1

Leadership
An Elusive Concept

Leadership has to take place every day.
It cannot be the responsibility of the few, a rare event,
or a once-in-a-lifetime opportunity.

R. A. Heifetz and D. L. Laurie,
"The Work of Leadership"

No issue is as important in health care today as the development and continual evolution of leaders. "Leadership is the pivotal force behind successful organizations. . . . To create vital and viable organizations, leadership is necessary to help organizations develop a new vision of what they can be, then mobilize the organization to change toward the new vision" (Bennis and Nanus, 1985, p. 12). An organization's success is directly correlated to its leaders' strengths. The failure of an organization to develop leaders at all levels, relying instead on a few strong leaders at the top, results in dismal outcomes. In the foreword of Gifford and Elizabeth Pinchot's book *The Intelligent Organization* (1996b, p. x), Warren Bennis notes that "traditional bureaucratic organizations have failed and continue to fail, in large part, because they tend to rely exclusively on the intelligence of those at the very top of the pyramid."

In the same way, relying only on formal managers for leadership limits the tremendous possibilities that exist when leaders are differentiated from managers. "Solutions . . . reside not in the executive

suite but in the collective intelligence of employees at all levels, who need to use one another as resources, often across boundaries, and learn their way to those solutions" (Heifetz and Laurie, 1997, p. 124). Health care is facing a daunting challenge: the development of leaders and viable succession planning. After the 1990s "the leadership pool in health care is shrinking in part because companies continue to ruthlessly excise management positions—formerly training grounds for aspiring executives—in the race to become leaner and meaner" (Grossman, 1999, p. 18). And although these tactics may save money in the short term, the long-term costs to health care are significant in the absence of qualified individuals to move into executive and leadership roles.

Unfortunately, few people understand clearly the distinction between leadership and management; as a result, this narrows the field from which organizational leaders might emerge. In some instances, organizations do not recognize leaders who emerge from the ranks; they sometimes resist them and label them as troublemakers or dissatisfied employees. This chapter explores the concept of leadership, differentiates it from management, identifies reasons leadership is so critical in today's health care organizations, and illuminates the major challenges facing current health care leaders.

Defining Leadership

Defining leadership is the first step. Most authorities on the topic define *leadership* as influencing others to do what needs to be done, especially those things the leader believes need to be accomplished. Kouzes and Posner (2002, p. xvii) identify the leadership challenge as "how leaders mobilize others to want to get extraordinary things done in organizations." Max DePree (1989, p. xx) believes the art of leadership is "liberating people to do what is required of them in

the most effective and humane way possible." This definition implies that leadership is not something one does to or for the follower but is instead a process of releasing the potential already present within an individual. The leader sets the stage and then steps out of the way to let others perform. True leadership enables the follower to realize his or her full potential—potential that the follower perhaps did not suspect.

Also implied in any definition is that leadership is work. It is about performance: achieving outcomes, getting needed results. Peter Drucker (1992, p. 199) says that "it has little to do with 'leadership qualities' and even less to do with 'charisma.' It is mundane, unromantic, and boring. Its essence is performance." Kouzes and Posner (2002, p. 13) reinforce this message: "Leadership is not at all about personality; it's about practice."

Leadership is mobilizing the interest, energy, and commitment of all people at all levels of the organization. It is a means to an end. "An effective leader knows that the ultimate task of leadership is to create human energies and human vision" (Drucker, 1992, p. 122). Bardwick (1996) clearly states that leadership is not intellectual or cognitive but emotional. She points out that at the emotional level, leaders create followers because they generate "confidence in people who are frightened, certainty in people who were vacillating, action where there was hesitation, strength where there was weakness, expertise where there was floundering, courage where there were cowards, optimism where there was cynicism, and a conviction that the future will be better" (p. 14).

Noted leadership scholar and author Warren Bennis, who has spent over three decades studying leaders, describes the leader as "one who manifests direction, integrity, hardiness, and courage in a consistent pattern of behavior that inspires trust, motivation, and responsibility on the part of the followers who in turn become leaders themselves" (Johnson, 1998, p. 293). Furthermore, he offers three key ingredients for successful leadership (Bennis, 1989):

- A clear vision of what needs to be accomplished
- Passion or an intense level of personal commitment
- Integrity or character

None of these are teachable by the methods often used for leadership development, such as reading or attending seminars and formal educational courses. However, all three can be learned or perfected through life's experiences. For most people, the development of leadership ability is lifelong work—a trial-and-error method of perfecting techniques and approaches, the evolution of personality and individual beliefs. Often the leader is not even aware of exactly how he or she influenced a follower. An opportunity or need to lead appeared, and the leader stepped forward to meet the challenge.

Harry Kraemer (2003, p. 18), as chairman and CEO of Baxter Healthcare, believes that the best leaders are "people who have a very delicate balance between self-confidence and humility." They are both self-confident and comfortable expressing their ideas and opinions, but they balance this expression with a healthy dose of humility and an understanding that other people may actually have better ideas and more insight on any given issue. And perhaps most telling are the results of research conducted by Jim Collins and his associates (2001), who studied extensively the difference between good companies and compared them to similar companies that had achieved greatness. Although Collins told his research team specifically not to focus on leadership at the top, the analysis revealed that leadership was a key factor for those companies with extraordinary success. The type of leadership was a shocking surprise to the researchers. They found that the characteristics of these successful leaders did not include high-profile personalities and celebrity status but just the opposite: "Self-effacing, quiet, reserved, even shy—these leaders are a paradoxical blend of personal humility and professional will. They are more like Lincoln and Socrates

than Patton or Caesar" (p. 12). Their ambition is first and foremost for their organization, not for themselves.

