CHAPTER 1

# Leadership

Louis Rubino

## LEARNING OBJECTIVES

By the end of this chapter the student will be able to describe:

- The difference between leadership and management;
- Followership and why it's as important as leadership;
- The history of leadership in the United States from the 1920s to current times;
- Contemporary models of leadership;
- Leadership domains and competencies;
- Leadership styles;
- Old and new governance trends; and,
- Why healthcare leaders have a greater need for ethical behavior.

## LEADERSHIP VS. MANAGEMENT

In any business setting, there must be leaders as well as managers. But are these the same people? Not necessarily. There are leaders who are good managers and there are managers who are good leaders, but usually neither case is the norm. In health care, this is especially important to recognize because of the need for both. Health care is unique in that it is a service industry that depends on a large number of highly trained personnel as well as trade workers. Whatever the setting, be it a hospital, a long-term care facility, an ambulatory care center, a medical device company, an insurance company, or some other healthcare sector, leaders as well as managers are needed to keep the organization moving in a forward direction and at the

same time maintain current operations. This is done by leading and managing its people.

Leaders usually take a focus that is more external, whereas the focus of managers is more internal. Even though they need to be sure their healthcare facility is operating properly, leaders tend to spend the majority of their time communicating and aligning with outside groups that can benefit (partners, community, vendors) or influence (government, public agencies, media) their organizations (Figure 1-1). There is crossover between leaders and managers across the various areas even though a distinction remains for certain duties and responsibilities.

Usually the top person in the organization (e.g., Chief Executive Officer, Administrator, Director) has full and ultimate accountability. There

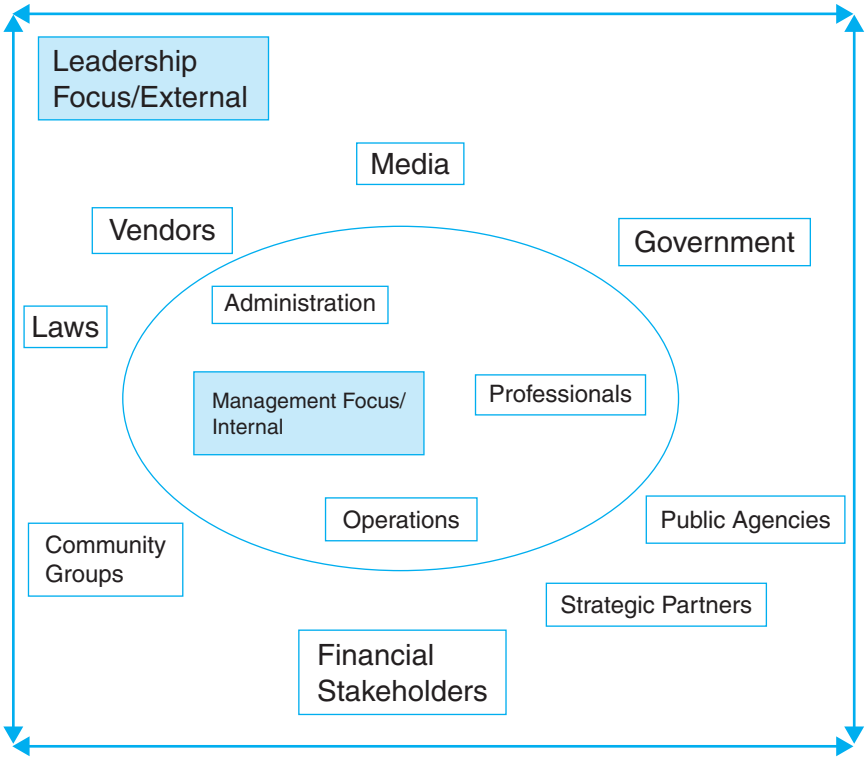


**FIGURE 1-1** Leadership and Management Focus

Figure Note: Arrows represent continual interactions between all elements of the model.

**TABLE 1-1** Leadership vs. Management Competencies

| Leadership Competencies | Management Competencies |
|---|---|
| Setting Direction or Mission | Staffing Personnel |
| Motivating Stakeholders | Controlling Resources |
| Being Effective Spokesperson | Supervising Service Provided |
| Determining Strategies for Future | Overseeing Adherence to Regulations |
| Transforming Organization | Counseling Employees |

are several managers reporting to this person, all of whom have various functional responsibilities (e.g., Chief Nursing Officer, Physician Director, Information Officer). These managers can certainly be leaders in their own areas but their focus will be more internal within the organization's operations.

