Chapter 1

A Call for New Leadership in Health Care

Salvador Esparza and Louis Rubino

Learning Objectives

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

- Understand how healthcare reform in the United States is changing leadership.
- Describe the difference between leadership and management.
- Know the shared models of leadership in an environment of reform.
- Explain the importance of understanding yourself and others for effective leadership.

Key Terms

C-suite
Ethics
Healthcare value
Leadership competencies
Leadership models
Learning organization
Mental models
Patient Protection and Affordable Care Act (ACA)
Psychological contract
Will-Ideas-Execution

INTRODUCTION

We are living in historic times. Reform of the healthcare delivery system in the United States is actively underway. The **Patient Protection and Affordable Care Act (ACA)**, enacted in 2010, was upheld in June 2012 as constitutional by the U.S. Supreme Court and is now being

implemented. Even though court challenges may continue for some of the ACA's provisions, most of the ACA's components are already becoming a reality in the U.S. healthcare industry. These vast changes to the healthcare industry will continue, motivated not only by legislative and legal processes, but also by market forces.

The ACA's scope extends beyond simple health insurance reform; it is the catalyst for additional reforms of our healthcare delivery system. For example, the ACA addresses quality and cost-effectiveness of care; public health, including disease prevention and wellness; the healthcare workforce; fraud and abuse; long-term care; biopharmaceuticals; elder abuse; and Indian Health Services (McDonough, 2012). New frameworks and structures, such as accountable care organizations, patient-centered medical homes, foundations, and health insurance exchanges, are being developed and implemented to enhance healthcare services and quality (McLaughlin, 2011).

The objective of these changes is to improve American **healthcare value** and accessibility. Even though the ACA does not provide for universal healthcare coverage, it does increase the availability of health insurance for most Americans, allowing more people to seek out and obtain medical care. "Value of services provided" is a more elusive goal. Cost-effective services,—that is, the provision of high-quality care at lower cost—will be critical to successful healthcare reform (Wachter, 2012).

Outstanding leadership is necessary to guide us well in this period of dynamic change. Strategies must be developed to achieve the performance benchmarks needed to survive in this new healthcare environment. Potential barriers to successful adaptation for healthcare organizations and their leaders include limited economic resources and increased government regulation. The healthcare workforce will be looking to their leaders and managers to steer them safely through these churning waters. Stakeholders from within and from outside healthcare entities will demand leadership that can appropriately address interests and concerns such as fiscal stability and sustainability. Healthcare reform will provide new opportunities for graduates entering the healthcare workforce who have the confidence, abilities, and skills to effectively lead under these challenging conditions.

LEADERSHIP AS A COURSE OF STUDY

Today's healthcare leaders must transform the way their organizations operate (Gabow, Halvorson, & Kaplan, 2012). A recent symposium, sponsored by the Robert Wood Johnson Foundation, invited more than 50 healthcare

leaders from across the United States to meet and develop recommendations for pursuing opportunities to improve the health of the nation and create workable health solutions for the upcoming 2 decades (Japsen, 2012). Of the four key areas of focus that were identified, one was the cultivation of new leadership to promote a healthy society. In its discussion paper, *A CEO Checklist for High-Value Health Care,* the Institute of Medicine also included governance priority as one of its foundational elements, recommending visible and determined leadership by healthcare CEOs and board members (Cosgrove et al., 2012).

In order to meet this need for new and dynamic leadership in the healthcare industry, educational institutions will need to expand their role of developing modern leaders. Leadership, as a course of study, should be included in all health professional training programs; effective leadership skills can be taught and learned. Early exposure to leadership principles will better educate and prepare our future managers and supervisors, and teach them to conduct ongoing personal assessments and to reflect on their successes and their failures (better termed, "learning opportunities"). Health professionals have frequently been promoted into leadership positions without formal instruction in health administration. Lack of adequate training, for example, could lead a new manager to spend most of his or her time on tactical problem solving rather than strategic decision making, diminishing his or her effectiveness. With trained leaders who possess the competencies proven to promote success, the healthcare industry will be in a better position to address the challenges in this environment of reform.

LEADERSHIP VERSUS MANAGEMENT

Leadership and management aim for similar outcomes: getting people to achieve organizational goals through certain acts and behavior. A main difference though is that in management, the way this is accomplished is through processes (i.e., organizing, staffing, controlling, planning, etc.); and for leadership, this is done through influence. Another defining feature is orientation. In general, managers have more of an internal focus, concentrating on the issues associated inside the organization. Leaders have more of an external focus, concentrating on issues outside of the organization but affected by its association.

A commonly debated question in the first session of any basic leadership course is: Can good leaders be good managers, and can good managers be good leaders? And, is there a differentiation of duties between leadership and management? Yes, some leaders can be good managers, and some managers can be good leaders—depending in large part on their training and skills.

Good leaders typically rise to their position of influence through the ability to successfully lead others toward achieving a mutually agreed-upon goal. Without others willing to be led, however, there can be no leaders. “Followership” is complementary and essential to leadership (Atchison, 2003). Not everyone has the skills or inclination to be an effective leader; successful leaders need capable followers to be able to achieve their organizations’ goals.