Differentiating Management and Leadership

How does leadership differ from management? Most would agree that not all managers are good leaders and not all leaders are good managers. However, differentiating between these two concepts concisely and concretely is difficult. A common misconception is that the legitimate authority of a position, such as holding a management job or an elected position, automatically confers leadership skills on the person holding that position. Nothing is further from the truth. Leadership and management are two separate and distinct concepts, although they may exist simultaneously in the same person. In an interview (Flower, 1990), Bennis compares management and leadership on several key points. As we will see, his viewpoint greatly increases clarity about these two concepts.

Efficiency Versus Effectiveness

The first differentiating point is related to the essential focus of the individual. A manager is concerned with efficiency, getting things done right, better, and faster. Increasing productivity and streamlining current operations are important, and managers often exhort employees to work smarter, not harder. In contrast, a leader is more concerned with effectiveness, asking: Are we doing the right thing? The initial question is not "How can we do this faster?" but "Should we be doing this at all?" To answer the latter question, a key deciding factor is whether the activity in question directly supports the organization's overall purpose and mission. Is the activity in alignment with the stated values and beliefs of the organization and the people within it? Will it produce desirable outcomes?

A classic example of this difference occurred some years ago in a 480-bed midwestern medical center. As the hospital's volume increased over the years, traffic flow on the elevators became a major

problem. Several process improvement teams attacked the problem at various times but came up with no lasting or truly effective solution. After years of frustration, a team assigned to this issue finally came up with a solution that involved building a new set of elevators for patients only. The intent was to move patients faster and more efficiently, a goal the medical center accomplished for several hundred thousand dollars.

A couple of years later, the organization went through a major reengineering and work-redesign effort. The first questions were the following: Why are we transporting patients all over the organization? Can we deploy any services to the patient-care unit to reduce the distance that patients travel? These are leadership questions; instead of asking how to move patients faster, the project team asked: Should they be moved at all? How can we reduce movement of patients? In fact, today new health care facilities are being built based on the concept of the universal room: the patient is admitted to a room and remains assigned to that room throughout the entire hospital stay. The level of care may change depending on the patient's needs, but the location of the patient does not.

How Versus *What* and *Why*

A second differentiating characteristic is that management is about *how,* whereas leadership is about *what* and *why*. A good manager is usually one who understands the work processes and can demonstrate and explain to an employee how to accomplish the work. Health care, which has a history of promoting people with job expertise to management and supervisory roles, clearly values these phenomena. The highly skilled practitioner becomes a manager, and overall this is the typical pattern regardless of the department or discipline in question. Health care workers tend to value job expertise in their managers and, in fact, often show disdain for the manager who cannot perform at a highly competent level the work of the employees they manage. This is understandable when we examine health care's history. Early hospitals were led and managed

by individuals with a high level of technical clinical expertise (physicians and nurses). Only in recent decades have a significant number of executives and managers with nonclinical backgrounds entered health care institutions. Some clinical health care workers today still doubt that individuals with nonclinical backgrounds can possibly understand enough to be effective leaders in health care organizations.

Knowing and controlling work processes are essential components of the managerial role—and rightly so. Management's origins were in the factories of the industrial age. The workforce of the late 1800s was very different from today's workforce. Most early factory workers were newly arrived immigrants, women, and children—poorly informed, uneducated, non-English-speaking, and uninvolved employees—working for survival wages. The work was compartmentalized, broken down into small manageable pieces that one person could easily teach to these early workers. The manager was responsible for ensuring that employees did the work correctly and was often the only person who understood the entire piece of work.

In contrast, a leader focuses on what needs to be done and why. He or she spends more time explaining the general direction and purpose of the work, and then the leader gets out of the way so that the follower can do it. Someone once characterized a leader as an individual who describes what needs to be done, then says, "It's up to you to impress me with how you do it."

This implies several different points. First, the leader knows what needs to be done and can clearly articulate this to others in a way that convinces the follower(s) that it is an appropriate direction. Second, the leader has the patience to share the reasons this course has been chosen and ensures that those reasons are acceptable and valid to the follower. Finally, the leader accepts that the follower may find a new and different way to accomplish the goals. The leader is not wedded to his or her way of performing a task or carrying out a responsibility.

Multiple examples of this leadership approach appeared in the 1990s in organizations undergoing major work-redesign or restructuring initiatives. In one medical center, the CEO addressed employees before redesigning work was begun, explaining the organization's current status, the external environment, and the reasons the board of trustees and executive team believed work redesign was necessary for the organization's future viability. The reasons were clear; in most instances, the employees viewed them as important and valued them. A team of employees was then formed that was instrumental in determining how to achieve results and carry out the project. In other organizations, work redesign has failed because it was undertaken with only a hospital-oriented mentality—a controlling leader who believed there was one right way to achieve needed outcomes—rather than a systems approach. Employees may have participated, but they did not believe in or value the reasons behind the project.

Structure Versus People

In contrast, Bennis (Flower, 1990) points out that management is about systems, controls, procedures, and policies—all of which create structure—whereas leadership is about people. Managers spend much of their time dealing with organizational structure. Anyone who has successfully participated in an accreditation visit by an outside agency has a sense of the number of policies and procedures that the average health care institution generates. There is usually a policy or procedure for every aspect of organizational and professional life. Infection control monitoring, risk management reporting, and patient-complaint resolution are only a few among the multitude of control systems designed to oversee organizational processes. These systems ensure that work is progressing as expected; they are designed to alert the manager to any deviation so that it can be investigated and corrected. Extensive policies and procedures, however, can sometimes be used to substitute for employees' good judgment and initiative in decision making. Relying heavily on the use of written

policies and procedures can inadvertently weaken the development of individual decision making in the organization.

