PART

I

Leadership Theories and Principles

CHAPTER 1

The Basics of Leadership

> In a society capable of renewal, [leaders] not only welcome the future and the changes it brings but believe they can have a hand in shaping that future.
>
> —J. W. Gardner, *Self-Renewal*

The 21st century has not unsurprisingly increased the amount of attention paid to the concept of change. Yet change has always been and always will be a fact of life. For instance, the passage of a national health reform package in the first decade of the 21st century provides evidence that accelerated change may occur in the public health field. However, the passage of this legislation in the United States has led to major turmoil among the two major political parties in the United States. With major federal deficits, this legislation may be substantially revised or appealed during the second decade of this new century. An increasing connection between primary care and public health seems to be happening as well. Public health is in constant flux and will continue to be in the future. To cite two contemporary examples where change is demanded, large segments of the U.S. population are unemployed or employed in low-paying jobs and thus remain uninsured or underinsured. Certain culturally diverse racial and ethnic groups, as well as many if not most illegal immigrants, have less access to health care than the population as a whole. The health reform legislation, if sustained, should address this for large segments of the population.

Public health agencies and professionals are experiencing an identity crisis because of the recent reconfiguring of their emergency preparedness and response leadership and service roles and responsibilities since the terrorist events of September 11, 2001, and the many natural disasters during the first decade of this new century. Adding to these crisis events is the public's lack of awareness of the nature of public health and the accomplishments of the public health system. Parents and friends still ask public health professionals what they do for a living. Of course, confusion about professional identity exists elsewhere in the health professions. Physicians who work for managed care organizations resist the restrictions placed on their ability to provide the tests and services they feel their patients require, not to mention the limitations on their salaries. The traditional caregiving roles of nurses are also

changing as hospital bed utilization declines and many hospitals close their doors.

In order to manage the changes that are occurring, health care and public health professionals need to become involved in advocacy at the political and policy development levels. They need to create their own vision of what personal health care and population-based health should be and to act in concert to realize that vision, and for these tasks to be accomplished, some of these professionals must acquire the full range of leadership skills and translate these skills into action. In 1988, *The Future of Public Health* made the argument that the creation of effective leaders must not be left to chance.[1] In line with this view, the report also stated a concern that schools of public health were not teaching the necessary leadership courses. This was reinforced in the 2003 report on *The Future of the Public's Health*, where a recommendation was made that leadership training needs to be a requirement for public health professionals working in the governmental public health sector.[2] In 2007, the Institute of Medicine listed leadership development as one of the 16 critical public health content areas in the training of physicians for careers in public health.[3]

The training of future leaders is critical. Public health leaders will need training not only in the specialties of public health but also in the latest management techniques and tools. To support public health activities at the local, state, and federal levels, they will require good communication, problem-solving, decision-making, and policy development skills, and skills in addressing all public health emergencies, among others. Leaders must learn how their organizations function; how to work across organizations, which has been called meta-leadership or boundary-spanning leadership; and how to integrate their organizations' activities into the communities they serve. In addition, the changing demographics of the U.S. population will lead to the need for ethnically diverse public health professionals to accept leadership positions in the governmental and primary care sectors.

There is a major difference between managing change and leading change.[4] To lead change, leaders must be able to develop a vision to partially define the future. They must then get others to share their vision and help realize it. Of course, managing change and performance management are also important, for they keep the system running smoothly.

Selling a vision to others can be especially difficult for people from ethnically diverse groups, people with disabilities, and women, for the vision they are trying to sell might well involve cultural, ethnic, community, and gender issues, and they will probably have to disseminate it to people who have a different background than they do.[5] Developing a vision that can be shared is critical in a society where diversity is the rule rather than the exception. Any vision will remain just a vision if it falls outside the belief system of the managers and the leaders.

In 1996, the Institute of Medicine released a report on the first year of its committee on public health. The report, *Healthy Communities: New Partnerships for the Future of Public Health*,[6] reviewed the 1988 *Future of Public Health* report and concluded that progress had occurred in leadership development in the 1990s. Among other signs of progress was the creation of a national public health leadership program and a number of state and regional leadership development programs. As I write this, the funding of these programs at the federal level (Centers for Disease Control and Prevention) has stopped. The training of public health leaders needs to continue, especially in this new era of health reform. Stress must be placed on the multidimensional aspects of leadership as well as the multidisciplinary approaches of the public health field as a whole. Building and strengthening the infrastructure of public health requires strong and effective leaders to address emergency situations as well as more traditional public health situations.

Note, however, that until now leadership development has been based on an industrial or agency paradigm of leadership.[7] Leaders of the 21st century must possess different skills with a systems thinking and complexity focus. They will also need to recognize that leading is a process in which they must pursue their vision through influencing others and the places they work. Leaders will find that advancing the skills of their workforce will increase the chance that their vision will become a reality. In addition, they will have to break down the barriers between organization and community to create an environment in which a shared value system and a shared vision for the future can come into being.