Katz (1955) conducted primary research on leadership and managerial effectiveness and determined that successful leaders and managers utilize three distinct sets of skills: conceptual, interpersonal, and technical skills. Conceptual skills include being able to work with ideas and concepts, critical to strategic planning for senior leadership. Interpersonal skills are needed by both leaders and managers. Technical skills are predominantly utilized by managers for operational functions, but can be valuable for senior leaders who are tasked with accountability data analysis. Different skills are critical to leadership versus managerial success.

Further distinctions between leadership and management foci are made by Manion (2011). Building on the original premises presented by Bennis (1989), Manion points out that those in charge must look differently at situations depending on their administrative level and position. For example, leaders are more concerned about effectiveness (*if* the task gets done), whereas managers are more concerned with efficiencies (*how* the task is done). Leaders are focused on “what” and “why,” whereas managers are more focused on “how.” Leaders are more concerned with people and relationships, and, even though managers are more concerned with organizational structure, people and relationships are also critical to good management. Leaders are focused on innovation and managers on “maintaining the status quo.” Most importantly, whereas managers are typically eyeing “today’s” bottom line, leaders look toward the horizon to help move the organization forward (see **Table 1.1**).

HISTORY OF LEADERSHIP IN THE UNITED STATES

Over the past century, leadership has been influenced by social and cultural contexts (see **Table 1.2**). From the industrial revolution to the 1920s and 1930s, the “Great Man” theorists believed that the best leaders had inherent traits such as strength, firmness, and male gender. During the 1940s and 1950s, after the devastation of World War II, leadership theories shifted toward considering relationships in addition to getting tasks

Table 1.1 Leader Versus Manager Focus

Leader Focus	Manager Focus
Effectiveness	Efficiency
What and why	How
People and relationships	Organizational structure
Innovation	Status quo
Horizon	Bottom line

Table 1.2 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	Needs of the subordinates
1970s	Contingency and Path–Goal	Considers style and situation
1980s	Transformational Approach	Raises consciousness and empowers followers
1990s	Team Leadership	Team development and performance
Contemporary Theories	Authentic, Servant, Spirituality and Emotional Intelligence	Leading with a purpose, serving others and being empathetic

Source: Modified from Buchbinder, S. & Shanks, N. (2012). *Introduction to health care management* (2nd ed.). Burlington, MA: Jones & Bartlett Learning.

done. In the 1960s and 1970s, the emergence of social consciousness led to situational approaches wherein the dynamic nature of relationships were examined, the needs of subordinates were considered, and the styles of leadership were assessed relative to subordinates. Path–Goal and Contingency are examples of two such theories. By the 1980s, the transformational approach became prominent, and in the 1990s, team building and leadership were heralded.

Since 2000, a number of contemporary approaches have been developed. Some specifically appeal to the "helping" mission popular in health care. Authentic leadership has people motivated by leaders who follow their internal compass of true purpose and associated values. Servant leadership

rests on the principle that leaders and followers are motivated by the desire to serve others: followers to serve clients, and leaders to serve the employees that implement the organizational mission. Spiritual leadership tends to be a good fit for an industry that is often sponsored by religious organizations. Emotional intelligence, with its five dimensions of self-assessment, self-regulation, self-motivation, social skills, and social awareness, can provide healthcare leaders using any of these leadership styles with a tool kit from which to draw strategies and solutions that respect both leaders and subordinates (Rubino, 2012).

Individual Leader Perspective

In healthcare organizations, there are many opportunities for leadership. The **C-suite**, for example, especially in larger organizations such as hospitals, contains several high-level executives who are responsible for the entire entity, or multiple affiliated entities (e.g., Chief Executive Officer, Chief Operating Officer, Chief Quality Officer). Others leaders might supervise specific groups of associates (e.g., Chief Nursing Officer and Chief Medical Officer) or have critical administrative and operational responsibilities (i.e., Chief Financial Officer and Chief Information Officer). All the department leaders are expected to work together as a leadership team to ensure the alignment of action with the organization's strategic plans and mission. Smaller healthcare organizations, such as nursing homes, clinics, and home health agencies, also identify leaders for their units, but with more limited human and financial resources, may provide fewer opportunities for the development of functional leadership teams and collegial camaraderie.

Healthcare organizations tend to be hierarchical. Professionals who provide patient care are typically supervised by physicians or nurses. In hospitals, a physician is usually elected or appointed Chief of Staff and oversees the breadth of clinical operations that are organized and provided as per the hospital's Medical Staff bylaws. Subdivisions and units such as Surgery, Pediatrics, Obstetrics, and the like will usually have a physician leader who has been trained in the unit specialty to supervise the unit's specialists and advanced practice nurses. Nursing units are typically supervised by experienced senior nurses, many of whom have master's or doctorate degrees. Physicians or nurses may be elected to serve as the Chairs of Quality Improvement and/or Patient Safety Committee and monitor the quality of care provided.

