A Personal Reflection On Our Future Leaders

By BILL BRINKMANN

I have had two interesting and rewarding careers, the first as an officer in the United States Navy, the second as a leader of formation programs in Catholic health care. Highlights during my Navy service included an end to the draft and a transition to an all-volunteer force, the fall of the Soviet Union and the emergence of information warfare as a new sphere of influence. These all entailed large-scale organizational change, the development of new leadership approaches and the development of new leaders.

In Catholic health care, I have witnessed the implementation of new models for sponsoring our ministries, the consolidation of many health care systems and the attempted reform of health care through the Affordable Care Act. These changes coincided with a significant investment by Catholic systems in leadership formation programs.

Much of what I have learned in Catholic health care has caused me to reflect on and even reevaluate my military experience, just as much of what I learned about leadership in the Navy has been useful in developing formation experiences for leaders in Catholic health care. I do not propose the Navy as our model for developing new leaders, but I would suggest that the level of effort the Navy places on grooming emerging leaders offers a potential benchmark.

Catholic health care's formation work in recent years has been vital to maintaining a ministerial identity during tumultuous times. Certainly, we must continue this work — but we also must turn attention to identifying new leaders from the ranks of our associates and supervisors. We must invite them into positions of increased responsibility and support them with formation programs designed to enhance their emerging skills, their deepening sense of mission and eventual progression into positions of senior leadership.

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COMING ABOARD

I'm not sure exactly what I expected in 2001 when I transitioned from a 30-year career in the Navy to serving in Catholic health care. I know I was pleasantly surprised to find that the mission of the healing ministry represented as strong an aligning force as did the mission of the Navy — in some ways, stronger.

In the Navy, commitment to the mission often meant complete dedication of available resources to the specific task at hand, that is, the mission of a particular operation. Mission in Catholic health care, I discovered, entailed a deep appreciation for the human dignity of all persons, with special attention to those who are most vulnerable, in order to bring about the reign of God on earth.

Further, I found an impressive cadre of workers in health care; talented people with altruistic motives and a commitment to helping others. I felt at home in my new role of developing and implementing health care leadership formation programs.

What Catholic health care has accomplished over the last decade in the field of formation is most impressive. Using a top-down strategy, many systems have initiated effective approaches for their senior leaders and directors. CHA's 2011 *Framework for Senior Leadership Formation* document


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summarizes programs developed across the ministry and describes their content, approaches, outcomes and methods. Such programs have touched hundreds of senior leaders, many of whom have reported being transformed personally.

But demographics are working against us. During the decade ahead, we can expect retirement to claim most of the senior leaders who have benefitted from a relationship with members of the sponsoring entities and who have experienced formation. Even more alarming, the leaders in the next tier are almost as old as their bosses — so they, too, will be leaving.

CHOOSING NEW LEADERS

Processes for selecting and grooming new leaders always will vary to fit specific cultures. The Navy, for example, nurtures leadership from the very beginning of a sailor's career. After two to three years of service, most sailors have gained enough knowledge and experience in their occupation to progress from the rank of seaman to that of petty officer, assuming the commanding officer approves. But before such advancement, the candidate must complete leadership training, including correspondence courses and instructor-led curricula. It's not an extensive process, but it begins a pattern of leadership development that will repeat at each successive rank. Each progression in rank is accompanied by symbols, rituals and increased responsibility. For example, the new petty officer is given small tasks to supervise so that he or she can grow in confidence. As his or her career progresses, responsibilities are added.

Like Moses, who never made it into the Promised Land, we must select, nurture and empower new leaders and then get out of their way as they create the new beginning, a new flourishing of the Catholic health care ministry.

In the Catholic health care ministry, leadership is approached differently.

For the past several years, eight Catholic systems have been using a tool called the Catholic Identity Matrix to help them assess how well they are living the principles of Catholic health care, based on observable, documented evidence. I have been fortunate to be a part of that assessment process, working with the Veritas Institute of the University of St. Thomas, in Minneapolis. The Catholic Identity Matrix is an effective diagnostic device for identifying organizational improvement opportunities, aligning leaders and training associates.

It concerns me, however, to see how little effort and few resources systems expend to identify, engage and develop new leaders from among the staff. Organizations use varying methods to determine the cost of training and development of leaders and to calculate the associated return on investment. Yet there appears to be no single recognized process for determining what percentage of the budget should be dedicated to developing leadership among associates.

