1

Leadership

AN ELUSIVE CONCEPT

CHAPTER OBJECTIVES

- Define leadership.
- Differentiate between leadership and management.
- Identify reasons that leadership is especially important today.
- Discuss challenges that health care leaders face today.
- Distinguish between a challenge and an excuse.
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.


No other 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 and the depth of internal leadership capacity. 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 to 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 on only formal managers for leadership limits the tremendous possibilities that exist when leaders are acknowledged from within any part or level of the organization. “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. “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 have saved money in the short term, the long-term consequences to health care were significant in the absence of qualified individuals to move into executive and leadership roles. This past decade has seen the further decimation of ranks of managers as older workers are
beginning to retire. The tremendous challenges of leadership positions today have resulted in situations in many organizations where the time required to recruit to frontline management positions has extended. The work is less appealing to potential candidates than it was in the past.

Many people fail to 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, without formal positional authority, emerge from the ranks; they sometimes resist them and label them as troublemakers or dissatisfied employees. “It is an illusion to expect that an executive team on its own will find the best way into the future. So you must use leadership to generate more leadership deep in the organization” (Heifetz, Grashow, and Linsky, 2009, p. 68).

This chapter explores the concept of leadership, differentiates it from management, identifies reasons that leadership is so critical in today’s health care organizations, and illuminates several major challenges facing health care leaders.

**Defining Leadership**

Defining leadership is the first step. It is a much more elusive concept than is management. Most authorities on the topic define leadership as influencing others to do what needs to be done, especially those things organizational leadership believes need to be accomplished. The term *transformational leadership* has become repopularized as a result of the Magnet recognition program that identifies organizations with internal cultures strongly supportive of excellence in professional practice. The new model for Magnet has five identified components, one of which is transformational leadership. Leading people where they want to go is easy; in some instances, the biggest challenge is getting out of their way. However, the transformational leader “must lead people to where they *need to be* to meet the demands of the future” (Wolf, Triolo, and Ponte, 2008, p. 202). It’s important to note here that the goal of the transformational leader is to transform the organization or department, not necessarily the people within it.
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 followers to realize their full potential—potential that the followers 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 four 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). He concludes that in addition to passion and an intense level of personal commitment, virtually every great leader has four competencies (O’Connell, 2009):
Leadership

- The ability to manage others' attention, through a clear vision of what needs to be accomplished
- The knack for managing meaning by communicating well
- The skill of managing others' trust through being a person of integrity and good character
- The self-knowledge that allows the leader to deploy his or her skills effectively

None of these is easily teachable by the methods often used for leadership development, such as reading widely or attending seminars and formal academic programs. However, all three can be learned or perfected through life’s experiences. For most people, the development of leadership capacity is lifelong work—a trial-and-error method of perfecting techniques and approaches and 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), 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 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). They 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, their final analysis revealed that leadership was a key factor for those companies with extraordinary success. The type of leadership the study revealed 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.

Several years later, Collins (2005) examined leadership in social sector organizations and found a striking difference between the social and business sectors. He described social sector leadership as a “legislative” type of leader. In other words, these leaders do not have the power of decision. Frances Hesselbein, CEO of the Girl Scouts of the USA, was asked how she accomplished her results without the concentrated executive power seen in the business sector. She replied, “Oh, you always have power, if you just know where to find it. There is the power of inclusion, and the power of language, and the power of shared interests, and the power of coalition. Power is all around you to draw upon, but it is rarely raw, rarely visible” (Collins, 2005, p. 10).

The complex and diffuse power structures common in health care organizations means that no executive has enough structural power to make the most important decisions alone. To those from other sectors, the leader may look weak and indecisive when in fact successful leaders in social sector organizations develop incredible skills of persuasion, political currency, and coalition building. Collins (2005) notes that the irony here is that those of us in the social sector “increasingly look to business for leadership models and talent, yet I suspect we will find more true leadership in the social sectors than the business sector” (p. 12). True leadership, says Collins, exists only if people follow when they have the freedom not to.

**Distinguishing Between 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 office, automatically confers leadership skills on the person holding that position. Nothing is further from the truth. In the same way, simply being able to biologically reproduce
Leadership does not make a person a good parent. 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. 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. Productivity reports and statistics are crucial for evaluating success. 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: building a new set of elevators for patients only. The intent was to move patients faster and more efficiently, a goal the medical center attempted to accomplish 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: 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 patients be moved at all? How can we reduce movement of patients? This kind of thinking has led to 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 usually 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 or technical expertise to management and supervisory roles, clearly values these characteristics. The highly skilled worker or practitioner becomes a manager, and overall this is the typical pattern regardless of the department or discipline in question. Healthcare workers tend to highly value job expertise in their managers and, in fact, often show disdain for managers 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 administration. 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. The workforce is remarkably different today, where most are considered knowledge workers.

