Indicators of leadership characteristics of health care administrators: Executive tenure, behavioral attributes, and self-professed values

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INDICATORS OF LEADERSHIP CHARACTERISTICS OF HEALTH CARE ADMINISTRATORS: EXECUTIVE TENURE, BEHAVIORAL ATTRIBUTES, AND SELF-PROFESSED VALUES

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
in
Health Services Administration

by
Kenneth Dale Kassinger
March 1998
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ABSTRACT

The study of leadership has often targeted variables such as traits, organizational circumstances, values and interpersonal skills to explain and predict leadership effectiveness. This study examined leadership effectiveness in light of 19 categories applicable to the manner in which leaders conduct their activities within their organizations. Basic demographic data were also assembled. Six hundred (600) health care executives were randomly selected to participate in this study and complete the self-assessment of their leadership effectiveness. Forty-three percent (43%) of the surveys were completed and returned.

The tabulated results of the completed surveys indicate that the categories about which the participants were surveyed do not indicate the effectiveness of the respondents in their roles as health care leaders, only their use of leadership attributes. There were some anecdotal replies in the "Other" category, with the responses, overall, being homogeneous and not offering any new attributes for predicting leadership effectiveness.
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CHAPTER ONE

Introduction

"Left foot, right foot, left foot, right. Feet in the morning and feet at night." So begins The Foot Book by Dr. Seuss (1968). Pictured later in the book are several creatures following after another creature who would be rather indescribable except for the pink, polk-a-dotted feet. This polk-a-dotted creature is leading the others along a path that leads right off the page. I have read this book over and over again to my young son, Charlie. This page reflects the image some of us have about leadership. Who is this headless, polk-a-dotted creature, and more importantly, where is it leading the others? Why do they follow? What leadership traits does this polk-a-dotted creature possess? What values give rise to the creature’s leadership traits?

The activities of leadership have been scrutinized for decades. Numerous studies dissecting the who, what and why of leadership have tended to reduce the concept to a constellation of behaviors associated with those persons to whom the role of leader has been associated. Much like Aristotle’s contention that the quality of a person’s life and character cannot be fairly assessed prior to death, so too, does it seem that the quality of one’s leadership is
based largely on after the fact evaluation of their effectiveness at leading others. The challenge is to describe leadership traits in individual functioning roles. The greater challenge is to describe leadership traits in health care executives.

**History of Leadership Research**

Historically, researchers have examined leadership skills from a variety of perspectives. Early analyses of leadership, from the 1900s to the 1950s, differentiated between leader and follower characteristics. Finding that no single trait or combination of traits fully explained leaders' abilities, researchers then began to examine the influence of the situation on leaders' skills and behaviors. Subsequent leadership studies attempted to distinguish effective leaders from non-effective leaders. These early studies attempted to determine which leadership behaviors were exemplified by effective leaders. To understand what contributed to making leaders effective, researchers used the contingency model in examining the connection between personal traits, situation variables, and leader effectiveness. Like leadership studies of the past, leadership studies of the 1970s and 1980s once again focused on the individual characteristics of leaders which influence
their effectiveness and the success of their organizations. The investigations led to the conclusion that leaders and leadership are crucial but complex components of organizations. In this paper, the concept of complex leadership components is taken a step further to explore health care administration. Health care organizations are complex and dynamic entities in an ever-changing environment, thus requiring flexible, confident, effective and competent leaders that are well-trained and experienced enough to provide leadership in such a dynamic field.

**Traits Model of Leadership: Leaders versus Followers**

Initial investigations of leadership considered leaders as individuals endowed with certain personality traits which constituted their abilities to lead. The studies investigated traits such as intelligence, birth order, socio-economic status, and child-rearing practices (Bass, 1960; Bird, 1940; Stogdill, 1948, 1974). Stogdill (1974) identified six categories of personal factors associated with leadership: capacity, achievement, responsibility, participation, status, and situation, but concluded that such narrow characterization of leadership traits was insufficient: “A person does not become a leader by virtue of the possession of some combination of traits” (Stogdill,
1948, p.64). The attempts to isolate specific individual traits led to the conclusion that no single characteristic can distinguish leaders from non-leaders. In health care, is there a combination of traits which can provide for a successful leader?

**Situation Leadership: Impact of the Setting on Leaders**

The early "trait" investigations were followed by examinations of the "situation" as the determinant of leadership abilities, leading to the concept of situation leadership. The early studies attempted to identify "distinctive characteristics of the setting to which the leader’s success could be attributed" (Hoy & Miskel, 1987, p.273). Hencley (1973) reviewed leadership theories and noted that "the situation approach maintains that leadership is determined not so much by the characters of the individuals as by the requirements of the social situation" (p.38). According to the situational research focus, a person could be a follower or a leader depending upon circumstances. Attempts were made to identify specific characteristics of a situation that affected leaders' performance. Hoy and Miskel (1987) listed four areas of situation leadership: "structural properties of the organization, organizational climate, role characteristics,
and subordinate characteristics" (p.273). Situation leadership revealed the complexity of leadership but still proved to be insufficient because the theories could not predict which leadership skills would be more effective in certain situations.

Effective Leaders: Two Dimensions

Other attempts to examine leadership and what makes effective leaders have yielded information about the various types of behaviors leaders have exhibited. Leadership behaviors have been categorized along two common dimensions: initiating structures, (concern for organizational tasks) and consideration (concern for individuals and interpersonal relations). Initiating structures include activities such as planning, organizing, and defining the tasks and work of people: how work gets done in an organization. Consideration addresses the social, emotional needs of individuals -- their recognition, work satisfaction and self-esteem influencing their performance. Covey (1990), a contemporary expert on leadership traits, develops this notion eloquently in Habit 5: seek first to understand, then to be understood.

The two dimension or "two-factor" theory was developed as the result of a post-World War II research program at
Ohio State University headed by E.A. Fleishman. A series of studies isolated the two leadership factors referred to earlier as initiating structure and consideration. Other researchers conceptualized these two dimensions as effectiveness and efficiency (Barnard, 1938), goal achievement and group maintenance (Cartwright & Zander, 1960), and system- or person-oriented behaviors (Stogdill, 1963). Speculation about which dimension, initiating structures or consideration, was more important for various situations, led to the assessment of leaders' skills along these two dimensions.

Among the assessment instruments developed to measure leadership skills, the Leader Behavior Description Questionnaire (LBDQ) has been the most used. Halpin (1966) stated that one of the major findings resulting from the LBDQ data was that "effective leadership behavior tends most often to be associated with high performance on both dimensions" (p.97).

Since the original research undertaken to develop the questionnaire, there have been numerous studies of the relationship between these two leadership dimensions and various effectiveness criteria. In a study at International Harvester, researchers began to find some more complicated interactions of the two dimensions. Supervisors who scored
high on initiating structure not only had high proficiency ratings from superiors but also had more employee grievances. A high consideration score was related to lower proficiency ratings and lower absences, (Fleishman et al, 1955).

Other studies have examined how male and female leaders utilize initiating structure and consideration. A literature review of such studies found that male and female leaders exhibit equal amounts of initiating structure and consideration and have equally satisfied followers. In summary, the situation approach to leadership supported the contention that effective leaders are able to address both, the tasks and human aspects of their organizations (Dobbins and Platz, 1986).

The Ohio State University personal-behavioral theory has been criticized for simplicity (e.g., only two dimensions of leadership), lack of generalizability, and reliance on questionnaire responses to measure leadership effectiveness. Researchers have cautioned against reliance on questionnaire measures of leadership initiating factors. One convincing argument is that when raters know about a leader’s performance, their ratings of the leader’s behavior may be substantially distorted. Hence, correlations between past performance and rated behavior may reflect performance-
induced distortions in behavioral ratings as well as real causal effects of past behavior on performance (Lord, 1985).

In summary, the situation approach to leadership studies have supported the contention that effective leaders are able to address both dimensions; the tasks of the job, and the human aspects of their organizations.

