Leadership in Healthcare and Public Health

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Julia Applegate; Colleen Baumer; Cindy Clouner; Kara Colvell; Paige Erdeljac; Erin Fawley; Emily Feyes; Angela Finnegan; Nicholas Fowler; Seth Frey; Haley Griffin; John Guido; Elizabeth Hustead; Elena Mircoff; Trevor Moffitt; Rana Roberts; Hilary Metelko Rosebrook; Lindsay Schwartz; Fadi Smiley; Chris Westrick; and Lena Schreiber

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Foreword

Thomas Huber

Can leadership be taught? If the answer is yes, then a highly interactive flipped classroom may be an ideal environment. Class time is used for case studies, simulations, interactive content, and working on gaining leadership experience individually and within student groups. The flipped classroom format was utilized for our Spring Course in Healthcare and Public Health Leadership. We asked students and ourselves to answer the following guiding questions: How do I define leadership and why is it important? How do I lead and what is my leadership style? How do I work with others? How do I follow and manage my boss? And how will I improve my leadership? The content utilized to answer these questions comes from six textbooks, case materials, interactive content, research, speakers, and practical experience from all of us as students of leadership and organizational behavior.

Leadership is a diverse area of study, and both academic and popular press literature abound with good and bad examples of ideas, knowledge, frameworks, paradigms, etc. about leadership. In order to keep us grounded, I chose the Northouse “Leadership: Theory and Practice” electronic version as a central guiding framework to introduce a comprehensive set of leadership theories. Harvard Business School cases and simulations provided additional content, along with leadership books by Ledlow and Stephens, Rowitz, Manion, Osland and Turner, and Galos. The course syllabus has our references listed, along with a larger group of additional leadership and organizational behavior titles in the reference section. In order to digest a large amount of material, slides were shared with the class ahead of time. Students were asked to write brief reflection papers on chapters within the reading that they would share with each other online and during our class sessions. Both an oral presentation and writing a chapter in our Pressbook were essential elements for learning the material throughout the course.

This Pressbook is a reflection of a diverse group of graduate students from health services, health management, health professions and a diverse group of mid-career professionals engaged in obtaining a Master of Public Health at The Ohio State University College of Public Health, while continuing to work usually more than 40 hours a week. This Pressbook is a gift from the students, TAs, and instructors for all of us. We have captured here (1) our collective learning in the 2018 spring semester, (2) our desire to share our knowledge with the students taking the course next year, and (3) our eagerness to share it with all of you – healthcare and public health friends and colleagues interested in learning about leadership and organizational behavior.

Introduction: Healthcare and Health Policy Leadership and Organizational Behavior in the 21st Century

Thomas Huber

We are in a crisis in healthcare and public health leadership. The diverse and rapidly changing political, technological, economic, and socio-cultural shifts in the last fifteen years have had a tremendous impact on healthcare delivery systems and public health. All aspects of the system seem to be shifting and changing with increasing rapidity at all times. We have moved from quality improvement (70's-80's) to total quality management (90's-10's) and now performance management (10's and beyond) with increasing pressure to meet the triple aim and value-based healthcare delivery outcomes. We spend more money than other countries, yet we consistently rank low in terms of outcomes related to safety, quality, and cost compared to other first-world countries (Commonwealth Foundation, 2014). Who is ultimately accountable for the health of our nation? What is the role of leadership across healthcare and public health settings? What aspects of leadership theory and models might apply to help us address the gaps and challenges of leading healthcare delivery system change and reform? In this Pressbook, students of the PUBHHMP 6615 course at The Ohio State University, College of Public Health tackle a variety of leadership challenges and apply their experiences, learning, and theories in their individual chapters throughout the book.

The study of leadership is growing, and there are a number of existing leadership theories. The way in which one leads may affect how individual followers, teams, and entire organizations function, prompting leaders to foster an atmosphere of teamwork. We start our journey with a chapter on *team science* is a collaborative and interdisciplinary approach to study groups, and **Hustead** explores the intersection of teamwork and leadership in her chapter. Leading virtual healthcare teams is both an art and science and is shared by **Clouner**. Big-Data and data analytics are a central aspect of 21st century medicine. **Mircoff** explores central technology enabled/challenging themes like empowerment, transparency and trust, inquiry and innovation, and values related to organizational change. An example of leadership from the top down is provided as **Schreiber** describes similarities and differences for Chief Medical Officers in central Ohio with a focus on leadership approaches, traits, and skills. **Frey** provides a personal early journey in leadership and reflects on his practice and understanding of leadership.

Healthcare in the 21st century spans a much wider range than ever before, and **Fawley** tells us about how leadership in public health can be viewed through a collective impact framework. Personal stories and reflections collected from central Ohio leaders are shared by **Finnegan** and **Baumer** and encompass both healthcare delivery and public health. Leadership is important during normal times, but becomes critical during a crisis. **Colvell** explores a management crisis framework and applies it to the Flint, Michigan public health water crisis.

Culture shifts are occurring within organizations, thus impacting how leaders manage diverse followers and raising important questions. For example, how do we define cultural humility in our LGBTQ communities? **Applegate** helps us understand critical factors in leading LGBT populations and what leadership theory tells us about managing disparities, empowerment, and skills. **Feyes** dives deeply into promoting and understanding leadership in diversity in organizations.

Medical errors and safety are a major problem across the U.S. healthcare system, and **Roberts** explains some of the leadership dynamics like hierarchy and role status. **Guido** reflects on his experience

as a physician hospitalist focused on leadership inclusiveness and psychological safety in the inpatient hospital setting. Communication and the science and art of feedback for leaders is crucial in creating an atmosphere of inclusion and safety. **Westrick** and **Erdeljac** explore these themes in their chapter on feedback in leadership. How do great leaders manage conflict that may arise during feedback? **Smiley** defines what is meant by conflict management and which leadership approaches might be most suited to managing conflict.

Employee wellness programs should be a priority for healthcare and public health leaders. **Griffin** provides an overview of wellness programs and their effects in the healthcare sector. **Schwartz** and **Rosebrook** both explore psychological safety, creating a culture of safety, and developing leadership behavior as a critical factor in setting the tone for well-being at work. In addition to employee wellness, burnout and compassion fatigue are a major concern for caregivers in the field of addiction and substance abuse. **Fowler** helps us understand how positive organizational psychology may be applied to palliative healthcare settings. In the context of the current opioid epidemic, **Moffitt** explores contributing and protective factors for individual care providers in addiction treatment facilities.

We encourage you to consider the implications of the above perspectives and insights and apply them in your own healthcare and public health leadership settings. We know change is inevitable. How we embrace change and influence it will be a measure of our leadership effectiveness. We encourage you to join us in exploring healthcare and public health leadership theory and practice.

Team Science and Transformational Leadership in the Healthcare Field

Elizabeth Hustead

Introduction

Complex healthcare environments, such as large, geographically dispersed hospital networks, specialized treatment centers, and research facilities, require strong leadership with multidisciplinary teams of healthcare professionals and scientists to work towards solutions (Stokols et al, 2008; Gadlin et al., 2010; Vogel et al., 2013; NRC, 2015). Modern healthcare problems cannot be solved in the traditional, linear manner because as new solutions to the problem are considered, the definition of the problem evolves (Stokols et al., 2008). A complex healthcare question, such as how to improve patient outcomes while reducing burden on a hospital, requires healthcare experts from many disciplines working together under the appropriate leadership. Having input from these healthcare professionals is vital in reaching a long-term, meaningful solution; each brings their own unique perspective based on their area of expertise (Stokols et al., 2005). Having the appropriate leadership in place is critical to a team's success and productivity. Without the correct leadership at the helm, even teams of the brightest professionals can run aground or flounder. As treatment centers and patient care become more complex, the need for collaborative research, team science, and team leadership will continue to grow.

This chapter describes the current state of team science and collaborative patient care in the field of healthcare. Using classic papers on collaboration, team science, and transformational leadership, we will review and critique several large-scale team science initiatives in the healthcare field from the Cleveland Clinic to Aligning Forces for Quality Program. We will also discuss the transformational leadership aspects of each initiative and how those leadership tactics contributed to the programs' overall success. Based on the current literature and the state of the science, recommendations will be made on the direction of future research in the healthcare field. The reader should finish the chapter with a thorough understanding of prior team science healthcare interventions and how transformational leadership can be employed to effect change at both the individual and team levels.

Background

One approach to solving complex modern organizational problems, including those in the field of healthcare, is called team science: *a collaborative, multidisciplinary research process that brings independent researchers or healthcare professionals together into a collaborative group* (Gadlin et al., 2010, Vogel et al., 2013; NRC, 2015). This has been a natural fit for healthcare organizations, such as hospitals or public health departments, as they shift their focus from disease treatment to preventative, whole patient care, and populations health (Zocchi et al., 2015). One example of this shift took place during the 2007 reorganization of the Cleveland Clinic, which will be discussed in further later in the chapter.

Team Science Overview

The past 20 years have seen a surge of investments into team science programs in innovation, research, and advancements in patient care. This kind of approach was often not possible within a single healthcare system working in isolation, but is now being explored through teams of healthcare professionals working together (Stokols, 2008). Healthcare research into organizations is further complicated by the fast-paced nature of technological advancement in modern medicine and public health. New technology is emerging every day that can improve patient outcomes and streamline hospital procedures. For example, how can healthcare facilities decide which changes to pursue and

which technologies to implement? This question can often seem overwhelming and is often unaddressed by healthcare facilities large or small, who have their hands full managing patient care and trying to stay financially solvent. This combination of circumstances often results in the same practices continuing for decades because that's "how things have always been done" even if more efficient or innovative methods emerge. Implementing team science is one way to bring large healthcare organizations into the future and explore benefits for patients, healthcare professionals, and the infrastructure of the healthcare system itself.

Challenges for Team Science

While team science has many advantages, there are also many challenges. Highly diverse team membership can create issues for research; there are cultural, linguistic, and institutional barriers to everyday interactions and long-term collaborations (Vogel et al., 2013; NRC, 2015). Deep knowledge integration presents difficulties as well; it challenges team members to share and build on each other's knowledge across boundaries and disciplines (Olson & Olson, 2008).

Boundaries in the healthcare field are also permeable and goals or priorities themselves can change over time, resulting in an ever-changing landscape that is difficult for healthcare teams to navigate. Additionally, team membership often fluctuates as healthcare professionals join or leave the team. Finally, geographic dispersion can be a significant barrier to disseminating innovations evenly, particularly with communication and coordination (teams in different locations have little face-to-face interactions and different time zones necessitate additional planning to determine convenient meeting times for all parties) (Borgman et al., 2008; Olson & Olson, 2008). Overcoming these obstacles can be difficult, but not impossible, with the appropriate tools in place to facilitate communication.

Communication is the common theme that unites complex modern research problems and collaborative solutions. One of the main determinants of the collaborative capacity (and thus potential success) of a healthcare team are the technological resources and organizational support that allow team members to network data over the course of a project (McGrath & Hollingshead, 1994; Majchrzak et al., 2000; Olson & Olson, 2008; Stokols, 2008). Working collaboratively, even within a single department or hospital, can be a challenging and when departmental or institutional boundaries are crossed, these challenges increase (Borgman, 2008; DeSanctis & Jackson, 1994, Galdin et al., 2010).

The National Institute of Health (NIH) 2010 Team Science Field Guide states that one of the biggest challenges facing new cross-organizational teams is that there are no procedures or infrastructure in place to facilitate these interactions (Galdin et al., 2010). This lack of infrastructure can be crippling to a healthcare network, particularly one that is new to team science and seeking to implement changes for the first time (Borgman, 2008; DeSanctis & Jackson, 1994, Galdin et al., 2010). These challenges will be addressed in this chapter and several cases of healthcare organizations who have attempted to implement these changes will be analyzed.

Context

In this chapter, we will address the context in which team science can be integrated into the healthcare field to improve outcomes such as hospital efficiency, patient satisfaction, and hospital costs. The NIH Field Guide describes team science as *"a collaborative and often cross-disciplinary approach to scientific inquiry that draws researchers who otherwise work independently or as coinvestigators on smaller-scale projects into collaborative centers and groups."* Team science requires strong and effective leadership to ensure a high-functioning, effective team. Most research on this topic focuses on transformational leadership, a leadership style that "induce[s] followers to transcend their interests for a greater good" (Kozloqski & Ilgen, 2006). There are myriad benefits to working with teams with strong leadership, particularly in healthcare or public health settings which by their very nature are interdisciplinary.

Puga et al. state that using transdisciplinary teams in healthcare "brings together a diverse group of

individuals who fully integrate theories, methodologies, and frameworks from their respective fields to work as a cohesive unit on complex issues." By working in teams, individuals are able to pool both physical and intellectual resources to "draw on multiple disciplines, fields, and professions" (Vogel et al, 2013). In research science, this results in more advanced and comprehensive interdisciplinary studies; in the field of healthcare, this results in a more comprehensive approach to patient wellness. Team science is a natural fit for healthcare systems such as the Cleveland Clinic where major restructuring organized healthcare professionals by organ system to improve patient care (Porter & Teisberg, 2016). Coordinating large scale healthcare systems and disseminating information through or planning improvements for those systems is also a task well suited to the team science structure (Zocchi et al., 2015; Porter & Teisberg, 2016). While team science is a valuable tool in healthcare settings, significant improvements need to be made in both the resources and support available for healthcare systems in order to further incorporate team science.

Healthcare Team Science and Transformational Leadership

Trans- or interdisciplinary teams are extremely valuable in the field of healthcare, as they "bring together a diverse group of individuals who fully integrate theories, methodologies, and frameworks from their respective fields to work as a cohesive unit on complex issues" (Puga et al., 2013). In a thorough literature review conducted by Buscemi et al., researchers recommend that a stronger emphasis be put on collaboration and teamwork between health professionals (2012). The results of those studies indicate that interdisciplinary teams can yield more positive patient outcomes and that inter-professional collaboration is most effective when all professionals treat each other's opinions with respect and communicate well (Buscemi et al., 2012). Because respect and communication are not always a given, the authors encourage evaluation and preparation for collaboration before the team is launched.

Team science is supported by several studies on transformational leadership. In their meta-analytic review, Wang et al. found that transformational leadership was "positively related to individual-level follower performance" and that strong leadership contributed positively to productivity outcomes at several levels (2011). The National Academy of Sciences corroborates these findings with their handbook "Enhancing the Effectiveness of Team Science" and states that transformational leadership approach facilitates "subordinate motivation and effort" and that effective transformational leadership often results in better outcomes at the team and individual levels than other leadership strategies (2015). There is a general consensus that future research is needed to analyze the efficacy of interdisciplinary teams and leadership (specifically transformational leadership) in the healthcare field and that additional tools should be developed to facilitate these goals.

Case Studies in Healthcare Team Science and Transformational Leadership

Aligning Forces for Quality Case Study

In their 2015 study, Zocchi at al. further examine the need for improved leadership and teamwork in a field of healthcare (emergency medicine, specifically) and implements and analyzes such extensive changes. For this study, 172 interventions were implemented across 42 hospitals as part of the Aligning Forces for Quality program. Two-thirds (28) of the hospitals from the study saw improvement on one or more metrics. Many of the truly impressive changes achieved through this study (reduction in patient wait time, rates of patients who left without being seen, unnecessarily long stays, etc.) were improved through changes in leadership and the introduction of teams, even if only for educational and not collaborative purposes.

While important improvements for a number of hospitals were made, one-third of the hospitals enrolled in the study did not show improvements, and 40 of the initial 82 hospitals who signed up to participate in the Aligning Forces for Quality program dropped out of the study, convinced that they could not make the changes necessary. More work needs to be done to help hospitals prepare for large-scale changes and incorporating teams. One of the main challenges reported was a lack of buy-in from

senior leadership and lackluster support for the "change champions" using transformational leadership strategies to implement the Aligning Forces for Quality program (Zocchi at al., 2015).

The authors suggest that one explanation is the lack of face-to-face meetings, resulting in reduced engagement and a lack of leadership opportunities, despite the transformational leadership style of team leaders (Zocchi at al., 2015). Zocchi et al. suggest that for future interventions team leaders of healthcare works should be more involved at the planning stage, so as to decrease staff resistance to change (2015). The authors also state that improved transformational leadership is necessary to early success of the program to even get the intervention started (2015).

Cleveland Clinic Case Study

In their review of the changes made at the Cleveland Clinic for the Harvard Business School Case, Porter and Treisberg emphasize the importance of working in teams with strong transformational leadership. After Delos M. Cosgrove, M.D. became the Clinic's CEO in October 2004, he instituted many changes starting with a stronger emphasis on patient care and satisfaction and a drive for unified clinical leadership. He also reorganized departments from medical/surgical classifications to teams focused on specific organs or organ systems and developed 106 "Care Pathways." While this initiative began as a way to improve the patient experience, it blossomed into the formation of multidisciplinary care teams lead by transformational leaders who were more cost and time efficient while also delivering a better patient experience. As a result, operating costs for the Clinic decreased, patient satisfaction increased, and several other major hospital systems began adopting this model.

Incorporating transformational leadership into the Cleveland Clinic re-organization was largely responsible for its success. Team were made up of "caregivers" (formerly referred to as non-professional staff) who work together in teams to discuss the mission, values, and patient experience. Data was collected from these teams on day-to-day hospital operations so that action items could be set at the team level for continued improvement (Porter & Treisberg, 2016). Known as "Leadership Rounding," this process encouraged all caregivers to take ownership in the success of the Clinic and patient satisfaction. The re-organization of the Cleveland Clinic clearly demonstrates the value of using teams of dedicated professionals and non-professional staff lead by transformational leaders in the field of healthcare.

Personal relevance

Working for SNAP-Ed (the Supplemental Nutrition Assistance Program- Education) requires a significant amount of interdisciplinary collaboration. SNAP-Ed serves low income audiences across the country and Ohio (ranked 6th in food insecurity in the nation) has a great need for that guidance. SNAP-Ed is housed in the Family and Consumer Sciences (FCS) branch of Extension at the Ohio State University. Within Extension, SNAP-Ed works collaboratively with the other Extension branches: Community Development, Agriculture and Natural Resources, and 4-H (youth programming).

Internal Transdisciplinary Teamwork

Each branch of Extension comes with their own priorities and areas of expertise. While the overarching goal of all Extension branches is to serve Ohioans, it can be challenging to work together because SNAP-Ed is required to focus exclusively on low income populations with very strict programmatic guidelines. These difficulties are compounded by the fact that each county in Ohio has an Extension office, each with their own Extension specialists, Program Coordinators, and Program Assistants. Because Extension personnel are intentionally geographically dispersed to better serve Ohio's diverse population, tools to enhance long-distance collaboration are desperately needed. In this vein, OSU Extension leadership have implemented several initiatives, including a major restructuring, an annual Extension conference, and the adoption of the Zoom collaborative software platform.

Within FCS, SNAP-Ed works collaboratively with other Community Nutrition programs, including EFNEP (the Expanded Food, Nutrition, and Education Program), Farm to School, and Healthy Living programs (including Healthy Relationships and Healthy Finances). While each of these teams fall under

the umbrella of Community Nutrition programs and are overseen by a single Associate Dean, they serve different audiences in different contexts in different settings across the state. While the shared focus and the fact that all Community Nutrition programs are housed on OSU campus make collaboration somewhat easier, there are still the typical challenges experienced by any diverse, interdisciplinary team.

External Transdisciplinary Teamwork

External transdisciplinary teamwork is also a critical facet of SNAP-Ed's outreach and success. SNAP-Ed was a founding member of the Ohio State Nutrition Action Committee (SNAC) and has spearheaded several innovation projects on behalf of SNAC. Most recently, SNAP-Ed launched a social marketing campaign, Celebrate Your Plate, with the support of SNAC members including the Ohio Department of Health (WIC and Creating Healthy Communities), Ohio Department of Education, Ohio Department of Aging, Ohio Department of Job and Family Services, EFNEP, and the Mid-Ohio Foodbank.

The success of this social marketing initiative is dependent on strong teamwork and communication between SNAC members to disseminate messages and materials across the state. External (and in this case inter-agency) collaboration at the state level can be complicated, even when team members are all highly motivated and working towards the same goal. There is often a disconnect between the implementing agency (in this case, SNAP-Ed) who needs to make the day-to-day decisions about the project and other team members. Additionally, SNAC is made up of one state-level representative of many government or non-profit agencies, so decisions that need to be approved by the various SNAC partners or regional level officials delay progress significantly. These challenges to transdisciplinary team science are being evaluated via a process evaluation so that changes can be made in the future to enhance collaboration.

Discussion

The field of healthcare, including public health, is becoming increasingly complex with the introduction of new technology and scientific developments. Complex problems, such as how to improve patient outcomes while reducing burden on a hospital, requires healthcare experts from many disciplines lead by an individual practicing transformational leadership. As we observed with the Cleveland Clinic case study, these challenges exist within a single hospital or healthcare system.

New leadership and teamwork strategies, such as team science, are essential to the continued success, development, and expansion of healthcare-related services. Having input, guidance, and pooled knowledge from a team of healthcare professionals allows team members to combine their expertise to achieve solutions far beyond what would have been capable with those individuals working in silos. When team science is combined with transformational leadership, the level of success increases exponentially. This transformational team science approach is a logical fit for healthcare and other public health organizations as healthcare problems have become more complex over time and require more advanced resources to resolve. In public health the utility of this approach is even more pronounced as the focus has shifted over the past century from disease treatment to disease prevention.

We used the Cleveland Clinic case study and the Aligning Forces for Quality Program to demonstrate that there is significant interest in using team science and transformational leadership to improve healthcare systems. In both cases, major changes were made to improve the patient experience as well as hospital functioning metrics. However, is it possible to apply these strategies to other healthcare systems? Would the Cleveland Clinic restructuring have been as successful without such strong support from management and administrative professionals within the hospital? Porter and Treisberg cite examples of how the strategies employed by the Cleveland Clinic have been implemented in other hospital networks. This indicates some potential for replicating these results in other systems, but without the administrative support and a significant amount of financial support this major restructuring would not have been possible.

Based on the literature and studies reviewed in this chapter, we can conclude that team science can be

successfully applied to healthcare settings if certain conditions are met. First, there must be significant support from management and administrative branches of the institutions looking to make the changes. Second, the future team members must be prepared to work together and embrace the shifting dynamic for the team to succeed. Team members might require training to become successful leaders or team members and how to work with others in a more collaborative setting. Ideally, the team leader will have had substantial leadership training and be prepared to employee transformational leadership strategies. Third, there must be sufficient resources (financial, infrastructure, personnel, etc.) to support the changes that are needed. As seen in the Aligning Forces for Quality study, hospitals who do not have sufficient resources, staff buy-in, or support from senior staff in the healthcare organization will not be able to make the necessary changes. Finally, sufficient tools and technology must be in place to support the emerging team science; long distance collaboration or even localized communication within a single organization or location must be optimized for teams to succeed.

Conclusions

After reviewing the Cleveland Clinic case study and the Aligning Forces of Quality initiative, it is evident that team science and transformational leadership can be effective tools in healthcare settings. Well implemented interdisciplinary teams can result in improved communication and collaboration between many levels of the healthcare system (among providers, patients, administration, community partners, etc.), improved patient and hospital outcomes, and enhanced sharing of resources among large, geographically dispersed organizations. While team science and transformational leadership can generate remarkable results in the field of healthcare, they must also be accompanied by senior-level leadership support from within the organization, buy-in from other staff, and sufficient financial resources to support restructuring and training to ensure success.

Leading Virtual Teams

Cindy Clouner

Introduction

Advances in technology have changed the ways teams function. In the late 1990's, organizations began adopting the idea that effective teams could be composed of individuals stationed across the country, or even the globe. These teams, known as virtual teams, were even touted as the "workplace of the future" (Townsend, et al., 1998). Twenty years later, virtual teams are used by nearly half of global organizations (Minton-Eversole, 2012).

This chapter will explore the characteristics of virtual teams and how they compare to conventional teams, identifying both the strengths of virtual teams and the challenges that they face. Though challenging for all types of teams, virtual teams must approach the issues of *goal alignment, motivation, and conflict management* differently than their collocated counterparts. Additionally, this chapter will explore the differences between transactional and transformational leadership, the strengths and weaknesses of each style as it relates to leading virtual teams, and answer the question "Is a transactional or transformational leadership style more effective when leading virtual teams?" Finally, the chapter will explore three phases of leading virtual teams and strategies for leading effective virtual teams.

Virtual Teams vs. Conventional Teams

Virtual teams have been defined as "groups of geographically and/or organizationally dispersed coworkers that are assembled using a combination of telecommunications and information technologies to accomplish an organizational task" (Townsend, et al., 1998). Bell and Kozlowski (2002) identified two key characteristics that differentiated virtual and conventional teams – spatial distance and information, data, and personal communication.

The distance between virtual team members could be great, with members living in different countries, or relatively small, with mere miles between coworkers. Although the actual distance matters less, Bell and Kozlowski (2002) indicate that it is how teams interact in spite of their distance that matters most in the determination of whether a team would be considered "virtual." A lack of face-to-face interactions due to their spatial distance can be considered a defining characteristic of virtual teams.

Although all teams utilize technology for communication, virtual teams rely more heavily on advanced communication technologies, such as the use of web-based apps for project management, videoconferencing, and schedule management, than conventional teams (Bell and Kozlowski, 2002). Rather than supporting the work of the team, virtual teams rely on communication technologies as a primary means of communication.

Gibson and Gibbs (2006) expanded Bell and Kozlowski's definition of virtual teams by considering four dimensions: *geographic dispersion, electronic dependence, dynamic structure, and national diversity*. Although geographic dispersion and electronic dependence are both commonly noted as characteristics of a virtual team, dynamic structure and national diversity are less often noted.

Dynamic structure relates to the frequently shifting organizational structure of virtual teams. A study of 101 virtual teams found that virtual teams are often grounded in shared team leadership, rather than having a strong hierarchal approach (Hoch and Kozlowski, 2014). Virtual teams are often more fluid in nature, relying less on the hierarchy common in conventional teams, and may be limited in the length of time they exist (Gibson and Gibbs, 2006).

National diversity speaks to ability that virtual teams have to be inclusive talent from multiple states

or countries (Gibson and Gibbs, 2006). Organizations utilizing virtual teams find that the decentralized nature of these teams lend themselves to increased diversity. Without the requirement to relocate, organizations broaden their applicant pool to include professionals outside of their local area, including crossing national boundaries (Johnson et. al., 2001). Additionally, the remote work environment of virtual teams can make positions more accessible for professionals with physical disabilities who may find challenges working in a traditional office environment or in locations that have limited accommodations (Bergel, 2008; Johnson et. al., 2001).

It can be argued that these dimensions of a virtual team are what make them advantageous to companies. Without the geographic constraints of conventional teams, virtual teams allow organizations to recruit the most qualified employees for positions (Bell & Kozlowski, 2002). Through the use of virtual teams, employers do not need to require relocation of their talent, diversifying their pool of potential employees (Bergel, 2008).

When teammates are not required to gather in a common place for work due to geographic dispersion, organizations can save money in the cost of providing physical workspaces to employees. Less on-site employees translates into smaller office spaces, less parking requirements, and less in utilities (Johnson et. al., 2001). Less money is also needed to be spent in travel costs, as well as the opportunity cost that is related to traveling (Bergel et. al., 2008). Additionally, employees may find working in a virtual team appealing because of the cost savings. Eliminating work commutes save employees the costs associated with car maintenance, gas, or public transportation. Additionally, employees recover the time that would otherwise be spent commuting (Johnson et. al., 2001).

Virtual teams lend themselves to hiring employees that focus more on productivity rather than other characteristics (Bergel et. al., 2008). The national diversity that virtual teams can bring lead to a more heterogeneous team and discourages discrimination based on race, age, gender, or physical ability (Bergel et. al., 2008).

Challenges of Virtual Teams

Although there are significant advantages to virtual teams, there are disadvantages to them as well. Because virtual teams rely so heavily on technology to facilitate communication, lack of experience in these applications among team members can be a significant barrier (Bergel et. al., 2008). This could mean that otherwise qualified team members may hesitate to take a role that requires them to work on a virtual team. Virtual teams may also not be conducive for every type of organization. Companies focused on manufacturing or have tasks that must be completed in a specific sequence may not be well suited for virtual teams (Joinson, 2002). Finally, another disadvantage to virtual teams is that not every professional has the skills to work in a virtual space. This could be particularly true for extroverted employees who thrive on social interaction, as well as those that struggle to stay motivated without the structures of conventional teams (Joinson, 2002).

Although there are benefits to the utilization of virtual teams, they present challenges to all team members. The dispersed nature of virtual teams can be a barrier to productivity that relies on the work of others. Having team members in other states, countries, or continents makes scheduling meetings challenging due to time differences (Bergel et. al., 2002). Frustrations can mount between team members who start and end their day at difference times, particularly if it holds up the progress of a team member (Joinson, 2002). There may be only a few hours of the day that all colleagues of a team are working congruently.

Although virtual teams allow for more diversity among team members, this can also lead challenges. Differences in language and culture among team members can lead to miscommunication and misunderstandings that hinder the development of trust on a team (Bergel et. al., 2008). Team members that all agree to speak a common language can still experience challenges if the common language is

not native to all team members, as it may be challenging to clearly communicate your needs, challenges, and ideas in a second language.

Even team members that do all speak a common language are at increased risk for miscommunication within a virtual team setting. When communicating in person, nonverbal cues such as gestures, eye contact, facial expressions, and body language play a significant role in how messages are received. Since often times the communication done in virtual teams occurs without looking at each other, miscommunication can easily occur (Bergel et. al., 2008).

Challenges are not just limited to the team members, but also to how virtual teams are led. Bell and Kozlowski (2002) discuss the challenges of executing the two leadership functions, performance management and team development, when working with virtual teams; both functions can be hindered by the lack of face-to-face interactions. Leaders of virtual teams may find it challenging to monitor the performance of their team members, as well as provide the coaching and recognition needed to have a highly functional team.

A review of the findings from both surveys and research about the challenges of virtual teams by Robert Lavasseur (2012) found the top three challenges for virtual teams to be *cultivating trust among team members, overcoming the lack of face-to-face contact, and overcoming communication barriers*. Since virtual teams, by definition, lack frequent face-to-face interactions, team members may miss out on nonverbal communication cues such as facial expressions, body language, and eye contact, leading to an increased risk of miscommunication. Johnson, Heimann, and O'Neill (2001) identified three common communication problems for virtual teams: (1) an unclear understanding of the expectations related to their tasks and how those related to the overall project; (2) challenges getting in touch with team members; (3) difficulty translating the true meaning of a message when it was relayed in a text-based means, such as emails.

Zander, Zettinig, and Makela (2013) found similar challenges to virtual teams in their research. They identified what they referred to as "three critical challenges:" *goal alignment, knowledge transfer, and motivation.*

Virtual team members may find they prioritize tasks differently than their peers based on their cultural experiences and make assumptions about how the team's objectives should be met. Leaders of virtual teams will need to find a way to align the goals of their team members so they can work as a cohesive unit. Knowledge transfer is also a challenge, as the lack of face-to-face contact can lead to communication barriers that impede the ability to share necessary information. Finally, motivation can be a challenge for virtual teams. Since leaders of virtual teams do not see their directs regularly, it is more challenging to identify their needs and respond to them. Additionally, members of virtual teams may have varying degrees of commitment to the team, which can impact performance (Zander, et. al., 2013).

In addition, *conflict, and the management of it,* can be a significant challenge for virtual teams. The lack of face-to-face communication can mean that it is hard to identify if miscommunication is happening and that conflict related to miscommunication can go unnoticed for longer than if occurring in conventional teams (Johnson, Heimann, and O'Neill, 2001). Lavasseur (2012) even referred to conflict as the "Achilles heel" of virtual teams. Because of this, leaders of virtual teams should be mindful of the detrimental impact conflict can have on team success and take steps to proactively address it.

Leadership Styles and the Virtual Team

Although there are a variety of leadership styles, I focus here on transactional leadership and transformational leadership are frequently discussed in the literature as it relates to leading virtual teams.

Transactional Leadership

Transactional leadership consists of three dimensions (Bass, 1997; Northouse 2015):

• *Contingent reward.* These leaders clarify expectations and provide rewards and recognition for meeting

those expectations. They create mutually beneficial transactions consisting of trading resources and support for effort made by their team members.

• *Active management by exception.* Active leaders provide ongoing monitoring that allows them to take action in potentially problematic situations before significant negative impacts are made on the team and its performance. Active leaders enforce the rules, taking action when guidelines are not followed.

• *Passive management by exception.* Passive leaders also take action in problematic situations, however, they tend to wait until they are made aware of the problem before intervening.

These dimensions mean that transactional leaders thrive in environments with structure and are likely to integrate structure, procedure, and policy throughout the teams they lead. They tend to be more focused on short-term goals and are capable of achieving those goals quickly (Spahr, 2016). This can be beneficial in virtual teams, as communication and setting clear expectations are necessary for the success of teams that are decentralized (Levasseur, 2012; Watkins, 2013). Since contingent reward is a key dimension of transactional leadership, leaders employing this style need to overcome the barriers related to monitoring performance and delivering rewards and recognition to team members with whom they do not have face-to-face interactions (Bell & Kozlowski, 2002).

Transformational Leadership

Bernard Bass and colleagues identified four dimensions of transformational leadership (Bass, 1997; Northouse 2015):

• *Idealized influence*. Also known as charisma, leaders with idealized influence may be seen as role models within the organization due to their ability to build trust, loyalty, and confidence. They have strengths in garnering support for a shared vision and making ethical decisions, even when the right choice is a difficult one.

• *Inspirational motivation*. These leaders foster enthusiasm and optimism among their team. They maintain high standards, yet provide sufficient encouragement for their team to reach them.

• *Intellectual stimulation*. For these leaders, emphasis is placed on creativity and innovation. Rather than follow procedure for procedure's sack, team members are encouraged to question traditions and find new solutions that may better meet the needs of the team.

• *Individualized consideration*. Recognizing that each team member is an individual with unique needs, these leaders excel at listening, coaching, and providing feedback to develop the skills of their team.

Leaders who employ the dimensions of transformational leadership are more likely to engage their team in critical thinking to solve problems versus relying on the status quo. This leadership style is beneficial to virtual teams for a number of reasons. First, leaders of virtual teams must be skilled in garnering support for a common vision. Zander and colleagues (2013) identified goal alignment as a key challenge for virtual teams and transformational leaders can utilize idealized influence and inspirational motivation as methods for building cohesion with the team around its goals. Secondly, the dimensions of transformational leadership lends itself well to overcome the challenge of motivation among virtual teams (Zander et al., 2013). These leaders foster enthusiasm, provide coaching, and develop loyalty within their team members that can encourage motivation. Although transformational leaders excel at building the trust needed for successful virtual teams, they may struggle to build the structure needed for a virtual team to succeed.

Although Avolio and Bass (1990) identify the dimensions associated with transformational to be more effective than transactional leadership, leaders of a virtual team may benefit from having a combination of these leadership styles. Although trust is paramount to a virtual team (Joshi, A., et al, 2009) and transformational leaders excel at developing trust amongst team members (Bass, 1997), leaders of virtual teams must clearly communicate expectations and develop policy and procedures to guide a virtual team- both skills in which transactional leaders excel (Bass, 1997). It has also been found that although transactional leadership may lead to increased productivity, transformational leadership may produce

higher quality results, greater team satisfaction with leadership, and group cohesion (Hoyt & Blascovich, 2003).

Phases of Leading Virtual Teams

Zander et. al. (2013) identified three phases of leading virtual teams, the welcoming, working, and wrapping up phases. Within each of the phases, Zander and his colleagues identified areas of focus for the leaders of virtual teams. These phases and focus areas address a number of the challenges of virtual teams that have been identified in the literature, including the challenges of goal alignment, knowledge transfer, and motivation.

The Welcoming Phase

The welcoming phase of a virtual team is the period of time when the team is initially formed and it introduced to the team's goals and objectives. Zander et. al. (2013) encourages a focus on goal alignment, relationship building, and task definition during this phase. It is during this time that leaders should put extra emphasis on clearly articulating the goals of the project and how they relate to overarching goals of the organization. Explicitly defining the tasks and their expected outcomes for each team member is important during this welcoming phase.

Additionally, efforts should be made to facilitate relationship building during this initial phase. Developing relationships within a team helps build trust amongst team members (Zander et. al., 2013).

Levausser (2012) also emphasizes the importance of the initial phase of a virtual team. It is during this formation stage of the team that leaders legitimize the behaviors that will ultimately lead to an effective team, including those that help develop trust and effective communication.

The Working Phase

The second phase of effective team leadership is the working phase. Zander and his colleagues identified roles and processes, coordination of tools, and operations as the focus areas during this time. As the leader of a virtual team, it is even more important to understand with whom the knowledge and skills needed to complete tasks resides. Additionally, leaders must be able to facilitate the access of this information to other team members. Coordination of tools refers to the need for a leader to ensure access to the technology needed to for the team's effective performance. Finally, during the working phase, operations is about the leader's responsibility for the regular communication of progress to the team and attention to potential conflicts (Zander et. al., 2013).

The Wrapping Up Phase

The wrapping up phase is the opportunity for teams to self-evaluate their success of meeting their outlined objectives. Zander et. al. (2013) recommend focusing on finalization and de-briefing during this final phase. Finalization provides the chance for team leaders to reflect on a team's success or shortcomings, as well as provide all team members with time to evaluate both their own performance and that of the entire team as it relates to meeting goal. De-briefing serves an opportunity for process evaluation for the virtual team, with team members exploring how goals were met, the process that the work was done, and how the team utilized technology or other communication strategies.