There is a breadth of leaders in many other healthcare organizational units/departments/divisions (imaging supervisors, laboratory scientists, business office managers, etc.), who have similar roles and responsibilities for their various specialty. In healthcare sectors that are not provider based,

such as pharmaceutical, medical supply, and insurance companies, many other leadership positions can be identified. The **leadership competencies** needed to be successful in these roles are transferable across multiple types of healthcare organizations.

THE LEADERSHIP COMPETENCIES

Competencies are a set of skills, knowledge, and abilities. An alliance of associations representing healthcare leadership groups—the American College of Healthcare Executives, the American College of Physician Executives, the American Organization of Nurse Executives, the Healthcare Information and Management Systems Society, the Healthcare Financial Management Association, and the Medical Group Management Association—collaborated to determine the set of competencies needed by successful healthcare leaders.

Leadership was identified as the central domain that intersected with four other domains: (1) communication and relationship management, (2) professionalism, (3) knowledge of the healthcare environment, and (4) business skills and knowledge. Within the area of leadership, the important competencies identified were leadership skills and behavior, organizational climate and culture, communicating vision, and managing change. The American College of Healthcare Executives (ACHE), as well as the other associations, now uses this set of competencies to help its members conduct self-assessments of their leaders' practices (ACHE, 2012).

The demands of U.S. healthcare reform for improved quality of care and cost-effectiveness have inspired a renewed examination of the competencies needed by healthcare executives who are preparing their organizations for change. A recent survey of hospital and other healthcare systems attempted to assess the promotion and adoption of these competencies in organizational leadership development programs (Awo Osei-Anto, 2011). Though leadership development programs were variable from organization to organization, the study demonstrated a correlation between leadership training in best practices and improved performance.

A more specific framework for leaders to achieve better performance is provided by the Institute for Healthcare Improvement (IHI; Reinertsen, Bisognano, & Pugh, 2008). Acknowledging the pressures healthcare leaders are facing, the IHI developed a roadmap that leaders who wish to improve their organizations can follow. The core elements of this model are **Will-Ideas-Execution**. Successful leaders must develop the organizational will to achieve results, generate or identify effective ideas or strategies for improvement, and then execute those ideas. In addition, setting direction and establishing the foundation will help spread the ideas across the organization and sustain them over time. A push–pull type of response is

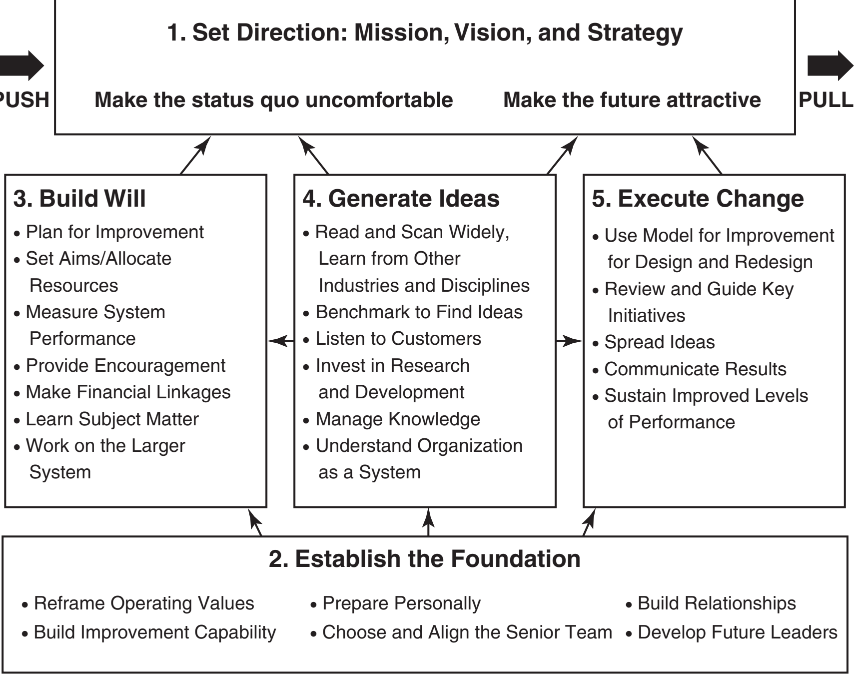


Figure 1.1 IHI Framework for Leadership for Improvement

Source: Reproduced from Reinertsen, J .L., Bisognano, M., & Pugh, M. D. (2008). *Seven leadership leverage points for organization-level improvement in health care* (2nd ed.). Cambridge, MA: Institute for Healthcare Improvement. (Available on www.ihi.org.)

typical in organizations implementing this model: building will and generating new ideas make the status quo uncomfortable, however, the execution of good ideas will make the future attractive. The IHI Framework for Leadership for Improvement includes 24 elements and provides a helpful perspective regarding the steps needed to achieve success in today's healthcare environment (see **Figure 1.1**)

IHI FRAMEWORK FOR LEADERSHIP FOR IMPROVEMENT

Healthcare reform in the United States will demand a different skillset from leaders to ensure ongoing success. Bolster and Larrere (2012) present six areas in which senior leaders will need to develop expertise in this new era: having political savvy, being influential, having the ability to lead during change, being adaptable, exhibiting excellent communication, and being a true visionary. All of these areas depend on the development of successful and effective interpersonal skills.