In contrast to a manager, 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 and then says, “It’s up to you to impress me with how you do it.”

This implies several points. First, the leader knows what needs to be done and can clearly articulate this to others in a way that convinces the followers 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 possibly better way to accomplish the goals. The leader is not wedded to his or her way of performing a task or carrying out a responsibility.

There are many examples of this leadership approach in health care organizations today. When a health care organization is undertaking a major cultural change initiative, executives often present it in a way that first explains the organization’s current status, the external environment, and the reasons the board of trustees and executive team believe this initiative is necessary for the organization’s future viability. When the case is made well and the reasons are clear, employees in most instances view them as important and valued. When the reasons for the change align with important values and beliefs that frontline employees hold, positive results are much more likely.

**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, corporate compliance protocols, 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.

Although control is really the essence of management, it shouldn’t be construed as a negative. There need to be organizing structures and processes in the most complex organizations. There is continual pressure to reduce variation and increase quality, and this is often accomplished by meeting established standards and expectations. The manager’s role is to control processes and structures to ensure that certain outcomes result. “This is managerial control. Managers must have many checks and balances to ensure timely, cost-effective, and high-quality results” (Vestal, 2009c, p. 6).

Leadership is about people and relationships. Leadership exists only 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 primarily 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 transformational 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 implementing new processes to create a desired 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 can even appear in the mission statement, 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 at least 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 quality has stimulated a move toward more creative problem solving and resolution without placing blame. Often referred to as a just culture, errors and mistakes are seen as an opportunity for improvement. Investigation is thorough, but responses to these situations are deliberate and based on many factors.

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. “With leaders, the future calls to them in a voice they can’t drown out. The future is more real than the present; it compels them to act” (Breen, 2005, p. 66). Managers ask: Are we within budget? Are we meeting our goals? What’s the deadline? How can we improve our productivity? 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 as they make difficult decisions on behalf of the organization and the people within it.

A leader with a vision of the future that includes highly engaged and passionate employees who feel ownership of their jobs, make decisions affecting work in their span of control, and work in partnership with the organization’s managers knows that in order to attain this vision, the organization will need to continually invest in employee learning and development 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 often are required in order to attain an alternative 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, it is relatively easy for a manager to use his or her legitimate authority and step in 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 and Leadership: A Final Word

That there is a difference between management and leadership is clear. However, it is more of a both-and choice rather than an either-or choice. None of this discussion is to imply that there is not a need for exemplary managers in today’s health care organizations, and often the best leaders have strong management skills. 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, are able to organize and structure it, and 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 on 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 scholars, 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. It was recognized 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 society to emphasize the importance of leadership skills. The increased number of titles about leadership in a popular bookstore reflects this emphasis. A search on amazon.com produces over sixty-three thousand hits, and when the search is narrowed to health care leadership, there are still 883 titles. Why this focus on leadership? Why is this a compelling issue in today’s world? There are at least three major reasons:

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

Change

Change has been the byword for over twenty years. Never before has the pace of change been so fast or 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 appraisal systems—pale by comparison to today’s changes, such as new locations for services, innovative business structures, 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
Leadership

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. There are now destination health care countries where American citizens can go to receive their care in countries such as India or Thailand, often in hospitals or clinics run by American-educated and -trained individuals. The cost is much less than in the United States.

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 who 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 for him or her to engage in a new way of thinking. A recently observed paradigm shift was seen in 2009 when health care reform was being hotly debated. Business owners and employers were seen as “the bad guy,” the ones with a hidden agenda that involved keeping the current system in place. As a result of this political climate, many of these voices were silent when the debate was held, although they certainly represented a tremendous source of knowledge about the system.

When paradigms shift, it is crucial to recognize the change, or your efforts will be fruitless. It is foolish to hold onto the belief that past or current success automatically leads to future success. When we hold to the old paradigm, we may be reluctant to make changes rapidly enough to adapt to the changing external environment. A common behavior is the overreliance on internal expertise and experience, resulting in an aversion to risk taking and a desire to dictate to others how things will be. None of these behaviors will lead to ultimate or enduring success.