Contingency Models: More than the Situation

Additional studies were conducted to identify leadership characteristics based on the fit between personality characteristics, leaders’ behaviors, and situation variables. The “situation leadership” approach contains an underlying assumption that different situations require different types of leadership, while the contingency approach attempts to “specify the conditions or situation variable that moderate the relationship between leader traits or behaviors and performance criteria” (Hoy & Miskel, 1987, p.274).

Fiedler (1967), differentiating between leadership styles and behaviors, concluded that leadership styles are indicative of leaders’ motivational systems and that leadership behaviors are leaders’ specific actions. Fiedler believed that group effectiveness was a result of the leader’s style and the situation’s favorableness.
House’s (1971) Path-Goal Theory included the interaction of leadership behaviors with situation characteristics in determining the leader’s effectiveness. House identified four leadership behaviors: directive, achievement-oriented, supportive, and participative, and two situation variables (subordinates’ personal characteristics and environmental demands such as the organization’s rules and procedures) that most strongly contributed to leaders’ effectiveness. The contingency model furthered the understanding of leadership but did not completely clarify what combination of personality characteristics, leaders’ behaviors, and situation variables are most effective.

Nonleader Leadership: Many Leaders

Similar to the contingency explanation of leadership is the notion of organizational leadership. Barnes and Kriger (1986) suggest that previous theories of leadership were insufficient because they “deal more with the single leader and multi-follower concept than with organizational leadership in a pluralistic sense” (p.15). They contend that leadership is not found in one individual’s traits or skills but is a characteristic of the entire organization, in which “leader roles overlapped, complement each other, and shift from time to time and from person to person ...
This concept of organizational leadership, though interesting and inspiring, has not been examined as closely in leadership studies as the investigation of individual leadership traits and behaviors.

An extension of organizational leadership is the concept of shared leadership. Slater and Doig (1988) refute the assumption that leadership is a possession of one individual and state that such a supposition ignores the "possibility that leadership may also be exercised by a team of individuals" (p. 296). Murphy (1988) states that the hero-leader framework "ignores the invisible leadership of lower-level staff members throughout effective organizations" (p. 655).

For health care systems, current trends in management recognize the scope of influence held by such formal groups as work groups, management teams, task forces, and standing committees (Shortell and Kaluzny, 1994, p. 142). In every instance, the vitality of the organization derives specialized information guiding decisions on matters of patient care and strategic planning to ensure the best positioning for changes occurring within the health care organization itself as well as the external environment.
Current Leadership Research

The leadership literature of the 1970s and 1980s, with its focus on effective leaders, revisited personal traits as determinants of leadership abilities. These studies primarily contributed to understanding the impact of personal characteristics and individual behaviors of effective leaders and their role in making organizations successful. Interestingly, Shortell and Kaluzny (1994) make the claim that for the health care industry, the leadership roles are typically occupied by professionals who take direct charge for patient care, and increasingly the leader is female (p.103).

These studies differentiated between leaders and managers and introduced a new leadership characteristic — vision — and explored its importance. Along with having vision, effective health care leaders are said to facilitate the development of a shared vision and value the human resources of their health care organizations.

Leaders versus Managers

Managers are people who do things right and leaders are people who do the right thing” (Bennis & Nanus, 1985, p.21). Burns (1978) describes managers as transactors and leaders as transformers. Managers concern themselves with the
procurement, coordination, and distribution of human and material resources needed by an organization (Ubben & Hughes, 1987). The skills of a manager facilitate the work of an organization because they ensure that what is done is in accord with the organization’s rules and regulations. The skills of a leader ensure that the work of the organization is what it needs to be. Leaders facilitate the identification of organizational goals. They initiate the development of a vision of what their organization is about. This is the capacity to maintain one’s commitment regardless of prevailing sentiment — discovering the organization’s destiny and having the courage to follow it (Webber, 1996).

“Management controls, arranges, does the right thing; leadership unleashes energy, sets the vision so we do the right thing” (Bennis & Nanus, 1985, p.21)

The central theme of the research is that those who find themselves supervising others in an organization should be both, good managers and good leaders. In the context of health care, Max DePree told an audience of the American College of Healthcare Executives Congress that “a merger of competence and moral purpose committed to the common good” is requisite for the kind of dynamic leadership effective in providing for quality care and acquiescing to community perception about the role of health care providers (DePree,
Vision

"All leaders have the capacity to create a compelling vision, one that takes people to a new place, and the ability to translate that vision into reality" (Bennis, 1990, p.46). Current leadership literature frequently characterizes the leader as the vision holder, the keeper of the dream, or the person who has a vision of the organization's purpose. In Leadership Is An Art (1989), DePree asserts that "the first responsibility of a leader is to define reality" (p.9). Bennis (1990) writes that leaders "manage the dream" (p.46). Vision is defined as "the force which molds meaning for the people of an organization". (Manasse, 1986, p.150).

According to Manasse, this force is "visionary leadership" and includes four different types of vision: organization, future, personal, and strategic. Organizational vision involves having a complete picture of a system's components as well as an understanding of their interrelationships. "Future vision is a comprehensive picture of how an organization will look at some point in the future, including how it will be positioned in its environment and how it will function internally" (Manasse,
1986, p.157). Personal vision includes the leader’s personal aspirations for the organization and acts as the impetus for the leader’s actions that will link organizational and future vision. "Strategic vision involves connecting the reality of the present (organizational vision) to the possibilities of the future (future vision) in a unique way (personal vision) that is appropriate for the organization and its leader" (Manasse, 1986, p.162).

A leader’s vision needs to be shared by those who will be involved in the realization of the vision. According to Jerry Porras of Stanford University, vision consists of two key components-- (1) core ideology, which defines values and purpose through organizational evolution, and (2) having ambitious goals that are so vividly described that “all those within the organization will adjust and adapt to changing pressures in order to meet those goals,” (p.1). To measure the effectiveness of the latter, 360° assessments afford the leader with anonymous feedback about his/her performance as a facilitator of the vision and how well other team members perceive allocation of resources necessary in the furtherance of their functions. The health care administrator has access to quality management data generated through utilization management, peer review, and
patient satisfaction surveys. There is perhaps no better measure of success in goal attainment than the feedback loop which includes the target service population.

Shared Vision

An important aspect of the vision is the notion of "shared vision". "Some studies indicate that it is the presence of this personal vision on the part of a leader, shared with members of the organization, that may differentiate true leaders from mere managers" (Manasse, 1986, p.151). A leader's vision needs to be shared by those who will be involved in the realization of the vision. Murphy (1988) applied shared vision to previous studies of policy makers and policy implementation; he found that those studies identified gaps between policy development and its implementation and concluded that this gap also applies to current discussions of vision. "It is rare to see a clearly defined vision articulated by a leader at the top of the hierarchy and then installed by followers" (Murphy, 1988, p.656). Whether the vision of an organization is developed collaboratively or initiated by the leader and agreed to by the followers, it becomes the common ground, the shared vision that compels all involved. "Vision comes alive only when it is shared" (Westley & Mintzberg, 1989, p.21).
Valuing Human Resources

Leaders go beyond the development of a common vision; they value the human resources of their organizations. They provide an environment that promotes individual contributions to the organization’s work. Leaders develop and maintain collaborative relationships formed during the development and adoption of the shared vision. They form teams, support team efforts, develop the skills groups and individuals needed, and provide the necessary resources, both human and material, to fulfill the shared vision. Indeed, hospital administrators today will find themselves in roles analogous to that of a head coach who allocates resources to various departments in an effort to find the best mix capable of increasing quality of care, maintaining efficiency and fostering good will by emphasizing the institution’s total role in society.

Transformational Leadership

Burns (1978) introduced the concept of transformational leadership, describing it as not a set of specific behaviors but rather a process by which “leaders and followers raise one another to higher levels of morality and motivation” (p.20). Burns further states that transformational leaders are individuals who appeal to higher ideals and moral values
such as justice and equality and can be found at various levels of an organization. Burns (1978) contrasted transformational leaders from transactional leaders which he described as leaders who motivate by appealing to followers’ self interest. Working with Burns’ (1978) definition of transformational leadership, Bass (1985) asserts that these leaders motivate followers by appealing to strong emotions regardless of the ultimate effects on the followers and do not necessarily attend to positive moral values.