Strategies for Leading Effective Virtual Teams

The decentralized nature of virtual teams can present significant challenges to leading them effectively. Research and personal experience have identified a number of strategies that have shown to be effective in leading productive virtual teams.

Building Trust

The importance of trust in conventional teams is well-documented. Trust among a virtual team is just as important, though it may be more challenging to achieve, because virtual teams by nature are limited in their face-to-face interactions (Brake, 2006; Bergel et. al., 2008).

Although by definition virtual teams do the majority of their communication from a distance, bringing a team together for a face-to-face meeting in the welcoming phase of a new team can help foster the trust

needed for an effective team. It is easier to facilitate relationship building, including getting to know team members both professionally and personally, during an in-person meeting (Watkins, 2013).

Setting Clear Expectations

Setting clear expectations is important for all teams, but critical for those of a virtual nature. Team members should have a strong understanding of the expectations as they relate to their role and objectives, as well as expectations for group process (Watkins, 2013).

One strategy to ensure that all team members clearly understand the purpose of the team and their individual role is the development of a team charter. In addition to identifying the mission and objective of the team, a charter should also clearly define how the team functions by outlining the group norms and decision-making process it intends to follow (Combs & Peacocke, 2007).

Research indicates that virtual teams often struggle dealing with interpersonal issues and group process (Levasseur, 2012). Another strategy for setting clear expectations is the development of ground rules can be a way to ensure that everyone understands expectations of their behavior and how to handle challenging situations. It is important that ground rules are established at the onset of a team's life and tailored to the unique constraints and culture of the team.

Group rules may focus on ways to avoid interpersonal conflict. Setting rules on accepting and embracing the diversity of teammates, exhibiting patience as new team members adjust to technology and any language barriers, and the expectations around communication are just a few examples (Levasseur, 2012). Clear expectations for managing conflict should also be set. Since conflict can take longer to identify in virtual teams, it is important that an expectation is put in place that team members identify and resolve conflicts as soon as they start (Levasseur, 2012).

In addition to group rules related to managing interpersonal relationships, establishing and following procedures for a team's work cycle is also important. For example, creating procedures for how meetings will be run and the appropriate way to engage in these meetings is important.

Developing meeting agendas and sending them in advance to team members, providing opportunity for community building at the opening of meetings, and wrapping up meetings with a list of actionable items and who they are assigned to can help keep virtual meetings on track (Malhotra et. al, 2007). Without these expectations on procedures, team members may find that they implement processes from past teams that may not meet the objectives of the team and can lead to misunderstandings.

Effective Communication

Effective communication is challenging enough in a conventional team setting. Leaders of virtual teams must put great emphasis on clear and timely communication. Ground rules should be identified for what acceptable communication looks like for the team (Combs & Peacocke, 2007). Establishing norms for the team's communication is an important step in building trust within the team. A 2007 review of research focused on virtual teams by Malhotra, Majchrzak, and Rosen discussed the importance of setting these guidelines that are unique to the team, as without them team members are likely to revert to using the communication norms of their local teams or past employers, which may not be conducive to the team's goals. Malhotra et. al. recommend virtual team leadership establish the proper procedures for how to handle the following situations:

- Identifying the communication technology that should be used and when to utilize each one
- How to utilize virtual work spaces, including what types of content to post, when to post it, how to comment on postings, and procedures for managing and storing documentation in the virtual work space
- Etiquette for electronic and verbal communication, such as beginning a response with the person's name to whom it is directed during audioconferencing and developing abbreviations that can be used to quickly see if emails require responses or not

To be most effective, these guidelines must be regularly revisited to ensure they still meet the needs of the team (Malhotra et. al., 2007). Miscommunication can also occur when teammates do not share a

common language. Spending time coming to a consensus about what the key phrases and words are to the work of the team can help reduce misunderstandings among teams (Watkins, 2013).

Building Cohesion

Although virtual team members may not be able to congregate in a break room or at the water cooler to build relationships with each other, the relationship building is still an important part of an effective team. Leaders must take extra steps to provide opportunity for team members to get to know each other and develop positive working relationships. In the Harvard Business Review, Michael Watkins encouraged leaders of virtual teams to develop a "virtual water cooler" or opportunities for informal interactions to take place. This can be done by providing a few minutes at the beginning of each meeting to share current personal events or facilitating formal team-building exercises (Watkins, 2013).

Combs and Peacocke encourage leaders to have team members develop personal profiles that include their professional expertise, personal interests, and a photograph (2007). Malhotra et. al. (2007) takes these personal profiles a step further and recommends the use of an "expertise directory," which makes these profiles publicly available between the team. This document should include details about a team member's expertise, past trainings and work, organization affiliations, and a photograph of the team member. This document would serve as a virtual team guide, facilitating collaboration among team members.

Provide Recognition

The de-centralized nature of virtual teams mean that leaders must make a more concerted effort to appropriately recognize the achievements of their team members. Leaders of virtual teams should identify strategies to celebrate both team and individual successes. Having tokens of appreciate delivered to team members, beginning meetings with recognition of accomplishments, and celebrating project completions are all examples of ways to provide reward a job well done (Malhotra, et. al., 2007; Combs and Peacocke, 2007).

Conclusion

The rise of technology over the last few decades have expanded the ways organizations can build and leverage teams. Virtual teams allow agencies to bring together the most talented individuals while saving costs, but can also lead to significant barriers in developing the trust that is needed to be effective. Although leading virtual teams can present more challenges than leading conventional teams, through taking steps to strengthen trust, enhance communication, and build cohesion virtual teams can be an excellent strategy for meeting the objectives of organizations, including those in the public health space, in an effective and efficient manner.

Virtual teams may be an underutilized tool in providing quality healthcare, particularly when considering the patient as a member of the team. In that situation, managing chronic disease, as well as treating rare illnesses, can benefit from the implementation of virtual teams. Using technology to connect a treatment team to a patient with a chronic disease, such as diabetes, can provide more comprehensive care with fewer in office visits. Additionally, since one of the benefits of virtual teams is that it allows the most qualified individuals to participate, even if they are separated by significant distance, patients with rare illnesses could have a treatment team including the foremost experts in their disease without having to travel to see them in person. Little has been published on how virtual teams are being utilized in the public health and healthcare fields and more research evaluating its utilization and benefits would be beneficial for the future.

Leaders Role to Create Organizational Culture that Embraces Big-Data and Data Analytics

Elena Mircoff

Introduction

It is believed there is more data moving across the Internet every second than stored in the entire Internet 20 years ago (Brynjolfsson & McAfee, 2012). Our society's technological, social, and cultural transformation into an era of big-data and analytics, introduces a new horizon of challenges and novel opportunities for competitive advantages. Leaders in organizations across a variety of industries, are realizing the utility and benefits of big-data analytics in addressing their problems and revealing innovative solutions (Marshall, Mueck, & Shockley, 2015). However, with this advent of unfathomable volume, velocity, veracity, and variety of data, many are realizing the challenges surrounding the world of big-data do not necessarily originate from a lack of technology but, instead, a lack of leadership (IBM, 2013).

Organizations must align their culture to embrace big-data and data analytics in order to successfully reap the potential benefits (Brynjolfsson & McAfee, 2012). In this chapter, we will define and discuss big-data and analytics, how leading organizations support and maximize benefits from big-data and analytics, and finally, address how big-data is revolutionizing the healthcare industry. We primarily aim to address the characterizations and attitudes of organizational culture that readily embrace big-data, data analytics, and how leaders can emulate these stances.

Interestingly, many of these values have been reiterated as ideal traits and qualities throughout our leadership education. However, it appears this unique cocktail of a culture of empowerment, trust, transparency, and inquiry adequately prime organizations to successfully embrace and maneuver the world of big-data and analytics. We also aim to highlight the benefits and challenges recognized in healthcare organizations that have adopted big-data and analytics into their processes. Our guiding question asks what core values must a leader emulate to guide their organization to stand as competitive and effective players in the big-data and analytics era?

What is big-data and analytics and why is it important?

It is vital to begin with the building blocks to set context and realign ourselves with the same foundation and definitions. Data can be defined as "basic, discrete, objective facts about something such as who, what, when, where" (Jennex, 2017). The knowledge pyramid, designed originally in 1986, stacks data as the base, leading to information, knowledge, then finally, wisdom (Jennex, 2017). This structure was revised and inverted in 2000 to acknowledge that there is more information than data. Wisdom is also replaced by intelligence, which accounts for actionable knowledge, and intelligence ultimately leads to organizational learning in this revised version (Jennex, 2017). How we think about knowledge represents the added complexity as we move from simply "data" to the advent of "big-data."

Big-data is entirely changing how we obtain knowledge and transform from intuition-based to evidence-based decision making (Jennex, 2017). Big-data is primarily used to translate data into business advantages and is described as 'big' in four or sometimes five key components (Brynjolfsson & McAfee, 2012). These four dimensions of big-data are referred to as the 4 V's: *'volume, velocity, variety, and veracity'*. *'Value'* has been added recently added as a fifth dimension by some thought leaders

("Infographics Master of Science in Leadership Big Data's Growing Role in Organizational Leadership & Development," n.d.).

Volume refers to the sheer scale of data created and available. IBM estimates that 2.5 quintillion bytes of data are generated every day (IBM, 2013). Walmart is estimated to collect 2.5 petabytes of data each hour which, for reference, is equivalent to about 20 million filing cabinets of text (Brynjolfsson & McAfee, 2012). One interesting driver to this quantity of data is the advent of genomic technology and whole genome sequencing (WGS). WGS allows a much more robust and phylogenetic perspective and introduces a new world of possibilities. Overall, the volume of data impedes many technological systems from readily accessing data and restricts humans from using this information without implementing any analytics. This volume is exponentially growing, supported by the estimation that 90% of existing data has been created in the last two years (IBM, 2017).

Velocity is the near real-time speed related to data creation and processing. Rapid insights provide the most useful advantage and therefore act as the gold standard to data digestion and output (Brynjolfsson & McAfee, 2012; Jain, 2016). Variety accounts for the diversity of incoming data, originating from images, text files, social media, videos, sensors, GPS signals, and more. Challenges in this diversity come in organizing and standardizing structured databases as well as processing multiple types of data in single databases (Brynjolfsson & McAfee, 2012; Jain, 2016). Veracity refers to the unknown, or uncertainty, of data. Beyond a lack of trust in data quality from one in three business leaders, poor data quality costs the United States $1.3 trillion per year (IBM, 2017). Finally, value "through insights from superior analytics" is the desired outcome associated with big-data usage (IBM, 2017). Data collection and data generation must have accurate and substantial value to serve any purpose (Jain, 2016).

Leaders are recognizing that big-data and analytics enable better prediction capacity to closer meet customer needs which gives their organizations a competitive edge (Marshall et al., 2015). Marshall et al. estimates that when organizations exploit big-data and analytics to drive innovative decisions, they are 36% more likely to outperform competitors who do not (Marshall et al., 2015). This revolution is transformative and allows data-driven decision making to largely replace intuitive, gut-based decision making.

It is indisputable that this era of big-data and analytics will affect every aspect of our society. Therefore, it is vital to address the key characteristics and attitudes that support and enable leaders to embrace big-data and analytics as integrated parts of their organizational culture. The following section will enumerate these characteristics and describe how leaders can adopt and emulate these to transform their culture.

Key Characteristics and Attitudes of a Big-Data Leader

Managing and extracting valuable meaning from big-data is not only a science challenge, but more than anything, a leadership challenge (Bolling & Zettelmeyer, 2014). Becoming a big-data enabled organization requires a culture of empowerment, trust, transparency, and inquiry. These qualities allow analytics to be woven throughout the fabric of an organization which elevates and reiterates the investment and commitment to analytics (Bolling & Zettelmeyer, 2014). Across the literature, it is acknowledged that the managerial and leadership challenges of big-data outrank the technical challenges associated with utilizing big-data to solve business goals (Bolling & Zettelmeyer, 2014; Michael S. Knapp, Juli A. Swinnerton, Michael A. Copland, & Jack Monpas-Huber, 2006; Woods, 2012).

Empowerment

It is vital to empower leaders to have the capacity to promote data-driven decision and analytics. One way this can be accomplished is through the creation of C-level individuals such as Chief Data Officers or Chief Analytics Officers (Stadolnik, 2014). By including positions such as these, an organization clearly commits to the pursuit of analytics and their priority of using data analytics to address problems (Davenport & Bean, 2018). Creating these roles also increase the odds that analytics will become

integrated into the organizational culture because strong analytics leaders now hold influence and power. Prior to these positions, data management was typically reserved exclusively for the IT department or was isolated into disparate departments (Stadolnik, 2014). Today, big-data and analytics are a pervasive component of high-performing companies. Surveys by McKinsey & Co revealed that "highly engaging, evangelizing leaders" should convene a data team to drive desired data agendas (Stadolnik, 2014). This theme of empowerment is supported when the right individuals are provided the opportunity to have a seat at the table and exhibit to the company the importance of embracing and leveraging data (Stadolnik, 2014).

There have been four distinct leadership roles that take on the challenges of navigating big-data and analytics for organizations. The Chief Data Officer is a senior position rising in popularity, as it is estimated that 90% of large companies will hire a CDO by 2019 (Stadolnik, 2014). A CDO should act as the data owner and architect and should set data definitions and strategies. Typically, the position of the CDO is primarily focused on finding data initiatives that will add to the business and understanding the rollout speed of which to integrate these initiatives.

Data scientists tend to be highly technical individuals and classically trained as data engineers, mathematicians, computer scientists, or statisticians (Stadolnik, 2014). Data scientists will excel as leaders if they are proficient in their understanding of business and are capable of asking questions relevant to the domain of work (Bolling & Zettelmeyer, 2014). Analytic positions serve a primary role of integrating real-time data to develop business insights. High-performing companies are creating Chief Analytic Officer roles to engage with the C-suite board and offer their expertise to the executives. The CAO often owns a board realm of responsibilities and functions to maintain forward-thinking progress. Finally, the leadership role of the data manager or data leader serves as the organizer and architect of data. The data manager oversees a fluid connection between the data agenda and technology agenda (Stadolnik, 2014). Again, this position can only reach its full potential if given a seat at the executive table.

Empowerment for Data and Data Analytics

Another way to develop an organizational culture that emphasizes empowerment towards analytics is to invest in employee trainings in analytics. This can create a data literate company that is capable of infusing analytics throughout the organization (Marshall et al., 2015). According to the survey by Marshall et al., individuals categorized as leaders are 110% more likely to support training all employees in analytics than those categorized into strugglers. If an organization creates a culture where all individuals have a working knowledge of data science, they will be able to ask the right questions and make stronger data-driven decisions (Bolling & Zettelmeyer, 2014). This emphasis on data literacy can also be promoted by adding analytics competencies to every employee role in some manner so that the organizational culture is one with a steady foundation of analytics (Marshall et al., 2015).

An organizational culture is more likely to embrace analytics and big-data if employees feel empowered to implement drastic changes based on their findings in data. Often, resistance towards change comes at a top-down pattern due to historical norms or hierarchical structure. Big-data may introduce challenge to what is thought to be dogma, and therefore, all individuals in an organization must feel empowered to speak up and address these findings regardless of their implications (Bolling & Zettelmeyer, 2014). Employees must feel empowered to take manageable risks or follow leads using data-driven information. Without a culture founded in empowerment, big-data and analytics goals will often be blocked or inefficient.

Distributed Leadership Roles

Consistent with themes of empowerment, building an organizational culture that elevates analytics can be achieved through distributed leadership roles. As discussed, there are several positions that can be added to emphasize the commitment to big-data and analytics, such as the CDO and CAO.

Organizations can also hire positions with analytic objectives across the board and invest in analytic training opportunities for their employees. One way this can be accomplished is if the organizational culture rewards expert authority over hierarchical authority, inherently distributing the typical structure of leadership (Michael S. Knapp et al., 2006). These types of leadership will be discussed in later parts of the chapter.

Transparency, Trust, and Relational Transparency

Key to priming an organization to be leaders in big-data and analytics is creating a culture that values transparency and trust. This has been a theme we see not only in terms of analytics but throughout leadership theory. Building an organizational culture that values transparency of information supports an atmosphere of trust and openness. Scholars also refer to **relational transparency** as a primary component of authentic leadership (Walumbwa, Avolio, Gardner, Wernsing, & Peterson, 2008). This concept addresses presenting one's authentic self by openly discussing thoughts and feelings, within appropriate limitations (Avolio, Walumbwa, & Weber, 2009). The benefits of transparency within an organization are also highlighted in the Cleveland Clinic case study (Porter & Teisberg, 2016). By displaying metrics openly, organizations hold themselves accountable to improve weak areas and encourage members to present new, innovative solutions (Porter & Teisberg, 2016).

Along these same lines, transparency is only meaningful if data is easily accessible in a relatively useful manner. Organizations can support analytic driven culture by creating systems that put company metrics at the fingertips of many users (Michael S. Knapp et al., 2006). Individuals throughout an organization should be able to access data, and understand the implications of said data, in a relatively reasonable time and manner (Michael S. Knapp et al., 2006). This relates back to building an organization that has is data-literate through empowerment and training of all employees so that big-data and analytics is woven throughout the organization (Zettlemeyer, n.d.). According to a survey of executives, 56% stated that the largest obstruction to reaping the benefits big-data offers is that the information is siloed or trapped in certain departments or by certain individuals (Capgemini, 2012). By educating employees on how to access and appropriately use metrics, leaders can feel assured that big-data adoption and benefits will be met efficiently and effectively.

Oftentimes, transparency in metrics is thought to present damaging results. However, companies should consider if and how the benefits outweigh the risks (Groves, Kayyali, Knott, & Kuiken, 2013). A report conducted on using survey data at universities states that, "In order to use data to initiate institutional change, transparency is crucial" (Benson & Trower, 2012). Transparency allows organizations to both confirm where their strengths are concentrated and identify weaknesses for improvement (Benson & Trower, 2012). When an organization fosters a culture of transparency, they must also be prepared for open discussion and debate in order to welcome creative and innovative solutions (Benson & Trower, 2012).

Similarly, they must recognize that revealing up data in a transparent way may incite demand for more data and more information (Benson & Trower, 2012). The disclosure of data in a "warts-and-all-approach" allows leaders to breed an atmosphere of trust among employees and clients by showing them that, regardless of the implications, honesty is a shared value of the organization (Benson & Trower, 2012). Organizations should feel confident that, "the right data to make the right decisions that support the right outcomes in the right moment" is the intention and goal of all members and leaders (Maxwell, Rotz, & Garcia, 2016).

Inquiry and Innovation

The final critical component of any leaders and leading organization that aim to weave big-data and analytics into its culture is the acceptance of innovation and inquiry. Those that are given tools to manipulate data to glean insights and inspire innovative solutions will excel as leading organizations (Marshall et al., 2015). Key to this is the component of acceptance, as employees of all statuses should

feel comfortable proposing innovative solutions and confident that their voice is valued and highly regarded. This again relates to building a culture with empowered employees that have access to quality and true data.

Marshall et al. coins the term "quantitative innovation culture" (Marshall et al., 2015) which adequately suits the goals of leaders who want to drive big-data initiatives in their organizations. Leaders, in particular, invest energy into encouraging a culture of innovation by outlining metrics of innovation. Successful organizations accomplish innovative aims by promoting collaboration and allowing space and time for creative and imaginative thought (Marshall et al., 2015).

If employees have been trained to be data-literate and are allowed open access to company metrics, they should have space to submit innovative ideas and feel assured that they have resources to achieve those results. Part of a quantitative innovation culture is measuring the success and failure of innovative solutions and programs. Careful measurement of these metrics allows insight into where future efforts should be concentrated. It may be beneficial for leaders to set big-data goals of various scales to encourage success and positive attitudes while driving momentum towards transformative goals (Groves et al., 2013). Leaders should implement innovative efforts that have short, medium, and long-term goals of accomplishments (Groves et al., 2013). Such early goals could deal with the use of real-time data to stay relevant and on top of current desires or trends. Medium goals may deal with data-storage and organization efforts so that information is more accessible and manageable in a useful manner. Long-term goals could involve a total shift in the data collection process or a re-appropriation of resources into more efficient software or technology.

Leaders can drive a culture that supports inquiry, defined as an organization with an embedded atmosphere of trust and physiological safety in which all feel safe to raise questions pertaining to how the company functions (Michael S. Knapp et al., 2006). Knapp et al. has designed their own version of the "culture of inquiry" cycle related to using data-informed leadership in the educational system (Michael S. Knapp et al., 2006). This cycle, as well as many other aspects that prime organizations to embrace big-data and analytics, is founded on the idea of distributed leadership (Michael S. Knapp et al., 2006).

Distributed leadership moves away from a centralized hero-figure towards collaborative shared leadership system that views leadership as a group activity (Bolden, 2011). The theory of distributed leadership rests on the principle that responsibility does not fall on one individual and therefore is shared throughout an organization (Bolden, 2011). This system of distributed leadership means that the organization functions less in a hierarchical system and invites input from all. Distributed leadership, or frequently termed as shared leadership, pays homage to the idea that the influence process is shared between many individuals rather than limited to a centralized leader (Avolio et al., 2009; Pearce & JA, 2003). Skills in data analytics may be dispersed throughout various individuals and not necessarily nestled in one department or one section of an organization so this mechanism of distributed leadership embraces and maximizes the capabilities of all (Michael S. Knapp et al., 2006).

Similar to this concept of distributed leadership, Groves et al. recommends "setting a top-down vision and stimulating creation of bottom-up innovation" (Groves et al., 2013). This appropriately sums up how ownership of innovative ideas and implementation should be a shared entity. Leaders should encourage innovation as an embedded part of the company by constantly being open and receptive to change, new ideas, and solutions. They need to display their commitment by supporting and adequately funding innovative efforts. Typically, top-down visions can disseminate guidelines and serve as a roadmap for others to follow, but they frequently stifle innovative thinking if they are too rigid (Raffaelli, 2017). Bottom-up leadership and innovation can lead to higher buy in and a greater diversity of expertise and ideas but require the support from top leaders (Raffaelli, 2017). Therefore, the dynamic of an organization wanting to embrace big-data and analytics to explore innovative solutions should balance leadership and distribute power to all members.

‘Values’ Relative to Organizational Change

As we have discussed, the three major components leaders and leading organizations can instill to efficiently embrace analytics and remain competitive in an era of big-data, we must refer back to the basis of organizational culture. The reciprocal relationship between organizational culture and leadership exists; organizational culture is developed from leadership and the culture can also impact how leaders are developed (Bass & Avolio, 1993). Culture is defined as an abstract force that motivates, drives, and influences action (Schein, 2010). The authentic leader is an emerging leadership theory that relies heavily on transparency and positive self-development (Avolio et al., 2009). Similarly, transformational leadership theory revolves around the idea that followers feel elevated and motivated in a positive manner by their leader, further motivating positive behavior and results (Avolio et al., 2009). These values closely align with the discussion here about employee empowerment and building a data literate company that embraces innovative thinking and problem solving.

A key tenet of authentic transformational leadership behavior is maintaining and promoting high ethical standards (Bass & Steidlmeier, 1999). Ethics, in this case, play into the role of honest and transparent data distributed to all members of community or organization. These individuals must feel confident that they trust the data and feel safe and empowered to point out controversial revelations that may stray from organization dogma. Attentive leaders can influence a change in organizational culture towards embracing big-data by consistently addressing empowerment, data transparency, and accepting inquiry. It is important for actions to match statements and for a consistent message to be relayed in order to properly drive organizational change (Bass & Avolio, 1993). Again, these components will be best accepted in atmosphere of distributed leadership where all individuals have a share in the actions and practices of an organization (Bolden, 2011; Michael S. Knapp et al., 2006). This involves weaving analytics into the objectives and priorities of every role and offering opportunities for innovative thinking to every participant.

Big Data in Healthcare

Shifting gears, it is vital to address how healthcare industries have already benefited from big-data and the opportunities still to come. Leaders in the healthcare industry have recognized these opportunities and have primed their organizations in exactly the ways previously discussed to embrace and reap the benefits big-data and analytics have to offer. With the advent of electronic health records (EHR), the volume of U.S. healthcare data is reaching yottabyte scale (1024) (Raghupathi & Raghupathi, 2014). These complex datasets are comprised as images, insurance claims, clinical data and therefore, a variety of datatypes that are difficult to store, manage, and interpret (Groves et al., 2013). However, if organizations manage to adequately take advantage of big-data, the potential to “improve care, save lives, and lower costs” are significant (Raghupathi & Raghupathi, 2014). When organizations embrace capacities to synthesize and aggregate big-data by creating cultures of openness with data-literate employees, insights can lead to better informed decision making and better health outcomes. Our future will undoubtedly involve real-time decision making using individual and population data to best inform physicians of the most efficient and effective, cost and outcome, treatment of patients.

Advantages of Electronic Health Records and Big-Data in Healthcare

One significant advantage of EHR in the healthcare realm is the network capacity to share and disseminate patient data within hospital networks or accountable care organizations. In this way, duplication is avoided and an individual can receive more consistent and safer treatment regardless of location. Patients are also able to readily access their medical data in new ways, such as with apps or mobile fitness tracking devices (FitBit, etc). This further empowers patients to take ownership and accountability of their own healthcare. Healthcare analytics can improve predictive capabilities by understanding population behavior and thereby estimating average length of stay which is a strong

indicator for medical complications or other hospital-acquired illnesses (Raghupathi & Raghupathi, 2014).

It is estimated that big-data and analytics can save the United States an estimated $300 billion per year (Raghupathi & Raghupathi, 2014). For example, the way we are able to analyze historical patterns of disease and track outbreaks can help us understand how to mitigate and halt these outbreaks faster. The rise of big-data will also support genomic analytics and allow us to begin to elucidate how the human genome can be used to make medical decisions (Raghupathi & Raghupathi, 2014). Groves et al. describes how big-data is allowing new value pathways: right living, right care, right provider, right value, and right innovation. Essentially, with changing capabilities towards analytics and big-data in the healthcare field, we can better align decisions to the expectations and benefit of the patient (Groves et al., 2013). Another advantage of adopting EHR is being able to disaggregate results to look at underrepresented groups or populations and determine areas of health disparities (Benson & Trower, 2012).

Challenges of Big-Data in Healthcare

Central to challenges of healthcare data is securing patient privacy while still sharing clinical data for its value and insights. Certain groups attempt to exploit healthcare data for their own benefit and thus, are adding to misuse and privacy concerns appropriately feared by many (Groves et al., 2013). This also explains the strong resistance towards adopting big-data in the healthcare industry. Unlike shopping preferences, personal health information is highly valued as private information so there are groups wary and skeptical about using complex technology to store and disseminate their information. In addition, there are currently limited systems to aggregate data from various sources from siloed departments to a single source. It could prove highly beneficial to integrate pharmaceutical, provider, and payer data together but systems must be designed with this capacity (Groves et al., 2013).

Thanks to a variety of legislation and governmental incentives, the resources for transitions towards EHR was much less burdensome. For example, the Health Information Technology for Economic and Clinical Health Act in 2009 authorized $40 billion for providers to adopt EHR and train staff (Groves et al., 2013). However, the time and money required to train employees and build this infrastructure are still cumbersome. Raghupathi et al. states that big-data analytics in the healthcare sector should be “menu-driven, user-friendly, and transparent” (Raghupathi & Raghupathi, 2014). Again, we recognize the necessity for transparency and a culture of openness with data-literate and empowered members owning a role in acknowledging avenues of improvement.

Conclusion

It is vital to recognize that an organization will not successfully integrate big-data and analytic agendas without first addressing their leadership values and organizational culture. To truly exploit the unrealized potential that big-data and analytics have to offer, leaders must verify that they have prioritized designing an organization founded on employee empowerment, transparency, and receptivity to innovative problem solving and thinking. This can be accomplished by giving analytic positions a seat at the executive table and investing in employee training opportunities. Furthermore, it is important to create a safe space that takes the time and resources to address findings of employees that are using and generating the data. Analytics should be woven throughout a company and involved in the objectives of every employee instead of siloed into IT departments as in the past.

Big-data provides the capacity to shift the world on its axis, as poignantly stated by Bolling and Zettlemeyer, “previous disruptions challenged the way things were done; big data challenges what we think we know.” (Bolling & Zettelmeyer, 2014). Overall, the time has come for leaders to apply the theories and values of transparency, empowerment, and innovative thinking to embrace the new world of big-data and data analytics and truly transform our society.

Leading from the Top – Chief Medical Officers and Their Leadership Styles

Lena Schreiber

Introduction

Chief Medical Officers are important players within the healthcare industry. They are physician leaders who play a big role in providing high-quality patient care for patients, and they can have a great impact on the overall performance of their hospitals (Angood & Birk, 2014). Because of their importance, this chapter examines Chief Medical Officer leadership characteristics through the lens of three different leadership approaches: the trait approach, the skills approach, and the behavioral approach. The main finding of the analysis of Chief Medical Officer leadership characteristics discussed in this chapter is that there is good consistency between leadership theory and practice exhibited by CMOs.

This chapter first highlights the importance of physician leaders in general and then describes common characteristics of the Chief Medical Officer. I provide an overview of traits, skills, and behavioral approaches to leadership, and then compare each of these displayed by CMOs.

The Role of Physician Leaders

In their paper, *The Value of Physician Leadership,* Angood & Birk (2014) make several statements that point to the importance of physician leaders. They point out that "[t]oday, approximately 5 percent of hospital leaders are physicians, and that number is expected to increase rapidly …" They also state that "[t]he American College of Physician Executives (ACPE), the nation's oldest and largest leadership education and career support organization for all types of physicians, champion the view that physicians are best suited to lead clinical efforts to achieve true patient-centered care." Moreover, "ACPE includes physician leadership as one of its nine essential elements required to provide optimal patient-centered care." The 2013 U.S. News and World Report rankings show that 10 of the 18 hospitals listed on the "Honor Roll" are physician led, with the top five all having physician leaders. (Angood & Birk, 2014). Goodall's *Physician leaders and hospital performance: Is there an association?* study, indicated that "The best-performing hospitals are led disproportionately by physicians" (Goodall, 2011). Overall, evidence suggests that physician leaders play a big role in providing high-quality patient care, and they have a great impact on the performance of their hospitals (Angood & Birk, 2014). Physician leaders can have different titles, like chief medical officer, vice president for medical affairs, or vice dean for clinical affairs, among others (Longnecker et al., 2007). The following sections will mainly focus on the Chief Medical Officer.

Background Information on the Role of the Chief Medical Officer

The role of the Chief Medical Officer was initially created around 1980 with the intent of having a physician on the senior management team *who understood both, the medical and administrative sides* and could function as a "liaison" between the two. In the late 1990s, the Physician Executive Management Center conducted a survey, asking physicians in senior medical management positions about the value they provide to their organizations. Respondents of the survey believed that they had essential knowledge and experience on the management, as well as the medical side. A solid medical background seemed especially important to be accepted as a leader by other physicians and to be able to function as the liaison between the medical side and management (Kirschman, 1999).

The concept that the CMO has the role of a "liaison" between medical and administrative side

is reiterated in many different studies. Longnecker et al. (2007) call this unique positioning an "intermediary" between the clinical and administrative side. Angood and Birk (2014) describe Chief Medical Officers as the bridge between management and medicine. Whereas non-physician executives might tend to focus more on financials, CMOs have that deep clinical knowledge about patient care that can make them more sensitive to clinical staff's needs, as well as patients' needs, and it makes it possible for them to work together with other physicians to find a solution collaboratively.

Cors (2009) argues that Chief Medical Officers are able to bridge the gap between management and the clinical side, as well as cost and quality. He adds that while first and foremost Chief Medical Officers are clinicians, they also have training in business, management and leadership, to be able to function as that "bridge." In their study of 340 physician leaders at 281 different AAMC member association, Longnecker et al. (2007) found that 32% of Chief Medical Officers had degrees closely linked to the business or health care field, like an MBA, MPH, or MHA. Eighty percent of the CMOs with this type of degree believed it had helped them with becoming CMO. They thought it had helped them develop additional knowledge and skills necessary to be successful on the administratively and to build credibility among people on the administrative side.

Longnecker et al. (2007) surveyed physician leaders at different organizations regarding their roles and responsibilities as physician leaders. They asked questions about demographics, titles, qualifications, tenure, reporting relationships, and others. The study showed that CMOs spend most of their time on administrative tasks and CMO duties, with only a small amount of time spent on research, teaching and clinical practice. Within their CMO duties, attention to clinical quality and patient safety, as well as coordination of inpatient and outpatient clinical operations, comprised more than half of their time (52%). The authors identified personal history, stature and relationships with colleagues, as well as senior leadership and executive commitment to the role as factors contributing to success in their position.

Background Characteristics of the Chief Medical Officer

The 1990s Physician Executive Management Center survey asked physicians in senior medical management positions about the value they provide to their organizations. Personal characteristics that seemed important for chief medical directors included *judgment, loyalty, rational thinking, common sense, ethics and integrity*. When asked what the respondents enjoy the most about their position, the highest response was working with other physicians and in the community, which involves education, mentoring, leadership and being the link between management and physicians. Management duties were mentioned often, especially daily operations, problem solving, implementation of new programs, negotiation, and managing a complex environment were highlighted in this category (Kirschman, 1999).

As described above, CMOs function as liaisons between the medical and administrative side. They have a strong clinical background which provides a shared history and common language with other clinical staff. This unique positioning helps CMOs build trust and support with others around them. It also helps to build credibility among clinical staff, which is essential for clinical integration and change efforts (Angood & Birk, 2014).

In his article "Secrets of a Chief Medical Officer," Chappell (2004) discusses lessons learned from the perspective of a CMO. He points out that Chief Medical Officers have many conversations every day, displaying integrity and telling the truth will keep them in their job. Chappell also highlights that *time references* (how frequently decisions need to be made) used by physicians and administrators are very different. While physicians make many decisions daily, administrative decisions take much longer. Functioning as the "liaison" or "bridge" between these two sides, it is important that the CMO understands these differences in time references. Chappell points out that for the Chief Medical Officer it is important to be principled but not inflexible because compromises and negotiations are important parts of the CMOs job.

Moreover, it is important for CMOs to not just rely on stories from others, but to go to the problem and make their own assessments. Additionally, some clinical staff members might feel like that the CMO is not "one of them" anymore, but Chappell highlights that it is important for Chief Medical Officers to remember that they got the job for a reason, and that is because they have the clinical background. Chappell points out the importance of being a life-long learner for CMOs, as well as the importance of continuous development of leadership skills. Lastly, in the CMO role, sometimes, conflict is inevitable and something that CMOs need to be prepared to handle. Here, Chappell highlights that it is important for the CMO to have accurate data, like dates, times and detailed examples of behaviors. Cors (2009) points out that the successful CMO possesses qualities which include being persuasive, being able to communicate excellently, exhibiting passion about quality, possessing trustworthiness, being viewed as supportive of the medical staff and exuding credibility.

According to Angood & Birk (2014) the Healthcare Leadership Alliance has created a list of 300 competencies that are required for effective healthcare leaders. They have grouped them in five main areas. First, knowledge in healthcare. Second, being professional, which includes having ethical and professional standards, having a sense of responsibility to patients and community and a willingness to continuously learn and develop, Third, being able to communicate and interact effectively and build relationships. Fourth, having business skills and knowledge, which includes being able to use business principles, like systems thinking. Lastly, leadership, which includes inspiring excellence, creating and attaining a shared vision and being able to manage change successfully.

In his article "Developing Physician-Leaders: A Call to Action," Stoller (2009) claims that physicians, due to the nature of their training and history, might be "disinclined to collaborate or to follow," which are important characteristics of leaders. He elaborates on this statement by discussing the fact that advancement on the medical side is often tied to improving clinical, or academic skills, not leadership skills and competencies. Moreover, he states that a lot of physicians value autonomy.

In his article "Can Physicians Collaborate?" Stoller (2004) points out four areas he found make it hard for physicians to collaborate. First, physicians' training is long and hierarchical. Second, physicians are usually evaluated on individual performance, not on group performance, i.e., board certifications and competition for residency slots. Third, Stoller believes that physicians may experience "extrapolated leadership," which means that physicians take their clinical authority and apply it to other fields where it might not be relevant. Fourth, physicians are trained to identify problems or deficits and solve these. It might be harder for physicians to get away from this type of thinking and instead of seeing deficits, to see the potential opportunity for change or development (Stoller, 2004). Weisbord (1976) adds that for health professionals, autonomous decision-making, personal achievement and improving ones' own performance are highly important. This is different from those people that work in other environments, like the business world.

Approaches to Leadership

Over the last century, different leadership approaches have been developed. Three of the earliest and well know ones are the trait approach, skills approach and behavioral approach to leadership. In short, traits are who leaders are, skills are what leaders can accomplish, and behaviors describe what leaders do and how they act (Northouse, 2015). The following sections break down the three approaches in detail.

1) Trait Approach

The trait approach was one of the first approaches used to learn about leadership. Researchers believed that traits were something people were born with and only those people that were "great" possessed those traits. Because traits were viewed as something innate, they were also largely seen as "fixed" (Northouse, 2015). The earliest study done on leadership traits by Stogdill in 1948 consisted of 124 trait studies between 1904 and 1947. Stogdill (1948) was able to identify important leadership traits that explained how people within groups became leaders and how leaders differed from other group

members in eight traits. Those eight traits were *intelligence, alertness, insight, responsibility, initiative, persistence, self-confidence, and sociability*. Another main finding of the study was that someone was not a leader simply because he or she possessed certain traits, but those traits had to be applicable and relevant to particular situations.