Models of Leadership

As mentioned previously, a model is a construct that helps us better understand and address a situation or environment. **Leadership models** can help us understand why leaders act the way they do and which leadership actions are most likely to lead to successful outcomes. Because different situations call for different leadership approaches, leaders must avoid getting stuck using only one type of model. Two well-regarded models that address common leadership challenges are the *Managerial Grid* and the *Four Framework Approach*.

Managerial Grid

The Managerial Grid, also known as the Leadership Grid, was developed by Blake and Mouton (1985), and it is based on two dimensions or axes, each of which has a range from 0 to 9: The axes are the extent to which there is a "concern for people/relationships," and the extent to which there is a "concern for results/production."

Data or observations collected for each leader are plotted on the grid (see **Figure 1.2**). Most leaders fall somewhere in the middle of the two axes (i.e., middle of the road). When we look at the extreme quadrants of the grid, however, we find four classic types of leaders:

- Impoverished—low concern for people and results
- Country Club—high concern for people, low concern for results
- Authoritarian—low concern for people, high concern for results
- Team Leader—high concern for people and results

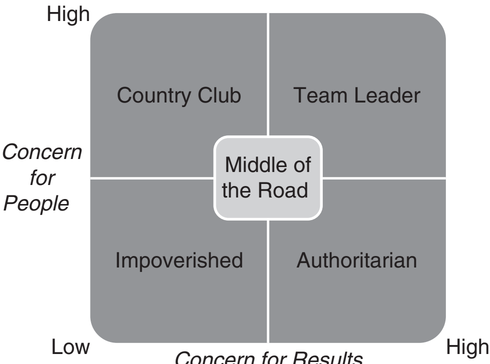


Figure 1.2 The Blake Mouton Grid

Source: Reproduced from Blake, R. R., & Mouton, J. S. (1970). The fifth achievement. *Journal of Applied Behavioral Science, 6*(4), 413–426.

Impoverished Leader

Leaders demonstrating this style detach themselves from their workforce and tend to allow their team or group members to do whatever they want. Lacking commitment to either group maintenance or task accomplishment, they generally "delegate and disappear."

Country Club Leader

Leaders demonstrating this style shy away from exerting authority or implementing disciplinary measures in the quest for improved outcomes because they fear jeopardizing the positive interpersonal relationships with their workforce. Instead, these leaders will almost exclusively use reward and recognition to encourage the team to accomplish its goals.

Authoritarian

These leaders are characterized by task orientation and a tendency to be tough with their group or team members. Authoritarian leaders will focus their energy on getting the work done at all costs and expect people to do exactly what they are told without questions. If something goes wrong, they are likely to "blame, shame, and train" in order to prevent the issue from occurring again. These types of leaders are intolerant of dissent and perceive it as disloyalty, making it difficult for their group or team members to comfortably contribute their valuable input.

Team Leader

These leaders strive to lead by example, foster a productive team environment, and encourage teams and individuals to achieve their highest potential. They constantly work at strengthening the bonds among team members and colleagues to promote successful outcomes and goal achievement.

The most desirable place to be on the grid is the Team Leader area. However, elements of the other leadership styles may sometimes be useful in specific situations.

Four Framework Approach

In the Four Framework Approach, Bolman and Deal (1991) propose that leaders frequently display leadership styles and behaviors that fit one of four types of frameworks: political, human resources, structural, or symbolic (see **Figure 1.3**).

This model suggests that leaders can be matched with one of the following four frameworks of leadership.

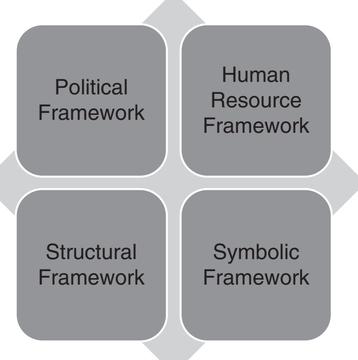


Figure 1.3 The Four Framework Approach

Source: Bolman, L., & Deal, T. (1991, Winter). Leadership and management effectiveness: A multi-frame, multi-sector analysis. *Human Resource Management, 30*(4), 509–534.

Political Framework

This leader is an advocate whose approach includes coalition building. Political leaders are clear and realistic about their goals, build connections with other stakeholders, determine distribution of power and interests, and use influence and persuasion before they resort to negotiation or coercion.

Human Resource Framework

This leader is a servant and advocate. Human resource leaders use an approach that is supportive and empowering; believes in people; is visible and accessible; shares information widely and encourages participation; and allows decisions to be made by relevant employees at all levels of the organization.

Structural Framework

This leader emphasizes analysis and design. Structural leaders serve as social architects to address issues, focusing on structure, strategy, environment, execution, and adaptation.

Symbolic Framework

This leader is inspirational and prophetic. Symbolic leaders view the organization as a theater in which they must communicate a vision to their audience. They play specific roles, use symbolism to create a setting or impression, and interpret and dynamically pitch the organization's potential future on behalf of its members.

In the healthcare industry, situations may arise in which one of the above frameworks or approaches may be more effective than another.

