

Mary Berchmans Daly: Moral Exemplar for Leaders in Catholic Health Care

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Abstract: Mother Mary Berchmans Daly, an Australian Sister of Charity, founded St. Vincent’s Hospital in Melbourne in 1893. This article argues that there are lessons from Berchmans as a leadership exemplar for leaders of Catholic health systems today. It focuses on such systems in the USA, Canada, and Australia. The article proceeds in three parts. First, it provides an overview of the context for Catholic health care systems today, with particular focus on the nuanced and ethically salient questions leaders of these systems face. Second, it offers detail about Berchmans’s life and ministry, focusing on her exemplary qualities as leader of a Catholic health system, considering how these yield practical moral guidance for today’s leaders of Catholic health systems. Finally, the article turns to Linda Zagzebski’s theory of exemplarist ethics. The “exemplar before theory” methodology of the article reflects Zagzebski’s approach, which holds that direct engagement with moral exemplars yields normative moral insights at a level prior to theory and is a practical method to support and develop moral reasoning. Noting resonances between Zagzebski’s approach and Catholic theological ethics, I use it to illustrate why reflecting on exemplars like Berchmans offers important and nuanced moral guidance for leaders of Catholic health systems today.

MOTHER MARY BERCHMANS DALY, AN AUSTRALIAN Sister of Charity, founded St. Vincent’s Hospital in Melbourne in 1893. A school teacher by background, Berchmans’s¹ proximity to the sick and poor in Melbourne convinced her of the need for a hospital. Her vision was realized through a combination of imagination, compassion, collaboration, determination, and system leadership.

The central proposal of this article is that there are lessons from Berchmans as exemplar for leaders of Catholic health systems today. The historical significance of Berchmans’s exemplarism was recognized

¹ Anne Daly took the name Mary Berchmans when she took vows as Religious Sister of Charity. As a vowed religious, she was known as Sister Mary Berchmans, and later Mother Mary Berchmans. Throughout the article, I use the shorthand Berchmans to refer to her, reflecting her identity as a religious sister.

soon after her death. Bishop John McCarthy said at the time, “She was too great to be appreciated at a close distance; it is in fifty or one hundred years from now that people will realize her greatness.”² Berchmans encountered significant challenges in resourcing, stakeholder engagement, and the politics of the day both within and outside of the church. Now, just over a century after her death, reflection on Berchmans’s moral character is fruitful for present leaders, whose contexts are different but who nonetheless face challenges which are similar in kind.

The article proceeds in three parts. First, I provide an overview of Catholic health services in the USA, Canada, and Australia today, and the complexities that exist for leaders in these settings. The second section turns to Berchmans’s life and ministry, focusing in particular on her exemplary qualities as leader of a Catholic health system in a nuanced and complex context. In this section, I connect Berchmans’s exemplarism with the work of leaders of Catholic health systems today, demonstrating how reflection on her as exemplar yields relevant moral guidance. Third, I provide a summary of Linda Zagzebski’s theory of exemplarist ethics. The “exemplar-before-theory” structure of the article is deliberate: Zagzebski suggests that engagement with moral exemplars yields normative moral insights at a level prior to theory and is a practical method to support and develop moral reasoning.³ Noting the resonance of this approach with Catholic theological ethics, I use it to illustrate why reflecting on exemplars like Berchmans is valuable in providing relevant and nuanced moral guidance for leaders of Catholic health systems today. I close by suggesting that such an approach offers an important addition to other forms of conscience formation.

THE CHALLENGES OF CATHOLIC HEALTH SYSTEM LEADERSHIP TODAY

My focus throughout the article is on the Catholic health systems that operate today in the USA, Canada and Australia, particularly those which retain their official connection to the church through canonical instruments such as Public Juridic Persons (PJPs).⁴ Such systems exist as Catholic entities under the stewardship of lay leaders. Many were founded by religious orders who established structures such as PJPs to

² Edna M. Skewes, *Mother Mary Berchmans Daly: Foundress of St. Vincent's Hospital Melbourne* (Spectrum Publications, 1989), 153.

³ I am grateful to one of my anonymous peer reviewers who suggested structuring the article to make this methodological point clear.

⁴ For brevity, I refer to these collectively as “Catholic health systems” below, acknowledging that other models exist elsewhere internationally.

enable the continuance of their ministries in settings where the orders themselves could no longer provide governance and leadership.⁵ Well-known examples are Ascension Health in the US, Providence Health in Canada, and St. Vincent's in Australia.⁶ Some, like Ascension, are conglomerates of smaller systems which have been combined into an overarching PJP.⁷ Though all have unique characteristics, there are many similarities on account of their origin stories, the scope of their current operations, and the challenges they face today.

This section is designed to provide a window into the nuance and complexity leaders of these systems face.⁸ The decision-making they are entrusted with today is the context in which Berchmans's leadership exemplarism becomes relevant. At a macro level, Gerald A. Arbuckle observes that there are at least four models of health care at play today. Each of these models has a dominant *telos* which sets out a different set of goals and priorities and can lead to fundamentally different decision-making for leadership.⁹ The biomedical model is focused on the technical application of scientific knowledge to health care need. The social model is focused on responding to the social determinants of health. The economic rationalist model is focused on the application of neoliberal economic principles to the delivery of health care. And the foundational model—familiar in the origin stories of Catholic health care—is focused on a holistic response to human suffering, inspired by the parable of the Good Samaritan. Each model pursues goods which are important for the delivery of health care. That said, Arbuckle notes in particular the dominance of the economic and biomedical models today, and observes that pursued on their own terms these models operate at the expense of important goods intrinsic to health care.¹⁰ Importantly, Arbuckle observes that “all four models

⁵ Gabrielle McMullen and Paul Oakley, “Ministerial PJPs Advancing Lay Leadership in the Australian Church,” *The Australasian Catholic Record* 97, no. 4 (2020): 450–459.

⁶ Information about each of these services, including their governance, can be found on their respective websites. See for example Providence Care, “Our History,” providencecare.ca/about-us/our-history, Ascension Health, *History & Sponsorship*, about.ascension.org/about-us/history-sponsorship, St. Vincent's, “Our Heritage,” svha.org.au/about/mission-and-values/our-heritage.

⁷ Ascension Health *History & Sponsorship*, about.ascension.org/about-us/history-sponsorship.

⁸ I include in this group senior managers, executives, board members, and sponsors or trustees of Public Juridic Persons. While each has specific responsibilities, all provide leadership which is central to the way in which Catholic health systems function today.

⁹ Gerald A. Arbuckle, “Have Catholic Healthcare Ministries a Future?,” *The Australasian Catholic Record* 101, no. 4 (2024): 428–446.

¹⁰ Arbuckle, “Have Catholic Healthcare Ministries a Future?,” 437–441.

can be present in the same healthcare facility,”¹¹ highlighting that they exist in tension with one another, including in Catholic health settings.¹² In what follows, I suggest that these tensions are salient in three common challenges for leaders of Catholic health systems today: mission drift; tensions with church, state, and community; and operational realities and resource constraints.

