

The Tradition of Mentoring Part II: Leadership and Mentoring in the Culture of Healthcare

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Editorial Note

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Author's Note

The opinions presented in this text are those of the authors and do not reflect the official policy or positions of the United States Government, the Department of Defense, the Department of the Navy, or Navy Medicine.

Abstract

Leadership is a multifaceted construct. It requires mentoring as a lifelong experience. Leadership is not an isolated phenomenon, but an activity completely interrelated with those one leads. It can never be separated from its essential community or organizational context. This makes the experience of mentoring all the more critical. Adding yet to its complexity are the principles and responsibilities that leaders must develop continually over time. To ensure successful leadership, the experience of mentoring requires four important pedagogies for mutual engagement between mentors and the leaders they seek to serve and guide. The four signature pedagogies are those developed by the Carnegie Foundation: interpretation, contextualization, performance, and formation. Effective mentoring in the contemporary world of leadership inevitably requires a new paradigm for understanding and giving living expression to the individual growth and development that leaders and their organizations must experience with one another as communal partners. Such a series of new and evocative paradigms is all the more critical in healthcare communities where servant leadership and professional service touch the human person at the most vulnerable and critical junctures of life.

Introduction

In the second half of this afternoon's presentation, I would like to discuss with you the complex yet fascinating interplay of leadership and mentoring in the culture of healthcare. Healthcare providers, regardless of role, inevitably exercise some form of leadership. Effective leadership requires equally effective mentoring. Contrary to some misconceptions, mentoring is a lifetime process. It never ends. It is also far deeper than simply the acquisition of technical skills and behaviors. True leadership, especially in the extremely sensitive arena of healthcare as a human service, requires a never-ending quest for personal as well as professional improvement. What makes this even more complex is that this leadership comes about not just in any ordinary context, but in the highly charged and extremely critical context of healthcare. Unlike many other realities, healthcare gathers human beings at the most sensitive moments of life. Therefore, the exercise of leadership and the mentoring required for leaders have a special and intricate value.

To understand this complexity, I will reflect with you upon five specific areas. First, we will explore the culture that is healthcare and the role of leadership and mentoring within. Second, we will review the basic principles of healthcare ethics that give shape to healthcare leadership and mentoring. Third, we will consider briefly four areas of responsibility in healthcare. Fourth, we will reflect upon four signature pedagogies of the Carnegie Foundation that can be valuable approaches for establishing long-lasting, positive experiences of leadership mentoring. Finally, I will reflect upon an image for sustaining and advancing the meaning and mission of healthcare leadership for the future. It is my firm belief that my final comments provide a critically needed re-imagining of the fundamental goals and content for the continuing education and ongoing mentoring of leaders in healthcare.

Mentored Leadership in a Zone of Cultural Contest

Leadership is a multifaceted construct. In organizations, we can identify leaders, managers, and technicians. While their relative areas of responsibility necessarily overlap, technicians are generally responsible for carrying out operations. Managers provide tactical direction for those operations. Leaders are those who strategically oversee all areas of the organization's tactical delivery. At an even higher level, leaders are those persons and groups who coalesce and integrate all tactical directions and operations with the general mission, purpose, and strategic or long-range plan of the organization itself. From another perspective, leaders are responsible for calling a group to its ultimate purpose, its Being.

I would not say that leaders are necessarily born. Leadership is not necessarily genetic. However, it does draw upon personality traits and innate skills and abilities. It does require significant nurturing and education. It also requires personal and professional mentoring. I do not think it would surprise any of us, when we think about historical circumstances, that it is too easy for the authority of leaders to devolve into tyranny and authoritarianism. This is one reason why the ongoing formation of leadership is as important as is continuing education in leadership skills. Leadership affects and is influenced to its very root experience by one's psychology, community background, values system, experience, and personal goals.

Within this context, it is easy for us to see why mentoring is critical. Just as it is true in any of the professions or in academics, mentoring is the means by which knowledge, skills, and abilities become grafted and integrated into the values formation of the individual leader. The “what” is married with the “who.” This is a lifelong task and it is filled with deep and abiding challenges.

