures of Egypt, Babylonia and China; and at the time of the Buddha (5th century B.C.), the inhabitants of what is now Sri Lanka and India had facilities set apart for the treatment of sickness.

Old Testament

Judaism understood sickness and suffering to be the consequence of sin (the broken relationship with God). Restoration of health signified a re-alignment with God and was a time for praise and thanksgiving. Salvation was understood as the moment of total healing when sin and suffering were taken away.

Jesus

The ministry of Jesus was the visible sign of God's healing power, and demonstrated that sickness, suffering and death could be overcome. The Good Samaritan parable teaches that the followers of Jesus must also care for the afflicted and the outcasts of society.

Apostles and Early Church

The apostles were bestowed with the authority to carry on the mission of Jesus—to be signs and witnesses to God's powerful presence in the world. The teaching and spreading of the Good News was always accompanied by concrete expressions of concern and care, especially toward the sick. St. Paul speaks of the gift of healing, which builds community.

From the time of the apostles, the healing apostolate has been an integral and essential component of the Church's mission. Christianity is unique for institutionalizing health care and making it serve as a formally religious witness to the world. Nowhere else was care for the sick so widespread, so well organized, and so self-sacrificing. Indeed, Julian the Apostate wrote in the 4th century: "*Now we see what makes Christians such powerful enemies of our gods. It is the brotherly love that they manifest toward strangers and toward the sick and the poor*".

Care for the sick is deeply rooted in the Christian virtue of hospitality: from early times, hospices have provided care and comfort to the traveller, help to the poor and needy, solace and concern for those afflicted with sickness, assistance to the elderly, homes for the orphans, the abandoned, and the widow. In 370 A.D. St. Basil the Great founded a large facility near Caesarea that became the model for the Christian hospital (where illness becomes a school of wisdom, where disease is regarded in a religious light, where misery is changed to happiness, and where Christian charity shows its most striking proof).

6th to 8th Centuries

Health care facilities were closely aligned to the local cathedral or monastery. Facilities such as the Hôtel-Dieu in Lyons (542) and Hôtel-Dieu in Paris (660) emphasized the spiritual well-being of the sick as well as their physical state.

9th Century

The monastic orders practiced medicine as an expression of the virtue of hospitality. For the Benedictines in particular, the monastery came to include: an "infirmitorium" where the sick could receive proper and adequate care fro their affliction; a pharmacy or dispensary where the necessary medications used in the treatment of illness were readily available; and a garden that produced the food for the monks and the various kinds of herbs used in the preparation of medication.

Middle Ages

The Crusades resulted in the formation of the Knights Hospitaliers of St. John (Order of Malta), which established a large hospital in Jerusalem to care for the sick, the injured and the dying. One of the legacies of this organization is the present-day St. John Ambulance Corps.

There was continued growth of health care facilities, especially hospitals and organized "confraternities of laymen," usually living under a religious rule, who dedicated themselves to the care of the sick.

However, the actual practice of medical science was gradually transferred to the secular domain for three reasons: the practice of medicine was perceived as a business; the motive was seen as having more to do with greed than charity; and there were conflicts with Church teaching on certain moral issues and medical practices and procedures. As a result, the Church's ministry of healing experienced a setback for the next 200 years.

16th–17th Centuries

New religious institutes, especially of women, included health care among their proper works. In response to a perceived lack of humane and Christian treatment of patients, especially the poor, neglected and abandoned, the involvement of the Church was redirected to the care of the sick, to compassion, and to the manner of treating the ill. The Sisters and their ministry brought a Christian presence to the experience of illness and disability, seeking to treat all patients equally, regardless of social and economic status, and with a special love for the neglected and powerless.

In **Latin America**, the earliest hospital facility was founded in 1503, at Santo Domingo; a second facility, the Immaculate Conception Hospital in Mexico City, was founded by Cortez in 1524. In **Canada**, the Jesuits established the mission of Ste-Marie-des-Hurons, which included a hospital; and in the same year, 1639, the Augustinian Sisters of the Mercy of Jesus founded the Hôtel-Dieu Hospital in Quebec City in 1639. A century later, in 1737, the Sisters of Charity (Grey Nuns), the first religious order founded by a Canadian-born woman, Marguerite d'Youville, took over the General Hospital of Montreal. Their apostolate was to live the spirit of the Gospel by caring for the sick, the poor and the dying.