A first common challenge faced by leaders of today’s Catholic health systems is mission drift, whether real or apparent. Such systems exist in a regulatory and financial environment which necessitates the adoption of contemporary corporate structures to govern their operational responsibilities. In such an environment, the place of the central mission of these systems (which tends to be some variation of “continuing the healing ministry of Jesus”) can become a less obvious part of leadership and daily operations. Financial sustainability is a key driver here, with the simplistic phrase “no margin, no mission” often used to frame the problem and its solution.¹³ Some have argued that contemporary leadership has insufficiently integrated mission, particularly in terms of focus on those who are poor, complex, or carry unmet need.¹⁴ In some contexts, it has been suggested that the very services for which these systems were established have become an adjunct to their main operations, and that the ethical standards these systems ought to uphold are relativized in favor of business-oriented considerations such as finance and stakeholder management.¹⁵ All of this is set within the dominant economic models of today’s healthcare.¹⁶ Hence, the capacity to demonstrate the place of mission in the context of today’s Catholic health systems is a central challenge for leaders of these systems.

A second common challenge is that of tensions within the church, as well as with the government and community. Tensions within the church are often related to perception of mission drift, or where church leaders are concerned with the integrity of ethical decision-making within Catholic health systems. A famous example is the so-called “Phoenix case,” in which the chair of an ethics committee at a Catholic

¹¹ Arbuckle, “Have Catholic Healthcare Ministries a Future?,” 430.

¹² Arbuckle, “Have Catholic Healthcare Ministries a Future?,” 441–442.

¹³ For a more subtle analysis, see Alex Schulte et al., “Mission vs. Margin: The Effects of Catholic Health System Ownership on Hospital Operations,” *Medical Care Research and Review* 82, no. 6 (2025): 465–476, doi.org/10.1177/10775587251355541.

¹⁴ See for example Samantha Liss, “As Nuns Disappear, Many Catholic Hospitals Look More Like Megacorporations,” *KFF Health News*, November 5, 2024, kffhealthnews.org/news/article/nuns-catholic-hospitals-profits-community-benefit.

¹⁵ Cory D. Mitchell and M. Therese Lysaught, “Equally Strange Fruit: Catholic Health Care and the Appropriation of Residential Segregation,” *Journal of Moral Theology* 8, no. 1 (2019): 36–62.

¹⁶ Arbuckle, “Have Catholic Healthcare Ministries a Future?,” 440.

hospital was excommunicated by the local bishop. The context was decision-making in a tragic case in which both maternal and fetal life were at risk.¹⁷ Another is the case of St. Vincent's Hospital in Sydney's attempt to establish a medically supervised injecting room in Sydney in the early twenty-first century. The Sisters of Charity (who still operated the hospital at the time) received an injunction from the Congregation of the Doctrine of the Faith to cease their plans to operate the service, despite having made their decision on the basis of significant discernment.¹⁸ Though acute examples of tension, both illustrate the way in which church leadership and Catholic health leadership can exist in tension with one another, highlighting a central challenge for leaders of such services today.

Tensions are not confined to the church. In the US, Canada, and Australia, government and community expectations around health care are sometimes at a distance from the Catholic tradition. Neuralgic areas include abortion, artificial contraception, care for transgender persons, and euthanasia. In Canada and Australia, these tensions are bound together with the sustainability of government-funded Catholic health facilities, which must demonstrate that they can operate in a way that both upholds their institutional identity and does not prevent individuals from accessing legally-available healthcare interventions.¹⁹

In some contexts, there has been pressure on governments to place significant restrictions on Catholic health services for this reason.²⁰ In Australia, a government forcibly acquired a Catholic public health service. Though the stated rationale for the acquisition was related to operational efficiencies rather than the institution's Catholic identity, most commentators recognized a connection between the decision and the fact that the hospital's maternity service could not provide the scope of services available in a secular hospital.²¹ Some saw this as

¹⁷ The case is discussed in M. Therese Lysaught, "Moral Analysis of a Procedure at Phoenix Hospital," *Origins* 4, no. 33 (2011): 537–549, ecommons.luc.edu/social_justice/26/; and Bernard G. Prusak, "Double Effect, All Over Again: The Case of Sister Margaret McBride," *Theoretical Medicine and Bioethics* 32, no. 4 (2011): 271–283, doi.org/10.1007/s11017-011-9183-z.

¹⁸ Elements of this history are recounted in Anthony Fisher, *Catholic Bioethics for a New Millennium* (Cambridge University Press, 2012), 80–83.

¹⁹ See, for example, the analysis in Gordon Self, "Lessons Learned about MAiD from a Catholic Healthcare Perspective," *Healthcare Management Forum* 36, no. 3 (2023), 154–161, doi.org/10.1177/08404704221109760.

²⁰ See, for example, Julia Kaye, Brigitte Amiri, Louise Melling, and Jennifer Dalven, *Health Care Denied: Patients and Physicians Speak out About Catholic Hospitals and the Threat to Women's Health and Lives*, American Civil Liberties Union (New York, 2016).

²¹ See John Warhurst, "Canberra Context Matters in Calvary Takeover Case," *The Catholic Weekly*, May 19, 2023, catholicweekly.com.au/john-warhurst-canberra-context-matters-in-calvary-takeover-case/.

evidence on the ongoing hostility of the secular state to the church and responded with similar hostility.²² In the US, a litigious approach was taken by the Little Sisters of the Poor, who set up a legal challenge with the government in response to a perceived threat to their religious liberty. This was in relation to a requirement that their health insurance for employees include the provision of artificial contraception.²³ Whatever one thinks about these issues and the manner in which these systems and the broader church community responds, it is clear that leaders of Catholic health systems today need to face the challenge of operating in multiple ecosystems which are not always hospitable to the ministries they lead.

Finally, leaders of Catholic health systems today need to respond to the challenges of technological change alongside operational realities and constraints. The terrain of technological change reflects the rapid advances of medicine and scientific knowledge. What is becoming possible in health care is exceeding our capacity to keep up with and be thoughtful about it. This includes the advent of AI and the impact it will have on all aspects of health care, from diagnosis of disease through to billing schedules for specific treatments.²⁴ Operational realities include the perennial challenges of attracting and retaining staff, providing high quality clinical care, meeting quality and safety expectations, and often providing governance for safe and efficacious research and innovation.²⁵ Furthermore, the relationship between health care leadership and different professions (medicine, nursing, allied health, and so on) is nuanced and can itself be complex terrain.²⁶ All of this is set in the context of resource constraints, which in large part are related to demands for increased efficiencies from funders—whether private health insurers or governments—at the same time that there is increased demand on health care services from

²² See, for example, Monica Doumit, “Calvary Takeover Reveals Political Endgame,” *The Catholic Weekly*, May 18, 2023, catholicweekly.com.au/monica-doumit-calvary-takeover-reveals-political-endgame.

²³ See M. J. Casey, “*Dignum et justum est*: Obamacare and Travail of the Little Sisters,” *Issues in Law and Medicine* 31, no. 2 (2016): 111–124.

²⁴ See for example Raj Sinha, “The Role and Impact of New Technologies on Healthcare Systems,” *Discover Health Systems* 3, no. 1 (2024): 1–14, doi.org/10.1007/s44250-024-00163-w.

²⁵ See for example Ana Maria Malik and Ezequiel Garcia Elorrio, “Governance and Management in Healthcare Organizations: Their Different Roles in Driving Safety and Quality,” *International Journal for Quality in Health Care* 35, no. 3 (2023): 1–2, doi.org/10.1093/intqhc/mzad046.

