

Diversity: Crossing the Comfort Zone

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In 1999, the board of directors took a leap of faith and appointed me president and CEO of Kingsbrook Jewish Medical Center. In the 72-year history of the medical center, I became the first female, physician, and gentile president and CEO: a trifecta!

Had the institution not suffered a financial meltdown, I doubt whether the board would have ventured outside its comfort zone to hire someone “out of the box.” During a crisis there is a unique, time-limited opportunity for the established homeostasis of a system to change and recalibrate. Such change occurred here, but with controversy and without consensus. At this time, the board was male (save for one female), Caucasian, and of one religion. They knew each other through historic family or business connections. I had worked at the institution for 17 years with a successful history of program development and increasing responsibility, yet remained an outsider. I actively politicked the power brokers to establish myself as a credible candidate and to become, for the majority, the “natural choice” based on past successes and as a keeper of the “institutional memory.” I committed to preserve the roots and traditions of the institution and to bring about the necessary changes to ensure its immediate survival and future viability.

The Brooklyn institution was founded in a cultural context by women who envisioned its mission to include meeting the cultural, religious, and dietary needs of the predominantly Jewish community. From 1925 to 1999 the demographics of the community changed while those of the institution’s decision makers remained the same. Today, Brooklyn, like New York City, has two key demographic features: population density and cultural diversity. Brooklyn has over two million people and nearly 40 percent foreign born. Our community is predominantly non-white, African, and Caribbean American, with a minority ultra Orthodox Jewish population.

To feel comfortable, consciously or unconsciously people tend to choose those whom they perceive as “like themselves” for friends, colleagues, and business associates, keeping differences or the unknown at arms length. How does one transform the interpersonal culture of a system? I drew on my skills as a psychiatrist to acknowledge that there was an entrenched, dysfunctional pattern of conformity and to create a plan to change it. I had learned lessons in two earlier roles: developing a new culturally diverse psychiatry program and general physician recruitment. Then, I engaged a Caribbean-American woman, a former hospital CEO who resided in the community, as a community liaison. It became clear that the community-based physicians held firmly entrenched perceptions that we had a “closed shop.” Years of community distrust would be difficult to surmount.

My first task was to persuade the board to embrace the cultural diversity of our community. My anxiety peaked when upon my proposal to restate our mission, to serve a “*culturally* diverse” community there was a compromise offered to include “diverse” without a reference to culture. It was seen as sufficient, but I knew that we had to go beyond “sufficient” and that the mission statement was just the beginning of a longer journey. We agreed that the ultimate goal was inclusivity while preserving the history.

My philosophy of leadership was of less immediate concern to our surrounding community than to our frontline employees, two thirds of whom resided locally and whose demographics did mirror the community we served. What changes would occur and how would they be impacted? The professional employees sensed my values having worked with me in my capacity as a treating psychiatrist, but who would I be now as the leader? As I opened the channels of

communication, and solicited and incorporated input, the atmosphere became hopeful. There were years of mistrust that needed to be overcome right at home. There was a complete organizational cultural shift that was required with perceptions of fairness, respect, and inclusion as central. This is a leadership challenge in any organization, but in the context of a diverse employee population it is more highly complex and charged. One wonders if this challenge is rooted in a lack of sensitivity and respect for difference or within a misattribution of intentions. Most likely it is both, and so all the more reason to address the issues head on.

I was pleased to find that changes natural to me were received by the staff as signs of respect and inclusivity. For example, we held an employee holiday party shortly after I assumed my new role. While rounding on the units, several staff lightly joked about the type of food that was historically served at these events—a fine menu except that it excluded culturally syntonic food that the staff enjoyed. I had the menu changed to include Caribbean dishes which meant to the staff that I had cared enough to listen. I later heard that dancing alongside staff at the party (i.e., full participation with staff at social events) was also meaningful.

Another opportunity presented itself when a former nurse leader of the medical center, whom I had known when I was a practicing clinician, called me. She had learned of the change in leadership and offered me her assistance. I seized the opportunity to have someone I respected and who could also offer a clinical perspective on the board. She was African American, and became the first board member of color in the institution's history.

With board support I hired the best people for open management positions and recruited a more diverse team. I promoted the director of quality, an African American female with whom I had worked closely in my former position as medical director, to the key position of compliance officer. She had the trust of the frontline staff. Employees felt so comfortable they raised concerns beyond compliance matters, offering me an additional perspective on issues that needed addressing.

I sought the partnership and input of a receptive and diverse group of local elected officials and community leaders on how best to serve our community and their constituency. They offered assistance, and two elected officials became board members. Forging these relationships was important and advanced our efforts in developing an open presence in the community, as for decades we had been below the radar, isolated and insular.

I discovered through my community outreach to all constituencies that we were not as sensitive to the diverse needs of our local Jewish community, which had also changed over time to an ultra Orthodox population. This insensitivity was clear in the matter of kosher dietary laws that we had followed since our founding. Here we were, financially challenged, with additional expense to keep kosher while the 10 percent of patients who were Jewish could not eat the food because they required a more stringent kosher standard. Upon my suggestion that we reconsider our food operations, one long-standing board member resigned. He would have preferred that I be terminated. Several years later a conscientious and courageous subset of the board, in collaboration with a rabbinical authority, reached a solution: provide non-kosher food for the majority and a satellite kosher kitchen that would be of the highest standard required of our local Jewish community.

Important to note is that the changes we were making at Kingsbrook were occurring within a larger cultural context. Our board was not alone in seeking to diversify culturally. In 2005, the Greater New York Hospital Association created the Center for Trustee Initiatives to assist

hospital association members to achieve diversity on their governing boards by creating a pipeline of candidates and matching these candidates with the members' governing boards.

In the process of employee recruitment, I discovered that candidates from different cultures had a reluctance to apply, assuming that they would not be seriously considered. Additionally, it may be beyond one's comfort zone to seek to join an organization where one will be in the minority. Everyone wants to feel that they bring true value, not that they are a token member or fulfilling a minimum quota. The task of diversity is bidirectional and it extends beyond the organization to the community and its leaders. We must all work together to actively seek diverse representation.

Currently, our board is 62 percent male, 38 percent female, 62 percent Caucasian, 15 percent Latino, 23 percent African/ Caribbean American, 54 percent Jewish with 43 percent of those individuals from the local ultra Orthodox Jewish community. While mindful of our desire to achieve cultural diversity, our board members bring a multiplicity of expertise. Without the board's "buy-in" and readiness to transform, I doubt we would have survived the onslaught of challenges in a market of declining reimbursement where 80 percent of our revenue is Medicare/ Medicaid.

Through our efforts at diversifying both our board and our staff, our organization underwent a major transformation. Our employees now feel free to celebrate the vibrant and rich mosaic of our cultures. Diversity has become part of the fabric of the organization; it is just who we are, whether it is the community advisory board that devotes itself to domestic violence across cultures and religions, the social work student who brings hospital chaplains of all faiths together to network, Chanukah or Ramadan observations, or a health fair within a gospel fest. This is a process that will require constant attention, but today we are a stronger, healthier organization. Our employees are more satisfied, which is reflected in our quality and customer satisfaction and growth in market share. Most of all, I am heartened by the many opportunities to earn the credibility and confidence of our community each time someone entrusts us with the care and health of their loved ones.

The Governance Institute thanks Linda Brady, M.D., president and CEO of Kingsbrook Jewish Medical Center, for contributing this article. She can be reached at lbradyjmc@aol.com.