Integrating Missions: The Crafting of Organizational Identities in Multi-Partnered Health-Care Systems Today

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In his latest book, NY Times columnist and Pulitzer Prize winner Tom Friedman reminds us that we live in an "age of accelerations," where the volume and the velocity of change impacts all of us across every sector of our lives (personal, familial, social, psychological, spiritual and cultural). Our workplaces have become globalized, digitized and robotized at a rate and range, scope and scale that we have never seen before. Most laymen were introduced to the supernova capability of today's computers to collect, digest, weigh and evaluate complex data when the computer, Watson, from IBM's Thomas J. Watson Research Center in Yorktown Heights, New York, played and won against two very successful men on Jeopardy in 2011. Friedman reminds us of the speed and power of computing in the medical field:

> The bridge to the future is a Watson that can make massive amounts of diagnostic complexity free. In the past, when it was determined that you had cancer, the oncologists decided between three different forms of known treatment based on the dozen latest medical articles they might have read. Today, the IBM team notes, you can get genetic sequencing of your tumor with a lab test in an hour and the doctor, using Watson, can pinpoint those drugs to which that particular tumor is known to best respond – also in an hour. Today, IBM will feed a medical Watson with 3,000 images, 200 of which are of melanomas and 2,800 are not, and Watson then uses its algorithm to start to learn that the melanomas have these colors, topographies, and edges. And after looking at tens of thousands and understanding the features they have in common, it can, much quicker than a human, identify particularly cancerous ones… estimates suggest that a primary care physician would need 630 hours a month to keep up with the flood of new literature that is being unleashed related to his or her practice.[1]

The exponential growth in technology and globalization challenges how we educate for the future and how we, as leaders, anchor and empower our workers for life-long learning and the unique skill set that only humans can bring to the enterprise of human flourishing in the 21st century. Business strategist, Heather McGowan, puts it this way. In an age of accelerations, "learning becomes more important than knowing" and "the new killer skill set is an agile mind-set that values learning over knowing." This mind-set, she says, "positions the individual with an expectation of lifelong learning and adapting with a focus on the uniquely human skills of empathy, social and emotional intelligence, judgment, creativity, divergent thinking, and an entrepreneurial outlook for a long career that may include, according to recent studies, up to twenty jobs across as many as five industries."[2]

The very nature of work is changing around us and, even in those industries celebrated as harbingers of progress, such as universities (where I work) and hospitals (where you work), it is still difficult to get segments of our workers to assimilate to change and understand our mission and purpose in the new economy that is emerging. Friedman offers a helpful image. In the 19th century, we worked in an "industrial economy," where we were all pretty much "hired hands," slaves to machines and the widgets our factories produced. In the 20th century, we adapted to a "knowledge economy," where America manufactured more ideas than products, letting robotics replace brawn in so many of the industries (like automatives, coal, etc.) that once ushered in America's prosperity after the First and Second World War. We became "hired heads" who used our computers to track efficiencies and spot innovative connections and solutions at the click of a mouse. We became aware that human progress needed more than muscular power; it demanded process and the virtues that insight required – transparency, accountability, participation, and dialogue.

But, what now? What is required of us as leaders now that we are fully immersed in our knowledge economy? Let me take my cue from the former Surgeon General, Vivek Murthy, who said when he was asked what was the biggest disease in America today. Without hesitation, he said: "It's not cancer. It's not heart disease. It's isolation. It is the pronounced isolation that so many people are experiencing today that is the great pathology of our lives today."[3] We are the most technologically connected generation in human history and yet we are increasingly disconnected interpersonally. My students reveal this to me consistently every year. Although they are the most institutionalized generation

[1] Thomas L. Friedman, *Thank you for being late: an optimist's guide to thriving in an age of accelerations* (New York: Picador, Farrar, Strauss and Giroux, 2016), 109.

[2] Quoted in Friedman, 258-259.

[3] Quoted in Friedman, 490.

ever, they report being disillusioned and alienated from most of the institutions to which they are tied. And, even though they are hard wired to social media and cannot imagine disconnecting from it, they admit to powerful streams of inexplicable loneliness, even as they text and tweet for hours on end every day.

This labored introduction brings me to my first point. This is precisely why and where mission and mission integration come in and are vital for the growth of your health care system. Mission is the inflection point of passion and purpose, where connection is made and where trust is established throughout your whole health network. It is the "why and wherefore" of what you do. It is the hierarchy of meaning that you live by and work for in units and departments and across your institutions. It is the "horizon of expectations" that you have for your relationships and for the work you do in the hospital, in the community and for the world. It's the world beyond widgets and Watson that frees up the uniquely human skills in us of empathy, social and emotional intelligence, judgment, creativity and compassion, the oldest medicines in the world. This is why Friedman says that the world beyond the knowledge economy of the 20th century will require us in the 21st to become "hired hearts," women and men not just with skills but with attitude "for the other."

The Purpose of Mission

There is a significant amount of confusion and not a little skepticism about the real purpose of mission statements and whether the whole field propagated around mission statements is not just the softer side of public relations and the engine of institutional and commercial propaganda.[4]

C.K. Bart, one of the leading researchers in the field of institutional or corporate mission, after reviewing mission statements across a wide spectrum of organizations, located 11 major purposes for and components of mission statements:

1. Statement of organizational purpose or raison d'être;
2. Statement of values/beliefs/philosophy;
3. Distinctive competence/strength of the organization;
4. Desired competitive position;
5. Relevant/critical stakeholders identified;
6. Statement of general corporate aims/goals;
7. One clear and compelling goal;
8. Specific customers/markets served;
9. Concern for employees;
10. Concern for shareholders;
11. Statement of vision.[5]

For more than 30 years, mission statements have been a widely used strategic tool to help emphasize an organization's uniqueness and identity. They have been used to introduce and induct new employees to the history and culture of an organization. They have become instruments to weave a common thread of purpose across the diverse systems, units, and departments of corporate networks. More recently, they have become the platform for organizational ethical decision-making, where the very culture of the corporation in its beliefs, emotions, rituals and resources are evaluated and assessed. The question on the table at least in the literature today is whether mission statements actually have an impact on employee and corporate performance.[6]

And it is here that I want to offer you some thoughts on mission integration and mission development in the complex and complicated world you live in as a multi-partnered health care system today. I want to share an assumption I hold about mission and it is this. Technically it is this – that mission is an expression of our narrative imagination. It is best told in stories of people with passion and purpose who made connections and constructed layers of trust that allow an innovative event, a healing and generative moment, to happen. Mission is best told in flesh and blood. Too often we try to capture mission in a definitional-type statement that is devoid of character and characters. The mission statement becomes abstract, theoretical and removed from the realism of originating moments that inspired and captivated individuals to trust one another for new purpose.