The Reverend Jim Jones of the Jonestown mass suicide could be an example of Bass’s definition of transformational leadership, wherein one man was capable of persuading hundreds of men, women, and children to kill themselves for a greater spiritual good and the promise of security in heaven. This would also qualify as a type of charismatic leadership, albeit misguided. Still, Weber might suggest Jones exceptional qualities motivated his followers to achieve “outstanding performance (1947).” Other researchers have described transformational leadership as going beyond individual needs, focusing on a common purpose, addressing intrinsic rewards and higher psychological needs such as self actualization, and developing commitment with and in the followers (Bass, 1985; Bennis & Nanus, 1985). An example of transformational leadership in the health care
field would be the support of the community to a hospital in which the hospital functions. Community support is essential to sustaining operations, and any activity perceived as contributing to health promotion and education amounts to reciprocal benevolence. This would be especially true in the case of public hospital districts.

More On Effective Leaders

The literature repeatedly suggests that effective leadership in an organization is critical. Early examinations of leaders reported the differences between leaders and followers. Other leadership studies differentiated effective from non-effective leaders. The comparison of effective and non-effective leaders led to the identification of two dimensions: (1) initiating structures and (2) consideration. Both revealed that effective leaders were high performers in each dimension.

Leadership was recognized as a complex enterprise, and as recent studies assert, vision and collaboration are important characteristics of effective leadership. What is it about certain leaders that enables them to lead their organizations to change? Is there a clear progression in the research literature from static to dynamic considerations in discovering the characteristics of leaders?
of change?

Characteristics of Leaders of Change

Leadership to promote and implement change has not been consistent nor uniform. Knowledge about the qualities of the individuals who have successfully implemented change strategies has been minimal. If the health care community has knowledge of successful strategies and programs, why is there limited implementation? Does the leader make the difference? What are the characteristics health care administrators possess that enabled them to change their hospitals?

Although knowledge is limited on what types of leaders are needed, there are a number of assumptions about leadership. In health care organizations, there is an assumption that leaders of change should be both leaders and managers. "We expect both leadership and management from the same individual" (Manasse, 1986, p.153). This idea may arise from hospitals and health care organizations where CEOs are the primary administrators and leaders. Nevertheless, "while we can distinguish management from leadership conceptually, in reality we often find the two roles coexisting in the same positions and the same person" (Manasse, 1986, p.153).
Another assumption about leaders who change their organizations is that only administrators will be leaders. However, this assumption, that change comes only from individuals in top positions, "ignores the invisible leadership of lower-level staff members" (Murphy, 1988, p.655). While studies of leadership have focused on leaders in administrative positions, it would be myopic to ignore the influence of department managers and their senior staff in shaping the culture of an organization and how that affects the development of the shared vision.

The followers, (health services department heads and mid-managers), are also leaders in their own sphere, which is essential for the top leaders' (hospital administrators/CEOs) success.

Information about leaders who have guided or provoked their organizations to change is also beginning to emerge. Individuals like Sam Walton and Bill Gates began with having a vision, developed a shared vision with their co-workers, and valued the organization's personnel. Leaders who promote change in their organizations were proactive and took risks. They recognized shifts in the interests or needs of their clientele, anticipated the need to change and challenged the status quo.

As stated earlier, leadership requires vision. It is a
force that provides meaning and purpose to the work of the organization. Leaders of change are visionary leaders, and vision is the basis of their work. "To actively change an organization, leaders must make decisions about the nature of the desired state" (Manasse, 1986, p.151). They begin with a personal vision to forge a shared vision with their co-workers. Their communication of the vision is such that it empowers people to act. According to Westley and Mintzberg (1989) visionary leadership is dynamic and involves a three stage process:

1. an image of the desired future for the organization (vision) is communicated (shared) which serves to
2. "empower those followers so that they can enact the vision" (p.18).

According to Manasse (1986), vision includes the "development, transmission, and implementation of an image of a desirable future" (p.150). He further states that the sharing of a leader's vision is an aspect of distinguishing leadership from management. Leaders invite and encourage others to participate in determining and developing a shared vision. The process of developing a shared vision promotes
collegial and collaborative relationships. The shared vision becomes a covenant that bonds together leader and follower in a moral commitment.

Believing that Hospitals are for Delivery of Care

The values and beliefs of individuals affect their behavior and in leaders they influence the vision leaders hold of their hospitals. Values are principles an individual considers to be important or desirable, for example honest communication. Beliefs are ideas considered to be true and on which people are willing to act, for example, believing that all members of a community should have access to health care. The values and beliefs of hospital administrators are what influence their approach to leadership and vision.

Manasse (1986) stated that vision is "based on personal or personalized professional values" (p.152). Manasse further states that "visionary leadership demands a clear sense of personal and organizational values" (p.151). A need exists to be aware of health care executives'/leaders' values because there is no way for leaders to avoid moral responsibility. Visions are normative statements and consequently, whoever would embrace them or urge others to
embrace them are responsible for their moral content. The connection between leaders' values or beliefs and their vision for their organization is important. Unfortunately, there is minimal information concerning the impact of values and beliefs of health care executives on the leadership abilities of effective leaders, a concern which this study will begin to reduce through its research and evaluation.

Establishing Clear Values

Clarity of professional values is related to role effectiveness. One value which might rank high for the health care administrator is the quality of care delivered by the hospital. Quality is a top priority in health care delivery and decisions are assessed in hospitals and communities alike as to whether those decisions enhance or threaten that quality.

Equity in interpersonal relationships and operational decisions would also be a value. Practices of delegation, teaming, flexibility of process and incremental planning with extensive communication reflects value in a collaborative method of change (Aplin, 1984).

The belief that the purpose of a medical center is to provide the highest level of medical intervention for its community is fundamental to the industry. An adjunct to
this belief is that the office of the CEO can serve to promote this vision. In fact, one CEO I had worked under in the Spring of 1995 was attracted to the post with an expectation that she would be able to wield the influence of her office to improve health care delivery.

Another value which might seem obvious is the hospital administrator's loyalty to the community in which their hospital functions. This loyalty includes a keen understanding of the community's values as well as consistent participation in community activities.

No two individuals are the same; neither can any two leaders be alike. The literature reveals that all effective leaders do share a common value, that of human resources -- the contributions, talents, and efforts -- of others in their organization. A description of this characteristic follows.

Valuing Human Resources

Leaders for change recognize that the people in the organization are its greatest resource. "To lead change the leader must believe without question that people are the most important asset of an organization" (Joiner, 1987, p.2). The belief in the value of human resources has three dimensions. The first dimension is that of the leaders'
valuing the professional contributions of the staff, while the second is the leaders' ability to relate to people. The third dimension is fostering collaborative relationship. Valuing people's contributions to an organization differs from relating to people and building collaboration. The first dimension acknowledges individuals' skills and expertise, while the latter two involve interpersonal skills. Leaders of change not only include the contributions of employees in determining and realizing the vision but also have the interpersonal skills that help them relate with others and develop collaborative relationships, foster environments and work processes to facilitate the organizations collective efforts, and address the needs of individuals as well as groups (Joiner, 1987; Barnes & Kriger, 1986). Leaders of change trust the strength of others and value their efforts and contributions in the realization of the organization's vision.

Ability to relate to others is the second dimension of valuing human resources (Alpin, 1984). In dealing with change the capacity to relate well to all types of people is essential, enabling the development of a strengthened management team, improve attitudes of the community towards the hospital, renew trust between administration and medical staff, and enhanced staff involvement.
The ability to relate to others has an impact on the third dimension, fostering collaborative relationships within the organization. Hospital administrators provide an environment that encourages and promotes collaborative relationships. They form teams, support team efforts, develop the skills that groups and individuals need, and provide the necessary human and material resources to realize the hospital vision (Shortell and Kaluzny).