²⁶ See J. Bornman and B. Louw, “Leadership Development Strategies in Interprofessional Healthcare Collaboration: A Rapid Review,” *Journal of Healthcare Leadership* 15 (2023): 175–192, doi.org/10.2147/jhl.S405983.

an aging population, and a broader population which includes those who live in poverty and have complex health care needs.²⁷

This brief overview provides the setting for leaders in Catholic health systems today who are entrusted with the continuation of the mission of their founders in this complex environment. In 1995, Richard A. McCormick observed a similar set of challenges and provocatively declared that navigating them with fidelity to the mission of Catholic health care was impossible.²⁸ Leadership in health care requires nuance in decision-making and a capacity to contend with complexity.²⁹ The context of Catholic health ministries adds to this nuance and complexity and challenges leaders to thoughtfully and wisely integrate the Catholic ethical tradition in their daily decision-making. In what follows, I suggest that a study of Mary Berchmans Daly as exemplar of leadership of a Catholic health system yields the kind of nuanced moral guidance that can support leaders of these systems today.

MARY BERCHMANS DALY: EXEMPLAR FOR CATHOLIC HEALTH SYSTEM LEADERSHIP

Mother Mary Berchmans Daly was born Anne Mary Daly in Lorrha, Ireland, in 1859. When she was six she travelled with her family to Australia and settled in the Southern Tablelands of New South Wales. As a young woman, she experienced a calling to religious life. She initially trained and worked as a teacher in the state school system. At the age of twenty-two, she entered the novitiate of the Sisters of Charity, taking the name Sister Mary Berchmans, after the Jesuit saint John Berchmans. In 1884, she made her profession of the three vows common to all religious: poverty, chastity, and obedience, as well as a fourth vow taken by the Sisters of Charity: service of the poor. Her early service as a Sister of Charity was as a teacher in Sydney.³⁰

In 1888, the Sisters of Charity were invited to Melbourne by Archbishop Thomas Carr. Knowing about their ministries in education and health in Sydney, the Archbishop described the needs to which he thought the Sisters were well placed to respond:

²⁷ For a comprehensive overview in the Australian context, see Australian Institute of Health and Welfare, *Australia's Health 2024* (Canberra: AIHW, 2024).

²⁸ Richard A. McCormick, "The Catholic Hospital Today: Mission Impossible?," *Origins* 25, no. 20 (1995): 648–653.

²⁹ Samantha Spanos et al., "Healthcare Leaders Navigating Complexity: A Scoping Review of Key Trends in Future Roles and Competencies," *BMC Medical Education* 24, no. 1 (2024): 720–733, doi.org/10.1186/s12909-024-05689-4, doi.org/10.1186/s12909-024-05689-4.

³⁰ This history is recounted in Skewes, *Mother Mary Berchmans Daly*, 1–15.

Amongst the works to be undertaken might be a hospital for children—perhaps even for foundling children. Then all the other works of charity, including at a future time a General Hospital, which are usually or frequently undertaken by your sisters. The care of schools will probably depend a good deal on the wish of the Sisters and the circumstances of the localities in which they will be settled down.³¹

The Sisters responded to this call, and three of their number—including Berchmans—travelled to Melbourne in January 1889. The Sisters' first ministries in Melbourne were in education, supporting existing schools and establishing new ones. Berchmans worked across each of these, and her leadership qualities were quickly recognized. In one instance she is described as *rara avis*, a “rare bird” or “exceptional.”³² In 1892, she was appointed rectoress of the Sisters' convent in Melbourne. These first three years in Melbourne were a time of significant poverty and need, which provoked Berchmans to consider how the Sisters' ministries could expand:

Mother Berchmans as a Sister of Charity had at her religious profession taken a vow to serve the poor. This she had been doing in the school and in the homes of people, but when she became the superior at the beginning of 1892, the needs of the poor “out there” were clamouring to be met.³³

Berchmans, at the age of thirty-three, envisioned and realized a systemic response to need: St. Vincent's Hospital in Melbourne.

Central to my argument in what follows is that what Berchmans achieved and how she did it makes her an exemplar: a person who by her character and impact elicits the emotion of admiration.³⁴ A character sketch for the St. Vincent's annual report by Fr. Michael Tansey following Berchmans's death in 1924 describes why. Though lengthy, I replicate it in full. It provides a comprehensive overview of Berchmans's character and impact as a leader, serving as a helpful introduction for readers unfamiliar with her:

Mother Mary Berchmans Daly, the late superior general of the Sisters of Charity in Australia, will ever remain in the memory of the writer as a cherished ideal of a great and remarkable woman; for she was gentle yet masterful, of simple faith yet shrewd discerning mind, stately yet approachable, unbiased in everything yet immovable on

³¹ Skewes, *Mother Mary Berchmans Daly*, 19.

³² Skewes, *Mother Mary Berchmans Daly*, 30.

³³ Skewes, *Mother Mary Berchmans Daly*, 33.

³⁴ This is a central component of Zagzebski's exemplarist theory, which I describe in part three below.

principles, and an everlasting friend to a friend. She possessed the sparkling humour of the Celt (for she was born in Ireland) and had a keen appreciation for the absurdities of men and things. Her Celtic temperament, however, could crystallise at will into cold, clear, determined action. She was Napoleonic in concept and act; once decided, no obstacle on earth could thwart her.

The genius of infinite pains was hers, and she inspired all about her with the divine fire of enthusiasm. Adamant people in high places became pawns in her hands. Friends rose from nowhere, and remembering the kindness of other years, opened wide the door, and the victorious little nun walked onwards. Her life was studded with gems of charitable action; and none she befriended ever forgot her. They were all deeply indebted to her in the days of their need and never failed to remember her in the days of their prosperity.

She was a born leader. Had her lines of life fallen in other places, the world must still have heard of her, for she had to rule. She was a valued servant of the State in her early life as a teacher in the Public Instruction Department; she ruled children then, as she ruled men and women afterwards. Her breadth of mind amazed one. When she sought advice from medical men as to the organisation of her clinical schools, she was bold enough to differ from many; and the event proved that she was right and they were wrong.

St. Vincent's Hospital in Melbourne is an everlasting monument to her skill and culture. She mothered it in its infancy, and it is now reckoned among the first hospitals of the world. It was she who created it a clinical school and lifted it to eminence in science and charity. She moulded, too, the destinies of St. Vincent's Hospital, Sydney, and hers would have been a happy day indeed had she lived to see the first students of her clinical school sweep the prizes before them.

Prudence often means timidity. Mother-General was not a prudent woman in that sense of the word. She feared nothing. Her foresight impelled her to purchase properties in every direction; and while other folks stood aghast, murmuring, "How will they be paid for?" Mother-General would wave her hand airily and answer, "God will look after it." And God did. Nor was she content to sit down among her laurels complacently contemplating her success. The best was not good enough for her. She made a tour of the American and Continental hospital systems and incorporated all of their good points in her own institutions.

And yet withal she was a very sick woman, who knew she was treading on the edge of eternity. But she was so busy living for God that she had no time to think of dying. Her faith was utterly childlike. I have seen her telling her beads at the door of a sick room whilst the doctors met in hopeless consultation; and the patient lived. I have known her to be in prayerful distress over the finances of her work, when a man whom she once befriended called at her convent and presented her with a thousand pounds. It sounds like a fairy story, but it is prosaically true.