Leaders have a particular set of competencies that are more forward thinking than managers. Leaders need to set a direction for the organization. They need to be able to motivate their employees, as well as other stakeholders, so that the business continues to exist and hopefully thrive in periods of change. No industry is as dynamic as health care with rapid change occurring due to the complexity of the system and government regulations. Leaders are needed to keep the entity on course and to maneuver around obstacles that come in its way, like a captain commanding his ship at sea. Managers must tend to the business at hand and make sure the staff is following proper procedures. They need a different set of competencies. See Table 1-1.

## FOLLOWERSHIP

For every leader there must be a follower. Leaders must have someone they can lead in order to accomplish what they set out to do. Not everyone can be a leader nor should be one. Leaders should have certain recognizable traits that will help them take charge, but also followers must have a willingness to be led as well as the ability to do the task requested. True leaders inspire commitment from dedicated people.

Atchison (2003) wrote about this process in his book, *Followership*. He describes followership as complementary to leadership and recommends that it be recognized as a necessary component for an effective leader. A

self-absorbed administrator will not make a good leader. A true leader will recognize the importance of getting respect, not simply compliance, from the people who follow. It is one thing to have people do what you say, but to have someone want to do it is another thing. The leader who understands this is on the way to greatness and will create a much more meaningful work environment. As Atchison says, "An executive title without followers has an illusion of power. These titled executives create a workplace without a soul."

## HISTORY OF LEADERSHIP IN THE UNITED STATES

Leaders have been around since the beginning of man. We think of the strongest male becoming the leader of a caveman clan. In Plato's time, the Greeks began to talk about the concept of leadership and acknowledged the political system as critical for leaders to emerge in a society. In Germany during the late 19th century, first Sigmund Freud described leadership as unconscious exhibited behavior and later Max Weber identified how leadership is present in a bureaucracy through assigned roles. Formal leadership studies in the United States, though, have only been around for the last one hundred years (Sibbet, 1997).

We can look at the decades spanning the 20th century to see how leadership theories evolved, placing their center of attention on certain key components at different times (Northouse, 2004). These emphases often matched or were adapted from the changes occurring in the society.

With the industrialization of the United States in the 1920s, productivity was of paramount importance. Scientific management was introduced and researchers tried to determine which characteristics were identified with the most effective leaders based on their units having high productivity. **The Great Man Theory** was developed out of the idea that certain traits determined good leadership. The traits that were recognized as necessary for effective leaders were ones that were already inherent in the person, such as being male, being tall, being strong, and even being Caucasian. Even the idea that "you either got it or you don't" was supported by this theory, the notion being that a good leader had charisma. Behaviors were not considered important in determining what made a good leader. This theory discouraged anyone who did not have the specified traits from aspiring to a leadership position.

Fortunately, after two decades, businesses realized that leadership could be enhanced through certain conscious acts and researchers began to study which behaviors would produce better results. Resources were in short supply due to World War II and leaders were needed who could truly produce good results. This was the beginnings of the **Style Approach to Leadership**. Rather than looking at only the characteristics of the leader, researchers started to recognize the importance of two types of behaviors in successful leadership: completing tasks and creating good relationships. This theory states that leaders have differing degrees of concern over each of these behaviors and the best leaders would be fully attentive to both.

In the 1960s, American society had a renewed emphasis on helping all of its people and began a series of social programs that still remain today. The two that impact health care directly by providing essential services, are Medicare for the elderly (age 65 and over) and the disabled and Medicaid for the indigent population. The **Situational Approach to Leadership** then came into prominence and supported this national concern. This set of theories focused on the leader changing his/her behavior in certain situations in order to meet the needs of subordinates. This would imply a very fluid leadership process whereby one can adapt one's actions to an employee's needs at any given time.

Not much later, researchers believed that perhaps leaders should not have to change how they behaved in a work setting but instead the appropriate leaders should be selected from the very beginning. This is the **Contingency Theory of Leadership** and was very popular in the 1970s. Under this theory the focus was on both the leader's style as well as the situation in which the leader worked, thus building upon the two earlier groups of theories. This approach was further developed by what is known as **Path-Goal Theory of Leadership**. This theory still placed its attention on the leader's style and the work situation (subordinate characteristics and work task structure) but also recognized the importance of setting goals for employees. The leader was expected to remove any obstacles in order to provide the support necessary for them to achieve those goals.