The danger is especially acute when diverse systems with very different histories are brought together. The well-intentioned effort to bring order out of the chaos of innovation sometimes results in mission being spoken of in universal, abstract, and general terms that, except for a word here or there, could be spoken of any well-meaning corpo-

[4] Ines Alegre, Jasmina Berbegal-Mirabent, Adrian Guerrero, and Marta Mas-Machuca, "The real mission of the mission statement: A Systematic Review of the Literature," *Journal of Management & Organization* 24:4 (2018), 456-473; I.M. Macedo, J.C. Pinho, and A.M. Silva, "Revisiting the Link between Mission Statements and Organizational Performance in the Non-Profit Sector: The mediating effect of Organizational Commitment," *European Management Journal* 34:1 (2016), 36-46.

[5] C.K. Bart, "Industrial Firms and the power of mission," *Industrial Marketing Management* 26:4 (1997), 371-383.

[6] Ines Alegre, Jasmina Berbegal-Mirabent, Adrian Guerrero, and Marta Mas-Machuca, "The real mission of the mission statement: A Systematic Review of the Literature," *Journal of Management & Organization* 24:4 (2018), 456-473.

rate institution in the field today. The danger is a soul-less expression that is engineered for maximum tolerance but which divorces participants from context and connections that make corporate trust real and serviceable. What is missing in many of the mission statements I work with is, what I might call, the *texture of suffering and sacrifice* that gave birth to the originating founding moment of innovation. This is where "narrative imagination" comes in. Your staff, employees, stakeholders and leadership need to hear the voices of your founders and their first-and second-generation staffs, doctors, nurses, janitors, administrators and communities who built connections with one another beyond the poverties they were experiencing, building trust which is the connective glue of innovation.

The Three Voices of Mission

It is simpler when there is a singular lineage in your institutional system, a somewhat straight-line through the generations of those who have served and been served by your hospital. When there is a single narrative, a common plot, a recognizable and familiar cast of characters with suffering and sacrifice, personal creativity and individual idioms, we can understand their distinct and differentiating passion and purpose with some ease. However, that is not the situation of many health systems today. With multi-partnered systems the founding moments and memories are different. The original inspirations are distinct. The partners may have some common elements, but take away the historical context and one ends up with abstractions and generalizations that may be more forced than inspirational and empowering.

To understand mission today one needs to be introduced to the multiple, non-linear, asymmetrical stories behind any one system. One needs to hear the tones and cadences of the various founding personalities or, better put, founding connections that trusted enough in a common future to put stakes into the ground and make a go of it together. That's the exciting moment of mission insight, when we finally look back and see, hear and feel how passion met purpose and gave it an institutional name and direction.

To break this open with you, let me offer that there are three missional voices at play in an integrated network such as yours. These three missional voices harken back to the founding imagination of your various hospitals, the stories each were trying to replicate from whatever "sacred sources" were available, useful and purposeful to them at the time. These missional voices resonate with the experiences of distress and disease, hope and happiness, sacrifice and suffering these founding individuals were willing to engage and endure to make a difference in their world. I think there may be three founding missions at work:

1. The Secular Vision;
2. The Judeo-Christian Vision;
3. The Franciscan Vision.

Each of these has a particular vision of the business of health care. Each of these engage what it means to work for the good life, for health and flourishing in slightly different ways. My assumption is that it will not be helpful in the long run to try to find what is common in all three and abstract that into a universal statement of purpose. That to me is the trap of modernity with its need to find a common and comfortable platform for tolerance. My assumption is that we will be more encouraged and inspired by listening to each of these voices in their own distinct language and with their diverse points of emphasis. The point of mission integration in the future is not to adopt one language, one history and one context but to be satisfied, engaged and empowered by the three founding voices in mutual dialogue with one another. We will grow by learning how each system speaks and appreciating the unity in diversity they engender when they meaningfully converse with one another.[7]

So, how do these three voices of health care mission sound? (Obviously, this could be a book in the making, but let me outline in the short time we have what are some of the general characteristics.)