Leadership is about people and relationships. Leadership only exists within the context of a relationship. If there are no followers, there is no need for leadership, just independent action. Leadership occurs when leader behavior influences someone else to act in a certain manner, and at the core of such a connection between people is trust. Chapter Two explores these concepts in depth. Leadership as a relationship may be disturbing news for managers who have limited people or interpersonal skills, for an individual who has difficulty in working with others will find it virtually impossible to become a fully effective leader. A book on policies and procedures cannot replace this key relationship. Fortunately, an aspiring leader can develop and hone people skills, but maintaining them takes more energy if they are not part of the individual's natural talent base.

Status Quo Versus Innovation

Whereas maintaining and managing the status quo are appropriate managerial behaviors (Bennis, 1989), leaders are more concerned with innovation and creating new processes for the future. This is a difficult area for many health care leaders because most health care organizations have not customarily encouraged or highly valued either creativity or innovation. The words are frequently used and appear in many mission statements, but only rarely are health care organizations flexible and fluid enough to encourage true innovation. Most are bureaucratic structures that respond to any deviation from standard practice as something to stamp out, control, or limit in some manner.

Punitive responses to mistakes are common, and many managers have learned not to rock the boat or deviate in any significant way. The incident-reporting mechanism is a common example. If an employee reports making a mistake, a familiar response is for the manager to determine what went wrong and how the employee

needs to change so that the mistake never occurs again—a return to the status quo. Less frequent is a response that investigates the mistake in partnership with employees to determine why the mistake occurred and what needs to change in the system so that the problem does not occur again. Recent emphasis on patient safety and the quality process has stimulated a move toward more creative problem solving and resolution without placing blame.

Leaders are always looking for ways to improve the current situation; they are never satisfied with the status quo. A leader's automatic response to a problem or mistake is to consider ways to capitalize on the opportunity that the mistake has created. For this reason, Bennis points out, "bureaucracies tend to suppress real leadership because real leaders disequilibrate systems; they create disorder and instability, even chaos" (Flower, 1990, p. 62).

Because a leader trusts people, he or she knows that the follower can always find a way to improve on the current situation. DePree (1989) describes highly effective leaders as those who are comfortable abandoning themselves to others' strengths and admitting that they themselves cannot know or do everything. This can be frightening to those who are not up to the challenge of continually questioning their own performance or established practices. Fearful individuals may react to this drive for continual improvement as implied criticism: "It was not good enough, and now we have to change it."

Bottom Line Versus Horizon

Managers keep their eyes on the bottom line; leaders focus on the horizon. Managers ask: Are we within budget? Are we meeting our goals? What's the deadline? The manager's emphasis is on counting, recording, and measuring to ensure that everything is on target. It is easy to forget that many things that count—that are important—cannot be counted.

By its very nature, leadership and its results are difficult to measure. How do you measure a relationship? What are the concrete, observable outcomes of a healthy working relationship? How do you

evaluate the success of an inspiring vision? Good leaders see beyond the bottom line to the horizon, where a vision of a different future for themselves and their followers guides their day-to-day decision making. This vision inspires them to make very difficult decisions on behalf of the organization and the people within it.

A leader with a vision of empowered employees who feel ownership of their jobs, who make decisions affecting work in their span of control, and who work in partnership with the organization's managers knows that in order to attain this vision, the employees will need continual learning opportunities. In many organizations today, employees are being asked to contribute more, learn additional skills, and take on more responsibility at the same time that their organizations have severely reduced education departments and learning resources. Leadership decisions to invest in employee education may not look good on the bottom line, but they are at the core of the vision of the future. Exemplary leaders recognize that organizations that do not invest in the development of internal staff resources now will have to pay a much higher price in the future.

Another simple example of the difference between focusing on results and paying attention to the future payoff is evident when we observe leaders who become actively involved in coaching their employees for improved performance. If an employee is having difficulty with a key vendor, people in another department, or perhaps a physician, a manager may tend to use his or her legitimate authority to solve the problem. Coaching and supporting the employee in solving the problem directly may be more time-consuming and riskier. However, this leadership approach creates stronger, more effective employees; and the payoff is in the future because employees learn how to handle their own problems.

Management Versus Leadership: A Final Word

That there is a difference between management and leadership is clear. None of this is to imply, however, that there is not a need for good, capable managers in today's health care organizations. Managers will

always be needed, and the role is so crucial that everyone in the organization must share managerial responsibilities. Highly efficient employees who understand their work, who are able to organize and structure it, and who can measure outcomes and take corrective action will always be in high demand. With a greater number of experienced and mature workers in health care today, organizations place higher expectations of employees than ever before. As more employees become self-managing, organizations may reduce the number of formal managers. At the same time, however, there is an increasing need for leaders. According to many recognized students of U.S. leadership, organizations in this country have been overmanaged and underled (Bennis and Nanus, 1985; Kouzes and Posner, 2002; Peters, 1987).

Why Leadership Is in Demand Today

During the 1970s health care organizations had a burgeoning interest in management development programs. Recognition that promoting technically competent employees into management positions produced a responsibility on the part of the organization to provide management and supervisory training and education. In the 1990s there was a shift in all sectors of our society to emphasize the importance of leadership skills. The number of titles about leadership in a popular bookstore reflects this emphasis. A search on amazon.com produces over seventy-eight thousand hits; and when the search is narrowed to health care, the hits number over fifty-four thousand. Why this focus on leadership? Why the need to differentiate it from management? There are at least three major reasons:

- The unrelenting crush of change
- Rapidly shifting paradigms
- Survival

Change

Change has been the byword since the early 1990s, for almost fifteen years. Never has the pace of change been so fast, nor have the changes altered so deeply the way people live and work. "The change and upheaval of the past years have left us with no place to hide. We need anchors in our lives, something like a trim-tab factor, a guiding purpose. Leaders fill that need" (Bennis, 1989, p. 15). Fundamental changes in health care are occurring so rapidly that it is hard to keep pace. What we all believed to be significant organizational changes in the 1980s—revised job descriptions, new management positions, novel performance appraisals—pale by comparison to today's changes, such as new locations for services, specialty or niche hospitals, distance medicine, virtual patients, health care on the Internet, replacing employees by automation, outsourcing, cross training of skills, forming partnerships within the community, simultaneously collaborating and competing with the same entity, and merging with other organizations or developing an entirely new system. Annison (1994, p. 1) states the case clearly: "During periods of stability we can be successful by doing more of what we already do; the focus is on management and maintaining the present. During periods of change, the emphasis is on changing what we do and the focus is on leadership."