In the later 1970s, the United States was coming out of a war in which many of its citizens did not think the country should have been involved. More concern was expressed over relationships as the society became more psychologically attuned to how people felt. The **Leader-Member Exchange Theory** evolved over the concern that leadership was being

defined by the leader, the follower, and the context. This new way of looking at leadership focused on the interactions that occur between the leaders and the followers. This theory claimed that leaders could be more effective if they developed better relationships with their subordinates through high quality exchanges.

After Vietnam and a series of weak political leaders, Americans were looking for people to take charge who could really make a difference. Charismatic leaders came back into vogue, as demonstrated by the support shown to President Ronald Reagan, an actor turned politician. Unlike the Great Man Theory earlier in the century, this time the leader had to have certain skills to transform the organization through inspirational motivational efforts. Leadership was not centered upon transactional processes that tied rewards or corrective actions to performance. Rather, the transformational leader could significantly change an organization through its people by raising their consciousness, empowering them, and then providing the nurturing needed as they produced the results desired.

In the late 1980s, the United States started to look more globally for ways to have better production. Total Quality Management became a popular concept and arose from researchers studying Japanese principles of managing production lines. In the healthcare setting, this was embraced through a process still used today called Continuous Quality Improvement or Performance Improvement. In the decade to follow, leaders assigned subordinates to a series of work groups in order to focus on a particular area of production. Attention was placed on developing the team for higher level functioning as well as how a leader could create a work environment that could improve the performance of the team. Individual team members were expendable and the team entity was all important.

## CONTEMPORARY MODELS

We have entered the 21st century with some of the greatest leadership challenges ever in the healthcare field. Critical position shortages, limited resources, and increased governmental regulations provide an environment that yearns for leaders who are attentive to the organization and its people, yet can still address the big picture. Several of today's leadership models relate well to the dynamism of the healthcare field and are presented here. Looking at these models, there seems to be a consistent pattern of self-aware leaders who are concerned for their employees, and understand

the importance of meaningful work. Perhaps we can project for the 2000s, the Self-Actualized Leadership Theory, taking the term from Maslow's top level in his Hierarchy of Needs (Maslow, 1943). See Table 1-2.

## *Emotional Intelligence (EI)*

**Emotional Intelligence** (**EI**) is a concept made famous by Daniel Goleman in the late 1990s. It suggests that there are a certain set of skills (intrapersonal and interpersonal) that a person needs to be well-adjusted in today's world. These skills include self-awareness (having a deep understanding of one's emotions, strengths, weaknesses, needs, and drives), self-regulation (a propensity for reflection, an ability to adapt to changes, the power to say no to impulsive urges), motivation (being driven to achieve, being passionate over profession, enjoying challenges), empathy (thoughtfully considering someone's feelings when interacting), and social skills (moving people in the direction you desire due to your ability to interact effectively) (Freshman & Rubino, 2002).

Since September 11, 2001, leaders have needed to be more understanding of their subordinates' world outside of the work environment. EI, when applied to leadership, suggests a more caring, confident, enthusiastic boss who can establish good relations with workers. Researchers have

**TABLE 1-2** Leadership Theories in the United States

| Period of Time | Leadership Theory | Leadership Focus |
|---|---|---|
| 1920s and 1930s | Great Man Theory | Having certain inherent traits |
| 1940s and 1950s | Style Approach | Task completion and developing relationships |
| 1960s | Situational Approach | Needs of the subordinates |
| Early 1970s | Contingency and Path-Goal Theories | Both style and situation |
| Late 1970s | Leader-Member Exchange Theory | Interactions between leader and subordinate |
| 1980s | Transformational Approach | Raising consciousness and empowering followers |
| 1990s | Team Leadership | Team performance and development |
| 2000s | Self-Actualized Leadership | Introspection and concern for meaningfulness |

**TABLE 1-3** Emotional Intelligence's Application to Healthcare Leadership

| EI Dimension | Definition | Leadership Application |
|---|---|---|
| Self-Awareness | A deep understanding of one's emotions and drives | Knowing if your values are congruent to organization's |
| Self-Regulation | Adaptability to changes and control over impulses | Considering ethics of giving bribes to doctors |
| Motivation | Ability to enjoy challenges and being passionate toward work | Being optimistic even when census is low |
| Empathy | Social awareness skill, putting yourself in another's shoes | Setting a patient-centered vision for the organization |
| Social Skills | Supportive communication skills, abilities to influence and inspire | Having an excellent rapport with board |

shown that EI can distinguish outstanding leaders and strong organizational performance (Goleman, 1998). For health care, this seems like a good fit. See Table 1-3.