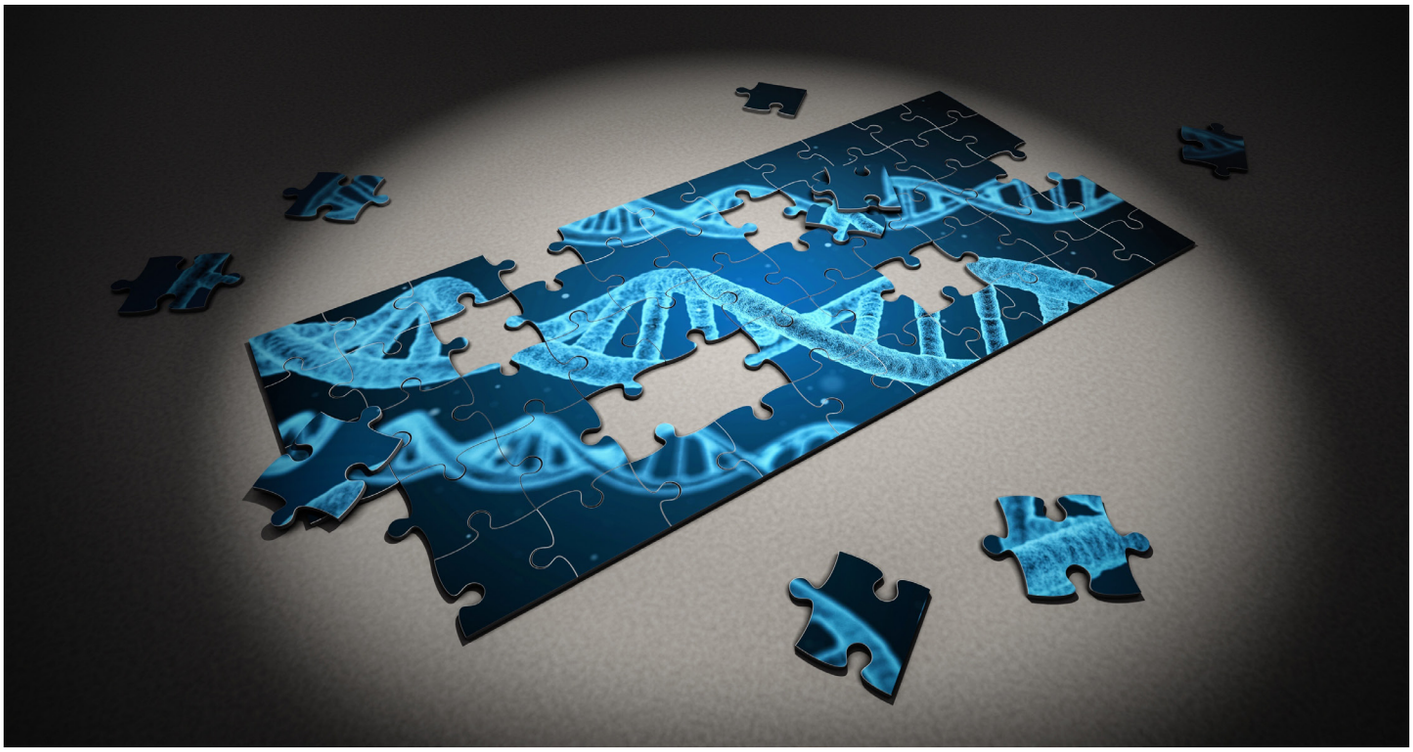
The Secular Mission of Health Care

In his latest book, *What is the Good Life,* the French philosopher, Luc Ferry, tries to describe the vision and meaning of health and flourishing in a post-modern world stripped of ultimate meaning, transcendent values, where the public square has been finally flushed of all remnants of the divine and we are left with our human reason, our commitment to science and our desire for love as the only tools we need to build the common good for each other.[8]

Ferry comes from a long line of French philosophers who want to rescue humankind from the "fables" of religious thought in order to secure humanity's progress and its health on the much firmer and surer ground of scientific thought alone. There is no room for any religion in this ultra-humanist's utopia, not even in the private corner where most philosophers assign God a somewhat safe and non-intrusive space. And so, unlike his philosophical predecessors who offered a quite depressing view of what comes of the project of "humankind come of age," with their talk of nihilism, deconstruction, the return to Thomas Hobbes' "war

[7] This thesis has been well-explored by David Tracy, *Plurality and Ambiguity: Hermeneutics, Religion and Hope* (Chicago: University of Chicago Press, 1987).

[8] Luc Ferry, *What is the Good Life* (Chicago: University of Chicago Press, 2005).



of all against all," and inevitable clashes between the rich and the poor (Marx), Ferry presents a more benign view of flourishing and the good life.

I wish to use him as our interlocutor today, because he represents a benevolent view of a secular vision of health care, one that stands on science and reason alone, without the intrusion of religious thought. Ferry posits that secular philosophy, the underlying substructure and flooring for secular corporations today, is itself a "story of salvation," a recommendation for what it takes to arrive at a good life and a flourishing existence in the here and now.[9] Modern secular philosophy doesn't need a God to make sense of death and disease; it doesn't need saints and angels to make good on safety and security; it doesn't require prayer and piety to deliver and develop health and wholeness. It relies on reason, scientific method, efficiency, common sense and the common good as the only equipment we need to save ourselves from the most dangerous hurts that haunt us.

Modern medicine, like all secular enterprises, needs to rid itself of all talk of the ultimate and every instance of the "here after." It should substitute them with discourse about "this moment" and only "the here and now." Ferry believes that is all that we have; it is all that we ever have – today, right now, here in this space and here in this moment. There is enough right in front of us to concern and commit us. Speculation is for Ferry nothing more than distraction, a disturbance of what ordinary life calls each one of us to do and be about – the business of caring for one another in the here and now, with the concrete tools and methods at our disposal, within the limits that we must admit truthfully are real and to be expected. Religion makes promises; sciences provides methods, methods of delivering, sustaining, and maintaining life but always to a point and within limits. Religion, Ferry would hold, is about promises, promises of redemption, justification, infinite glory and, ultimately, of eternal life. But, a hospital is not heaven. It cannot and should not make those promises. It cannot be perfect, either. Its workers can be kinder, gentler, more cordial, more rigorous, more intelligent, more committed and more compassionate. However, they cannot and will not be perfect.

What Luc Ferry is doing is trying to construct a humanist, non-theist and non-religious motive for happiness, human flourishing and the good life. He argues that there are two alternate concepts of salvation: the one that is constructed on divinity and the promises of an afterlife and the other, increasing in popularity today, which is defined by its profound commitment to this world, at this time, with individuals with both their amazing passions and particularities but also their annoying insensitivities and insecurities, as well.

If we are to understand our sisters and brothers who are constructing among us a secular view of medical care, we must understand their vision and their project outside the antagonizing stereotypes and reductions leveled against them – tropes we find maddening when they are leveled against us. Those who build and run hospitals from a purely secular frame of reference do so with intelligence, compassion, a dedication to scientific truths and the scientific method and a commitment to the dignity of the human person, as we do. However, there is more to their project. We must hear the sounds, tones and cadences of their commitments. The post-modern secularists in our hospitals are not the angry,

[9] Luc Ferry, *A Brief History of Thought: A Philosophical Guide to Living* (New York: Harper, 2011).

contrarian atheists of old whose only project seems to have been the dismantling of traditions and the disenchantment of everything of original value.