In ancient Greece, philosophers said that society and each person are guided by one’s “telos,” one’s end-point. We might surmise that a telos is one’s personal North Star guiding the vessel of our lives. Mentoring is that critical and deeply important lifelong formative experience that continues to draw one’s attention to one’s North Star --- and to evaluate how well or how poorly one is following the North Star --- and to evaluate how well or how poorly one is following the North Star. The mentor will call attention to the motivations and inner workings of the self that keep one aligned with one’s telos, with the path that is best and surest.

Concomitantly, it is critical to remember that leadership in healthcare has its own beauty and challenges. At this juncture, it is important that we recall that, from a particular perspective, healthcare is a culture. It has many constitutive parts. Like other cultures, healthcare organizations and communities have shared language, patterns of communication, abilities, vision, behaviors and approaches. As a culture, healthcare itself has shared meanings.

At this point, it is likely important for me that I share with you a personal reflection. Over the last half-century in particular, our healthcare institutions have been looking for ways to reduce costs, to improve benefits, and to ensure efficient delivery of services. In short, healthcare organizations and their professional leaders have tried to enact sound business practices. Yet when we observe a variety of examples, we wonder whether the proverbial carriage has gotten in front of the horse. Healthcare seems to have been made into a business.

But is this a worthy or appropriate equation? Healthcare always must make use of the best business practices and models. But healthcare must never be allowed to become a business in the ordinary sense of that word. It is a human service. It is not a business transaction or a commodity. It is not just what civilized people do for those citizens who are sick. As an ethicist, I contend that healthcare is an absolute human right because it defends, protects, preserves, and increases the dignity and worth of each human being.

To be caught up in the complexus that we call healthcare, we need to recognize that it is fundamentally a community partnership among patients, families, communities, providers, and organizational leaders. To accomplish the goals of healthcare and the quality improvement of human life, one can never approach any aspect of healthcare as simple or easy to enact. Healthcare is not a set of clear operations that require occasional maintenance like a software upgrade. Walk through an emergency room and hear the cries of those who are suffering. There is no upgrade that can take away their pain. Look into the eyes of those who are present to a dying family member in the intensive care unit. There is no technical improvement that can erase the ambiguity and loss that makes white the knuckles of those grasping the guardrail on a bedside. Perhaps we prefer to make healthcare into a business because it is easier to handle. Yet for those of who know in ourselves the depth of suffering that comes with human illness, we understand that the caring for those who are sick is far from easy. It costs us in ways that can never be captured on a spreadsheet or ledger. Hence,

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educating and forming those who would be healthcare leaders requires a very different, in fact a very ancient, form of mentoring. Mentoring is not about academic advisement. It is not about performance appraisal or laboratory supervision. Mentoring, real mentoring, is about entering into companionship in what is the inevitable vortex of human relationships at those junctures of human life that are most vulnerable. Such an experience can never be a business. In fact, its reality is beyond words. It is much like the image of Virgil who accompanies Dante throughout his journey into the Inferno.

This image of entering into a vortex came home most powerfully to me when I was in doctoral studies. My doctoral area involved ritual studies and the social sciences. One of the nearing graduates eventually published on a concept of rituals that spoke of them as “zones of cultural contest.” As she theorized, ritual is a zone in which cultures and individuals engage in a heated wrestling, an “acting out” of sorts, of values, goals, beliefs, and fundamental meanings to human life. The image she portrayed has stayed with me through the years.

In fact, based upon my initial reading of my former colleague’s work, I have come today to believe that healthcare itself, just as other cultural processes, is a zone of cultural contest. In it, the various partners collide over needs, expectations, assumptions, resources, ethics, belief systems, and values. As a zone of cultural contest, healthcare is a place of volatile change agency. Underneath the often-frantic activity of healthcare, there is an ever-changing sea of paradigms always shifting. It is an experience of ultimate complexity especially in the diverse relationships among patients, families, communities, and the healthcare institutions to which they come for help. Where then might this place those who are healthcare leaders?