The remainder of the chapter comprises two short sections containing a definition of leadership and five essential skills for a public health leader and a long section that discusses 16 important principles of public health leadership. As part of their effort to understand the nature of leadership, students should do Exercise 1-1, which provides an opportunity for students to express what they believe about leadership in general and public health leadership in particular. This exercise also presents the option of developing a journal to record ideas, leadership notes on papers or books read, and personal reflections on leadership experiences.

DEFINITION OF LEADERSHIP

Leadership is creativity in action. It is the ability to see the present in terms of the future while maintaining respect for the past. Leadership is based on respect for history and the knowledge that true growth builds on existing strengths. Leading is in part a visionary endeavor, but it requires the fortitude and flexibility necessary to put vision into action and the ability to work with others and to follow when someone else is the better leader. Leaders also need resilience to function in normal and not-so-normal times.

Public health leadership includes a commitment to the community and the values for which it stands. A community perspective requires a systems thinking and complexity orientation. Community refers not only to the local community in which a person works but also to the larger global community that can affect the health of the public over time. Whatever health crises occur in other parts of the world will have an effect on what will eventually affect the health of the public in our local communities. It also includes a commitment to social justice, but public health leaders must not let this commitment undermine their ability to pursue a well-designed public health agenda. In addition, public health leaders need to act within the governing paradigms of public health, but this does not mean they cannot alter the paradigms. Leaders propose new paradigms when old ones lose their effectiveness. The major governing paradigm today relates to the core functions and essential services of public health.

LEADERSHIP ESSENTIALS

Over the past 20 years, I have read probably more than 1,000 books on leadership and management. A large number of these books present theories about what leadership is and how it works. Many leaders have embraced one theory, a combination of theories, or their own theory about leadership and how they practice it. As these theories are examined (see a sample of well-known books that present differing approaches in Case Study 1-A), it becomes useful to try to determine the essential skills of successful leaders. To simplify this task, let's limit the essentials to the five most important skills:

1. *Ability to identify the most useful information and to use it*. Leaders are bombarded with new information on a daily basis from new health data statistics, new public health technical reports, new funding opportunities, and new demands for service based on emerging threats or program emphases. All this new information has to be translated into the context of public health and the governing paradigms that drive public health action.
2. *Ability to motivate and work with others*. Leaders have learned that the technological expertise that brought them into public health careers is secondary to their relationships with colleagues and external partners. Leaders must have the social skills necessary to collaborate with others with ease. This set of basic skills has come to be called *emotional intelligence* in recent years.
3. *Ability to take risks and follow through*. Not only do leaders need to be visionary and creative, they need to be able to take risks and to translate their ideas into action with well-defined projected outcomes. Every new vision or creative idea has a potential risk associated with it. Many people are fearful of change. Risk taking is the attempt to change the status quo and move in new directions.
4. *Ability to communicate at many different levels*. Leaders have to learn to communicate both verbally and in writing. They need to listen to others carefully. They may also have to communicate cross-culturally or to others who do not speak their native language. They need to be able to communicate through the Internet. Social networks can become critical to their work. Most leaders are excellent at using real-life events to show how their theories work. They can also be excellent storytellers.
5. *Ability to act as systems thinkers with an understanding of how complexity affects their work*. Leaders understand that they need to concentrate on the big picture. They look at their agency as a whole organization with interacting parts. They see their agency in the context of a whole community. They understand that most of their work is about upsetting the status quo in order to change things for the better. Public health leaders think about the population and how to improve the health of everyone in their geographic jurisdiction. They also understand that the best plans may still lead to unanticipated consequences.

All the other leadership skills that are described by the many leadership writers and by leaders themselves grow out of these five essential skills.

PUBLIC HEALTH LEADERSHIP PRINCIPLES

One way of filling out the definition of public health leadership in particular is to consider some of the principles that public health leaders should use to guide their actions. Following is a list of 16 such principles. In a study of 130 public health leaders in the United States, England, Scotland, and Ireland during 1996, the author conducted an hour-long conversation with each of these leaders to find out his or her view of the future role of public health agencies. The perspective of these leaders is still relevant today.

The public health leaders interviewed generally thought that they and business leaders have much in common. Good leadership is essential for the effectiveness of companies engaged in business and can increase the effectiveness of public health agencies as well. But although the leadership practices of business and public health leaders are similar, there are also important differences. For example, the social justice perspective that characterizes public health is more or less absent from the business world where a profit motive predominates. One of the leaders interviewed argued strongly that the social justice perspective is critical for public health but that public health leaders must be careful not to let this value interfere with the work that public health needs to do. One way of putting this is that social justice is only part of the leadership value system. Gardner[8] integrates that value with the values of freedom, social and ethnic equality, the worth and dignity of each individual, and the brotherhood of all human beings.

Principle 1

The public health infrastructure and the system in which it is embedded must be strengthened by utilizing the core functions of public health and its essential services as a guide to the changes that should occur. The future of public health will be determined by the way in which core functions are carried out and essential services are provided. Public health leaders must evaluate the health status of the population, evaluate the capacity of the community to address its health priorities, and implement preventive measures to reduce the effect of or even avoid public health crises. Leaders must not rely on the current assurance models (service interventions) but need to implement new assurance models built on integrated and collaborative systems of service and program delivery. Leaders must also help to restructure the policies and laws that govern health and public health. Leaders must be policy makers who have a view of the future grounded in the realities of the present and built on the experiences of the past.