The second important study around leadership traits was conducted by Mann (1959). He analyzed more than 1,400 findings about traits and leadership and was able to identify six main traits that distinguish leaders from others. Those six traits were *intelligence, masculinity, adjustment, dominance, extraversion, and conservatism.*

In 1974, Stogdill conducted another important study around leadership traits. This time, he focused less on the situation a leader was in and he identified the following important traits associated with leadership: *drive for responsibility and task completion, vigor and persistence in pursuit of goals, risk taking and originality in problem solving, drive to exercise initiative in social situations, self-confidence and sense of personal identity, willingness to accept consequences of decision and action, readiness to absorb interpersonal stress, willingness to tolerate frustration and delay, ability to influence other people's behaviors, capacity to structure social interaction systems to the purpose at hand* (Stogdill, 1974).

A more recent study by Kirkpatrick and Locke (1991) found that leaders differed from others through six traits: *drive, motivation, integrity, confidence, cognitive ability, task knowledge*. A study done by Nichols and Cottrell in 2014 questioned what people desire in their leaders in terms of traits. They found that *trustworthiness and intelligence* were consistently desired traits across study participants.

Many studies have been conducted regarding traits and leadership, and many different traits have been identified during the last 50 to 75 years. There are five overarching trait themes that can be identified across many of these different studies: *intelligence, self-confidence, determination, integrity, and sociability* (Northouse, 2015). Leaders have been found to have a higher intelligence than other people; more specifically, this focuses on a leader's ability to articulate him or herself verbally in a strong way, perceptual ability, as well as being able to reason with others (Zaccaro et al., 2004).

According to Northouse (2015), self-confidence has to do with being certain about one's own competencies and skills. This includes self-esteem, self-assurance, and "the belief that one can make a difference." Determination is about wanting to get things done. Northouse states that some characteristics of determination are *initiative, persistence, dominance, and drive*. According to Northouse, integrity is characterized by honesty and trustworthiness. People with integrity are loyal, others can depend on them, they are not deceptive, they usually have a strong set of principles they adhere to and they take responsibility for their actions. Lastly, sociability is about relationships with others. Northouse describes people that display sociability as individuals that are "*friendly, outgoing, courteous, tactful, and diplomatic."* He also describes them as people who are "sensitive to others' needs and show concern for their well-being," as well as individuals who have good interpersonal skills and create cooperative relationships with their followers."

2) Skills Approach

The skills approach focuses on skills and abilities that can be learned and developed. Research around skills and leadership started in 1955 with Robert Katz's article "Skills of an Effective Administrator," published in Harvard Business Review. At that time, leadership research was mainly focused on traits, but Katz was able to approach it from a different angle (Northouse, 2015).

The Three-Skill Approach developed by Katz (1955) focuses on technical, human, and conceptual leadership skills. Katz describes technical skills as the "knowledge about and proficiency in a specific type of work or activity." These types of skills are most important for lower and middle-level management. Katz describes human skills as the ability to work effectively with other people at different levels in the organization, the knowledge about people, the ability to help others work in a cooperative

manner, the ability to create an environment of trust, and being sensitive to other peoples' needs and motivations. Human skills are important at all levels of the organization. The last skill included in Katz's Three-Skill Approach is conceptual skills, which focus on ideas and concepts. People that have conceptual skills are good at communicating ideas and concepts, they are good at working with abstracts and hypotheticals. Conceptual skills are especially important when developing visions and strategies. Conceptual skills are very important at upper and middle levels of the organization, and they are less important at lower levels.

In the early 1990s, Mumford and colleagues built on Katz's findings, giving the skills approach in leadership more recognition. Mumford et al. conducted their study over several years with over 1,800 Army officers, examining why some leaders are good problem solvers while others are not. They wanted to further examine what skills distinguish high-performing from lower-performing leaders and how individual attributes, as well as the environment, play a role (Northouse, 2015). The researchers found that *problem-solving skills, social judgment skills and knowledge* are the three most important competencies in terms of *leaders' ability of effective problem solving and high performance* (Mumford et al., 2000). Mumford et al. (2000) define problem-solving skills as the a "leader's creative ability to solve new and unusual, ill-defined organizational problems. The skills include being able to define significant problems, gather problem information, formulate new understandings about the problem, and generate prototype plans for problem solutions."

Zaccaro et al. (2000) define social judgment skills as *"the capacity to understand people and social systems."* It is about being able to work with others, being able to solve problems and being effective as a leader. This includes understanding other people's attitude towards certain problems, what motivates them, as well as the ability to communicate a vision to others. These social judgment skills are similar to Katz's human skills (Northouse, 2015). Mumford et al. (2000) argue that knowledge is an important leadership skill because it is directly linked to the leader's capacity to define a problem and attempt to solve it.

In addition to the three most important competencies in terms of leaders' ability of effective problem solving and high performance, the study also found that there are individual attributes that influence a leader's competencies, like cognitive abilities (a person's intelligence and intellectual ability), motivation (willingness to take on complex problems and exert influence) and personality. Past experiences and the environment can also influence a leader's competencies and therefore leadership outcomes. Leaders can improve and develop their capabilities through experience and training (Northouse, 2015).

In 2008, Rebecca Mannel published a series on essential leadership skills. The first part highlights the importance of having a clear vision. She states that a vision is "what could and should be," and a visionary leader has to *"define a problem, identify a solution, and determine what must be done."* Having a clear vision is an essential leadership skill because it challenges people to take action and to bring about change (Mannel, 2008). The second part of Mannel's series focuses on team building, which she states is necessary to work towards a vision. The essential skills here are honesty and integrity of the leader so that followers can build trust. Mannel's third part deals with the essential skill of collaboration, which she defines as "an active process that involves creating something to grow." Collaboration includes *"building a climate of trust," "building relationships" and "giving value to all ideas."*

3) Behavioral Approach

The behavioral approach to leadership focuses on the behaviors of the leader. Behaviors can generally be divided into task and relationship behaviors. Behaviors describe what leaders do and how they act. Two important early studies on the behavioral approach were conducted by two researchers, Blade and Mouton, at **The Ohio State University** (Northouse, 2015).

Researchers at The Ohio State University conducted a study in the late 1940s, looking at leaders within groups and organizations and how they acted as leaders within that setting. They identified two main themes centered around initiating structure and consideration (Stogdill, 1974). Northouse (2015) explains that examples for initiating structure behaviors are "organizing work, giving structure to the work context, defining role responsibilities, and scheduling work activities." Consideration behaviors include *"building camaraderie, respect, trust, and liking between leaders and followers."* Northouse adds that initiating structure behaviors are closely aligned with task behaviors and consideration behaviors are closely aligned with relationship behaviors.

In the early 1960s, Blake and Mouton developed the "Managerial Grid," which today is called the "Leadership Grid." It was developed to aid in explaining how leaders help their organizations reach their goals by looking at two areas: concern for production and concern for people (Northouse, 2015). These two areas are closely related to the two main themes (initiating structure/task behaviors and consideration/relationship behaviors) that researchers at The Ohio State University identified. Blake and Mouton (1964) explain that concern for production deals with organizational tasks. Examples include *"attention to policy decisions, new product development, process issues, workload, and sales volume."* They explain that concern for people deals with *"building organizational commitment and trust, promoting the personal worth of followers, providing good working conditions, maintaining a fair salary structure, and promoting good social relations."*

According to Blake and Mouton, leaders show concern for production and concern for people on a continuum from low to high. Depending on where leaders fall in these two categories, they display different leadership styles. For example, someone could score very high on concern for production, but very low on concern for people. These leaders view their followers as "tools for getting the job done." This type of leader is often seen as "controlling, demanding, hard driving, and overpowering" (Northouse, 2015). A leader could also score very high on both ends. Northouse states that the phrases *"stimulates participation, acts determined, gets issues into the open, makes priorities clear, follows through, behaves open-mindedly, and enjoys working"* could be used to describe such a leader (Northouse, 2015).

Overall, the behavioral approach provides a framework for leaders to examine their leadership style based on tasks and relationships, and it reminds them that *"their impact on others occurs through the tasks they perform as well as in the relationships they create"* (Northouse, 2015).

Comparison between Leadership Approach Theory and CMO Leadership Characteristics

The following matrix describes the similarities and differences between Traits, Skills and Behavioral Leadership Theory and Chief Medical Officer (CMO) characteristics as described in the CMO and physician leadership literature.

Leadership Approach Theory - Traits Approach (who leaders are)	Chief Medical Officer Literature
Intelligence: Strong articulation, perceptual ability, ability to reason with others	**Intelligence:** Persuasive/ability to reason (Cors, 2009)
Self-confidence: Certain about own competencies and skills, self-esteem, self-assurance, belief in being able to make a difference	**Self-confidence:** Stature (Longnecker et al., 2007)
Determination: Wanting to get things done, initiative, persistence, dominance, drive	**Determination:** Training to become a physician is long and hierarchical (Stoller, 2004)
Integrity: Honesty, trustworthiness, loyalty, dependability, strong set of principles, takes responsibility for actions	**Integrity:** Loyalty, integrity, ethics (Kirschman, 1999); Integrity/telling the truth (Chappell); Principled but not inflexible (Chappell, 2004); Trustworthiness (Cors, 2009); Ethical and professional standards (Angood & Birk, 2014); Responsibility to patients and community (Angood & Birk, 2014)
Sociability: Relationships with others, friendly, outgoing, courteous, tactful, diplomatic, sensitive to others' needs/ well-being, cooperative	**Sociability:** Relationships/working with colleagues (Longnecker et al., 2007; Kirschman, 1999); Clinical knowledge makes them sensitive to clinical staff and patient needs (Angood & Birk, 2014)
	Differences: Common sense (Kirschman, 1999); Passion about quality (Cors, 2009)

Leadership Approach Theory - Skills Approach (what leaders can accomplish)	Chief Medical Officer Literature
Technical skills/knowledge: Knowledge/ proficiency in a specific type of work/activity, capacity to define problem and ability to solve it	**Technical skills/knowledge:** Clinical background (Chappell, 2004); Knowledge in healthcare (Angood & Birk, 2014); Business skills/knowledge (Angood & Birk, 2014); Training in business, management and leadership (Cors, 2009); Understands medical and administrative sides (Kirschman, 1999)
Human/social judgment: Ability to work with/help others, people/social system knowledge, cooperation, create environment of trust, sensitive to peoples' needs/ motivations/ attitudes, solve problems	**Human/social judgment:** Understands differences between medical/ administrative needs (Chappell, 2004); Builds trust/support/credibility (Cors, 2009; Angood & Birk, 2014); Ability to work with other physicians collaboratively (Angood & Birk, 2014); Ability to compromise (Chappell, 2004); Negotiation skills (Chappell, 2004); Judgment (Kirschman, 1999); Clinical knowledge makes them sensitive to clinical staff and patient needs (Angood & Birk, 2014); Ability to handle conflict (Chappell, 2004)
Conceptual: Good at communicating ideas/ concepts, good with abstracts/ hypotheticals	**Conceptual:** Communication skills (Chappell, 2004; Cors, 2009; Angood & Birk, 2014); Creating/attaining a shared vision (Angood & Birk, 2014)
Problem-solving: Good at defining problems, gathering information, creating new understanding, coming up with solutions	**Problem-solving:** Problem solving (Kirschman, 1999); Trained in identifying and solving problems/deficits (Stoller, 2004); Rational thinking (Kirschman, 1999)
	Differences: Disinclined to collaborate or follow (Stoller, 2009); Value autonomy (Stoller, 2009); Change management skills (Angood & Birk, 2014)

Leadership Approach Theory - Behavioral Approach (what leaders do/how they act)	Chief Medical Officer Literature
Task behaviors: Initiating structure (organizing work, giving structure to work context, defining role responsibilities, scheduling work activities); Concern for production (attention to policy decisions, new product development, process issues, workload, sales volume)	**Task behaviors:** Implement new programs (Kirschman, 1999); Manage a complex environment (Kirschman, 1999); Daily operations (Kirschman, 1999)
Relationship behaviors: Consideration (building camaraderie, respect, trust, and liking between leaders/followers); Concern for People (building organizational commitment/trust, promoting personal worth of followers, providing good working conditions, maintaining fair salary structure, promoting good social relations)	**Relationship behaviors:** Acts as a liaison/intermediary (Kirschman, 1999; Longnecker et al. 2007); Build credibility and trust (Cors, 2009; Angood & Birk, 2014); Builds acceptance on medical and administrative sides (Kirschman, 1999); Bridges gap between management and clinical side (Cors, 2009; Angood & Birk, 2014); Builds relationships (Angood & Birk, 2014)
	Differences: Disinclined to collaborate or follow (Stoller, 2004 & 2009); Values autonomy (Stoller, 2009); Value autonomous decision-making, personal achievement, improving own performance (Weisbord, 1976); Life-long learner (Chappell, 2004; Angood & Birk, 2014); Continuous development (Chappell, 2004; Angood & Birk, 2014); Inspires excellence (Angood & Birk, 2014)

Trait Leadership Theory and the Chief Medical Officer

There is some evidence that Chief Medical Officers also display intelligence, self-confidence and determination. They display intelligence because they are persuasive and they can reason with others. Longnecker (2007) identified stature as a factor to success for CMOs. This could imply self-confidence (although I was not able to determine if CMOs are generally certain about their own competencies and skills), self-assurance, or self-esteem and if they believe in being able to make a difference. In terms of determination, it takes a long time and a lot of training to become a physician, which could imply that a CMO must be determined to become a physician in the first place. I was not able to explicitly find anything written on CMO's initiative, persistence, dominance, or drive in their leadership role. Two more points that seemed to differ between leadership theory and the Chief Medical Officer literature were that CMO need common sense in their position and they a lot of times are passionate about quality.When comparing Chief Medical Officer traits, skills and behaviors to what theory says about the traits, skills, and behavioral approach to leadership, there are many similarities, and surprisingly few differences.

In terms of the traits approach, I discussed above that theory states that leaders are intelligent, they are self-confident, determined, they display integrity and are sociable. These five traits all describe Chief Medical Officers to some degree. The most overlap occurs for integrity and sociability. Chief Medical Officers display integrity in that they are loyal, they tell the truth, they are principled but not inflexible, they have strong ethics and professional standards, they are trustworthy, and they have responsibility to patients and communities. CMOs display sociability because they value and build relationships with others. Moreover, due to their clinical background, they are sensitive to what clinical staff members and patients need.

Skills Leadership Theory and the Chief Medical Officer

For the skills approach to leadership, theory states that four overarching skills are important for leaders. They have technical skills, or knowledge, they have human and social judgment, they have conceptual

skills, and they have problem-solving skills. Chief Medical Officers display all four of these skills. They have a strong clinical background and knowledge in healthcare. At the same time, they have business skills and knowledge, and many times, they have training in business, management and leadership. This shows the high degree of technical skills and knowledge CMOs have.

In addition, CMO's also possess human and social judgment skills. Because Chief Medical Officers have knowledge of both the medical and administrative sides, they are able to understand the differing needs of people in each department. They are able to build an environment of trust and support and they build credibility. They also have the ability to compromise, work with other physicians collaboratively and handle conflict; they have negotiation skills, and they have judgment. In terms of conceptual skills, different papers highlight CMO's excellent communication skills.

CMO's are able to create and attain a shared vision, which to some degree could require being able to communicate ideas, concepts, abstracts, or hypotheticals. Lastly, Chief Medical Officers have problem solving skills. During their medical training, they were trained to identify problems or deficits and to solve them. A lot of time, they also display rational thinking, which can be helpful in the problem-solving process. While a CMO's medical training has most likely enabled them to identify a problem and come up with a solution quickly, it also trained them to be autonomous decision makers. Valuing autonomy is something that is very different from what theory states a leader looks like under the skills approach. As stated by Stoller (2009), this value of autonomy can potentially disincline CMOs to collaborate or follow. Autonomous decision making can potentially also stand in contrast with being able to work and cooperate with others, which falls under the human and social judgment skills of skills approach theory.

Behavioral Leadership Theory and the Chief Medical Officer

In terms of the traits approach, I discussed above that theory states that leaders have task behaviors, which includes initiating structure and concern for production, and they have relationship behaviors, which includes consideration and concern for people. For this approach, there was more overlap between leadership theory and CMO literature for relationship behaviors than for task behaviors. This approach was also the one in which I identified the most differences. For task behaviors, CMOs implement new programs, they manage a complex environment, and they are involved with many daily operations. These examples of task behaviors are very general, and I was not able to identify more specific task behaviors, like defining role responsibilities, scheduling work activities, and attention to policy decisions.

For relationship behaviors, CMOs display consideration and concern for their people because they act as an intermediary, or liaison, between the clinical and administrative sides, which positions them uniquely to build acceptance on both sides and take both sides' needs into consideration. They behave in a way that builds credibility and trust, and they build relationships with others. As mentioned in the paragraph above, Chief Medical Officers are trained to be autonomous decision makers, which could potentially disincline them to collaborate or follow. This stands in contrast with relationship behaviors, especially "linking between leaders and follower" and "promoting good social relations." The Chief Medical Officer literature also highlights that CMOs have to be life-long learners, and they need to continuously develop themselves and their people. Additionally, they inspire excellence in others. These were behaviors not included in the behavioral approach theory.

Conclusion

In summary, physician leaders play an important role in delivering high-quality patient care and the performance of their hospital, overall. The specific type of physician leader analyzed in this chapter was the Chief Medical Officer. CMO leadership characteristics were analyzed through three different lenses: the traits approach, skills approach and behavioral approach to leadership. Chief Medical Officer leadership characteristics overlapped with the three leadership approach theories. One difference that

stood out was that CMOs potentially highly value autonomous decision making, which could make them more disinclined to collaborate or follow, due to their type of medical education and training. This stands in contrast to the human and social judgment skills of skills approach theory, as well as with relationship behaviors of the behavioral approach to leadership theory.

In a larger organizational context, it is important for hospital leadership to remember the importance of the Chief Medical Officer role to the overall success of their organization, as well as the impact on patient care. Therefore, it is crucial to recognize and support this role. In terms of hiring decision for Chief Medical Officers, the analysis of CMO leadership characteristics discussed in this chapter can inform hospitals on what leadership characteristics make a successful Chief Medical Officer. The analysis also points out the potential difference of CMOs value of autonomous decision making, which could disincline them to collaborate or follow. Since collaboration is a skill and relationship behavior, it can be learned and developed, which is also important to remember and pay attention to when hiring or developing Chief Medical Officers.

An Overview of Leadership Principles and Theories

Seth Frey

Throughout my 10+ years of experience in both business and healthcare, I have personally moved from roles that fit the more traditional definition of a follower, to that of a manager, and more recently to that of a leader. As I have progressed to my current level of the organization, I have also witnessed, and been a participant in, areas with both effective and ineffective managers and leaders that have tremendous amounts of followers or some leaders that have no true followers.

Over the course of this chapter we will cover a high-level definition a leadership, the differences between leadership and management, why leadership has become a dynamic factor in healthcare systems, and different leadership principles and theories. These topics will also be further enhanced with personal reflections of my decade worth of experience in both business and healthcare.

What is Leadership?

There are thousands of specific ways to define leadership but most follow a definition similar to that of how Bruce E. Winston and Kathleen Patterson of Regent University define (in part) leadership: "A leader is one or more people who selects, equips, trains, and influences one or more follower(s) who have diverse gifts, abilities, and skills and focuses the follower(s) to the organization's mission and objectives causing the follower(s) to willingly and enthusiastically expend spiritual, emotional, and physical energy in a concerted coordinated effort to achieve the organizational mission and objectives. The leader achieves this influence by humbly conveying a prophetic vision of the future in clear terms that resonates with the follower(s) beliefs and values in such a way that the follower(s) can understand and interpret the future into present-time action steps…" (Winston & Patterson, 2017).

This definition encompasses all the aspects that I personally feel an individual need to do/have to be considered a leader. Not until recently did I think of myself as a leader. This epiphany did not occur until I understood how my thoughts on the future of my organization were being perceived by others. For example, my organization was very price focused and believed that the only way to compete in a mature sector was to continue to lower price; my thought (developed through my MBA coursework) was that we should build a strategy to best serve our customers so they continue to buy our product. I, at the time, was pushing for the option to say "no" and the realization that we (the organization) cannot satisfy everyone; we need to build a strategy where we satisfy several customers and are comfortable giving away margin to our competitors. This thought process is now being implemented (since I have developed consensus and a large follower base), and we are see sustainable growth in markets we once did not.

How to Differentiate Leadership from Management

The terms leadership and management are often used interchangeably. This regularly leads to a belief that leadership and management cover the same aspects which cannot be further from the truth. Leadership is a more elusive concept than management. In leadership the key concepts are about influencing and knowing how to appropriately incentivize someone. This is not to be confused with management which is more transactional and concentrated on efficiencies than effectiveness. Also, management is about control; it is about having checks and balances in place to properly measure success, while leadership is about the people and relationships and how best to utilize them to reach a common goal. Leaders are concentrated on "innovation" where new ideas are brought to the forefront and treated as a highly valued skill derived from a creativity aspect (Bennis and Nanus, 1997).

These differences between leadership and management can be further described in the way managers and leaders see the future. Managers see the future as a bottom line, in other words as a short-term financial goal. Leaders see the horizon, they see the aspirational goal of moving the organization in a certain direction that will lead to a long standing competitive advantage. Finally, these aspirational goals that move the organization are not truly effective without the accumulation of followers (and their engagement). Having these organic followers is another key distinction between manager and followers. Alberto Silva of Keiser University recently defined this organic follower aspect of leadership the following way, "Leadership is the process of interactive influence that occurs when, in a given context, some people accept someone as their leader to achieve common goals."

I have personally been confused about the differences between leaders and managers and, until recently, used them interchangeably. I also considered managers to be lesser than leaders and considered the evolution of an individual to be at an end state of a leader with the manager state being necessary but quick, as the final goal was to be a leader. Through my research, I have learned that not only are managers and leaders two different things, but being an effective manager can be very rewarding and necessary for certain instances. For example, in my previous role, I was a manager of operations which required constant feedback from my direct hires and metrics to be established to understand if we were hitting the benchmarks we had determined. My operations role involved thousands of transactions and several audit checks to make sure our efficiency was accurate. This type of work could only be done by a manager that can assess quickly, think short-term and always consider efficiencies/effectiveness as a cost reduction measure. A leader in this type of role might lose track of the daily transactions and be fatigued by the rigidness and certainty of each day's deliverables.

Why Leadership Has Become a Dynamic Factor in Healthcare Systems?

As healthcare has changed drastically over the past 20 years, the correlations and similarities between business and healthcare have only increased. One such area that is similar in both business and healthcare systems is the satisfaction of the consumer or patient. In business the satisfaction of the consumer leads to a relationship of continual purchases and loyalty, in healthcare, satisfaction of the patient leads to referrals of other patients, additional medical services and more effective community outreach.

As businesses constantly aspire to achieve sustainable competitive advantage, so do healthcare systems and public health institutions. While it might be hard to ascertain, it is in the best interest of healthcare systems or public health institutions to implement strategies that will foster an edge against other systems, or in public health institutions, a better network to facilitate protocols and community outreach.

One such way that healthcare systems and public health institutions can create an edge is through differentiation. This is very similar to the strategy first devised from Michael Porter. This strategy, created in business, says that for sustainable growth, an organization must either work to be a cost leader or differentiate themselves from their competition (Tanwar, 2013). While cost leadership might not be a tool at the disposal of healthcare systems, differentiation is. Most healthcare systems have started to find that their best chance at differentiation is through their people and the leadership they implement. In fact, Dr. Mark Britnell of KPMG recently wrote "that a typical (healthcare) organization can become around 15 percent more efficient purely through operational, administrative and workforce improvements." Scaled up to a global level, this suggests that the prize of better managed healthcare services may be in the order of one trillion dollars (Britnell, 2016).

While my experience in healthcare systems and public health institutions is relatively limited, my current employer has several longstanding contracts with these types of organizations. These longstanding contracts have afforded me the opportunity to collaborate with several leaders of local healthcare systems and public health institutions. As I have been in my role for six years, I have

witnessed the healthcare landscape change and profit margins become a more and more important metric. While discussing the business models of these leaders, I learned that to be different in a crowded segment, you have find your niche and run with it (which is very similar to what my business organization does). As David Blom, CEO of Ohiohealth mentioned in an interview from 2016, their advantage is leadership. Below is an excerpt from that interview:

Q: If you could teleport back in time and counsel yourself, what lessons from now would you impart?

Blom: If there's one thing I wish I had learned earlier in my career, its leadership. I never had a leadership course in high school, college, or even in graduate school. Had I understood leadership more clearly earlier in my career, I could have avoided a lot of mistakes.

Q: Speaking of leadership, you talk about focusing on "hands, heads, and hearts." Can you explain that philosophy?

Blom: First I consider, do I have the hands to do the job? You've got to recruit the right people, those who have the values, competence, and character you want. As far as heads, we do a lot of work to explain what we're doing and why. There are no strategic secrets in the organization. Then you also need to light people up, and you do that with their hearts.

If you get all three of those things, it's something really special.

Different Leadership Principles and Theories

Healthcare systems are made up of numerous professional groups and departments with competing goals and constraints that often lead to inefficiencies when it comes to obtaining goals and an overall strategy. This is where leadership comes into play. Through leadership, the organization can utilities the diversity of the organization and efficiently work to properly manage processes and teams to maintain a common organizational goal.

As mentioned previously, over the course of my 10 years of experience, I have witnessed and partaken in several leadership principles here is a curated list of the leadership types I view as most effective:

Servant Leadership

Servant leadership is the theory that suggests that in order to lead, one must first be a servant. A servant leader knows that through emotional intelligence there is a better chance of encouraging passion in others. Servant leaders exhibit immense amounts of care for others, have the ability to set good examples for others to follow, provide a standard set of ethics that are never put into question and hold an immense drive to support others.

The core values that makes servant leadership such a great fit for healthcare systems are as follows (Montgomery, 2016):

1. **Prioritize Service:** Servant leaders strive to serve the most vulnerable first. Much like that of a triage nurse that determines those that need immediate attention, servant leaders will look to prioritize resources towards those issues that need the greatest need first.
2. **Share Power:** By nature, servant leaders want their followers to assume leadership responsibilities when appropriate. With servant leaders, decision making is shared and each individual feel like they have a voice that is treated equally.
3. **Demonstrate Care:** In this core value, the leader strives to show empathetic interest. Of course, having empathy is especially crucial in the healthcare industry.
4. **Develop Others:** A servant leader really measures success by developing others. Through empowerment, the follower often stakes on more ownership and provides additional activities and outcomes.
5. **Eschew Wealth:** Servant leaders will work for the greater good, not for an accumulation of money. Their aspirations are about principles and not about what the job market dictates.
6. **Build Trust:** Much like the other theories to come, trust is a vital part of those that are of a servant leadership mindset. Without trust, followers will not stay continually engaged.

7. **Create a Safe Space:** A servant leader also has the core value that the workplace should be safe, where measurable mistakes can occur and individuals will feel like they need to hide an issue.

A current co-worker of mine is the quintessential Servant Leader. Her team of direct and indirect reports realize that she "cares" and that she wants every one of her individuals to succeed. She works by always being available for questions, prides herself not by hitting certain metrics, but by, how safe her followers feel in making mistakes and learning from them. She also knows her job is never done in mentoring those of her group who have moved onto other roles. Several of my direct reports have come from her team, and she makes a point to check in to make sure they know that she is always available to help (even if she is not their direct supervisor).

Transformational Leadership

While transactional leadership is more in alignment with manager styles of measuring supervision and process, transformational leadership theory emphasizes that people work more effectively if they believe in the mission of the organization. Transformational theory requires leaders to communicate the vision in a meaningful way that not only creates motivation but also a sense of empowerment in the follower. Typically, transformational leadership is a byproduct of a healthy relationship between the leader and the follower. The core factors of a healthy relationship follow these four elements: trust, mutual respect, support and communication (Manion, 2011).

1. **Trust:** In this element, the leader must learn and implement the virtues of trust. This means that not only is the follower trusting the leader, but the leader trusts the follower. As the relationship grows and each participant understands that they can be a trustor and a trustee at times, the relationship creates a bond that allows calculated risk and reward to occur (Green, 2012).

2. **Mutual Respect:** This element covers the power of humbleness. When a leader and follower relationship incorporate mutual respect, the follower feels no recourse for communicating adverse news, incentivize learning on both sides of the relationship, and finally implement the need for discipline as a mechanism for producing leadership, either in a transformational state or shared leadership state.

3. **Support:** As described in the article *How Team Leaders Show Support–or Not*, support as an element can only be created if the follower feels that the leader is exhibiting the following four types of effective behavior: 1) Reviewing the work effectively by giving proper actionable feedback that is timely. 2) Providing support through reducing stress, socializing, articulating personal information and offsetting a follower's negative outlook. 3) Recognizing great work through public and private means. 4) Creating an environment where a leader can consult their follower on the creation of new ideas and issue resolution (Lagace, 2004).

4. **Communication:** This core element means the leader must communicate the message or strategy that connects with the follower. As Bill Black, the CEO of Maritime life said, "a leader must communicate, communicate and then communicate some more." Communication, by definition, supplies the messaging but communication can also play a role in being transparent to help garner a healthy relationship between the leader and the follower. This communication can take many shapes both formally (via meetings/emails) or informally (via quick chats or walking meetings), and an effective leader will use both interchangeably (Beslin, 2004).

With these core elements in place, I have personally watched transformational leaders change their approach to their respective followers to be more of colleagues that can provide guidance and reliability on issues that the leaders might not know.

One example comes to mind of a transformational leader. About five years ago, I worked with a transformational leader that oversaw the health information systems department for a large pharmaceutical distribution company. He noticed that the company was relying on data more and more and needed to put in place an effective tool that could grow with the company. He envisioned a switch in how the company cared for and stored and utilized their data to make important financial decisions. His

vision of data interpretation is still being implemented and followed by his followers to this day, even though he has moved on to a new company and his original blueprint is five years old.

How is Transformational Leadership Reflective in the Healthcare Setting?

One study provided the following outputs on a review of transformational leadership in a healthcare setting. The focus on transformational (and transactional) leadership was also identified in a systematic review performed by Gilmartin and D'Aunno (2007), examining health care leadership research from 1989 to 2005. They concluded that studies in health care provide strong support for transformational leadership theory and identified links with staff satisfaction, unit or team performance, organizational climate and turnover intentions. They suggest these effects are stronger when assessed among more junior than senior staff (West, 2015).

Collaboration/Meta Leadership Theory

Collaborative/Meta leadership involves communicating information to coworkers and associated organizations to allow them to make their own informed decisions. This approach creates strategies that enhance dialogue between multiple stakeholders, the sharing of knowledge and experience and the overall simplification of the healthcare organization structure. Of course, levels of responsibility will prevail and need to be engaged with this leadership process, but the overall engagement at every level will lead to quicker adaptiveness and agility with the ever-changing demands of the healthcare organization. This meta leadership requires a work environment in which varying levels of the organization are encouraged to work collaboratively toward the implementation of effective practices with the patient in mind. Through this collaboration diverse thought, each stakeholder will be in lockstep with the shared vision and goals and work to build synergies through motivation.

The Five Elements of Collaborative/Meta Leadership

According to a recent Harvard study there are five main elements of Meta Leadership (Marcus, 2009):

1. **The person behind the leadership.** This means that the leader of the group needs to have a good understanding of their impact and a high emotional intelligence so they can effectively collaborate with others at different levels within the organization.
2. **Understanding the issue at hand.** This element is reflective in the sense of identifying the issue at hand, the amount of evidence available to understand the issue and how to navigate the different needs/wants of different levels of the organization.
3. **Leading your core followers.** This element discusses the necessity of having a core competency of certain skills within the organization. Through a trusted group of followers (typically in this case the main department the leader oversees), the meta leader can have consensus built and leverage that when rolling out larger solutions with other groups not under the direct leadership of the meta leader.
4. **Leading up.** This element discusses the impact of "managing up" and not letting hierarchical rank be a deterrent. This element is tricky as those that have a direct manager/leader need to be aware that through meta leadership they might obtain more informal power than their direct manager. Additionally, meta leaders will be able to effectively call out and challenge the status quo that is instructed from above. Typically, this delivery of critical advice/guidance manifests through leveraging their direct team, their subject matter expertise and their overall proximity to the work.
5. **Leading across the system.** In this element the impact of meta leadership "spills over to other areas of the system. This impact leads to more cohesive and impactful change. By leading across the system change becomes a concerted effort with results that are beyond what a singular leader can obtain.

I personally think I am a meta leader since I have found myself leading across the system and bridging the gap/dismantling the silos of areas that partner with my area. One example of this is how my current employer treats business specific knowledge. In my role, I noticed that we were defining things in different ways, causing unnecessary confusion. I quickly noticed the gap in common knowledge and worked with six teams to build a common vocabulary. As simple as this sounds, it required knowing the

impact of the change, addressing any issues from high levels of leadership, finding core followers that would be "agents of change" and managing different priorities/needs of the six teams.

Shared Leadership Theory

The principles of shared leadership work through empowering staff/team members to make decisions on processes within the confines of their work. This chance to develop new strategies has proven to be a great way to increase morale and satisfaction. Of course, this increased morale and satisfaction cannot be sustained without efficient teamwork that leverages efficiencies that align with the values of the team. Through shared leadership, the group and organization can obtain improved patient results. From the case *The shared leadership challenge in strategic alliances: Lessons from the U.S. healthcare industry* (Mcsweeney-Feld, M. H., Discenza, S., & Feis, G. L. (2010), one can ascertain that having a more ingrained shared leadership (at least at the executive level) can lead to a departure from a short-term view of decision making to that of long term view. This case also echoes the theory that alliances, created through shared leadership, equate to better customer value and care and not a 100% focus on bottom-line financial decisions.

According to Voss Graham, there are seven key factors that need to exist for Shared Leadership to exist:

1. **A common goal:** By creating a goal there is meaning and purpose. If you do not have a goal, productivity and focus drop. The group also runs the risk of someone else assigning the goal and not having the right version of value.
2. **Respect for everyone:** Diverse thought is a key piece of what each individual brings to the group. By incorporating diverse thought and incentivizing where appropriate, the unity of the group increases. When the unity increases there is a larger opportunity to pledge to a larger purpose.
3. **Trust in each other:** Trust connects everyone to the larger group. When there is a lack of trust, factors like fear of failure, low self-esteem and an over reliance upon rules and laws become commonplace.
4. **Personal accountability for results:** Accountability is a major contributor to high performance for individuals and teams. Personal accountability is the understanding that under-performing and over-performing are all about the right type of goals being obtained.
6. **Effective communication:** Communication drives results and productivity, and it is a two-way street where you must over-communicate and truly make sure that your communication is effective. While most people articulate in a way that they understand, without the feedback of their group, they will never know if their messaging is being understood.
7. **Discipline to stay the course:** Without discipline, the scope of work can widen and cause the goals to be unattainable. Throughout the course of work, distractions and roadblocks will occur. Discipline is the key element to face those adversities head on and work to find ways to stay the course. A lack of discipline could very easily lead to failure and improper implementation of new processes

While barriers to shared leadership exist, I believe the intent and impact of shared leadership cannot be discounted. Possible constraints with this leadership theory include: large workloads, increased turnover rates, transactional/mundane work, and poor scope of goals. Additionally, shared leadership has the additional work of continuously evaluating whether or not the impact is measurable in a quick paced environment like healthcare. This additional work might not be seen as value added, but the impact of shared leadership can not only affect the team in which it is occurring but can have longstanding effects of influencing and increasing the perspective of the group in the overall hierarchy of the organization.

One individual with whom I currently work is what I would consider a Shared Leader. He is currently the leader of an account management team and through alliances has implemented several key initiatives that were created in his organization but affect several other areas. The methodology that he implements is that his team cannot be truly effective if there are inefficiencies up or downstream from his department. So, he has worked to create key alliances with organizations on both sides, and this has

led to key learnings and enhanced commitment from all internal stakeholders and the solidification of broad goals.

Conclusion

Through reading this chapter, you will notice that are is not one specific leadership style, principle or theory. Great leaders can follow a shared leadership style, a meta leadership style or even a transformational leadership style and be equally effective. As each style might seem different, they all have a base definition of the core relationship of leader to follower. The only way this relationship stays healthy and effective is through communication that not only works top down (leader to follower) but should also work from bottom up (follower to leader). This transparency of communication leads to the ability to adjust tactics, strategies and styles.

As I have lead multiple teams now in my decade long career, I have learned that the only true way to create a great base of followers is to be authentic, transparent and ethical. In my career, I have also implemented different versions of these different leadership styles with great effect. As previously mentioned, sometimes taking on a manager type of approach is useful, so to are the correct usage of these leadership styles. For example, in my organization I have been a part of teams that had leaders that were transformational to get a sustainable business model fleshed out, and then the leader switched the style to more of a shared leader to get buy-in from other areas, finally creating an environment where meta leaders in the organization can broaden the interest and collaboration across the organization.