During my time in the Navy, we estimated that we annually spent 12 percent to 14 percent of our operating budget on training. In the U.S. industry in general, I believe that number is probably closer to 3 percent to 5 percent allocated to training.

Yet I have observed that many health care systems struggle to spend even this much of their budget on developing their people. Some health care systems use a financial metric for training activities, but with an associated goal of decreasing the expenditure. I think this is destructive. It creates a climate that labels training as "unproductive time." Especially in clinical departments, time off the floor for training is discouraged, and typical employee-to-leader ratios often exceed 30 to 1, making significant mentoring, development, counseling or performance feedback even more difficult.

I believe that failure to invest adequately in developing those who serve in our ministries, permitting high employee-to-leader ratios and ignoring low employee engagement scores from those frustrated by their lack of voice in decision-making have greatly affected our ability to foster new leaders.

HOW TO DO IT

What might a model of new leader identification and formation look like? Selection and nomination to the process will be critical, but first we must reorient our culture in order to view training not primarily as a cost, but as an investment in our most valuable resource — those who serve with us.

1. **Middle managers**, often not the beneficiaries of formation themselves, will be essential in identifying new leaders from among those in the front lines who report to them. Middle managers are critical to the process and will require training in the discernment of others' readiness for leadership.

2. Senior leaders who have been the beneficiaries of our formation programs should be expected to **mentor emerging leaders**. How else can the top-down strategy of formation be effective?

3. **Reporting structures** that assign a reasonable number of associates per supervisor will be required.

4. The **deepening of alignment** to the mission and values of the ministry would be useful for all new leaders. Reflection on one's personal call and giftedness — commonly used at the senior leader level — also would be generative.

5. **Exploration of** the ministry's **founding stories** will enable our new leaders' spiritual roots to develop and to provide sustenance for the perseverance leaders need.

6. **Theological reflection** certainly is not beyond the reach of this audience. Reflections on the importance of viewing ourselves as a ministry; the nature of suffering; the imperative of creating structures that are socially just and the rationale for our ethical guidelines should all be in play when forming new leaders.

Most existing formation programs for senior leaders address these topics and will provide useful starting points in adaptations for new leaders. But the position and responsibilities of our new leaders also have some unique formational requirements, for it is in their work that the ministry's strategy and planning become reality. They are the final arbiters of how policy becomes practice.

There should be specific roles and expectations developed for new leaders in a ministry. These might include leading prayer, consoling other associates in loss, empowering others, demonstrating integrity and articulating to associates the significance of being in a ministry.

Many of the administrative requirements that come with leadership carry a spiritual component. Formation therefore will benefit these newcomers to conducting performance reviews; assigning tasks to others; holding others accountable; resolving conflicts; implementing policies. Now that we have made significant progress in our formation of senior leaders, it seems time to learn from that experience and make a significant investment in new leader selection and formation.

In the article "Getting Them through the Wilderness: A Leader's Guide to Transition," consultant William Bridges, PhD, uses the Exodus story as an image for leading change.[1] Borrowing Bridges' metaphor for those of us in Catholic health care, Egypt would represent the suboptimal current state in which a ministry finds itself. For the healing ministry, Egypt might represent an industrial model of pay-for-procedure in which patients are reduced to a commodity. Caregivers are all making bricks for the Pharaoh, a symbol for monotonous tasks accompanied by little voice in how things get done.

To reach our Promised Land of compassionate, holistic, person-centered care, we must leave the relative comfort of Egypt (our current models of care and reimbursement structures) to transit the uncertainty and danger of the desert, a wilderness of unknowing where innovation, experimentation and risk will be essential, requiring leaders to prophetically proclaim a vision of our intended destination.

Then comes what is perhaps the most difficult of leadership's responsibility. Like Moses, who never made it into the Promised Land, we must select, nurture and empower new leaders and then get out of their way as they create the new beginning, a new flourishing of the Catholic health care ministry.

You and I most likely will not make it to this Promised Land, but it could be our privilege to participate in the identification of fledgling leaders who will.

I truly believe that developing our next generation of leaders is our most important ministerial task. Then, like Moses, we can watch those who have served with us progress in the service of others.

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NOTE

1. William Bridges, *Getting Them through the Wilderness: A Leader's Guide to Transition* (Larkspur, Calif.: William Bridges & Associates, 1987), www.wmbridges.com/pdf/getting-thru-wilderness-2006-v2.pdf.

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