Successful leaders may be able to adopt aspects of a different framework to achieve a specific outcome.

UNDERSTANDING YOURSELF AND OTHERS: THE KEY TO SUCCESSFUL INTERPERSONAL SKILLS

The 6th century BCE Chinese philosopher Lao Tzu is known to have said, "He who knows others is wise. He who knows himself is enlightened." In no milieu is this adage truer than in the practice of leadership. How can one lead others if one is uninformed about, and unable to lead, oneself? The manner in which leaders engage in professional behaviors such as conversation, planning, problem solving, decision making, and a host of other leadership functions has profound effects on other individuals. Our personality and our environment influence our innate behaviors, but when behavior change is valuable in order to enhance leadership effectiveness, we are able to learn new skills and behaviors that will make us more productive and successful.

Before setting out to understand and work effectively with others, we must first strive to understand ourselves. We must become aware of our individual mental maps or models. Peter Senge (1990, p. 8) in his classic book, *The Fifth Discipline,* defined **mental models** as:

> . . . deeply ingrained assumptions, generalizations, or even pictures or images that influence how we understand the world and how we take action. Very often, we are not consciously aware of our mental models or the effect it has [*sic*] on our behavior.

Our mental model serves as a window, which frames (and sometimes distorts) the world we see (Osland, Kolb, Rubin, & Turner, 2007). We react in different ways because our "windows" show us different perspectives. One of the best ways to understand our own perspectives, reactions, and behavior is to identify our maps or models and become aware of our own beliefs, values, and expectations by using self-assessment instruments. These tools of self-discovery include instruments that assess characteristics central to leadership effectiveness such as learning style, personality, motivation, and **ethics**.

THE PSYCHOLOGICAL CONTRACT: MUTUAL EXPECTATION SETTING

When we enter into a personal or professional relationship, we aim for the relationship to have a strong foundation of trust. Trust allows us to develop integrity and credibility in our relationships. Employees joining an organization are establishing a professional relationship with their employer. This relationship starts with an implicit, unwritten **psychological**

contract. Psychological contracts are defined as a person's beliefs, formed by the organization, regarding the terms and conditions of a reciprocal agreement between people and their organization (Rousseau, 1995). The development of mutually agreed-upon expectations between the employee and employer, and stability and reciprocity in the professional relationship, promotes employee and organizational productivity.

Unfortunately, psychological contracts can be violated or broken. Broken contracts occur when one of the parties fails to meet the stated obligations or expectations. The result can be a negative impact on attitudes, behaviors, performance, and productivity.

Setting expectations can be a double-edged sword. Researchers have demonstrated a *Pygmalion Effect*—that is, "people perform in accordance with a rater's expectation of them" (Osland et al., 2007, p. 13). If a rater expects an employee to perform at a high level, the employee is likely to meet that expectation. Leaders may give highly rated employees more challenging assignments and provide the support and encouragement the individual may need to achieve the assignments successfully. On the other hand, if a rater expects poor performance, poor performance is more likely because the leader may interact negatively with the low-rated employee and not provide the support and direction necessary to succeed. Effective leaders seek to identify their perceptions, prejudices, and preconceived notions that could negatively influence interactions with their employees and take the necessary corrective actions to minimize potentially negative behaviors.

Understanding one's own theories of management and identifying one's personal leadership style is imperative in this self-development process. Effective leaders make every effort to analyze their skills, perceptions, and values; develop strategies to implement necessary changes; educate themselves in the areas and skills they need to master; practice newly learned skills; and obtain feedback about how well they are performing.

A method of managing psychological contracts is called the *Pinch Model* (see **Figure 1.4**), developed by Sherwood and Glidewell in 1972 and still in use today (Osland et al., 2007). This model describes the dynamic nature of these contracts and recommends ways to mitigate the negative consequences of changing expectations.

The Pinch Model

Osland and colleagues (2007) identify and describe the stages of this model as follows:

Stage 1—The first stage of an employee/employer relationship is characterized by the sharing of information and the subsequent negotiation of expectations of one another. If the individual or

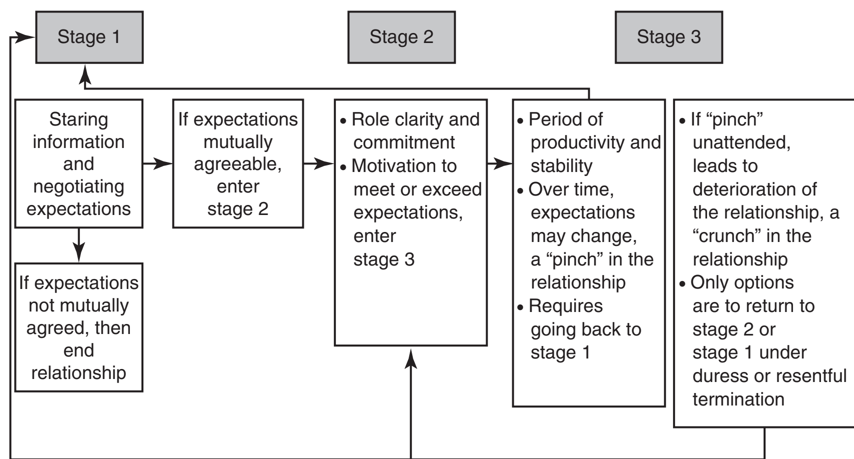


Figure 1.4 The Pinch Model

Source: Adapted from Sherwood, J. J., & Glidewell, J. C. (1972). Planned negotiation: A norm-setting OD intervention. In W. W. Burke (Ed.), *Contemporary organization development: Orientations and interventions* (pp. 35–46). Washington, DC: NTL Institute.

organization determines the expectations to be unreasonable, then they will deselect themselves from the relationship (i.e., "planned termination"). On the other hand, if both parties accept the mutually agreed-upon expectations, then they enter Stage 2.