Today's secularist is fundamentally committed to the here-and-now. On the whole, they do not want to build politics or progress on either the past and its traditions or the future and its insecure promises. The truth, Ferry suggests, is in the intensity and particularity of the present moment, these people at this time in this place for this unique situation. He writes (somewhat poetically) –

The precise occasion does not matter: each of us possesses a memory of one of these blessed moments of lightness in which we feel that reality is not something to be transformed, to be bettered laboriously by effort and hard work, but something to be savored immediately with no thought of the past or the future, in contemplation and enjoyment rather than in struggle and the hope of better days.[10]

Some of you may be sitting there rolling your eyes and wondering whether this philosopher has ever been in an emergency room on a Friday night, hardly a time for "moments of lightness." Are these not precisely the moments that actually need to be bettered "by effort and hard work?" Who savors the gunshot wound, the aneurysm racing toward the heart, or the leg that needs to be amputated? True enough, Ferry waxes a little too poetic for his own good, but what he is getting at and what he is trying to explain about our sisters and brothers who share his more positive view of the secular mindset is that of a profound commitment to what is, as it is, here and now, without any emotional distance from it based on traditions of the past or promises of the future. The secularist accepts reality as it is, with its agonies and its ecstasies, and (here's the tough part) desires nothing other than what presents itself in the moment for action. In Latin, this is called *"amor fati,"* – the love of what the present brings. Ferry quotes Nietzche:

My formula for greatness in a human being is amor fati: to want nothing to be other than it is, neither in the future, nor in the past, nor in all eternity. Not merely to endure what happens of necessity, still less to hide it from oneself – all idealism is untruthfulness in the face of necessity – but to love it… (Ecce Homo, "Why I Am So Wise")[11]

Ferry summarizes the thought:

To hope a little less, regret a little less, love a little more. Never to loiter in those unreal corridors of time – the past and the future – but try on the contrary to live and embrace the present as much as possible (with a 'dionysiac affirmation,' a reference to Dionysius, the Greek god of wine, festivity and joy – who above all other deities loved life).[12]

A humanist doctrine of salvation that saturates the secular project of health care in the postmodern world resonates with a belief that we must "save ourselves by ourselves," with the profound lights of reason, to conquer fears with the amazing scientific tools of progress, however well-aware we are in the 21st century of the potential for science to destroy us as well. Walter Bruggemann, the eminent Old Testament theologian, reminds us of the new soteriology (theory of salvation) increasingly popular among young adults today, the one that revolves around the doctrine of "self-invention for self-sufficiency."[13] We are producing a generation well-accustomed to the volume and velocity of change who have come to the realization that they must accept radical change without deference to the past or trepidation of the future.

The lay spirituality emerging from a secular mindset holds to three specific tenets: singularity, intensity and love.

Singularity relates to the respect that is to be accorded to each and every individual, simply because they are an unrepeatable event of all humanity. It is not simply a respect for differences but a celebration and encouragement of the potential that exists in each person, not only for herself or himself, but for all of humanity. It implies a "nondogmatic, nontribal, nonnationalistic conception of cultural identities that although (or, rather, because) they are particular, enrich the world to which they are addressed and of which they truly become part as soon as they speak the language of the universal."[14]

Singularity involves more than a vague respect for others or vague concepts of "tolerance," "dialogue," or "concern for the other." Singularity in a secular mindset is not simply an "acceptance of diversity," but it is reverence for and celebration of diversity.

When a secularist in our hospital speaks of diversity and the respect for individual rights, she is not simply implying some low bar of mutual tolerance or some half-hearted need for differences to be heard within some framework of begrudging dialogue. It is the kind of human communion that leads to what Ferry refers to as *intensity.*

Intensity is the second emblem of the secular mindset. Luc Ferry suggests that it is "the most enlarged life (that) is the most singular, the richest and the most intense."[15] A good life, he remind us, is one that brings together "in harmony the greatest possible diversity of experiences that enrich our view of humanity."[16] The good life, then, is one that encourages us to perfect ourselves, to stretch ourselves, to

[10] Luc Ferry, *What is the good life,* 255-256.

[11] Luc Ferry, *A Brief History of Thought: A Philosophical Guide to Living* (New York: Harper, 2011).

[12] Luc Ferry, *A Brief history of thought,* 190.

[13] Walter Brueggemann, *The Practice of Prophetic Imagination* (Minneapolis, MN: Fortress Press, 2012).

[14] Luc Ferry, *What is the good life,* 282.

[15] Luc Ferry, *What is the good life*, 284.

[16] Ibid., 284.

travel beyond ourselves rather than, as he says, "clinging to the rock we grew up on." The happy life is one in which we discover the human world, enrich our experiences, broaden our views by engaging the diversity of cultures and persons around us, getting beyond the particularities of our origins and personal points of departure.

A secular mindset finds its authenticity in a final element, which he simply calls "love." Ferry makes a distinction between early or infatuated love, where we are attracted to another individual by what he calls "particularities," the intimate qualities of his or her beauty, intelligence or the like. We fall in love first because he is so cute, she is so beautiful, and he is so smart, she is so witty and kind. But, Ferry says that happiness cannot survive simply on these initial particulars. We change. We get old. He is not as handsome as he was in his twenties; she is not as thin as she was in her teens. Ten, twenty and thirty years on, we change in so many ways. Ferry says that what we must attend to in a secular spirituality is the "singularity" of the other. He describes it this way:

The thing that makes someone likable, that gives us the feeling of being able to choose that person among all others, and continue to love him or her even if disfigured by illness, is of course the very thing that makes that person irreplaceable as he or she is and not otherwise. What we love in someone (or what someone loves in us, as the case may be), and what we must constantly seek to develop for others as in ourselves, is not mere particularity or abstract qualities (the universal), but the singularity that distinguishes that person and makes him or her unlike anyone else. One might say affectionately to the person one loves, "Thank you for existing," but also, with Montaigne, "because it was he; because it was me," rather than "because he was handsome, strong, intelligent, courageous," and so forth."[17]

Thus, the secular mindset has a theory of compassion, love and service that we should hear within its distinct framework of hope and care. Those of us who begin within the structures of religion and those who start from a secular scaffolding of their thoughts and aspirations both believe in salvation. We both care about a better existence, a good world and flourishing life. Put bluntly: "religion offers the promise that we will be saved; philosophy invites us to save ourselves."[18]

Our sisters and brothers who are building their lives on the platform of a secular mindset, as we have seen, structure their lives and their work on *singularity, intensity, and love.* When they speak of mission, they will speak firmly and passionately in the present tense. They are focused on patients in the here and now, with diseases and pains in the present moment. If they are good secularists (and all of us are more or less good at being what we say we are), they will be fiercely, passionately, intensively devoted to the moment in which they find themselves because salvation is not in the here-after and they are not waiting for anything or anyone to extricate the world as they know it from the jaws of death. If good is to come, if health is to be achieved, there is an intensity to this time and this place for which they want your attention and commitment.