The issue of changing paradigms is easy to talk about intellectually but difficult to deal with in its reality. What will it really take to become a fluid
and flexible organization, capable of dealing with the enormously tumultuous external environment? How can we provide mobile health care services instead of being limited to an institution and its four walls? How can we shift from the old methods of communicating and move into the tremendous opportunities that new communication technology and the Internet present?

**Survival**

The final and perhaps most important reason that we need leadership today is 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 as during the immediate aftermath of the devastating terrorist attacks on the United States on September 11, 2001. 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 organizational integrity is crucial. “There is a pervasive, national concern about the integrity 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 prophetic. In the past few years, Americans have become almost inured to corporate scandal and wrongdoing. The collapse of Enron, Arthur Andersen, and WorldCom was just the beginning of what seems to be a never-ending parade of corporate corruption. Many Americans now fully expect that people in positions of power lack personal and professional integrity and can be counted on to lie and cheat. Political corruption and lack of faith in national leaders is at an all-time low.

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 before has the need for ethical, exemplary leaders been more crucial as we face the challenges of the next decade.

**Challenges Facing Today’s Leaders**

Today the opportunities and possibilities for leaders are endless, as are the challenges. Difficulties are not all bad. Strong leaders see difficult times as offering tremendous opportunities. Often the times and events that push us the most also have the capability of bringing forth our very best. It’s important
Leadership

Leadership

19
to notice the difference between a challenge and an excuse. Every one of these challenges presented here can also be used as an excuse in the organization. “I couldn’t make a decision when things were so uncertain.” “You just can’t please everyone. I don’t know how you can motivate these young people today!” When we give up on the challenge, we are letting it become an excuse, a reason that we cannot accomplish the results we need. For every one who uses a challenge as an excuse, there is a leader somewhere who uses the same challenge to achieve stunning results.

Demands are different for today’s leaders and have ramifications for anyone aspiring to lead others. Recent dramatic upheavals have left no sector untouched. “The financial, political, environmental, and social challenges have affected us all in different ways and, in turn, have impacted our organizations and employees. It leaves us all wondering what will happen next that will change the world we live in and the places we work” (Vestal, 2009a, p. 6). The more a leader understands these issues, the more likely it is that he or she can find the strength and courage to meet the test that these challenges present. A handful of representative challenges include these:

- Accelerating levels of ambiguity and uncertainty
- Workforce issues
- Diversity in the workforce
- Turbulent business and regulatory environments
- The leader’s energy drain

Accelerating Levels of Ambiguity and Uncertainty

Probably the most apt description of today’s world is uncertainty. Leaders today are dealing with a level of ambiguity and uncertainty almost unparalleled in our memories. Although uncertainty and ambiguity are not measurable, they are palpable in workplaces. Change continues to accelerate at a pace that makes it impossible to predict even the near-term future with any accuracy. And as change begets more change, the challenges become more complex and difficult to meet.
Today’s solution rapidly becomes tomorrow’s problem that must be dealt with. In no other area is this clearer than in technology. The advent of the electronic medical record (EMR) created visions of a health care environment where workers could be more productive, the electronic processing of medical information making their lives much easier. Nurses would spend more time at the bedside caring for patients. Members of various departments and different disciplines could communicate virtually through real-time computing technology. Errors would be reduced and patient quality increased.

The reality for many people today is quite different from the original vision and the promise implied, if not explicitly made. In many organizations, problems abound with the EMR. Decisions about hardware and software were made with limited or low-quality input from end users, and as a result, they are inadequate to meet practitioners’ needs. Organizations invested major portions of their financial resources into technology, only to find it seriously outdated within a few years. Years are spent waiting for upgrades, either because of their lack of availability or lack of resources on the part of the organization. Productivity for many has declined rather than improved. Caregivers navigate multiple screens to access pertinent information. Duplication continues to exist as practitioners are forced to complete screens of information that may not even apply to the individual for whom they are caring, such as a decubitus ulcer assessment on an ambulatory clinic patient. And the quality of patient care? Of course, in many ways it has improved because of the technology capabilities inherent in the EMR. However, the impact of a caregiver or physician sitting with his or her back to the patient busily inputting data into the computer was never considered as a serious consequence of the technology. Relationship-based care, the underlying foundation of an effective relationship between patient and health care worker, can be seriously and negatively affected when caregivers lose the high touch of person-centered care in our high-tech world of today.