Leading in Public Health through Collective Impact

Erin Fawley

Introduction

Non-profits have worked in silos for many years to address specific issues and have seen successful results. Though silo work produces success, there are more social factors that contribute to sustaining outcomes, especially in the public health sector. To better address social issues across the board, a company named FSG (Foundation Strategy Group) created the Collective Impact (CI) model (Turner et. al, 2010). This model is expected to be the future of public health leadership, and the model fits into Institute for Alternative Futures' (IAF) Public Health 2030 Scenarios to address population or community health to stray away from isolated impact and work together to utilize resources (Institute for Alternative Health, 2014). Collective Impact is utilized to move agencies out of silos and integrate efforts to improve topics like health, homelessness, addiction, and educational success. This framework is forecasted to be the future in public health leadership as it addresses community health in a collaborative format that mixes both public and private sectors. Leadership styles can vary in Collective Impact efforts, but transformational leadership is very relevant in addressing complex and social issues. In this chapter, we examine the Collective Impact (CI) Model and transformational leadership.

Background

Many nonprofits currently work in a category of "isolated impact" where it appears to be necessary to work with a single issue, but social problems are often very complex and require collaboration between multiple organizations. Isolated impact may contribute to temporary fixes, but there are typically multiple factors that cause the issue to reoccur (Kania & Kramer, 2011). Collective Impact recognizes that there is not one agency or organization who can solve social issues single-handed. One of the first documented implemented efforts of CI was by the Greater Cincinnati Foundation with their Strive initiative. Strive is an initiative in Cincinnati and Northern Kentucky that took the Collective Impact approach to address the student achievement crisis and successfully improved 34 of the 53 success indicators (Turner et. al, 2010). The recent push of "from cradle to career" has motivated many agencies to align by realizing changing one aspect on the educational continuum does not fix the problem. All aspects of the continuum must improve together to make an impact. They found that to observe improvements in students, it involved after school efforts, tutoring, nutrition, etc. More than 300 agencies and organizations were involved in the effort to improved student achievement through high school and set them up for college experience (Kania & Kramer, 2011).

Collective Impact is an emerging paradigm to address systemic changes. The CI framework relies on having "backbone organizational support" to ensure the effort creates progress and impact. A backbone organization ultimately guides the vision and strategy and supports the aligned activities by the overall coordination of the program/project (Kania & Kramer, 2011). In addition to backbone leadership, there are a few added requirements for the CI to be implemented; these include a *common agenda, shared measurement, mutually reinforcing activities, and continuous communication* (Kania & Kramer, 2011). If efforts do not have these five key elements, then CI may not be the most suitable framework. A project cannot use the CI framework unless all of those involved have a similar idea of the issue and ways of solving the issue with steps agreed upon. A shared agenda involves establishing boundaries or scope of the project and develop a strategic action plan (Kania & Kramer, 2011). It is necessary to work through challenges and put them aside so that the group does not dissolve or lose sight of the common vision.

Shared data is the only way to measure success consistently across the board; this could be one of the most difficult implementation steps. It is critical to consistently measure the same indicators to continue on a shared path and vision, as well as benchmarks. Shared data can identify patterns, strengths, and weaknesses while keeping those involved accountable for their part (Kania & Kramer, 2011).

Social issues are interdependent, therefore each entity involved has a different role to play, but it is necessary for all those involved to have a part that falls under the mutually reinforcing plan of action. CI is successful when there is clear coordination between all involved, rather than involving as many partners as possible (Kania & Kramer, 2011).

The most successful CI initiatives have multiple years of meetings and shared language, vocabulary, and visions (Kania & Kramer, 2011). In order to be successful, the initiatives had to learn to communicate effectively and learn to set their personal agenda aside for a solution that worked better. All interests are taken into consideration, but continuous communication allows for no single entity to be favored. The key to constant communication is the face-to-face conversations held at meetings. Kania & Kramer studied how the effective initiatives had the top-level leaders from each organization at in-person structured meetings. In many cases, such meetings are delegated to lower level staff and result in frequent absences (Kania & Kramer, 2011). By having leaders actively involved, there is a better likelihood that the project will have impact and success.

There are three phases to CI. The first phase is *initiating action through identifying those to be involved, collecting data on the known issue to identify the known gaps, and facilitate community outreach* (Hanleybrown, et al., 2012). After that is done, the framework moves into the second phase of *organizing for impact*. This is where a backbone organization and common agenda is identified, as well as establishing the shared metrics that will be used (Hanleybrown, et al., 2012). The final phase is *sustained action and impact*. In this phase there is continued engagement from the community and continual data collection to track progress. It is important to remain aligned with the initial scope of the project during this phase. Goals should be set at the beginning but may be flexible later on as long as they were established as critical points of success (Hanleybrown et al., 2012).

Collective Impact is an innovative approach to social change, but since introducing the framework early thinkers are now identifying "mindset shifts" as a critical component. These shifts include "who is engaged, how they work together, how progress happens" (Kania, Hanleybrown, & Splansky, 2014). To start, it is important to involve the correct people and cross-sectional organizations. Successes will happen, but it is important to not have individuals take credit when it is a joint endeavor; instead, all credit should be shared (Kania, Hanleybrown, & Splansky, 2014). Integrity to the framework is one of the most important aspects to funders. When money is put on the table, it is important to not use CI as a buzzword and stay true to inter-agency approach. The last mindset shift is moving from technical solutions to adaptive work (Kania, Hanleybrown, & Splansky, 2014). The social sector has always involved technical approaches but when using CI, there is not a known solution so there is a need to constantly learn and adapt. In many cases, CI stakeholders are encouraged to not look for the "silver bullet solution" but think of it as a "silver buckshot" that includes how everyone's work fits into the larger puzzle (Kania, Hanleybrown, & Splansky, 2014).

Strengths

Across many public and private sectors, many health care professionals have common agendas that lead to mutually reinforcing activities; this alignment results in the collective impact framework and aims to make social changes that are longer lasting. This concept is now transitioning from the education realm to nutrition, including obesity, and is proving to be the future of healthcare (Boyce, 2013). For example, the United States Breastfeeding Committee (USBC) is currently using CI to create PSE changes to increase breastfeeding rates and eliminate disparities (Boyce, 2013). Funders also want to focus more on projects that achieve the most progress towards social problems instead of an isolated and

narrow focused. This supports more groups to collaborate on their shared agenda to progress in creating solutions to social issues/concerns (Boyce, 2013).

Collective Impact is complex, but transparency can help combat that anticipated barrier. Every organization involved can benefit and learn together which leads to coordinated responses. Since CI aims to address social issues, there is not a predetermined solution and requires multiple players including government, private, and nonprofit sectors (Kania & Kramer, 2013). Creating a common agenda is an essential component of CI, but this step does not mean that there is a common solution; it means that everyone has a common understanding of the problem. Complexity is reduced when the collaboration realizes the common goals or possible steps to achieve the common goal (Kania & Kramer, 2013).

Also, there is a benefit to have cross-sector partners so that viewpoints are represented, specifically non-profits and funders. Rather than viewing CI as a solution, the CI Forum encourages viewing CI as a "collaborative problem-solving process (Collective Impact Forum)."

Weaknesses

While equality is the aim, the process needs to go one step further and think in terms of equity. While CI is normally aimed for the top levels of the organizations involved, community members need to be engaged to be most impactful. This thought process is normally overlooked, but for the community to feel they are fully heard, it is critical for participation and ownership. Frameworks like Community-Based Participatory Research (CBPR) can sometimes be better suited due to the interest in the community working with higher powers and officials.

One common example of such a structure is HEAL MAPPS (Healthy Eating and Active Living: Mapping Attributes through Participatory Photographic Surveys) presented by OSU Extension and the Kirwan Institute (FORC). Community members conduct the research about the strengths and barriers related to food access, food quality, and physical activity in areas where they live by mapping their routes and taking pictures along the way. The viewpoints are then turned into a story map and presented to community stakeholders; the issues identified can be tackled through CI (FORC).

Leadership is a critical point that is not initially addressed in the CI framework. Not only does the leader have to facilitate and manage, they also must convey a shared focus. This can be difficult among participants and their organizations, but commitment to transformational change can keep everyone aligned (Collective Impact Forum).

Co-production and Transformational leaders are typically more productive in the leader role for a CI project (Batalden et al., 2016). Transformational leaders are known for their charisma and inspiring followers (Northouse, 2015). These styles can complement the framework by followers staying motivated to produce change, especially those tied to a moral or value issue. Co-production has been used in many healthcare settings to ensure better patient involvement. Services are seen to be coproduced when producers and consumers both provide input on the product (Batalden, et al., 2016). CI could implement such concepts to have input and engagement from the community members to ensure sustainability.

While CI does indeed result in changes, the framework does not address the systems or policy changes to make impact sustainable without dispute. Changes in the environment can be enough for short term changes, but to see longstanding issues across a community, there needs to be more systemic practices put in place. CI could achieve such changes if policy makers and elected officials are stakeholders represented in the initiative, but the framework itself does not specifically point to policy for social changes (Wolff, 2016).

CI currently also does not have research to back up such practices and only has a few case studies to explain the successes of implementing. The concept of CI was not introduced until 2011 and has been deluging in Public Health ever since (Kania & Kramer, 2011).

While the popularity increases, more evidence is needed to support such complex and innovative

thinking. The Collective Impact Forum is now a resource for many from do's and don'ts to a small selection of featured case studies. Many large agencies, including United Way, are training partners on the CI framework to help serve communities and build off their mission of improving the common good in every community (Collective Impact Forum). Funders, including the Robert Wood Johnson Foundation, are looking more for innovative solutions that embrace collaboration (Boyce, 2013). With all the recent attention, it is only a matter of time for the published research to convert this weakness into a strength.

Additionally, backbone organizations are assumed to have sources to funding. Since many backbones are nonprofits, most apply for sufficient funding to truly carry out the desired project through grants or supply in-kind services, neither of which is permanent and sustainable. Due to the mix of public and private sectors in this framework, it is critical to be aware of potential conflicts of interest, mainly pertaining to the private sector and academics that have specific perspectives (Boyce, 2013).

Luckily there are a few opportunities for backbones to ensure the project has enough money to function. First, there are some initiatives that used "shared backbone" strategies, meaning there are two organizations that collaborate to become the lead on the project. This can combine financial resources as well as expertise in different subjects (Turner, et al., 2012). Secondly, as previously mentioned, funders are now looking for collaborative efforts and grantees that have the CI frameworks in place while applying for grants.

CI, Community Coalition Action Theory (CCAT), Quality Improvement, CBPR: Similarities and Differences among Models

Health promotion has been finding success among collaborative models for some time, but the most developed in terms of track-record is the Community Coalition Action Theory (CCAT). This theory helps support the Collective Impact framework, but there has not been significant research conducted over the success of the initiative. Like Collective Impact, CCAT promote collaboration to sustain change across multiple sectors while removing silos and duplication of efforts (Flood, et al., 2015).

One main difference between CI and CCAT is that CCAT focuses on community member involvement instead of CI model of public-private partnerships. The CCAT approach emphasize community residents' involvement, which is opposite of the CI involvement of CEOs or leaders of organizations from the community involved (Flood et al., 2015). CCAT also focuses on sustainability regarding PSE change interventions and advocacy. The focus on advocacy and policy change that CCAT presents can "increase community capacity [while improving] health and social outcomes (Flood et al., 2015).

Tenderloin Healthy Corner Store Coalition Case Study

The case study of Tenderloin Healthy Corner Store Coalition, explained how CI was not planned, but the sense of urgency aligned with the framework. The coalition stemmed from the high rates of chronic disease and a tobacco-free initiative, which also led to the discovery of the food access and poor nutrition issues (Flood et al., 2015). The coalition trained five Tenderloin residents on food systems to become advocates, officially named "Food Justice Leaders." This setup fell under Community-Based Participatory Research (CBPR) and took a bottom-up approach (Flood et al., 2015). The residents then took their findings and needs to policy makers. By doing this, officials are more likely to stand behind such efforts because there is community ownership of the problem, and they want to see change; in turn, this can become more successful and result in more sustainable changes (Flood et al., 2015).

As most would expect, they still encountered issues with funding and shifting mindsets, especially business owners. With some tweaking, they found that CI can be used for health education and promotion programs (Flood, et al., 2015). Tenderloin also had success because of the early recognition of silo work for tobacco, nutrition, and preventable disease. They did not have a defined leader per-say at the initiation of the coalition, but her influence and creation of the Food Justice Leaders fit into the CI framework as such (Flood et al., 2015). From there, the residents in combination with community

organizations already conducting silo work created the coalition. Because of the involvement from public-private sectors, and the common agenda, the Tenderloin coalition moved from a CCAT approach into CI (Flood et al., 2015).

For many local and state health departments, there has been a push to address complex demands in innovative ways as we move towards accreditation. The San Francisco Department of Public Health's (SFDPH) Population Health Division used the accreditation process as a promoter in restructuring the organization. In the process they found that Collective Impact was a "quality improvement framework applied to complex social problems (Aragon & Garcia, 2015)." They then produced the Health Equity X (HEX) model to serve as a visual representation on how complex, diverse, and connected all groups are, but it also can organize collective thinking (Aragon & Garcia, 2015). As SFDPH discovered, collective impact "complements other community-engagement approaches," but will be of great use to public health due to many players having a common agenda and based on quality improvement (Aragon & Garcia, 2015).

As SFDPH pointed out, Collective Impact does have *similarities to quality improvement frameworks*. According to IHI, a quality improvement project determines specific aims, establishes measures, and selects changes (Institute for Healthcare Improvement). Setting the aim is basically making a SMART (Specific, Measurable, Achievable, Relevant, Timely) goal, like Collective Impact's shared agenda. Establishing measures is simply that, trying to find ways to measure if the change actually improved the problem presented. CI takes the measuring concept a step further to have all agencies involved agreeing to track and measure in the same ways. Selecting changes in the IHI model is answered by asking "what change can we make that will result in an improvement (Institute for Healthcare Improvement)?" That step of quality improvement is present in CI's key conditions of mutually reinforcing activities, and continuous communication.

Personal Relevance

After attending a training program on Collective Impact, I realized that it was the missing piece to help bring my vision to life in the community of Greene County, focusing on food access and insecurity. My career had led me to research areas where I found food deserts and abundances of dollar stores, like the Tenderloin neighborhood in San Francisco. This led to my role in co-initiating the Greene County Local Food Council. There was no doubt from the beginning that community members wanted to see change, but it was difficult for everyone in the room to agree completely. The group was comprised of educators, city officials, agricultural producers, public health employees, food pantries, and many others, but all viewed food access differently. Some saw economic development, while others saw improving health disparities and chronic disease. After months of discussions, the group had great ideas, created a mission and vision for the council, but there was no clear direction on how to implement any changes.

A few members of the council attended Collective Impact training, and suddenly it made sense; combine resources for a shared backbone support with projects of interest/focus to achieve smaller levels of documented success to support future funding opportunities. Greene County Public Health in combination with OSU Extension met to bring all the voices together, including health, nutrition, agriculture and natural resources, and economic development. The first project of interest for the council was implementing community gardens after completing community readiness assessments.

The leadership strategically selected the community gardens to begin the project to keep all established working groups involved in some sort of aspect and eliminated opportunities of favoring a single agenda. Adding a garden to a neighborhood in a food desert helps with food access and health, while getting food producers or Master Gardener Volunteers involved, teaching communities to make their own sustainable fresh food systems. At the same time, it also allows elected officials to gain more perspectives from community members on what they value and opportunities for future economic development, like creating farmers' markets.

While the Greene County Local Food Council project fits well into the Collective Impact model, there were some concerns. The main concern was funding. A group creating a coalition coming together to solve social issues do not necessarily do so with funds at the initiation.

For this project we were mainly providing in-kind services with support from an outside grant. Second, the group struggled to find ways to collect and share measurable data. While many members of the council were collecting their own data, we still struggled on how we all collect the same measurable to know the impact on the social issue and not just the action item at plan. Lastly, we did want as much community say as possible, so we started with readiness assessments to see if we were problem-solving in a manner that agreed with residents of the community. Once we got the community buy-in, the council then shifted to having the community residents take ownership of projects to truly make the changes sustainable.

Leadership and Collective Impact

Successful leaders of CI projects are curious. They embrace uncertainty, but it never deters them from the end destination (Kania & Kramer, 2013). Leadership in these models relies greatly on goal-setting. Path-goal theory can explain how CI works. Leaders motivate followers in a way that are preferred by the followers to successfully reach the end goal. CI is complex, as it is trying to solve social issues together so there are often obstacles that are encountered. In path-goal theory, the leadership removes such obstacles while defining goals, clarifying the desired path, and provides support (Northouse, 2015). Leaders following the path-goal theory are also described as being directive, supportive, participative, and achievement-oriented (Northouse, 2015). Directive leaders are clear in expectations and performance standards, while supportive leadership focuses on remaining approachable by treating followers as equals. Participative leaders would be preferred for CI frameworks because they value the ideas and opinions of followers; in CI, all agencies have value, and it is imperative that there is not one voice that is always valued over another. Achievement-oriented leaders emphasize high work ethics and excellence, but they also display that they have confidence in the followers that they can achieve the highest levels of success (Northouse, 2015).

Collective Impact also is described as a transformational change, therefore supporting transformational leadership. Transformational leadership is described as “a process that changes and transforms people. It is concerned with emotions, values, ethics, standards, and long-term goals” (Northouse, p.162). Like path-goal leaders, transformational leaders are charismatic and influence followers to achieve the highest level of work/success as possible.

In terms of motivation, transformational leaders empower followers and encourage them through change. Also, “they attempt to raise the consciousness in individuals and to get them to transcend their own self-interests for the sake of others” (Northouse, p.176). Transformational leaders also create a vision by combining interests of various individuals involved. This created vision serves as the guide for all to follow, just like a shared agenda in CI projects (Northouse, 2015).

The other correlation between CI and transformational leadership is that this leadership does not provide a clear set of instructions on how to conduct tasks, instead, it is a generalization that is adaptable (Northouse, 2015). By prescribing specific tasks the project can feel too restricting. In life and public health, there are constant changes so allowing for such complications can help the project become more relevant and individualized for the community. Like previously mentioned, CI is viewed as collaborative problem-solving which needs to be tailored for each specific community to serve those effected (Collective Impact Forum).

Summary

As Collective Impact theory is emerging, we can compare how these efforts differ from other forms of collaboration which can be identified through the five key conditions: *common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone support.* These

factors combined provide the platform for larger success in social progress, but there is more needed for effective population level changes, one being that the project focuses on equity, including class and race. Collective Impact must adapt to the needs of the community while building trust and relationships with residents and partner agencies (Kania and Kramer,2011).

Collective Impact is a framework that has crossed into many topic areas to address and problem solve social issues. Public Health has worked in silos for many areas in what is now defined as isolated impact. While individual areas have achieved successes and improvements, there is a lack of systemic change because most issues span across multiple areas. CI was created to encourage collaboration to fix social issues, rather than temporarily fixing one issue at a time (Hanleybrown, Kania, & Kramer, 2012).

While CI has strengths, including preference in funding opportunities and the public-private cross sector involvement, there are some challenges to using this approach. Most stem from community involvement from residents rather that CEOs and leaders of agencies involved in the collaborative effort (Flood et al., 2015).

To truly have sustainable change, residents are encouraged to be involved, and the collaboration should promote a system and policy change. Collective Impact is evolving and becoming more relevant. Community-Based Participatory Research (CBPR) has been using community involvement to conduct evidence-based practices and taking into to leadership and stakeholders to see change (Flood et al., 2015). Others have argued that CI is a type of quality improvement project because both have a specific aim, form of measure, and select a change to see impact and change as a result. The Community Coalition Action Theory also exhibits similarities to CI in that they both encourage collaboration and removing silos to improve the well-being of the community (Flood et al., 2015).

Leadership plays a large role in the effectiveness and success of CI projects. Leaders are there to motivate, direct, and able to set goals for followers. The path-goal theory helps explain CI since leaders motivate followers so that they feel capable of doing the work and achieve results to improve the social issue identified (Northouse, 2015). Transformational leadership is also preferred due to the similarities in this style and the design of the CI framework: creating a vision using opinions from all involved, motivating to work at follower’s highest levels to improve the common good and generalized guidelines to transform for the community (Northouse, 2015).

Collective Impact will be discussed heavily in the future of Public Health and population health management. Public Health 3.0 will focus on communities working as a cross-sectional collaboration, including a mix of private and public stakeholders to improve the social determinants of health, much like CI. Also, shared data is represented in the proposed scenario to share across communities to assess the level of change and how it increases equity (U.S. Department of Health and Human Services).

Personal Stories in Healthcare and Public Health Leadership

Colleen Baumer and Angela Finnegan

Introduction

In this chapter we share stories of several great leaders in public health and health care that we have encountered throughout our careers. This topic spoke to both of us, as we wanted to learn from experience and example rather than only text. Some of the leaders we interviewed are people we have worked with directly and can personally attest to their leadership abilities. Other leaders we have watched through the public eye, and we were interested in learning more about their leadership journeys. In working together to write this chapter, we first met to discuss how we wanted to go about choosing our leaders. Do we choose people we know personally, or only ones we had heard about? Do we focus specifically on different areas, or pick people we think might agree to meet with us? Turns out . . . it is a little of everything. We wanted to interview leaders that we admired, that we looked up to and *wanted* to learn from. We discussed who we admired within the healthcare field which led us to Medicaid leaders, medical directors and physicians between both the medical and the public health field. We discussed different areas of public health that were prominent and that interested us – guiding us to disaster management, tobacco cessation, and state and local level public health.

Regardless of our relationships with these leaders, we hoped to gain a fuller understanding of each of these individuals. We thought it important to learn about their journeys so that we can continue their legacy of great leadership in our own careers and for the future of healthcare and public health. Each leader has a unique definition of and approach to leadership that works for them. This supports the idea that there is not one correct way to be a good leader but an array of different characteristics and traits that are evident in "good" leadership. We hope readers of these interviews will be inspired, educated and motivated to see all the ways one can lead, *learn* to lead, and model effective leadership which expands far beyond the reach you may expect.

The leaders in this chapter shared with us their journeys to achieve where they are today, including obstacles and hardships that they faced. We hope you enjoy reading their stories and take away the important messages each of them has to share. We begin by sharing an overview of public health in order to frame the context of leadership in public health.

Brief History of Public Health

Ask any public health group about personal leadership stories within public health, and you may be met with a resounding 'John Snow!' from the crowd. No, not our beloved John Snow from Game of Thrones, although we hope he is up to date on his winter safety tips from his local health department. Public health John Snow of the 1850s studied the local cholera outbreak, and, based on his assessment of illness location and sewer water flow, he was able to conclude how some in the community were falling ill and made necessary changes to manage the outbreak. But before his time, beginning as early as the 1300s, history is filled with many people dedicated to creating theories on the spread of disease, inventing equipment for their studies, and starting the discussions on something that seems as basic as hygiene. We are where we are today because those in our history were willing to ask the needed questions and find the necessary answers. They were true leaders of the profession and for the health of the communities they served (Lamort, 2015).

We can examine other examples of public health leadership that may be more relatable than those of the more distant 1500's. During the 1980s, the HIV/AIDS outbreak became mainstream news. While

something the public knew about and was aware of, many do not know the behind-the-scenes work that took place to determine how the disease was transmitted, methods that could stop it, and interventions that could treat it. Don Francis was an epidemiologist that was part of the team working on managing the AIDS epidemic. Don worked tirelessly to overcome barriers in funding, educate an administration that was resistant, and fight stigma that kept many from remaining safe or having access to safety measures (Frontline, 2006).

Another modern-day example is that of Michelle Obama's Let's Move! program which she championed as First Lady. Michelle (we're on the first name basis) focused on creating a healthy path for ALL children in the early years of their life. She did this through helping make healthy choices available, providing schools with healthy food items, and ensuring that families have access to healthy and affordable food. The reach of this program spanned from schools to corporations and even the private sector. She was a leader full of grace, strength and confidence in her practice. Oftentimes at the hospital where I work I will hear complaints about the vending machines not carrying 'good' (healthy) food. Thanks, (Michelle) Obama! (Let's Move, 2016)

By studying these historical examples and advances in public health, we can see how leadership has developed over time and how individuals have made advances for populations worldwide. When asked about the definition of leadership, popular answers are 'leading by example', 'making changes for the greater good for all people', and 'positive energy to keep people motivated'. We have men and women starting back in the 14th century recognizing that changes can be made for their communities and beginning the problem-solving process for poor hygiene and the spread of disease. They took initiative to increase the quality of living for themselves and their communities. While we may not know much about their trials and tribulations to reach these goals, one can assume the path was not easy with a lack of resources and technology; much of which we have today is due to their steps in leadership. We have seen people within the science community and those in positions of great power and influence use their roles to push forward with widespread challenges, like the AIDS epidemic and childhood obesity. Leadership does not have to come in the form of an election or well-known title; it can come in the form of advocacy for those that cannot always advocate for themselves, passion for a cause, persistence to see the fight through, and the knowledge to create an effective and realistic plan of action.

Below we have captured more personal stories of those within our own Ohio State and Central Ohio community who are leaders within the world of public health and healthcare. Each has had their own path, education and experience which they have graciously shared for this chapter.

Leaders in Health Care

Dan Bachmann, MD

Dan Bachmann is a Medical Team Manager for Ohio Task Force 1, leading the medical side of a search and rescue team that operates under the Federal Emergency Management Agency (FEMA). He manages the medical rescues and ensures safety of the team, works side by side with others that manage logistics, technical search and rescue, K-9 missions and materials. Each of the team members are specifically trained within their own scope of practice, ready to hand the reins over when best suited for the rescue. Dan highlights that each leader has something to offer, each complimenting the other members and providing a level of support that keeps the team functioning. This team deploys to some of the worst natural disasters our nation has seen, witnessing the deep human aspect of loss and catastrophic change. This kind of work calls for leaders with insight, quick and thoughtful decision making, and the ability to make tough decisions. During Dan's 'day job' as an Emergency Department physician these traits are part of team leadership theory built on real-life group work. As an ED physician, Dan often has to make timely decisions that affects both the treatment team and the patient outcome. These skills are directly transferred to his role leading rescue missions with TF-1. On each mission, Dan discusses how hard it is to 'sit back' and 'wait your turn'. In this atmosphere, sitting and waiting, rather than doing and working,

is the hardest part. Logically, he and the other leaders are aware that resting and creating a well thought out mission is ultimately the most important and efficient way to function, as with so many moving parts and aspects to their team, an ill thought out plan could cause more damage.

Team Leadership

Northouse highlights team leadership as having a flatter organizational structure, not operating from the top down, allowing the team to communicate across the plane and enhancing decision making and problem solving. Dan provides a great example of a leader being able to shift the power around to create the most positive outcomes, and in this case, saving lives. Team leadership also allows for full assessment of both internal and external circumstances which will come into play within a rescue event, creating an environment of assessing ability and determining what control exists in the current climate. As one of the leaders, Dan will need to assess internally the skills of his team, communicate the goals of the mission for the team, and advocate for input from other perspectives to ensure a successful mission. Externally, Dan will communicate with those outside of the direct mission to determine next steps for the group and report back what was successful or challenging to better inform outside sources of circumstances for the team.

Susan Moffatt-Bruce, MD, PhD, MBA

For Dr. Susan Moffatt-Bruce, leadership is a 'state of mind' that is cultivated with experience and vision. True to her definition, Dr. Moffatt-Bruce has a vision and a lot of experience in leadership. She currently serves as the Executive Director of University Hospital at The Ohio State University Wexner Medical Center (OSUWMC). Prior to being named the Executive Director, she was the Chief Quality and Patient Safety officer at OSUWMC for six years. Along with the leadership roles she has held, she is also a practicing cardiothoracic surgeon and has a PhD, MBA, and MBOE. Nationally, Dr. Moffatt-Bruce is the Chair of the Board of Directors for America's Essential Hospitals and sits on a committee at the National Quality Forum. In all of these roles she has had a common vision, to improve the quality and safety of patients. The importance of having a common vision is explained in an article by Oliver (2006) in which she argues that a true leader has the ability to explore and define personal and team motives to accomplish change and achieve a shared goal. Dr. Moffatt-Bruce's ability to set a common vision, mission, and goal is evident in her work and part of what makes her a great leader.

Adding to her definition of leadership, she recognizes that leadership is different for each individual . . . so the key is for each person to make it 'real' for them. She views her particular leadership style as servant leadership. As defined by Parris and Peachey (2013), servant leadership theories emphasize service to others and recognize that the role of an organization (or a leader) is to create people who can build a better tomorrow. She is not a dominant leader but rather a facilitator and prefers to lead by consensus. She recognizes that there are different leadership styles and points out that regardless of one's leadership style, the main goal of leadership is the same, *"the leader needs to create a vision and pull people together, the leader is the connector"* (Northouse, 2018). A leader needs to be able to reach out to all the stakeholders and get everyone on board to be successful long term. She notes that one can have all the funding in the world for a project, but without pulling a team together to achieve the vision, they will fail.

When looking back, Dr. Moffatt-Bruce did not think she would become a leader of this scale. She came from a traditional background; her mom was a nurse and her dad was a police officer, and she always knew she wanted to be a doctor. When she got to Ohio State there were a lot of opportunities for leadership and she took an interest in quality and patient safety. She invested a lot of time and effort in leadership development, including taking a strength leaders survey, and her results indicated that she is heavily an achiever. She says this strength has helped leverage her to always excel and climb up the ranks.

As she was describing her journey she also pointed out that she 'always says yes' when she sees

an opportunity to improve the health care system, which is evident by the numerous roles that were described earlier. Her willingness to take on new roles and projects has a positive effective on the people who work with and under her. In the couple months that she has served as Executive Director of University Hospital at OSUWMC, employees have noticed the email updates she sends out highlighting progress being made on projects and invitations to forums being held to share what is going on in the hospital and where it is heading. People appreciate these updates and the availability of her leadership because it helps create a positive culture which helps them feel more confident, hopeful, and optimistic about their work (Woolley, Caza, & Levy, 2011). Her openness and willingness to take on change are just a couple of the characteristics that make Dr. Moffatt-Bruce a great leader.

When Dr. Moffatt-Bruce took on the position as the inaugural Chief Quality and Patient Safety Officer at OSUWMC, she did not feel prepared. She recalls that she went from being responsible for her own work to being responsible for a team of individuals. This was a big change but she credits her role models and mentors for helping prepare her for the position. When she stepped into her role as the Executive Director of University Hospital and became responsible for even more people, she realized delegation, trust, and prioritization become more important the more you take on. She has also learned that including her family and support system in her work decisions is important, which is not something she previously emphasized. She says she now includes her family in decision making processes and that it has had a positive impact.

'Change' is common to the nature of improving quality and patient safety, so she is familiar with leading change within an organization. Although difficult regardless of how you go about it, she says there are a couple different ways you can approach organizational change. She believes you need to have a strong will for change or an attitude of 'if there is a problem we are going to fix it.' In her view, leaders are responsible for establishing a burning platform and defining the problem. Once the problem is defined, a team should be pulled together to come up with a solution, measure the change, and then evaluate to determine if an improvement has been made.

When gathering a team and getting people on board with a change, she says it is important to understand why some people are not on board and meet them in the middle when possible. She also sees resonating importance with people, relating to them, and appealing to their sensitivities as approaches to getting people on board. One example she recalls is leading the change requiring surgeons to mark surgical sites prior to entering the operating room. She remembers receiving pushback from the surgeons because they believed this was a job that could be done by residents. To rally support, she had them meet a patient who was part of a wrong surgical site event to make the issue more real and appeal to their sensitivities.

Dr. Moffatt-Bruce's steps to leading change are similar to those outlined in Osland, Turner, Kolb, and Rubin (2011). Osland et al outlines eight steps to managing change in an organization as:

1. Increase urgency
2. Build the guiding team
3. Get the vision right
4. Communicate for buy-in
5. Empower action
6. Create short-term wins
7. Don't let up
8. Make change stick

Although these steps are slightly different, as I was reading this chapter, I was very much reminded of Dr. Moffatt-Bruce's approach to leading change and based on her success in leading different aspects of the OSUWMC. I am not surprised that her method is so well aligned with those that are in the literature. In her final thoughts about leadership, Dr. Moffatt-Bruce says that, "*ultimately leadership is a privilege*

and it is earned, you have to work at it and earn the right to lead people." Leadership is a privilege she has indeed earned.

Jim Allen, MD

Jim Allen has been the Medical Director of the University Hospital East (UHE) location for just over three years, having taken over in 2014. Leading up to this position, Jim states that he had taken various leadership positions over time, beginning with his time as chief resident during residency. Since then he has taken on a number of positions on councils and committees throughout the hospital, even requesting formal training for physicians in leadership to better prepare himself. While he knows that he has made mistakes and will continue to make some mistakes, his goal is to only make them once, learn from them, and keep moving forward.

Currently, UHE is applying to become a Level 3 Trauma center, something that will affect the entire hospital in multiple ways. When asked how he is leading the change he speaks of 'cultivating change'. These changes come from a consensus, but the impact will be both positive and negative for others depending on their role and changes they will face. How does he do it? Clear communication. He recommends 'communicating' often to ensure the correct message is shared. He likens a lack of communication to a game of telephone – soon it is all rumors and incorrect versions of changes that are spreading like wildfire. He also believes in sharing the vision and reason for the change which is to meet the healthcare needs of the community, not just to advance careers.

Presence is a theme that continued to appear throughout our discussion. When asked how he encourages sharing of ideas and advancement of newcomers, he returns to this act of presence. He attends department staff meetings and rounds daily to not only speak to the staff but to be in their environment, to see what they see, experience their experiences, and give staff the comfort of sharing their ideas and feedback on their own turf. When asked by new doctors "How can I become a medical director?" his advice is NOT to "go get a Masters of Business Administration (MBA)." Rather, his answer is leadership 'presence'. This means joining committees, speaking up at meetings, and communicating with colleagues. This also means attending different departmental meetings and becoming an active part of the organization. While earning an MBA might help you secure your first job, early 'involvement' and 'presence' will lead to new opportunities and advancement.

We also read about 'transformational leadership' in Northouse which is focused on leaders inspiring followers (Northouse 2015). In this case, physicians and staff working together to accomplish positive outcomes while also focusing on the needs and motives of the staff. Much of what Jim states in how he leads fits perfectly with 'transformational leadership'. He plays off of the goals of the hospital and those that are choosing to work for the community, modeling positive patient care and acting as an engaged leader. His goal of clear communication creates trust which is another important trait of a transformational leader, making him an ideal candidate for this position.

Transformational leadership also includes role modeling for followers and empowering everyone to work to their fullest potential. Jim meets with staff in their comfort zone and works to see experiences through their perspectives to better support and advocate for not only the staff, but the hospital and community. Personally, I have seen Jim at my monthly staff meetings since he took over his role of Medical Director. He invites and welcomes feedback and innovative ideas but also uses corrective criticism and the occasional reality check, setting limits and boundaries. He is kind and confident in his communication, and thus, garners respect from staff (Northouse, 2015).

Mary S. Applegate, MD

At the Ohio Department of Medicaid, Dr. Mary Applegate is at the forefront of the leadership team. She currently serves as Ohio's first medical director for the Department of Medicaid. Dr. Applegate is a board certified pediatric physician in both pediatrics and internal medicine and continues to see patients in the clinic one day every week. Dr. Applegate has also served in other leadership roles throughout her

career, including Medical Director of Pediatric Services at Memorial Hospital of Union County, Medical Director of Loving Care Hospice Program in Union County, and Deputy Coroner of Union County. In response to how she came into the numerous leadership roles she has held throughout her career, Dr. Applegate said, *"I always saw a need and I stepped up to the challenge. I never set out to be a leader, I set out to do the best I could."* Dr. Applegate stepped up to almost every leadership position she has held because she saw a challenge and knew that she could handle it.

Dr. Applegate describes herself as a 'servant leader'. She believes that one of her roles as a leader is to recognize people's skill sets and to help them by getting them what they need to be successful. While listening to her describe herself as a servant leader and hearing the passion she has for helping patients, especially children and the underserved, I thought of part of the definition by Sendjaya (2015) who describes servant leadership as an "approach that reflects an internal orientation of the heart to serve others." Along with making sure people have what they need to succeed, she also sees importance in letting people learn. Her example comes from her time as a resident medical school. She recalls some of her mentors allowing the residents to work through tough cases on their own and only stepping in to help as a last resort. She says that letting people figure things out on their own is a great way for people to build their skill set and knowledge for the future.

One of the things that people need to be successful is a good team. The people on a team and members' skills can affect the results that the team ultimately achieves. Manz, Pearce, & Sims (2009) write that having an empowered team helps produce more quality outcomes, causing the organization to be more effective. Manz et al point out that sharing leadership among teams can have a powerful impact on the team's performance and empowers different team members to exercise leadership in different ways at different times. This can help make a team more successful and willing to take on more projects in the future. Dr. Applegate believes that finding those people is accomplished by defining the goal and then letting people bring their voice and passion to the vision. This will give the group a sense of 'owning' the project and then, when they are successful, they will want to tackle another project. The dynamics of the team are also very important. Diversity among the group, whether it be skills, careers, gender, cultures, etc., will build a richer product. Obtaining input from a diverse group of people will bring in many perspectives and ideas that a homogenous group likely would not have.