Stage 2—The second stage allows the relationship to move to role clarity and commitment between the parties. Leaders and their employees accept and understand the roles each plays and are presumably motivated to meet or exceed those expectations. This process leads to Stage 3.

Stage 3—This stage is characterized by a period of productivity and stability in the relationship and allows for maximum energy to be dedicated to the work at hand. However, as in most relationships, with the passage of time, changes in expectations may occur due to intrinsic or extrinsic reasons. Sherwood and Glidewell (1972) call this a "pinch point" in the relationship and suggest that this is a warning sign to return to the first stages of the relationship to avoid disruption. When expectations change, one option is to renegotiate, meeting agreed-upon expectations. If renegotiation is successful, both parties will move through the stages of role clarity and stability once again. However, if renegotiation fails, one or both parties may decide to terminate the relationship.

Left unaddressed, a dissonance in shared expectations can lead to a deterioration of a professional relationship. Uncertainty or ambiguity can

eventually lead to anxiety and resentment. If this occurs, the relationship may respond via three options: (1) a return to Stage 2 by attempting to return expectations to the previous contract, (2) a return to Stage 1 by renegotiating expectations (under duress), or (3) termination of the relationship either administratively or emotionally.

The key to successful leadership is to be clear about mutual expectations and to manage those expectations just like any other important operational function or process.

INDIVIDUAL AND ORGANIZATIONAL LEARNING

A **learning organization** is one that is skilled at acquiring, creating, and transferring knowledge, and modifying its behavior to reflect this new knowledge and insight (Osland et al., 2007). Members of successful learning organizations are active adult learners. Kolb (1999) has postulated that adult learning is a cyclical process composed of four primary modes:

1. *Concrete experience* or learning by experiencing. This is a feeling mode that is characterized by responses to specific experiences, relating to people, and sensitivity to feelings.
2. *Reflective observation* or learning by reflecting. This is a watching mode characterized by observation before making judgments, viewing issues from varying perspectives, and looking for meaning in functions or events.
3. *Abstract conceptualization* or learning by thinking. This mode is characterized by the logical analysis of ideas, systematic planning, and the intellectually based responses to situations.
4. *Active experimentation* or learning by doing. This mode is characterized by taking risks, demonstrating the ability to get things done, and influencing people through action.

Most adult learners tend to favor one or more of these learning modes. Organizations can benefit by having members with different learning styles involved in problem solving and decision making. Leaders who identify their learning mode can better understand how they approach work-related issues and how they can best interface with others who use a different mode or style.

Personality

Personality has been defined as a person's consistent pattern of thought, behavior, and emotions, and the psychological mechanisms that drive and support those patterns (Osland et al., 2007). Effective leaders are aware of

their own personality traits and the traits of others, and understand the impact these traits may have on professional interpersonal relationships. Instruments such as the Myers-Briggs Type Indicator (MBTI) and Jung Typology are available for leaders to identify and learn about the components of their own personality as well as those of colleagues and employees. Both of these instruments suggest four components to personality:

- Extraversion/Introversion (E/I): how an individual interacts with society
- Sensing/Intuiting (S/N): how an individual collects information
- Thinking/Feeling (T/F): how an individual evaluates information
- Judging/Perceiving (J/P): how an individual prefers to make decisions

Effective leaders try to develop a robust picture of all the individuals with whom they work and attempt to understand their personalities and their "rules of engagement." They strive to analyze the causes of individual behaviors, remembering to observe specific characteristics such as motivation and skills, to be able to ensure that the "job, group, and organizational characteristics are exerting the intended consequences on behavior" (Osland et al., 2007, p. 90), and not triggering unintended negative outcomes.

Motivation

It is often heard that good leaders "motivate" others. This expression is frequently misunderstood to mean that motivation is something that is done by someone to someone else. Motivation is, in fact, an internal state, something within an individual that directs him or her toward certain goals and objectives. Motivation is facilitated by internal psychological forces that influence behavior, levels of effort, and levels of persistence (Osland et al., 2007).

It has been said that it is much better to light a fire within someone than to light a fire underneath them. The task of an effective leader is to understand, enhance, and guide the motivation employees already possess, and channel the motivation toward activities that further the goals and objectives of the organization. Effective leaders understand that the sources of motivation can be either intrinsic (e.g., the work itself) or extrinsic (e.g., economic rewards). Different people are motivated by different things; there are a variety of tools (i.e., Maslow's hierarchy of needs, McClelland's theory of motivation, Alderfer's ERG theory, etc.) available to determine people's motivators. The leader's role is to create an environment that encourages motivation by setting clear standards of performance and ensuring that there is a good "fit" between the needs of the employee and the position.

