CHAPTER 2

Leadership

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LEARNING OBJECTIVES

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

- Distinguish between leadership and management;
- Define followership and why it's as important as leadership;
- Summarize the history of leadership in the United States from the 1920s to current times;
- Compare contemporary models of leadership;
- Describe leadership domains and competencies;
- Compare leadership styles;
- Summarize old and new governance trends;
- Discuss how culture plays a role in leadership; and
- Provide a rationale for 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 their organizations (partners, community, vendors) or influence them (government, public agencies, media). See Figure 2-1. There is crossover between leaders and managers across the various areas, 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 are several managers reporting to this person, all of whom have various **functional responsibilities** (e.g., Chief Nursing Officer, Physician Director, Chief Information Officer). These managers can certainly

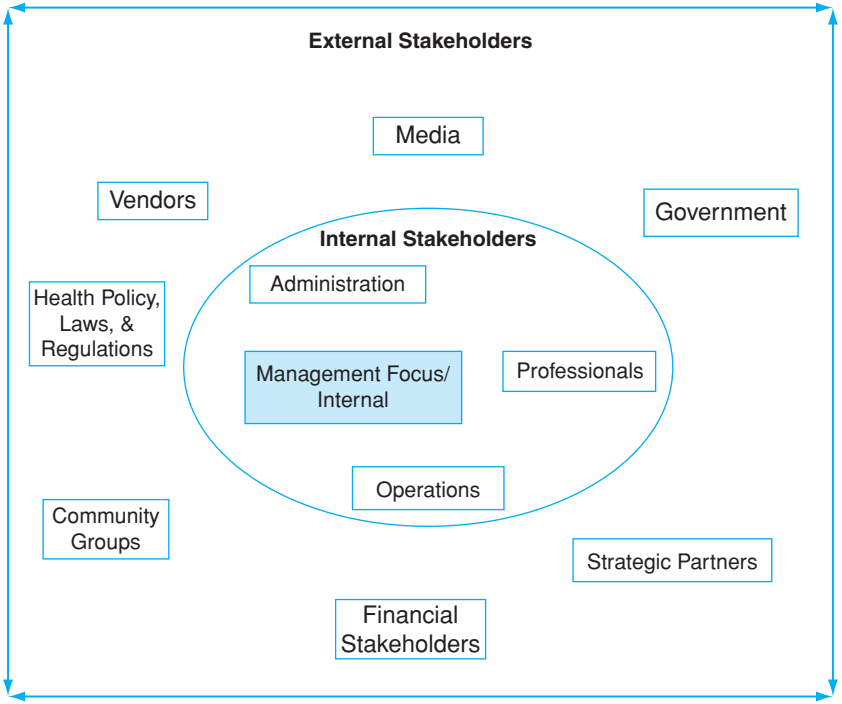

FIGURE 2-1 Leadership and Management Focus

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

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 require more forward thinking than those of 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, 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 2-1.

FOLLOWERSHIP

For every leader, there must be followers. Leaders must have someone they can lead in order to accomplish what they set out to do. Not everyone can or should be a leader. Leaders should have certain recognizable traits that will help them take charge, while 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.

TABLE 2-1 Leadership vs. Management Competencies

Leadership Competencies	Management Competencies
Setting direction or mission	Staffing personnel
Motivating stakeholders	Controlling resources
Being an effective spokesperson	Supervising the service provided
Determining strategies for the future	Overseeing adherence to regulations
Transforming the organization	Counseling employees

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, Sigmund Freud described leadership as unconscious exhibited behavior; 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 100 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, 2010). These emphases often matched or were adapted from the changes occurring in 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 beginning 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 or 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 theories. This approach was further developed by what is known as the **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 the Vietnam 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 and on 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 personnel 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. As we entered the 2000s, the **Self-Actualized Leadership Theory**, taking the term from Maslow's top level in his **Hierarchy of Needs** (Maslow, 1943), defines this type of leader. Today requires leaders to use **Adaptive Leadership** to create flexible organizations able to meet the relentless succession of challenges faced (Heifetz, Grashow, & Linsky, 2009). Plus, today's astute healthcare leaders recognize the importance of considering the global environment, as health care wrestles with international issues that impact us locally, such as outsourcing services, medical tourism, and over-the-border drug purchases. See Table 2-2.