Dr. Applegate sees a lot of importance in good leadership. She believes that, "*anytime we do something that is not the status quo, leadership is important.*" The leader is there to help guide the team toward a common goal, a key responsibility of the leader also mentioned by Dr. Moffatt-Bruce in her interview. Once that goal is set, the leader should help guide the team but never tell people what to do, as that is not motivating. If the group is passionate they will decide how to get to the goal. The leader should also be just as passionate about the goal as the group. She recalls one point in her career when her boss was leaving and she was worried about what direction the organization would go with a new boss. She remembers one of her coworkers saying, "*we will be okay, it matters if you leave because you're the heart of the organization.*"

Another important responsibility for leaders is creating a positive work culture. Dr. Applegate believes that, "*leaders help shape (or change when needed) the culture of organizations by practicing consistent behaviors that support priority values.*" Among these values she listed honesty, integrity, and fairness. Honesty as a leader is seen by many people as being transparent in your processes and open to sharing your beliefs. Integrity is important as a leader because it gives people trust that their leader will do what is right and stand for what they believe in. Having a fair leader is critical for followers because they want to know that everyone has the same opportunities. These things are evident in how people are treated, how promotions are handled, and how work is performed, creating a safe environment in which can people can feel free to be heard and show their best selves.

In leading change from the bottom, Dr. Applegate believes that one of the most important things one

can do is learn as much as possible about the issue at hand. She says that in order to develop a good plan, one needs a deep understanding of what the problem is, how the organization is currently functioning, and a clear vision of what outcome is desired. There also needs to be an understanding of systems that already exist surrounding the issue because it would be inefficient to begin building something that is already established. Once the issue is understood and a vision is produced, there needs to be a large enough group of people who believe in the cause and want to help create a solution for the issue. She said of people who lead these types of bottom up changes, "they often do not realize they are leading something until they have followers."

Ericka Bruns, MSEd, LPCC-S

Ericka is a personal friend and mentor, and I have been lucky enough to see her journey into leadership firsthand. She was an incredible wealth of knowledge for me when I was fresh out of grad school, practicing community social work, thinking I would easily change the world with my newly acquired skills. Her confidence and brilliant skill level led me to often asking her for help and being in awe of all she knew. She eventually became the supervisor to a very small crisis team of which I was a part (3 employees, including her!), and to be completely transparent, I could have been a better subordinate. This was her first taste of leadership; she was no longer my co-worker but now my supervisor. Our dynamics had shifted, and I did not know if I had a new boss or an old friend. I did not know how to communicate through the change, and we both continued to try to learn. Let's just say we both learned a few things about leadership and followership.

She now supervises 73 staff members over six programs, including coordinators and entry level staff. Over time, she has championed funding for additional staff and resources to address the growing psychiatric need of our community's children, as well as advocating for herself for appropriate advancement, compensation and well-deserved respect. Ericka created this empire and made the department what it is today by confidently stating what was needed, not backing down at wrinkles in the plan, and following through with fighting the good fight. Not only do these traits make her someone you want with you when you buy a car, they make her someone that you want with you when you are learning and developing skills in your new career, empowering your team, and advocating for the community.

Ericka says she had no plans to become 'a leader' when she was completing her schooling, but she was approached for the small team and accepted the position. She believes she was chosen because she was a good therapist, not a good leader. I would argue that her level of knowledge, confidence in her craft and desire to address the needs of the community made her more of a leader than she was aware. She is currently back in school working on her MBA, learning more skills to help her with the business of leading to continue the success of the department.

Completing assessments on leadership style, learning what that style meant and how to build upon it are steps Ericka has taken to grow in her leadership role. What was the most important thing she has learned? How important emotional intelligence and transparency are to leadership. Emotional intelligence, or EQ, embodies self-awareness, empathy, social skills and motivation. She has learned more about her own EQ and has been able to build on her strengths and address her weaknesses. She firmly believes that without EQ one will fail at leadership. Ericka also deeply believes that transparency with staff is important. Staff can tell if they are being kept in the dark, and this will create tension and remove respect from the equation. She acknowledges that you must be humble and take accountability of your team, but each team member also has a level of responsibility.

After interviewing Ericka and being privy to her story from both experience and friendship, she slides easily into the authentic leadership role. She carries herself as genuine, doing right for her team and for the community, trusting that she will educate herself and listen to the needs of her staff, and responding to the needs and values of those around her. She seeks out ways to improve herself, listens to feedback from her team and actively problem solves to create balance and good outcomes. Ericka shows her

purpose and value through her dedication to the team and community and has worked with a number of different departments and services to build strong relationships to achieve goals. She has the self-discipline to focus on the end game and weather the storm along the way, none of which can be achieved without compassion for those that she works for and side by side within the field. (Northouse, 2015).

Leaders in Public Health

Lois Hall, MS

To know Lois Hall, is to love Lois Hall. To be in the midst of Lois Hall, is to LOVE public health. Upon meeting this champion of public health and a radiating woman that encompasses the idea of practicing for the greater good, we quickly see how she is a leader within the public health community. While declaring the hard truths, she follows up with thoughtful solutions backed by research and experience, making one certain that only good will prevail. She encourages the sharing of ideas, inviting them to be shared and developed, as one of them could one day make great advancements in public health.

Lois believes leaders are born with the innate ability to lead, however these skills can be cultivated and built upon over time with being reflective. A natural leader, Lois is able to recognize if another might be better suited or has a different air of passion regarding a certain cause. Lois supervised the AIDS and cancer programs with Ohio Department of Health, followed by becoming the executive director of the Ohio Public Health Association (OPHA), and she is now easing into retirement, advocating for proper grief recovery services for all. When falling into the ED position with OPHA, Lois did not feel qualified but operated by the motto, *'They won't care how much you know, until they know how much you care'*. Yes, one must have skills and knowledge, but the best leaders have genuine interest and heart, and this is easily conveyed as her truth.

Lois is a delightful mix of 'trait leadership' and 'authentic leadership' styles. Being around her, it is amazing how naturally she can lead, educate, and move a group into genuine excitement about public health. She possesses a natural awareness of herself, her surroundings and her company, and is open to feedback and discussion to enhance her skills. She will make exclamations of joy when endearing and honest moments are shared, further making those around her buzz with energy (Northouse, 2015). Her sincerity is easily unquestioned when in discussion with her. It is clear that she is not only hearing what is said, but she is listening. She offers advice, references current literature, and makes suggestions on connections for advancing an idea. Lois highlights the characteristic of secure relationships by the strong connection she continues to have with past co-workers, colleagues and students (highlighted by the immediate acceptance to be interviewed for this book). She values sincerity, trust and purpose, all of which become clear within the first minutes of meeting her (Northouse, 2015).

Vince Caraffi, RS, MPH

Vince Caraffi is currently a supervisor with the Cuyahoga Board of Health, overseeing the Environmental Health Service Area for the last 16 years. He came into the role after observing a strong leadership team, and through this, he felt prepared to lead by what he had seen in the past. Although not perfect, Vince is aware that acknowledging and apologizing for mistakes can go a long way – we are all human. He experienced this first hand after a moment of heated interaction between himself and a TV reporter, an experience that Vince draws from in his leadership style.

Maintaining a trusting and a respectful relationship through active listening and open communication has been an important base for Vince in his time with the Board of Health. This again aligns with authentic leadership (Northouse, 2015). Vince values those that work for him as people, their ideas and input, and will listen to identify what needs they might have from him and their career. If he is leading others to achieve goals, this leadership style expresses commitment not only to that goal, but to his followers, as well. Sharing failures and successes with those that are looking to advance provides them with additional knowledge so they can avoid unnecessary challenges. He also understands the benefit in talking *with* staff, listening to their ideas and perspectives and giving others the chance to succeed.

In talking with Vince, he often alludes to listening to those that he works with and building relationships with all levels of staff, giving an air of 'appreciative inquiry' to the way he manages his role. Like 'appreciative inquiry', Vince believes in creating dialogue that can generate change and advancements, and much of this transformation can take place within the people he is working with and guiding (Rothwell, Stavros & Sullivan, 2016).

Mary Ellen Wewers, PhD, MPH

With over 30 years of experience in the field, Mary Ellen Wewers, PhD, MPH is a leader in the area of tobacco cessation research. Dr. Wewers started her career as a nurse working in an intensive care unit and quickly became the head nurse for her unit. During her time as a nurse, she became increasingly interested in primary care and disease prevention, so she decided to return to school to get her Master of Science in Nursing. While getting her MSN, she discovered her interest in research and ultimately decided to continue her studies and earn a PhD in Nursing. After working in the field of public health for several years, she then decided to go back to school one more time and earned a Master of Public Health with a specialization in Health Care Management and Policy.

Dr. Wewers has held many different leadership positions throughout her career, for each of which she felt increasingly prepared. When she was first asked to be the head nurse in the ICU, she said she did not feel prepared and thought there were more experienced people for the position. She ultimately accepted the position, however, because she was encouraged by leadership to apply for the job and decided she was up for the challenge. After going back to school and completing her degrees, Dr. Wewers became an associate professor at The Ohio State University in the College of Nursing. She eventually became the PhD program director in the College of Nursing and the Co-Program Director of Cancer Control at The Ohio State University Comprehensive Cancer Center. Her next career move was into the field of public health as a professor and the Interim Director at the Center of Health Outcomes, Policy, and Evaluation Studies. She later became the Associate Dean for Research, served as the Acting Dean, and served as the Interim Chair of Epidemiology. She pointed out that much of her success at The Ohio State University could be credited to the opportunities for leadership development at the university. She recalls receiving good mentorship from her peers and formal leadership training provided by OSU to all deans and chairs across the university.

Dr. Wewers defines leadership as having both a formal and an informal aspect. She says that the formal definition of leadership is an appointment with a title in which there are job responsibilities, people or an agency to oversee, and goals and objectives that must be met. The informal definition of leadership is when a person within a group steps forward with their opinion, behaves in a way to be viewed as credible, and is genuinely interested in achieving a goal. Her definitions of formal and informal leadership are very similar to the definitions described by Pielstick (2000). He differentiates the two by stating that formal leaders are those who are in positions of power and informal leaders are those who do not hold formal positions but are still recognized as being leaders (Pielstick, 2000).

She describes her leadership style as a combination of many different things but her strengths include *listening, being respectful, and keeping people's faith alive when working toward a goal*. She believes that when leading, it is important to get a consensus from your team and have a clear vision of what you want to do moving forward. After clearly defining the vision, she says the leader needs to identify where team members stand in terms of supporting or opposing the vision. For those team members who are on board and those who have neutral opinions on the topic, she helps them move toward achieving the end goal. For those who oppose the vision, she says it is important to hear them out, listen to their concerns, and address those concerns. Ultimately, she says you will never get everyone 100% on board, but the goal is to get the majority.

When it comes to following, Dr. Wewers believes it depends on the boss. Some bosses will welcome the opinions of subordinates and let them weigh in, while others will not be so welcoming, so it is

all about learning how your boss leads. She says she is fortunate that she has always had good bosses that are willing to listen to others' ideas. This willingness to listen has been shown in the literature to help raise one's self-perception on what he or she does well or poorly and helps a leader notice when there is a discrepancy between their own self-awareness and how others perceive them. This can help leaders adjust their behavior and makes followers more apt to provide feedback (Oc and Bashshur, 2013). Along with learning a boss's leadership style, Dr. Wewers believes it is important for people to 'do their homework' on a topic when they want to make a case to their boss so that they seem credible and their boss is more likely to listen. She says ultimately if you want to make a change within your organization, you need to get your boss on board, and if you show passion for the issue, that will likely happen.

Karen Fields, MS, BSN, RN

Karen Fields has been a Sexual Health Clinic Manager for over 10 years for Columbus Public Health, taking over a role that previously had not had a manager stay for more than two years. She credits being able to read her team, make tough decisions, give credit, and encourage laughter and lightness. Karen has taken a leadership course and relates to servant leadership, a role that emphasizes attentiveness to the needs of her followers, empowering them and helping them develop to their full capacity (Northouse, 2015).

While Karen does not necessarily see herself as a follower in any regard (she reports she was always taught to lead), she recognizes that, at times, someone else needs to 'drive'. She gives the example of geese flying, taking turns leading the group in the direction of their goal. She is part of a team, but the team will not let one member get too worn out before reaching the destination.

Karen also discusses some of her most difficult times as a leader, in dealing with toxic co-workers, both to themselves and to the team, as well as ethical concerns that have led to letting go a beloved team member. From these experiences, she can say that she would have liked to manage the co-worker differently, but has learned more about her own integrity and developed her leadership ability because of experiences such as these.

These kinds of experiences and Karen's response to them pull from Positive Organizational Scholarship, and have taught her how to look at situations through a new scope and create an atmosphere of resiliency for herself and those working in her department. Keeping laughter and hopeful outlooks have served Karen well on her path to leadership (Bakker, 2013).

Mysheika Roberts, MD, MPH

Although new to her current position as the Health Commissioner and Medical Director for Columbus Public Health, leadership is nothing new for Dr. Mysheika Roberts. Prior to her current appointment, Dr. Roberts served as the assistant health commissioner at Columbus Public Health and has held positions at the Center for Disease Control and Prevention and at the Baltimore City Health Department. She is also a participating member of the community, active on boards at Columbus Medical Association Foundation, Young Women's Christian Association (YWCA) of Columbus, Mid-Ohio Foodbank, Lifeline of Ohio Minority Advisory Group, and OhioHealth's Faith, Culture, and Community Benefit Committee.

Dr. Roberts views leadership in many different ways. Individually, she says leadership is *believing in something*, being confident to take a stand, and acting so that your actions reflect what you believe. From a team standpoint, she sees the leader as someone who will give people the tools they need to be successful and then giving them space and flexibility to work on the task at hand. When leading her team, Dr. Roberts leads by example and never asks anyone to do something she would not feel comfortable doing herself. She also likes to be motivational, giving people a vision and challenging them to execute, something she believes allows people's skills to shine. When co-leading with another individual, Dr. Roberts sees value in a 'divide and conquer' approach. She explained that she likes to take a task, divide it up and reconvene at a later time to gauge progress and either finish or decide the

next steps for the project. She says sharing the responsibility, meeting in the middle, and being confident in your colleague are important when working with others.

Leadership has been a part of Dr. Roberts' life since she was in high school. She recalls she was the class vice president during high school and held a similar role during medical school. She says she always had a leadership 'vibe', but she never thought that she would have such high roles as the Health Commissioner at CPH. Due to her natural leadership characteristics, she has never taken any formal leadership courses but admits she is drawn to leadership articles. Her awareness of her own strengths and weaknesses as a leader, desire to uphold her moral values, and ability to communicate the importance of change for the health of the community are some of the characteristics of her natural leadership style that would lead me to describe her as an authentic leader (Woolley et al., 2011). Authentic leaders also recognize the importance of developing a relationship between leaders and followers, so it is no surprise that Dr. Roberts has an open channel of communication with her staff. She also values the perspectives of other leaders she has encountered throughout her career and appreciates their perspectives on things, such as making teams thrive. Her mentors, especially the women, she says, have also helped her build the skills required of her to be a great leader.

Early in her career, many of the challenges she faced were related to race, age, and gender. Being a young, African American female, she felt like people did not take her seriously. She says from this she learned that she needed to *"always be prepared, make sure her voice was heard, and to be confident but not cocky."* Now, challenges in her career are more centric to her work. She says there is always a lot to be done and high expectations. She also pointed out that as you move up the chain of command, there is more responsibility to 'take the heat' for things that do not go well for the organization but the flip side is that there are rewards for when things go well. She says this is something she is learning from her transition from assistant health commissioner to health commissioner.

Leading change is something she recognizes is hard for most people. Much of the challenge is due to feelings. Osland et al (2011) argue that "people change what they do because they are shown a truth that influences their feelings and less because they are given analysis that shifts their thinking." This is similar to what Dr. Moffatt-Bruce noted about appealing to people's sensitivities to lead change and what Dr. Applegate emphasized about finding people who are passionate to make ideas for change reality. Dr. Roberts also says rallying the troops or team to understand that change is good is often the first step and then gathering everyone's ideas should be next. It is also important for everyone to recognize that just because a change is being proposed does not mean something is being done poorly, rather that it can be done better. She says it is also important for everyone to know that they have the ability to lead change no matter their position. For someone at the bottom, they should have a clear vision, communicate it with the chain of command, and show a sense of leadership and willingness to go above and beyond. She says managers see potential 'self-starters' and are usually willing to support their passion.

Concluding her thoughts on leadership, Dr. Roberts says, *"Leadership is a journey, leaders are always learning and being challenged. No one should ever feel that their challenge or journey is over."* It is evident by her passion for public health that Dr. Roberts journey is nowhere near being over.

Conclusion

What makes a great leader within health care and public health encompasses a number of different characteristics, behavior, and traits. The case studies we have described reveal a range of approaches to leadership, from those who seek out their own training and education, to those who learn as they go, learning from successes and failures and making changes along the way. When we look at what we can do as health care and public health leaders, we are reminded that a good leader within the field has the ability to assess team and individual performance capabilities and uses a critical eye when necessary. A leader will be able to address barriers head on, such as limited financial support, other economic limitations, and changing agendas due to changes in political leadership. Leadership is also

being encouraged to use horizontal connections rather than leading from the top down to encourage all to work together at local, national and world levels (Popescu, G.H, Predescu, V., 2016).

Many of the leaders that were interviewed, including Ericka, Lois, Vince, and Dr. Roberts, exhibited 'authentic leadership' (Northouse, 2015). This is telling, highlighting that this leadership style makes a leader approachable, respected, and open to sharing an experience with others willing to learn. Approaching someone that does not value guidance and relationships may very well receive a different response. This makes us hopeful for the future of our healthcare and public health systems that we can choose leaders that lead out of genuine desire for those they serve, rather than for self-serving reasons.

'Servant leadership' was also exhibited by several of the leaders interviewed for this chapter, including Dr. Moffatt-Bruce, Dr. Applegate, and Karen. Servant leaders tend to put their followers first, organization second, and their own interests third. This type of leadership fits well with the nature of work that comes with a public health or healthcare career. These types of careers focus on helping improve the health and well-being of patients and the community, so having a leader willing to serve those people first is important. A combination of authentic and servant leadership theories were seen in almost all of the leaders interviewed, which is evident in their approaches to creating and working toward a vision of a healthier population.

'Teamwork' was another common topic of discussion in many of our interviews. The leaders we interviewed highlighted the importance of building teams with the skills and abilities to work together to work toward a common goal. Teams allow for the workload to be divided up among many different people and for many different perspectives and ideas to be added to the project, creating a richer product, as pointed out by Dr. Applegate. The ability to create a successful work team also encourages the team members to perform their jobs better and increases the chances that the team will want to work together on projects again in the future.

The willingness of people to want to work together on projects is important in an ever-changing world of health care and public health. Nearly all of the leaders we interviewed had something to say about the importance of change and how to manage it. 'Leading change' is something they recognize is not always easy but requires persistence, communication, and the development of a clear vision. As Dr. Roberts pointed out, making changes does not always mean something is being done wrong, but that it could be done better, a truth we in health care and public health know very well, as we are always working toward a healthier population.

Through the wealth of knowledge that was gained in doing these interviews, we are happy to realize that we have come away knowing that *working together, listening to one another, and acknowledging that we cannot manage this world of healthcare and public health alone* was an overarching theme. We heard about the importance of 'listening to others', 'encouraging ideas', and 'giving credit where credit is due'. The leaders we interviewed are the leaders that can bring positive changes to our healthcare and public health systems. These are the leaders we can and will learn from over time. These are the leaders that *want* us to learn, and in that revelation alone confirms that we have wonderful leadership here in Central Ohio.

We will leave you with the idea behind 'Public Health 3.0', as it is gaining steam and becoming increasingly popular within many professional and leadership circles. This idea is encouraging local leaders to serve as Chief Health Strategists, partnering with multiple sectors across the community. We see this as our leaders are working with grief specialists, multiple specialties in hospitals that provide direct patient care in different modalities, and the community directly. This data will be used to address social, environmental and economic conditions affecting health and equity. Our leaders want this data to invite new ideas and strategies to address the needs of our communities and those that we serve. A new mindset is being promoted to get ahead of public health concerns, becoming preventative instead of reactive (DeSalvo, K.B. et al, 2017). Leadership is beginning to take an upstream approach,

acknowledging that we may not have all of the power from the top down, but we can use the abilities we do have and make positive changes given the ever-changing policies of current national leadership. In reviewing what our current leaders are doing now and what they can do for the future of healthcare and public health, it is safe to say we are in good hands to begin our path to Public Health 3.0.

Leading During a Crisis

Kara Colvell

Introduction

In this chapter we will be going over how to handle a crisis as a leader before, during, and particularly after a disaster. In the Miriam Webster dictionary, a crisis is defined as "an unstable or crucial time or state of affairs in which a decisive change is impending; especially: one with the distinct possibility of a highly undesirable outcome" (Webster, 2018). When in a leadership position, being in crisis is the norm, though the scale can drastically change. The reassuring view that this current crisis is simply a phase that will pass is true, but it will continue into another high-stakes gambit for the continuance of the company or community. If we were to break a crisis apart, there would be a total of four stages: signal detection, acute stage crisis, chronic crisis, and learning (Rowitz, 2014).

1. *Signal detection*. This is a pre-crisis stage. There are usually warning signs before a disaster, and the objective at this stage, barring averting the disaster, is to acknowledge the signs and get a head start on disaster resolution.

2. *Acute stage crisis*. This can be the most demanding stage; the crisis is in full swing. As a group, individuals can either respond frantically or thoughtfully. If some warning signs were noted and heeded, the added time can ensure responding to the crisis a cumulative and deliberate effort. This phase can also be called the "emergency development phase." During this time, the leaders job is to stabilize and plan out the crisis.

3. *Chronic crisis*. The crisis is still in effect but action has taken place to reduce the effect; this development is also known as the adaptive occurrence. Here is where the underlying cause of the crisis is unfolded and the direction the leader will take is determined, which is to either lead in such a way as to ensure the avoidance of a similar situation or embrace the new direction and determine how to thrive. (Heifetz, Grashow, & Linsky, 2011)

4. *Crisis resolution*. The goal in any crisis is that at the end things return to normalcy. This is generally the case but situations never revert back to exactly how they were before the crisis. A new sort of normal is the result of the catastrophe.

I am going to apply management and leadership practices and theories to the Flint Water Crisis in this chapter which will include an investigation and application of: *crisis management, adaptive leadership, distributed leadership, reform, crisis communication, and the situational crisis communication theory (SCCT)*.

Background to the Flint Michigan Water Crisis

The water crisis in Flint could be called one of the most severe public health catastrophes in the last decade. What makes this tragedy so devastating is that if regulations had been followed the entire situation would have been avoided. Events leading up to the disaster can be traced back to 1897 when the city instituted a policy that all pipes connected to the main water supply were to be made with lead. The understanding at the time was that lead was easy to work with and less expensive than using iron. Concerns for lead poisoning began in 1859, but it was not until 1920 that efforts were ubiquitously taken to restrict their use (Rabin, 2008).

Until 1967, Flint was treating and using their own water from the Flint River; at this time the city decided to begin purchasing their drinking water from the Detroit Water and Sewage Department due to a growing population and the burden it was to bring their water to standard due to manufacturing plants

contaminating the river. Local water was kept as a backup and was treated but neither with consistency nor the frequency necessary to be considered ingestible. This went on for forty-five years; meanwhile, the city was no longer as profitable or populated as it used to be. In an effort to save money, the City of Flint decided to join the "Karegnondi Water Authority," which would enable them to build their own pipeline to Lake Huron instead of buying that same water from Detroit.

At this point in time the city had clean water and no major problems; the upcoming decisions would be the turning point for Flint. The options were as follows: continue their contract with Detroit, which did not have a short-term option for when their pipe was completed, or treat the Flint River water at their own treatment facility. Because they were unable to receive a shortened contract, the city leaders of Flint made the executive decision to use their local water source until the pipeline work was completed in-spite of community outcry. Almost immediately there were concerns over the water's taste, color, and odor along with an increased number of rashes particularly seen in children. Along with the physical manifestations, there were reportedly large numbers of water main breaks, and companies complained of the corrosive nature of the water damaging their equipment.

In the summer of 2014, there were also numerous alerts for the citizens to boil their water due to elevated rates of *E. coli.* Due to these problems, an evaluation was requested in September, 2014, and the leaders of Flint were notified that they were in violation of the Safe Drinking Water Act.

In 2015, one sample of water was taken from a residency and found to by high in lead; later that year more than 100 samples had been analyzed, and 20% of them were above the action level for lead. In September of 2015, a team of pediatricians published their data, proving that blood lead levels in the children of the community had increased exponentially after switching water sources in excess of 2.5 times. This data forced the city to conduct sampling for lead and copper which proved high and prompted the city to switch back to the original water supply of Lake Huron only 1.5 years after the original switch.

The treatment of water has a variety of applications and does not have a universal standard. The treatment needs for different bodies of water are different and can fluctuate in different seasons. This was the case with the Flint River; the treatment needs were complex and fluctuated based on rainfall. Testing is recommended for corrosivity and corrosion control when switching water sources. It will come as no shock to anyone that this testing was not conducted and because their water treatment facility had not been used in half a century, the plant was understaffed and undertrained. The reason is unknown, but during treatment of the Flint River the use of an anti-corrosion agent was not used. At baseline, this water was found to be highly corrosive, which in turn deteriorated the pipes and caused the iron and lead levels in the water to reach toxic levels along with causing the reddish color of the water. Moving forward, the objective is to replace all the lead pipes in Flint. Even with this course of action, Flint still has a long journey ahead to overcome this disaster (Masten, Davies, & Moelmurry, 2016).

Leading in Flint, what went wrong?

In many ways, the leadership traits displayed during the Flint water crisis can be used as a guide of what not to do. Reputations were ruined, charges of involuntary manslaughter have been made, and the governor of Michigan, Rick Snyder, called this disaster "a failure of government at all levels" (Carravallah & Woolford, 2017). The first instance that can be attributed to poor leadership was the initial change from Lake Huron water to the Flint River; this was done despite community outrage by the emergency manager after the city was pushed to bankruptcy. After the switch, in an effort to dispel fears over the drinking water, a press release came out stating that testing had been done and met drinking water standards; even the mayor made a statement touting the normalcy and purity of the water (Kennedy, 206). The Press Release was meant to assuage the fears of the community, and at the time it could have, but in hindsight the spirit of this statement was proven untrue, and instead instilled a deeper distrust of government leaders in the community.

One of the definitions of a good leader is bringing individuals together towards a common goal, in this situation there was discord and the goal of either party were not shared by the other. The leaders only thought, so it seems, was to cut costs, and the most impactful way to do that was ending the water agreement with Detroit. The whole disaster would have been averted if the city accepted the longer water contract, or if Detroit would have compromised on a shorter commitment. The citizens on the other hand had a top priority of safe drinking water for themselves and their families. The leaders did not take the communities priorities into account and instead relied on their own objective which ultimately caused the public health crisis. If the city had either been able to negotiate a shorter contract with Detroit to provide water to Flint, or accepted the longer contract, the whole crisis would have been avoided completely.

There was continuous evidence of the defects in the water, one of which was the elevated instances of bacteria which prompted the multiple times citizens were advised to boil their water before consumption. There was also the instance when General Motors would no longer use the water on their machine parts for fear of corrosion. Eventually the city was found to be in violation of the Safe Drinking Water Act, and in light of that information, the state chose to buy bottled water for their employees. Each occasion was an opportunity to prompt further investigation into the water, which would have decreased the extent of the catastrophe. As previously discussed, the first step to managing a crisis is the attempt to predict a crisis. If you can see it coming then you are one step ahead for finding a solution; in this case the warning signs went unheeded.

Eventually concern for lead was brought into play due to a memo leak, which is one of the worst ways that information can be divulged to the public from a leadership point of view. Concern for elevated lead levels were denied, even after a team from Virginia Tech sampled hundreds of home water lead levels and their preliminary data found disturbing results (Kennedy, 206). A team of pediatricians eventually shared the data with the press? that the instances of elevated lead levels in children had doubled since the water switch. These findings were still dismissed by authorities, but at this point in the narrative the knowledge of contamination gained traction, and the City of Flint finally released a lead advisory warning to the community. Very quickly afterwards, the community was provided with water filters and the water supply was switched back to Lake Huron.

During this time elections for city mayor were in process and the current mayor's opponent ran on the platform of fixing the water crisis. She eventually won and declared a state of emergency over the elevated lead levels. Below is an abbreviated list of points that led to the crisis:

- Regulating lead pipe use for main water
- Failing to negotiate a contract and switching to Flint water
- Inadequate water treatment, inadequate training
- Ignored community concerns
- Inadequate testing
- Failure to accept other test results

Managing a Crisis

(1) Pre-Crisis Planning/Signal Detection

How can effective managers and leaders plan for or be prepared for a crisis? The objective of pre-crisis planning is instilling a course of action with the goal of circumventing or minimizing the effects of a crisis; allocating resources and responsibilities before encountering a disaster will free up time in the acute phase of a catastrophe. Due to the introduction of different factors in every situation, it is impossible to take every circumstance into account. Some examples of different factors include: Leadership style, proclivity to accept help, individuals involved and their temperament, among other unaccounted factors. There is evidence to suggest that planning for a crisis does hold an important role in crisis resolution by providing direction and a sense of familiarity in the individuals involved, it

does not mean that the crisis will go remotely as planned or well (Eriksson & McConnell, 2017). It is important to remember that flexibility and improvisation is an important part of any disaster plan, as much as following the plan is reassuring, there is a place for creativity (Eriksson & McConnell, 2017). It is important to be observant and look for the tell-tale signs of a disaster waiting to happen. Obviously not every crisis has warning signs, but many of them do, and a leader can get ahead of the problem if they are willing to acknowledge that something is wrong.

There were several warning signs during the Flint water crisis: community dissatisfaction, disgruntled individuals, water color, General Motors changing their water source for their factory and citing corrosion, multiple water boiling warnings.

An important aspect of leadership is communication and listening to others, especially when a large group of individuals are worried about the same thing. In the Flint water crisis, there was a large community who was unsatisfied with the situation that was unfolding. Instead of taking their concerns seriously and doing their due diligence with regards to water safety, the community was plied with assurances without any substantive acts or behaviors of leaders.

(2) Acute Crisis

Clearing the health catastrophe is the primary and most important objective once the issue is known. It is important that a leader is fluid and does not double down on outdated or ill-fitting procedures during this time, as it is a time of change (Heifetz, Grashow, & Linsky, 2011). Effective leaders in this situation are ones who look towards the future and develop long term fixes in increments over time. It might be hard but embracing this time of crisis to reevaluate and gain momentum for policy change can help to get through the acute phase and after effects of the crisis (Heifetz, Grashow, & Linsky, 2011).

When test results were finally released and pollution levels of Flint drinking water were discovered, it was a turning point from pre to acute. Leaders initially gave out filters to the citizens, which rapidly progressed to bottled water as a means to revert back to normality. During this time, city appointed officials were up for re-election and the current mayor was not voted back into office. It is worth noting that his opponent ran on the basis of providing clean water to the city.

(3) Chronic Crisis

After the acute phase of a crisis is over, the initial concern for public wellbeing is at an end, and normalcy is tentatively reached, the next step is to provide damage control, specifically, the reputations of the leaders involved during the disaster. There are certain policies that can be put into place to make this endeavor much easier, and the most effective is crisis communication.

The reasoning behind putting time and effort into honing this particular protocol is that if good crisis communication occurs during the disaster, then it will be easier in the aftermath to come out with a more reputable character than if communication is not adequately used. This is due to crisis communication being the act of managing information and meaning; this includes the endeavor to manage perceptions of the disaster and the act of disseminating information to the public. Due to the unorganized nature of a crisis, the means by which communication is propagated differs per instance. There are different variables that can be applied to the eminent crisis which will better aid efforts in determining how to communicate effectively while keeping reputations intact (Coombs, 2008). This is the most damaging error in leadership that Flint leaders made during this crisis; there was no crisis communication. The leaders' simply spouted assurances that fell on disbelieving ears. Due to the "doubling down" that was done in proclaiming that the water was okay, once the testing came out, that there were high lead levels the leaders were publicly shown as having been dishonest to their constituents.

(4) Learning

Within the leadership organization, once a crisis is over and before it is forgotten, some questions need to be asked and the answers thoughtfully considered. The primary inquiry to be made is "How can we use what happened?" or "What can we learn from this catastrophe?" The objective is to either prevent

or minimize a future disaster with the information that can be gleaned from preceding events, such as instilling into practice new procedures. It is also important at this time to take into account the practices that worked well, for instance the timely response to a crisis or managing it in such a way that reputations were not ruined (Crandall, Parnell, & Spillan, 2013). There is usually resistance in learning from a crisis. This is typically due to different narratives as to why the crisis occurred and the culpability that is taken with the introduction of process change. Different types of learning can present. These approaches are called; learning as crisis, learning for crisis, and learning from crisis. Learning as crisis is the concept of a crisis happening which shakes your belief and makes you question other aspects. The example is given of Dr. Shipman in the UK who killed his patients. This was unheard of and individuals started seeing rogue doctors where there were none. It provided the momentum necessary to look at different sectors and inadequacies in thinking. The same with a hurricane, which due to the evacuation order, left thousands stranded on highways due to gas shortages. Learning for crisis is the act of taking cautionary steps to prepare for an eventual crisis, preparing the necessary individuals on what to do when crisis occurs. Some criticisms to this approach are the lack of urgency that is adopted from not being in a crisis, and which translates to less of the pre-emergency steps having secure foundations in an individual and the industry at large. Learning from crisis is the point where more crisis plans are implemented, which is after a crisis. The major role during this implementation is to investigate and get to the bottom of why the catastrophe occurred; too often analysis is superficial and only small aspects are recognized as at fault. Criticisms of learning from crisis is that individuals are too busy, tossing blame that no one is ready nor willing to accept that their processes need to change.

During this time of crisis, city appointed officials of Flint were up for reelection and the current mayor was not voted back into office. It is worth noting that his opponent ran on the basis of providing clean water to the city. The new leadership learned from their opponents' mistakes and were resolved to fix the issue in Flint, or at the very least to provide clean water. The same problems occur in learning from a crisis that we previously discussed, scapegoats were chosen and blame kept getting pushed aside. In conclusion; scapegoating, failure to own responsibility, and root cause failure are three aspects that provide challenges to learning from a crisis (Smith & Elliott, 2007).

Reform after a crisis

After a crisis, either normality is reached or there is a new normal, and either way certain things will need to change. If things are reverting back to normal, then policies need to be put in place to prevent a similar disaster from occurring again, practices need to be looked into, and an investigation for the root cause of the crisis needs to be discovered so policies can be changed. Because a crisis can be the basis of reform, leaders need to be knowledgeable about the intricacies of long lasting reform and the balance between policy progress and crisis containment. Crisis and leadership go hand in hand, when times are uncertain leaders are looked to, to establish normalcy and safety.

The "crisis reform thesis" advocates that a crisis provides an opportunity for reform which leaders can exploit to gain approval for differing policies and practices. In the article "Public leadership in times of crisis, mission impossible?" the argument is made that "the requisites of crisis leadership are at odds with the requirements of effective reform" (Boin & Hart, 2003), stating that when a crisis is occurring there is pull for change but often the foundation is lacking to make the effects long term. This often causes the policy to flounder and produces criticism for the leader down the road, reform needs to be founded on a base of supporters without skipping steps; this provides the leader with more credibility and results in the reform being more likely to meet intentions (Boin & Hart, 2003).

Due to the leadership mistakes that were made, the key objective for the current leaders is to regain that trust lost after the overwhelming lapse in judgement for which the citizens of Flint Michigan paid the cost. The water crisis in Flint was and is a terrible public health failure, but through that unfortunate disaster, some good can be scavenged. The unique circumstances of this city provide researchers with a

very good opportunity to study the effects of lead and other topics that are not generally problematic in our first world society; however, the citizens of Flint are unwilling to trust outsiders and individuals that they see are out there to gain from what happened to them. There is a chance to put this populace at ease in order to study the community researchers instilled community level ethical protections, and not only IRB processes, that helped the population feel more informed and pull the citizens together. Currently the City of Flint has a Community Ethics Review Board which is led by local residents. In addition, they have partnered with the Healthy Flint Research Coordinating Center which is in charge of vetting research studies for this community (Key, 2017). There are a variety of approaches that can be used in measuring "crisis management" including the Crisis Impact Scale which is discussed next.

Crisis Impact Scale

The crisis impact scale is a model which forecasts the level of a crisis, taking into account different variables and the weight that is put on them. This allows customizability in the scale to better suit the circumstances of each individual case. These factors include; intensity escalation, media and/or government scrutiny, effects on the operation of the organization, the image of the business/community, and financial effect. The scoring for each variable is from 0 (low risk) to 10 (high) and these numbers are then added together and divided by the number of factors applicable to the impending/present disaster. The closer the score is to 10, the worse the crisis. The ability to forecast a catastrophe does not mean we can predict a crisis or the outcome; most of this knowledge is used to "type" a disaster, be it Economic, informational, physical, human resource, reputational, psychopathic, or a natural disaster (Rowitz, 2014)

The crisis impact scale would have been a good start for leaders in Flint to have used when the warning signs of a crisis began to appear, with the design to ensure the continued service of their leadership to the citizens of Flint. Using the crisis impact scale along with a firm crisis communication protocol at the very least could have circumvented the more egregious leadership failures and diminished the scope of the crisis. In addition to measuring critical aspect of 'crisis management', there are leadership principles, practices, and theories that might help us understand what leaders in Flint could have done differently – we examine a few of these next.

