Breaking through the Ceiling at CHI

BY ED GIGANTI

Catholic Health Initiatives (CHI) hosted its third biannual national leadership conference September 17-19 in Covington, KY. In her address, CHI president and CEO Patricia Cahill presented an impressive list of the system's accomplishments and innovations, including the Executive Diversity Fellowship, a new program designed to move experienced women and minority health care managers into executive positions. During the conference, I caught up with Michael Fordyce, CHI's chief administrative officer, and Dave Black, vice president of leadership development, to find out more about this approach to increasing leadership bench strength.

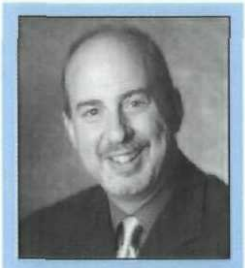
"CHI established this program as a business priority to both develop our leadership benchstrength and ensure that our leadership increasingly represents the diverse populations we serve and employ," Black said.

Fordyce said that CHI's investigation of career growth for women and minorities in health care showed that, after earning master's degrees in health administration (or other related fields), these people did not have problems getting jobs. "But they hit a ceiling after three to five years," he said, "and they can't take that next step up to vice president.

"That led us to develop this program for that population who have earned their MHAs, been identified as true leaders already, and are doing a terrific job," Fordyce said.

To be considered as a candidate for the fellowship, an applicant must:

- Be a woman and/or member of a racial or ethnic minority
- Have at least three years of experience in a management role in health care
- Have completed a master's degree in health care management or related field
- Have demonstrated competence in achieving results, collaboration, developing people, and increasing "customer value"
- Share the same values, mission, and vision as expressed by CHI
- Be in a career track that fits the system's executive needs



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Employment within CHI is not a requirement for consideration, Fordyce said, but it may be a tiebreaker in final selection.

Black said that the target position for the pilot of the Executive Diversity Fellowship is vice president of operations. (Because most CHI facilities are small—100 beds or less—few have chief operating officers. The vice president of operations is a comparable position to the chief operating officer.) The target position may change from year to year based on the organization's needs.

The two fellows selected for the pilot program will gain experience at three levels of the system over the course of a year. First, each will be assigned to one of CHI's "market-based organizations" (MBOs), where he or she will work and learn under the mentorship of the MBO CEO for five months. Next comes a similar five-month mentorship with a system vice president of operations who has responsibility for eight to 10 MBOs. Finally, the candidates will be mentored for two months by CHI's chief operating officer Kevin Lofton. (Fordyce credited Lofton, who is African-American, as "instrumental" in the development of the fellowship program.)

"Our intent is to first give the fellows in-depth exposure to all aspects of hospital operations," Black said, "from leading committees and interacting with boards and physicians to strategic planning and gaining experience in leadership decision making. Second, they will learn how to drive operational success, how to build strong partnerships, and how to identify and implement best practices. In addition, they will better understand a leader's role and responsibility in developing CHI as a national health ministry."

Fordyce, Black, and Lofton, along with several other members of an oversight committee, interviewed candidates for final selection the day after the Leadership Conference. The original pool of applicants resulted from CHI's advertising the fel-

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PART SIX OF THE *DIRECTIVES*

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DIRECTIVE 72

Directive 72 was added in the 2001 revision. In arrangements with other-than-Catholic partners, it is essential for the Catholic organization to ensure that what was agreed to, especially with regard to cooperation with the partner's wrongdoing as well as overall consistency with Catholic moral teaching, is being observed. The directive calls for a periodic assessment of the implementation of the agreement (not of the agreement itself), assuming that the original agreement was consistent with Catholic moral teaching.

The 2001 revisions of Part Six of the *Directives* will directly affect the structuring of new arrangements with other-than-Catholic partners that are involved in wrongdoing. Considerable moral distance will need to be established and maintained between the Catholic entity and the provision of prohibited services, such that the arrangement constitutes mediate material cooperation. This may be particularly difficult when the Catholic hospital would become the sole provider in the community.

What is at issue here is the integrity of the Catholic organization. How do Catholic health care facilities remain true to their identity—their beliefs and commitments—in the complex, secular, and pluralistic world of health care while meeting the needs of the communities they serve? The goal of any moral assessment of a possible arrangement with an other-than-Catholic partner—whether that assessment is conducted by Catholic health care providers, diocesan bishops and their consultants, theologians, or ethicists—is to ensure the identity and integrity of the Catholic organization, taking into account the uniqueness and complexities of each situation. The principle of cooperation—one of the most difficult moral principles to apply—is a tool in that process. □

RESPONSIBILITY AND COOPERATION

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eration will lead to scandal. Institutional applications of the principle will be more susceptible to scandal because of the public nature of institutions. Scandal is most likely to be an issue when "partnerships are not built upon common values and moral principles" (*Ethical and Religious Directives*, Introduction to Part Six). Obviously, the more divergent the values of the partners, the higher the risk of scandal.

The traditional definition of scandal is "leading another person into sin." Scandal is of such importance in the application of the principle that "cooperation, which in all other respects is morally licit, may need to be refused because of the scandal that might be caused" (Directive 71). Keeping the issue of scandal in mind will ensure that institutional survival does not depend upon sacrificing Catholic identity through wholesale accommodation or through dilution of one's sense of wrongdoing. At the same time, the ambiguity often caused by partnering must not be exaggerated to preclude legitimate forms of cooperation. "Scandal can sometimes be avoided by an appropriate explanation of what is in fact being done at the health care facility under Catholic auspices" (Directive 71). So although the bishops rightly encourage "an increased collaboration among Catholic-sponsored health care institutions" we should resist the temptation to fall into a ghetto-like mentality in Catholic health care.

The assessment of the possibility of scandal will build on a nuanced consideration of the kinds of evil that may be involved in the cooperation in wrongdoing. Abortion and assisted suicide are, for example, graver evils than reproductive technologies or sterilization. To attack and destroy human life is a graver evil than bringing life about or suppressing the reproductive function. One can formulate an axiom: The graver the evil, the higher the risk of scandal; the higher the risk of scandal, the more distant the Catholic partner must be from the wrongdoing. □

LEADERSHIP DEVELOPMENT

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lowship through 60 colleges and universities with MHA programs as well as 14 professional organizations of minorities and women in health care, among them the National Association of Health Service Executives (NAHSE).

CHI has a strong relationship with NAHSE, an organization for African-Americans in health care leadership. Lofton is a past president. "We learned through NAHSE that members of racial and ethnic minority groups really thrive in mentorship relationships," Black said. "That's why we built the program this way."

About 100 inquiries and 20 formal applications resulted from CHI's communications about the fellowship. "The challenge has not been in recruitment or in program development," Fordyce said. "The challenge will be insuring that at the end of the fellowship, we have good spots to place these people in." To that end, he added, CHI is taking a longer-range approach to filling vacancies in the vice president of operations role. "Six months into the program, we are going to start identifying the jobs for these fellows."

The fellowship represents a sizeable investment for CHI: approximately half a million dollars in direct costs, according to Fordyce. Included in the costs are executive salaries for the fellows. "Most programs offer a modest stipend," Black said. "We are paying the fellows a starting salary for the target position—vice president of operations—for the fellowship year. Because this program targets high-potential leaders, we feel we need to pay them accordingly."

Fordyce said that CHI's board—briefed on the fellowship program during the leadership conference—is very supportive. Cahill told me that she is "enormously excited and proud" of this effort to ensure leadership that matches the increasingly diverse populations CHI serves. With success in the fellowship, there will be some new faces and more diverse representation at CHI's next national leadership conference in 2004. □