Emotional Intelligence (EI)

Emotional Intelligence (EI) is a concept made famous by Daniel Goleman in the late 1990s. It suggests that there are certain 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 about one's profession, enjoying challenges), **empathy** (thoughtfully considering others' feelings when interacting), and **social skills** (moving people in the direction you desire by 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

TABLE 2-2 Leadership Theories in the United States

Period of Time	Leadership Theory	Leadership Focus
1920s and 1930s	Great Man	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	Both style and situation
Late 1970s	Leader–Member Exchange	Interactions between leader and subordinate
1980s	Transformational Approach	Raise consciousness and empower followers
1990s	Team Leadership	Team performance and development
2000s	Self-Actualized Leadership	Introspection and concern for meaningfulness
2010s	Adaptive Leadership	Build capacity to thrive in a new reality
2010s	Global Leader	Recognizing the impact of globalization for their industry

a more caring, confident, enthusiastic boss who can establish good relations with workers. Researchers have shown that EI can distinguish outstanding leaders and strong organizational performance (Goleman, 1998). For health care as an industry and for healthcare managers, this seems like a good fit. See Table 2-3.

Authentic Leadership

The central focus of **authentic leadership** is that people will want to naturally associate with someone who is following their internal compass of true purpose (George &

TABLE 2-3 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 with the 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 the board

Sims, 2007). Leaders who follow this model are ones who know their authentic selves, define their values and leadership principles, understand what motivates them, build a strong support team, and stay grounded by integrating all aspects of their lives. Authentic leaders have attributes such as confidence, hope, optimism, resilience, high levels of integrity, and positive values (Brown & Gardner, 2007). Assessments given to leaders in a variety of international locations have provided the evidence-based knowledge that there is a correlation between authentic leadership and positive outcomes based on supervisor-rated performance (Walumbwa , Avolio, Gardner, Wernsing, & Peterson, 2008).

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 the quality of leaders caring passionately about their employees and their work yet being 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 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 composition, 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). Healthcare leaders are called to be role models for **cultural competency** (see Chapter 14 for more on this important topic) and to be able to attract, mentor, and coach those of different, as well as similar, backgrounds (Dolan, 2009).

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 & 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 (e.g., 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 deepen their understanding and at the same time be more 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 (see Table 2-4). They practice five common behaviors of effective leaders as described by Kouzes and Posner (1995): (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 2-4 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; Northouse, 2009; Studer, 2008). 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.

In a **coercive leadership style** power is used inappropriately to get a desired response from a follower. This very directive format 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 or her. These managers will respond better and be more productive if the leader is **participative** in his or 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.

In a **pacesetting style**, a leader sets high performance standards for his or her followers. This is very effective when the employees are self-motivated and highly competent—e.g., 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 or her followers rather than the work tasks. This should be reserved for followers the leader can trust and those who have proven their competence. See Table 2-5.

TABLE 2-5 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

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 (Dye & Garman, 2006; Shewchuk, O'Connor, & Fine, 2005). Criticism has been directed at 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, National Center for Healthcare Leadership, and American College of Healthcare Executives) 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 & Moulton, 2004). Another way to examine leadership 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 2-6 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 they 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 realize 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 employees. These appropriate ways in which a leader acts are called **protocols**.

There is no shortage of information on what protocols should be followed by today's healthcare leader. Each year, researchers, teachers of health administration, practicing

TABLE 2-6 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	Lifelong 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.

administrators, and consultants write books filled with their suggestions on how to be a great leader (for some recent examples, see Dye, 2010; Ledlow & Coppola, 2011; and Rath and Conchie, 2008). There are some key ways a person serving in a leadership role should act. These are described here and summarized in Table 2-7.

Professionalism is essential to good leadership. This can be manifested not only in the way people act 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.