She was a real woman of God, strong in faith, unconquerable. I saw her lying on her death-bed like a proud tower flung down by the storm. But she was still the same tender, thoughtful woman. Though racked with agony, she went calmly to God, and her soul was rich beyond compare with faith and good deeds. She was a rare woman, and her value was as things that are brought from afar and from the remotest coasts.

Eternal rest grant to her, O Lord, and let perpetual light shine upon her. May she rest in peace.³⁵

It is clear that these impressions of Berchmans were shared by many of her contemporaries. As noted in the introduction, Bishop John McCarthy saw her historical significance, suggesting that her true greatness would only be appreciated in time.

In what follows, I will focus on this character sketch and other narratives about Berchmans to offer four key descriptions of her exemplarism and suggest how leaders of Catholic health systems might emulate and take moral guidance from these today. These are organized in subheadings taken from Tansey's character sketch: 1) a vision for eminence in science and charity, 2) simple in faith yet shrewd and discerning, 3) bold enough to differ from many, and 4) none she befriended ever forgot her.

A Vision for Eminence in Science and Charity

One of the most striking things about Berchmans is the scope of her vision. Service of the poor is a vow for the Sisters of Charity, and Berchmans was able to connect this service with a level of ambition for scale that moved well beyond the possibilities envisaged by many of her contemporaries. "Eminence" is the best word to describe the vision that animated her. She imagined a hospital that was large, equipped with the latest technology, and beautiful in design. Its services would be available to any person who needed them.³⁶ Those who could not pay would receive care for nothing, and those who could were asked to subscribe to the hospital or pay their fees in full—an early form of a mixed public and private health system.³⁷ As her vision expanded, it included a dedicated private hospital, Mt. St. Evin's. This facility provided for doctors to receive money for services from patients who could pay and a profit margin for St. Vincent's,

³⁵ Skewes, *Mother Mary Berchmans Daly*, 151–153.

³⁶ Bryan Egan, *Ways of a Hospital: St. Vincent's Melbourne 1890s–1990s* (Allen & Unwin, 1993), 1–22.

³⁷ Skewes, *Mother Mary Berchmans Daly*, 54–55.

which, in turn, enabled the hospital to continue to serve the poor in the public hospital for free.³⁸

The connection between science and charity was central to her vision. Berchmans saw that the hospital's capacity to serve unmet need would expand through the skill of the best medical and nursing practitioners, and she actively worked to build trust with those who excelled in both fields. Given her background in education, Berchmans saw the hospital in expansive terms. It was at once a response to immediate health care need as well as an institution which could form doctors and nurses to shape the future of health care. For this reason, she established a robust partnership with the University of Melbourne to establish a clinical school. Indicative of the trust she put in partners, she asked the University to "demand what was necessary to make it a perfect institution for clinical teaching."³⁹ Her vision extended to care and hospitality for medical and nursing students. A letter to Berchmans from the Medical Students' Society in 1910 demonstrates her efforts to provide housing for students during their studies and captures something of her impact, which was at once personal, systemic, and future-oriented:

Dear Madam – At the last meeting of the Medical Students Society, I was instructed by the committee to write to you expressing our extreme gratitude for the treatment that medical students attending St. Vincent's Hospital have received in regard to accommodation.

The committee consider that the way in which students' rooms were erected and furnished was far beyond their expectations. The students at your hospital are, of course, the most immediate gainers, but in all probability the whole medical school will be ultimate gainers, as, with the example of St. Vincent's treatment of students as a guide, the other hospitals may be stimulated to an attempt to reach the same ideal

I desire to convey to you the heartiest thanks of the whole Medical Students' Society, and I hope that the students will endeavour to prove themselves worthy of the trust you have reposed in them by giving over to them such a splendidly fitted up set of rooms.⁴⁰

Elsewhere in the letter, the extent of Berchmans's generosity is acknowledged, with the committee noting that every one of their requests had been met with "several very material additions."⁴¹

³⁸ Skewes, *Mother Mary Berchmans Daly*, 55.

³⁹ Skewes, *Mother Mary Berchmans Daly*, 89. A history of the founding of the clinical school can also be found in Egan, *Ways of a Hospital*, 44–54.

⁴⁰ Skewes, *Mother Mary Berchmans Daly*, 100–101.

⁴¹ Skewes, *Mother Mary Berchmans Daly*, 100.

Charity was at once the purpose of St Vincent's Hospital, and the disposition offered to its staff, both present and future.

For her "Napoleonic" vision, Berchmans was also particular in her focus. She knew the staff and many of the patients by name and, though not a clinician, spent a significant amount of time in the wards with those in need. This proximity to need alongside her understanding of the practicalities of the system enabled her to hold the worlds of patient care and system leadership together. Consider the following handwritten fundraising letter, penned by Berchmans in 1913, which at once paints a vivid image of the work of the hospital, identifies challenges in conditional funding offered by government, and invites the community's support through subscription to the hospital:

My dear kind friend.

It is 9 o'clock, Wednesday evening. The moon shines through the open windows of St. Columba's ward and throws a shadow across long rows of beds. This has been a busy day at St. Vincent's. Discharged 18 patients, admitted 22. Beds and stretchers and cots up everywhere. Everybody is now quiet, and there is a subdued silence. . . . Listen to the sad moan from that poor boy, who was operated on this afternoon. The parents are waiting. How sad the poor mother looks! How anxious the father. The ray of hope and both faces brighten. "Your son is out of danger, and should make a good recovery. Go home now, and please God we shall have good news for you in the morning." 11pm. Ambulance at the door. Another poor sufferer. Urgent operation. An accident.

How the work goes on night and day It is consoling however to know that the poor each are relieved of pain, nursed back to health, and made well enough to return to their own homes. But how few think that it takes 250 pounds a week to keep the hospital going. The government has promised 2000 pounds if the balance of 5400 pounds be subscribed before the end of June.

Won't you help us?

Very faithfully yours,

Sr. M. Berchmans Daly⁴²

In just over two hundred words, Berchmans is able to connect the need the hospital responds to—the pain of a specific patient, the fraught experience of a family, resource constraints, and a call for help.

In view of these reflections, we can begin to consider how Berchmans as exemplar offers morally relevant insights for leaders of Catholic health systems. One of the most notable features of

⁴² St. Vincent's Hospital Melbourne Fundraising Letter, May 31, 1913. Source: St. Vincent's Melbourne Archives.

Berchmans's leadership was the way in which she held together the pursuit of technical excellence, business acumen, and the work of charity. As we have seen, a critique of large Catholic health systems today is that charitable work is a supplementary function to the main enterprise. Berchmans inverts this vision but does so in a sophisticated way. It is not that charitable work replaces technical advancement and the robustness of business decisions. Instead, she delivered on her charitable goals precisely by building a system that was technically excellent and fiscally sustainable. Doing so with the fourth vow "service to the poor" at the center makes for a different kind of health care system: one where charity is front-and-center of all of the work. Leaders today might consider how they can emulate this approach, and the way in which this can correct the deficits of each of Arbuckle's models of health care when they are taken in isolation.

Berchmans also led in a way which expressed charity to both patients and staff. She realized that technical excellence was only possible with a team rightly composed and so made efforts to build such a team. Her capacity for longitudinal vision and her experience as an educator connected this with a practical ambition to form the next generations of doctors and nurses, who would in turn go on to lead within St. Vincent's, around Australia, and internationally. Staff were not objects to be used to meet organizational goals but persons worthy of the care, attention, and formation that would enable them to make their own lasting impact. Leaders might consider emulating such an approach in the way in they build and nourish the teams that are entrusted with the work of Catholic health care today.