While most effective hospital administrators value and encourage staff efforts and contributions to hospital improvement, department heads tend to be the recipients of and not the initiators of such support. Consequently, some manager leaders report different experiences, generally due to lack of clear understanding of the role of the manager leader by other department heads, and that these other department heads did not participate in the selection of their peer as leader. This only serves to undermine the peer leader’s efforts. A consequence of this confusion would be the hindrance of the manager leader’s ability to work cooperatively with their fellow department heads.

Leaders of change are communicators and listeners. Foster’s (1985) discussion of leadership stresses the importance of communication; he states that leadership is conditioned on language. Honest communication about
progress toward realization of the vision is vital. 
"Messages must be clear and unwavering or the leader loses credibility and thus the ability to lead" (Gates, 1996). 

Communicating and listening skills form the basis for leaders’ ability to articulate a vision, develop a shared vision, express their belief that health care services are for promoting the wellness of the community, and demonstrate that they value the human resources of their peers and subordinates. Being an effective communicator and listener is also a key ingredient necessary for success in being proactive and taking risks, being a leader of change. 

Health care leaders of change are proactive. They take the initiative, anticipate and recognize changes in their organizational environment, and begin to explore possible courses of action to respond to those changes. A leader continuously scans the environment noticing where change is needed. They are always testing the limits in an effort to change things that no one else believes can be changed. Health care leaders are proactive because they challenge the status quo of their organization to respond to changes that affect the organization’s business. 

Leaders of change recognize shifts in the health care environment and guide their organization to be responsive to those changes. Health care executives are aware of the
realities of their environment and thus guide the organization to rethink the vision (Joiner, 1987; Barnes & Kriger, 1986). DeGues (1988) described this ability as organizational learning: "understanding the changes occurring in the external environment and then adapting beliefs and behavior to be compatible with those changes" (Stata, 1989, p.67).

Leaders of change in health care recognize paradigm shifts in areas such as patient care, reimbursement, managed care, governmental and accreditation policies. They also constantly scan their community noticing where change is needed or taking place. They anticipate the changing needs of their service population and take the initiative to identify the appropriate course of action.

Leaders of change focus the organization away from maintaining the status quo to exploring various options of the organization’s vision. Joiner’s (1987) discussion of these leaders of change included the skill to “access the reality of the present and determine the gaps that exist” (p.3-4). Leaders of change guide the discussion of how continuing the organization’s current way of operating will short change the organization and thus become advocates for a different vision.

“Change must be initiated by leaders who are willing to
risk their reputations for the future benefit of their companies" (Joiner, 1987, p.4). Risks are not taken haphazardly but tend to be considered as opportunities that will improve the organization and assure long-term growth and survivability.

Health care leaders of change provide the needed stimulus for change. Calling attention to the possibilities, they take risks and encourage others to initiate change. Hospital administrators encourage their staff to experiment with various managerial methods to meet the clinical needs of the service population while containing costs. They guide and provoke the staff to explore options that more adequately address the needs of the community and provide the environment that makes risk-taking safer. Health care executives provide their staff with opportunities to consider and implement changes in clinical pathways as well as encourage experimentation with different arrangements of organizational structures. While effective leaders may stretch the rules, they are not rebels; they do play the game (Mazzarella and Grundy, 1989).

The available literature clearly spells out the complex dynamics of leadership. Technical knowledge of the health care industry is not sufficient in the execution of
effective leadership. Looking at deficient leadership, the “failure or inferior performance in a specific (leadership) position can be traced to the attitudes, motives, style, and personal characteristics (leaders) rely on to carry out the responsibilities of their jobs” (Holland & William’s, 1994, p. 14). Yet, it is likewise evident that the successful health care leader will be adept in the technical expertise associated with the constellation of tasks at hand.

Who becomes an effective leader remains difficult to predict if not impossible. Individuals may attain the designation of leader by birthright, appointment, election, or force, but the quality of good leadership may be absent. The traits model theorists have been somewhat inconclusive about the infinite combinations of characteristics available in assessing effective leadership. Still, credence is given to the notion that not everyone has leadership potential. “It would be a disservice to leaders to suggest that they are ordinary people who happened to be in the right place at the right time. In the matter of leadership, the individual does matter” (Kirkpatrick & Locke, 1991, p.59). To borrow from Benjamin Franklin, leadership potential is like silver in the mine. Experience tells us that precious metals cannot be found merely by digging in any given place long enough. Knowing approximately where to begin digging is
based on geological factors associated with previously successful mining operations.

Common to the research into leadership is its dependence upon cross-sectional and/or retrospective data. Predicting effective leadership continues to confound theorists. In the chaotic environment of health care administration, successful leaders are required to incorporate into their repertoire behaviors associated with value systems which would not have been deemed appropriate to their predecessors as few as ten years ago.

For now, short of some type of exotic forecasting process which might evolve through DNA research, predicting the leadership capacity of an individual with any degree of confidence remains out of reach. Improving on the quality of leadership offers an alternative to the business of predicting leadership.
CHAPTER TWO

Research Method

Sufficient information on leadership has been published attempting to define, predict and produce the elements which effective leaders bring to the table — a certain blend of values and behaviors. Based on this premise, this study will attempt to determine if a relationship can be found as concerns the consonance of values and activities articulated by identified leaders in the health care industry and the effectiveness of their leadership. Tenure in their position will serve as an indicator. A self-survey will utilize non-parametric data to evaluate the sample. No control group will be used.

Top executives in health care seem to require more specialized training and education in order to effectively address the needs of the stakeholders involved with providing health care services. Boards of directors, hospital personnel, practitioners, and the target population all have agendas the contemporary health care leader must acquiesce to. Matters related to compliance with government regulations, adequately meeting quality standards by the Joint Commission on the Accreditation of Hospital Organizations, (JCAHO), reimbursement difficulties attributable to the proliferation of managed care companies,
which also have an impact on quality management and utilization by practitioners - all pose challenges to creative leadership for even the consummate expert.

Executive leadership in health care is not for the unprepared or easily discouraged. But leading a health care entity toward a goal which emphasizes its total role in society as provider of health promotion and education, employer, and community benefactor has to be an experience not often found in other enterprises. Hopefully, some inferences about how to identify a successful, effective health care executive can be drawn from the results of this study.

Perhaps the results will better explain who the polk-a-dotted creatures are, where they are leading others, why others follow them, and what leadership traits they exhibit based in the behaviors which originate in their value systems.

More to the point, is leadership effectiveness measurable in terms of tenure and associated character values and behaviors? The outcome of this study shows the relationship between gender, age, educational level, professed values and behaviors of health care executives, and tenure in their positions as indicative of their effectiveness as leaders.
Hypothesis

This study attempts to determine which attributes of character and deportment, coupled with training and education will result in exemplary leadership in a health care setting. Tenure in an executive position will serve as an indicator of leader effectiveness. Here it is assumed that an individual who has been able to retain his/her post in the fast-track field of health care administration has possession of the formula for succeeding as a leader who others elect to be guided and motivated by. Simultaneously, these persons have also managed to perform in a manner which meets the needs of the governing body to which they answer. Perhaps an even greater assumption is health care executives want to remain in their jobs for any considerable period. However, this study does not examine the motives to address that particular assumption and will leave that for another study.

Several traditional research methods were employed to assure a scientific study was conducted, e.g., proper sampling technique, protection of anonymity, questionnaire gathering and confidentiality. Other demographical categories will also be included in the measure. Such areas as gender, age, and length of tenure in former positions may contribute to our understanding about what components will
likely produce a candidate for leadership in health care.

**Sampling Method**

The subject group for this study is a randomly selected sample to be drawn from the health care executive field. The criteria for eligibility is that the participant be the identified chief executive officer or administrator for a health care facility in the United States, said facility to be licensed for at least 200 beds, and be accredited by the Joint Commission for the Accreditation of Hospital Organizations.