Shifting Paradigms

Paradigms, or the models through which we view the world, are rapidly shifting. Barker (1992, p. 37) describes it this way: "A paradigm shift, then, is a change to a new game, a new set of rules." This shift creates confusion and unease as well as new possibilities. In some instances, a player in the health care sector changes the paradigm, whereas in other situations the impetus comes from without. The rules and game plan may suddenly change, leaving those in the game to figure out the new rules.

Competition in health care is a good example of a paradigm that continues to shift. Not so long ago, the major competitor for a hospital was the other hospital in town, just down the road. Today competition comes from everywhere: stand-alone health care facilities, such as ambulatory-care centers, specialty hospitals and services, and diagnostic centers in physician offices; hospitals from other communities that set up satellite or full-service facilities outside their originating communities; and even previous customers who decide to become providers on a limited basis.

The lines and boundaries are no longer clear. As the business world has demonstrated, one must sometimes collaborate with close competitors (Annison, 1997). Consumers buying an Apple computer may be purchasing a machine manufactured by Toshiba; MasterCard and Visa collaborate on automatic teller machines and choose to compete on marketing and customer service. Similarly, in health care, two hospitals from competing systems have jointly built a wellness facility in their community; and a major medical center has partnered with a large clinic-based physician practice on several joint projects while competing with it on several others.

Times of great change and rapidly shifting paradigms call for leaders. As Barker (1992, p. 164) points out: "You manage within a paradigm. You lead between paradigms." When times are stable and game rules remain consistent and known, structures, standards, and protocols enhance the manager's ability to optimize the paradigm. In fact, this describes the manager's job exactly. However, during a shift to new paradigms, leadership is required, as Barker explains: "Leaving one paradigm while it is still successful and going to a new paradigm that is as yet unproved looks very risky. But leaders, with their intuitive judgment, assess the seeming risk, determine that shifting paradigms is the correct thing to do, and, because they are leaders, instill the courage in others to follow them" (p. 164).

When paradigms shift and the rules change, everyone involved goes back to zero. Put simply in the words of a colleague: "What got you to the party won't keep you there!" It is time to let go of

past successes and look for new ways of doing things. There is no guarantee that the organization, group, or individual that was very good with the old game rules will be as good with the new ones. In fact, the more successful the individual or organization was with the old model, the more difficult it is to engage in a new way of thinking.

One of the major leadership gaps that market research for this book identified was a refusal to let go of the hospital mentality and traditional modes of service. Potential consequences of this pitfall include the following:

- Belief that past or current success automatically leads to future success
- Reluctance to make changes rapidly enough to successfully adapt to the changing external environment
- Overreliance on internal expertise and past experience
- Aversion to risk sharing with physicians and key stakeholders and risk taking by executives and board members
- Attempts to control and dictate community health initiatives rather than collaborate with community stakeholders

This issue is easy to talk about but difficult to deal with when we are faced with a shifted paradigm. During a team retreat for surgical services leaders, initial discussion revolved around changes the team and service were experiencing. The anesthesiologists were especially upset because, with increasing managed-care penetration in their community, surgery was for the first time being considered a cost center rather than a revenue source for the organization. In their words, "We used to be able to get whatever we wanted; now we're being seen as a drain on the resources of the organization." This leadership team needed to figure out how to be successful with the new game rules in order to continue to thrive.

Survival

The final and perhaps most important reason that we need leadership today is simply survival. Bennis (1989) reported the work of a scientist at the University of Michigan who examined and listed what he considered to be the ten basic dangers to our society, factors that he believed were capable of destroying the human species. The top three are

A nuclear war or accident, capable of destroying the human race

A worldwide epidemic, disease, famine, or financial depression

The quality of management and leadership in our institutions

There was probably no clearer example of the importance of leadership in our world as during the immediate aftermath of the devastating terrorist attacks in this country on 9/11. The actions and decisions of our national leaders were crucial. Hasty and reactive actions could have led to even more devastating results. The quality and importance of leaders who emerged was striking.

Leaders are responsible for an organization's effectiveness. As an industry, health care is vulnerable as a result of regulatory changes, technological pressures, globalization, the litigious mind-set, changing demographics, and environmental challenges. Strong leadership is needed to take us into a very uncertain future. Pinchot and Pinchot (1996a, p. 18) eloquently describe the need for leaders: "The more machines take over routine work and the higher the percentage of knowledge workers, the more leaders are needed. The work left for humans involves innovation, seeing things in new ways, and responding to customers by changing the way things are done. We are reaching a time when every employee will take turns leading. Each will find circumstances when they see what must be done and must influence others to make their vision of a better way a reality."

Finally, the role of leaders as it influences organizations' integrity is crucial. "There is a pervasive, national concern about the inte-

grity of our institutions. Wall Street was, not long ago, a place where a man's word was his bond. The recent investigations, revelations, and indictments have forced the industry to change the way it conducted business for 150 years. Jim Bakker and Jimmy Swaggart have given a new meaning to the phrase 'children of a lesser God' " (Bennis, 1989, pp. 15–16). Although Bennis wrote those words years ago, they seem almost prophetic. In the last few years, Americans have become almost inured to corporate scandal and wrongdoing. The collapse of Enron, Arthur Andersen, and WorldCom are just samples in what seems to be a never-ending parade of corporate corruption. Many Americans now fully expect that people in leadership positions who lack personal and professional integrity will lie and cheat.