Principle 2

The goal of public health is to improve the health of each person in the community. Public health leaders believe deeply that health promotion and disease prevention are possible. In fact, a focus on prevention is intrinsic to public health. In this regard, public health contrasts with the medical care system, which places an emphasis on treatment and rehabilitation. Every citizen needs to learn about the benefits of public health and how quality of life can be greatly improved if certain rules are followed and if people take personal responsibility for their own health needs.

A public health leader who truly believes in this principle will become a teacher and mentor for the community. Education will be the prevailing program model rather than medical care. The leader will reach out to schools, churches and synagogues, businesses, physical fitness centers, households, and healthcare providers and promote the vision of good health for all throughout life. The leader will also be concerned with the quality of care. If someone becomes ill, access to the best possible care is a community requirement. A visionary leader sees the total health system existing in the community and helps to ensure that the system is integrated and comprehensive, provides the services that are necessary, and does not contain duplicate services and programs, which are a waste of valuable resources.

A public health leader can play an important role in promoting a sense of community among community members. The leader might help define the values of the community and clarify the cultural aspects of the community life. Not all geographic areas have a cohesive cultural infrastructure. In an area that lacks such an infrastructure, the public health leader can help the community to define itself.

Principle 3

Community coalitions need to be built to address the community's public health needs. Public health is both a community responsibility and a population-based activity. This means that the mission of public health is to work with all groups in a community to improve the health of all members of the public.

All communities have assets and all sorts of community resources. Unfortunately, communities, like people in general, tend to be careless with their assets.[9] Consequently, each community needs to learn how to manage its assets if it doesn't know how to do that already. In short, it needs to take responsibility for its future. It may be too dependent on those who work in human services. Promoting good health is every citizen's responsibility. Public health leaders can play a critical role in helping the community move from a value system based on dependency to one based on shared responsibility. Public health leaders and their cousins in the human services field are thus the true servant leaders.[10]

Coalition building and other forms of collaboration require knowledge and creativity. First, coalitions made up only of managers are doomed to failure.[11] Coalitions need leaders to guide the process. Second, coalitions require trust among their members. If there is no trust, change will not occur. Third, there must be positions of power in a coalition. Key players must not be excluded or the process will fail. Expertise is also necessary so that informed decision making will occur. Fourth, the coalition must have credibility so that it will be taken seriously by others (both inside and outside the community) who can affect the implementation of the change agenda.

Principle 4

Local and state public health leaders must work together to protect the health of all citizens regardless of gender, race, ethnicity, or socioeconomic status. Public health leaders firmly believe in the principle that all people are created equal. Several U.S. public health leaders interviewed by the author stated that the U.S. public health system must be understood within the context of the American political tradition and that it is impossible to be an effective public health leader without knowing about that tradition.

Access to service is sometimes affected by who you are. Women have found that the healthcare system does not always respond to their special medical needs. Public health leaders see that they have a responsibility to press for improvements in health care for women. They also have a responsibility to develop health promotion programs for women as well as men. For example, local health departments can take a leadership role in the development of breast examination programs for cancer prevention. Cultural and ethnic groups often have difficulty in accessing health programs because of color, language, or socioeconomic status. Diabetes-screening programs are often the first programs to go when funding cuts occur, despite the critical need for these programs in our communities. Public health leaders have important tasks to perform in protecting the rights of the unserved and underserved.

We live in a culturally diverse society. Our diversity is a strength as well as a weakness. Public health leaders must deal with their personal prejudices each day and consciously move beyond them to create a public health system that respects the needs of every citizen. State public health leaders must monitor the needs of all citizens as well as create the policies of inclusion that will lead to an improvement in the public's level of health. In addition, these leaders must make state legislators and other elected officials partners in this enterprise. The other critical partner is the local public health leader, who, in conjunction with the local board of health or county board of commissioners, is the gatekeeper for the community. What the state proclaims, the local leaders must adapt for local implementation. Local public health leaders must be extremely creative in the adaptation process. They must also speak loudly for the unique needs of their local community and take the local public health agenda to places where the state leaders do not tread.

Principle 5

Rational community health planning requires collaboration between public health agency leaders, the local board of health (if such a board exists), other local and county boards, and other external community stakeholders. The relationship between the administrator of the local health department and the chair of the board of health needs to be a close one and based on a philosophy of equality and trust. The chair and the other members of the board of health do more than approve the health department budget and select the health administrator. The board members are residents of the community. They are the protectors of the community's interests and, with the administrator, serve an important gatekeeper function. Shared leadership and a shared vision are critical here. The health department and the board of health must be partners, not adversaries, which means they must work collaboratively to achieve agreed-upon outcomes. The exchange of information is an important part of the relationship, because relevant information is essential for the making of good public health decisions.