Determining what motivates an individual is not always an easy task. In addition to using the tools mentioned above, leaders can observe the individual in the work setting and discover what type of work or projects they enjoy. Face to face discussion, for example, during the performance appraisal or annual evaluation, can allow employees to provide leaders with feedback about their areas of interest for future assignments.

Ethics and Values

Healthcare leaders are frequently faced with ethical dilemmas that may challenge their decision making. These issues may include clinical challenges such as end-of-life care, queries regarding experimental research on human subjects, and operational questions about contractual and revenue-generating arrangements. Effective leaders have a responsibility to set the moral tone of an organization, should always strive to behave in an ethical manner, and should set clear expectations for subordinates and others to do the same. Standards or codes of ethical behavior have been clearly identified by professional associations such as the American College of Healthcare Executives (ACHE). Members of ACHE are accountable for adhering to codes of conduct that cover responsibilities to

- The profession of healthcare management
- Patients and others served
- The organization
- Employees
- Community and society
- Report violations of the codes

In addition, the ACHE has developed ethical policy statements that encompass such areas as leader–vendor relationships, reductions in force (layoffs), and health information confidentiality. The code of ethics and ethical policy statements can be viewed at www.ache.org/ABT_ACHE/code.cfm.

Much of a leader's behavior is rooted in his or her personal values, ethics, and moral reasoning. It is critical for effective leaders to understand their own value system and project their response to issues and situations that may arise. Values are defined as core beliefs that guide attitudes and actions. Terminal values are desired end-states or goals, either social or personal, that people would like to achieve. Instrumental values are preferable modes of behavior or means to achieving terminal values. There are two types of instrumental values: competence and moral. Osland and colleagues (2007) have identified an instrument titled the *Rokeach Values Survey*, which

can identify both instrumental and terminal values for self-exploration. Individuals are placed into one of four value orientation quadrants:

1. Preference for personal competence values
2. Preference for social competence values
3. Preference for personal moral values
4. Preference for social moral values

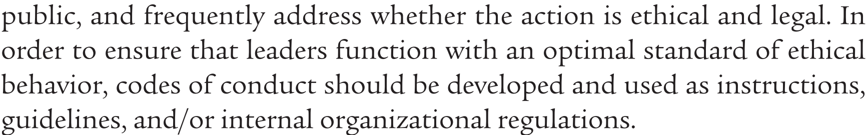
Ethics, on the other hand, refers to standards of conduct that "indicate how a person should behave based on moral duties and virtues arising from principles about right or wrong" (Osland et al., 2007, p. 146). An ethical framework that successful healthcare leaders adopt includes:

- Respect for persons
  - Autonomy (self-governing)
  - Truth telling
  - Confidentiality
  - Fidelity (duty)
- Beneficence
  - Refraining from actions that worsen a problem or cause negative results
- Nonmaleficence
  - First, do no harm
- Justice
  - Consistently apply clear and prospectively determined criteria in decision making

Effective leaders work at identifying and understanding different perspectives on issues and then discuss the benefits, risks, and consequences of alternative actions. One way to promote positive ethical practices is through the use of the Josephson Ethical Warning System (Josephson, 2002), which includes the following elements:

- Golden Rule—Are you treating others as you would want to be treated?
- Publicity—Would you be comfortable if your reasoning and decisions were to be publicized?
- Kid on your shoulder—Would you be comfortable if your children were observing you?

Healthcare organizations are launched with mission statements that ideally define their values, beliefs, and vision, which in turn determine the responsibilities of their leaders and stakeholders. After an organization makes a decision or takes action, the consequences are scrutinized by state and federal regulatory agencies, accrediting and licensing agencies, and the



public, and frequently address whether the action is ethical and legal. In order to ensure that leaders function with an optimal standard of ethical behavior, codes of conduct should be developed and used as instructions, guidelines, and/or internal organizational regulations.

Healthcare leaders can use resources such as the *American College of Healthcare Executives' Code of Ethics* for guidance regarding standards of behavior and ethical decision making. The Code can also be used as a basis for developing the organization's policies and performance metrics, and can serve as a teaching tool for colleagues, employees, and students.

Understanding yourself and others, and respecting and appreciating our differences, is key to effectiveness and success as a healthcare leader and should be a commitment that begins early in your career and continues throughout your professional life. Your efforts in this regard will ensure that your colleagues, clients, and communities will be "gifted" by your leadership.

SUMMARY

Health care in the United States is in a very exciting phase. The delivery system is rapidly changing due to a combination of government and market reform measures. These new platforms provide numerous professional opportunities for healthcare leaders with modern competencies. Use of best practices and development of skilled leaders are needed to assist the healthcare industry in meeting the challenge of improving access and establishing value through higher quality and lower costs. Today's healthcare leaders must seek to continuously improve the quality of their leadership and the quality of the services of their organizations. Critical to this process is active learning and ongoing self-assessment of one's ethics and values, and one's leadership and interpersonal styles and skills.