Without question, healthcare leaders are in the very epicenter of a zone of cultural contest. Healthcare leaders stand at the crossroads of every professional and personal interaction that happens within their communities. If they truly are leaders, they hear all. They experience all. They are impacted by all the questions. They must continually navigate the community through every experience and assist the group to maintain fidelity to its mission, its Being. Leaders’ service in this context can never be perfunctory or mechanical.

Perhaps because of the overwhelming immensity of it all, there are those who choose the more facile pathway of keeping accounts and metrics. Yet for those who stare boldly into the very meaning of healthcare itself, there is the never-ending challenge to renounce every form of power, territoriality, and ego so that the needs of the other are greater than the needs of the self. For the institution, this means that leaders are called to public service on behalf of the public trust.

Trust. A curious concept. Never easily given. Never easily achieved. Always must be earned. It is easily bruised. It can be broken. It can also be mended, but only with intense effort and care. It requires a transparency to self that, unless authentic, will never permit anyone else to be transparent back to you. And this is where mentoring is needed.

As I said earlier, mentoring is not about academic advisement. It is not about professional supervision or performance appraisal. Real mentoring is the experience of allowing someone else to be your companion on the journey to mirror back to you exactly who you are and what you do so that your own paradigms shift for the greater good continually and without end.

But changing to achieve what? What might be the guides for mentoring leaders in healthcare today?

Ethics in Mentored Leadership: A Question of Tradition and Principles

As a culture, healthcare has an ethos, a fundamental character. Over many centuries, this ethos has been articulated into four traditional ethical principles. I believe that these principles are the foundation for what needs to be “passed on” to leaders in the act of mentoring. One might say that these principles are the foundation also for the ethos of mentoring. Before proceeding, though, I do want to point out that I have reflected on these four traditional principles and have added a fifth. Let me leave that fifth principle and my reason for its addition until I come to it specifically.

The first of the ethics principles in healthcare is that of respect for persons and their autonomy. The place of human rights has a long and volatile history. We do not need to recount that. We know that it has been a long and arduous path of inquiry as to what constitutes human nature and the human person. We know intimately well, as recently as the last hundred years, of the myriad ways in which tyrants and the powerful questioned the humanity of some peoples and races. Yet there has been the consistent cry from ethics that the human being has a fundamental right to respect and dignity. Healthcare as a human service is one of the chief expressions by which society upholds the dignity of each individual and each person’s right to self-determination, to autonomy. In the experience of mentoring for leadership there is a critical need to identify and address the leader’s role in preserving and protecting the human dignity of patients and their autonomy. Concomitantly, mentors need to be aware of those areas in the lives of their protégés that could reveal human bias and the temptation to power. If and when these instances become visible, the mentoring experience can call the individual to a greater sense of authentic leadership by addressing issues, discovering their origin and meaning, and taking the steps to move beyond these so as to be more deeply committed to the good of the other and not the self.

Correlatively, it has occurred to me over the years that the ethical principle of respect for persons is influenced greatly by Western society’s emphasis upon utilitarian individualism. From our emergence into what some call the modern era, we have a tremendous respect for the rights of the individual. Yet none of us lives as an island. We are not isolates. We are contingent beings who live our lives ever “in context.” Hence, I suggest that respect for persons requires a new ethical principle in partnership, namely respect for communities and their traditions. When a patient comes for care, they do not come alone. They bring with them, even if only invisibly, families, relationships, local communities, neighborhoods, the world. I have found it wonderfully refreshing in the last several years to listen to physicians and nurses who speak of systems medicine. Together with those who understand the nature of palliation as a total human experience not just for the dying or chronically ill, the treatment of patients is not the treatment of a single disease, a single cell, a single entity. Rather, one treats the whole person, and part of my whole personhood is all the “others” to whom I belong. In essence, then, arising from the ethical principle of respect for persons, mentored leadership must lead the leader to a greater commitment to care for, respect, nurture, and advance the communities from which we come and the communal nature of who we are as human beings.