Distributed Leadership

When talking about leadership the dialog used to focus on the actions of a single person and the outcomes of their action can be either negative or positive. Leadership theories, such as trait and charismatic theories, focus on the leader and their qualities with the assumption that when a leader acts, but resigns the followers to be 'reactive' (Northouse, 2015). In leadership research today, both actions of the "leader" and the "follower" are important to analyze, as the reaction shapes future actions that the leader will make (Chatwani, 2017). Distributed leadership tends to increase the impact of organizational development. When this type of leadership is in effect, cultural and social barriers tend to be diminished which enables the organization to be more fluid (Harris, 2009).

Complicated clinical situations that lead different specialists to merge their training in an unorganized and uncommon situation have different leadership needs. In predictable cases, specialists can almost work in solidarity without interference or help from other specialties; once the situation becomes unstructured, the need for distributed and coordinative leadership is in effect. Distributed leadership is the process of taking the responsibility of different roles. In the case of surgery, different physicians would be in charge of different organs. This still provides challenges, such as combining the differing functions into a united combined effort. Differing specialties proved useful in aligning roles easily based on usual functions outside of a crisis. This is unfortunately not the case when one or more of the individuals are not an attending but rather a resident. In this scenario, seniority does matter; it is understandably difficult for the resident to take charge of a situation even when their specialty correlates more directly with the skills needed over the other senior staff. "Transitions of leadership should occur after critical situations have subsided, never within it, or when one's expertise is surpassed." This

reinstates that leadership is generally static but is adaptable to becoming fluid (Paquin, Bank, Young, Nguyen, Fisher, & Nugus, 2017). Distributed leadership is recognizing that different individuals have different strengths and weaknesses and choosing a leader for a task based on the skills most needed at the moment. Some criticisms for distributed leadership are that it muddies the responsibilities of individuals and there is no clear order, it can also enhance the problem of competing leadership styles (Harris, 2009)

What happened at Flint can be described as distributed leadership gone wrong. Due to the bankruptcy of the city, the power was placed in such a way that individuals who would help solve the monetary problem were placed in control. With too much emphasis being placed on cost savings, this allowed other areas to be silenced and resulted in a more lenient stance on regulations. If distributed leadership had been used effectively, it would have still put an emphasis on cost saving leadership, but it would not have been the most important aspect. Other individuals would have still used their leadership capabilities to search for warning signs, implement the crisis impact scale, and create a crisis communication chain. It would not necessarily avoid the crisis, but it would help with the cleanup.

Adaptive Leadership

Another leadership style that can be applied very directly to a crisis situation is adaptive leadership. This style helps leadership organizations flourish in changing times. Crisis can be termed an "adaptive challenge;" it demands improvisation and experimentation that have not been needed previously. This is partly due to the progress we are seeing both societally and technologically. Adaptive leadership has been defined as leaders promoting adaptability in their followers, the attention is placed on how the follower responds to problems (Northouse, 2015). This leadership tactic has the leader mobilizing individuals to solve problems on their own, giving them the resources necessary to succeed. There are four different viewpoints in the process of adaptive leadership: systems, biological, service orientation, and psychotherapy perspectives (Northouse, 2015). The systems perspective is the assumption that a problem has many different sides to it, and they also have the ability to change and connect to different things in unknown ways. Biological perspective is the recognition that individuals evolve based on the need for adaptation, both from internal stimuli and external. Adaptive leadership has a service orientation; the critical part of this leadership style is the ability to empower individuals to confront complex problems. Part of empowering individuals is being available and giving guidance and resources as needed. They psychotherapy perspective is the understanding of how individuals best overcome problems, by facing them directly and being able to distinguish between real and imaginary dilemmas and learning new ways to conduct themselves during problems, and to resolve conflict (Northouse, 2015).

The most important aspect of adaptive leadership is diagnosing a problem; usually individuals are so wrapped up in fixing the problem that examination of the root cause gets pushed aside. According to Heifetz et al., leaders need to separate themselves from the activity to be able to diagnose the challenge. The second step in this process is to determine if the issue is ready to be addressed. If a crisis is occurring, automatically assume that people are ready for change. Though in a pre-crisis phase not everyone will see the problem and it can be difficult to create the adjustment necessary to avoid a disaster. Third, leaders should understand what perspectives or biases they may bring to the crisis. People who have worked closely with someone or know them well can expect certain actions in different circumstances, changing things all at once can have unanticipated consequences. Fourth, determine how to dispel the information. Give clarity to why this adaption is important and how things will change, this gives shows that thought has been put into change on every level and enables followers to anticipate the impact this latest change will have one them. The last step is to give the initiative time to work; change is not easy for a lot of people, and it generally requires an interval to get ready and then make the adjustment (Heifetz, Grashow, & Linsky, 2009).

Summary

In conclusion, leading during a crisis is a fundamental aspect of leadership, and the consequences of poor leadership decisions can have devastating effects on populations. There are ways a leader can facilitate their organization to mitigate a crisis or avert it completely. The most important component in averting or mitigating a crisis is the ability to see a catastrophe coming, watching for signs and recognizing them as they appear is crucial. The crisis impact scale can provide a general idea of how to manage the incoming/ongoing crisis depending on which variables (organization image, public scrutiny, reputations, etc.) are most important to the organization. If a crisis occurs that cannot be avoided, implementing a crisis communication protocol will aid in all phases of the disaster, particularly in salvaging reputations. There are leadership styles that do work best during a crisis; distributed and adaptive leadership styles both have their roots in empowering individuals to play to their strengths.

Cultural Humility and LGBTQ Communities in the Healthcare Environment

Julia Applegate

Introduction

Over 10 million people in the United States over the age of 18 identify as LGBTQ (Gates, 2017). Due to systematic inequities, disparities, and injustices, the LGBTQ community is disproportionately affected by physical and mental health illnesses, are less likely to have health insurance, and experience worse health outcomes compared to the general population. Despite being a population with pronounced healthcare needs, LGBTQ individuals face a lack of culturally humble and structurally competent providers, which further increases their obstacles to accessing and securing safe and high-quality health care.

Equitas Health is a health care delivery system with 17 offices in 11 cities serving 67,000 individuals on an annual basis across the state of Ohio. With nearly 400 employees, Equitas Health employs nurses, social workers, physicians, pharmacists, HIV prevention specialists, and a wide range of other staff devoted to taking care of the LGBTQ Community, People Living with HIV (PLWH) and anyone looking for a medical home. The organization also provides education and training for health and social service providers, and for community members, who identify as LGBTQ. These services are provided through the Equitas Health Institute for LGBTQ Health Equity. In the two years since the formation of the Institute, over 5,700 providers in settings as diverse as a children's hospital, an adolescent inpatient psychiatric facility, a home health agency, countless college classes, and a veterinary clinic have been conducted in an effort to decrease the many health disparities experienced by LGBTQ community members.

This chapter explores in depth the tactics deployed by Equitas Health and the Institute for LGBTQ Health Equity to activate its mission of providing 'Care to All' in the most culturally humble and inclusive manner for serving LGBTQ communities.

A Case Study on Leadership Best Practices for Serving the LGBTQ Population

Health Disparities in the LGBTQ Community

Among the health disparities experienced by the LGBTQ community, LGBTQ people experience a disproportionate amount of suicide, homelessness, mental health challenges, breast and cervical cancer, HIV and other STIs, as well as obesity, tobacco, alcohol and other substance abuse. The transgender community is at even greater risk for many of these concerns than their lesbian, gay and bisexual counterparts. While some of these health disparities are a result of behavior, the vast majority of them are associated with social and structural inequities resulting from institutionalized homophobia, transphobia, stigma and discrimination levied against LGBTQ people. The health disparities experienced by LGBT people can be grouped into four basic categories; (Healthypeople.gov, 2010)

1. Infectious Disease
2. Chronic Disease
3. Behavioral Health
4. Quality of Life Issues

The LGBTQ community is less likely to regularly seek medical care and more likely to be uninsured or underinsured. A major barrier to seeking medical care for members of the LGBTQ community is prior

discrimination. According to a Lambda Legal report in 2010, 56% of LGB people and 70% of TGNC individuals report at least one experience of the following; being refused care, health care professionals refusing to touch the patient or using excessive precautions, health care professionals using harsh or abusive language, being blamed for their health status, and health care professionals being physically rough or abusive.

Additionally, education regarding *culturally humble treatment* of LGBTQ patients is absent or near absent from professional training across most health-related disciplines. Treating patients/clients with cultural humility in the case of LGBTQ community members includes respecting patient pronoun usage, asking demographic questions that include sexual orientation and gender identity options, making waiting rooms LGBTQ friendly, etc. Cultural humility is a lifelong process and commitment to self-evaluation, self-critique, learning, reflection, and working in partnership with those belonging to a different culture. It is evident that in order to reduce health disparities in the LGBTQ community, attention must be paid to both provider and patient education, provider-patients interactions, and organizational structures, processes, policies and practices. Thus, strong leadership from health care organizations, health care education entities and community-based organizations is critical in order to achieve health equity for this historically marginalized community.

Role of Cultural Humility Training for Students and Providers

Cultural humility not only requires a lifelong commitment, but also requires that we recognize and address power dynamics in any provider-patient/client relationship. To improve the overall safety and quality of care, organizations should aspire to meet the unique needs of their patients – patient by patient. Addressing patients and clients from a place of cultural humility increases overall engagement and retention in care, resulting in better health outcomes. Cultural humility is an important tool for tackling issues of health disparities and health inequities in the LGBTQ community. Serving the LGBTQ community effectively requires the delivery of culturally humble care and services. Because this underserved population is often misunderstood, it is important to begin efforts to close the gaps in care by implementing a curriculum designed to increase the cultural competency and cultural humility of health care providers serving the LGBTQ community. Implementation of these kinds of trainings for providers and medical students has been shown to improve access to and quality of care for LGBTQ patients thus contributing to a reduction in health disparities.

Structural Competency: From the Waiting Room to the Patient Room

Another recent approach to improving health care experiences for LGBTQ populations as a supplement to cultural humility training is the concept of structural competency (A. Donald, 2016). Structural competency is an innovative approach to be adopted when training health care providers, particularly in medical school settings, to take care of LGBTQ individuals. Rather than relying solely upon teaching students to consider the unique needs of LGBTQ communities as a function of cultural difference, the structural competency approach requires providers to consider systemic factors that contribute to disparate health outcomes. Recognition that structural factors such as discriminatory public policies, codified practices that stigmatize LGBTQ identities, implicit bias, etc. contribute to disparate health outcomes will enable health care providers to increase their ability to provider culturally and structurally competent care to the LGBTQ population.

Structural competency requires the implementation of practical steps for indicating the ability to appropriately serve LGBTQ individuals. Examples of these practices include incorporation of LGBTQ specific support groups, inclusion of pronouns on patient intake forms, display of posters, magazines, stickers and other physical markers of LGBTQ inclusion, application of trauma informed care practices, and the provision of ‘all gender’ restroom facilities in healthcare settings.

Equitas Health: Best Practices Case Study Deployed

Equitas Health employs nurses, social workers, physicians, pharmacists, HIV prevention specialists,

case managers and a wide range of other administrative staff devoted to taking care of the LGBTQ community, People Living With HIV (PLWH) and anyone looking for a welcoming healthcare home. Serving 67,000 individuals on an annual basis, Equitas Health is committed to providing all of it services with a culture of humility and commitment to inclusivity.

This commitment to LGBTQ Cultural Humility is evident in a number of ways and can be seen in three areas including; (1) provider-patient relations, (2) patient education and empowerment efforts, and in (3) larger organizational policy and employment practices. A study of these three aspects illustrates the implementation of best practices for serving LGBTQ communities with cultural humility. Each of the three areas deployed by Equitas Health are explored in the rest of this chapter.

(1) Provider-Patient Relations

Patient-provider relations are an important part of the health care experience for LGBTQ community members. The ability to seek care from providers who are known to be culturally humble to the unique needs of the LGBTQ community addresses one of the primary barriers to care for this population. There are many ways patients are able to assess the cultural humility of providers in Equitas Health clinical settings.

HEI Designation

The Human Rights Campaign is the largest policy and advocacy organization devoted to the equal treatment of the LGBTQ community in the United States. Each year they publish *The Healthcare Equality Index Report* devoted to the evaluation of health care providers nationwide. Participating providers complete an evaluation to measure their degree of cultural competency for serving LGBTQ community members. Facilities who score well on the survey earn the coveted designation as a "Healthcare Equality Leader." This designation signifies that awardees provide LGBTQ inclusive care.

Equitas Health has received the designation of Healthcare Equality Leader for the past four years and displays this designation proudly in clinic spaces and on relevant patient materials. In order to receive the designation, Equitas Health had to verify its compliance with the four core criteria of the evaluation. The four core criteria evaluated are:

1. Non-discrimination and Staff Training
2. Patient Services and Support
3. Employee Benefits and Policies
4. Patient and Community Engagement

Patient-provider relations are best reflected in the Patient Services and Support measure. Equitas Health received high scores in all areas of Patient Services and Support (LGBTQ patient services and support, Transgender patient services and support, patient self-identification and medical decision making). In 2018, Equitas Health was one of only 19 health care facilities in Ohio to receive the HEI Leader Designation.

WPATH Certification

WPATH is the World Professional Association for Transgender Health. It is a globally respected professional organization dedicated to transgender health. WPATH publishes the Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. These guidelines assist physicians, surgeons, nurses, psychiatrists, counselors, and others in the treatment of gender dysphoria.

WPATH also operates an education initiative designed to certify health providers in delivery of culturally humble, medically appropriate care for transgender, transsexual and gender non-conforming (TGNC) individuals. WPATH Certification ensures transgender patients that their care provider is skilled in the core competencies required for delivery of culturally humble transgender health care.

As a demonstrable commitment to the provision of culturally humble care, several staff members at Equitas Health have untaken WPATH training. These providers include the Chief Medical Officer Chad Braun, Physician Kelly Seifert, Nurse Practitioners Mimi Rivard and Jessica Sherman, and Psychiatric Nurse Practitioner, Justin Kerr. Presently one staff physician, Dr. Kelly Seifert, has completed WPATH certification and sees a large transgender, non-binary and gender non-conforming patient panel. This certification is not required to care for TGNC patients, however, WPATH is a globally recognized authority on TGNC health and as such, supporting providers in their pursuit of WPATH certification demonstrates Equitas Health's deep commitment to TGNC specific cultural humility.

Patient self-identification

Sexual orientation and gender identity (SOGI) data is not routinely collected in most health care settings. The perception that asking these questions will be considered rude or invasive is often cited as justification for not collecting this data (Cahill, 2014). However, the ability of LGBTQ patients to self-identify is a critical component of providing culturally humble healthcare experiences. All patient intake forms used in clinical and case management settings at Equitas Health include specific questions about sexual orientation and gender identity. Further, these questions are written in an inclusive and expansive manner, designed not just to ask about SOGI, but to do so in the most expansive ways possible. For example, questions about gender identity allow patients to identify as male, female, transgender, genderqueer, gender non-conforming, non-binary, and as 'something else,' with a space given for patients to write-in the term with which they most closely identify. Additionally, patients are asked to share their pronouns and preferred name with providers. Because legal name and preferred name frequently do not align for transgender patients, it is critical to make space for this important information to be shared. Providers also routinely introduce themselves with the pronouns they use when meeting with clients. Routinizing this behavior ensures clients will have an opportunity to refresh providers with the current pronoun they use at each visit-an important element of culturally humble care for patients who are exploring their gender identity.

LGBTQ Cultural Humility Training

As discussed above, cultural competency and humility training is an important mechanism for increasing the likelihood that providers treat LGBTQ patients in the most culturally appropriate manner. As an important demonstration of its commitment to cultural humility all Equitas Health staff are required to complete at least one LGBTQ cultural humility training. Training is provided by staff of the Institute for LGBTQ Health Equity. These trainings are designed according to best practices for teaching LGBTQ cultural humility, are certified for continuing education credits in nursing, social work, psychology and other disciplines as required, and are regularly evaluated for effectiveness.

The Institute maintains a large curriculum which is described in detail by the Education and Training Brochure and an example of the training curriculum developed by the Institute follows:

(2) Patient Education and Empowerment Efforts

A significant obstacle preventing consistent linkage to health care reported by sexual and gender minorities is discrimination and disrespect from providers. The need to enhance patient-provider interactions has been highlighted repeatedly by many research studies. However, most studies' recommendations approach the issue from the provider perspective, arguing in favor of efforts to improve the cultural competency/humility of healthcare providers. Few studies argue for the empowerment of patients directly despite volumes of research documenting the benefits of patient empowerment on the outcomes of chronic illnesses.

In an effort to empower patients to take control of their healthcare experiences, Equitas Health has developed several important tools to increase patient levels of confidence when seeking medical care. Those tools are described below:

Patient Empowerment Workshops

Over the course of a two-year period, The Equitas Health Institute for LGBTQ Health Equity conducted workshops exploring multiple methods of patient empowerment with LGBTQ patients. These workshops include modules on mindfulness/emotional regulation, knowing one's legal rights as a patient and the use of assertive communication techniques. Preliminary data collection has demonstrated the effectiveness of the Patient Empowerment Workshops in improving community member's sense of participation, knowledge, and self-efficacy. Patient Empowerment Workshops are conducted on a quarterly basis in the two Columbus medical clinic settings.

Field Guide to LGBTQ Health

As an accompaniment to the Patient Empowerment Workshops the Institute has developed the LGBTQ Field Guides Health and Wellness. The purpose of this guide is to educate the LGBTQ community about overcoming barriers to care and interacting more effectively with their healthcare providers. The guide provides insight into the unique health needs of different groups within the LGBTQ community, tips on what to discuss with healthcare providers, information about patient rights and tools to help patients prepare for medical appointments.

LGBTQ Healthcare Provider Guide

Another tool created to increase patient empowerment is the LGBTQ Health Provider Guide. This is a resource to connect LGBTQ community members with health and social service providers who are committed to providing LGBTQ centered care. Providers who are listed in the directory must pledge to comply with at least one of four measures that contribute to making healthcare experiences inclusive for LGBTQ individuals. This guide is distributed widely across the state of Ohio and is available on the Equitas Health Institute webpage.

http://www.equitashealthinstitute.com/wp-content/uploads/2018/02/ProviderDirectory-fullpage.pdf

(3) Organizational Policy and Employment Practices

Providing culturally humble care and services to patients is the cornerstone of LGBTQ cultural humility, however, it is also essential to ensure the organization has internal policies and procedures that protect and empower its LGBTQ employees. There are numerous strategies employed by Equitas Health to do just that. A discussion of those strategies follows:

Employment Non-Discrimination Policies

In the absence of federal protections against employment discrimination based on sexual orientation and gender identity, LGBTQ employees cannot expect to be protected from being fired for their perceived or expressed sexual orientation or gender identity. This type of protection is found only in places of employment or municipalities that adopt specific legislation or employment practices that extend protections to LGBTQ employees. Equitas Health has explicit non-discrimination clauses in its patient

and employer policies that prohibit discrimination based on all of the federally protected classes, as well as sexual orientation and gender identity. This provides and additional layer of comfort for LGBTQ employees.

Hiring Practices

As a caretaker of the LGBTQ community, Equitas Health finds value in the employment of LGBTQ community members. As such, explicit attention is given to the recruitment and retention of LGBTQ employees. The organization has a newly formed Employee Resource Group for lesbian employees and is in the process of developing a similar group for trans and gender non-conforming employees. Supporting staff with affinity groups is an additional measure to create a supportive work environment for LGBTQ employees.

Trans Inclusive Health Insurance

Few employer health insurance plans provide comprehensive insurance policies to meet the need of transgender employees. In the aftermath of the Affordable Care Act it is more common to see health insurance plans provide coverage for hormone replacement therapy for individuals who identify as transgender, but few cover surgical intervention and other therapies that may help alleviate the impact of a gender dysphoria diagnosis (speech therapy, tracheal shave, vaginoplasty, orchiectomy, metoidioplasty, etc.). Equitas Health has a partially trans inclusive health insurance policy for all full-time staff and is working toward a fully inclusive policy in the near future.

Solidarity Tool Kit

Finally, in an effort to employ structural competency practices with their own employees, Equitas Health has created a Solidarity Tool Kit to help staff convey their cultural humility to the patients and community we serve. All staff are provided with a tool kit that contains pronoun buttons, stickers, a lanyard pull and a lapel pin that utilize LGBTQ pride symbols. The use of the rainbow and the colors in the transgender pride flag serve as a visual indicator of employee commitment to serving the community with humility.

Conclusion

In April of 2016, the AIDS Resource Center of Ohio rebranded as Equitas Health. The change in name reflected a mission change from a focus on HIV case management, prevention and treatment, to a broad-based LGBTQ Patient Centered Medical Home (PCMH) health care delivery model. During this time, Equitas Health has shown significant leadership in the implementation of best practices for serving LGBTQ communities with a focus on cultural humility. One data point that drives home the success in

this area is the increase in the transgender patient panel cared for by Equitas Health physicians and nurse practitioners.

In January of 2016, Equitas Health served 35 transgender patients with HIV care services. By January of 2018, 583 transgender patients sought medical care at Equitas Health clinics, a massive increase in patients served and a positive indication of the degree of cultural humility and structural competency conveyed by the providers. The emphasis on a culturally humble healthcare delivery model ultimately seeks to result in a reduction of healthcare disparities for this vulnerable population. If the first two years of implementation are any indication, Equitas Health is one its way toward making a dent in these disparities.

Appendix

Equitas Health patient intake form:

Legal Name* **Last** **First** **Middle Initial** **Preferred name:**

Legal Sex (please check one)* **Female** **Male** **Pronouns:**

*While Equitas Health affirms the range of sexual orientation, gender identity and gender expression, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your name and pronouns you use are different from these, please let us know so that we may address you as you wish.

Date of Birth Month Day Year / / /

Social Security # **State ID # or License #**

This information is for demographic and care purposes:

1.) What is your annual income?

– No income

1a.) How many people (including you) does your income support?

2.) Employment Status

– Employed full time
– Employed part time
– Student full time
– Student part time
– Retired
– Unemployed
– Other

3.) Racial Group(s) (check all that apply)

– African American / Black
– Asian
– Caucasian / White
– Native American / Alaskan Native / Inuit
– Pacific Islander
– Other

6.) Preferred Language (choose one:)

– English
– Español
– Français
– African (Specify:_____)
– 中文
– Other
– I need an interpreter

7.) Do you think of yourself as:

– Lesbian, gay, or homosexual
– Straight or heterosexual
– Bisexual
– Something else
– Don't know

8.) Relationship Status

– Married
– Partnered
– Single
– Divorced
– Other

9.) Veteran Status

– Veteran
– Not a Veteran

10

–
–
–
–
–
Wo
–

11.) What is your gender identity?

– Female
– Male
– Genderqueer
– Non-binary
– Something else

12.) What was your assigned sex at birth?

– Female
– Male
– Intersex

13.) Do you identify as transgender?

– Yes
– No
– Don't know

Leadership and the Promotion of Diversity in the Work Force and Beyond

Emily Feyes

Introduction

Increasing diversity is a complex issue dealing with deep seated beliefs and both implicit and explicit biases. Enhanced diversity will not be accomplished easily and requires time, planning, and a willingness to be uncomfortable. In this chapter, we will explore what qualities and theories of leadership will help an individual steer an organization through the cultural shifts needed to promote and foster diversity within the health care workplace and out into the community. To do this, we will focus on four leadership approaches/theories: *Situational Leadership, Leader-Member Exchange Theory, Transformational Leadership, and Authentic Leadership*. The discussion will then shift to what actions leadership can take to promote diversity within their work force followed by a discussion on the actions that can be taken to promote diversity and cultural sensitivity in interactions with members of the communities being served.

The demographics of the United States have changed over the past 40-50 years, and this is projected to continue. The number of non-Hispanic, white Americans has been decreasing since the 1980s and is projected to encompass 64.3% of the U.S. population by 2020, a 15.7% decrease (Judy, 1995). With this comes an increase in the percentages of other ethnic or racial populations. By 2020, it is projected that 12.9% of the U.S. population will be African American, 6.5% will be Asian, and 16% will be Hispanic (Judy, 1995). These changes in the overall population will also be reflected in the labor force. By 2020, only 68% of the U.S. labor force is expected to be non-Hispanic white individuals, down from 76% in 1995 (Judy, 1995). It is predicated that by 2020, 14% of the labor force will be Hispanic individuals, 6% Asian, and 11% African Americans (Judy, 1995).

As these demographics have shifted, companies, including health care organizations, have been working to increase the diversity of their work force to match the populations that they serve. Companies are actively recruiting and hiring individuals that have historically been in the minority in terms of identity characteristics such as race, gender, ethnicity, sexuality, religion, and socioeconomic status. The desire to increase diversity stems from the benefits that come along with approaching problems from different perspectives instead of through a single homogeneous lens. For health care organizations, the benefits of diversity extend into the communities in which they serve.

Increasing work place diversity requires an overall shift in an organization's culture, which is often easier said than done. Historically, the work force has been dominated by Caucasian, middle-to-upper class men. During this time dominated by a single demographic, the multiple levels of culture (artifact, espoused values, and basic assumptions) were established and became part of employees' work identity. When workers are faced with the challenge of adapting this culture, they may themselves feel threatened and become defensive by what they see as a question of their own personal identity (Osland, 2011). A strong leader willing to work with employees through their complex, personal beliefs is necessary to successfully facilitate a cultural shift.

Organizational leaders play a critical role in establishing and promoting work place culture. Employees look to leaders to set the context in which they will function within an organization. Establishing an environment that reflects the desired values of an organization requires more than just

words from leadership; it requires action and the embodiment of these values. If employers espouse certain values but act in ways that directly contradict them, employees will see through the empty words and will look outside of the organization for a company that demonstrates the culture that they desire to participate in. A disingenuous atmosphere can make it difficult for companies to attract and retain talented individuals and becomes especially important when considering work place diversity. We will explore what behaviors leaders can demonstrate and what actions they can take to successfully promote diversity in their organization.

Background

Diversity and Cultural Competence

Financial incentives have been a major driver of increasing diversity in the work place. From a business perspective, companies have recognized that hiring employees with different perspectives and ideas drives innovation and problem-solving within their organizations (Nemeth, 1986). From a health care perspective, diversity in the work force has been shown to result in better healthcare outcomes in minority populations. A literature review done by The U.S. Department of Health and Human Services in 2006 found that minorities and non-English speaking patients received better healthcare when treated by workers of a similar background (HHS, 2006). The evidence reviewed attributed this to patients having a better understanding of health information discussed, increased likelihood of follow-up visits, and better interpersonal relationships with the health care provider (HHS, 2006). This study showed that increased diversity in the healthcare work force resulted in increased access to quality health care and an overall improvement in public health (HHS,2006).

Webster's Dictionary (2018) defines diversity as "the inclusion of different types of people (such as people of different races or cultures) in a group or organization." This definition is a good starting point to consider when a company wants to change the culture of its workforce, but what it fails to encompass is that establishing diversity in an environment requires more than just inclusion. It requires cultural respect and competence toward 'different types of people'.

Cultural competency requires an individual to consider how culture can affect how another person perceives and understands the world around them. In the work place, this involves embracing difference perspectives and ideas and ensuring that deserving individuals are rewarded (either through promotion or some other form of recognition) within the organization to demonstrate that they are not just employed to fill an arbitrary quota.

In a health care setting, cultural competency is best defined as "the knowledge, skills, attitudes, and behaviors required of a practitioner to provide optimal healthcare services to persons from a wide range of cultural and ethnic backgrounds" (Cohen et al., 2002). Cultural competence requires that health care providers can use a completely different approach than they would for someone with a similar cultural background as they themselves have. Demonstrating cultural competence is critical in a healthcare setting, as it can play a role in decreasing health inequity (Betancourt, 2005; Cohen et al., 2002).

Some argue that achieving true diversity requires more than just cultural competence. Competence is often viewed as a set of skills that once learned can be mastered and applied to every situation (Lokko,2016) which is not necessarily the case. Diversity and cultures are dynamic which requires constant education and adaptation of skills, which is why Lokko et al. (2016) recommend the *promotion of cultural respect as opposed to cultural competence*. Cultural respect requires an individual to accept that there will always be skills to learn and mistakes made. It involves a sense of humility because it is an acknowledgement that one cannot possibly know everything that there is to know about a person's cultural identity in every given situation.

Promoting diversity, cultural competence, and cultural respect within an organization requires a strong commitment from leadership. In the next section of this chapter, we will discuss how leaders ought

to commit to change within themselves to embrace diversity as well as encourage change within their followers/employees.

Leading the Way Toward a More Diverse Work Force

When leaders are driving a cultural change within an organization, it does not solely revolve around changing follower/employee attitudes; it involves self-reflection and personal change. Leaders ought to first identify and understand their own feelings and biases toward diverse populations to understand what they will face when working with their employees (Rowitz, 2013). This introspection will also allow them to assess their leadership style and skills to identify both strengths and weaknesses that will work for and against them during this cultural shift. In this section, we will first discuss what leaders can do as individuals to aid in promoting a diversity culture shift; we will then discuss how different leadership styles can both help and hinder this process.

According to Rowitz (2013), cultural competency, which is necessary for true diversity to thrive, occurs in the following stages: awareness, understanding, and action. One does not just decide that they are going to advocate for diversity and start doing so. They must first come to terms with their own stereotypes and biases, understand cultural values and norms of the groups they intend to interact with, and then act to promote diversity within their target area. This is especially important for individuals in leadership roles. Before they can develop an atmosphere designed to promote diversity within their organization, they need to first understand the obstacles that will be faced when working toward this cultural shift. Leaders ought to honestly address what stereotypes they have toward different groups and consider what implicit biases they may have. According to the Kirwan Institute for the Study of Race and Ethnicity at The Ohio State University website (2015), implicit bias is defined as "the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner." This type of bias is not always consistent with how an individual believes that they view those that are different from them.

Biases are shaped by our experiences and influences as we grow and develop in our environments. Because these biases occur on a subconscious level, they require an individual to seek out tools to help identify what groups they may be directed toward. Leaders need to critically evaluate how they think about, speak to, and act toward members of different cultures. Once they gain awareness about their own thoughts, feelings, and interactions, they can begin to educate themselves to overcome their prejudices.

Leaders should not isolate themselves in this quest for understanding, they should reach out to members of minority groups that they wish to engage with in their community or in their work force to gain perspective about the discrimination and challenges that these individuals face daily (Rowitz, 2013). They should learn about culturally appropriate language to promote inclusivity and respect in their environment. Leaders should recognize that this is a lifelong learning process and should seek out and encourage feedback (Rowitz, 2013). Diversity and inclusion are sensitive topics, and missteps will be made. Leaders need to be prepared for conflict and discomfort as they work to understand the perspectives of others; these instances should be approached with empathy, humility, and a willingness to learn.

During this time of self-reflection, leaders should assess their leadership style, along with their strengths and weaknesses, and evaluate how these will influence their goal of promoting diversity both in the workforce and in their community (Myers, 2007; Rowitz, 2013). There are many different leadership theories/styles that have been studied and researched, some involving natural-born leadership traits and some involving skills that can be developed. In this section, we will focus on four of these leadership styles and how they might work for or against an organizational shift toward diversity.

Context for Diversity and Leadership

Promoting Diversity and the Situational Approach to Leadership

The first leadership style that we will evaluate is the Situational Approach to Leadership. This approach

is interesting because it does not just consider leader characteristics, it looks at followers, too. Situational leadership involves a leader analyzing the level of follower competence and commitment to the goal, in this case diversifying the work force population, and adjusting their leadership style to match it (Northouse, 2016). Leaders should strive to find a balance between directive behaviors (such as establishing goals and timelines, defining roles, and giving directions) and supportive behaviors (such as asking for input, sharing information about oneself, and listening) based on follower/employee competence and commitment levels (Northouse, 2016).

Situational leadership may be beneficial in an organization that is working to increase diversity and cultural competence either in their work force or in their interactions with the community that they serve due to the overall flexibility of the approach. As followers learn and grow, their competence will improve and this approach will allow leadership to adjust their style to meet the changing needs of their followers.

For example, in a company where employees have a low level of commitment to improving diversity and a low level of competence, particularly cultural competence, a coaching leadership style with high directive behaviors and high supportive behaviors would be required (Northouse, 2016). Leaders would need to set clear goals and expectations regarding the development of cultural competence and inclusion in the work place while also demonstrating the achievement of these goals in their own behaviors. Leaders would also need to be available to listen to employee concerns regarding the changes in company culture and how they may feel threatened by this change. Leaders should also help manage conflicts as they arose and provide praise when goals are met. Within this approach, leaders can adjust their style as employees' attitudes and competence improved.

This approach does not come without some drawbacks, though. One hurdle associated with taking this approach when working to increase diversity is that it fails to take follower demographics into account when assigning them to a category. It also fails to distinguish between one-on-one leader-follower relationships and leader-organization or leader-group relationships (Northouse, 2016). Leaders may be forced to assign a category to the organization, especially in large health care systems, instead of to individuals resulting in mismatch between leadership styles and follower categories for several individuals. If this occurs, it may affect the strength of support or dissent that a leader faces when working toward this cultural shift.

Promoting Diversity and Leader-Member Exchange Theory

One leadership style that could prove to be detrimental to expanding diversity in the work place is the practice of Leader-Member Exchange (LMX) theory. This theory focuses on the relationships established between a leader and a follower. High quality relationships involve a high level of trust and partnership between individuals and can result in things like low employee turnover, job promotion, and more rapid career advancement (Northouse, 2016). Low quality relationships result in fair treatment of employees but strictly within the confines of their contract.

Employing Leader-Member Exchange theory in the work force can be detrimental to the development of diversity because these high vs low quality, or in-group vs out-group, relationships can be influenced by conscious and/or unconscious biases. In-group relationships may occur more frequently between individuals with similar cultural or ethnic backgrounds, as individuals may find it easier to establish trust with someone to whom they can more easily relate (Tsui,1992). This may prevent minority individuals from achieving the same career levels as equally or even less qualified majority individuals despite their best efforts and qualifications. If this practice is occurring within an organization that is claiming to support diversity, employees will see through the talk, and retention rates of minority individuals will decline. This leadership practice will work against expanding diversity because it appears to be discriminatory (Northouse, 2016). If a leader identifies this practice within their organization, they should address this with transparency and encourage others to expand their in-groups, offering all employees the opportunities to advance through hard work and innovation.

Promoting Diversity and Transformational Leadership

Leaders that utilize a transformational approach may see increased success in promoting diversity and shifting the culture of their organization. With this leadership approach, leaders are working toward increasing the ethics and standards within themselves and their followers (Northouse, 2016). Goals are clearly outlined and leaders demonstrate the morals/values that they want to see promoted within the company. These leaders are often charismatic and able to inspire their followers to change and find their place within the new culture (Northouse, 2016). Transformational leaders not only inspire their followers, they provide support and guidance, which is important during culture shifts.

Transformational leadership lends itself to increasing diversity and inclusion within an organization as this often requires individuals to re-evaluate how they view people who are different, which often means identifying their own prejudices and faults. Having a leader who embodies the change and values while also providing a supportive, judgement-free environment to change and grow allows followers to emulate someone they respect and make mistakes along the path to change. Transformational leaders recognize the need to be lifelong learners which is necessary when dealing with diversity and cultural competency as these concepts are dynamic and not a set of skills that can be singularly mastered.

As mentioned earlier, research concerning transformational leadership has found that individuals exhibiting this form of leadership tend to be charismatic individuals who can easily garner follower support through their confident, clear, and inspiring communication skills (Northouse, 2016). This implies that transformational leaders are born with the traits needed to successfully use this approach and that these are not skills that individuals can learn. If this is indeed the case, a downside to this leadership approach regarding diversity promotion is that it will only be applicable in organizations that have a transformational leader directing the cultural shift in the company. It implies that any attempt at this leadership style by someone not possessing the necessary traits will result in a lack of buy-in by followers. If the research is incorrect and these are traits that can be strengthened and/or learned, this leadership approach would be ideal for promoting diversity, as its ultimate intent is to direct an organization toward values that "reflect a more humane standard of fairness and justice" for all (Northouse, 2016).

Promoting Diversity and Authentic Leadership

The Authentic Leadership approach may have the most potential for widespread promotion of diversity. This approach has not been studied for as long as some of the other leadership styles and different researchers have different perspectives regarding authenticity. In this chapter, we will focus on the developmental perspective of authentic leadership because, at its core, this is something that an individual can learn and develop throughout their life. The fact that it is not defined by the possession of certain inherent traits increases its potential for widespread adoption; people are not excluded from embodying this style based on personality characteristics that they may or may not possess.

Developmental authentic leadership focuses on four distinct components which are enhanced by certain characteristics. The first component *is self-awareness or the ability to recognize one's own strengths and weaknesses* (Northouse, 2016). This is a critical component for promoting diversity. As discussed earlier in this section, awareness is the first step toward cultural competency. A leader's ability to understand where they fall short or excel in terms of cultural perspectives and assumptions will allow them to educate themselves and grow while also allowing them to empathize with the changes that they are asking their followers to make.

The next component is *internalized moral perspective which involves allowing one's own values and beliefs to guide decisions made and actions taken as opposed to being influenced by outside forces* (Northouse,2016). This is a very important thing to consider when trying to adopt a new culture that embraces and promotes diversity. A leader will be faced with many challenges during a cultural shift and their vision will be called into question at different points throughout the transition. An authentic leader

will listen to others' perspectives but will ultimately follow their own moral compass toward what they know is right. A strong moral compass is enhanced by a leader's ability to truly understand their purpose and follow their values that guide them toward the right thing to do (Northouse, 2016). Being self-aware allows an authentic leader to acknowledge that they are not always right and may not always know how best to approach a conflict or challenge to their overall goal.