## *Inspirational Leadership*

This model's focus is on leaders who inspire by giving people what they need. This can be very different from what they want. Inspirational leaders are not perfect and in fact expose their weaknesses so people can relate to them better. As with emotional intelligence, empathy is recognized as important. **Inspirational leadership** supports the concept known as "tough empathy," which is when leaders care passionately about their employees and their work yet are prudent in what they provide in the way of support. Inspirational leaders will rely on intuition to act and use their uniqueness (e.g., expertise, personality, or even something as simple as a greeting) as a way to distinguish themselves in the leadership role (Goffee & Jones, 2000).

## *Diversity Leadership*

Our new global society forces healthcare leaders to address matters of diversity whether it is with their patient base or with their employees. This commitment to diversity is necessary for today's leader to be successful. The environment must be assessed so that goals can be set that embrace the concept of diversity in matters such as employee hiring and promotional practices, patient communication, and governing board composi-

tion, to name a few. Strategies have to be developed that will make diversity work for the organization. The leader who recognizes the importance of diversity and designs its acceptance into the organizational culture will be most successful (Warden, 1999).

## *Servant Leadership*

Many people view health care as a very special type of work. Individuals usually work in this setting because they want to help people. **Servant leadership** applies this concept to top administration's ability to lead, acknowledging that a healthcare leader is largely motivated by a desire to serve others. This leadership model breaks down the typical organizational hierarchy and professes the belief of building a community within an organization in which everyone contributes to the greater whole. A servant leader is highly collaborative and gives credit to others generously. This leader is sensitive to what motivates others and empowers all to win with shared goals and vision. Servant leaders use personal trust and respect to build bridges and use persuasion rather than positional authority to foster cooperation. This model works especially well in a not-for-profit setting since it continues the mission of fulfilling the community's needs rather than the organization's (Swearingen and Liberman, 2004).

## *Spirituality Leadership*

Recently, the United States has experienced some very serious misrepresentations and misreporting by major healthcare companies as reported by U.S. governmental agencies (some examples being HealthSouth, Tenet, and Paracelsus Healthcare). Trying to claim a renewed sense of confidence in the system, a model of leadership has emerged that focuses on spirituality. This spiritual focus does not imply a certain set of religious beliefs, but emphasizes ethics, values, relationship skills, and the promotion of balance between work and self (Wolf, 2004). The goal under this model is to define our own uniqueness as human beings and to appreciate our spiritual depth. In this way, leaders can become more profound and at the same time productive. These leaders have a positive impact on their workers and create a working environment that supports all individuals in finding meaning in what they do (Table 1-4). They practice five common behaviors: 1) Challenge the process, 2) Inspire a shared vision, 3) Enable others to act, 4) Model the way, and 5) Encourage the heart, thus taking leadership to a new level (Strack & Fottler, 2002).

**TABLE 1-4** Spirituality Leadership's Application

| Behavior | Definition | Leadership Application |
|---|---|---|
| Challenge the process | Always striving to do better | Change management |
| Inspire a shared vision | Collective sense of purpose | Strategic orientation |
| Enable others to act | Meeting needs of followers to get results | Gaining trust and confidence to achieve goals |
| Model the way | Setting a personal example | Coaching to motivate |
| Encourage the heart | Developing others to find meaning in work | Encouraging personal development of followers |

## LEADERSHIP STYLES

Models give us a broad understanding of someone's leadership philosophy. Styles demonstrate a particular type of leadership behavior that is consistently used. Various authors have attempted to explain different leadership styles (McConnell, 2003; Schaeffer, 2002; and Goleman, 2000). Some styles are more appropriate to use with certain healthcare workers, depending on their education, training, competence, motivation, experience, and personal needs. The environment must also be considered when deciding which style is the best fit.

A **coercive leadership style** is when power is used inappropriately to get a desired response from a follower. This should probably not be used unless the leader is dealing with a very problematic subordinate or is in an emergency situation and needs immediate action. In healthcare settings over longer periods of time, three other leadership styles could be used more effectively: **participative, pacesetting, and coaching**.

Many healthcare workers are highly trained, specialized individuals who know much more about their area of expertise than their supervisor. Take the generally trained chief operating officer of a hospital who has several department managers (e.g., Radiology, Health Information Systems, Engineering) reporting to him/her. These managers will respond better and be more productive if the leader is participative in his/her style. Asking these managers for their input and giving them a voice in making decisions will let them know they are respected and valued.