Six hundred facilities were selected to respond to the survey. To identify the prospective sample, the American Hospital Association Guide, (1991), was used. The first twelve facilities in each state which meet the established criteria for eligibility will be selected for the sample. In some states, there may not be twelve health care facilities which met the criteria of at least 200 beds or JCAHO accreditation. In those instances, the total required for the sample will be shifted to the next state alphabetically, and that state's number may be greater than 12 selected. For example, in Alaska, there are two (2) facilities which met the eligibility criteria. Therefore, an additional ten (10) facilities will be selected from
Arizona to compensate. The process occurs in alpha-numeric sequence without preference to region or service population. Therefore, no bias is expected in the survey results.

Use of the Questionnaire

The questionnaire, (see Appendix A), was designed to use the top nineteen (19) leadership characteristics plus demographics, to obtain the fundamental data needed for the study. It was administered at the lowest cost to the participant/subject possible, time-wise. A single sheet questionnaire with return postage was inserted along with a cover letter (see Appendix B) which instructed the subject in completing the survey. Confidentiality and anonymity was stressed. The respondent was asked specifically to avoid any reference which could possibly breach the confidential nature of the survey. There are only general demographic categories in addition to the value/behavioral categories contained in the survey as the quality of privacy and confidentiality are instrumental in obtaining the candid self-appraisals hoped for in this study, (see Appendix A).

Collection of Data

The survey was sent to the 600 prospects with the cover
letter and self-addressed, pre-paid return. The respondents were asked to respond to a 5-point Likert-type scale to evaluate their own activities and values related to their own leadership effectiveness, rating themselves from one (Never) to five (Almost always). A return of 259 surveys (33%) was experienced.

The survey instrument, itself, was designed following a model developed by Thomas C. Timmreck, used in a previous research project. It is important to emphasize the discreet and confidential nature of the instrument. Critical to the value of the responses obtained is that no one's privacy would even appear to be compromised, yet the responses solicited encompass the requisite data categories rendering the outcome of the study indicative of the hypothesis.

Analysis of the Data

Non-parametric data was drawn from the 259 randomly selected health care executives, who are responsible for facilities in the United States which are licensed for at least 200 beds and are JCAHO accredited, and responded to the survey. It will be the purpose of this study to determine if effective leaders can be identified through self-appraisal of their professed values, behaviors, and educational accomplishments. The indicator of effectiveness
will be tenure in their current position as executive of their respective organization. Gender and age will be examined as they may relate to the findings. Measures of central tendency will provide the data to tabulate the findings.

The Questionnaire

"Leadership" has become the rallying cry of the nineties in American business. Organizations need great leaders to help them successfully survive the many difficulties of this challenging decade. Yet, the very notion of leadership has rapidly degenerated into a cliche', a buzz word. In many people's minds, leadership has become identified with an overly simplistic conception of vision and empowerment. Although these concepts do play an important role in the leadership process, they only scratch the surface of what an exceptional leader does on a day-to-day basis.

Leadership is not bossiness, nor is it stubbornness. It is not blind insistence on having one's own way. The effective leaders, the ones others want to follow, never force a response. Instead, they challenge others with the privilege of performing for them.

The following nineteen leader behaviors and
characteristics were explored utilizing a sample response of sufficient size to provide clues as to what the winners are doing. Some of the attributes listed below involve building participatory teams, some involve using situational management strategies, while others enhance personal resources.

Traits/Characteristics of Leadership Used to Develop the Questionnaire

After a thorough review of the management and health care literature, nineteen (19) characteristics seemed to continue to surface as strong traits of leaders and leadership:

Acknowledgers.

Leaders acknowledge viewpoints other than their own. They let others inform them while holding onto fundamental beliefs and principles. When listening to others, they acknowledge the validity of the other’s beliefs. By doing so, leaders take the first step that will allow people to follow them, whether they agree wholeheartedly or not. It is easier for people to follow your way of thinking when you acknowledge theirs.
Motivators.

Leaders know how to motivate. Good leaders communicate their enthusiasm for a project and saturate their groups with the same urgency and dedication they feel. They build a fire and stroke it with a combination of praise, constructive criticism, and support for the group effort.

Expressing one’s approval is also very important. Compliment, in public, those who warrant it. It is best to use praise judiciously; too little, and it can be missed, too much, and it is cheapened. In the case of leadership and supervision, one must act fairly. When work is being assigned or compliments are in order, it is important not to play favorites. In disciplinary situations, the leader must be objective and impartial.

Coaches.

Leaders are coaches who will get their hands dirty when necessary; they get directly involved in projects and demonstrate processes and procedures. Like good coaches, good leaders are often expected to train and prepare others for the task at hand.

Visionary.

Leaders are visionary but they are realistic. They
understand what they are asking of their employees. They brainstorm the potential results of their goals. They understand everyone's function within the group. They set their sights high, but not so high that the goal is out of reach. Leaders nurture their ability to see the big picture without losing critical details.

Confident.

Leaders are also confident. Through learning and experience, leaders develop self-confidence. This is an indispensable asset to a good leader because it is communicated to others. People respect leaders who genuinely know what they are doing. When one develops leadership experience, he/she can base real confidence on fact rather than fiction.

Inspirational.

Leaders shape self-confidence, experience, and values into a personal integrity that commands respect and fosters trust. People who are in positions of leadership are able to inspire. Leaders are not necessarily brilliant strategists or the most able administrators. They may even lack technical expertise, though more and more such is not the case for health care leaders. But leaders do one thing
well - they know how to inspire others and motivate them for the task at hand.

_Fearless._

Good leaders do not shy away from responsibilities or hard work. They do not quit when faced with unexpected obstacles. The mental fuel that motivates them is a continuing eagerness to grow and improve at every level. Still, successful leaders are realistic about goals. They do not waste time reaching for the moon.

_Not Abusive._

Using commands sparingly is always in order. Avoiding orders such as, “Do this now!” or “Stop it!” will help one’s relationship in the workplace. Curt commands provoke resentment. They should be used only in cases of flagrant laziness, insubordination or emergency. A leader should request rather than demand. Try saying, “Let’s do this.” or “I’d like to try that.” Asking for suggestions from subordinates can be rewarding. One might ask, “What do you think ought to be done here?” or “How would you tackle this?” It is important for a leader to show respect for each associate. Superiors and subordinates are equally entitled to respect. If the leader shows employees the same
consideration that he/she would like to receive, the leader will benefit. Leaders cannot fake interest; insincerity is easy to spot.

Faith in People.

It is important to organize and delegate, but then step aside. One should be as discreet and unobtrusive as possible. Supervisors in positions of leadership who check up on someone's work every few minutes, do so at the risk of leadership. Subordinates should be encouraged to speak up and contribute to ongoing discussions. A good leader will welcome suggestions and prompt subordinates to think creatively.

Decision Maker.

A leader is a person who makes decisions. Sometimes the decisions turn out right, sometimes they blow-up in the leader's hands. Either way, the decisions are made. Leadership decisions are required to be made quickly.

Developing People and Influencing Others.

Good leaders have a strong interest in the personal and professional development of their people. They encourage their staff to push beyond their limitations and give their
personal best. Leaders have their staff members share their ideas with the rest of the group. The leader will point out the common denominators in the shared ideas so that the groups' own experiences flesh out a composite picture of what it is like to offer people the support they need.

Encouraging Teamwork.

A good leader not only develops his/her people as individuals but also knows how to get the best out of people when they work on teams. Being able to deal with the dynamics of a whole group of people is not equivalent to dealing with the sum of its parts. Some groups are results oriented. Some work on process, while others focus more on the relationships among team members. In analyzing these three aspects of teamwork, the leader is able to understand the way staff members work best individually and in teams.

Empowering Others.

Empowerment involves four dynamics: giving people important work to do, encouraging autonomy, offering visibility and public recognition, and helping employees establish networking skills.

