Expert Leaders for Healthcare Administration

COMMENTARY

Mary E. Stefl, PhD
Professor and Chair Trinity, University, San Antonio, Texas

Abstract

This commentary explores the role of graduate programs in developing future leaders in health administration. The five-stage Dreyfus model for skill acquisition is applied to graduate education and continuing professional development, and barriers to producing the type of leader capable of transforming the healthcare system are discussed.

In this issue of *HealthcarePapers*, Peggy Leatt and Janet Porter have provided a cogent explanation of the turmoil surrounding leadership in healthcare today. Their arguments should inform the discussion that currently surrounds both graduate education and continuing professional education in the health services administration field as well as provoke new ideas and initiatives.

Leatt and Porter begin with a succinct review of the efforts to understand the "essentials of leadership" and explain how leadership theory has evolved in the last 50 to 60 years. They note how trait and behavioural approaches have yielded to concepts of leadership involving emotional competence and suggest that team leadership, where decision-making is shared by various members of interdisciplinary teams, might be appropriate in complex organizations such as hospitals and other healthcare entities.

The authors judiciously note that leadership theory continues to evolve. While the long-standing debate about

whether a leader is born or bred seems to have been resolved in favour of learning, the attitudes, competencies and behavioural repertoire that define the effective leader continue to be elusive. The sheer volume of texts and articles produced annually attests to the seemingly unending quest to define leadership. Still, current theory tilts toward the transformational leader who can display a variety of leadership styles and behaviours depending on the context and circumstance.

What has also evolved is the concept of who wears the leadership mantle. While a leader was once defined as a person with a key position on an organizational chart, current theory argues that every person can display leadership abilities (Kouzes and Posner 2002). Closely aligned with theories that emphasize emotional intelligence, Kouzes and Posner stress that leadership accomplishments stem from relationships, values and personal will. Leadership, they argue, cannot only be learned but must be practised. Leaders can and should be found at all levels of the organization.

Leadership Development in Health Care

Egalitarian theories of leadership aside, the question of the leadership gap focuses on the executive ranks. But if leadership can be developed, whether in the line manager or the corporate CEO, who or what is responsible? Leatt and Porter note that corporations have written off the ability of MBA programs to prepare future corporate leaders. Instead, promising young careerists are targeted for internal corporate development programs, and a large number of corporations sponsor their own external executive development programs that are specifically tailored to develop leaders for their organization.

Employee and leadership development in healthcare is much different. Notorious for the lack of resources devoted to employee development, healthcare organizations have relied on individuals to pursue continuing education through professional societies and meetings of trade groups. In many organizations, the resources available for even these types of professional development are limited, and the concept of identifying a promising young executive and providing him or her with extensive development is foreign to many healthcare institutions.

Of course, there are good reasons for healthcare's lack of financial commitment to professional development, as Leatt and Porter carefully explain. Healthcare has historically been anchored at the community level, and that has meant that communities were served by a few or several free-standing hospitals. Within these relatively small organizations, few promotion opportunities existed for ambitious young professionals. Career advancement in this "cottage industry," then, meant moving to another organization. There was little incentive for the organization to invest in the young professional who would eventually be moving on.

Integration now characterizes much of healthcare delivery. Hospitals and other organizations have created both local and national integrated delivery systems, and ample opportunities for career advancement typically exist within a given system. Still, the prevailing culture of health services administration has limited the amount of effort devoted to professional and leadership development.

Leadership and Graduate Education in Health Services Administration

With so little investment in executive development, it was de facto the responsibility, Leatt and Porter argue, of graduate programs in healthcare administration to provide the foundation for future leaders in the healthcare field. Unlike their business school counterparts, not only were new careerists in health administration expected to have the skills to succeed at their first position, but it was also assumed that they would have an arsenal of skills and learning techniques to continue to develop professionally. Given the complexity of healthcare delivery today, such an expectation hardly seems realistic.

Hubert and Stuart Dreyfus (1986) have provided a model for skill acquisition that can be applied to leadership development. The original Dreyfus model posits five stages for skill development: Novice, Advanced Beginner, Competent, Proficient and Expert. As individuals begin to learn a skill, they learn the rules governing the situation and then how and when to apply them. As their level skill increases, explicit reliance on these rules fades, and complex situations can be handled with greater ease and flexibility. As skill increases, actions stem more from intuition than mapping a given situation to pertinent rules and accepted standards; individuals see a pattern in a situation and know reflexively what solution to apply and action to take. By the time an individual progresses to the expert stage, he or she is able to intuit almost immediately the type of action required.