A pacesetting style is when a leader sets high performance standards for his/her followers. This is very effective when the employees are self-

**TABLE 1-5** Leadership Styles for Healthcare Personnel

| Style | Definition | Application |
|---|---|---|
| Coercive | Demanding and power based | Problematic Employees |
| Participative | Soliciting input and allowing decision making | Most Followers |
| Pacesetting | Setting high performance standards | Highly Competent |
| Coaching | Focus on personal development | Top Level |

motivated and highly competent like research scientists or intensive care nurses. A coaching style is recommended for the very top personnel in an organization. With this style, the leader focuses on the personal development of his/her followers rather than the work tasks. This should be reserved for followers the leader can trust and who have proven their competence. See Table 1-5.

## LEADERSHIP COMPETENCIES

A leader needs certain skills, knowledge, and abilities to be successful. These are called competencies. The pressures of the healthcare industry have initiated the examination of a set of core competencies for a leader who works in a healthcare setting (Shewchuk, O'Connor, and Fine, 2005). Criticism has been directed at the educational institutions for not producing administrators who can begin managing effectively right out of school. Educational programs in health administration are working with the national coalition groups (e.g., Health Leadership Alliance and National Center for Healthcare Leadership) and healthcare administrative practitioners to come up with agreed upon competencies. Once identified, the programs can attempt to have their students learn how to develop these traits and behaviors.

Some of the competencies are technical, for example, having analytical skills, having a full understanding of the law, and being able to market and write. Some of the competencies are behavioral, for example, decisiveness, being entrepreneurial, and an ability to achieve a good work/life balance. As people move up in organizations, their behavioral competencies are a greater determinant of their success as leaders than their technical competencies (Hutton and Moulton, 2004). Another way to examine leadership

**TABLE 1-6** Leadership Domains and Competencies

| **Domain: Functional and Technical** | **Domain: Self Development and Self Understanding** |
|---|---|
| Competencies: | Competencies: |
| Knowledge of Business/Business Acumen | Self Awareness and Self Confidence |
| Strategic Vision | Self Regulation and Personal Responsibility |
| Decision Making and Decision Quality | Honesty and Integrity |
| Managerial Ethics and Values | Life Long Learning |
| Problem Solving | Motivation/Drive to Achieve |
| Change Management/Dealing with Ambiguity | Empathy and Compassion |
| Systems Thinking | Flexibility |
| Governance | Perseverance |
| | Work/Life Balance |
| **Domain: Interpersonal** | **Domain: Organizational** |
| Competencies: | Competencies: |
| Communication | Organizational Design |
| Motivating | Team Building |
| Empowerment of Subordinates | Priority Setting |
| Management of Group Process | Political Savvy |
| Conflict Management and Resolution | Managing and Measuring Performance |
| Negotiation | Developing Others |
| Formal Presentations | Human Resources |
| Social Interaction | Community and External Resources |
| | Managing Culture/Diversity |

*Source:* Hilberman, Diana (Ed.), The 2004 ACHE-AUPHA Pedagogy Enhancement Work Group. June, 2005.

competencies is under four main groupings or domains. The Functional and Technical Domain is necessary but not sufficient for a competent leader. Three other domains provide competencies that are behavioral and relate both to the individual (Self Development and Self Understanding) and to other people (Interpersonal). A fourth set of competencies falls under the heading Organizational and has a broader perspective. See Table 1-6 for a full listing of the leadership competencies under the four domains.

## LEADERSHIP PROTOCOLS

Healthcare administrators are expected to act a certain way. Leaders are role models for their organizations' employees and need to be aware that their actions are being watched at all times. Sometimes people at the top of an organization get caught up in what they are doing and do not real-

ize the message they are sending throughout the workplace by their inappropriate behavior. Specific ways of serving in the role of a healthcare leader can be demonstrated and can provide the exemplary model needed to send the correct message to the employees. These appropriate ways in which a leader acts are called **protocols**.

There is not a shortage of information on what protocols should be followed by today's healthcare leader. Each year, researchers, teachers of health administration, practicing administrators, and consultants write books filled with their suggestions on how to be a great leader (for some recent examples see Manion, 2005: McGinn, 2005; and Spath, 2005). There are some key ways a person serving in a leadership role should act. These are described here and summarized in Table 1-7.