Developing, influencing, encouraging, and empowering are four ways for a leader to get honest support. The best
method to accomplish all these characteristics is to be a role model of an intelligent, caring person who truly listens. Equally important is the ability to analyze each organizational task and the staff who are to perform it. Sometimes a leader can delegate the work without supervision, but more often leaders need to coach, to facilitate or to direct so that the task is accomplished well and the employee learns how to become more independent. But leaders have to lead. They are expected to know problem situations and how to handle them appropriately. Using multiple options thinking and intelligent risk-taking are two ways to move beyond traditional management techniques that focus on single solutions and avoidance of any risk.

**Multiple Options Thinking.**

Exceptional leaders do not stop at the obvious. They know that the first answer they may get may not always be the best answer, and even the "right" answer may not be appropriate for a particular situation. Thinking in terms of multiple options in any given situation has the capacity for making new solutions appear. Utilizing the critical thinking skills of teams to develop multiple options is the approach of exceptional leaders.
Intelligent Risk Taking.

Good leaders know how to analyze the risks inherent in a particular course of action. They know when an action is high risk or low risk. Even more importantly, they know how to gain consensus from their staff about the level of risk for particular actions, so that their people do not treat high risk activities as low risk, or vice-versa.


Personal resources are equally important to the development of an exceptional leader. Having a passion for the work as well as a strong, clear vision are most often noted when people are asked to describe leaders they admire. The leader's ability to inspire and project into the future helps others feel worthwhile in their own work and have a sense of purpose. For some the vision is very specific; for others it is simple and direct. But more important is the combination of words that work with actions so that others trust the vision and feel confident about its possibility.

Stretching One's Personal Creativity.

When a leader is able to stretch personal creativity continually, it pulls together all the other behaviors. The
sense is that exceptional leaders are always learning something new. They are willing to stretch out into new arenas and discover things they did not know before.
CHAPTER THREE

Results

Return of Surveys

First, of the six hundred (600) surveys posted to the sample population, 259 (43%) were returned as usable. There were another 9 which were returned as undeliverable by the Post Office. Another 15 were returned by the Post Office and had been substantially shredded by their sorting technology, 2 returned as the respondents reported that their facilities no longer met the criteria for eligibility, and one, because the hospital had been closed. Anecdotally, one survey returned had been completed by the administrative assistant to the recently fired administrator of a hospital. The evaluation by this individual of their former superior was hard-hitting and direct, and reference was made to the absence of effective leadership traits as contributing to the “release” from his duties as administrator. After reading this particular survey, the thought occurred to me that this approach would likely yield some interesting fruit as well, i.e. asking administrative assistants to rate their bosses while concurrently asking the bosses to rate themselves.

The respondents were asked to complete and return the surveys promptly, and of the 259 usable surveys received,
over 200 were received within ten (10) days after the mailing. Many included handwritten notes commenting on the ease with which the instrument could be completed. Some contained well-wishes. Another jokingly suggested that I pursue some other, more stable professional environment, such as business.

**Gender Differences**

Perhaps the greatest and most obvious finding dealt with gender. Of the 259 responding, 215 identified as males, composing 83% of the sample population. There were 44 female respondents (17%). The ages of the sample population ranged from 30 to 72 years, with an average of 50. As a group, women were 51 years old on the average (Figure 1), and men checked-in at an average of 49 years (Figure 2).

Among both sexes, the position title most commonly associated with health care executives in this study is some combination of President and/or Chief Executive Officer, (51 or 20%). The position held by most prior to moving into their current post was Chief Operating Officer (60 or 23%).
Women's Ages - Range 30 to 72 years

Figure 1.
Men's Ages - Range 34 to 68 years

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-35</td>
<td>3</td>
</tr>
<tr>
<td>36-41</td>
<td>23</td>
</tr>
<tr>
<td>42-47</td>
<td>63</td>
</tr>
<tr>
<td>48-53</td>
<td>73</td>
</tr>
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<td>54-59</td>
<td>38</td>
</tr>
<tr>
<td>60-65</td>
<td>14</td>
</tr>
<tr>
<td>66+</td>
<td>1</td>
</tr>
</tbody>
</table>

n = 215  Mean = 49  Median = 50  Mode = 53

Figure 2.
The highest level of education reported is overwhelmingly Masters level, 210 out of 259 responses (81%). The survey grouped Master of Arts and Master of Science together, and few who identified with that educational level distinguished one from the other. There were some who specifically listed additional educational accomplishments within the Masters category, such as MBA (25), JD (7), MHA (18), MPH (3), MPA (1), and M.Ed (1).

The number responding who hold a Bachelor of Arts or Bachelor of Science degree was 18 out of 259 (7%), one of whom also listed Certified Public Accountant as a credential.

Medical Doctors accounted for 13 of the respondents (5%). Ph.D is the degree held by 7 out of 259 (3%) of those responding, and there was one Doctor of Public Health (<0.5%). There were 3 Post-graduate respondents (1%), one respondent with a high school education (<0.5%), and 6 of the 259 (2%) who chose not to respond (Table 1).

The average tenure in the sample population’s current position is 6.3 years. The length of service in their former position was 7.25 years. As this breaks down by gender, women have been in their current position 4.84 years with a range of < 0.5 to 18 years (Figure 3). For men the average is 6.55 years with a range of service from 3 months
Table 1
Summary of Survey Results

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>215 (83%)</td>
<td>44 (17%)</td>
</tr>
<tr>
<td>Age (Years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>49</td>
<td>51</td>
</tr>
<tr>
<td>Median</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Mode</td>
<td>53</td>
<td>55</td>
</tr>
<tr>
<td>Current Position (both genders)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mode</td>
<td>Pres./CEO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>167 (64%)</td>
<td></td>
</tr>
<tr>
<td>Length of Current Tenure (Years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>6.55</td>
<td>4.82</td>
</tr>
<tr>
<td>Median</td>
<td>4.75</td>
<td>3.00</td>
</tr>
<tr>
<td>Mode</td>
<td>3.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Previous Position (both genders)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mode</td>
<td>COO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>61 (24%)</td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>259</td>
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</tr>
</tbody>
</table>

(table continues)
Table 1

Summary of Survey Results

<table>
<thead>
<tr>
<th>Length of Previous Tenure (Years)</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>7.35</td>
<td>6.70</td>
</tr>
<tr>
<td>Median</td>
<td>6.00</td>
<td>5.00</td>
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<tr>
<td>Mode</td>
<td>5.00</td>
<td>5.00</td>
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</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>No. of Subjects</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Ph.D./MD (includes all doctorates)</td>
<td>21</td>
<td>8.5</td>
</tr>
<tr>
<td>Post-Graduate, not doctorate</td>
<td>3</td>
<td>1.0</td>
</tr>
<tr>
<td>MA/MS (includes all graduates)</td>
<td>210</td>
<td>81.0</td>
</tr>
<tr>
<td>BA/BS</td>
<td>18</td>
<td>7.0</td>
</tr>
<tr>
<td>High School</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>No Response</td>
<td>6</td>
<td>2.0</td>
</tr>
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</table>