The authentic secularist is committed to the fullness of life, as much as possible and as completely as possible, whatever the circumstances. Their commitment to the dignity of each and every person is neither vague nor politically correct. It flows from their adherence to the intensity of life. Everyone, no matter their station, status, or present condition should be allowed to live as meaningfully or authentically as he or she wishes to do so, because each individual is an instantiation of the whole of humanity, a reflection of cosmic beauty in the here and now. The doctrine of "patient care" resonates uniquely and discretely with our secular sisters and brothers. Their doctrine evidences a profound commitment to the "instants of eternity," as Nietzsche called them, the moments we live with determination, without pretense, escape or half-measures. With this as their standard, our sisters and brothers, whether in the boardroom, the lab or on the floors, wish to secure the best or most excellent life possible with profound realism.

It would be wrong to suggest that our secular sisters and brothers only see beds, numbers, cash flows and expenditures. Any one of us can fall into the materialist trap. Greed knows no particular denomination. What I am suggesting is that our secularist sisters and brothers have a unique spiritual voice, so that when they come to the table to speak about mission, we have the right to expect to hear more than materialism from them (in the narrow sense). They should not be expected to cede the moral or spiritual high ground to Christians, Muslims or Jews. For within their own philosophical tradition, there is the deep voice of conscience and commitment, indeed a secular mysticism, for those who want to speak it and those who want to hear it

The Judeo-Christian View of Mission in Health Care

To this point, I have given a positive view of the secular vision of medicine. I do not want to be naïve about the emerging social forces that are creating an even more stringent and materialist secular perspective of medicine, one that can de-personalize our patients and objectify their care. Harvard Medical School professors Drs. Michael and Tracy Balboni published a book on medicine and religion this year and note the consequences of an extreme secularist and materialist view of medical care:

There are now rival views expanding across medicine… There has been an increasing rejection of medical concern for the soul since it does not fall within the purview

[17] Ibid., 286.
[18] Ibid., 19.

of the material realm. This has resulted in a perception of the patient not as an agent of God's presence honored as sacred, but as a depersonalized object. As an object, these rival views transform the patient as primarily a sufferer into a "body" to be worked on, or a "customer" to be placated, or as a "number" within a bureaucratic machine. As these impersonal social forces have encroached on the meaning of medicine, its practice is no longer publically acknowledged as a divine gift but tends to be interpreted as a human achievement subject to whatever ends we so choose.[19]

Drs. Michael and Tracy Balboni trace the theological alliance that once existed between medicine and the Judeo-Christian faiths that created, they indicate, "an aura of sanctity around care for the sick and dying." The alliance between Christianity and medicine is a long and favorable one. Last year, theologian and historian Dr. Bart Ehrman took up that very alliance between the early Christians and the Roman Empire in his 2018 book, *The Triumph of Christianity: How a Forbidden Religion Swept the World.*[20] The thesis goes that Christianity overwhelmed the Roman Empire not by its unique view of God or its provocative pronouncement of a Savior in the world. It was due largely to its distinct care of the sick and dying. Romans had a diffident and hard-hearted view of the care of the sick and dying. Once an individual demonstrated signs of a sure or imminent death, the Romans provided no further end-of-life care. The bodies of the dying were discarded into the streets as if they were trash.

Christians, immersed in their new theology of Resurrection and in line with their view that Christ was coming again soon to resurrect us bodily as well and to recreate a new heavens and new earth, took an opposite view of the care for the sick and dying. It was immediate, immanent and hands-on, and it was apparently successful in many cases. Ordinary pedestrian care resulted in many of the dying reviving. Romans thought it miraculous – that Christians had unique power over death and dying. And so, they flocked to the faith. The Roman Empire was undone not by military force but by ordinary medical care, enlightened by faith.

Drs. Michael and Tracy Balboni locate three theological pillars to the Judeo-Christian mission of medical care: (1) the importance of the soul in medical care; (2) hospitality and (3) medicine as a gift of God.[21] These will give the sound of mission in Catholic or Christian hospitals a distinct cadence.

There has been, the Balboni's propose, a long-standing "theology of medicine" behind our practice of medical care in the West and its first principle is an alliance and *correspondence between body and soul*, so that we understand physical illness as a spiritual experience as well as a bodily event. For clinicians, this means that a physical worldview, which limits the practice of medicine only to disease processes, physical symptoms, and bodily cure or comfort is insufficient. Theologians and physicians have long spoken about the relationship between what is happening in the body and what is going on with our spirit. St. Basil long ago in his letter to Eusthasius the physician applauds physicians who practice medicine as if they operated with "two right hands" – indicating that "soul care is as much the domain of the medical art as bodily care."[22] Thus, hospitals have long held to the importance of pastoral care within the medical arts.

The second way in which the Judeo-Christian tradition has shaped the mission of medical care in the West is in the particular view we have taken of *hospitality* or, what theology calls the "imago Dei" of the patient as the "image of God," or, in Christian terms, the Christ-bearer in their illness. From the Christian perspective, for example, we are not simply speaking of the dignity of the person who comes for medical care but something more intense and indeed more sacramental. It is that we identify the patient as an encounter with the divine, an experience with God in the dis-

[19] Michael J. Balboni and Tracy A. Balboni, *Hostility to Hospitality: Spirituality and Professional Socialization within Medicine* (New York: Oxford University Press, 2019), 155.

[20] Bart Ehrman, *The Triumph of Christianity: How A Forbidden Religion Swept the World* (New York: Simon and Schuster, 2018).

[21] Balboni, 148-155.