Berchmans led in a way which connected the aspiration and practicalities of delivering on the mission of Catholic health care all at once. Her fundraising letter demonstrates this *par excellence*, and accounts of her life demonstrate that this was a consistent disposition of character. The budget and tensions with the government were at once connected to the hospital's ward, particular episodes of patient care, and invitations to support through fundraising. This was particularly important when she encountered resistance. Leaders today might consider their own proximity to the need their services respond to, and the caregivers who respond directly to it. Further emulation invites reflection on the robustness of the connections leaders are able to draw between the strategic and operational priorities of their systems and their capacity to deliver the kind of care they are established for.

We saw earlier that there was an expansiveness to Berchmans's vision. She did not see the limitations of her context, but the possibility of the future, which led to robust partnerships with individuals and organizations who could make those possibilities real. Leaders seeking to emulate Berchmans's leadership might consider whether

their vision and partnerships are expansive enough, given the importance of the mission entrusted to them.

Simple in Faith yet Shrewd and Discerning

Berchmans's vision was at once sophisticated and simple. She wanted to change the landscape of health care in Melbourne to better serve the poor. It is well documented that many of her contemporaries, most notably the Archbishop of Melbourne, saw her vision as either naïve or impossible. To take one example, it was common for people around Berchmans to raise the problem of money. The concern was well-founded: her plans were well beyond the resourcing envelope available at any given time. In the context of the ecclesial structures of the day, one can sympathize with an Archbishop who was concerned that she would drive the Sisters of Charity and the Archdiocese into impossible debt.

There is a simplicity in the way Berchmans would respond to these cautions. In her letters we read variations of "bother the money, God always pays well for work done for him" and "God will look after it."⁴³ This trust in Divine Providence—a central tenet of the Sisters of Charity's founder, Mary Aikenhead—was alive in Berchmans.⁴⁴ And yet a simple faith is not the same as a naïve faith. The straightforwardness of Berchmans's faith was combined with her shrewd and discerning mind. The most significant example of this was when she sought to develop a purpose-built hospital to replace the aging terrace house in which St. Vincent's was founded. The architectural plans revealed a grand structure which would, if built, become a highlight in Melbourne's burgeoning city. They were also costly plans, yielding a resistance Berchmans was familiar with: "It is too expensive."⁴⁵

Her retort, "Bother the money, God always pays well for work done for him" was combined with one of the most significant fundraising efforts ever seen in Victoria. A month-long fundraising bazaar at Melbourne's Royal Exhibition Building yielded £10,000 and enabled the building of Berchmans's "impossible" vision.⁴⁶ That same disposition can be seen in the manner by which she established the clinical school. A similar endeavor at St. Vincent's in Sydney in relationship with the University of Sydney had faltered in 1884. There, Cardinal Patrick Moran, the Archbishop of Sydney, had appointed a doctor to the medical staff without following the hospital's processes.

⁴³ Skewes, *Mother Mary Berchmans Daly*, 38.

⁴⁴ Margaret Donovan, *Apostolate of Love: Mary Aikenhead (1787–1858), Foundress of the Irish Sisters of Charity* (The Polding Press, 1979), 13.

⁴⁵ Skewes, *Mother Mary Berchmans Daly*, 66.

⁴⁶ Donovan, *Apostolate of Love*, 247.

The University promptly withdrew its support for the St. Vincent's clinical school: as a secular University, it would not tolerate ecclesial interference in medical practice.⁴⁷ With a simple faith that St. Vincent's in Melbourne could be "the perfect institution for clinical teaching," and perhaps with the history of the Sydney failure in mind, Berchmans placed the governance of the clinical school entirely in the hands of the University from the outset.⁴⁸ This was a discerning move, which ultimately set the foundations of the clinical school on solid ground.⁴⁹ That clinical school still functions today and has trained generations of doctors who have made both a national and international impact on the discipline of medicine. Indeed, many went on to do this with a particular commitment to those who live in poverty or are subject to injustice, a realization of the hope Berchmans had for the formative medical education that would be provided at St. Vincent's.⁵⁰

A final example has to do with staff safety. St. Vincent's was built close to need in a challenging neighborhood, and Berchmans discovered that nurses travelling the short distance between their accommodation and the hospital were at risk of harm, particularly at night time. The straightforwardness of her conviction—that delivering on the mission required care for her teams—led her to build tunnels between quarters and ward, providing safe passage for her nurses to ensure they could deliver on care.⁵¹ The tunnels are still in use today.

Berchmans's combination of simplicity and practical wisdom enabled her to lead through significant complexity without losing sight of her central goals. I suggest the focus for those leaders who emulate this aspect of her leadership has to do with the virtue of hope. Aquinas defined the object of hope as "a future good, difficult but possible to attain."⁵² Berchmans demonstrates this virtue in the richest of ways. Her bold and creative vision for a future good was bound together with a commitment to pursuing that good, and with a faith that God would support her and the community's efforts. This was a simple faith, and yet it was connected to "shrewd and discerning" efforts, which ultimately meant that she delivered on that vision in an impactful and sustaining way. In today's corporate health contexts, it can be easy for

⁴⁷ Anne-Marie Whitaker, *St. Vincent's Hospital 1857–2007: 150 Years of Charity, Care and Compassion* (Kingsclear Books, 2007).

⁴⁸ Skewes, *Mother Mary Berchmans Daly*, 89.

⁴⁹ Interestingly, it was Berchmans who would eventually recover the relationship between St. Vincent's in Sydney and the University of Sydney following her appointment as Mother Superior for the Sisters of Charity and subsequent relocation to Sydney. Skewes, *Mother Mary Berchmans Daly*, 141.

⁵⁰ Many such accounts can be found in Egan, *Ways of a Hospital*.

⁵¹ Skewes, *Mother Mary Berchmans Daly*, 106.

⁵² St. Thomas Aquinas, *Summa Theologiae* II-II, q. 17, a. 1.

leaders to lose sight of the central good for which their services were established. The vices of hope are ever near: despair that no future good can be realized or presumption that it will happen without discernment and effort.⁵³ Further, the conflicting ends that the dominant economic rationalist and biomedical models of health introduce can quickly create goal confusion in leadership decisions. In place of these, Berchmans shows how a simple faith, combined with discernment and effort, can realize goods that are “difficult but possible.” This includes delivering on the central goods for which Catholic health care exists in ways that are biomedically rigorous, fiscally responsible, oriented towards the common good, and attentive to the individual dignity of those in need.

Bold Enough to Differ from Many

Berchmans is celebrated for the way in which she was able to envision and create a hospital system in a setting where others thought her vision impossible. This is certainly admirable. However, this telling of her legacy neglects that she did this in a fraught context, marked by tensions within the Catholic Church, between Protestants and Catholics, and in any intersection between church and state. Pressures in all three domains were consistent throughout Berchmans’s leadership, and her responses demonstrate a boldness which arises out of the confidence with which she held on to her vision, even when it was at a distance to what others expected.