Of course, the world is not worse off because of the invention of the computer. And no one would advocate stopping or even slowing the tremendous advances that have been made through technology of all kinds. Nanotechnology holds great hope for treating and curing diseases that have plagued humankind throughout its history. However, these changes often
complicate our lives in unforeseen ways. Leaders know that the current change simply brings us closer to the next one.

Living during times of great ambiguity and uncertainty requires tremendous energy, both personal and organizational. 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. Transformational 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.

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.

The pace of change in the world today results in ambiguity and uncertainty in every arena of our lives. Some of this change will be for the better, but it is likely that at least some will increase the difficulties people experience in both their personal and professional lives. The entire structure of health care is changing. Health care reform will reshape our systems
in ways that will create challenges as well as opportunities over the next decade. Other factors at work requiring critical shifts in thinking by health care leaders—for example:

- A shift from current reimbursement structures to pay-for-performance and bundling of costs
- 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 changing business practices and structures of physicians, moving from independent status to employment
- The continued shift from a discipline-centered production organization to a customer-focused service orientation
- A continuing shift from an illness and disease model to a wellness paradigm with a focus on alternative or complementary medicine

These high levels of uncertainty and ambiguity are to be expected when so 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 individuals may 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 Issues

The large number of Baby Boomers nearing retirement age and the declining numbers of younger workers entering health care are rapidly reaching a crisis point. This challenge will be one of the most difficult in this new 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. This has become a major concern of governments and countries throughout the developed world (Manion, 2009a) as they face the unpleasant situation of higher-paid workers exiting the active workforce through retirement and beginning to draw on government pension plans. The result is less tax revenue being collected at a time when entitlement liabilities are increasing. Both organizations and governments are seeking ways to delay retirement age through legislation and making the workplace more attractive for older workers.

In the not-so-recent past, one of the biggest issues in the arena of workforce management was the recruitment and placement of qualified people. “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 were not limited to one discipline or one job category in 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 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.
In the more recent past, the tremendous economic downturn has changed the landscape considerably. There are now fewer vacant positions. In many instances there are many more applicants for a position than will be hired. The unemployment rate has skyrocketed, and the official statistics likely underreport the true situation because they don’t take into account those who are unemployed and have given up looking for work. In health care organizations, many part-time workers have converted to full-time positions or opted for more work hours when they are able to get them. Temporary staff members working in agencies are seeking a job where there is more stability in their work hours. Close-to-retirement workers are delaying their exit from the workforce in order to replenish personal retirement accounts depleted during the downturn. The result is that our organizations have fewer vacancies. However, many of these people made these decisions not by free choice, but because of a perceived need to do so. The new workforce challenge in health care organizations has become how to attain high engagement levels of employees when they are there from a lack of choice. Chapter Three addresses this issue more fully.

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; Gelinas and Bohlen, 2002; Unruh, 2004). The quality of the workplace has become even more important when the external environment is so uncertain. The challenge for today’s health care leader is to create positive work environments that not only attract high-quality candidates but retain them (Jazwiec, 2009; Manion, 2009b). 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.

Diversity in the Workforce

When frontline health care leaders are asked what their greatest challenges are today, increasing diversity in the workplace is almost always near the top of the list. As a leader in a recent program noted, “In our organization, there
Leadership

are sixty-five different languages spoken.” Globalization has certainly made an impact in the workplace in terms of the 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. For the first time in history, four generations are actively working side-by-side in our workplaces.

Although we have always been aware that the generations differ in attitudes and beliefs, focusing primarily on the differences can increase friction among members of these age cohorts. While it may actually be less of a problem between coworkers, juggling the different needs and desires of such a variety of people can be a daunting challenge for leaders. Generational cohorts are defined as a group of individuals who experienced similar major events during their formative years. However, with the pace of change accelerating so wildly, the time required to produce significant differences between age groups may be compressing; whereas our grandparents were markedly different from our parents and from us, now there are significant differences between three siblings ages twenty-one, seventeen, and twelve (Maun, 2004). All of this adds to the tremendous complexity for leaders.

The challenge for health care leaders 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?

Turbulent Business and Regulatory Environment

The business environment within which health care organizations exist is tumultuous and unpredictable. Declining levels of reimbursement, increasing costs of products and materials, new business models, government-managed health care reform, the availability of Internet-based health care, the litigious mind-set, the appearance of watchdog groups focused on patient outcomes and safety, escalating workforce issues and worker demands, increasing competition from physicians, and the demands of increasing regulation: all serve
to foster 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. This translates to health care as, “Every leader must wake up and be ready to face the challenges every single day or be left behind.