Third, traditional healthcare or medical ethics speaks of non-maleficence. This is the very familiar, “*Primum non nocere*.” First, do no harm. In traditional clinical bioethics discourse, this has particular meaning for the choices that one might explore to treat a patient. Will a chosen curative path ultimately cause more harm than good? What is the best course of action that will decrease pain within the long-range consequences for prolonging with quality this patient’s ability to live? This is the traditional and extremely important base experience. However, in line with our discussion here, I would suggest that mentored leadership needs to raise this ethical principle up in a nuanced fashion. If leadership is about caring for the other, mentoring must raise up all the possible avenues by which the service of the self will increase harm and negate or decrease benefits. What approaches might I enact that might increase any measure of harm to the patient and all the others to whom the patient is connected? Do I understand the forces of “malevolence” that could be operative within me as leader, even subconsciously? How am I to remain aware of such forces and how they subtly or overtly “first do harm? This is a very exacting principle. It requires one to look into the mirror of the self and see the possible. Hence, mentoring is critical to looking at the self honestly and courageously.

The fourth traditional principle I wish to comment upon is that of beneficence. *Bene facere*. To do the good. Leadership not only must avoid that which would harm, but must also move toward the best possible avenues for the benefit of others. The evaluation of benefits is not automatic. Many times, there are a whole series of benefits that could be available. How does one choose the best? I suggest that there is no one simple equation or algorithm. Each situation has its own circumstances that will give shape and color to the decisions that have to be made. However, what is key is that leaders in healthcare understand the complexity of ethical decision-making. Much as we heard earlier today from Dr. Elizabeth Holmes, we must avoid biases, subconscious or otherwise, that would lead us to believe that ethics is the acquisition of easy moralistic answers to complex ethical situations. We are complex beings. The situations in which we live and find ourselves are equally complex. We need to learn to live within the shades and nuances of life, both personal and professional. In this complexity, one of our most human tasks is to evaluate and discern what is the greatest good for this person or this situation given what we know at this time. In healthcare leadership, mentoring is critical to assist the leader to acquire ever more deeply a personal sense of courage to engage in ethical decision-making. Comfort creatures as we are, we can gravitate toward the easy answer. Yet healthcare leadership is exercised in the most uncomfortable of all human contexts — the context of human fragility. It takes a tremendous sense of sensitivity and internal humanness to assess critically what are the best possible choices. Hence, mentoring for beneficence is an experience of personal and professional formation that opens up the whole human person to understand the magnanimity of the best choices and what may be their long range results and implications for all.

Finally, there is the ethical principle of justice. In clinical or healthcare research, this principle is often the basis for ensuring that risks and benefits are equally shared by participants or patients, and that no one part of the population is placed more at risk or is more privileged than any other. This is one important aspect. In terms of mentored leadership, something else strikes me. Justification is itself a term that has its origins in theology. From early Judeo-Christian thought, there is an understanding that the justice of God is not really about the doling out punishment of sin. Rather it is the filling up, or justifying care, for all those things that we lack. I find this an intriguing perspective for mentored leadership.

How able am I to see and understand the experience of “lacking” that is evidenced in the lives of those who come to us for care? How sensitive am I to how this particular person’s experiences are lacking? Do I understand the possible rage at not feeling complete? How able am I to be present to this raw experience in another person? As an instrument of justice, admitting that there may be nothing at all that I can do to help, am I at least able to face the unseemly paradoxes, ironies, discomforts, and agonies that inevitably are part of the healthcare experience? Obviously mentoring has to be involved to assist me to become ever more deeply an authentic leader in this context.

In the final analysis, healthcare is not just about medicinal cure. One might entertain that the above ethical principles remind us that real healthcare is cure + care + compassion. Such an arithmetic is never easy. It does not always add up the way we wish. Sometimes the hard realities and complex choices that face leaders seem insurmountable. Often we will fail. We must. We are only human. But there is the need to hold on to the above broad principles of ethics that help to guide our journey into the never-ending vortex of healthcare leadership. The continual presence of mentors in our lives is a critically important resource from which we can never afford to stray. Mentored leadership is essential to remembering our various responsibilities. Now, let us turn to those responsibilities by way of reminder.