Health care is not immune to the issue of integrity. Hospital executives indicted for Medicare fraud, home health agencies led by criminals previously convicted of fraud, a cardiovascular surgeon falsifying information and performing hundreds of clearly unnecessary surgeries, a pharmacist diluting chemotherapeutic agents to increase profit, executives at a well-known rehabilitation company indicted for illegal practices, or a community hospital's senior executives convicted of embezzlement—all have made the headlines in recent years. Never has the need for ethical, exemplary leaders been more crucial as we face the challenges of the next century.

Challenges Facing Today's Leaders

Today the opportunities and possibilities for leaders are endless, as are the challenges. Demands are different for today's leaders and have ramifications for anyone aspiring to lead others. The more a leader understands these issues, the more likely he or she can find the necessary strength and courage to meet the test that these challenges present:

- The rapidity of change
- Workforce shortages
- The rise of the free-agent mentality

- Diversity in the workforce
- New organizational structures
- Turbulent business environments
- The leader's energy capacity

The Rapidity of Change

Change is occurring at an accelerated pace today, and change experts assure the public that the rate of change will continue to increase through the end of this decade. According to Connor (1993, p. 39), change in previous eras was different in magnitude and pace, the approach required, the increasing seriousness of its implication, and the short shelf life of solutions: "In tumultuous environments, every solution brings more complex problems, not worse necessarily, but ones requiring more creative approaches. For example, the world is not worse off because of the invention of the computer. But even with all the good that these machines have provided, information systems have complicated our lives in unforeseen ways." It can be discouraging when a leader realizes that today's solution may become tomorrow's problem. Leaders know that the current change simply brings you closer to the next one.

Change takes energy; and as we experience more change, it can feel like an endless energy drain. Because influencing others positively when we are exhausted is difficult, leaders must take good care of themselves during changing times and manage their energy wisely (Loehr and Schwartz, 2003; Cox, Manion, and Miller, 2005). Not all changes are for the better, and a leader is challenged to remain optimistic and enthusiastic yet truthful. This can be arduous in the face of personal discouragement. As Connor (1993) describes it, effective leaders have a high degree of resilience in their ability to demonstrate courage, strength, and flexibility in the face of change and frightening disorder.

Sometimes the challenge for a leader lies in determining which changes to make and which to forgo. It is easy to become swept up

in the tide of change and go overboard. Many leaders find change exhilarating and forget that the organization's ability to sustain a certain pace of change may not match the leader's capacity for change. Winston Churchill said, "When it is not necessary to change, it is necessary not to change" (Curtin, 1995, p. 7). This sage advice is easy to forget when all the changes look positive. The knack of looking beyond the initial excitement and potential promise to determine whether the change is necessary and beneficial is a leadership skill worth developing.

A community hospital undergoing a major restructuring and work-redesign effort provided an unintended example of this tendency to get caught up in unnecessary change. As the hospital restructured departments, management asked clinical employees to reapply for their positions. There was concern that the secretaries and executive assistants in the organization would not have the same opportunity (yes, it was considered an opportunity). As a result, all employees in secretarial positions were allowed to apply for a transfer into any position for which they were suited. The outcome was an extreme version of "fruit basket upset." The secretary for the behavioral health department transferred to education; the education secretary went to human resources; the human resource secretary transferred to purchasing; the infection control secretary went to administration; and so on. The result was mass confusion and significantly decreased effectiveness in the organization for a good six months while these people were being oriented—all for what was, in the end, unnecessary change.

Peter Drucker talks about this same issue (Flower, 1991, p. 53), but he refers to it as being effective. He says the leader has to sometimes say no: "The secret of effectiveness is concentration of the very meager resources you have where you can make a difference." Thus, the leader's role is to carefully assess what changes are most important and likely to help achieve the organization's goals and attain its vision while avoiding the energy drain of nonessential change.

Every major sector of society is undergoing massive change. The entire structure of health care is changing. A book edited by Chawla and Renesch (1995) found factors at work requiring critical shifts in thinking by health care leaders, factors such as the following:

A shift from fee-for-service to discounts and capitation, in which providers are responsible for quality and cost

A shift from inpatient acute-care to outpatient services, requiring health care leaders to rethink traditional hospital boundaries, investments, and relationships with key stakeholders

The rise of primary care physicians as gatekeepers and care managers in a capitated environment

A shift from a discipline-centered production organization to a customer-focused service orientation

A shift from an illness and disease model to a wellness paradigm with a focus on alternative or complementary medicine

Along with this challenge is the fact that many people are in transition. The word *change* means to alter or make something different. *Transition* is the psychological adaptation to change and is not over until the person can function and find meaning in the new situation (Bridges, 1991). If a transition has occurred, something has been lost, even if it is as simple as loss of comfort with the old way. Thus, stages of transition include stages of grief, which engender some of the most difficult emotions humans face. People often experience and express anger, depression, anxiety, fear, and just plain contrariness. Trying to lead people who are grieving is fraught with difficulties and can tax even the most proficient leader.

These emotions are complex enough to face in an individual, much less when multiplied by hundreds and even thousands in an organization. Understanding where people are in their emotional cycle helps prevent inappropriate or unhelpful responses. The fact that they may all be in different places at the same time makes the

challenge more intense. Adding to the complexity is the fact that the leader may be feeling some of these difficult emotions as well. Chapter Five explores the transition process in more detail.

Workforce Shortages

The large number of baby boomers nearing retirement age and the declining numbers of younger workers entering health care is rapidly reaching a crisis point. This challenge is surfacing as one of the most difficult in this decade and is likely to remain a paramount concern for many years into the future. A poll of hospital CEOs by the American Hospital Association (2001) found that 72 percent of respondents identified workforce shortages as one of the top three concerns. Demographics alone tell us that workforce shortages are not just a temporary challenge but part of the landscape for many years to come.