TABLE 2-7 Key Leadership Protocols

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

Even a leader's mood can affect workers. A boss who is **confident, optimistic, and passionate** about his or 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 or her work—these poor qualities can be acquired by others.

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. Quint Studer (2009), founder and CEO of Studer Group, states how "**rounding**" can help leaders meet certain standard goals: making sure that the staff know they are cared about, know what is going on (what is working well, who should be recognized, which systems need to work better, which tools and equipment need attention), and know that proper follow-up actions are taking place. Leaders must be **open communicators**. Holding back 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 in a not-for-profit setting and a board of directors in a proprietary, or for-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 U.S. 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 that set new or enhanced standards for proprietary companies that are publicly traded. 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 or her own personal interests and to make all decisions concerning the entity for the good of the organization. Many believe the not-for-profits should have the same requirements and are applying pressure for them to fall under similar **rules of transparency**.

Although healthcare boards are becoming smaller in size, they recognize the importance of the **composition** of their members. A selection of people from within the organization (e.g., system leaders, the management staff, physicians) should be balanced with outside members from the community (see Table 2-8). 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

TABLE 2-8 Healthcare Governance Trends

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

fair, open, and honest strategic oversight (Gautam, 2005). A new way of looking at governance goes beyond fiduciary and strategic responsibility, whereby the board serves as the generative source of leadership, espousing the meaning for the organization's healthcare delivery (Chait, Ryan, & Taylor, 2005).

BARRIERS AND CHALLENGES

Health care is one of the most dynamic industries in the world. The only constant is change. Healthcare leaders are confronted with many situations that must be dealt with as they lead their organizations. Some can be considered barriers that, if not managed properly, will stymie the capacity to lead. 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 2-9.

Due to the complex healthcare system in the United States, many **regulations and laws** are in place that sometimes can inhibit innovative and creative business practices. Leaders must ensure that the strategies developed for their entity comply with the current laws, or else they jeopardize its long-term survivability. Leaders are expected to sometimes think "outside the box," i.e., go beyond the usual responses to a situation, to provide new ideas for the development of their business, but this can be challenging when many constraints must be considered. Some examples are the government's antitrust 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 and other laws and regulations can affect a healthcare leader's ability to lead.

The healthcare industry is unique. Major players in the arena, **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 that the healthcare leader find ways to include doctors in the process of setting a

TABLE 2-9 Key Healthcare Leadership Barriers and Challenges

1. Laws and regulations (Barrier)
2. Physicians (Challenge)
3. New technology (Barrier)
4. Culture of safety (Challenge)
5. Resource limitation (Barrier)
6. Economy (Challenge)

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 pharmaceuticals, will be items the leader must have in place in order to lead his or her healthcare organization into the 21st century.

Safety concerns have traditionally been a management responsibility. However, safety 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 throughout the organization that mistakes will not be tolerated. Coordinated efforts must shift from following up on errors to preventing their recurrence to developing systems and mechanisms to prevent them from ever occurring. The Joint Commission has leadership standards for all sectors, calling for the leaders in the healthcare entity to accept the responsibility for fostering a culture of safety. The focus of attention is on the performance of **systems and processes** instead of the individual, although reckless behavior and blatant disregard for safety are not tolerated (The Joint Commission, 2010).

ETHICAL RESPONSIBILITY

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

TABLE 2-10 American College of Healthcare Executives Code of Ethics

Responsible Area	Sample Guidelines
To the profession	Comply with laws Avoid any conflicts of interest Respect confidences
To the patients or others served	Prevent discrimination Safeguard patient confidentiality Have process to evaluate quality of care
To the organization	Proper resource allocation Improve standards of management Prevent fraud and abuse within
To the employees	Allow free expression Ensure a safe workplace environment Follow nondiscrimination policies
To the community and society	Work to meet the needs of the community Provide appropriate access to services Advocate for healthy society
To report violations of the code	Healthcare executive–supplier interactions Decisions near the end of life Impaired healthcare executives