Principle 6

Novice public health leaders must learn leadership techniques and practices from experienced public health leaders. Mentoring is a critical part of leadership. A mentor is a person who helps another person learn about the world and how it works.[12] Mentors also help people in their care choices. Mentors tend to be well-known individuals who help their protégés meet their major goals.[13]

Murray[14] discusses what she calls "facilitated mentoring," which is a process designed to develop effective mentoring relationships. It is also designed to guide the teaching of the person being mentored. If the mentoring experience is successful, there will be an effect on the mentor, the person mentored, and the agency promoting the mentoring experience.

Mentors are ideally not threatened by the professional progress of their protégés. They personally feel good about the mentoring experience. All of the leaders interviewed by the author said that they had been mentored at various times in their public health careers. They thought that mentoring was important and that the need for mentoring does not stop with the attainment of a leadership position. Mentoring is beneficial to leaders throughout their careers. Furthermore, leaders who have been mentored have a responsibility to pass on the gift of learning they received.

Principle 7

One issue of import is whether leaders are born or made. If leadership is innate, leaders wouldn't need to develop their skills, but if leaders are made, anyone has the potential to become a leader. The most defensible position is that leaders are both born and made—that some people are natural leaders with the talents necessary for successful leadership but nonetheless need to develop their leadership abilities.[15]

In fact, public health leaders must continuously work to develop their leadership skills. Leaders never stop learning. They are like detectives who pick up clue after clue in order to find the solution to a mystery. Leaders seek solutions to challenges rather than to mysteries, but the attainment of new knowledge is just as important for finding these types of solutions. Furthermore, each solution leads to new challenges and the need for additional learning.

Support for programs for lifelong learning is critical. There has been a tendency in recent years not to allocate funds for learning activities, based partly on the argument that the public does not want to pay for training programs. When the funds are available, they tend to be classified as discretionary and used for purposes other than training. Yet allowing leaders to improve their skills can lead to substantial benefits.[16] Very few public health practitioners have ever received major job-related training, to the detriment of the agencies they work for.

Over the past 20 years, a unique experiment occurred, funded by the Centers for Disease Control and Prevention and state health departments. A national public health leadership institute and a number of state and regional leadership programs were created to help state and local health department professionals, board of health members, local and state legislators, faculty members, and community leaders develop their leadership potential. The programs, which teach public health theory and practice, promote the education of public health professionals and, through them, the education of all citizens in a community. Public health leadership development, at its best, can create a partnership between public health leaders, the public health academic community, and the public health professional community in the public and private sectors. The main lesson learned from this experiment is that public health leadership development must build on the mission of public health but must orient itself to the future of public health. A second lesson is that these programs need to be experientially based and need to focus on projects that strengthen the infrastructure of the public health system. These programs also have the value-added result of increasing networking among the public health leaders who attend these programs.

Principle 8

Leaders must be committed not only to lifelong learning but to their own personal growth. Self-esteem is a key factor in personal growth and is essential to the personal competence necessary to cope with life's challenges.[17] Furthermore, the higher a leader's self-esteem, the more able the leader is to inspire others. Research on children has shown that children with high self-esteem are more willing to take risks and to assume leadership roles than children with low self-esteem.[18] Sethi has described the seven R's of self-esteem:[19]

1. *Respect*. It is necessary to respect and trust your employees.
2. *Responsibility and Resources*. Encouraging creativity among employees and delegating responsibility for tasks are essential.

3. *Risk Taking*. Only through risk taking can innovation occur.
4. *Rewards and Recognition*. People need to be recognized for their accomplishments.
5. *Relationships*. The quality and quantity of personal relationships have an effect on self-esteem.
6. *Role-Modeling*. The work practices of an organization should be consistent with its values.
7. *Renewal*. It is critical to maintain a strong belief in lifelong learning.

Self-esteem is tied to each of the seven R's. Each factor affects the self-esteem of the leaders and their associates inside the agency and in the community. Building the self-esteem of leaders and associates is a prerequisite for the building of strong organizations.[20]

Principle 9

The infrastructure of public health must be built on a foundation of health protection for all, democratic ideals and values, and respect for the social fabric of American society. The assumption underlying this principle is that physical, psychological, emotional, economic, and social health are all elements of the health of a community. By acting as role models for the community, public health leaders strengthen the infrastructure of public health in the community. This infrastructure is not just a physical building or an official agency called the department of public health; it comprises the entire community.

Principle 10

Public health leaders should think globally but act locally. Although public health professionals practice their craft primarily at the community level, they should not ignore the rest of the world. Emerging viruses know no boundaries. Disease is carried not only on the wind but even in airplanes. Public health leaders need to be vigilant in looking for potential health problems. The Centers for Disease Control and Prevention has a national center for infectious disease that monitors emerging diseases globally, and public health professionals located throughout the world are investigating potential worldwide health problems such as the possibility of a pandemic influenza outbreak. Some multiregion crises have been documented in books such as R. Preston's *The Hot Zone*,[21] L. Garrett's *The Coming Plague*,[22] and J. B. McCormick and S. Fisher-Hoch's *Level 4: Virus Hunters of the CDC*.[23] When a crisis hits, the international public health community must work together on the problem. Public health leaders thus have several overlapping communities to which they owe allegiance, and they must understand how to coordinate their multiple allegiances.