[22] Balboni, 150.

tinct moment of suffering. As the Balboni's indicate:

Within this view, patients are not primarily vulnerable and weak human persons in need of human pity. Based on Christ's overturning of the social order, "the last will be first, and the first will be last" (Matthew 20:16), rather than being stigmatized, abandoned, or pitied, the sick (among other marginalized groups) are held in highest honor.[23]

In Christian thought, God took on flesh and became man in Jesus Christ. To the Christian perspective, the sick embody and represent Christ who came among us in the flesh. And, as Christ emptied himself of majesty and divinity in the incarnation, Christians see in the sick a special instantiation and witness of that process of becoming lowly through the ravages of illness. Furthermore, there is a special connection made between illness and the crucifixion of the Christ, who voluntarily gives up his health and well-being for the sake of redemption. "Christ's close identification with sinners and human weakness comprises the internal logic in why caring for the sick is to receive Christ himself."[24]

In the Christian sense of mission and, especially in those denominations with an intense view of a sacramental correspondence of the material and the spiritual such as we might find in Catholicism and Anglicanism, caregivers are thereby called to receive and care for their patients as if they were directly caring for the Suffering and Crucified Christ. This is a radical vision of hospitality, which goes far beyond the niceties of polite and uplifting conversations at the bedside. Medical practice in this model creates sacred spaces whereby hospital staff at every level begin to realize the deepest spiritual import of what they are doing – they are visiting Christ in the experience of treating the suffering patient. Once again, the Balbonis tease out the pastoral dynamic at work. "Patients are not merely passive objects who hold the sick role but are active agents offering hospitality, receiving guests, including their caregivers, into their presence under difficult circumstances."[25]

Mission finds its third pillar in the realization that medicine, in the Judeo-Christian mindset, is a *gift from God.* From this perspective, medicine is more than a human achievement and greater than an instance of human genius or ability. Medicine is more than our work and our technology. The Judeo-Christian framework is immersed in a world of God's abundance, where the world is suffused with the beauty, truth and goodness of a God who is "good, all good, supremely good, all the time and to everyone." Thus, health is not simply a human project. One's ultimate hope is not totally or fully in the hands of clinicians or administrators. Our ultimate well-being and flourishing are in God; life and death are in God's hands and not simply in ours.

This may seem intensely spiritual and other-worldly, but it has practical consequences. This framework resists the reduction of medicine simply to a commodity or to a calculus of risk management and cost benefits. The Balbonis tease out the implications of a view of medicine consistent with the Christian notion of agape love:

While costs incurred need to be foreseen and engaged by sound business practices, any underlying motivations toward wealth generation, corporate greed, stock portfolios, and so on are corrupting influences within the service of the sick. If medicine is a divine gift, then humanity should not in turn treat it as a commodity for purchase or sale. Likewise, the sick should receive excellent care even if they cannot adequately pay the actual costs of care. Yet the religious rationale that frames medicine as a divine gift will not require nor force human generosity through legal or final compulsion… Medicine should be freely given, motivated by human love, upheld as a gift for all to hold in generosity and compassion. The Abrahamic vision of medicine grounded in agape stands in rivalry with some contemporary views of medicine.[26]

Thus, the sound of mission in a Judeo-Christian vision of the human person and of medical care is distinctive, as it is radical. The human person is an image and experience of God, not a body to be healed or a client to be accomodated. Medical care is not simply a service to be provided and it is not a commodity driven largely or solely by impersonal market forces designed for profit. There is an end or a *telos* in the provision of medical care that cannot be captured by the narrow framework of metric efficiencies.

A hospital in the Judeo-Christian heritage has a sound with certain resonances:

Hospital is a business and every business is a vocation.

A hospital may exist for profit, but it must always fundamentally exist for purpose.

Innovating efficiencies are the hallmark of our medical technological mindset, but medical care is a sacred trust between clinicians and patients who are images of God not commodities on the public market.

Every hospital founded on the images and parables of the Scriptures exists because those sacred stories provided a command to care and a reason to innovate. One of the most favorite of the parables of the New Testament that is used in medical settings is the story of the rich man and Lazarus (Luke 16:19-31). Lazarus is an extremely poor man who is dying, while he begs for food outside the gate of a very wealthy but uncaring man. He begs for food, scraps from the table of a man that the Bible says "eats sumptuously every day." Lazarus is covered in sores. The rich man refuses to respond; he refuses to care. Even the dogs notice; even the

[23] Balboni's, 151.
[24] Balboni's, 152.
[25] Balboni's, 153.
[26] Balboni's, 154.

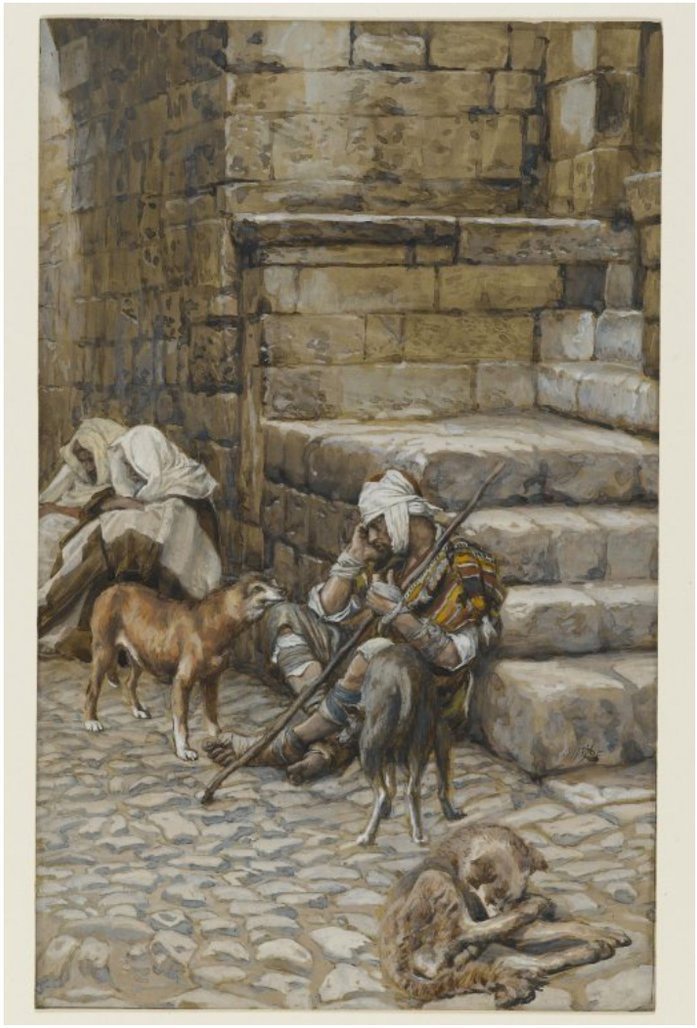
dogs care; even the dogs can muster a compassion that the rich man will not. The dogs come and lick Lazarus' wounds. But, the parable tells us something more. It gives us a haunting vision of injustice today. We have in our heads so many theories of what injustice is: the calculation of more evils than goods, the refusal to give someone what is owed to them, unfair processes that lead to unequal consequences. The Gospel cuts through all of them by giving us the image of a chasm. What is being constructed here is a chasm, distance that the rich man creates between himself and the poor man Lazarus, as Lazarus lay dying at the rich man's gate. And this distance gets transferred into the next life as the experience of hell.