Appendix E. Resources for Reference and Learning

This Appendix is intended to provide basic assistance to begin the next steps beyond the Guide itself. Some readers may want to do additional personal reading; the few documents and Web sites mentioned here provide suggestions. Others may be at the point of looking for, or creating, educational programs; there are suggestions in that vein as well. The entries are current as of March 2009.

The Appendix is not exhaustive; by no means should the reader assume that all worthwhile resources are listed here and that anything not listed has been judged to be inferior. Like the Guide itself, it provides a starting point for further work, rather than all the needed content.

Further, resource lists need to evolve. Indeed, it would be most useful if the Appendix was used as the starting point for tailored lists of resources that meet the particular requirements of individual organizations.

In addition to the programs cited below, there are many programs of religious studies, theology and ministry that might fill a gap for some learners, for instance on theology, Catholic social teaching or Church history. These are not mentioned in this Appendix.

References and other reading

The Canadian Conference of Catholic Bishops (cccb.ca) lists numerous publications, including relevant pastoral letters, for example

- CATHOLIC HEALTH MINISTRY IN CANADA. Pastoral Letter by the Permanent Council of the Canadian Conference of Catholic Bishops, 11 February 2005. http://www.cccb.ca/site/Files/PastoralLetterHealth.pdf

The Catholic Health Alliance (formerly Association) of Canada (chac.ca) is an excellent source, with more than a dozen relevant publications including the *Health Ethics Guide*. Look at both the publications catalogue (http://www.chac.ca/resources/index.php) and under "other resources" (http://www.chac.ca/resources/otherresources.php). Several highlights:

- "Sponsorship of Catholic Health Care Organizations" by Rev. Dr. Michael McGowan presents this topic thoroughly, from canon law sources to the opportunities and challenges of sponsorship. http://www.chac.ca/resources/other_resources/sponsors.pdf

- The link for the *Health Ethics Guide* is http://www.chac.ca/resources/ethics/ethicsguide.php

- In addition to the most recent CCCB Pastoral Letter on Catholic health ministry (see above), CHAC provides access to four other pastoral letters on aspects of this topic. http://www.chac.ca/resources/pastoral.php

A video of the address of Fr. Gerald Arbuckle to the May 2008 CHAC Conference on the centrality of the Good Samaritan story is available from CHAC.

The Web sites of provincial Catholic (or Christian, including Catholic) health associations offer newsletters, announcements of conferences, and various publications.

- Alberta: www.chaaa.ab.ca
- British Columbia: www.chabc.bc.ca
- Manitoba: www.cham.mb.ca
- New Brunswick: www.nshealthnetwork.ca
- Nova Scotia: www.nshsc.ns.ca
- Ontario: www.chaont.ca
- Québec: www.carrefourhumanisationsante.org
- Saskatchewan: www.chassk.ca

For example, the Catholic Health Association of Ontario provides a compendium of "mission applications" described in short paragraphs, illustrating how values relevant to Catholic identity are being put into practice by member organizations (www.chaont.ca/publications/mission_applications.php).

Mission Driven Organizations: a Board and *Senior Leadership Guide to Identity, Mission, Values, Evaluation and Selection* (2001),

written by Thomas D. Maddix (CSC, D.Min), was prepared for the Catholic Health Association of Ontario but is applicable beyond CHAO's members. Integrated mission, vision and values are applied to the responsibilities of trustees, CEOs and executive leaders, and reflected in an organizational self-assessment tool. Contact chao@on.aibn.com

The bi-monthly journal Health Progress of the Catholic Health Association of the United States (chausa.org) is a source for many articles that apply to Canadian experience too (for example, numerous articles by Fr. Francis Morrisey and Fr. Gerald Arbuckle).