Principle 11

Public health leaders need to be good managers. In the above-mentioned interview study of public health leaders, the leaders pointed out that they, as heads of agencies, not only define their agencies' practice activities but also help to implement those activities. Managers do not have to be leaders, but tomorrow's leaders will need to possess both management and leadership skills (see **Table 1-1**). Reconciling these two sets of skills will not be easy, because they are based on two different ideological and talent perspectives. Managers are oriented toward ensuring that current systems are functioning smoothly. They tend to orient their activities to strengthening the public health agency in which they work. Leaders are change agents who are concerned with moving their agencies forward. Because change is unavoidable, today's managers will become obsolete if they cannot keep up with the ever-increasing pace of change. Leaders and dynamic managers will have to steer their organizations in new directions, and they will have to utilize cutting-edge leadership skills and managerial tools to do this.

Principle 12

Public health leaders need to walk the walk. They must not only define a vision but sell the vision and inspire others to accept it and try to realize it.[24,25] In his book on visionary leadership, Nanus[26] pointed out that there are four major types of leadership activity. First, a leader has to relate to the managers and other workers in the organization. The leader should be the guide to and motivator of action in the organization. Second, the leader has to relate to the environment or community outside the organization. A public health leader, for example, must carry the agency's vision and message into the community. Third, the leader has to influence all phases of the operation of the organization. Finally, the leader has to anticipate future events and move the organization forward in a manner that takes these events into account. If it is clear that managed care organizations will provide medical care for all members of a community, then the public health leaders of that community need to get the public health department out of the direct service business and into population-based health promotion and disease

TABLE 1-1 A Comparison of the Characteristics and Responsibilities of Practitioners, Managers, and Leaders

Practitioners	Managers	Leaders
The practitioner implements.	The manager administers.	The leader innovates.
The practitioner follows.	The manager is a copy.	The leader is an original.
The practitioner synthesizes.	The manager maintains.	The leader develops.
The practitioner focuses on programs and services.	The manager focuses on systems and structures.	The leader focuses on people.
The practitioner relies on compliance and behavior change.	The manager relies on control.	The leader inspires trust.
The practitioner has a narrow view.	The manager has a short-range view.	The leader has a long-range view.
The practitioner asks who and where.	The manager asks how and when.	The leader asks what and why.
The practitioner's eye is on the client and the community.	The manager's eye is always on the bottom line.	The leader's eye is on the horizon.
The practitioner separates programs from services.	The manager imitates.	The leader originates.
The practitioner protects the status quo.	The manager accepts the status quo.	The leader challenges the status quo.
The practitioner is in the infantry.	The manager is the classic good soldier.	The leader is his or her own person.
The practitioner is a conflicted pessimist.	The manager is a pessimist.	The leader is an optimist.
The practitioner is a reflective thinker.	The manager is a linear thinker.	The leader is a systems thinker.
The practitioner follows the agency agenda.	The manager does things right.	The leader does the right things.

Source: Modified from *On Becoming a Leader* by Warren Bennis. © 1989, 1994, 2009 by Warren Bennis, Inc. Reprinted with permission of Perseus Books Publishers, a member of Perseus Books Group.

prevention. In general, this has occurred since 1996. The deterioration of the economy since 2008 has led to some reevaluation of this argument as the community health center movement has gained prominence, with some local health departments getting back into the direct service business by opening community health centers with federal funds.

Principle 13

Public health leaders need to be proactive and not reactive. Up to the present, they have mostly tended to respond to public health crises as they occurred rather than focus on preventing crises. A reactive stance will probably always be part of the strategy of any state or local health department. However, reactivity tends to tarnish a health department's image. Public health agencies and professionals need to develop action plans to address the health needs of the citizens in their service area. Assessment activities will help to evaluate the health status of the community and give guidance for action. Action planning is more than planning for a crisis, which is an anticipatory activity that assumes a problem is on the horizon. Action planning is essentially preventive. Its goal is to create programs to prevent the occurrence of problems rather than create programs to deal with problems after they occur.

Principle 14

Each level of the public health system has a need for leaders.[27] In fact, a leader does not need to have an

official position to be a leader, and nonpositional power is likely to become more and more important. However, a defined leadership position does not hurt. Change will come from many different sources, and leaders will step forward to make sure the required tasks are accomplished. For example, if an environmental crisis occurs in a community, the environmental director from the health department, a community resident who is an engineer, a firefighter, a police officer, and others may form a leadership team to deal with the crisis. When the crisis has passed, the members of this ad hoc leadership team will step back into their normal roles. Much has been written on this issue since the tragedy of September 11, 2001. The National Incident Management System (NIMS) is one example of this team effort to address a public health emergency.

Each level of an organization also has a need for leaders.[28] And like members of a community, members of an organization often share leadership tasks by forming a team to tackle issues. These critical shared leadership experiences are often ignored in the leadership literature.