Discussion Questions

1. Can leadership be taught?
2. How have leadership theories changed over the last century?
3. Which competencies are most important for successful leadership during this era of healthcare reform?
4. Why is it important for leaders to "know themselves"?
5. What is the value of understanding mutual expectations?
6. When faced with an ethical dilemma, which approaches could a leader use to resolve the issue?

RELATED WEBSITES

American College of Health Care Administrators: www.achca.org
American College of Healthcare Executives: www.ache.org
American College of Physician Executives: www.acpe.org
American Organization of Nurse Executives: www.aone.org
CEO Checklist for High-Value Health Care: www.iom.edu/CEOChecklist
Complete Patient Protection and Affordable Care Act: http://docs.house.gov/energycommerce/ppacacon.pdf
Health and Human Services Summary of the ACA: www.healthcare.gov/law/provisions/index.html
Healthcare Financial Management Association: www.hfma.org
Medical Group Management Association: www.mgma.com

References

American College of Healthcare Executives (ACHE). (2012). *Competencies assessment tool.* Chicago, IL: Healthcare Leadership Alliance and the American College of Healthcare Executives.

Atchison, T. A. (2003). *Followership: A practical guide to aligning leaders and followers.* Chicago, IL: Health Administration Press.

Awo Osei-Anto, H. (2011). Preparing hospital and system leadership for change. *Hospitals and Health Networks, 85*(9), 62.

Bennis, W. (1989). *On becoming a leader.* Reading, MA: Addison-Wesley.

Blake, R. R., & Mouton, J. S. (1985). *The managerial grid III: The key to leadership excellence*. Houston, TX: Gulf.

Bolman, L., & Deal, T. (1991). *Reframing organizations*. San Francisco, CA: Jossey-Bass.

Bolster, C. J., & Larrere, J. B. (2012). The next great explorers. *Trustee, 65*(2), 19–21.

Buchbinder, S., & Shanks, N. (2012). *Introduction to health care management* (2nd ed.). Burlington, MA: Jones & Bartlett Learning.

Cosgrove, D., Fisher, M., Gabow, P., Gottlieb, G., Halvorson, G., James, B., . . . Toussaint, J. (2012, June 5). A CEO checklist for high-value health care. *Institute of Medicine of the National Academies.* Retrieved July 19, 2012 from www.iom.edu/CEOChecklist.

Gabow, P., Halvorson, G., & Kaplan, G. (2012, June 5). Marshaling leadership for high-value health care: An institute of medicine discussion paper. *Journal of the American Medical Association*. Retrieved July 19, 2012 from http://jama.jamanetwork.com/article.aspx?articleid=1172505.

Japsen, B. (2012, June 22). *Health leaders look to 2032 for opportunities to improve the health of the nation*. Robert Wood Johnson Foundation. Retrieved July 19, 2012 from www.rwjf.org/pr/product.jsp?id=74533.

Josephson, M. S. (2002). *Making ethical decisions* (2nd ed.). Los Angeles, CA: Josephson Institute of Ethics.

Katz, R. L. (1955). Skills of an effective administrator. *Harvard Business Review*, *33*(1), 33–42.
Kolb, D. A. (1999). *Learning style inventory*. Boston, MA: McBer and Company.
Manion, J. (2011). *From management to leadership: Strategies for transforming health care* (3rd ed.). San Francisco, CA: Jossey-Bass.
McDonough, J. E. (2012, July 5). The road ahead for the Affordable Care Act. *New England Journal of Medicine*. Retrieved October 7, 2012 from www.nejm.org/doi/full/10.1056/NEJMp1206845.
McLaughlin, D. B. (2011). *Responding to healthcare reform: A strategy guide for healthcare leaders.* Chicago, IL: Health Administration Press.
Osland, J. S., Kolb, D. A., Rubin, I. M., & Turner, M. E. (2007). *Organizational behavior: An experiential approach* (8th ed.). Upper Saddle River, NJ: Pearson Prentice Hall.
Reinertsen, J. L., Bisognano, M., & Pugh, M. D. (2008). *Seven leadership leverage points for organization-level improvement in health care* (2nd ed.). Cambridge, MA: Institute for Healthcare Improvement.
Rousseau, D. M. (1995). *Psychological contracts in organizations: Understanding written and unwritten agreements*. Newbury Park, CA: Sage.
Rubino, L. (2012). Leadership. In S. Buchbinder & N. Shanks (Eds.), *Introduction to health care management* (2nd ed.). Burlington, MA: Jones & Bartlett Learning.
Senge, P. M. (1990). *The fifth discipline: The art and practice of the learning organization*. New York, NY: Doubleday Currency.

Sherwood, J. J., & Glidewell, J. C. (1972). Planned negotiation: A norm-setting OD intervention. In W. W. Burke (Ed.), *Contemporary organization development: Orientations and interventions* (pp. 35–46). Washington, DC: NTL Institute.
Wachter, R. M. (2012). Why the Supreme Court's decision means a lot . . . and not so much. *The Governance Institute's E-Briefings, 9*(4), 1–2.