Target Areas of Responsibility for Healthcare Leadership

It is important for us to recall four areas of major responsibility in healthcare leadership. It is these areas that become the zones of cultural contest that require a clear understanding of and commitment to ethical principles. Briefly let us recall these areas of responsibility before moving on to consider strategies for sound mentoring for leadership.

The first and clearest area is that of patient-centered responsibilities. Without belaboring the issue too greatly, it really can never be said enough that our first commitment must be to the care of those who come to us in need. The origins of healthcare are in human service. They are the longing and desire of the caring person to meet the needs of those who suffer. As I reflected earlier, I believe that there are segments in our institutions that find it easier to care for the “business” of healthcare than the caring that is health. Simply, the magnitude of what it means to care for the sick and the dying is enormous. It is far easier to care for metrics and two dimensional outcomes reports. Yet the nature of healthcare itself is about people and the volatile zones of life in which they find themselves. We are called into that circle of volatility. Not to enter is to betray the fundamental purpose of who and what we are called to be.

To care for others in this way brings us to a never-ending commitment to academic and professional enrichment. Our knowledge, skills, and abilities are at the service of others, not the self. Unless we stay prepared and at the forefront of our knowledge and operational base, we risk harming others or harming the initiatives, programs and resources that we are meant to steward and lead for the benefit of others. We humans have an incredible temptation toward inertia. There is always the danger that one can believe that, upon achieving the doctorate or another degree, one knows all there is to know. Yet there is no resting place. There is no time or plateau in our lives where we ever will know enough, be proficient enough. To care for our own dignity and to care for the good of others must always lead us to know more, to understand more, to practice more proficiently, to care more, to “be” more.

Such caring is not just about my individual relationship with patients and their families. It also is about how our institutions are shaped, formed, and advanced over time. In a day and age when nations and individuals have been threatened by new forms of terror and oppression, our institutions must stand ready for new forms of service and healthcare leadership. One of the exemplars that leads us in this fashion is healthcare and medical research. Research, like healthcare itself, is not a commodity or a business. It is part and parcel of healthcare delivery. Unless it is so aligned, it fails. It has no relationship to its ultimate meaning. It loses its ethos and can devolve into practices that violate the fundamental humanness of healthcare. One only needs to read the newspaper accounts of ethical violations that have happened during clinical trials in developing nations to realize how this can happen. While research is not the only form of what I am sharing with you at this time, it is a central example of how our institutions have to remain open to new and sometimes uncomfortable places of change. What is our mission yesterday may not be our mission tomorrow. As human needs mutate over time, our institutions need to stand ready for the ever possible. As mentored leaders, one of our clear contributions is to call our institutions to be attentive to the needs and opportunities that are calling us to change and advance for the good of others and their dignity.

Finally, healthcare is tied to the fundamental nature of the public trust. Our care for the sick and the needy is not simply an individual act of personal goodness or sentimentality. We are all well aware that society has an obligation to care for the less fortunate. We need not review those mandates here. They are well known to us all. Mentored leaders have at the core of our service a responsibility to the public trust. This area requires some important reflection for us all. I wonder if we say words such as “public trust” but then minimize their impact. Perhaps because the “public trust” seems so immense, we hear the words but never carefully consider the overwhelming price of what it means to be public servants as healthcare leaders. Ours is not a leadership or profession that belongs to me alone as if it is a private act. To enter into the zone of cultural contest that is healthcare is inevitably to wrestle with one’s responsibility to society. As human beings come to us connected to their communities and to society, when we bid them enter our institutions the care we give them powerfully touches the public trust that we individuals and our institutions must serve without compromise.

But how do we continually allow ourselves to be mentored for this type of leadership in healthcare?

I would suggest there exist strategies that help us maintain a continuous approach to personal and professional formation. Indeed, these are not areas in which we can ever enter alone. Mentoring is therefore a lifelong experience. These are important areas of growth and development for each of us and for those who grace us by being our mentors.