There is extensive information on the Web on Catholic social teaching. A Compendium of the Social Doctrine of the Church can be found at http://www.vatican.va /roman_curia/pontifical_councils/justpeace/documents/rc_pc_ justpeace_doc_20060526_compendio-dott-soc_en.html

The 1983 Code of Canon Law and the Catechism of the Catholic Church are available on the Vatican web site at http://www.vatican.va/archive/ENG1104/_INDEX.HTM and http://www.vatican.va/archive/ccc/index.htm

Learning programs

TWO REPORTS

Report on the CHAC Health Care Leadership Program 1999 to 2006 (Dr. Maureen Duffy) describes seven of the nine course modules of that Program: Christian Anthropology, Catholic Health Care, Organizational Ethics, Religious Experience, Communicating Values in an Organizational Framework, Christian Leadership, and Christian Hope. Available from CHAC.

A Strategic Review of Catholic Healthcare Leadership Development (Rev. Dr. Michael McGowan, 2007) provided an essential step in the renewal of leadership development. It contains many useful observations on effective practices and possible innovations in this area of adult learning. Available from CHAC.

LEARNING PROGRAMS, MATERIALS, SERVICES

Responsibility in Ministry: A Statement of Commitment (CCCB, 1996). (Catalogue code 184-318) For lay and religious alike who carry out ministry in the name of the Church, the document contains clear, detailed statements of commitment regarding five dimensions of responsibility for leadership and ministry—"to those to whom we minister; to colleagues; to the diocesan and universal Church; to the wider community; and to ourselves: personal and professional development in the service of others." Appropriate for personal reflection as well as group discussion, it ends with suggestions for half-day and full-day workshops.

Called to Health and Healing: A Discussion Guide (CHAC). Description: "Parishes, Christian groups, health care facilities and dioceses will find this insightful guide enormously helpful in their facilitation of small group discussions. Easy-to-follow notes provide the group leader with direction and questions for

facilitating productive and rewarding discussions, linking health, healing and the health care ministry to one's personal life and group activities."

The *Foundations in Leadership* program, designed and supervised by Thomas D. Maddix (CSC, D.Min), is offered in three weekend modules. Its purpose is "To enable senior leaders, managers and directors in Catholic health and social service organizations to more effectively carry out their unique responsibilities as leaders of Catholic organizations." It has been delivered in BC, Alberta and Ontario. The participants, typically about 30, come from various organizations and localities, allowing for networking and comparing experiences among learners. Sponsored by Caritas Health Group (Edmonton) and Providence Health Care (Vancouver), this program recently adopted a new umbrella title, "Centre for Leadership Development for Catholic Organizations." Contact: Tom Maddix (VP Mission, Ethics & Spirituality, Providence Health Care, Vancouver, BC) at 604-806-8510; tmaddix@providencehealth.bc.ca

St. Jerome University, Waterloo Ontario, began offering a Masters in Catholic Thought in 2005. The required courses explore the core topic, while electives include Catholic social teaching and contemporary bioethics. http://www.sju.ca/courses/MCT

The University of St. Michael's College (Toronto) Continuing Education Division offers a Certificate in Catholic Leadership. The program currently focuses on educational leadership, but some components are of wider interest. Some courses combine on-line learning and discussion with some on-campus gatherings. http://www.utoronto.ca/stmikes/conted/

Also at St. Michael's is the Master of Arts in Catholic Leadership http://www.utoronto.ca/stmikes/theology/basic_programs/master_artscathlead.html

The Diploma in Ministry and the Certificate in Lay Ministry of St. Francis Xavier University (Antigonish, Nova Scotia) are offered in print-based distance education format with phone or electronic contact with the instructor plus local advisors and group meetings. http://www.stfx.ca/academic/continuinged/ministry.html

The following Canadian organizations offer professional development and other educational programming that is specific to health care but is not faith-based:

- Canadian College of Health Service Executives (CCHSE) http://www.cchse.org
- Canadian Healthcare Association http://www.cha.ca/
- Canadian Medical Association: The Physician Manager Institute http://www.cma.ca/index.cfm/ci_id/20291/la_id/1.htm
- CHLNet (the Canadian Health Leadership Network) http://www.chlnet.ca/
- Executive Training for Research Application (EXTRA) http://www.chsrf.ca/extra/
- Health Leaders Institute (HLI) and the Dorothy M Wylie Nursing Leadership Institute (DMW-NLI) www.healthleaders.ca, www.dwnli.ca
- The HealthCare Leaders' Association of BC http://www.hclabc.bc.ca/

- RRU Centre for Health Leadership & Research (home of the 5C Capabilities Framework) http://www.royalroads.ca
- UBC Centre for Health Care Management: Faculty of Medicine/Sauder School of Business http://www.chcm.ubc.ca
- WRHA/RRC Health Services Management Certificate Program http://www.wrha.mb.ca/osd/RedRiverProgram.htm

Appendix F. Reflection and Discussion

These quotations from early Biblical times to the present are offered to stimulate personal and group reflection and discussion. Special thanks to Dr. Maureen Duffy for assisting the Steering Committee in assembling these quotations.

1. "Thus says the Lord God: [My people] seek me day after day, and they seem eager to know my ways … This… is… what I want: that those bound unjustly be released… that the oppressed be set free… that you share your bread with those who are hungry, that you give shelter to poor wanderers, that you clothe someone when you see him naked, that you do not reject your own flesh and blood… Then your goodness will shine forth like the dawn, and your own hurt will quickly be healed…" (Isaiah 58: 2, 6-8)

2."A merry heart does good, like medicine." (Proverbs 17: 22)

3. "Compassion is that which makes the heart of the good move at the pain of others." (The Buddha)

4. "Honour the doctor with the honour that is due him for his services, for his healing art comes from the Most High….

The Lord has brought medicines into existence from the earth, and a sensible human being will not despise them…. By them [the Lord] heals and takes away pain…. and from him health extends across the face of the earth."   (Ecclesiasticus 38: 1-2, 4, 7-8)

5. "He has shown you, O man, what is good; and what does the Lord require of you but to do justly, to love mercy, and to walk humbly with your God." (Micah 6:8)

6. "Go tell John what you hear and see: the blind receive their sight, the lame walk, the lepers are cleansed, the deaf hear, the dead are raised, and the poor have good news brought to them." (Matthew 11:4-5)

7. "In so far as you did to the least of these, you did it to me." (Matthew 25:40)

8. The parable of the Good Samaritan. (Luke 10: 25-37)

9. The call of Jesus to "love one another." (John 13:31-35)

10. Jesus washing the disciples' feet. (John 13:1-15)

11. "I can do all things through Christ who strengthens me." (Philippians 4:13)

12. Compassion: "Love readily bearing all things for the sake of the loved object." (St. Augustine, 354-430 A.D.)

13. "The person who shows love and compassion to those in any kind of affliction is blessed, not only with the virtue of good will but also with the gift of peace." (Saint Leo the Great, Pope, 440-461 A.D.) (Sermo 6 de Quadragesima, 1-2 in Patrologia Latina 54:285-287)

14. “Frances [Saint Frances of Rome, wife and mother, 1384-1440 A.D.] was not satisfied with caring for the sick she could bring into her home. She would seek them out in their cottages and in public hospitals, and would refresh their thirst, smooth their beds, and bind their sores. The more … [repulsive their condition]…, the greater was the love and care with which she treated them.” (M. M. Anguillaria, Life of Saint Frances of Rome)

15. “So many poor people come here that I very often wonder how we can care for them all…. Many… come to the house of God, because the city of Granada is large and very cold especially now in winter. More than a hundred and ten are now living here, sick and healthy, servants and pilgrims. Since this house is open to everyone, it receives the sick of every type and condition: the crippled, the disabled, lepers, mutes, the insane, paralytics, those suffering from scurvy and those bearing the afflictions of old age, many children, and above all countless pilgrims and travelers, who come here, and for whom we furnish the fire, water and salt, as well as the utensils to cook their food. And for all this no payment is requested, yet Christ provides.” (St. John of God, 1495-1550, priest and founder of the Brothers Hospitallers of St. John of God.) (Hospitallers archives, Granada, Spain)