The American College of Healthcare Executives (ACHE) does an excellent job in educating its professional membership as to the ethical responsibilities of healthcare leaders (American College of Healthcare Executives, 2009). 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 2-10). A healthcare leader who is concerned about an ethical workplace will not only model the appropriate behavior but will also have 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 that one cannot be taught how to be a good leader. The growing trend, however, is that leaders can, in fact, be taught skills and behaviors that will help them to lead an organization effectively (Parks, 2005). In health care, many clinicians who do well at their jobs are promoted to supervisory positions. Yet they do not have the management training that would help them in their new roles. For example, physicians, laboratory technologists, physical therapists, and nurses are often 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 developed **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 that make a good leader in the current environment, and therefore, professional development, provided through internal or external programs, should be encouraged. The **Baldrige National Quality Program** recognizes in its most recent criteria for performance excellence the need for senior leaders to create a sustainable environment for their organizations through the continual development of future leaders by enhancing their personal leadership skills (Baldrige National Quality Program, 2009). Yet Garman and Dye (2009) caution us to distinguish **leader development** from **leadership development**. They call for the need to bind leadership development activities into a collective network of leaders who are linked to organizational level goals rather than each leader's individual performance. Further understanding of the difference can be explained through decision making. A leader collaborating with his or her superior would be considered leader development, but in leadership development, the process would be team based.

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. Another benefit for leaders is that these groups provide up-to-date information about their particular field. **Professional associations** are a good way to network with people in similar roles, a highly desirable process for healthcare leaders. Also, ethnic professional associations link healthcare leaders from representative minority groups as they attempt to increase diversity in the healthcare profession and improve health status, economic opportunities, and educational advancement for their communities. Most of these various professional groups have student chapters, and early involvement in these organizations is highly recommended for any future healthcare leader. Table 2-11 lists some of these associations.

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 need to be 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.

TABLE 2-11 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
National Association of Health Services Executives	NAHSE	Black healthcare leaders	www.nahse.org
National Forum for Latino Healthcare Executives	NFLHE	Latino healthcare leaders	www.nflhe.org
Asian Health Care Leaders Association	AHCLA	Asian healthcare leaders	www.asianhealthcareleaders.org

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, as well as attending industry conferences, helps to keep leaders in the know and allow them to determine how changes in the field could impact their organization. Leaders who remain current will be better positioned to act proactively and to provide the best chance for their organizations to seize a fresh opportunity.

The healthcare leader who is concerned about the future, as well as today's business, must continuously reassess how he or 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 or 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 ensure 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 ensure the passage of accountability so that the followers can realign themselves with the new leader.

Finally, the recently enacted **Patient Protection and Affordable Care Act** may not yet provide us full healthcare reform, but it will dramatically alter the way health insurance is administered. A call is made for a new breed of leaders at every level to tame the chaos associated with this dynamic industry (Lee, 2010). These will certainly be challenging times for healthcare leaders, and some of the key elements identified for success will be perspective, adaptability, and finding their inner passion as a personal driving force (Sukin, 2009). There is no doubt there will be opportunities for leaders in all disciplines to make a difference for their organizations and their communities as we enter this exciting new phase of American healthcare delivery.

DISCUSSION QUESTIONS

1. What is the difference between leadership and management?
2. Are leaders born, or are they trained? How has the history of leadership in the United States evolved to reflect this question?
3. List and describe the contemporary models of leadership. What distinguishes them from past models?
4. What are the leadership domains and competencies? Can you be a good leader and not have all the competencies listed in this model?
5. Why do healthcare leaders have a higher need for ethical behavior than might be expected in other settings?
6. Do healthcare leaders have a responsibility to be culturally competent? Why or why not?
7. Why is emotional intelligence important for healthcare managers? Identify three ways someone who is new to the field can assess and develop his or her EI quotient.

Cases in Chapter 17 that are related to this chapter include:

- Choosing a Successor—see p. 442
- Emotional Intelligence in Labor and Delivery—see p. 433
- The Merger of Two Competing Hospitals—see p. 406

Additional cases, role-play scenarios, video links, websites, and other information sources are also available in the online Instructor's Materials.

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Additional Websites to Explore

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:	www.healthcareleadershipalliance.org/
Coach John Wooden's Pyramid of Success:	www.coachwooden.com