Principle 15

Public health leaders practice their craft in a community setting and must understand what a community is. Shaffer and Anundsen stated that Americans are searching for a revitalized sense of community.[29] A community is more than a place; it consists of people living together who "participate in common practices; depend upon each other; make decisions together; identify themselves as part of something larger than the sum of their individual relationships; and commit themselves for the long term to their own, one another's and the group's well-being."[30(p.10)]

Human beings have a desire to be free and independent, but those who take independence as an absolute value risk becoming profoundly lonely by not including other people in their lives.[31] Being part of the community involves inclusivity, commitment, and consensus. It also can lead to a sense of realism, because communities, through the actions of individual members, contemplate and evaluate themselves. Finally, communities tend to be safe places, which is one reason Americans, with their increasingly well-founded fear of violence, have a renewed interest in the sense of community.

In the now classic book *Habits of the Heart*,[32] Bellah and his collaborators argue that we Americans have become committed to the lexicon of individualism and have consequently lost our way morally. We are losing our sense of community and our commitment to improve society at large. Everyone from our politicians to our educators is pushing for a return to our moral roots, by which is meant a return to community.

Public health leaders have traditionally had a strong belief in community. Their focus, after all, is on improving the health of the communities they live and work in. Public health leaders also believe they can strengthen their communities by working with community leaders to bring about change. If they are to be effective in bringing about change, they need to study and learn how their communities function. In particular, they need to know how to empower the members of their communities and get them to take their share of the responsibility for improving their own health.

Leadership Tip

Read your mail or answer e-mails when your energy level is low. Do important tasks when your energy levels tend to be high.

Principle 16

Public health leaders must practice what they preach. If they are promoting family values, they must live lives that are consistent with these values. If they are promoting good health and developing programs to get people to stop smoking, they should not smoke themselves.

This principle is not always easy to abide by. Some of our most successful leaders have personal lives that are in shambles. O'Neill called this the paradox of success.[33] Leaders often become prisoners of their official position and are unable to find a workable balance between their professional commitments and their private lives. Indeed, achieving a balance between work and home is becoming more difficult, as individuals are required to work harder due to such factors as downsizing. Decisions regarding the balance between work and home must be built into the culture of the places where we are employed,[34] especially as nowadays both spouses in a marriage usually work. The costs of not achieving a proper balance are high. Conflicting pressures and stresses can have serious health consequences.

I was running a leadership program and was planning for a six-month follow-up meeting to an initial program. All trainees from the first meeting were expected to come to the second meeting. One day before the second meeting was to occur, I received a telephone

call from one of the trainees. She told me that her son was ill and that she was trying to find someone to take care of him. She was worried about missing the meeting. I asked her what she thought she needed to do. She said she felt she needed to stay with her son. I told her she had made the right choice. Balancing is making the right choice.

SUMMARY

The one thing that a review of the leadership literature makes clear is that leadership is a complex series of processes affected by many factors. These factors, for public leaders in particular, include the principles described above, which apply to leadership style, leadership practices, the public health system, the core functions and essential services of public health, and leadership tools (see **Figure 1-1**).

Leading is a multidimensional activity. Every leader uses leadership skills in his or her own way, which is to say that every leader has his or her own leadership style and unique set of personal talents. Every leader engages in a set of leadership practices and uses a unique set of tools. All these elements determine whether a leader is successful. In Case Study 1-B, I interview Dr. Virginia Caine, a former president of the American Public Health Association and director of the Marion County Health Department in Indianapolis, Indiana, about leadership in public health.

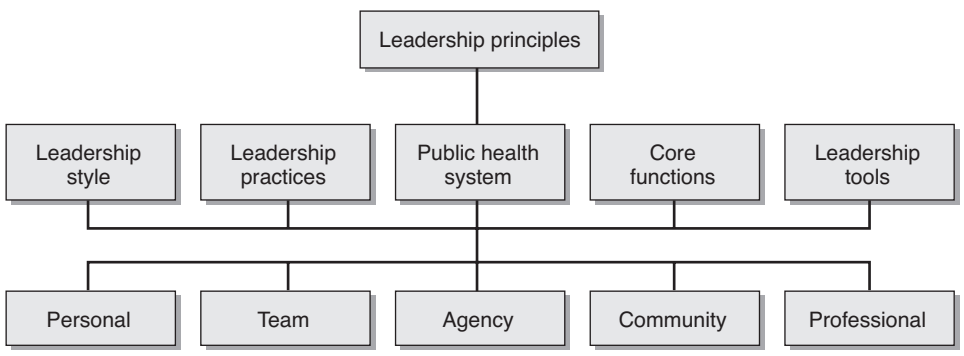

FIGURE 1-1 Conceptual Model of Public Health Leadership.