Lazarus wasn't just suffering from a disease. More than that, Lazarus was suffering from the social construction of distance – social distance, political distance, and religious distance—all the rationalizations that the rich man gave himself as to why he didn't have to care, he didn't have to treat, he didn't have to have compassion on Lazarus.[27] We know that what is happening is a human and social construction and not a fact of nature, because even the dog refuses to play into the distance imposed by the rich man. The dog comes close and licks the wounds of the poor man.

These kinds of stories and parables will be in the background of what these hospitals founded in the Judeo-Christian heritage will do and how they will live out their mission. Parables like these may find themselves in the windows of your entrance ways and your chapels. They may speak from the statues that remain in the atriums of your medical facilities. Some may want to dispense with the ancient imagery and find a way to tuck these symbols away from public view for fear of giving offense or in the hopes of securing the status of a universal tolerance so near and dear to the modernist project. But, those statues project a powerful commitment to break down the isolation and alienation that is endemic in our post-modern frenzy. As every school child once knew, the rich man suffers from the torment that his own distance created and it is the once marginalized and excluded Lazarus who now remains eternally close, in the embrace and indeed in the very bosom of Abraham.

The Franciscan Vision of Mission

There is one final story to tell, another sound of mission among you, and it comes from a young man standing naked in the public square near the beginning of the 13th[h] century. He is the son of wealthy cloth merchant whose adolescent dreams were of becoming a knight for the good and glory of Assisi, but whose hopes were dashed and his spirit crushed by the brutality and futility of a war that butchered his young comrades and left him profoundly disillusioned with his society, his family, and his church's obsession with greed and violence.



As we see him at the age of 24, Francis stands naked in the public square, ready to renounce his family, his culture, and his former way of life, because he now wants off the social grid, out of an economic system designed for the wealthy few over against the destitute many. He no longer wants any part with the parties of his youth. Having seen the toxic and torturous nature of war and what it did to his soul, he now wants only to serve the lepers who have been thrown out of the town of Assisi and forced into perpetual exclusion from any form of civilization. Francis wants to do nothing more than "have mercy" on them, as he feels God has done "mercy" on the drunken and lust-laden days of his wild youth.

Francis of Assisi's conversion begins in the health care crisis of his day, the inability and unwillingness of contemporaries to find a solution to the emotional and social problem of leprosy. Francis doesn't expect a medical cure; that is too much to ask. But, Francis intends to deconstruct the distance that society has created to define the disease. Francis intends to build a new social experiment that he calls "fraternity," that will inspire other young men and women

[27] We are applying the thoughts of Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Tavistock Publications, 1973).

The Seven Freedoms of Clare	Implications of the Freedoms For Mission
1. Freedom to find God in her voice and experience.	Do we take women's experiences seriously in all our institutions, units, departments and programs? Do we take *all* women's experiences seriously? Do we regularly consult and converse about the increasingly complicated lives women in our health care network are expected to negotiate as professionals and patients? Are diverse groups included, empowered and treated fairly at all stages of the work cycle? In what departments or programs are women under-represented and perhaps underpaid? Do we name and follow through on the diverse needs of women today? Are we focused on the specific and distinct health needs of women and girls in all our social communities? Does the larger community understand and accept a specific commitment to women's health care needs? Does the imagery, iconography, art of our hospitals reflect the "Franciscan feminine" and engage both women and men in the power of the Franciscan feminine to innovate and create new ethical spaces for dialogue in a polarized world?
2. Freedom to live an intentional life of compassion and mutual charity	Processes and procedures designed for mutual charity vs. hierarchy and control; Leadership, governance and decision making that is collaborative
3. Freedom to live a life of simplicity, outside the conventions expected of women **4. Freedom to live a direct experience of the divine** **5. Freedom to live a spirituality of feminine strength that challenges the notion of the "weaker sex"** **6. Freedom to have economic independence and construct relationships of collaboration and generosity**	Work-life balance Procedures that support female advancement in the workplace Holistic assessment of spiritual needs of patients Work culture free of harassment and exploitation Positive promotion and access to advancement Pay equity Development of fraternal/relational economy Transparency, dialogue, accountability, solidarity and austerity
7. Freedom to develop a spirituality of the feminine body that upends masculine definitions of women's bodies as "evil" and "tempting."	Programs for women's health and thriving

like himself to work in total service to the very poor among them. They will renounce everything they now own or could own in the future to draw lepers and the poor out of the shadows of their loneliness and marginalization. He will bring them close, indeed he will draw lines of connection through everything in the cosmos and, with his *Canticle of the Creatures,* he will create a vision of a universal fraternity where everything in creation becomes a brother or sister. Nothing is above or below. Nothing dominates and nothing is deprived. Hierarchies of power and privilege are dismantled so that everyone can enjoy the basic freedoms, the original goodness of life received humbly and simply by everything and everyone, from a good and gracious God.