Our appreciation of the rapidity with which the business environment can change began 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. Previously stable organizations have found that their financial situation can radically change within a few months. The recent economic downturn has had an impact on organizations with major investment portfolios just as significantly as it has had for individual citizens. The financial health of today’s health care organizations can best be described as highly volatile.

**The Leader’s Energy Drain**

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 leaders locate and protect their sources of personal energy? And perhaps more important, how do they increase their capacity 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 our outstanding leaders and managers represent,
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 energy, not becoming increasingly proficient at managing time, is the key to high performance and personal self-renewal. “Once people understand how their supply of available energy is influenced by the choices they make, they can learn new strategies that increase the fuel in their tanks and boost their productivity” (Schwartz, 2010, p. 65). The most effective strategies are rituals that help replenish stores of physical, emotional, mental, and spiritual energy. A ritual can be as simple as shutting down e-mail for a couple of hours a day or taking a midafternoon walk to get a mental breather.

We know that most people in leadership roles fully expect to work well beyond a forty-hour week. According to a survey reported in the Harvard Business Review (Perlow and Porter, 2009), of one thousand professionals, 94 percent said they put in more than fifty hours a week, with nearly half that group turning in more than sixty-five hours a week. And that doesn’t include the hours at home monitoring their BlackBerry and e-mail. Too many managers and leaders today report spending their last day of vacation at home going through e-mails that have accumulated so they don’t have to deal with all of them on their first day back on the job. Perlow and Porter (2009) found that designating periods of time off, called predictable time, increased people’s effectiveness. The biggest problem was getting these people to take the time off. It meant not checking e-mail and voice mail. The result was happier, more engaged workers and increased productivity and effectiveness. Finding and keeping a reasonable balance of work, family, and personal worlds is a remarkable yet crucial feat for today’s organizational leader (Friedman, 2008; Bowcutt, 2004; Fields and Zwisler, 2004; Larson and William, 2004; Kemp, 2009; Ulreich, 2004; Van Allen, 2004).
A less frequently considered source of energy drain is the depletion many leaders experience in the spiritual domain when they face ethical and moral issues in the workplace that they feel unable to influence. This can create high moral distress, which has been defined as “the inability to translate moral choices into moral action” (Coles, 2010, p. 28). It occurs when a person knows ethically the right course to take but feels or is unable to act on it. The result is a perception that personal values or core ethical obligations are being violated. When this occurs, there is a tremendous depletion of personal energy, and it spirals out into the organization in negative ways. Moral distress happens at every level in organizations from the caregiver in the intensive care unit who is forced to participate in what is perceived as futile care to the highest-ranking executive who feels unable to be honest and transparent with board members for fear of losing his or her job. During an assessment in one organization, staff nurses admitted to entering false information in the EMR because it “forced them to do so” in order to move on and complete their work. These issues are rarely addressed openly in organizations because they are difficult to talk about. Truly excellent leaders are willing to do things for others and take the moral high road without regard to what’s in it for them (Kaplan, 2008). Being a leader means being willing to speak up, even when you’re expressing an unpopular view.

These are only a few of the major challenges that health care leaders face today. The increased complexity of our world today demands intense passion, courageous action, and unwavering belief and faith from its leaders. Challenges can help us focus and force us to reaffirm our commitment on an ongoing basis.

**Conclusion**

Developing leaders and increasing internal leadership capacity is one of the most important issues 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 for leaders are closely intertwined and interdependent:
accelerating uncertainty and ambiguity, workforce issues, increasing diversity in the workplace, the tumultuous business and regulatory 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.

**DISCUSSION QUESTIONS**

1. Think about people who have been effective leaders who influenced your life in a positive way. Why did you follow them? How were you influenced by them? What were the leadership behaviors they exhibited that you observed or remember?

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 and competencies. Where do your strengths fall? Are you a stronger leader or a stronger manager? Where do you have opportunities for increasing your capacity?

4. Reflect on the activities of your day. What do you spend most of your time doing? Are they managerial or leadership activities? Do you need to change your mix of activities? What would you gain from increasing your activities in a particular area? What are the barriers that keep you from doing so?

5. Think about the person to whom you report. Where do that person’s strongest skills lie: in management or leadership? Why did you select one or the other? What kind of impact does this have on you?

6. Think about a time when you were at your very best: you were passionate about what you were doing, highly engaged and committed, and getting results that were important to you. As you think back about this situation, were you demonstrating any leadership or management characteristics?

7. 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?