Case Study 1-A

Leadership Bookshelf

Louis Rowitz

1. Stephen Covey, ***The Seven Habits of Highly Successful People***. Covey is one of the most read of the leadership authors. This book has become a classic in its discussions of the seven habits of being proactive, being oriented to end actions, dealing with important things first, having a win-win orientation, increasing understanding of other people's positions, being synergistic, and being oriented toward continuous improvement.
2. John Gardner, ***On Leadership***. The complexity of modern-day events and increasing complexity of our organizations has pointed to the need for strong leadership. It is important that leaders understand the needs of the people they work with and the needs of people outside their organizations. Gardner explores these issues extensively in one of the most important leadership books in the field.
3. Peter Senge, ***The Fifth Discipline***. This book lays the groundwork for the need for leaders to be systems thinkers. The archetype of systems thinking is also developed.
4. Ronald Heifetz, ***Leadership Without Easy Answers***. By studying famous leaders, Heifetz explores leadership and what makes leaders succeed and sometimes fail. This book begins the exploration of adaptive behavior that Heifetz explores in later books like ***Leadership on the Line***.
5. James MacGregor Burns, ***Leadership***. Burns, who is a historian, has written an excellent book about the differences between transactional and transformational leaders.

6. Daniel Goleman, ***Emotional Intelligence***. Goleman is credited with being a major voice in recognizing the importance of emotional intelligence (EI) skills for leaders. EI involves self-awareness and awareness of others.
7. John Kotter, ***Leading Change***. This is an excellent book about change and how it works.
8. Ken Blanchard, ***Leadership and the One Minute Manager***. Blanchard's books are all based on the idea that different situations require leaders to act in different ways. He uses stories to explain his leadership principles.
9. Edward De Bono, ***Six Thinking Hats***. This is one of my favorites. It presents a great tool for generating new ideas and solutions to old problems.
10. Bernard Turnock, ***Public Health: What It Is and How It Works***. This is the best book for leaders who want to understand how public health in the United States works.
11. James M. Kouzes and Barry Z. Posner, ***The Leadership Challenge***. This is a very practical book that explores the five practices that make great leaders.
12. Max DePree, ***Leadership Is an Art***. This is a wonderful little book. Leadership is about ideas. It is about relationships and drawing your personal strength from others. The art of leadership is trusting others to find the way to do things in the most effective and efficient manner. Servant leadership is very important.
13. Warren Bennis and Burt Nanus, ***Leaders***. This classic book addresses such issues as the importance of character, the ability to build organizations and systems, the importance of passion for work, the need for a vision, the ability to communicate trust through positioning, and the ability to empower others. It was hard to choose between this book and Bennis's ***On Becoming a Leader***.

It would be interesting to see what books you would put on your bookshelf. The only challenge for me is that when this bookshelf was completed, I wanted to add a second bookshelf with other books. Reading about leadership is always a fun activity. That may be why I wrote my books. In your comments, I hope you will add your favorite books.

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Case Study 1-B

Public Health Practice Quiz for Virginia Caine

1. How would you define leadership?

Leadership is

- Creating a vision others can see
- Promoting the capacity of other people to take action on that vision
- Taking a diverse group of people with different backgrounds and ideas, focusing the group on a common goal, and motivating the group to overcome obstacles and reach the goal

2. What do you think are the critical strengths needed to be a successful public health leader?

Successful public health leaders are those who are visionary, decisive, good communicators, change agents, and risk takers. They have the conviction of their values and are deeply committed to improving the health of everyone in this country.

These leaders are also politically astute, are able to listen and hear what people are really saying, are respectful of different cultures, have emotional intelligence, are resilient and future focused, and have a love for public health.

They understand that relationship building and collaboration are the cornerstones of public health work.

3. What will be the major challenges of public health in the next 10 years?

The major challenges for public health in the next 10 years include the following: the improvement of the health of everyone in the country; the strengthening of the public health infrastructure; the aging of the public health workforce; the changing demographic populations (age distribution, cultural diversity) and their impact on disparities; chronic diseases; lack of access to health care and the uninsured; global health; health promotion and behavior change; environmental hazards and global warming; and the integration of public health and traditional medical information systems.

(*Continues*)

Other challenges for public health include genomics and ethical issues, credentialing and accreditation, emerging infectious diseases and drug-resistant bacteria, and the ability to convene and collaborate with people across the political and opinion spectrum.

4. What needs to be done to develop a culturally diverse leadership workforce?

We need to encourage and promote diversity in our public health leadership training across the entire public health system, not just the public health departments. Also, public health agencies in collaboration with the education system, from preschool to the academic institutions, that is, colleges, need to create opportunities for students of all cultures to gain the knowledge and skills needed. Public health agencies need to promote more recruitment where it's robust and not passive of a culturally diverse workforce.

Some of these opportunities may include partnerships with diverse populations and organizations, providing scholarships, peer counseling, internships, and outreach educational endeavors for students of all cultures to gain the knowledge and skills needed to be 21st-century public health leaders with appropriate incentives.

5. Is leadership in the private sector similar to leadership in the business sector?

Leadership is leadership no matter what system you are in.

Leadership Tip

Think and act locally with global health issues involved in your activities.