Professionalism is essential to good leadership. This can be manifested not only in the way a person acts but also in their mannerisms and their dress. A leader who comes to work in sloppy attire or exhibits obnoxious behavior will not gain respect from followers. Trust and respect are very important for a leader to acquire. Trust and respect must be a two-way exchange if a leader is to get followers to respond. Employees who do not trust their leader will consistently question certain aspects of their job. If they do not have respect for the leader, they will not care about doing a good job. This could lead to low productivity and bad service.

Even a leader's mood can affect workers. A boss who is confident, optimistic, and passionate about his/her work can instill the same qualities in the workers. Such enthusiasm is almost always infectious, and is passed on to others within the organization. The same can be said of a leader who is weak, negative, and obviously unenthusiastic about his/her work—these poor qualities can be acquired by others.

**TABLE 1-7** Key Leadership Protocols

1. Professionalism
2. Reciprocal trust and respect
3. Confident, optimistic, and passionate
4. Being visible
5. Open communicator
6. Risk taker
7. Admitting fault

Leaders must be very visible throughout the organization. Having a presence can assure workers that the top people are "at the helm" and give a sense of stability and confidence in the business. Leaders must be open communicators. Harboring information that could have been shared with followers will cause ill feelings and a concern that other important matters are not being disclosed. Leaders also need to take calculated risks. They should be cautious, but not overly so, or they might lose an opportunity for the organization. And finally, leaders in today's world need to recognize that they are not perfect. Sometimes there will be errors in what is said or done. These must be acknowledged so they can be put aside and the leader can move on to more pressing current issues.

## GOVERNANCE

Individuals are not the only ones to consider in leadership roles. There can be a group of people who collectively assume the responsibility for strategic oversight of a healthcare organization. The term **governance** describes this important function. Governing bodies can be organized in a variety of forms. In a hospital, this top accountable body is called a board of trustees for a not-for-profit setting, and a **board of directors** for a proprietary or profit setting. Since many physician offices, long-term care facilities, and other healthcare entities are set up as professional corporations, these organizations would also have a board of directors.

Governing boards are facing heightened scrutiny due to the failure of many large corporations in the last decade. The United States government recognizes the importance of a group of people who oversee corporate operations and give assurances for the fair and honest functioning of the business. Sarbanes-Oxley is a federal law enacted in 2002 to enforce this disclosure for proprietary companies. Many believe the not-for-profits should have the same requirements and are applying pressure for them to fall under similar rules of transparency. Financial records must be appropriately audited and signed off by top leaders. Operations need to be discussed more openly so as to remove any possibility of cover-up, fraud, or self-interest. Each governing board member has fiduciary responsibility to forgo his/her own personal interests and to make all decisions concerning the entity for the good of the organization.

Although healthcare boards are becoming smaller in size, they recognize the importance of the composition of their members. A selection of peo-

ple from within the organization (e.g., system leaders, the management staff, physicians, etc.) should be balanced with outside members from the community (see Table 1-8). The trend is to appoint members who have certain expertise to assist the board in carrying out its duties. Also, having governing board members who do not have ties to the healthcare operations will reduce the possibility of conflicts of interests. Board meetings have gone from ones in which a large volume of information is presented for a "rubber stamp," to meetings that are well prepared, purposeful, and focused on truly important issues. A self assessment should be taken at least annually and any identified problem areas (including particular board members) addressed. This way, the governing board can review where it stands in its ability to give fair, open, and honest strategic oversight (Gautam, 2005).

## BARRIERS AND CHALLENGES

The healthcare industry is as dynamic as it gets. The only constant is change. Healthcare leaders are confronted with many situations that must be contended with as they lead their organizations. Some can be considered barriers that, if not dealt with properly, will stymie the leader's capability. Certain other areas are challenges that must be addressed if the leader is to be successful. A few of the more critical ones in today's healthcare world are presented here. See Table 1-9.

Due to the complex healthcare system in the United States, many regulations and laws are in place that sometimes can inhibit innovative and

**TABLE 1-8** Healthcare Governance Trends

| Area | Old Way | New Trend |
|---|---|---|
| Size of board | Large (10 to 20 people) | Smaller (6 to 12 people) |
| Membership | Many members from within the organization | Many with a balance of members within and outside |
| Conflicts of interest | Some present, not disclosed | Must be disclosed but prefer none |
| Meetings | Voluminous, detailed | Strategic information and trends presented |
| Evaluations | If done, not taken too seriously | Taken seriously to identify and correct issues |

**TABLE 1-9** Key Healthcare Leadership Barriers and Challenges

1. Laws and Regulations (Barrier)
2. Physicians (Challenge)
3. New Technology (Barrier)
4. Culture of Safety (Challenge)

creative business practices. Leaders must assure that the strategies developed for their entity comply with the current laws or else they jeopardize the long-term survivability of their organization. Leaders are expected to sometimes think "outside the box" to provide new ideas for the development of their business, yet this can be challenging when many constraints must be considered. Some good examples are the government's anti-trust requirements, which can affect developing partners; federal moratoriums on certain services, which can affect growing the business; and safe harbor requirements, which can affect physician relations. These, as well as other laws and regulations, can affect a healthcare leader's ability to lead.