The Dreyfus model has been applied to the development of competencies or skills in nursing (Benner 1984) and medicine (Batalden et al.2002), and there is no reason to assume that it cannot also have utility for healthcare management. But which skill levels should we expect new graduates to display? Applying the Dreyfus model to the development of medical students, Batalden et al. (2002) label freshman medical students as beginners or Novices and do not expect the achievement of the Expert level until mid-career, many years later. Resident physicians typically attain the Competent level.

Implicit in the Dreyfus model is the interaction of experience with the rules (theory and empirical knowledge) applicable to the situation. While a new graduate manager might deal with a distraught and angry patient by referring to the policies manual, a seasoned executive would respond intuitively and in a manner that draws on both experience and values. The more mature executive would have internalized the explicit rules and accumulated knowledge of how to apply (or not apply) the rules to the situation at hand. The intuitive and discriminatory knowledge can only be gained from experience and practice in applying management skills.

Most health administration graduate programs incorporate some type of field experience. Some have administrative residency programs lasting six to twelve months; others direct their graduates to fellowship programs of one to two years. These experiences provide a structured mentorship for young careerists and allow them the opportunity to practise their beginning-level skills in leadership and the other competency domains that health management requires. These supervised experiences should accelerate the progression from the Novice stage, but they are

unlikely to take managers with little or no previous experience to the higher stages of the model (Proficient or Expert).

Of course, this argument assumes "traditional" healthcare administration students, young men and women with little post-baccalaureate experience. In reality, health administration graduate students are quite diverse. Many have considerable previous experience in healthcare or some other area. Their progression from Novice to Expert may move more quickly (due to appropriate experience) or more slowly (based on experience that actually interferes with leadership development).

Graduate programs in health administration, then, can only be expected to lay the appropriate foundation for leadership skills. They can do that by emphasizing the competencies most relevant to a healthcare management, and ensuring that they foster leadership skills and values appropriate to all levels of management. It must also be recognized that graduates will enter the field with a variety of experience and in various stages of developing their leadership and other management skills.

Expert Leaders

If this application of the Dreyfus model is appropriate, then the development of Expert (and perhaps even Competent and Proficient) leaders is beyond the scope of academic programs. It must occur through on-the-job experience coupled with continuous learning activities. In order to move the learner to a stage where intuitive decisions can be made, some type of systematic and disciplined reflection must accompany experience.

Despite the limitations of leadership development in healthcare noted above, the evidence for a leadership gap in today's environment is arguable. There is no doubt that leading a healthcare organization involves some of the most formidable management challenges around, and yet recent reports suggest that turnover of chief executive officers in U.S. hospitals is low (Reilly 2003). Presumably, existing CEOs are performing satisfactorily, especially given the tumultuous fiscal environment.

A New Type of Leadership in Healthcare

Leatt and Porter refer to the Institute of Medicine's report *Crossing the Quality Chasm* (Institute of Medicine 2001), a seminal document that calls for a complete redesign of the U.S. healthcare system. In interpreting that report, Berwick (2002) argues that the U.S. healthcare system is not capable of providing the type of healthcare that the public deserves and echoes the report's call for a completely redesigned system.

To achieve this vision will require strong leadership at both the policy and institutional level. Moreover, it will require an expanded scope of leadership than is visible today. It will require expert leaders who can look beyond individual institutions, interface with the community, argue for political change and not always put the welfare of their individual organization first.

Promoting this type of leadership requires commitment beyond the profession of healthcare administration. Boards of trustees and boards of directors, who provide oversight and stewardship for our healthcare institutions, must have a commitment to this vision. While CEOs

typically have considerable latitude in their authority, they are ultimately responsible to their governing body. Responsibility is typically defined in fiscal terms. The governing body expects the organization to show a positive bottom line and holds the CEO accountable. In for-profit systems, a positive bottom line means satisfying stockholders. Non-profit systems act on a premise that states: "No margin, no mission." These fiscal mandates have changed little even as more and more healthcare organizations or systems have adopted a corporate model of governance.

While today's healthcare executives may be providing the type of leadership that promotes the current healthcare system, they may have neither the freedom nor the incentive to provide leadership that will transform the healthcare system. To do that will require resolve and commitment from all stakeholders in the healthcare field, including governing boards, graduate programs and practising executives.

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