Leaders must also be able to employ *balanced processing, which involves a leader seeking out and actively listening* to dissenting views or opinions with an open mind to determine if there is a better way to approach a problem or view a situation (Northouse, 2016). Balanced processing is especially valuable for promoting diversity as leaders ought to be willing to consider perspectives of individuals from different cultural and ethnic backgrounds without bias or prejudice. Doing this will result in leaders garnering trust and respect from their followers which will enhance their commitment to the overall goal of promoting diversity.

Finally, an authentic leader must practice *relational transparency; they must be willing to share their honest, authentic selves with their followers* (Northouse, 2016). This requires that leaders share their own successes and struggles as they move along the path toward reaching their goal. This helps followers to relate to the leader as they experience similar situations which builds trust. It allows followers to see the leader in action working toward the common goal and not just telling them how they should be doing things or what values they should uphold. Though there is not a lot of data demonstrating organizational outcomes of authentic leadership, the components discussed above clearly demonstrate an approach that lends itself to promoting diversity within organizations and in community partnerships with healthcare organizations.

Discussion

Leading to Promote Organizational Diversity

Increasing diversity within an organization will not happen without a cultural shift in the work place. Even with structural mechanisms in place to increase diversity, a lack of diversity-embracing culture will undermine these mechanisms and cause employees to seek work elsewhere (Myers, 2007). This shift does not happen overnight and it does not occur without setbacks and opposition. Leadership within the organization needs to be prepared for these challenges, and this can best be done through proper planning and by employing leadership styles/approaches that we discussed earlier in the chapter.

Leaders will need to first be willing to perform a self-assessment to determine their own level of cultural competency and areas of weakness that they should address while guiding their company toward a more diverse culture (Rowitz, 2013). They need to look at whether their own biases result in more frequent promotion of individuals that are like them, whether they are distributing workload equitably among different groups, and whether they are more likely to praise or criticize an employee based on their cultural or ethnic backgrounds (Myers, 2007). Leaders need to be ready to do more than talk about diversity; they need to demonstrate cultural competency in how they treat employees with diverse identities (Rowitz, 2013).

Leaders should also assess the organization to determine where it is falling short in promoting diversity; this allows for proper strategic planning and allocation of resources to improve the work environment and overall employee attitude toward diversity and cultural change (Chin, 2012). Without acknowledging the problems that exist, it becomes very difficult to adequately address them. This can lead to problems with retention of minority workers; if the promotion of diversity is present in speech but not in action (through promotions, mentoring, non-hostile environments), skilled, marginalized employees will seek out other opportunities for employment, even if it results in decreased compensation (Myers, 2007). It is also very valuable for leaders to speak with members of marginalized groups to gain their perspective on the company culture and experiences in the work place. Obtaining and applying

feedback will result in the development interventions that are more likely to meet the needs of the diverse population that the company is trying to attract (Rowitz, 2013).

Once leadership has performed a thorough evaluation of the current company culture regarding diversity, they can develop a strategic plan that clearly outlines how they will move forward to increase diversity within the organization. Weech-Maldonado et al. (2018) promotes doing this via a systems approach to improve the likelihood of success. Cultural shifts to promote diversity cannot be accomplished at an organizational or individual level alone; they need to occur at every level of the system. At the management level, cultural competency and diversity promotion need to be incorporated into the management system; adequate resources must be planned for and allocated to sustain any training programs utilized; diversity goals need to be set, communicated, and assessed; and policies, such as anti-bullying and anti-harassment policies, need to be put into place (Chin, 2012; Cordova, 2010; Etowa, 2017; Weech-Maldonado, 2018).

At the human resources level, active and deliberate recruitment and retention of minority/marginalized employees is necessary to increase and sustain diversity within an organization. Cultural competency training should be provided for current and future employees (including at the management and leadership levels), diversity policies should be incorporated into on-boarding materials and advancement training, and managers should receive training on incorporating cultural competency and inclusion into work load allocation, performance goal setting, and promotions (Cordova, 2010; Weech-Maldonado, 2018). Finally, at the individual level, employees should be encouraged to evaluate their own potential biases and how their cultural background affects and shapes these (Weech-Maldonado, 2018).

Leaders should also look for diversity champions at different levels throughout the company; these are the individuals that strongly support the promotion of diversity in the company and are willing to aid leaders in moving the company forward toward its inclusion goals (Chin, 2012; Etowa, 2017). Champions can provide support to coworkers struggling with the culture shift and how they fit into the new system as well as to marginalized coworkers looking for acceptance in the work place.

Leaders should be prepared to face conflict among individuals and should encourage the sharing of different perspectives. By doing this, they can give a voice to marginalized individuals and allow them to identify problems that still need to be addressed within the organization (Etowa, 2017). Encouraging and mediating conflict also maintains open communication where people can feel safe voicing their concerns and frustrations. Making employees feel heard will most likely result in more buy-in to the culture shift.

Strong leadership support is required to successfully steer a culture shift to increase organizational diversity and, to be most effective, this ought to be done at all levels of the company. To increase the likelihood of success, leaders need to carefully assess the current work climate, be deliberate in their diversity promotion planning/goal-setting, solicit input from marginalized groups to ensure their needs are being addressed, and prepare to evaluate and adjust systems as the plan moves forward. In the next section, we will discuss how many of these same principles can be applied in health care organizations to improve care delivered to culturally and ethnically diverse patient populations.

Leading to Address Diversity in Communities Served

In a health care organization, it is important for leaders to address the diverse needs of individuals in the communities being served. Fortunately for leadership, this is often done through improving diversity within the organization. Having a work force that mirrors the community being served can reduce health disparities among minority populations, as it can increase access to care (Lokko, 2016). Providing cross-cultural and cultural sensitivity training to medical providers and staff can also improve community relationships and encourage members to seek out care as needed (Betancourt, 2005; Lokko, 2016). As discussed in the previous section, leaders need to be aware of how they and their organization fall short in addressing the needs of the individuals they serve. Leaders should go out into the community to

hear firsthand what services and policies are lacking within their organization that may be perceived by residents as barriers to receiving care (Rowitz, 2013; Lokko 2016).

One area that often needs to be addressed within healthcare is language barriers. Patients that do not speak English as their first language, or at all, require the services of an interpreter and ideally medical literature translated into their native language. This can reduce the likelihood of misinterpretation of medical information and medical errors that may result from this misinterpretation while also demonstrating a respect for cultures other than one's own (Anderson, 2003).

Leaders should also incorporate diversity and inclusion parameters in organizational quality assessment tools (Betancourt, 2005). Getting feedback from patients and community members regarding how their cultural needs are or are not being met will provide valuable insight regarding where diversity policies may be falling short or excelling. This evaluation will help to avoid continued use of policies that fail to meet community needs so that they can be redesigned or ended, allowing resources to be directed toward programs that are working or toward the development of new programs designed to more effectively address community needs.

Conclusions

We are living in a global community, and the United States is especially unique given its culturally and ethnically diverse population. Organizations, particularly those in the health care sector, need to address and promote diversity to remain relevant in this constantly evolving society. In this chapter, we learned about several different leadership approaches/styles an individual attempting to improve cultural diversity within their organization may employ. This chapter serves to highlight styles that may be particularly beneficial or harmful in situations of organizational cultural shifts. We also discussed key steps for leaders to consider when attempting to improve diversity within their organization and when working with diverse communities; these included steps at both the individual and organizational levels. Promoting diversity is a large undertaking challenged by biases, sensitivities, and an overall fear of change. Strong leadership is necessary to direct an organization through resistance and roadblocks to achieve diversity goals and improve inclusion.

How Leadership Dynamics in Health Care Can Contribute to Medical Errors

Rana Roberts

Introduction

Leadership dynamics and hierarchies inherently exist in organizations. While these dynamics can be beneficial to an organization, some leadership dynamics can be harmful. Leadership dynamics in the health care setting can be especially dangerous as these dynamics can contribute to medical errors. Medical errors are the third leading cause of death in the United States following heart disease and cancer (DeAngelis, 2016). Furthermore, research from Johns Hopkins reveals that nearly 250,000 Americans lose their lives each year due to a medical error. This number is a rough estimate due to the broad range of medical errors that can occur. A variety of factors may cause a medical error, such as a breakdown in communication among a treating team to issues with technology design (Deangelis, 2016).

While it is difficult to count the number of deaths that have been caused by a medical error, factors that lead to medical errors can be explored in order to determine the best practice in prevention. Tucker and Edmonson point out that the reported number of hospital errors tend to focus on errors that result in the death of a patient, but there are also more subtle errors that occur on a daily basis in the health care setting that deserve attention as well. (Tucker & Edmonson, 2003). Medical errors are of public health concern because any patient in a health care setting is vulnerable to having a medical error. Evidence suggests that medical errors also impose a high economic burden on our society; it is estimated that nearly 15% of hospital expenditures are attributed to medical errors. Among the most burdensome adverse events that occur in the United States are healthcare-associated infections (HAI), venous thromboembolism (VTE), pressure ulcers, and medication errors (Slawomirski, 2017). Leadership dynamics and hierarchies that exist in the health care setting are contributing factors to these medical errors.

This chapter explores psychological safety along with how leadership, hierarchy, and teamwork may create less or more safe environments. A systems science perspective is introduced along with examining the nurse-physician relationship and personal experiences with psychological safety.

Teamwork

Leadership in the health care setting serves an essential role in ensuring that quality care is being delivered. Cross-disciplinary teams work together to share responsibility of caring for a patient, which can create challenges. A recent study by Nembhard shows 70-80% of medical errors are related to interactions among healthcare team members (Nembhard, 2009). These interactions within cross-disciplinary teams are essential in delivering the most efficient and quality care. Due to the increase in specializations of the health care field, patients are typically treated by several individuals rather than just one primary care physician. These individuals are referred to as cross-disciplinary teams and are comprised of individuals who have various specializations such as nutrition, respiratory therapy, and physical therapy (Nembhard, 2009).

As cited in Northouse's book on *Leadership: Theory and Practice*, organizational team-based structures are essential for having the ability to respond quickly and adapt to constant, rapid change which is inevitable in the health care field (Northouse, 2016). Looking at how these teams share leadership can determine whether or not a team is performing its best. The complexities of the health

care setting can cause frustration, misunderstandings, and miscommunications which ultimately results in tension among a treating team. This tension creates a risky environment that is more susceptible to error (Clough 2008). The various perceptions among a team can also cause miscommunication which may cause medical errors. Surveys and interview studies on healthcare providers perceptions of teamwork in dynamic medical environments reveal how healthcare providers tend to perceive the quality of teamwork differently.

Clinicians are more likely to perceive the quality of the leadership and the communication of the team more positively than the nurses. Similarly, doctors who were still training reported more negative perceptions of teamwork than their senior counterparts. One study specifically analyzed how the various members of a treating team of an operating room perceived the same situation. The operating team was comprised of surgeons, nurses, and anesthesiologists and each rated tension levels differently (Manser, 2008). The study conducted on this operating team revealed how each member of this team perceived responsibility; the surgeons, nurses, and anesthesiologists would rate their respective profession as having less responsibility than the other profession (Manser, 2008). These findings indicate that team members from different health care professions do not fully understand the importance of one another's role. And ultimately, pointing fingers at which profession should have more responsibility does not help eliminate a medical error. Team members should instead be knowledgeable in the importance of each team member's role in treating the patient and they should also understand how each role fits together cohesively to provide the best quality care for that patient. A retrospective analysis of adverse event reports revealed that communication and issues with teamwork were among 22-32 percent of contributory factors (Tucker, 2003).

Human Error vs. Systems Error

When analyzing medical errors in the health care setting, two approaches can be used: the individual approach and the systems approach. The individual approach examines individual characteristics that may contribute to an error such as forgetfulness, carelessness, or moral weakness. The system approach is more concerned with the conditions and the environment in which the individual is subjected. The systems approach also recognizes that humans are prone to error, and this should be expected even in the most successful organizations. While many medical errors in a health care setting are caused by an individual error, the complex environment of health care creates a risky environment for many systems errors.

Edmonson and Tucker point out that historically, hospitals have relied on highly skilled health care professionals to compensate for operational failures. The issue with relying on the most dedicated or knowledgeable nurses or physicians to help reduce medical errors is that this approach fails to recognize the role that management and leadership can have in ensuring quality care (Tucker, 2003).

In an extensive study performed on work system failures on the front lines of delivery in hospitals, Tucker and Edmonson analyzed 239 hours of observation and 26 nurses at 9 different hospitals in order to understand the importance of the relationship between organizational learning and process failures. The hospitals that were selected were referred by nursing governing boards for being hospitals that processed reputations for nursing excellence. By including hospitals that were all deemed as 'excellent organizations,' this allowed for Edmonson and Tucker to obtain results on how excellent nursing hospitals handle service failures (Tucker, 2003). The result revealed that nurses experienced five broad based problems including:

1. Missing or incorrect information
2. Missing or broken equipment
3. Waiting for a human or equipment resource
4. Missing or incorrect supplies
5. Simultaneous demands of their time

An interview with an oncology nurse points the blame at down-stream internal support departments as the main source of disruptions; "The daily problems we face are from the outside of our own unit—central supply and housekeeping, for example. It is not the people on the unit. It is not what we do or don't order for our supplies. It is a system problem (Tucker, 2003)." While it is important to look at the entire system, it is also necessary that the nursing staff own up to their own errors as well rather than pointing the blame elsewhere.

Nurse vs. Physician Collaboration and Challenges

Collaboration among different specializations of health care workers can create a break-down in communication which can ultimately lead to medical errors. The dynamic between nurses and physicians, specifically, has been the most studied in the health care field and studies reveal how this dynamic in the hospital setting has historically been problematic. Nurses are often viewed as the "non-physician caregiver" and are depicted as being inferior to the treating physicians; this dynamic can have unintended consequences when treating the patient. Tucker and Edmonson analyzed this nurse versus doctor relationship and identified that, *"….although nurses witness and experience a variety of problems and employ a number of creative solutions to resolve emergent issues, they generally do not communicate these to other members in the hierarchy"* (Nembhard, 2009).

The U.S. Department of Health and Human Services' (DHHS) Agency for Healthcare Research and Quality (AHRQ) asked the Institute of Medicine to conduct a study to identify aspects of work environment and working conditions that may have an impact on patient safety. When an individual is hospitalized, living in a nursing home or rehabilitation facility, or delivering a baby, that individual spends the most time interacting with the nurse than any other health care provider, including the treating physician (Institute of Medicine, 2003).

Although nurses play such a critical role in minimizing medical errors, the field of medicine has long been entrenched with a status hierarchy which has made it difficult to speak across professional boundaries (Nembhard, 2009). This professional hierarchy in medicine has been well studied and reveals that surgeons are ranked with the highest level of prestige followed by specialty physicians, then primary care physicians, followed by nurses, physical therapists and subsequent allied health workers (Nembhard, 2009). The status between physicians such as primary care physicians compared to specialty physicians is smaller than compared with physician versus non-physicians such as physician and a nurse. (Nembhard, 2009).

The role of nursing and physicians themselves also differ in their communication styles. Nurses are typically taught to communicate in broad terms with regard to clinical situations, and they tend to have a broader view. Physicians, on the other hand, are very concise and detail oriented. In a typical hospital setting, the nurse is usually responsible for relaying a medical situation to the physician. Because nurses often do not make the diagnosis for a patient, they may communicate a very long and detailed narrative to the physician which can ultimately lead to an error as the physician is impatiently waiting for the nurse to get to the point.

The Institute for Safe Medication Practices (ISMP) revealed in a study of 2,000 health care professionals that intimidation was a main contributor to medication error. Health care professionals reported that they have administered a medication to a patient even when they felt uncertain due to pressure and intimidation (Institute of Medicine, 2013). Furthermore, a content analysis on medical malpractice cases across the United States revealed that care teams were comprised of low status and high-status members with physicians being the high-status member and the nurses being the low status members. The analysis revealed that physicians have completely disregarded vital information that was communicated to them by a nurse. On the other hand, nurses admitted that they have refrained from sharing relevant information for diagnosis and treatment from physicians (Nembhard, 2009). This status-

consciousness and hierarchical environment is very problematic in the health care field as human life is at risk.

Psychological Safety

The health care field is known to be very hierarchical, and this type of environment is at risk for medical errors. When workplaces lack psychological safety, employees are less likely to feel comfortable speaking up about an issue even if they believe they know they are correct. In health care settings that lack psychological safety, nurses tend to feel hesitant to speak up to a physician (Castel, 2015). The nurse withholding information from the physician is an example of the impact of psychological safety. When an individual remains silent and does not feel that they can speak freely, this is not a safe environment. In this content analysis of the interaction between nurses and physicians, it is evident that a lack of psychological safety exists; this inefficient communication can lead to medical errors. In an in-depth study on system failures in hospitals, 70% of the nurses that were interviewed reported that they believe that in the event that an issue occurs during their shift, their manager would want them to work through the issue on their own. The nurses also noted that speaking up or asking for help was a sign of incompetence (Tucker, 2003).

Amy Edmonson points out that when an environment is psychologically safe, four main things occur: *learning, risk management, innovation, job satisfaction/job meaning*. If an individual is in a psychologically safe environment, that individual is more likely to ask more questions, listen, ask for help, and gain more data. Edmonson points out that personal learning is not only important for that individual, but it is crucial for the entire organization or team in which the individual is working. For example, if an individual works in an intensive care unit, psychological safety allows one to feel more comfortable speaking up about what they observe and allows one to point out a discrepancy or a process failure. This ability for a team to *speak openly with one another* is crucial in creating a safe environment for the patient. Risk management in the health care setting is essential among a care team. The care a patient receives is highly interdependent which means that the patient outcomes depend on discussions, coordination, and decision making from multiple caregivers. Psychological safety links a care team with the patient outcomes, as it is a tool that helps teams make decisions more thoughtfully and skillfully without a team member feeling afraid to speak up. *Innovation* is the third important outcome that occurs when an environment is psychologically safe; innovation allows team members to brain storm and collaborate more effectively. Innovation also allows individuals to engage in learning processes, such as rapid cycle learning processes that allow teams to determine what works and what does not work which is essential in providing quality care. The fourth important outcome is *job satisfaction*. Edmonson points out that when an individual works in an environment that is psychologically safe, they report a higher sense of worth to the company and respect by their colleagues. When people feel more confident about their job, they are more motivated to perform to the best of their abilities (Edmonson, 2018).

Personal Experience

As a clinical research coordinator for The James Cancer Hospital, I have experienced first-hand issues with psychological safety. I work with different clinics at the hospital, and it is evident that some clinics have a more welcoming environment than others. Part of my job responsibility is to assess patients on clinical trials for any toxicities they may have experienced. The patient typically sees me (the research coordinator), a nurse, a patient care assistance, a nurse practitioner, and their treating physician. As the research coordinator, I typically feel inferior to the other health care professionals that interact with the patient. Many times, the patient may not provide the same information to me, the nurse, and the treating physicians, and in cases where I do not feel comfortable approaching a physician, this can create a break down communication which can ultimately harm the patient. Creating a psychologically safe environment is not just about creating harmony among team members, but it can also drastically improve a patient's quality of care.

Case Studies/ Research Examples

Founded in 1945, Kaiser Permanente is the largest, non-profit health system in America. Known for its integrated care model, it provides care to nearly 8.3 million patients. This health care system is often analyzed due to its high level of quality care and patient safety. As part of Kaiser Permanente's model, standardization is essential. An example of the effectiveness of their standardization for medical responses is how the staff handles fetal distress. In the event that fetal distress has been identified by an individual, simple rules are to be implemented. If an individual sees a problem, they have one minute to analyze the situation by themselves, two minutes to observe the problem with another person, and by the third minute, that individual is taking action to correct the problem. The rationale behind this simple three-minute rule is to remove the uncertainty that nurses may have in regards to communicating with the doctor. Some nurses may have a moment of judgement where they are wondering if this is urgent or if the doctor is busy and if they should call the doctor or not. Rather than dwelling on these questions that may contribute to long delays, the three-minute rule provides a clearer response that can help avoid a serious medical error: fetal asphyxia. (Leonard, 2004).

Transformational versus Transactional Leadership as a tool to reduce medical errors in hospitals

Identifying how these medical errors occur in various health care setting is essential in determining what can be done to reduce these errors. Leadership style in health care settings has a significant impact on the quality of care that will be produced. Furthermore, research has shown that certain leadership styles can be effective in improving patient safety. **Transformational leadership** is viewed as the most effective management style that helps to establish a culture of safety. Transformational leadership is defined as "The process whereby a person engages with others and creates a connection that raises the level of motivation and morality in both the leader and the follower" (Northouse, 2016). With this type of leadership style, leaders work in collaboration with their followers in pursuit of common goals. This relationship of mutual stimulation helps to raise the level of aspirations of both the leader and the follower which ultimately has a transforming effect on both. The leader also must maintain the relationship with their followers by promoting two-way communication and the exchange of knowledge and ideas. When implemented properly, this leadership style creates organization change that is necessary to achieve increased patient safety (Institute of Medicine, 2003).

The transformational leadership style is viewed as more efficient than the traditional transactional leadership style with respect to increasing patient safety. A **transactional leadership** style would be more concerned with individual interests rather than a group of people with common interests working towards a common goal. Transformational leadership seeks to encourage individuals to collaborate with one another for the common goal of patient safety. One can compare both transactional and transformational leadership in the nursing role and how this can impact patient safety. For example, a nurse who enjoys the flexible hours of nursing may request to work a 24-hour shift on a weekly basis in order to have more days off throughout the week.

A transactional leader would try to accommodate this type of request for all of the nurses, despite evidence that shows extended work hours may be detrimental to patient safety (Institute of Medicine, 2003). Contrary to transactional leadership, the transformational leader would educate the nursing staff on patient safety and worker fatigue and would collaborate with the nursing staff to develop work hour policies and scheduling that would help encourage and prioritize the patients' needs (Institute of Medicine, 2003). The leader characteristics and behaviors that have shown to have a positive impact on safety culture include an empowering leadership style, delegation of important duties to junior members of a team, and enhancing employee engagement (Singer, 2013).

The Institute of Medicine has reviewed behavioral and organizational research on effective workforce environments and high-reliability organizations. They identified five management practices that have

proven to show successful achievement in keeping patients safe within the context of health care organizations (HCOs). These five management practices include: "(1) balancing the tension between production efficiency and reliability (safety), (2) creating and sustaining trust throughout the organization, (3), actively managing the process of change, (4) involving workers in decision making pertaining to work design and work flow, and (5) using knowledge management practices to establish the organization as a learning organization" (Institute of Medicine, 2003). In order for these five management practices to be carried out efficiently, each organization's board of directors, midlevel management, and senior level management must participate.

Medical errors in the health care setting cannot be completely eliminated, but further analysis on health care systems can help reduce medical errors and improve patient safety and quality of care. Due to the high complexity of health care systems and care across various specializations, the environment is at risk for medical errors. The etiology of medical errors can be multi-factorial in a health care setting and these can occur at the individual, team, agency, community, and professional level. Research has shown that leadership and management styles of health care organizations can help reduce these errors from occurring. The historical hierarchy of health care professionals has created status conflicts that reduce psychological safety. Health care environments that lack psychological safety further facilitate miscommunication across care teams. By instilling transformational leadership styles in healthcare delivery along with further reducing medical errors by flattening out the existing hierarchy and working in interdisciplinary teams (Leonard, 2004).

Leadership Inclusiveness and Psychological Safety in an Inpatient Medical Team

John Guido

“I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.” -Maya Angelou

Introduction

I am a current hospitalist physician in a large not-for-profit hospital in Columbus, Ohio. I have been practicing medicine for approximately three years. Physicians are the de facto leaders of an inpatient medical team, and rightfully so, as the overall care of the patient is their ultimate responsibility. My day to day duties require seemingly thousands of individual decisions. To do this effectively, and in the best interest of each unique patient, I need the honest input of each member of my entire medical team (consultants, nurses, therapists, social workers, etc.). We all differ in our own individual training and work/life experiences, and when combined can formulate the best treatment plan possible for the patient. This collaboration is actually more of a requirement than a luxury, as increasing amounts of medical knowledge and specialization has led to more interdependence of multidisciplinary medical team members. Partnership requires effective communication and a strong working environment.

Physicians who see patients on multiple different units across a healthcare system will be part of numerous multidisciplinary teams in contrast to the various “unit-based” nurses, therapists, care coordinators, and ancillary staff. This inherently creates a non-standardized workflow and a sense of unfamiliarity between the physician and other team members. In fact, the medical industry is unique in that the teams can be very dynamic (and this is really the norm), which is far different from most other service industries. Teams are based on each unique patient’s needs, may come together for short periods of time, consist of multiple specialists or other service providers, and must integrate numerous professional cultures (Manser, 2008).

In medicine, a perceived hierarchy exists where non-physician team members may defer their opinion/ input to the physician for fear of reprimand or embarrassment. I have seen this first hand. This weakens the team morale and care for the patient. It is the responsibility of physician leaders to create an environment where every team member feels safe in offering their opinion without hesitation. This is generally not something a young pre-medical student takes into account, no matter what their intentions

for entering the field may be. Given this, I have had to inwardly seek and adapt my own leadership style in a relatively brief amount of time.

Synopsis

The dynamic of inpatient medicine has been rapidly evolving such that physicians and other members of a comprehensive care team are more specialized than ever before. This creates an increased reliance of all members of the care team towards one another, with physicians acting as the leader. All members of the care team offer invaluable information, ideas, and expertise in caring for the patient, yet may feel apprehensive in speaking out due to fear of embarrassment or ridicule.

It is the ultimate job of the leader to create a culture of inclusion and mutual respect for all disciplines on the multidisciplinary medical team. This can be accomplished through the practice of leadership inclusiveness. This practice draws from several well-established leadership theories that serve to strengthen the relationship between the leader and followers as well as help followers become more comfortable with themselves, the team, and their situation. In turn, this creates a psychologically safe environment where all team members are able to work without fear of negative consequences. This ultimately enhances team member production, creativity, and satisfaction as well as improving communication between all members of the care team.

Changing Healthcare Dynamic and Creation of Multidisciplinary Interdependence

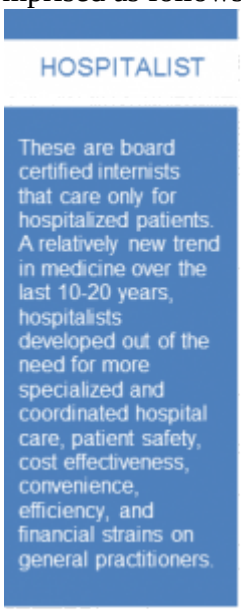
The dynamic of inpatient medicine, caring for patients in an acute care hospital, has changed dramatically over the previous decades. Gone are the days when general practitioners and family physicians would put in a full day's work in a private practice outpatient clinic and then go to the local hospital to manage the full inpatient needs of their acutely ill patrons.

Science, innovation, medical advancements, and knowledge gains have rapidly progressed since that time, leading to an inpatient healthcare dynamic that would seem foreign to those earlier general practitioners. These advancements have led to countless new treatments that are allowing people today to live longer and healthier than at any other point in history. However, *no single individual can any longer absorb all of the new knowledge and become proficient at all of the advanced techniques that are now standard in today's hospitals.*

This has led to the increased specialization of healthcare, necessitating an increased depth but with decreased breadth for healthcare professionals. This fragmentation of healthcare, while allowing the delivery of the best evidence-based medicine possible, has led to the division of critical knowledge amongst many different practitioners. This knowledge division has in turn lead to the creation of multidisciplinary teams with increased interdependence of working group members. The team as a whole depends on the expertise and input of each individual member which is then integrated to formulate an all-encompassing care plan for the patient. However, multidisciplinary collaboration is something that must be actively learned and improved upon. It is generally not inherent. The Institute of Medicine's landmark report Crossing the Quality Chasm: A New Health System for the 21 Century notes that "members of teams are typically trained in separate disciplines and educational settings, leaving them unprepared to practice in complex collaborative settings" (Institute of Medicine, 2001).

The Inpatient Healthcare Team of Today

The typical inpatient care team would likely be unrecognizable to practitioners of prior generations. There are currently many different healthcare professionals and specialties that may be involved in the care of any particular patient. Each group member has a unique knowledge and skill set that will be used in creating an overarching care plan for the patient. Plans of care can realistically change from moment to moment depending on the evolving clinical status of the patient. For this reason, teams are being increasingly valued for their potential to innovate, solve problems, and implement change (Nembhard and Edmondson, 2009). Just like plans of care, team members are also dynamic, ever changing based on the patient's needs. A typical medical inpatient care team and their general responsibilities would be comprised as follows: (Freshman et al., 2010)



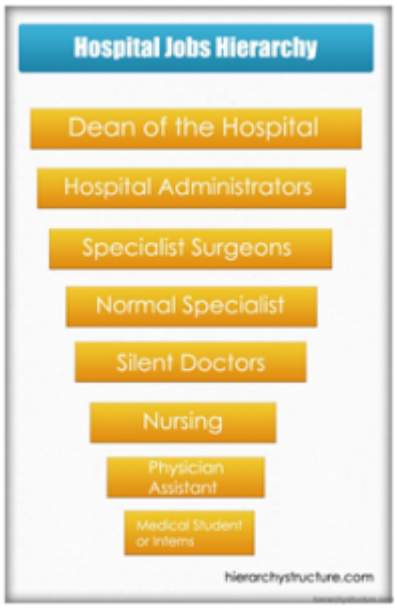
- **Hospitalist** – serves as the primary medical decision maker.
- **Consultants** – physicians with a specialized area of expertise, often within a single organ system (cardiologist, oncologist, neurosurgeon, etc.). With advancements in knowledge, medicine, and technology, the number of consulting specialties has grown rapidly. Today, there are 26 specialties and 93 subspecialties within the major specialties (Nembhard and Edmondson, 2009). Hospitalists may seek advice or services from a consultant depending on the needs of the patient.

- **Nurses** – provide the primary bedside hands-on care to patients by administering medications, managing intravenous lines, observing and monitoring patients' conditions, maintaining records, and communicating with doctors.
- **Pharmacists** – prepare medications, offers pharmacological information to the multidisciplinary health care team, monitors patient's drug therapies.
- **Therapists** – physical, occupational, and speech therapists give evaluation of, and prognostic information regarding, the functional limitations of a patient as well as individualized exercise therapy treatment programs.
- **Ancillary service providers** – any of the many numerous remaining diagnostic, therapeutic, and custodial service providers.
- **Care coordinators** – case management and social workers provide patient education, monitor treatment and insurance coverage plans to ensure that a patient's needs are entirely met, and coordinate services needed after discharge.

Physicians possess specialized medical expertise while nurses, therapists, and ancillary service providers have a greater deal of bedside patient-provider interaction. Ideally, the comprehensive medical team would integrate the various skills and professional expertise of each member to realize the maximum patient benefit. However, this is often "easier said than done." Care is becoming increasingly complex, broader in scope, and more challenging – thus, compiling an effective and efficient medical team has also become more challenging.

Generally, the production of high-quality care is not hampered by lack of clinical expertise in the individual professions but rather by lack of appropriate knowledge and experience among these groups as to how to make these multidisciplinary teams work well (Freshman et al., 2010). Improving the quality of care delivery processes necessarily requires different viewpoints, each grounded in deep knowledge of a different aspect of the process (Nembhard and Edmondson, 2009). Yet, many health professionals tend to operate in uni-professional silos that can make knowledge sharing more difficult. Diversity and the resultant unfamiliarity, if not managed well, can lead to friction, hostility, and poor performance (Mitchell et al., 2015).

Medical Professional Hierarchies



The existence of physician/physician and physician/non-physician hierarchies in and amongst medical professionals has been well established. Non-formal hierarchies in medicine are generally based on a multifaceted set of characteristics: *power, wealth, time invested in training/clinical practice, effort regarding rigor and roughness of practice, measurable skills, and increasing level of specialty* (Aguirre et al., 1992) whereby those that possess more of these characteristics are seen as superior to those who do not. Physician status is generally viewed as more prestigious than non-physician status (Schwartzbaum et al., 1973).

The existence of hierarchies in medicine is problematic in that it discourages members of the healthcare team from speaking across professional boundaries, leading to decreased communication, problem-solving, and opportunities for quality improvement. Persons of perceived lower status are more likely to underestimate their value and contributions to the medical team. Medical hierarchies have been significantly associated with undesirable patient outcomes (Feiger and Schmitt, 1979) and increased medical errors (Institute of Medicine, 2003).

The Communication Divide

Despite the need for increasing collaboration across multidisciplinary teams, effective communication can break down for a variety of reasons (Nembhard and Edmondson, 2009). More risk-averse persons may be unwilling or afraid to participate in team medical decision making. The reason for this is as more care has been directed to the outpatient setting, persons

who are admitted to the hospital today are generally more acutely ill then previously. This raises the stakes of participating on a multidisciplinary medical team, which unlike other service industries, is engaged in more fast-paced and uncertain situations (Edmondson, 2003). Patient care is highly actionable and a single mistake can have serious consequences. While leadership inclusiveness and psychological safety can be beneficial in the above situations, these leadership tools are most commonly thought of in relation to communication deficiencies related to medical hierarchies. Perceived status differences and inability/unwillingness to cross role boundaries has been shown to lead to poor communication (Atwal and Caldwell, 2005). In the same vein, people tend to act as "impression managers," meaning that they are reluctant to engage in behaviors that could threaten the image others hold of them, such that in the presence of others with more perceived power, subordinates may fear being seen as ignorant, incompetent, negative, or disruptive if they speak out (Edmondson, 2008). Overtime, if left unchecked, this creates a learned pattern of behavior that is detrimental to the overall function of the team. These theories are supported by the findings of Atwal and Caldwell, who in observing the real day to day functions of numerous multidisciplinary medical teams, found that physician leaders were highly active in participation, physical and occupational therapists as well as social workers were rarely involved, and nurses were involved to a varying degree (Atwal and Caldwell, 2005).

Leadership Inclusiveness and Leadership Theory

"The art of communication is the language of leadership." -James Humes

It is possible to negate or balance these fears as well as status and other differences by creating a **culture of inclusion and mutual respect** for all disciplines on the multidisciplinary medical team. This should be modeled by the designated leader (most typically the attending physician of record) as followers look to leader behaviors, actions, and advice for clues regarding how to act and what is expected of them. This can be accomplished through the practice of **leadership inclusiveness**, which is defined as the *"words and deeds exhibited by leaders that invite and appreciate others' contributions"* (Nembhard and Edmondson,2009). The foundation of leadership inclusiveness draws from several well-established leadership theories, most notably the **Behavioral Approach, Leader-Member Exchange Theory, and Authentic Leadership.**

The explicitly stated focus of the **Behavioral Approach** is in regard to *"what leaders do and how they act,"* including the *"actions of leaders toward followers in various contexts*" through the combination of task and relationship behaviors. Leader task behaviors help followers to achieve their goals while relationship behaviors help followers to feel comfortable with themselves, the team, and their situation (Northouse, 2018). An equal and strong concern for results and interpersonal relationships, as is the case on an inpatient medical team, leads to a "team management" style with high levels of member participation, teamwork, and commitment. Qualities of a Behavioral Approach leader that practices a team management style are: *stimulates participation, acts determined, gets issues into the open, makes priorities clear, follows through, behaves open-mindedly, and enjoys working*. These are all characteristics that physicians should strive to achieve when leading a medical team.

Leader-Member Exchange (LMX) Theory conceptualizes leadership as a *"process that focuses on the interactions between leaders and followers."* The dyadic leader-follower relationship is central to this theory (Northouse, 2018). Within every organizational work group, inpatient medical teams not excluded, each member will become part of the in-group or out-group based on their interactions with the leader and willingness to take on non-contractual responsibilities. *"Personality and other personal factors largely make this*

determination. In-group members are afforded more information, confidence, and concern from the leader which leads to a state of mutual trust, respect, and influence" (Northouse, 2018). Each member of the medical team has a unique personality, and without leader awareness and support, some may more easily find themselves in an out-group. This is detrimental to the overall function of the team and patient care, as each member is the "team expert" in their designated field, and input from each member is needed to create the best possible comprehensive care plan.

Northouse offers the construct of "leadership making" for developing high quality exchanges that help make all followers feel as if they are part of the in-group. This requires time as the leader-follower dyads move through three phases of forming a transformational partnership (Northouse, 2018). While a useful tool, the time it takes to reach this end goal would be expected to be much longer on a medical team due to the high turnover of team members.

Authentic leadership focuses on leadership that is genuine, honest, and good while building a sense of trust with the followers. Authentic leaders exhibit four core characteristics: *self-awareness* and the impact their actions have on others, an *internalized moral perspective* that resists outside negative influence, *balanced processing* that seeks and analyzes others' opinions before making a decision, and *relational transparency* in presenting their true self to others. (Northouse, 2018). Physician leaders should understand these values and the positive influence of these behaviors toward others and the common good of the group. Authentic leadership can be learned and developed overtime, making it ideal for use on an inpatient medical team given the paucity of formal leadership training in medical schools.

"If your actions inspire others to dream more, learn more, and become more, you are a leader." -John Quincy Adams

How to Develop an Inclusive Leader

Since leadership inclusiveness is integral to creating a welcoming work environment, which in turn will hopefully breed maximum efficiency and effectiveness, yet its tenets are not formally taught to most medical professionals, it is important to understand the characteristics of inclusive leaders such that these can be inwardly sought and explicitly practiced. Leadership inclusiveness has been associated with specific actions, behaviors, antecedents, and leader characteristics.