"Never before have organizations paid more attention to talent . . . keeping it. Stealing it. Developing it. Engaging it. Talent is no longer just a numbers game; it's about survival" (Kaye and Jordan-Evans, 2002, p. 32). Workforce shortage issues are not limited to one discipline nor one job category in our organizations but cut across all boundaries. Although the literature often focuses on the cost of turnover of higher-paid professionals such as pharmacists, nurses, and physical therapists, a significant cost is also associated with the turnover and vacancy of workers in positions such as housekeepers, dietary aides, and nursing assistants. This cost may be lower per individual, but the sheer number of these workers employed in the average health care organization makes the cost almost prohibitive. A recent study of long-term care organizations reported turnover rates of nurse aides near 100 percent annually. This represents a tremendous cost to the organization, one that far exceeds the financial impact.

The stability and quality of the workforce is directly linked to better outcomes and higher-quality services in our organizations (Aiken, Clarke, and Stone, 2002; American Hospital Association,

2001; Batcheller and others, 2004; Gelinas and Bohlen, 2002; Unruh, 2004). Although recruitment of talented individuals into health care is an important strategy, it is clearly not adequate. Not only are pools of possible workers smaller, but the competition is greater because of the wide variety of career and vocational options that are available to people today. Health care no longer offers the same level of security that it did in the past. In addition to the loss of job security, safety concerns and stress are major issues today (American Nurses Association, 2001; AbuAlRub, 2004).

The challenge for today's health care leader is to create positive work environments that not only attract high-quality candidates but retain them. And although people seldom join an organization today with the intent of remaining in its employment throughout their career, simply extending the length of tenure of high-quality employees by several years can have a positive impact on vacancy and turnover rates.

The Rise of the Free-Agent Mentality

In the earliest days of modern organized health care, hospitals operated with student nurses and perhaps a limited number of professional nurses. Other specialized workers did not exist. Patients or their families employed graduate nurses as independent contractors. They functioned as free agents rather than as employees of the organization.

This mirrors a fundamental shift in work life that is occurring across the United States today and affecting people in unexpected ways. The shift is away from the job as a concept. William Bridges, author of several best-selling books, including *Transitions*, *Managing Transitions*, and *Surviving Corporate Transition*, describes this concept in his book *JobShift* (1994a). He notes that the concept of a job was only invented at the beginning of the industrial revolution, when people went to work in factories. With the decline of manufacturing and the evolution of the information age, the very concept of the job as we knew it is disintegrating.

"As a way of organizing work, [the job] is a social artifact that has outlived its usefulness. Its demise confronts everyone with unfamiliar risks—and rich opportunities" (Bridges, 1994b, p. 62). This trend is disturbing to many people who have remained in a long-term employment setting their entire work life. It is difficult to conceive of a dejobbed health care organization, and yet many examples are already apparent. With growing workforce shortages and the increasingly stiff competition between organizations for qualified employees, health care workers are more likely to move among organizations for their employment. There is an increase in outsourcing and use of consultants and independent contractors. Part-timers outnumber full-time employees in some organizations; it's not uncommon to have employees with two to three jobs; and the consistent use of per diem or registry staff is expanding to disciplines beyond nursing. These are all examples that support this trend toward dejobbing health care.

Although it is unlikely that health care will ever be completely dejobbed (Flower, 1997), this trend does have implications for leaders. "The main impact is . . . that tomorrow's leadership is going to have to be able to activate and focus the efforts of people who lack long-term connections with or loyalty to the organization. You don't lead a group of freelancers the way you lead long-term employees" (Bridges, 1995, p. 5). Influencing these people and getting commitment from them is much tougher than when the employees' connections to the organization were stronger.

Closely related to the dejobbing challenge yet somewhat different is the altered contract that organizations have with their employees. Not so very long ago, when an institution hired employees, the implication—and reality—of the agreement was that as long as the employee completed work according to expected standards, the employee retained the job. Even in the face of economic downturns, health care workers enjoyed fairly high job security. Not so anymore. There are no longer guarantees of any kind but instead what author David Noer (1993, p. 13) describes as a new employment contract: "This psychological contract fits the new reality. It says

that even the best performer or the most culturally adaptive person cannot count on long-term employment. It replaces loyalty to an organization with loyalty to one's work."

Examples of this abound in health care since the early 1990s. Even employees with long-term employment in an organization have found themselves suddenly and inexplicably out of a job. In one case, a director of staff development attended a professional seminar on a Friday; the topic was dealing with change in the workplace. When she returned to work the following Monday, she learned that she needed to decide by noon which two employees she would choose to eliminate or lay off. At one o'clock she learned that she would be reporting directly to the vice president of human resources because the director of education (to whom she usually reported) had been eliminated. None of these employees was doing a bad job; the organization had simply eliminated the positions because it had experienced a significant financial downturn and viewed these job cuts as a way to reduce expenses.

Another organization eliminated several long-term, excellent employees when it outsourced their function in the human resource department. In yet another organization, the vice president of human resources helped lead the "rightsizing" campaign—only to discover that the last position to be eliminated was his own! In the 1990s many organizations consolidated management positions and eliminated people even though they were contributing and highly committed employees. Entire categories of positions were eliminated, such as supervisors, clinical nurse specialists, lead technicians, assistant managers, clinicians, and charge nurses, to cite a few examples.

Not all of these changes were bad; perhaps they reflected the beginning of a transition to a more fluid, flexible organization of the future. However, the end result is a clear understanding within the hearts of health care workers that the job is not sacred, that they too can be eliminated at the whim of organizational need. And fortunately or unfortunately, many of these organizations found that you can eliminate

people much more easily than the actual work; and they have since found it necessary to reinstate these or similar positions. All this leaves employees questioning whether leaders actually know what they are doing when they make some of these sweeping decisions.