The common words for mission like dignity, respect, participation, dialogue and discovery seem mild and, indeed paltry, before the magnitude of mission that Francis of Assisi is proposing. Francis, when dealing with the health care of the brothers, does not speak of "chairman," "presidents," "chief operating officers." He never uses paternal or military terms in this regard. He speaks in powerfully maternal terms. The brothers should act like mothers; they should gather the poor and sick like "hens gathering their chicks." Francis knows that he is turning social roles upside down, not simply to disrupt the greed and violence that had such a corrosive effect on the health care of his day. He is proposing disrupting ges-

tures to break down the distance that keeps the lepers and all the poor not only marginalized in society, but also excluded from the basic benefits of social life. Francis' gesture toward the lepers and those of his brothers and sisters are not "private acts," best catalogued under the piety of the friars. He is offering a radical disruption that requires a social reconstruction that puts clinicians and leaders, administrators and staff, doctors, nurses and patients into a new ethical space of mutual support. The fraternity they are creating by their new form of hospitality is an ethical space of mutual care, provided in humility by both patient and caregiver, who are to see Christ in one another. The technical skills of one are of no greater import than the humble reliance and resilient courage of the other. Hospital space is not stratified by economic class, professional degrees, technical skills or salary compensation. In a mission-driven by Franciscan principles, these are replaced by new fraternal and sororal relationships, where highly-skilled physicians and weak indigent patients are brothers and sisters needing one another.

No Franciscan does this better in the earliest days of the Franciscan movement than the Lady Clare, a young girl of 18 who steals away from the family palace on a dark Palm Sunday night. In a covert operation to renounce her title, her fortune, and the requirement to marry the man of her father's choice, she chooses to follow the humble Francis in his primitive but radically new and humble mission to the very sick poor of Assisi. This young woman faces the disgust and disgrace, the rage and the violence of the men of her family, but she withstands it to become what I have called her, "the proto-feminist of hope."[28] At such a young age, she has the presence of mind and the strength of will to take medical care in her own hands and refashion it in a new and never before seen feminine way. She provides new optics for understanding what medical care is really all about and what roles and relationships of trust are needed to provoke innovation, which has been the signature mark of her conversion to Franciscan life.

As the minister-abbess of her community, she creates a new ethical space in which the sick and the poor engage, trust and serve one another. From the radical position of the most humble kind of love, she finds ways to tease out new opportunities for agency, discovery, care and comfort, support and strength in the in the most tragic times of illness and dying. She does it through what I have recently called, "The Seven Freedoms of Clare."

Let me present an outline of those seven freedoms and provide a very brief orientation to them.

I want to argue that the sound of Franciscan mission in health care sounds radically different when we finally hear

[28] David B. Couturier, OFM Cap., *The Voice of Victims. The Voice of the Crucified* (St. Bonaventure, NY: Franciscan Institute Publications, 2019), 55-80.

the voice of the first Franciscan woman.

In the schema below, we posit the seven freedoms Clare discovered in her new experiment with Franciscan life. In the second column, we highlight some of the implications for mission that we might gain from them today.

The Franciscan Voice in the Mission of Health Care: its modern resonances

We promised at the beginning of this paper that the Franciscan voice in health care would be different than the secular model and even the Judeo-Christian model, from which it comes. The Franciscan voice doesn't contradict the Catholic or Christian voice; it adds a particularly prophetic sound to its sense of mission. Therefore, its sounds are more intense and urgent in its calls for reform and change, especially when it comes to the needs of those who are the poorest among us.

Franciscans find their spiritual roots in the liberation tradition of the Scriptures, as when Moses frees the Jews from slavery because Yahweh has heard the "cry of the victims" in the brickyards of Egypt. This is for Franciscans a remarkable turn-around in history, for, as we know, no one hears and no one truly listens to the cry of the poor in history. No one cares what happens to the slaves, the sick and the broken. The gods of the ancient world do not care; the Pharaohs of Egypt couldn't be bothered, which makes it all the more noteworthy that Yahweh enters history as a political agent that who will disrupt and undermine Pharaoh's work project and labor force. Yahweh demands that Pharaoh set the slaves free. Pharaoh refuses. He considers it madness that a foreign god of an insignificant tribe should dare think of disrupting his workforce and strategic plan. Nonetheless, Yahweh liberates the poor and they are permissible victims no more.

Similarly, Jesus in his time takes up the cause of the poor and marginalized, the prostitutes and tax collectors. He dies for that association but returns as the Risen and Crucified One, still bearing the brand marks as the victim of Roman's brutal domination. More than that, his return as the Resurrected One means that he returns to be once and forever the "forgiving Victim," the compassion of God for all who are diseased and in distress, all those stricken and stereotyped.

I have made the case in my latest book on *The Voice of Victims* that the "voice of God" in the 21st century is the "voice of victims," every person who has been marginalized, abused, victimized, alienated and abandoned.[29] The sound of mission in Franciscan hospitals, therefore, must have a direct resonance with this retrieved and liberating cause. Dignity, respect, dialogue, and discovery are too vague for the depth of pain and suffering, the trouble that the poor and traumatized are facing in our world today.

Let me summarize what having three diverse voices of mission might mean for you moving forward.

In conclusion

Modernity taught modern medicine the art of a universal approach that could apply to all, or at the least, to be efficient for the majority who needed it. And so, across our systems we tried as best we could to collapse and consolidate people and processes to have the greatest returns in effectiveness for the slimmest margins of cost and expenditure of resources. We are learning over time that consolidation may not work for mission integration in multi-partnered systems with diverse histories.

Especially in the area of organizational identity, mission may be the least amenable to consolidation. We need to acknowledge and celebrate the reality of multiple missions which are best told in stories with textures of suffering and sacrifice. These are stories that emerge from "sacred spaces" within our communities and the heroic stories in historical chronicles and sacred myths in the Jewish and Christian scriptures. They remain in stained glass windows and in our historical texts: parables of disease and distress, hope and healing, care and compassion that are our collective memories of passion and purpose. They are the engine that drive us to work with integrity. We retrieve them and practice them in our "narrative imagination" in all their distinct contexts and with their various characters. They are the miracle stories, both religious and secular, that gave rise to our great health care systems. We should carry them forward every time we get a chance to tell a story, so that our staff and patients remain convinced of their singularity and integrity, their sacred image and purpose, now and into the great future that, I believe, God has ordained for us.

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[29] David B. Couturier, *The Voice of Victims. The Voice of the Crucified* (St. Bonaventure, NY: Franciscan Institute Publications, 2019).