16. “Christ has no body now on earth but yours, no hands but yours, no feet but yours. Yours are the eyes through which Christ’s compassion must look out on the world. Yours are the feet with which he is to go about doing good, yours are the hands with which he is still to bless.” (St. Theresa of Avila, 1515-1582, quoted in Lucinda Vardey, *The Flowering of the Soul. A Book of Prayers by Women,* 2002)

17. "The hospital affords accommodation for 16 patients and even 20 if necessary. They will accept all patients irrespective of creed who may seek admittance and who really require care or treatment. In fact, the religion of patients will not be inquired into." (Statement issued at the 1890 opening of St. Joseph's Hospital in Chatham by the Sisters of St. Joseph.) (Sister Genevieve Hennessey, C.S.J., "The Chronicles of the Sisters of St. Joseph of the Diocese of London 1868 – 1932." Unpublished.)

18. "The Sister nursed the stricken but also brought mercy of Christ to the people; it was the sacrament of God's goodness and mercy that they wanted to announce." (Blessed Josaphata, Sisters Servants of Mary Immaculate, 1869-1919)

19. "I was asked why I did not give a rod with which to fish, in the hands of the poor, rather than give the fish itself as this makes them remain poor. So I told them: 'The people whom we pick up are not able to stand with a rod. So today I will give them fish and when they are able to stand, then I shall send them to you and you can give them the rod. That is your job. Let me do my work today.'" (Mother Teresa of Calcutta, 1910-1997, founder of the Missionaries of Charity)

20. "If you are really in love with Christ, no matter how small your work, it will be done better; it will be wholehearted. Your work will prove your love. You may be exhausted with work, you may even kill yourself, but unless your work is interwoven with love, it is useless. To work without love is slavery." (Mother Teresa, quoted in Lucinda Vardey, The Flowering of the Soul. A Book of Prayers by Women, 2002)

21. "…we call upon all the baptized working in these [Catholic health care] institutions to continue to develop in them this Christian attitude of concern for the whole person. The entire staff, professional and volunteer, skilled and unskilled, need constant growth in spiritual maturity for this service. Thus both patients and staff should receive ongoing pastoral care and education in faith." ("New Hope in Christ: A pastoral letter on sickness and healing," Canadian Conference of Catholic Bishops, 1983)

22. "Always remember how closely your daily concerns touch on what was at the heart of Jesus' ministry: to heal the sick and to comfort the suffering. Care for all people equally, according to their need but independent of creed, colour or income, for each person is created in God 's image and has unique importance within His creation. In your reflections you will draw even deeper inspiration from the knowledge that it is Jesus Himself who comes to meet us in the sick and suffering: "I was sick and you visited me" (Mt. 25: 36). 'Our Lord, the sick' they used to say in the medieval Hotel-Dieu institutions. What better way to instil profound respect and love for the suffering?" ("New Hope in Christ: A pastoral letter on sickness and healing," Canadian Conference of Catholic Bishops, 1983)

23. "Healing best takes place in an atmosphere of love and understanding which includes reconciliation with oneself and with others. Thus, to rely on faith without medicine would be irresponsible, but to rely on medicine without faith would be also inadequate." ("New Hope in Christ: A pastoral letter on sickness and healing," Canadian Conference of Catholic Bishops, 1983)

24. "I believe that humans are wired for faith and that there is a special healing generated by people who rely on faith." (Herbert Benson, *Timeless Healing: The Power and Biology of Belief,* 1997)

25. " … being present to people at the critical points where life can be fostered, where people are born and die, where they learn and are taught, where they are cured and healed, and where they are assisted when in trouble." *(Health Ethics Guide*, CHAC, 2000)

26. "Those in positions of leadership must recognize their role is, first of all, a ministry of loving service and relationship." (*Health Ethics Guide,* CHAC, 2000)