This disruption in employment can also be healthy for the industry as a whole. Noer (1993) believes that the past model sustained an unhealthy, outdated organizational codependency. It was not unusual for employees to depend on the organization for far more than a job or a way to earn a living. It was similar to the old company store mentality, and employees expected the organization to provide everything: a network of friends, a social life, recreational opportunities, education support, and health care benefits.

"This battle is among the most important struggles that we and our organizations have ever faced. Individuals must break the chains of their unhealthy, outdated organizational codependency and recapture their self-esteem; organizations must achieve their potential and thrive in the new world economy. For the organization, holding on to the familiar old is not the answer" (Noer, 1993, p. 4). And, for the individual, holding onto the job is not always the healthiest option.

Noer's advice (1993, p. 15) is striking: "The only way you provide security for yourself is by making sure that your work experience is as up-to-date as possible so that if tomorrow happens, you are able to go out and get another job because you have skills people want. That's the only way you have security. You aren't going to get it from the company. It will never be that way again." He perfectly describes the free-agent mentality that the health care employee needs today.

This new employment contract has significant ramifications for health care leaders. These chains of organizational codependency can be as difficult to break for those who have provided these benefits and implied job security as for those who have been the recipients of the supposed rewards. Many leaders still feel benevolence toward employees and do not want to accept that a healthier relationship is a full

partnership between the employee and the organization. The generosity of the "we will take care of you" attitude has inadvertently created employees who are overly dependent on the organization. And as organizations reduce benefits and talk less of the "big, happy family," employees naturally respond as if organizations are taking away what the employees had felt entitled to.

Diversity in the Workforce

When anyone asks health care leaders what their greatest challenges are today, increasing diversity in the workplace is almost always at the top of the list. As a leader in a recent program noted, "In our organization there are sixty-five different languages spoken." The globalization of our world has certainly made an impact in the workplace in terms of the various cultures and ethnic groups of the people who work together. However, this is not the only diversity creating increased challenges for leaders. Never before has there been such diversity in workers' ages. The health care workforce employs large numbers of women, and the baby boomers reaching retirement age are the first generation of women who entered and remained in the workforce throughout an entire career.

Additionally, although we have always been aware that the generations differ in attitudes and beliefs, friction between members of these age cohorts seems to be accelerating. Furthermore, there is a suggestion that the time required to produce significant differences between age groups is compressing; whereas our grandparents were markedly different from our parents and from us, now there are significant differences between three siblings, ages twenty-one, eighteen, and fifteen (Maun, 2004). This stems directly from the rapidity of world changes we are experiencing in this very tumultuous environment.

The challenge for the health care leader can feel overwhelming at times. How can one person lead such a diverse group of employees who are providing service and care to an even more widely diverse group of patients and families? How can we benefit from the

creativity and opportunity that such diversity represents while respecting the many differences and not allowing relationships to degenerate into unmanageable conflict and confusion?

New Organizational Structures

We need new organizational structures to meet the demands of changing times. The transition from a resident-based to a mobility-based model of care (Porter-O'Grady and Malloch, 2003) requires a more fluid and dynamic organizational model. This is a major challenge given that most of today's leaders have spent the majority of their organizational life in a bureaucratic structure, one with which they are comfortable. Whether this structure can survive into the future is debatable.

In the 1990s organizations tried new, more fluid and flexible structures with the belief that these newer structures would enhance response to customers, increase the rate of innovation, and create work environments that stimulate employee commitment, curiosity, and ownership. In their book *The Intelligent Organization,* Pinchot and Pinchot (1996b, p. xiv) write: "The transformation from bureaucracy to organizational intelligence is a move from relationships of dominance and submission up and down the chain of command to horizontal relationships of peers across a network of voluntary cooperation and market-based exchanges."

Leadership scholars have been pointing out for years that bureaucracies are not well equipped to meet changing times. Bennis notes, "Bureaucracies are self-sustaining only in times of stability, when the environment is placid. They are very ineffective when times are changing. When the world is turbulent, the managerial environment is spastic, fluid, and volatile. Then the bureaucracy seems to be particularly inadequate because it keeps repeating yesterday's lessons and fighting the last war" (Flower, 1990, p. 62). Organizations of the future are more likely to be based on a network or a flattened hierarchy model. In fact, Bennis is very clear on this point when he says in the same interview, "Organizations

that operate on the nineteenth-century model of the bureaucracy—a model based on the words control, order, and predict—are just not going to cut it. . . . They already aren't" (Flower, 1990, p. 62).

One new form of organizational model is what Waterman (1992) called the adhocracy, which is any organizational form that challenges the bureaucracy in order to embrace new ways of doing things. He notes that the concept of adhocracy is not new. In the mid-1960s, he writes (p. 18), "Warren Bennis argued the need for adaptive, problem-solving, temporary systems of diverse specialists linked together . . . in an organic flux." This is much more difficult to do in a bureaucracy than it appears. People hold specific jobs and have responsibilities that must be accomplished regardless of temporary assignments or project team commitments. Health care during the 1990s saw more of a move toward flexible assignments than was in evidence prior to this time. When undergoing major reengineering or work-redesign initiatives, many organizations appointed employees or managers as project directors or project team members. This pulled employees and managers out of their jobs and moved them into these semipermanent yet temporary assignments. It allowed organizations to move some of their best and brightest people to the critical initiative of the day.