The healthcare industry is unique in the way a major player in the arena, the physicians, are not always easily controlled by the medical organizations where they work (e.g., hospitals, insurance companies, long-term care facilities). Yet, this very influential group of stakeholders has substantial input over the volume of patients that a healthcare facility receives. This necessitates the healthcare leader to find ways to include the doctors in the process of setting a direction, monitoring the quality of care, and fulfilling other administrative functions. The wise healthcare leader will include physicians early on in any planning process. Doctors are usually busy with their own patients and practices, but if they are not looked to for their expertise and advice on certain important matters in the facilities where they work, then they will become disengaged. This could cause essential functions to be overlooked. It could also cause physicians to alter the referral patterns for their patients. Everybody would much rather work at a place where their opinions are requested and respected.

Technology is a costly requirement in any work setting. Information systems management and new medical equipment are especially expensive for the modern healthcare facility or practice due to the rapidly changing data collection requirements and medical advances in the field. Healthcare

leaders must assess the capabilities of their entities for new technology and determine if their systems and equipment are a barrier to making future progress. Healthcare leaders cannot be successful if their organizations have antiquated systems and out-of-date support devices in today's high tech world. Computer hardware and clinical software must be integrated to provide the quality and cost information needed for an efficient medical organization. Electronic medical records, wireless devices, and computerized order entry systems, as well as advanced medical equipment and new age pharmaceuticals, will be items the leader must have in place in order to be able to lead his/her healthcare organization into the 21st century.

Safety concerns have traditionally been a management responsibility. However, it has become such an important issue in today's healthcare world that leaders must be involved in its oversight. A top-down direction must be given through the organization that mistakes will not be tolerated. Coordinated efforts must shift from following up on errors, to preventing their reoccurrence, to developing systems and mechanisms to prevent them from ever occurring. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has recently proposed new leadership standards for all sectors, calling for the leaders in the healthcare entity to accept the responsibility for instilling a culture of safety. A systems approach is being recommended that will anticipate and prevent human errors, prevent errors from reaching the patient, and mitigate harm when they do (JCAHO, 2005).

## ETHICAL RESPONSIBILITY

Ethics is exhibiting behavior and conduct that is appropriate in a certain setting. It is a matter of doing right vs. wrong. Ethics is especially important for healthcare leadership and requires two areas of focus. One area is **bioethics** and the actions a leader needs to consider as he/she relates to a patient. Another is **managerial** ethics. This involves business practices and doing things for the right reasons. A leader must assure an environment in which good ethical behavior is followed.

The American College of Healthcare Executives (ACHE) does an excellent job in educating its professional membership as to the ethical responsibilities of healthcare leaders (ACHE, 2005). Ethical responsibilities apply to several different constituencies: to the profession itself, to the

patients and others served, to the organization, to the employees, and to the community and society at large (see Table 1-10). A healthcare leader who is concerned about an ethical workplace will not only model the appropriate behavior but will also have a zero tolerance for any deviation by a member of the organization. A Code of Ethics gives specific guidelines to be followed by individual members. An Integrity Agreement would address a commitment to follow ethical behavior by the organization.

## LEADERS LOOKING TO THE FUTURE

Some people believe that leaders are born and one cannot be taught how to be a good leader. The growing trend though is that leaders can in fact be taught skills and behaviors that will help them to lead an organization effectively (Parks, 2005). In healthcare, many clinicians who do well at their job are promoted to supervisory positions. Yet, they do not have the management training which would help them in their new roles. For example, physicians, laboratory technologists, physical therapists, and nurses are pushed into management positions with no administrative training. We are doing a disservice to these clinicians and setting them up for failure.