The most well-documented tensions were between Berchmans and Archbishop Carr. Typically, these related to money and to the Archbishop’s concern that Berchmans’s plans were so far from what could be achieved that they were irresponsible. Carr expressed these concerns in writing to Berchmans, who, in response, would re-articulate the need she was seeking to respond to and her trust in Divine Providence.⁵⁴ Interestingly, Berchmans did not seem fazed by whether or not the Archbishop actively supported her plans. Her confidence in the future she was called to create did not rely on approval from authorities. In one notable exchange, the Archbishop advised Berchmans that he did not approve of her plans for a convalescent home. Berchmans simply replied “I did not ask for *positive approval*. I asked for permission.”⁵⁵ She went on to describe that she had already established the home and admitted patients, and made a commitment to her Mother General to work with the Archbishop to resolve any tension:

⁵³ Aquinas, ST II-II, qq. 20–21.

⁵⁴ Skewes, *Mother Mary Berchmans Daly*, 67.

⁵⁵ Skewes, *Mother Mary Berchmans Daly*, 132.

The place has been advertised and there are patients in the home. To close it would place me in a very false position with the public. The matter must be gone into again before I decline to take patients. I must go into it for the sake of my good name and the Hospital . . . I must see His Grace.⁵⁶

The confidence with which she articulated and drove towards her vision enabled her to respond boldly, even when different, and confidently work with the authorities of the day, including in moments of tension.

The sectarian tensions of the early twentieth century also made themselves known to Berchmans and the early St. Vincent's Hospital. While the Sisters of Charity made it clear that all of their hospitals would provide care to all in need, regardless of denomination, accusations of Catholic favoritism were always near. Further, the establishment of privately-funded beds within the original hospital led some to accuse Berchmans and St. Vincent's of moving away from charitable works. A particularly terse and revealing response from Berchmans to a set of questions from a Melbourne newspaper follows:

For what class of patients does St. Vincent's Hospital Provide?

For three classes. 1st, the destitute sick poor. 2nd, the middle class, who are expected to contribute according to their means, and who, moreover, give satisfactory proof that they are not in a position to pay private hospital fees . . . 3rd, the well-to-do class, who can afford to pay surgeons' and physicians' fees . . . patients of this class are designated private patients.

Why does St. Vincent's Hospital admit those of the 3rd class, or private patients?

Solely to assist the Sisters in maintaining the sick poor admitted to the wards.

Is the hospital subsidised by government?

No. And this is the principal reason why the Sisters of Charity are obliged to work, as it were, a private hospital in conjunction with the charitable institution.⁵⁷

Following a line of questioning about the composition of beds at the hospital (thirty-six for first and second class patients, four for third

⁵⁶ Skewes, *Mother Mary Berchmans Daly*, 132.

⁵⁷ Skewes, *Mother Mary Berchmans Daly*, 53–54.

class private patients), the newspaper asks: "As to the religious denomination. Were all these patients Roman Catholics?" Berchmans responds "no," and gives statistics which show that less than half of the patients the hospital sees are Catholic. It is striking here that the same confidence expressed in the face of criticism from the Archbishop, infused with a deep proximity to the details of the work of the hospital, carries through in the public square.

In the setting of relationship between church and state, in 1919 the Victorian government requested that Berchmans take over the running of a government hospital set up to respond to the Spanish influenza pandemic. The hospital was flailing on account of a nursing shortage. Clearly Berchmans's leadership was recognized outside of St. Vincent's and outside of the church. She promptly agreed to another opportunity to offer her skills and the resources of St. Vincent's in response to need. However, she met resistance from the existing governance of the hospital and the broader community. The resistance was founded on suspicions of a Catholic religious order running a government service and led to the plan collapsing.⁵⁸ Berchmans's response here is interesting: in the face of the plan failing, she publicly re-states her reasons for accepting the state's invitation, namely "to render help in nursing the sick poor owing to a shortage of nurses." She then directs that same help to an orphanage in South Melbourne.⁵⁹ The closing of one door in the midst of contention simply led to a refocusing of effort in another area of need.

I suggest that these narratives reveal something of the bind between courage and practical wisdom that Berchmans exemplified. Her courage gave her the capacity to meet opposition with a steady confidence. As Tansey noted of her, "Once decided, no obstacle on earth could thwart her."⁶⁰ And yet it is clear from her story that this did not amount to foolhardiness. She had done the work needed to achieve clarity in goals and that enabled her to pursue them despite obstacles. This opened up to a practical wisdom that could find an appropriate way to deliver on her vision in the midst of obstacles. Such obstacles did not lead Berchmans to waver; she simply found another way to deliver on the goods entrusted to her.

Leaders in Catholic health today face many obstacles in delivering on the goods entrusted to them. As we have seen, there are plenty of reasons to abandon these goods, relativize them, or be drawn into conflicts and interests which distract from them. I suggest that Berchmans offers a different path: a leader emulating her approach can acknowledge these obstacles but not be distracted by them.

⁵⁸ Egan, *Ways of a Hospital*, 55.

⁵⁹ Skewes, *Mother Mary Berchmans Daly*, 138.

⁶⁰ Skewes, *Mother Mary Berchmans Daly*, 151–153.

Berchmans demonstrates that leaders can find a way to deliver on the goods entrusted to them in the midst of the many obstacles that present themselves.⁶¹ There is a steadfastness and wisdom in her leadership through adversity. With this, she created a future which would have seemed impossible from the perspective of today's stakeholder or risk management logics, and there is an important lesson in that for leaders today.

None She Befriended Ever Forgot Her

Though Berchmans was bold, it is clear that this was combined with deep love for those around her, including those with whom she disagreed. For all of the tension with the Archbishop of Melbourne, he was often the first to provide financial support for her initiatives once they were underway, and there was clearly a personable and fraternal connection between them. The letter from the medical students' society, included above, demonstrates the affection with which she was held by them. In various biographies, stories can be found of Berchmans's discovering the talent of a hitherto unnoticed trainee doctor or nurse and offering them encouragement. Many of these went on to make an enormous impact in their respective fields. Berchmans clearly took time to know and relate to the people around her. She was not a leader at a distance. And she offered those she worked with both charity and encouragement. In one particularly tender example, she gifted a book to Ida O'Dwyer, one of the first graduate nurses of St. Vincent's who would go on to serve in the First World War. Her inscription reads: "Gratitude and kindness are two gems which shine the brightest and linger the longest in the memory of the heart. With love, dear Ida, from S M. Berchmans."⁶²

For the grandness of her vision, Berchmans was deeply personal and proximate to those around her. There is no doubt that this characteristic garnered enormous support for her ambition among the community. As Tansey's character sketch reads: "Her life was studded with gems of charitable action; and none she befriended ever forgot her. They were all deeply indebted to her in the days of their need and never failed to remember her in the days of their prosperity."⁶³ And yet Berchmans was neither a consequentialist nor a cynical politician.

⁶¹ I note a resonance here with Pope Francis's use of gradualism in various writings to observe the importance of realizing the good that is possible even in the midst of restrictions outside one's control. See, for example, the discussion in Daniel J. Fleming, "Might We Celebrate a Small Step? Beyond Deculpabilization in *Amoris Laetitia*," *Irish Theological Quarterly* 84, no. 1 (2019): 39–56, doi.org/10.1177/0021140018815854.

⁶² St. Vincent's Hospital Melbourne Archives.

⁶³ Skewes, *Mother Mary Berchmans Daly*, 151–153.