Strategies for Ongoing Formation and Mentoring in Healthcare Leadership

The Carnegie Foundation in the United States has been developing and authoring a series of highly informative texts that address various aspects central to the education and formation of individuals entering the traditional professions: law, medicine, education, ministry/theology. Termed as “signature pedagogies,” the Carnegie Foundation presents a variety of approaches that are critical to the ongoing development in these professions. I believe that these are central to the continuing formation of mentoring for healthcare leaders. Let me share with you four that I have found particularly intriguing.

Before summarizing these for you, however, let me make a preliminary comment. Each of these pedagogies is an example of praxis. Praxis is an interesting word. It comes to us from a variety of disciplines. In essence, it means something akin to “action in reflection.” In other words, a praxis is an experience where someone is asked to stand apart from one’s experience and reflect critically and prudently upon its implications and meaning. In our society, we emphasize too often the acquisition and utility of information, as if information is a two-dimensional reality. In contrast, the information we glean from reflection on our lived experiences is not two-dimensional. It has significance and meaning. I invite us, then, to consider that the four Carnegie pedagogies I would like to share with you as lenses through which mentors and protégés can seek to understand the lived experience of healthcare leadership—and to reflect carefully and deeply upon the meaning of it all. This is an essential approach if one is going to grow and develop and mature in effective ways into the future. I find this interesting because, from my own academic background, of a particular insight that has challenged me over the years. In the 11th century Anselm of Canterbury defined theology as “faith seeking understanding.” In a non-religious sense, one might redefine this as “experience seeking meaning.” Or alternatively, we might think of it as “data seeking interpretation.” Mentoring is a unique, intense, and challenging experience whereby the mentor assists the protégé to interpret the data of one’s professional behaviors and come to a new awareness of their meaning. In the delicate world of healthcare provision and leadership, there is an intense and urgent need to be open to such awareness so as to approach the quantum leaps of revision that are always needed if we are to remain true to our calling for the service of those in need.

All this being said, let me now proceed to the four pedagogies I wish to share. The first is the pedagogy of interpretation. Social sciences and theology often talk about hermeneutics, the science of interpretation. Many years ago, I read a text that talked about the origins of this curious term. The author posited that within the word is the name of the Greek god, Hermes. Hermes, the messenger of the gods, would never come to deliver a message precisely. He would somehow take on different forms and play tricks on the recipient to get him or her to understand the message in curious and new ways. In a certain respect, Hermes would subvert the assumptions of the hearer. The pedagogy of interpretation seeks to get individuals to return to the body of knowledge of their profession and to understand it in fresh, new ways. For many of us in professional life, it is easy to believe that we have achieved perfect knowledge. Yet we know that not to be the case. Mentors have a particular responsibility to ensure that protégés continually revisit their body of knowledge. However, mentors need to urge protégés not just to “re-learn skills,” but more importantly to plumb the depths of the meaning of one’s profession and re-understand its body of knowledge in ways that would lead to discovery, innovation, and better leadership.

A second of these pedagogies is contextualization. Leadership is not exercised in a vacuum. It takes place in real time, with real people, in the real world. In every act of leadership, much like in language, there is the need to translate one's service given the context in which one serves. As human beings, we all can find it easy to assume that others see or experience things exactly the way we do. Leaders need to be extremely careful to avoid this assumption at all costs. In each and every community, there are a wide variety of differing beliefs, values systems, structures of relationships, and base experiences that give rise to unique social psychologies. Mentors must assist healthcare leaders to reflect carefully and critically upon the contexts in which they may serve. They need to assist protégés to develop a well-developed sensitivity or "radar" to ensure that they are reading the contextual signals with some measure of accuracy. Sometimes, leaders are surprised when they find that they fail to communicate or relate successfully. Often, these failures are due to a lack of understanding about the lives, expectations, and systems of values operative in the communities they serve. Successful mentoring for healthcare leaders must therefore raise up issues of context.