This resulted in many other difficulties, however, the prime predicament being what to do with these people when they had completed the temporary work and the organization had filled or eliminated the individual's previous job. It is the same problem in other businesses and industries, as Waterman (1992, p. 26) notes: "Today's companies need, but seldom have, the ability to move seamlessly from bureaucracy to adhocracy and back again. Today's managers need, but seldom have, the skill and security to leave their posts for a while and become effective members of project teams. But without that ability, companies and people go on making the same old mistakes. They do not learn. This is the Achilles' heel of corporate America." This remains an issue in today's health care

organizations. Some larger systems may be more flexible in creating roles designed to take on current initiatives; however, financial constraints have severely limited resources in most organizations, which do not have the luxury of being flexible.

Another promising organizational form attempted in the 1990s was the team-based organization. This structure "replaces or supplements traditional hierarchical structures with semiautonomous teams in order to flatten management, revitalize employees, and enhance productivity" (Manion, Lorimer, and Leander, 1996, p. xi). Many organizations attempted to create employee work teams that replaced the department as the smallest unit of an organization's structure. Teams were touted as a way to forge a partnership between leaders and employees, capable of producing an undreamed-of synergy as teams built on the strengths of everyone in the organization. Unfortunately, few organizations were able to truly convert their systems to a team-based structure; and most organizations that made the attempt have only remnants of the structure remaining today. Although a team-based structure offered a possibility for softening the bureaucratic, hierarchical structure of a health care organization, it simply did not materialize in most organizations. The true essence of teams involves transfer of real responsibility and authority to the team and formation of a collaborative relationship between manager and team. Creating a true team-based organization challenges both leadership skills and beliefs. It simply cannot occur without strong leaders who have a clear vision of a different future and are willing to share power.

Shared decision-making models are similar in concept and more accurately describe current work aimed at modifying the organizational bureaucracy. These approaches are based on the belief that those who are closest to the work should be involved in the decisions affecting that work. Organizations espousing this belief establish structures that enhance employee participation in decision making.

Turbulent Business Environment

The business environment within which health care organizations exist is tumultuous and unpredictable. Declining levels of reimbursement, increasing costs of products and materials, the availability of Internet-based health care, the litigious mind-set, the appearance of watchdog groups focused on patient outcomes and safety, escalating workforce shortages and worker demands, increasing competition from physicians, and the demands of increasing regulation all serve to create uncertainty in the health care marketplace. These create tremendous challenges as well as opportunities for leaders. Struggling to stay one step ahead requires leaders to spend tremendous energy and renew their commitment day to day and sometimes even hour to hour.

A story illustrates this challenge perfectly. In Africa each day a lion wakes up. He knows he will need to outrun the fastest gazelle if he is to eat that day. Each day in Africa, a gazelle wakes up and knows he will need to outrun the fastest lion if he is to stay alive that day. The moral: it does not matter if you are a lion or a gazelle, as long as you wake up running! Translated for health care: every leader must wake up ready to face these challenges every single day, or we will fall behind.

The rapidity with which our business environment can change became evident in the late 1990s. One home health agency lost over 60 percent of its reimbursed business overnight with a change in the reimbursement of phlebotomy. Hospitals with healthy bottom lines experienced severe reversals in their financial picture within months due to unanticipated reimbursement changes. The financial health of today's health care organizations can best be described as highly volatile.

The Leader's Energy Capacity

In light of these challenges, or perhaps as a result of these issues, health care leaders face the personal challenge of maintaining and expanding their own energy capacity. This is likely the ultimate

leadership challenge of this decade. In the face of increasing demands and escalating complexity in our environment and work, how do I as a leader locate and protect my sources of personal energy? And perhaps more important, how do I increase my capacity in order to deal with these multiple challenges?

Health care leaders not only have permission to care for themselves, they have a responsibility to do so (Collins, 1992). When you think of the tremendous national resource of our outstanding leaders and managers, they are indeed a precious asset. Often these leaders come from the ranks of people who started their career in service to others or as caregivers. Self-care may not come naturally to those who have spent their life in service to others. As Collins (p. 5) writes, "Caring for others is a hazardous occupation . . . those of us who care for others have trouble caring for ourselves."

Everything we do consumes energy. Understanding the flow of energy within a system, whether the organization or the self, is a way to increase our proficiency at managing energy and ultimately increasing our capacity (Cox, Manion, and Miller, 2005). Loehr and Schwartz (2003) believe that managing our energy is the key to high performance and personal self-renewal, not becoming increasingly proficient at managing time. Finding and keeping a reasonable balance between our work, family, and personal worlds is a remarkable yet crucial feat for today's organizational leader (Bowcutt, 2004; Fields and Zwisler, 2004; Larson and William, 2004; Ulreich, 2004; Van Allen, 2004).

Conclusion

Developing leaders is one of the most important issues currently facing health care organizations. In defining leadership, it is important to distinguish between leadership and management. The growing need for strong leadership is directly related to the unrelenting crush of change we experience today, which in the health care world is reflected in the rapid shifting of paradigms and concern for survival

into the future. The many challenges facing today's leaders are closely intertwined and interdependent. They include the rapidity of change, workforce shortages, the free-agent mentality, increasing diversity in the workplace, the need for new organizational structures, the tumultuous business environment, and the need for managing one's own energy capacity. These factors have resulted in a tremendous sense of urgency in health care organizations and have made clear the need for the identification and development of internal leaders as well as the mastery of new, nontraditional skills for these leaders.

Conversation Points

1. Think about people who have been effective leaders in your life. How did their behaviors compare to the description of leadership that this chapter offered?
2. What does your organization emphasize—leadership or management? Consider carefully both the verbal and the behavioral messages from established organizational leaders.
3. Think about your own skills. Where do your strengths fall? Are you a stronger leader or a stronger manager? Where do you have opportunities for improvement? Do you need to change your mix of skills?
4. Think about the person to whom you report. Where do that person's strongest skills lie: in management or leadership? What kind of impact does this have on you?
5. What are your biggest challenges as a leader today? If you are not currently functioning as a leader, what are the biggest challenges that leaders in your organization, religious organization, community, or our country face today?