She offered charity to all around her because it was intrinsically good to do so, and good fruit followed. Turning again to emulation, leaders of Catholic health systems today might consider the integrity of their professional relationships with staff and stakeholders. Are these merely instrumental? Or do they reflect the approach exemplified by Berchmans, who saw and loved the dignity of those around her and managed to reflect that in her relationships, even when difficult?

EXEMPLARIST ETHICS AND THE CATHOLIC ETHICAL TRADITION

Throughout this article, I have been proposing that Mary Berchmans Daly is an exemplar for Catholic health system leadership, and I have suggested some ways in which emulation of her morally praiseworthy characteristics offers normative guidance for leaders of Catholic health systems today. In this final section, I turn to Linda Zagzebski's 2017 *Exemplarist Moral Theory* to provide an account of *why* an exemplar such as Berchmans has this kind of normative significance.⁶⁴ I argue that her approach resonates with Catholic theological ethics. I also suggest that it provides a robust method for conscience formation for leaders in nuanced and complex settings, precisely because it offers the possibility of drawing on exemplars who responded to ethical challenges that were similar in kind to their own.

Zagzebski's approach was an innovation in twentieth- and twenty-first century philosophical ethics. The philosophical frameworks which have been used to answer the central questions of morality (what is the good? What kind of person should I be? What should I do in response to this particular moral choice?) are often deductive. They begin with metaphysical commitments around the nature of the good life (such as virtue ethics) or the principles and outcomes which ought to guide moral decision-making (such as deontological or consequentialist frameworks). Each of these approaches deduces answers to the questions of morality from *a priori* commitments, with varying levels of attention to the nuance of the context in which they arise.⁶⁵ An important pedagogical implication of such approaches is that moral development is bound together with an individual's capacity to advance in conceptual knowledge about ethics.

In contrast, Zagzebski's approach begins with direct reference to moral exemplars, in the way that I have sought to model in this article.

⁶⁴ I was introduced to Zagzebski's work in Daniel J. Daly, *The Structures of Virtue and Vice* (Georgetown University Press, 2021). Daly has subsequently drawn on Zagzebski in "Exemplarist Medical Ethics," *Journal of Medical Ethics* 50, no. 7 (2024): 447–451, doi.org/10.1136/jme-2023-109150.

⁶⁵ Lawrence M. Hinman, *A Pluralistic Approach to Contemporary Moral Issues*, 5th Edition (Cengage Learning, 2013), 122–179.

She suggests that, just as we can identify water without understanding the chemical structure of H_2O , we are able to identify moral exemplars in the absence of ethical theory.⁶⁶ She defines exemplars as “supremely admirable persons who show us the upper reaches of human capability and, in so doing, inspire us to expect more from ourselves.”⁶⁷ Such persons are identified not first through a theoretical lens but by the emotion of admiration, which is the resultant state we experience when we encounter the excellent.⁶⁸ Berchmans’s story elicits admiration, by providing evidence of the excellent and exemplary qualities of her leadership.

Moral reflection on such exemplars, engagement with their stories, and emulation of their morally admirable characteristics can yield normative guidance. This includes concepts of excellence (providing the *end* which is critical for virtue theory) and examples of what good action looks like across a variety of circumstances (providing the action guidance needed for applied ethics).⁶⁹ Critically, these concepts follow from the experience of admiration for the exemplar. As Daniel J. Daly describes the process:

Our admiration arises when we encounter morally attractive and imitable persons. Essentially, exemplars elicit an emotional response of admiration in us. Our admiration is aroused when we view news footage of Martin Luther King Jr. marching for voting rights in Selma or of frontline health workers risking their lives by caring for patients during the COVID-19 pandemic. These are morally attractive persons. We desire to possess the traits of such people.⁷⁰

The approach is inductive: beginning with the moral content that can be discovered through reflection on an exemplar, one can conceptualize the normative commitments that one ought to strive for in one’s own life.⁷¹ Hence the method I have used in the preceding section.

⁶⁶ Linda Trinkaus Zagzebski, *Exemplarist Moral Theory* (Oxford University Press, 2017), 11.

⁶⁷ Zagzebski, *Exemplarist Moral Theory*, 1.

⁶⁸ Zagzebski, *Exemplarist Moral Theory*, 2.

⁶⁹ Zagzebski, *Exemplarist Moral Theory*, 2, 12.

⁷⁰ Daly, *Structures of Virtue and Vice*, 152.

⁷¹ Of course, there is risk attached to this approach in that an individual’s morally praiseworthy characteristics can function in tandem with morally distorted characteristics and behaviors. Zagzebski recognizes this problem. For example, she holds that we may be mistaken in identifying exemplars, a point to which I return below. Part of the reason for this is that one might be an exemplar in one aspect of life and not others (“a person who is highly admirable for some trait but is contemptible in some other respect”). In view of this, Zagzebski’s challenge is to identify exemplars whose moral integrity makes them exemplary in a comprehensive sense: not merely for this or that

Exemplarist moral theory has three clear resonances with Catholic theological ethics.⁷² The first is with conscience: in suggesting that it is innate to humans to be able to recognize the good in exemplars, Zagzebski's approach is aligned with the capacity of conscience to perceive and respond to moral goodness.⁷³ Conscience can also "err without losing its dignity"⁷⁴ when a decision is made in good faith but is mistaken, and Zagzebski recognizes that our admirations might at times be mistaken in a similar way. That said, she retains the same hopefulness that the Catholic tradition holds for conscience: despite our fallibility, our capacity to recognize what is good and admirable is ultimately trustworthy.⁷⁵

This is related to a second resonance. In Zagzebski's theory, just as there is such a thing as water, there is such a thing as an exemplar, whose characteristics are worthy of admiration by other persons. This means that moral goodness exists and can be discovered, a central tenet of Catholic natural law theory.⁷⁶ Furthermore, moral agents are able to identify the good in a way that precedes the articulation of principles, a position which aligns with several contemporary approaches to natural law.⁷⁷ These resonances provide focus for the

trait, but through the coherence of their whole character. This necessitates a critical approach to identifying exemplars and one which is oriented towards discerning the moral integrity (or otherwise) of those we admire. See Zagzebski, *Exemplarist Moral Theory*, 75.

⁷² I note that Daly, Stephen J. Pope, and Patrick M. Clark have also commented on the place of Zagzebski's theory in relation to Catholic theological ethics. I draw on their work where relevant below but do not provide a comprehensive summary of their contributions. For further detail, see Daly, *The Structures of Virtue and Vice*, 151–53; Stephen J. Pope, "Christocentric Exemplarism and the Imitation of Jesus," *New Blackfriars* 101, no. 1093 (2020): 301–310, doi.org/10.1111/nbfr.12412; Patrick M. Clark, "The Case for an Exemplarist Approach to Virtue in Catholic Moral Theology," *Journal of Moral Theology* 3, no. 1 (2014): 54–82.

⁷³ Vatican II Council, *Gaudium et Spes*, no. 16.

⁷⁴ *Gaudium et Spes*, no. 16. Zagzebski, *Exemplarist Moral Theory*, 2.

⁷⁵ Zagzebski, *Exemplarist Moral Theory*, 2. I note here a limitation of this approach inasmuch as it remains naïve to the impact that structural injustice can have on the formation of conscience. Bryan N. Massingale explores this problem in "Has the Silence Been Broken? Catholic Theological Ethics and Racial Justice," *Theological Studies* 75, no. 1 (2014): particularly at 141–143. That critique could also extend to limitations in our capacity to identify and admire exemplars in settings of injustice, a point which is made in Alfred Archer, "Moral Exemplars and the Moral Community," *The Journal of Value Inquiry* 60, (2025): 199–212, doi.org/10.1007/s10790-025-10053-w.