A third pedagogy for successful leadership mentoring is performance. I would suggest that this is a very important yet very delicate area in today's context. Over the last decades, a wide variety of professionals have tried to explore diverse ways of setting up measures for professional performance. Many of us have experienced these seemingly endless models for performance evaluation. As I have observed them, one of the facets that strikes me is how these are skewed toward quantitative measurement. Metrics of productivity are only one means for measuring performance. However, quantitative measures need to be balanced with qualitative approaches. For example, if I were a healthcare provider, I could be measured on the number of patients seen in any given day. However, there must also be an equal assessment of the quality of what occurred in those patient visits. To use the research of my doctoral peer that I mentioned earlier, mentors would do well to help protégés understand that together there is a need to explore the "performative meaning" of what is rendered, and not just the number of performances accomplished.

Lastly, there is the need to incorporate a pedagogy of formation into the leadership mentoring experience. Perhaps 20 years ago, the theologian James White published a work in which he integrated a variety of psychological and educational theories to address how humans develop and mature over the years. One of the very successful portraits he painted was how human beings are moved in successive stages of life to embody the things they do and the ideas or beliefs they espouse. In other words, there are invitations in life for all of us to put flesh on the words we use or the ideas we have. This is a longer way of describing the experience of formation in the professions. Formation is not about the acquisition of new or better skills. Rather, it is the process by which what we do makes a difference upon who we are as persons. It is the process, sometimes arduous, of evolving from utility to embodiment. It requires a never-ending wrestling within the self to face naivete, bias, or a lack of courage to change. It requires a challenging understanding that what I do as a professional is more than just behavior. It makes an impact on the person that I am. Inevitably, the experience of formation is one that leads me to a never-ending series of passages and transformations of the self as a person and as a professional. This indeed is an experience that is best done in companionship with one who understands, with one who is ever on the same road, with one who has earned human trust.

Four pedagogies. Four approaches for effective mentoring for healthcare leaders. These are the tools that we can take with us on the journey of mentored leadership in the healthcare professions. But what guide can we adopt that will help our journey succeed? What images might we keep before our eyes as we journey ever more deeply each day in the act of healthcare leadership?

Conclusion

A New Constellation for Guiding Mentored Healthcare Leadership

In the final analysis, what might serve as an overall guide for this approach to mentoring for healthcare leaders? I have been with Navy Medicine now for nearly 20 years. One of the abiding images I have from my community's culture is the image of the ship being guided on its ocean journey by a north star. Sailors over the years navigated the oceans successfully by keeping their eyes fixed on the constellations in the sky. In the spirit of that image, let me close my remarks today by suggesting what I would like to refer to as three stars in a new constellation that guides the mentoring experience for healthcare leaders.

I need to repeat that healthcare is far deeper than the business models we use. It is deeper than just medicinal cure. We honor healthcare best when we remember that it is a systemic experience of cure + care + compassion that affects the whole human person and all the individuals and communities to whom the human person is attached. Such a systemic and comprehensive experience cannot be accomplished without the ongoing mentoring of healthcare leaders. This is central to giving flesh continually to the theme of this entire conference, *Retrieving the Human Face of Science: Understanding Ethics and Integrity in Healthcare, Medicine and Research*. Unless we keep mentoring an essential part of healthcare leadership, we indeed will forget the human face of science and healthcare. We will become that which we criticize the most. Our ship of service will run aground. How then do we stay not only afloat but moving forward to new ports of service on behalf of others in need? I suggest that we follow a new constellation made up of three stars: Presence, Prophecy, and Poiesis.

Judeo-Christian theology has debated and argued over the concept of "real presence" for centuries. Unfortunately, various religious denominations have stoked misunderstanding by concentrating only on the debate from the perspective of sacrament and ritual. The concept is understood far more effectively and with greater accuracy and ultimate significance when one remembers that the fundamental theological experience is not about real presence in sacrament, but the passionate human belief that the Divine is really and truly present to us as humans. We humans fear being alone. We stand in mortal dread of being both alone and lonely. It is part of our lot in life to be separated from each other. From the time the cord is cut at birth, it seems we are ever engaged in a long search to find that "other" who can satisfy the emptiness within. One of the most dynamic and demonstrative beliefs in the Judeo-Christian theological systems is the urgent belief that the Divine chooses out of love to be connected and "present" to us in ways that are radical, ways to the "root" or "radix" of the persons who we are. The Divine, who is portrayed as needing no other, chooses to pierce our lives and ravish us in love. We are therefore never alone. This image from theology gives us our understanding of the first star in our constellation. Healthcare leaders enter into the lives of others at the most vulnerable and frightening moments. Regardless of whether we are providers, financiers, managers or in any other position, when we walk

through an emergency room or past a clinic waiting room, we must always remember that we must be “really present” to those who come to our institutions. It might only be an act of passing kindness or a simple word. Yet what we say and how we carry ourselves can be the difference in how another person is able to negotiate the alienation that is part and parcel of the experience of human illness. Real Presence. The first star.