n = 259
Table 1

Summary of Survey Results

<table>
<thead>
<tr>
<th>Attribute Ranking (both genders)</th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
<th>$s$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledger</td>
<td>3.99</td>
<td>4</td>
<td>4</td>
<td>0.44</td>
</tr>
<tr>
<td>Motivator</td>
<td>4.34</td>
<td>4</td>
<td>4</td>
<td>0.58</td>
</tr>
<tr>
<td>Coach</td>
<td>4.20</td>
<td>4</td>
<td>4</td>
<td>0.56</td>
</tr>
<tr>
<td>Visionary</td>
<td>4.28</td>
<td>4</td>
<td>5</td>
<td>0.68</td>
</tr>
<tr>
<td>Self-confident</td>
<td>4.42</td>
<td>4</td>
<td>5</td>
<td>0.56</td>
</tr>
<tr>
<td>Inspirational</td>
<td>3.80</td>
<td>4</td>
<td>4</td>
<td>0.61</td>
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<tr>
<td>Fearless</td>
<td>3.51</td>
<td>4</td>
<td>4</td>
<td>0.74</td>
</tr>
<tr>
<td>Not Abusive</td>
<td>4.50</td>
<td>5</td>
<td>5</td>
<td>0.70</td>
</tr>
<tr>
<td>Puts faith in people</td>
<td>4.35</td>
<td>4</td>
<td>4</td>
<td>0.54</td>
</tr>
<tr>
<td>Decision maker</td>
<td>4.45</td>
<td>5</td>
<td>5</td>
<td>0.58</td>
</tr>
<tr>
<td>Develop / influence others</td>
<td>4.42</td>
<td>4</td>
<td>4</td>
<td>0.53</td>
</tr>
<tr>
<td>Encourage teamwork</td>
<td>4.65</td>
<td>5</td>
<td>5</td>
<td>0.47</td>
</tr>
<tr>
<td>Empower others</td>
<td>4.39</td>
<td>4</td>
<td>4</td>
<td>0.54</td>
</tr>
<tr>
<td>Thinking stops with the obvious</td>
<td>2.89</td>
<td>3</td>
<td>3</td>
<td>0.81</td>
</tr>
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</table>

n = 259

(table continues)
<table>
<thead>
<tr>
<th>Attribute Ranking (both genders)</th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
<th>s</th>
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</thead>
<tbody>
<tr>
<td>Risk taker</td>
<td>3.91</td>
<td>4</td>
<td>4</td>
<td>0.47</td>
</tr>
<tr>
<td>Have a strong, clear vision</td>
<td>4.29</td>
<td>4</td>
<td>4</td>
<td>0.53</td>
</tr>
<tr>
<td>Passionate about work</td>
<td>4.43</td>
<td>5</td>
<td>5</td>
<td>0.58</td>
</tr>
<tr>
<td>Frequently challenge own knowledge base</td>
<td>3.94</td>
<td>4</td>
<td>4</td>
<td>0.55</td>
</tr>
<tr>
<td>Cheerleader</td>
<td>3.95</td>
<td>4</td>
<td>4</td>
<td>0.63</td>
</tr>
<tr>
<td>Population</td>
<td>4.15</td>
<td>4</td>
<td>4</td>
<td>0.82</td>
</tr>
</tbody>
</table>

\(n = 259\)
Tenure in Current Position - Women

- Total: 31
- 0 - 6 years: 9
- 7 - 11 years: 4

Sample size: 44
Mean: 4.82
Median: 3
Mode: 2
Range: 0.42 - 18.00

Figure 3.
to 30 years (Figure 4). Tenure in previous posts for women ranged from one to 20 years, with an average of 6.71 years. For men, the range is one to 27 years and an average of 7.35 years.

Of the sample respondents who have been in their current position less than the average period of 6.3 years, 31 (71%) of the women responding have been in their current post less than the average for their group as a whole (Figure 5), while 128 males (60%) are similarly categorized (Figure 6). The average age for each gender in this sub-group is 50 and 47 years, respectively. The average educational level for both genders is MA/MS. Women have been in their jobs on the average, 2.48 years, men for 2.63. Length of tenure in previous posts was 6.12 years for women and 7.55 years for men.

Category Data

Looking at the categories for expressed values and behaviors, one finds very little to distinguish between those health care executives who have enjoyed greater-than-average tenure (Figure 7) in their positions from those who have "just arrived" so to speak (Figure 8). Again, the subjects were asked to evaluate their own leadership style using a Likert-type scale of one (Never) to five (Almost
always), as the category applies to them. The average self-rating in the 19 specific categories of leadership beliefs and activities was 4.14 (Figure 9). Delineated by gender, the average was 4.21 for women (Figure 10), and 4.13 for men (Figure 11). Categorized in terms of which side on the average length of tenure indicator the measure is taken, we see that women who have been at the chief executive level greater than the average show an aggregate rating of 4.21 (Figure 12), while men in that cohort gave themselves an average of 4.14 (Figure 13).

Conversely, the self-appraisals for the women tally at an average rating of 4.19 (Figure 14). For men, the figure is at 4.16 (Figure 15).

The data gathered for this study and the information inferred from it provides a reasonably accurate profile of the contemporary health care executive in the U.S. The responses found in the sample appear to be candid and forthright with respect to the purpose for which they were solicited. The measures of central tendency used to describe the data are adequate.
Tenure in Current Position - Men

- \( n = 215 \)
- Mean = 6.55
- Median = 4.75
- Mode = 3
- Range (Years): 0.06 - 30.00

**Figure 4.**
Women in Current Position Less Than Sample Average

- **10**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>&lt;1 - 1.99</th>
<th>2 - 3.99</th>
<th>4 - 6.3</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$n = 31$  
Mean = 2.48  
Median = 2  
Mode = 2

**Figure 5.**
Men in Current Position Less Than Sample Average

<table>
<thead>
<tr>
<th>Length of Tenure</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 - 1.99</td>
<td>43</td>
</tr>
<tr>
<td>2 - 3.99</td>
<td>49</td>
</tr>
<tr>
<td>4 - 6.29</td>
<td>36</td>
</tr>
</tbody>
</table>

n = 128  Mean = 2.63  Median = 2.38  Mode = 3

Figure 6.
Attribute Ratings From All Respondents w/Average or Above Tenure in Current Position

Range: 1 (Never) - 5 (Almost always)
n = 100

Figure 7.
Attribute Ratings From All Respondents w/Less Than Average Tenure in Current Position

Range: 1 (Never) - 5 (Almost always)
n = 159

Figure 8.
Figure 3.1

Range: 1 (Never) - 5 (Almost Always)

Rating: Mean = 4.1 Median = 4 Mode = 4
n = 259

Attribute

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently challenge one's limits</td>
<td>4.2</td>
</tr>
<tr>
<td>Have a strong, clear vision</td>
<td>4.0</td>
</tr>
<tr>
<td>Thinking stops at the obvious</td>
<td>3.4</td>
</tr>
<tr>
<td>Risk taker</td>
<td>3.0</td>
</tr>
<tr>
<td>Have a strong, clear vision</td>
<td>3.0</td>
</tr>
<tr>
<td>Passionate about work</td>
<td>2.8</td>
</tr>
<tr>
<td>Encourage teamwork</td>
<td>2.6</td>
</tr>
<tr>
<td>Decision maker</td>
<td>2.3</td>
</tr>
<tr>
<td>Motivator</td>
<td>2.2</td>
</tr>
<tr>
<td>Puts Faith in People</td>
<td>2.0</td>
</tr>
<tr>
<td>Empower others</td>
<td>1.8</td>
</tr>
<tr>
<td>Motivator</td>
<td>1.6</td>
</tr>
<tr>
<td>Empower others</td>
<td>1.5</td>
</tr>
<tr>
<td>Decision maker</td>
<td>1.4</td>
</tr>
<tr>
<td>Thinking stops at the obvious</td>
<td>1.3</td>
</tr>
<tr>
<td>Risk taker</td>
<td>1.2</td>
</tr>
<tr>
<td>Passionate about work</td>
<td>1.0</td>
</tr>
<tr>
<td>Encourage teamwork</td>
<td>0.8</td>
</tr>
<tr>
<td>Have a strong, clear vision</td>
<td>0.6</td>
</tr>
<tr>
<td>Frequently challenge one's limits</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Composite of Attribute Responses, Both Genders
Figure 10.