⁷⁶ See for example International Theological Commission, *In Search of a Universal Ethic: A New Look at the Natural Law* (2009), vatican.va/roman_curia/congregations/cfaith/cti_documents/rc_con_cfaith_doc_20090520_legge-naturale_en.html.

⁷⁷ Zagzebski, *Exemplarist Moral Theory*, 15–16. There is contrast between Zagzebski's approach and some formulations of the natural law in that the good is discovered not by identifying precepts but through identifying exemplars. This applies primarily to

work of conscience formation, moving away from learning about ethics at the level of theory to engaging directly with exemplars.

Finally, Zagzebski identifies a resonance with Christian approaches to ethics “because of the centrality of Jesus Christ as a moral exemplar in Christian teaching,” which draws the theory into dialogue with the tradition of the *imitatio Christi*.⁷⁸ She also recognizes the place that Biblical narratives and reflection on the lives of the saints would have in this approach.⁷⁹

With these resonances in mind, it is important for the focus of this article to consider how Zagzebski’s approach universalizes the work of ethics. This is important for today’s leaders in Catholic health care, many of whom are professionals with significant leadership experience who are thoroughly committed to their organization’s mission but who do not have formal training in Catholic theology or ethics.⁸⁰ On Zagzebski’s view, ethics is not first the terrain of experts who have spent time clarifying the definitions and principles of the discipline, nor members of a particular community. Instead, it is intrinsic to the moral practice of each and every person in the setting of their own lives, including their professional responsibilities, because all can recognize and work to emulate exemplars. Such an approach can function to empower leaders of Catholic health systems to seek out and learn from those who have been exemplars in their particular setting and introduces opportunities for conscience formation that do not rely on cultivating technical expertise in theological ethics.

derivatives of the so-called “New Natural Law Theory,” the central proponents of which are Germain Grisez, John Finnis, and Joseph Boyle. For an overview see Germain Grisez, John Finnis, and Joseph Boyle, “Practical Principles, Moral Truth, and Ultimate Ends,” *American Journal of Jurisprudence* 32 (1987): 99–151. For a discussion and critique, see Jean Porter, “Basic Goods and the Human Good in Recent Catholic Moral Theology,” *The Thomist* 57 (1993): 28–42. This contrast does not exist in all formulations of natural law. For example, the Australian ethicist Thomas Ryan draws from Aquinas to suggest that the way in which conscience recognizes the good is largely through pre-intentional attunement. Thomas Ryan, *Conscience, Virtue, and Worship: Theological Perspectives* (Generis Publishing, 2022): 18–40. Here Ryan draws from Raimond Gaita, *A Common Humanity: Thinking about Love, and Truth and Justice* (The Text Publishing Company, 1999), 17–19. See also Daniel J. Fleming and Thomas Ryan, “Witness, the Pedagogy of Grace and Moral Development,” *The Australasian Catholic Record* 95, no. 3 (2018): 259–272.

⁷⁸ Zagzebski, *Exemplarist Moral Theory*, 32. On the significance of *Imitatio Christi* for theological ethics, see James F. Keenan, *A History of Catholic Theological Ethics* (Paulist, 2022), 95–98. Pope makes this link to Zagzebski’s work in “Christocentric Exemplarism and the Imitation of Jesus.”

⁷⁹ On this approach, see William C. Spohn, *Go and Do Likewise: Jesus and Ethics* (Continuum, 1999).

⁸⁰ See for example the discussion in Celeste De Schryver Mueller, “Formation: Connect the Practical to the Theological,” *Health Progress* 92, no. 2 (2011): 52–55.

Further, Zagzebski suggests that the common methodology for identifying exemplars is through narrative.⁸¹ This is related to our capacity for moral development (or, in the Catholic tradition, conscience formation).⁸² According to Zagzebski, such development “often takes place in the telling and re-telling of narratives and in the imitation of models.”⁸³ Through storytelling, individual moral agents are able to identify the morally praiseworthy attributes of an exemplar and work to emulate them. Hence, an important way by which conscience is formed is by dwelling in narratives about exemplars.

Daly takes the further step of suggesting that focus on exemplars whose experience is relatable to one’s own (Daly’s example is medical professionals focusing on exemplars from medicine) can provide still more robust ethical guidance, a position supported by recent research in moral education.⁸⁴ This is important for leaders of Catholic health systems today, who exercise their responsibilities in nuanced and complex contexts. Recognizing their particular challenges, I have used narratives about Berchmans—a leader familiar with similar challenges—to demonstrate the ways in which emulation of her yields relevant and practical normative insights. Of course, such leaders will also have access to exemplars who are particular to their contexts (both historical and contemporary). In universalizing the ‘work’ of ethics, the approach I have modelled in this article, and that Zagzebski has defined in theoretical terms, can provide encouragement for leaders in Catholic health systems to identify and emulate exemplars in their own contexts as well.

CONCLUSION: “IT IS IN FIFTY OR ONE HUNDRED YEARS FROM NOW THAT PEOPLE WILL REALIZE HER GREATNESS.”⁸⁵

In this article, I have proposed that the legacy of Mary Berchmans Daly provides an illustration of exemplary leadership which is relevant to leaders of Catholic health systems today. I have chosen to focus on the scope of her vision for a health care system, her capacity to drive towards clearly identifiable goals in a sophisticated way, her willingness to differ, and her depth of love for those around her in drawing out these exemplary characteristics. I bring the article to a close by noting that these characteristics are made cohesive by

⁸¹ Zagzebski, *Exemplarist Moral Theory*, 15.

⁸² See Daniel J. Fleming, “From Theory to Praxis: Challenges and Insights for Conscience Formation Today,” in *Doing Asian Theological Ethics in a Cross-Cultural and Interreligious Context*, ed. Yiu Sing Lucas Chan, James F. Keenan, and Shaji George Kochuthara (Dharmaram Publications, 2016), 291–304.

⁸³ Zagzebski, *Exemplarist Moral Theory*, 4.

⁸⁴ See Daly, “Exemplarist Medical Ethics.”

⁸⁵ Bishop John McCarthy, quoted in Skewes, *Mother Mary Berchmans Daly*, 153.

Berchmans's extraordinary commitment to the fourth vow of the Sisters of Charity: service of the poor. It is clear by her life that she saw her work as a sacred duty. Any one of her exemplary characteristics might be deployed in isolation in pursuit of some other goal. They are made cohesive by their orientation towards a sacred duty which recognizes the face of God in those in need.⁸⁶ If there is one final opportunity for emulation by leaders of Catholic health systems it is this: all of their work ought to be oriented towards this sacred duty, which both corrects and directs any of the other goals that can interfere with the mission of their systems. Correlatively, in orienting all to this sacred duty the work itself can reflect the same integrity that Berchmans showed in her extraordinary leadership. Jesus of Nazareth observed that "you will know them by their fruits" (Matthew 10:16). Berchmans and her legacy are a case in point, and one which leaders of Catholic health systems today might consider a measure for their own efforts. **M**

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⁸⁶ See Arbuckle's defense of the cohesiveness of such "foundational" models of health care in Arbuckle, "Have Catholic Healthcare Ministries a Future?," 431–436.