The second star is prophecy. Prophets do not foretell the future. They forth-tell the Truth. Biblical theology reminds us that the prophetic function was to call the community to the task of its system of beliefs. Prophets often risked life and limb because they refused to close their eyes to the contradictions of their societies—when people said they believed in one thing yet acted in stunning opposition. Such was the case in early societies where tribal peoples said they cared about the poor, but then refused to share with them their bread and their compassion. When television advertisements call our attention to the less fortunate, it is easy at that moment to feel something burning inside and caring. Yet when we walk out into the streets and a homeless person comes to us, we feel afraid and perhaps run away. True prophecy calls into question our behaviors and our inconsistencies. It calls for us ever to be in need of change. I remember an old story I once was told about a soul food kitchen in a poor area of Washington, DC. I have no idea if the story is true, but it makes the point. The story says that a woman named “Mother Minnie” ran a kitchen out of her home. She used to stand outside and invite people to come in: “You all come in now and eat.” But when a person would come up to enter, she would grab him or her by the arm, look them square in the eye and say: “But if you come in to eat, you all gotta be changed.” Prophecy is like that. Mentors call out to us. Each time we enter into the realization that we are healthcare leaders, we break open the bread of our profession. But are we ready always to be changed, to be deepened, even at the price of personal pain and discomfort?

Finally, there is the third star—poiesis. This is the root word for our English term, poetry. Yet it is rather untranslatable. It is best described in an experience. When I was much younger, one of my favorite things was to go the seashore with my friends for weekends. I loved to stay up all night and then watch the sun come up. There was a favorite place in the seaside town I used to visit. I would be there by myself at the edge of a small rock jetty. I would wait and wait through the hours before dawn in the hope of the light. Suddenly, it seemed to me that something was appearing on the horizon. Right where the black sky seemed to touch the dark ocean waters, it looked as if something were cracking open. Not sure. Maybe it was my imagination. Maybe it was wishful thinking. But it seemed that a small line of light was appearing. Not formed, ambiguous. Unclear. Yet my attention was grasped. In some ways, this was the experience of poiesis—attentive and poised for the possible but without knowing what it was nor being able to control it. All I could do was wait for it to unfold. My job was to remain attentive and ready for what was about to be. Poiesis is the critically essential star for mentoring healthcare leaders. Mentors and protégés remain attentive to the invitations to change and deepen and grow and develop. We look for signs and small cracks of something yet to be made apparent. And in that waiting we realize that in so many ways we are not in control. We are instruments for processes and possibilities that are always much larger than we ever could be. We anticipate that which is yet to come. And in our waiting we learn to be servants of the possible, not rulers of the controllable.

These then are the three stars of a new constellation guiding the experience of mentored healthcare leadership. There is, of course, always, the possibility that one can refuse to board the experience and sail. That is always an option. Presence, prophecy and poiesis are not comfortable. They require being open to change both subtle and significant. Yet if we are to remain faithful to the wrestling in the zone of cultural contest that is healthcare, how can we refuse the journey?

Each of us, when we first entered into healthcare leadership, undoubtedly did so because we wanted to make a difference. Today, we are called ever to hear again the cries of the sick and the poor. Like Ulysses in the *Odyssey*, they are voices that call out to us. But they are not sirens who are luring us to our death. Well, maybe to a type of death—the death to self that is necessary for anyone who wishes to care truly for others in need. But these voices call out to us begging for the life that is truly found, nurtured, matured, and born each time we care enough to love and embrace those who need us most.