Fortunately, this common occurrence has been recognized and many new programs have sprouted to address this need. Universities have devel-

**TABLE 1-10** American College of Healthcare Executives Code of Ethics

| Responsible Area | Sample Guidelines |
|---|---|
| To the Profession | Comply with laws<br>Avoid any conflicts of interest<br>Respect confidences |
| To the Patients or Others Served | Prevent discrimination<br>Safeguard patient confidentiality<br>Have process to evaluate quality of care |
| To the Organization | Allocate proper resources<br>Improve standards of management<br>Prevent fraud and abuse within |
| To the Employees | Allow free expression<br>Ensure a safe workplace environment<br>Follow nondiscrimination policies |
| To the Community and Society | Work to meet the needs of the community<br>Provide appropriate access to services<br>Advocate for healthy society |

oped executive programs to attract medical personnel into a fast-track curriculum to attempt to give them the essential skills they need to be successful. Some schools have developed majors in Healthcare Leadership and some healthcare systems have started internal leadership training programs. This trend will continue into the future since healthcare services are expected to grow due to the aging population and thus there will be a need for more people to be in charge. In addition, leaders should continually be updated as to the qualities which make a good leader in the current environment, and therefore, professional development, provided through internal or external programs, should be encouraged.

Each of the different sectors in health care has a professional association that will support many aspects of its particular career path. These groups provide ongoing educational efforts to help their members lead their organizations. Also, professional associations are a good way to network with people in similar roles, a highly desirable process for healthcare leaders. Another benefit for leaders is that these groups provide up-to-date information about their chosen field. Most have student chapters, and early involvement in these organizations is highly recommended for any future healthcare leader. Table 1-11 lists some of these associations.

**TABLE 1-11** Professional Associations

| Name | Acronym | Targeted Career | Website |
|---|---|---|---|
| American College of Healthcare Executives | ACHE | Health Administrators | www.ache.org |
| Healthcare Financial Management Association | HFMA | Healthcare Chief Financial Officers | www.hfma.org |
| Association for University Programs in Health Administration | AUPHA | Health Administration Education Program Directors | www.aupha.org |
| Medical Group Management Association | MGMA | Medical Groups Administrators | www.mgma.org |
| American College of Health Care Administrators | ACHCA | Long-Term Care Administrators | www.achca.org |
| American Academy of Nursing | AAN | Nurse Leaders | www.aannet.org |
| American College of Physician Executives | ACPE | Physician Leaders | www.acpe.org |

To prepare an organization for the future, its leader needs to be looking out for opportunities to partner with other entities. Health care in the United States is fragmented, and to be successful, different services need to be aligned and networks created that will allow patients to flow easily through the continuum of care. It is the astute leader who can determine who are the best partners and negotiate a way to have a win-win situation. Of course these efforts to develop partnerships must be in line with the organization's mission and vision, or the strategic direction will have to be reexamined.

A leader who is concerned about the future will stay on top of things in the healthcare industry. Reading newspapers, industry journals, and Web reports will keep the leader in-the-know and allow him/her to determine how changes in the field could impact the organization. A leader who remains current will be better positioned to act proactively and to provide the best chance for his/her organization to seize a fresh opportunity.

Finally, the healthcare leader who is concerned about the future, as well as today's business, must continuously reassess how he/she fits in the organization. Nothing could be worse than a disenchanted person trying to lead a group of followers without the motivation and enthusiasm needed by great leaders. A leader should consider his/her own succession planning so that the organization is not left at any time without a person to lead. Truly unselfish leaders think about their commitment to their followers and do their best to assure that consistent formidable leadership will be in place in the event of their departure. This final act will allow adequate time for a smooth transition and insure the passage of accountability so that the followers can realign themselves with the new leader.

## DISCUSSION QUESTIONS

1. What is the difference between leadership and management?
2. What is followership? Why is it as important as leadership?
3. Are leaders born or are they trained? How has the history of leadership in the United States evolved to reflect this question?
4. List and describe the contemporary models of leadership. What distinguishes them from past models?

5. What are the leadership domains and competencies? Can you be a good leader and not have all the competencies listed in this model?
6. Why do healthcare leaders have a higher need for ethical behavior than might be expected in other settings?

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## Additional Websites to Explore

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| National Center for Healthcare Leadership | www.nchl.org |
| Health Leadership Council | www.hlc.org |
| National Public Health Leadership Institute | www.phli.org |
| World Health Organization Leadership Service | www.who.int/health_leadership |
| Health Leaders Media | www.healthleaders.com |
| Institute for Diversity of Health Management | www.diversityconnection.org |
| Healthcare Leadership Alliance Competency Directory | http://www.healthcareleadershipalliance.org/ |