27. "Above all, care of the sick is inspired and judged by the spirit of the Gospels. The sanctity of human life is protected for all… Gospel stewardship of health care resources and not-for-profit motivation keep us responsible to patients, to society, and to God. Our goal must always be to reach out to serve those who are suffering, not to sell a product. We are committed to care for the spiritual well-being of those whom we serve, and to respect their unique human identity." (Six Alberta Bishops and administrators, "The Healing Ministry of Jesus Christ," *Western Catholic Reporter,* 15 February 2000)

28. "Fr. J. Bryan Hehir, Th.D, a noted theologian, suggests that people who come to Catholic health care organizations must find 'a social attitude that radiates' from them. 'In our high-tech age, physicians, nurses, receptionists, technicians—indeed, everyone in Catholic health care—must look into each patient's face and see the human being behind the suffering, the person behind the disease.'" (Suzy Farren, "Jesus' healing of the leper is a message for our ministry," *Health Progress,* May/June 2002)

29. “More than ever, all hospitals and long-term care institutions must be experienced as beacons of hope, centres of warm welcome and excellence, where compassion, holistic care, ethical reflection, and faith-driven leadership are palpably and conspicuously in evidence. This is precisely where Catholic care-givers can and must make a difference. This is where their voice, their presence and their advocacy role on behalf of the sick can make a distinct and altogether indispensable contribution to the existing Canadian health care system. Like the ‘inn’ in the parable of the Good Samaritan, health-care institutions must be havens where even the marginalized and disadvantaged are admitted and find care.” (Catholic Health Ministry in Canada, Pastoral Letter of the Canadian Conference of Catholic Bishops, 2005)

30. “The hallmark of Catholic health care is conspicuous in several respects: a deep respect for the dignity of every person; just and appropriate treatment afforded to everyone without distinction; spiritual and religious care; ongoing reflection on the ethical questions of the day; compassionate end-of-life care; and a readiness to reach out to the vulnerable and sick in society, who are frequently left behind and are least able to fend for themselves. The Church brings her religious faith to bear on all these aspects of her health and healing care.” (Catholic Health Ministry in Canada, Pastoral Letter of the Canadian Conference of Catholic Bishops, 2005)

31.“Catholic health and social care should distinguish itself by service to and advocacy for those people whose social conditions puts them at the margins of our society and makes them particularly vulnerable to discrimination” (Sister Ketteler SGM, 2007)

32. “We act not in our own name, not for our own prestige, but with the power of the One who has called and inspired us.” (*Holy Memory, Faithful Action*, Catholic Health East, USA, 2007)

33. “The medical and human aspects [of health care] must never be separated and it is the duty of every nursing and health-care structure, especially if it is motivated by a genuine Christian spirit, to offer the best of both expertise and humanity. The sick person… understands in particular the language of tenderness and love, expressed through caring, patient and generous service…” (Pope Benedict XVI, Address to the 23rd International Conference of the Pontifical Council for Health Care Ministry, November 21, 2008)

34. “Ethics is a process of intelligent inquiry about what may, ought or ought not to be done in the area of personal decisions, professional action and social policy.” (Dr. David Roy, Institute of Clinical Research Montreal, Quebec)

Appendix G. Acknowledgements

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"Healing best takes place in an atmosphere of love and understanding which includes reconciliation with oneself and with others. ... [The hallmarks of Catholic health care are] a deep respect for the dignity of every person; just and appropriate treatment afforded to everyone without distinction; spiritual and religious care; ongoing reflection on the ethical questions of the day; compassionate end-of-life care; and a readiness to reach out to the vulnerable and sick in society, who are frequently left behind and are least able to fend for themselves."

Canadian Conference of Catholic Bishops

"We care for everyone and we employ all kinds of people, regardless of their religious beliefs or lack of, and we are motivated to do that out of a love of Christ."

Susan House, Executive Director, Catholic Health Association of BC

This introductory text is both a learning resource and a reference guide for forming leaders of values-based or faith-based health care. It complements the Health Ethics Guide, also available from the Catholic Health Alliance of Canada.

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