Range: 1 (Never) - 5 (Almost Always)

n = 44 | Mean = 4.2 | Median = 4 | Mode = 5

Attribute

Attribute Ratings by Women
Figure 11:

Rating: 1 (Never) - 5 (Almost Always)

n = 215
Mean = 4.10
Median = 4
Mode = 4

Attribute

Frequently challenges the knowledge base
Performs at a high level
Risk taker
Thinking outside the obvious
Develops creative/unique ideas
Makes tough decisions
Data facts in people
Best Rescuer
Encourager
Inspirational
Self-confident
Cheerleader

Attribute Ratings by Men
Attribute Ratings By Women w/Less Than Average Tenure In Current Position

n = 12  Mean = 4.20  Median = 4  Mode = 5
Range: 1 (Never) - 5 (Almost always)

Figure 12.
Attribute Ratings By Men w/ Less Than Average Tenure
In Current Position

Figure 13

n = 79  Mean = 4.10  Median = 4  Mode = 4
Range: 1 (Never) - 5 (Almost always)

Figure 13
Attribute Ratings By Women w/Average or Above Tenure In Current Position

![Attribute Ratings Graph](image)

n = 32  Mean = 4.20  Median = 4  Mode = 5
Range: 1 (Never) - 5 (Almost always)

Figure 14.
Figure 15.

Range: 1 (Never) - 5 (Almost Always)

Mode = 4  Median = 4  Mean = 4.20  n = 136

Attribute

In current position

Attribute ratings by men/average or above/tenure
CHAPTER FOUR

Discussion

The intent of this study was to attempt to pry open the cupboard where the contents for effective leadership might be found. The design was to demonstrate a relationship between certain values and practices as disclosed by the sample, to the longevity enjoyed in their current positions as hospital executives. No such relationship can be shown to exist based on the data gathered from this sample. It is believed that the sample is representative of the population surveyed, and that the responses given are fundamentally truthful and accurate. There are some profiles as to who health care executives are, based on demographic data — males, approximately 50 years of age, with a Masters level education, in his current post 6.3 years after having been a COO for more than 7 years. The likelihood of a woman being found in the role of chief executive, according to this sample, is about 5:1 against such an occurrence. She will have held her current post nearly 5 years after having been the president and/or CEO in another capacity or organization over 6.5 years. She will, like her male counterpart, hold a graduate degree.

Essentially, this study sharpens the focus on the area which lies somewhere between the situational leadership
theorists and their theoretical adjuncts, the contingency model theorists. While circumstances do appear to guide the evolution of leader behaviors, the notion that motives driving the leader in a given situation in conjunction with the situation's favorableness more directly contribute to effectiveness. Certainly, the classical traits theorists have heard their echoes once more; there does seem to be a consistent combination of traits which constitute leadership in health care.

What this study indicates is the similarity in self-appraisal by both, men and women, with women scoring themselves higher in nearly all categories than do the men, though without a significant difference.

For those women in their posts less than the average length of tenure, the categories of self-confidence and not abusive are rated highest. These categories are also among the highest for those in their jobs greater than the average, though for the latter group, "developing and influencing others" along with "encouraging teamwork" were very highly tauted attributes of leadership.

For men, "encouraging teamwork" was ranked highest for both groups. For those in their jobs less than the average period of tenure, "not abusive" was scored second highest, although the men who have greater than average tenure score
themselves more than 0.6 less than women in the same group when responding to the statement about being abusive. "Decision maker" and "developing and influencing others" finished in a dead heat for second among the men who had been in their positions longer than the average period of tenure.

Noticeably low scores in the categories of "inspirational" and "fearless" were recorded for both groups and genders. The 14th category, in which subjects were asked to score the statement, "thinking stops with the obvious", women of both groups scored lower than the men.

The two-dimension aspect of leadership, in which initiating structures is coupled with consideration, tends to be supported by this study, and parallels the one most frequently reflected in the Leader Behavior Description Questionnaire, (Halpin, p.97). The dominant values and practices in the arena of effective leaders are demonstrated by the frequency of occurrence indicated by the data here. The research by Dobbins and Platz (1986), is also affirmed by the information taken from this study i.e., male and female leaders exhibit equal amounts of initiating structure and consideration.

Perhaps more indicated than other arguments for identifying leadership effectiveness in health care settings
is the reiteration of Barnes and Kriger (1986), who assert that leadership is more a function of the organization rather than the individual. No where in this study were apparent instances of remarkable leadership indicated, though there are, no doubt, responses from highly effective health care leaders included among the survey responses --- they simply do not draw attention to themselves here.

By way of analogy, the jury remains "out" in the research component attempting to isolate the variables which might predict effective leadership, yet the survey was able to show that compassion is a leadership trait common to female health care executives and team-building is common to their male counterparts. The average tenure in the position of chief executive for a hospital does not appear to be tied to any specific bundling of professed values and their related actions. In fact, the chief executive of a hospital would appear to need to keep his or her vitae current, due to the fast track nature of the position. And while the overwhelming majority of respondents to this study are male, there does not appear to be any greater likelihood that a female in the top administrative post of a hospital will fare any better in terms of longevity than a male.

Further research on the relationships among the characteristics of health care administrators could include
examining institutional attributes, observations by other management team members of the CEO's traits and attributes and/or comparative characteristics of those former CEOs removed from their positions.

The polk-a-dotted creature remains silent about its thinking, motives and ambitions. It will not define itself here, though it is clearly leading, and followers are following. We know that you are. We just want to know how you come to be.
APPENDIX A

Leadership Attribute Survey

<table>
<thead>
<tr>
<th>TITLE/POSITION</th>
<th>HOW LONG</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREVIOUS POSITION</td>
<td>HOW LONG</td>
</tr>
<tr>
<td>AGE</td>
<td>GENDER</td>
</tr>
</tbody>
</table>

As a health care executive, how often do you perceive yourself as engaging each of the following practices or traits:
(Circle one number per item)

<table>
<thead>
<tr>
<th>Practice</th>
<th>NEVER</th>
<th>RARELY</th>
<th>SOMETIMES</th>
<th>USUALLY</th>
<th>ALMOST</th>
<th>ALWAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Acknowledger</td>
<td></td>
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<tr>
<td>B. Motivator:</td>
<td></td>
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<tr>
<td>C. Coach:</td>
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<tr>
<td>D. Visionary:</td>
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<tr>
<td>E. Self-confident</td>
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<tr>
<td>F. Inspirational</td>
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<tr>
<td>G. Fearless:</td>
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<tr>
<td>H. Not abusive:</td>
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<tr>
<td>I. Puts faith in people:</td>
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<tr>
<td>J. Decision maker</td>
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<tr>
<td>K. Develop/influence others:</td>
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<td></td>
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<tr>
<td>L. Encourage teamwork:</td>
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<td></td>
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<tr>
<td>M. Empower others</td>
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<tr>
<td>N. Thinking stops with the obvious:</td>
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<tr>
<td>O. Risk Taker:</td>
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<tr>
<td>P. Have a strong, clear vision:</td>
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<tr>
<td>Q. Passionate about work:</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>R. Frequently challenge own knowledge base:</td>
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<tr>
<td>S. Cheerleader:</td>
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<td></td>
</tr>
<tr>
<td>T. OTHER</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

( specify )
Dear Healthcare Executive:

I am a candidate for the Master of Science degree in Health Services Administration at California State University, San Bernardino. In fulfilling the requirements for the thesis program, I have elected to conduct a study of the topic of leadership. The enclosed survey will provide me with valuable data that will constitute the essence of this study. This is where I am hoping for your assistance in obtaining my degree and getting out of the hair of my graduate advisors.

Your facility was selected randomly from the American Hospital Association Guidebook, circa 1991. The factors used in selection are that (a) the facility be accredited by the JCAHO, and (b) there be at least 200 beds.

The survey will take approximately five minutes to complete. Responses should be based on your understanding of the category. As I do NOT want information which will identify you personally, I am counting on rigorously honest responses. Please describe what you, as a leader, do or believe NOW in your practice.

I know you are busy and I need to dispense with this letter and let you get on with the survey, but I would like to ask you one more thing - please return this to me within the week. The return postage is paid. Fold it at the line on the back so my address shows, use your favorite fastener, (tape, staple, rivet), and drop it into the outgoing mail. Thank you for your kindness as a participant in this study. I realize the value of your time and I appreciate you sharing it with me. If you have questions or additional ideas that you wish to share with me, please contact me at the above address. I would consider it an honor to hear from you.

Sincerely,

Kenneth D. Kassinger
REFERENCES