DISCUSSION QUESTIONS

1. What is your personal definition of leadership?
2. Who is a living person whom you define as a leader and why?
3. What, in your view, are the differences between business leaders and public health leaders?
4. How does creativity play a role in leadership activities?
5. How is collaboration related to leadership?
6. What role does social justice play in public health?
7. What are the main goals of public health?
8. What does it mean to say that public health leaders should think globally but act locally?
9. Is leadership different from management?

EXERCISE 1-1: Course Expectations

***Purpose*:** to explore the expectations that students have at the beginning of a leadership course

***Key concepts*:** expectations, leadership development, preconceptions

***Procedure*:** Each student writes down initial thoughts or preconceptions about leadership and also writes down expectations for the course and for leadership training in general. The class then divides into groups of 5 to 10 members, and each group discusses the preconceptions and expectations. The students should keep the lists they have created. One way to make this a meaningful experience is for students to start a leadership journal in which their list becomes the first page of a journal.

REFERENCES

1. Institute of Medicine, *The Future of Public Health* (Washington, DC: National Academies Press, 1988).
2. Institute of Medicine, *The Future of the Public's Health* (Washington, DC: National Academies Press, 2003).
3. Institute of Medicine, *Training Physicians for Public Health Careers* (Washington, DC: National Academies Press, 2007).
4. J. P. Kotter, *Leading Change* (Boston: Harvard Business School Press, 1996).
5. S. E. Melendez, "An Outsider's View of Leadership," in *The Leader of the Future*, ed. F. Hesselbein et al. (San Francisco: Jossey-Bass, 1996).
6. Institute of Medicine, *Healthy Communities: New Partnerships for the Future of Public Health* (Washington, DC: National Academies Press, 1996).

7. S. M. Bornstein and A. F. Smith, "The Puzzles of Leadership," in *The Leader of the Future*, ed. F. Hesselbein et al. (San Francisco: Jossey-Bass, 1996).
8. J. W. Gardner, *Self-Renewal* (New York: W.W. Norton, 1981).
9. J. McKnight, *The Careless Society* (New York: Basic Books, 1995).
10. R. K. Greenleaf, *The Servant as Leader* (Indianapolis, IN: Greenleaf Center for Servant Leadership, 1970).
11. Kotter, *Leading Change*.
12. F. Wickman and T. Sjodin, *Mentoring* (Chicago: Irwin Professional Publishing, 1996).
13. L. Phillips-Jones, *The New Mentors and Proteges* (Grass Valley, CA: Coalition of Counseling Centers, 2001).
14. M. Murray, *Beyond the Myths and Magic of Mentoring*, rev. ed. (San Francisco: Jossey-Bass, 2001).
15. P. Hersey et al., *Management of Organizational Behavior*, 9th ed. (Upper Saddle River, NJ: Prentice Hall, 2007).
16. P. M. Senge et al., *The Fifth Discipline Handbook* (New York: Dell, 1994).
17. N. Brandon, "Self-Esteem in the Information Age," in *The Organization of the Future*, ed. F. Hesselbein et al. (San Francisco: Jossey-Bass, 1997).
18. D. Baumrind, "An Exploratory Study of Socialization Effects on Black Children: Some Black-White Comparisons," *Child Development* 43 (1972): 261–267.
19. D. Sethi, "The Seven R's of Self-Esteem," in *The Organization of the Future*, ed. F. Hesselbein et al. (San Francisco: Jossey-Bass, 1997).
20. K. Blanchard and N. V. Peale, *The Power of Ethical Management* (New York: Fawcett Columbine, 1988).
21. R. Preston, *The Hot Zone* (New York: Random House, 1994).
22. L. Garrett, *The Coming Plague* (New York: Farrar, Straus & Giroux, 1994).
23. J. B. McCormick and S. Fisher-Hoch, *Level 4: Virus Hunters of the CDC* (Atlanta: Turner Publishing Co., 1996).
24. J. M. Kouzes and B. Z. Posner, *The Leadership Challenge*, 4th ed. (San Francisco: Jossey-Bass, 2007).
25. P. M. Senge, *The Fifth Discipline: The Art and Practice of the Learning Organization* (New York: Doubleday, 2006).
26. B. Nanus, *Visionary Leadership* (San Francisco: Jossey-Bass, 1992).
27. S. Helgesen, "Leading from the Grass Roots," in *The Leader of the Future*, ed. F. Hesselbein et al. (San Francisco: Jossey-Bass, 1996).
28. J. W. Gardner, *On Leadership* (New York: The Free Press, 1990).
29. C. R. Shaffer and K. Anundsen, *Creating Community Anywhere* (New York: Jeremy P. Tarcher and Perigee, 1993).
30. Shaffer and Anundsen, *Creating Community Anywhere*.
31. M. S. Peck, "The Fallacy of Rugged Individualism," in *In the Company of Others*, ed. C. Whitmyer (New York: Jeremy P. Tarcher and Perigee, 1993).
32. R. N. Bellah et al., *Habits of the Heart* (Berkeley: University of California Press, 1985).
33. J. R. O'Neill, *The Paradox of Success* (New York: Jeremy P. Tarcher and Putnam, 1994).
34. J. Kofomidos, *The Balancing Act* (San Francisco: Jossey-Bass, 1993).