Howard, et al. identify three specific physician leadership behaviors that exemplify leadership inclusiveness: *explicitly soliciting team input, engaging in participatory decision making, and facilitating the inclusion of out-group members* (Howard et al., 2012). As previously mentioned, medical team members (particularly those of lower perceived status) have numerous reasons for not freely voicing their opinions. Explicitly soliciting input in an inviting way is an effective and safe technique to gather the thoughts of each team member.

The contributions should be acknowledged and the team member thanked. In participatory decision making, the physician remains actively engaged in the decision-making process by sharing opinions and respectively challenging team members to reflect on the consequences of their decisions which leads to clearer and more rational group thinking. The inclusion of out-group members is important in a healthcare setting to achieve maximum team collaboration and downstream patient benefits.

Given the uncertainty and complexity surrounding inpatient medical care, Edmondson postulates that actions of followers in this type of environment require the specific behaviors of active *learning, questioning, experimenting, seeking help, and feedback.* These behaviors

are accomplished through the following set of leader characteristics, which are antecedents to leadership inclusiveness (Edmondson, 2008), and can be practiced by any physician:

- **Accessibility** – freely invites questions, problems, and input. Encourages learning and is personally involved in the team.
- **Acknowledging fallibility** – followers may see the leader as infallible, yet this is certainly not true. A leader acknowledging their own vulnerabilities, mistakes, and actively soliciting feedback shows followers their input is respected and moves along the continuum of "leadership making" toward a transformational partnership.
- **Maintaining accountability** – maintaining inclusiveness does not mean that quality and accountability are sacrificed, rather expectations are clear and people are not punished for asking for help or humiliated for an error.
- **Setting goals** – setting clear and defined goals help team members develop a sense of autonomy and group cohesiveness while successful goal accomplishment enhances self-worth and job satisfaction.

"Coming together is a beginning, staying together is a process, and working together is success." -Henry Ford

The **Optimal Distinctiveness Theory** postulates that members will feel included in a group when they are afforded high levels of belongingness and uniqueness (Shore et al., 2010). According to Swanson, this is done by leaders expanding their perspectives to not only understand but also appreciate others through staying in the present, increasing comfort level with ambiguity, decreasing distortion, and choosing actions that support the desired outcomes (Swanson, 2004).

Ideally, a culture of inclusion would be built into each individual medical team and the larger healthcare system as a whole. This panacea for inclusion would be composed of an inclusive climate, leaders, and general practices (Shore et al., 2010). An inclusive climate strives for fairness and celebrates diversity while inclusive practices help members feel as if they belong yet retain their individual uniqueness.

Psychological Safety is Positively Associated with Leadership Inclusiveness

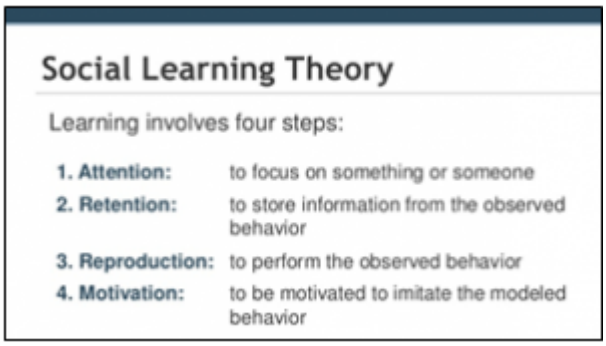
When leaders demonstrate inclusiveness through the aforementioned leadership theories and methods, those of lower perceived status (the non-physician medical team members) will feel supported and valued as a team member. In this manner, leadership inclusiveness is a precursor to, and positively associated with, psychological safety, which is defined as "*being able to show and employ one's self without fear of negative consequences of self-image, status or career*".

Psychological safety on a medical team is generally perceived on an individual level, although group level (and to a lesser extent organizational level) psychological safety has been described (Newman et al., 2017). Numerous key antecedents have been strongly associated with the attainment of psychological safety. These include proactive *personality, emotional stability, openness to experience, learning orientation, autonomy, role clarity,*

interdependence, and peer support (Frazier et al., 2016). These are all positively affected by positive leader relations developed through leadership inclusiveness.

Putting it All Together for Improvement in Performance and Outcomes

The attainment of these antecedent qualities leads to numerous positive outcomes. In this way, psychological safety acts as a mediator between leadership inclusiveness and development of a desirable work environment, employee satisfaction, and performance. Psychological safety is the mechanism by which supportive environments transmit desirable outcomes (Newman et al, 2017). Specific individual level outcomes that have been shown to be strongly associated with psychological safety include work engagement, task performance, information sharing, creativity, learning behaviors, commitment, and satisfaction (Frazier et al., 2016). On the other hand, a lack of psychological safety has been associated with emotional exhaustion, burnout, poor job satisfaction, and lack of organizational commitment/intention to find new employment (Manser, 2008).



Two main theories describe how psychological safety develops and influences work outcomes: **social learning theory** and **social exchange theory** (Newman et al., 2017). **Social learning theory** is a theory of learning and social behavior that postulates new behaviors can be acquired cognitively by observing and imitating others. Leaders who engage in active listening, forwarding support, and providing clear and consistent directions to followers are able to show followers that it is safe to take risks and engage in honest communication, which followers then start to emulate. **Social exchange theory** is based on a process of negotiated exchanges between the leader and followers such that when followers are supported by the leader, they will reciprocate with supportive behaviors themselves, creating a psychologically safe environment (Newman et al., 2017). Because they are built through learning and emulation, rather than point-in-time exchange, outcomes formed via social learning theory are felt to be stronger and longer lasting (Newman et al., 2017).

When investigating these two social theories link to leadership theory, it becomes clearer why social learning theory would be more influential and enduring. **Social learning theory** is more akin to **Transformational Leadership,** whereby leaders act as strong role models with

high standards of moral and ethical conduct who listen closely to follower needs and help actively shape and inspire them to become committed to the team. **Social exchange theory** is more transactional in nature in that processes are negotiated and may be more reactive. This does not necessarily focus on the active personal development of the followers. Social learning theory also holds more of the constructs described in change-oriented leadership, which includes analyzing information in the external environment to identify threats and opportunities for the team, encouraging innovative thinking, envisioning and proposing change with enthusiasm and conviction, and taking personal risks to promote desirable change. These factors have been shown to be transformational in developing team learning behavior and enhancing team performance (Ortega et al., 2013) – all through the tenets of leadership inclusiveness and psychological safety.

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Personal Experiences and Advice

I think that in many ways I exhibit some principles of the **Behavioral Approach, Leader-Member Exchange, and Authentic Leadership** each day when leading an inpatient medical team. I have come by these styles both through my natural personality characteristics and observing/learning from physicians with more clinical experience.

I think that establishing a culture of psychological safety is something to which certain practitioners may be more naturally inclined based on personality. If a leader takes an authoritarian, unsupportive, or defensive stance, team members are more likely to feel that speaking up in the team is unsafe. In contrast, if a leader is democratic, supportive, and welcomes questions and challenges, team members are likely to feel greater psychological safety in the team and in their interactions with each other (Nembhard and Edmondson, 2009). I strongly self-identify with the latter.

Developing a culture of psychological safety is also something that can be learned, practiced, and improved upon.

The previous sections describe how to develop an inclusive leader, and although some people may be more naturally inclined, these are skills that all physician leaders can attain. I have made concerted efforts to solicit team input, engage in participatory decision making, and facilitate inclusion of “out-group” members and do so in a manner that is welcoming and professional. These methods help people believe that their voices are genuinely valued. Without a recognizable invitation, impressions derived from the historic lack of invitation will prevail (Nembhard and Edmondson, 2009). Furthermore, I have learned that to create a truly transformational medical team culture, appreciation of everyone’s role and ideas is equally important. Without appreciation (i.e., a positive, constructive response), the initial positive impact of being invited to provide input will be insufficient to overcome the subsequent hurdle presented by status boundaries (Nembhard and Edmondson, 2009).

The innumerable interworking dynamics of an inpatient medical team are complex and ever changing. However, these principles of leadership inclusiveness and psychological safety are unwavering. When implemented thoughtfully and correctly they provide a sense of constancy

and help the team achieve universal cohesiveness and goals that may have previously been thought impossible.

Feedback and Leadership - Leadership in Public Health

Paige Erdeljac and Chris Westrick

"Feedback: The supply of an input to some process or system as a function of its output" (feedback). First documented in the latter half of the 1910s, the noun, feedback, was derived from the verbal phrase feed back. Providing feedback in the form of performance reviews began in the 1950s when the U.S. Government passed the Performance Rating Act, incentivizing government employees with pay increases and recognition for a job well done (Whitlock).

This chapter will take an in-depth look at feedback within the context of leadership. It will review feedback from a leadership quality perspective and discuss various available tools (360-degree feedback and performance appraisals) to assist with the provision of feedback. This chapter will also provide a detailed look at a few types of feedback as well as discuss the equally important response to aforementioned feedback. Methods for communicating feedback will be highlighted, as it is potentially as important as the feedback itself. We end the chapter with our response to the Five Guiding Questions for each of us.

Introduction

While there is no single "best" option for feedback, this chapter will help the reader understand the importance of and complexity to the provision of feedback, including some tools that may be used to improve its effectiveness. A question and answer session through the lens of the Five Guiding Questions with the authors will conclude the chapter on the quest to improving leadership and personal reflection on why they are so passionate about this topic. Let the journey begin!

Feedback in Leadership

Akin to an immunization or handwashing, feedback delivery and/or reception has long lasting positive impacts. While immunizations may sting temporarily, the long-term effects keep us healthy and strengthen our immune systems, and in some cases, have eradicated disease. Hand washing, while not unpleasant, can feel tedious, but is an extra step in preventing spread of germs. Likewise, feedback may not always be a "feel-good" experience and if done often (as it should be!), can start to feel unexciting (Riegel, 2017). However, multiple studies show that feedback, when delivered properly and at appropriate intervals, can ultimately reap multiple benefits that can include less burnout, less depression, improved immunity, increased job satisfaction, and greater mental and physical longevity (Nowack, 2014). As painful as it may be at the time, even negative feedback can incur positive benefits such as self-awareness and insight on what to work on next (Garnett, 2017).

There is such a thing as a healthy feedback culture where leaders and team members are open to and provide continuous feedback to one another in a way that promotes engagement and maximizes performance. Organizational psychologist, Adam Grant, an expert on originality writes "feedback is where we get other people to hold up a mirror and say, 'These are the ones that are promising. These are the ones that are dead on arrival…'" with respect to idea proposal. The same rings true in the world of healthcare leadership regarding tasks and performance (Grant, 2017).

Feedback from and for leaders is integral in leadership growth and building a strong, productive team. When and how to provide feedback is the gray area that often leaves leaders scratching their heads or attempting to avoid the process altogether. Thankfully, leadership feedback is an area with a good amount of prior studies, thus providing tools to assist leaders in this critically important facet of leadership.

Why focus on feedback and leadership?

"Feedback is the Breakfast of Champions" is how one leadership expert puts it (Blanchard, 1982). Feedback on results is one of the biggest motivators for individuals; it keeps people going. (Blanchard, 1982). Talk about some powerful words! Motivators and drivers of motivation are key to performance. While some individuals will put their best foot forward because it is the right thing to do, many are seeking something in return. It may be a positive performance evaluation while looking for a raise or a simple 'thank you'.

Regarding the latter, it is important to realize that individuals work hard for 'some reason' and one reason may be the gratitude they receive from a job well done. According to a Gallup study looking at companies with the highest levels of engagement, recognition and praise are often used to increase commitment (Schwantes, 2016). This is also noted in healthcare organizations. In the journal article "Constructive Performance Appraisal Feedback for Healthcare Employees," author Kent V Rondeau reports that "both healthcare leaders and their employees dislike performance evaluations." Citing that these evaluations often are not considered as providing accurate or appropriate appraisal of one's work and result in what can be deemed a "power struggle" rather than producing a conversation that results in improved outcomes (Rondeau, 1992).

Just like how many individuals overlook its importance and skip a healthy breakfast, many leaders overlook the importance of providing feedback and miss out on the positive impacts it may produce. A 2009 Gallup study of over 1,000 companies based in the United States demonstrated that 98% of companies failed to engage its employees secondary to providing little to no feedback. Lastly, feedback can have a major impact on work productivity other than just motivation. According to Dr. Kenneth Nowack, several physical and mental benefits can be seen such as:

1. Decreased depression
2. Decreased burnout
3. Greater longevity
4. Enhanced immunity
5. Less physical illness
6. Greater longevity

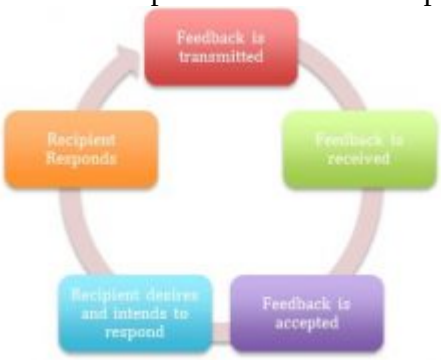
These benefits are seen secondary to the fact that "feedback" demonstrates that individuals are paying attention and noticing the effort put forth. Feedback demonstrates caring for another individual and appreciating their contributions. Ultimately, feedback (when given appropriately) results in individuals feeling more engaged, appreciated, fulfilled, and healthier overall (Riegel, 2016). Furthermore, a feedback-rich culture is a hallmark sign of a high performing organization (Wimer, 1998).

Opposite the positive effects of well-given feedback, poorly given feedback can have equally negative effects on one's mental and physical health. It [negative feedback] can feel like social rejection and result in real pain. This was demonstrated by a study conducted by C. Nathan DeWall from the University of Kentucky. It is important for feedback, especially feedback that can be perceived as 'negative,' to be task-focused or task-related behavior. This minimizes the potential for it be perceived like an attack. When task-focused feedback is provided, even if negative or demonstrating an opportunity for improvement, the result can still be a positive outcome and be beneficial to leaders, teams, and organizations. It is vital to create a healthy feedback culture; this benefits everyone. It is also important to note that the creation of this healthy feedback culture is the role of ALL team members, it does not rest solely on the leader's shoulders (Riegel, 2016).

Types of Feedback and Response

Simply put, feedback can be viewed through two separate lenses: praise and criticism. Both are extremely important and necessary for improvement and growth. Without praise, individuals can fail to receive the required appreciation and motivation to continue moving forward. Similarly, without

criticism, growth and improvement would cease to be seen. One model, first noted in 1979, demonstrates that feedback is a process of several steps:



It is important to note that the feedback must be accepted and the recipient must respond if the feedback is to be utilized and be considered effective. An important factor that will determine if the feedback is accepted is the source of the feedback and how well that source is trusted. It can be derived that as trust of a source decreases, the effectiveness of the feedback process decreases. It is also possible for a recipient to accept feedback, but for not change to be seen in performance. The desire to act is related to the perceived importance of the feedback and the anticipated results from a change due to a response (Earley, 1986).

Praise versus Criticism

The balance of positive and negative comments can be essential to producing an effective response from providing feedback. Too much focus on only the positive and sometimes the negative can be overlooked or perceived as unnecessary. Too much focus on only the negative, and the individual may feel undervalued or underappreciated which may result in further lack of productivity desire for improvement.

An article written by Zenger and Folman in the Harvard Business Review discussed previous research as well as their own on the “ideal ratio” of positive to negative feedback. While some questions have arisen about the validity of the previous data they mention in their article, the overall premise is that more positive feedback is the better course of action. In general, positive feedback is what motivates others to continue doing what they do well, potentially even better and with an increased passion, vigor, and desire. Even with the best of intentions, criticism can result in a lack of self-confidence and decrease self-initiative. Zenger and Folman state that the ideal time and place for negative feedback is when someone is “heading over the cliff” or when someone needs to “start doing something they are not doing right away.” Negative feedback can result in some change but does not spark initiative or motivate others to put in their best effort (Zenger, 2013).

Executive Feedback

A unique category to consider when discussing feedback is the top executives of a company. While it is often easy to provide praise to the boss (although sometimes this can be viewed as a negative, i.e. to fawn or brown-nose), it can be quite difficult to feel comfortable providing criticism to the individual who is responsible for your employment. Typically, a top executive will achieve their current position through years of highly successful performance. These individuals may not see the benefit or need to change and, in fact, may feel that change will dampen their success. However, in the event that change is necessary and inevitable to continue with success, there needs to be a way to provide feedback in an effective manner. Depending on the type of feedback needed, current barriers in the way of providing necessary feedback, and the available resources (time and money), there are a number of strategies to use to provide executive level feedback. Strategies for top executives may include:

1. Psychological testing

• Useful if feedback about cognitive capacity is desired
• Provides the ability to compare against similar individuals through benchmarking
• Highly objective, but can be viewed as threatening to the individual receiving it
• Legitimate concerns may include job-relatedness and or usefulness of feedback
• Some limitations can be compensated for through experience, leadership skills, industry knowledge, and high achievement drive which may not be present in this type of testing
2. Individual competence
• Conducted by an external consultant
• Utilizes a comprehensive, in-depth interview focusing on behavior traits
– Uses open-ended questions to assess for strengths and developmental opportunities
– Soley job-focused and stems from assumption that the best predictor of future performance is based upon past performance
3. Multisource assessment feedback
• Also known as 360-degree feedback or multi-rater feedback
• Involves feedback from boss, peers, customers (internal/external), and self-assessment
– Feedback is compiled and categorized based on source
• Can be administratively time-consuming, but results can be equally powerful
• One concern is that the feedback can be considered "subjective" or a "popularity contest", however, this can be mitigated through the design of the survey questions
• While the opinion of a single individual can be easily dismissed, it is more difficult to dismiss a similar opinion of several peers

Regardless of the method chosen, the effectiveness will come down to appropriately identifying the necessary (and accurate) information to promote a superior performance and improve the feedback culture of the organization. Accuracy also depends on an evaluation of several potential environmental factors, organizational factors, and the executive's role within an organization (Guinn, 1996). This data will likely result from one or more of the tools available to create and deliver feedback. A variety of tools are available to implement feedback, we discuss the 360-Degree tool next.

360-Degree Feedback Tool

What is it?

360-degree feedback is known by multiple names including multi-source feedback (MSF) or multi-rater feedback (MRF). Essentially, these terms are referring to a type of performance rating system gathered from the individual's relevant network of coworkers. As one would expect, coworkers includes not only supervisors but also their peers, other team members, their subordinates, and sometimes even external stakeholders (Day 2000). Hence, the term 360-degree feedback. Feedback is anonymous. Ideally, this comprehensive method provides thorough assessment of the individual from multiple perspectives. Another advantage of this tool is the increase in self-awareness. Many studies have been completed on the usefulness of 360-degree feedback. There are also some studies that discuss where 360-degree feedback may not be useful and some challenges that pose a barrier to its use.

What research supports its use?

Beverly Alimo-Metcalf described the usefulness of the 360-degree feedback tool in leadership development in the late 90s (Alimo-Metcalf, 1998). At the time, the tool had only been available for use for a few years and the data available was limited yet promising. Alimo-Metcalf posed the question: Is the 360-degree feedback tool helpful for leadership development? She specifically looked into the role of the tool with respect to transformational leadership. Select conclusions, below, were based on the available research at the time and ultimately establish that managers lack self-awareness and are not in tune with their own strengths and opportunities for improvement.

Examples include:

1. Managers' self-ratings are less highly related to the ratings of others make of them than peers', bosses', and staffs' ratings are with one another.
2. Managers' self-ratings are less accurate than others' ratings when compared to 'objective criterion measures'.
3. Staff are more satisfied with their manager and their job when their manager matched the managers' self-perceptions. More 'successful' managers (as rated by their staff and boss) are less likely to inflate self-ratings of leadership.
4. Managers who have 'inflated' self-ratings: (i) overestimate their influence and (ii) are likely to misjudge and misdiagnose their own need for improvement.

How is it best used?

Leslie Atwater published "Multisource feedback: Lessons learned and implications for practice" in 2007 which included a review of the literature studying 360-degree feedback use and considerations for use up to that time. Importantly, Atwater noted that the context and culture in which 360-degree feedback is implemented is crucial. Other factors to consider before use of the tool include perception of the process, the actual process, and individual differences such as personality and goals. Factors to keep in mind regarding feedback are the characteristics of the feedback (positive, negative etc.), organizational support to implement the feedback provided and, again, individual attitudes and behaviors regarding the feedback. Atwater and colleagues conducted a three-year study to investigate the reactions from feedback provided through the 360-degree feedback tool and how it influences behavior change (if at all) in two separate organizations. A notable finding from their work included feedback format. The authors found that feedback should be provided numerically with or without text commentary for better reception, as it is perceived more clearly. The authors hypothesized this is from an inundation of numerical values placed on other aspects of wellbeing such as blood pressure, IQ etc. With respect to how feedback is delivered, they concluded that "…reactions to negative feedback were not transitory mood states with minimal implications for leadership development, but rather influenced subsequent behavior. These findings reinforce the need for organizations to consider how they facilitate feedback distribution and how they encourage developmental activities following feedback." (Atwater, 2007).

Wimer and Nowack (1998) provide seven tips/guidelines on how to maximize the features of the 360-degree feedback tool. These include:

1. Have a clear purpose: Ensure people know why they are filling out surveys and what they are expected to do with their results.
2. Start at the top: It is critical that leaders enthusiastically participate in 360-degree feedback to promote a positive example for their followers and peers.
3. Have an open mind and be willing to change: Choose to be receptive to others' perceptions and critiques as an opportunity to learn about self.
4. Conduct a pilot test: Consider a "test run" to weed out any bugs or other logistical issues. This will make for a smoother transition and may be perceived as less radical if all the kinks are worked out beforehand.
5. Communicate: Make sure that all involved individuals know who they are completing the survey for and what is going to be done with the data.
6. Safeguard confidentiality at all times: Protect the data and the rater's identity. If confidentiality is breached (or perceived to be breached), the information gained is useless.
7. Evaluate and fine tune the system: As with any successful process, continuous quality improvement is a vital step. Feedback on the feedback tool is important in creating a feedback-rich culture.

Ultimately, utilizing the 360-degree feedback tool exhibits that everyone's feedback is important, shows that feedback is taken seriously and displays that the organization is taking steps to invest in their leaders' and employees' development.

Limitations of 360-degree feedback

While this tool may seem like the end-all be-all to performance evaluations and delivering feedback among leaders and employees alike, there are some limitations and elements to consider. As with any process, if an error is made along the way, it can have immediate and downstream effects. One such error includes lack of training. As the author of *360-degree feedback: Royal Fail or Holy Grail?* eloquently stated, "Unfortunately, data, even good data, do not speak for themselves." If the employees and leaders are not educated on how to interpret and use the feedback generated, the data is useless to them (Edwards 1996). Like most data generating tools, it is how the data is applied that makes the tool valuable. Edwards lists additional limitations of the 360-degree feedback tool including:

1. Culture shock. If implemented in a culture that is not open to or used to feedback, use of the tool may not be beneficial without first a proper introduction and education.
2. Non-timely feedback. Once the feedback is obtained, the turn around time to deliver it to the individual should be short so that the information can be useful to them.
3. Gamers. Some individuals will try to "game" the process to help or hurt others which can dilute the data and ultimately destroy any confidence in the results, ruining the use of the tool for others.

While barriers to implementing the 360-degree feedback tool do exist, organizations can take steps to overcome or lessen these barriers. Some solutions may include but are not limited to: ask for participation from everyone in rolling out the tool, get feedback on the feedback tool to ensure accuracy (does it "look right" or "seem fair"), train all users/ raters, ensure anonymity, automate the process by using electronic surveys in favor of paper, and implement safeguards to eliminate bias. The 360-degree feedback tool can be a great resource as long as it is used appropriately and expectations are managed accordingly.

Performance Appraisal

What is it?

Performance appraisal is another term used to describe the feedback provided to employees about their job performance and influences promotion, pay increases, and candidacy for termination or increase in responsibility (Lam 2002). It is important to note the distinctions between performance appraisal and 360-feedback are that the appraisal is typically from one source (supervisor) and is not anonymous. Lam notes that feedback, when provided in a timely fashion and comprehended, can be beneficial to the ratee and the organization. Typically, research has shown that favorable performance feedback is assumed to develop more favorable work attitudes that persist for the ratee. What about the impacts of negative performance appraisal? Lam and colleagues, have described such effects in their work and detail the long-term effects on employees and their work affect.

What research supports it?

Performance appraisal has been an integral part of measuring employee day to day workings for decades. Research on performance appraisal has been conducted since the early 1980s (Levy 2004). Data has been collected on performance appraisal from several perspectives, including social and organizational contexts. More specific areas of research include performance appraisal paired with personality types, performance, and work attitudes just to name a few. These areas of research extend beyond the scope of this chapter.

How is it best used?

Similar to 360-degree feedback, performance appraisal implementation will vary based on the organization utilizing this tool. Performance appraisals are typically delivered at a minimum of once a year. Organizations with a healthy feedback culture may perform them more often. (Levy, 2004). Some argue that the performance appraisal is outdated and does little to acknowledge true performance and motivate behavioral change in those who warrant it (Murphy 2016). How and how often feedback

via performance appraisals is delivered can make all the difference. See below for more on feedback delivery.

What are the limitations of performance appraisals?

Some experts describe the performance appraisal as an archaic tool that was useful for evaluating "replaceable cogs in the business wheel" (Murphy, 2016). Murphy went on to describe the role of performance appraisals as useful when "labor was viewed as a nuisance needed to achieve business outcomes. The original performance appraisal was a management tool intended to control workers 'too stupid to understand what they were doing.'" While this view is quite extreme, this opinion is widely shared by many leaders and employees alike.

One argument against performance appraisal is that it brushes over and hinders the growth of intrinsic characteristics vital to success such as purpose, autonomy, and mastery (Murphy, 2016). In order to inspire passion, these skills must be nurtured. Studies have revealed that up to 66% of employees indicated that not only are performance reviews unhelpful and irrelevant, but that they hinder their productivity (Meinert, 2015). The performance appraisal may be an outdated tool, but some may argue that any feedback is better than none, and it is a good starting point to cultivate a healthy feedback culture.

Feedback and Communication

Delivery of Feedback

The delivery of feedback can be nearly as important as the feedback itself. The ultimate goal is to provide feedback in a meaningful way that reinforces positives, while also identifying areas of improvement and potentially a plan to address these areas. It is not uncommon for an employee to enter an appraisal interview with an above average thought on their performance, which in turn, can result in the individual having a defensive reaction if their personal viewpoint differs from that of the individual performing the appraisal interview. Several factors that may affect the recipients "viewpoint" of the feedback include:

1. Appraiser's knowledge of the appraisee's performance
2. Appraiser's general status level
3. Ability of the appraiser to communicate the feedback
4. Ability of the appraiser to control rewards and sanctions based upon the feedback
5. How well the appraisee trusts the motivations of the appraiser (Rondeau, 1992).

In what is now considered a classic, The Appraisal Interview by Norman Maier published in 1958 identified three key strategies for providing appraisal feedback:

1. **"Tell and Sell."** This consists of providing feedback to an employee while attempting to convince the individual that the feedback is both accurate and fair. This approach is more appropriate and satisfying for individuals who are considered under-performers, new to their role, or young and inexperienced. This was one of the most common practices at the time of publication, but not necessarily so today.
2. **"Tell and Listen."** The key difference with this method is that it encourages feedback from employees, which in turn, helps reduce employee defensiveness to areas of potential improvement and provides the satisfaction of one's thoughts and concerns being heard and taken into consideration. While considered not as common at the time of publication, this has grown significantly more popular over the decades since.
3. **"Problem Solving."** This method is designed to promote employee growth and development through active listening and mutual discussion of ideas, interests, and goals for the future. The process also meets employees needs for recognition and self-worth while also meeting needs of employer providing feedback. This method has also grown in popularity over the decades since publication (Maier, 1958).

The "sandwich technique," which is declining in popularity, was very popular for several decades. The basis of this technique is to begin with a positive attribute, follow with an area of improvement, and

then conclude with another positive. This method was thought to reduce likelihood of defensiveness and to ensure focus on the positives while also pointing out an area of improvement.

Whatever method is chosen, it is important for the intended purpose of the performance review to be clear. It can be beneficial to allow the employee to speak to their own past performance then point out positives followed by areas of opportunity for improvement. Most importantly, specific goals with a follow-up plan should be set prior to the conclusion.

Specifically, for healthcare institutions, this feedback process can be challenging. This is in large part due to the vast number of varying specialties and disciplines that are being evaluated. In this setting, it may be beneficial to have varying types of processes for varying individuals based upon several factors, including job scope, quality of performance, employee's motivation, ability of employee to accept constructive criticism, employee's experience and tenure, and lastly the appraiser's ability to communicate feedback. The 360-degree feedback tool can be customized for healthcare administrators to include the domains most important to them (Garman, 2004). Performance appraisals in health care may also be tailored to fit the needs of the organization and leadership (Chandra, 2004). Regardless of how feedback is delivered, it should be organization-specific and meaningful.

Several points have also been made on communication style. These include, say what you mean and mean what you say, utilize active listening, limit criticism, ensure feedback is clear and unambiguous (Rondeau, 1992). Another expert, Kenneth Nowack, explains how communication is key to "taking the sting out of feedback." In his article, he talks about how, even though feedback is often required, it can have several side effects, including mental, physical, physiological, and emotional. While the research on this topic has not provided a clear-cut, best-choice method, he recommends choosing options that provide a clear message, involve both highlighting positives while also identifying opportunities for improvement and involving input from both parties. (Nowack, 2014).

Summary

Lastly, some experts will argue relevance of performance evaluations in today's society. Research suggest that ~95% of employees are not satisfied with how they are evaluated at work and ~90% do not feel the evaluation provides an accurate appraisal. Arguments are made in how today's "employees" are much more highly trained than back in the 1900s "when employees were treated as replaceable cogs in the business wheel." Today, employees expect autonomy, purpose, and mastery to be an expectation of their workplace environment. With this type of expectation, many annual appraisals can feel tedious and meaningless. When individuals are as highly skilled and trained as many professionals are today, there are other methods which may be more effective for promoting growth in the workplace. Some of these considerations are weekly or quarterly conversations with employees about progress, having more formal performance conversation quarterly for more constant feedback, connecting employees with a "shared purpose" to highlight the importance of their work, and keeping tabs on the overall morale of employees and levels of engagement (Murphy, 2016).

Stories from the battlefield – Q&A with the authors on the Five Guiding Questions on the quest for improving leadership and giving/receiving feedback

1. **How do you define leadership? Why is it important?**

HPE: I define leadership as a quality or characteristic exhibited by someone in a position to guide others to perform to the best of their ability while providing the tools and motivation necessary for success.

Someone exhibiting leadership is proactive in their efforts to improve their environment. Leadership is not going with the flow, but instead having the vision for what the flow should be and employing others to create and maintain it, as well as propel it forward to be completely optimized. It also means recognizing when the flow should be readjusted and calculating how to do so then collaborating with others to figure out how to go about it. To me, a successful leader inspires others to perform to their fullest potential ability. This is important in many fields but personally, I look for leadership opportunities in my area of healthcare. Leadership is essential for providing direction and demanding accountability. Without leadership, systems would likely not function efficiently and processes would be disorganized.

CDW: I define leadership as the ability to influence others to work together towards a common goal. A "true" leader may or may not be in a position of power, but rather, their passion and charisma are more important than their actual "title" or "role." Leadership is important to make progress and to allow change to occur to accomplish the greater good. Some lead from the front, some the back, and some the middle. Ultimately, leaders know how to motivate and encourage others to become leaders and to put their best effort into all they do.

2. **How do you lead? What is your leadership style?**

HPE: I would consider myself to be a leader in my personal life in areas of fitness activities. In my powerlifting gym, I am often the one who gathers the workout from the trainer and relays it to my group. I keep my group organized by suggesting the lifting order and selecting the weight used. This is done in a team based way. Throughout the workout I help identify areas of improvement and provide positive feedback on things done well.

I would identify my leadership style as transformational because I use encouragement and am the person others can look to for the instructions or feedback on their performance. I use a mix between coaching and supportive because I want the workout to progress but not at the expense of people feeling bad about themselves or unsupported.

CDW: I prefer to follow the old adage of "lead by example." I love to teach and demonstrate to help others grow. My style of leadership is one of high expectations, just as I would expect my "followers" to have high expectations of me. I do not shy away from confrontation, but when necessary, it is done with the utmost respect, and the response I typically receive is of similar respect. I have greatly improved my ability to delegate over the years, but I am also not opposed to stepping in when necessary. At the end of the day, I take full responsibility for the situations I control, and while I will "allow" others to learn from their own mistakes, I will not allow something to fail if I perceive it to be too great of a step in the wrong direction.

3. **How do you co-lead and work with other people?**

HPE: Where I work, I am one of three other pharmacists, and I co-lead with them by maintaining consistency with our process of treating our patients and keeping the lines of communication open amongst the three of us. I like to be supportive of my co-workers and would identify more as a follower. I jump in to help whenever I see the opportunity to, and oftentimes, I try to help before something needs done to help decrease the workload of my coworkers.

CDW: I work very well with others and do not mind sharing the leadership role as long as my counterpart(s) and I have a common ground. We do not need to agree on everything, as a difference of opinion can often lead to growth. However, a degree of common ground is required to ensure the shared leadership role is fruitful and leads to productivity and desired results. Depending on the scenario and my passion for the specific task at hand, I may tend to be more of a hands-on type of co-leader while other times I take a step back and provide support as a co-leader.

4. **How do you follow? How do you manage your boss?**

HPE: I follow with high competence and high commitment most of the time. There are instances when

I do not feel like I have the ability to complete a task, but I remain highly committed to figuring it out or asking for help. My boss has a supporting/transformational leadership style, so it feels like we are more teammates than subordinate/boss.

CDW: As mentioned above, I have high expectations of my "leader." As long as I can understand the position of the leader and buy-in to the goal, I provide unwavering support to help accomplish the desired goal. However, if I potentially disagree with the direction we are headed, I do not hesitate to speak my mind and help influence and change the direction we are headed.

5. **How will you improve your leadership?**

HPE: I can improve my ability to lead and enhance my leadership qualities by understanding how leaders and leadership have evolved over the past years. Additionally, I can improve by recognizing that there is no perfect definition of a leader and acknowledge that there is a balance between art and science in what generates a great leader. I will be open to constructive criticism on how to improve and be deliberate in making strides toward incorporating the skills and examples of other successful leaders. I will improve my leadership by setting goals of how to be a better leader than I was the day before because there is no end point when a leader has "made it" or learned all that can be learned.

CDW: I have years of experience with varying leadership roles and have taken several courses and certificate programs which focus on leadership. Every day I continue to grow through knowledge gains and new experiences. I have used this course to continue my growth and understanding of leadership and continue to mold my leadership style to one that remains effective and useful with the current culture. I strive for constructive criticism (realizing its importance) and seek it out to continue to improvement in all aspects of my life, whether professional or personal.

6. ****BONUS QUESTION** Why is feedback and leadership important to you personally? What personal experiences prompted you to do more research on feedback and leadership?**

HPE: My pharmacy education, subsequent experiential rotations, and two years of residency provided numerous opportunities for feedback from preceptors and for self-assessment. It can be difficult to rate yourself on a scale of one to five when you are just learning how the real world works. The feedback I received during residency spanned from helpful to deleterious, depending on who and how the feedback was delivered. I often felt completely incompetent following a feedback session and questioned my ability to be a good pharmacist. Knowing that one day I would be responsible for evaluating a student or resident on their work, I was motivated to learn how to provide feedback constructively while preserving the ratee's psychological well being. After conducting research on how to best deliver feedback and understanding some of the tools available to assist leaders in feedback delivery, I feel better equipped to rate others and be rated in return. It helps that I found some articles along the way that help raters not feel so incompetent after feedback was not provided in the most effective of ways.

CDW: Similar to my co-author, I received A LOT of feedback during my pharmacy education, experiential rotations and two years of residency. Some of this feedback shaped me to become the pharmacist I am today. Some of it, however, was extremely toxic! Thankfully, being optimistic and having a strong support system helped me to overcome the toxic feedback and focus on the feedback that was truly helpful. These experiences helped me learn what works well for me and ways of providing feedback I should never employ as an evaluator myself. I have learned that self-evaluation is key as a working professional as a means of growth and development. I have also learned that many individuals provided false feedback,as they are "afraid" to provide truthful responses. When I truly need honest feedback on something, whether it be a professional presentation or when considering a job change, I look toward individuals who will give the straight truth without sugar-coating anything, and I appreciate their honesty. I have also been the evaluator of 100+ pharmacy students in my career and have approached every one of them with the approach I have found helpful over the years. I also request their honest feedback in return. The outcome? I approach my professional students with a high level of

expectation while also demonstrating that I truly care about them and their career. Whether positive or negative, I am always 100% straightforward with them. Sometimes this is easy, other times not so easy. However, I have learned that when you are deeply honest with others (positive or negative) while also maintaining a high level of respect, the outcome is impressive. I have had many students reach out in the future to thank me for how "hard" I was on them once upon a time and thank me for truly caring. My methods have been reinforced with the constant return of positive responses to my approach. I take great joy in helping to shape these individuals lives and hope they will continue to do the same for others in the future. That being said, I am constantly looking for opportunities for further growth and development. I take great joy in helping shape lives, but I also know how important of a role I have and do not take it lightly. I likely spend "too much" time providing evaluations, but I do not regret the outcomes it produces. Just like the thanks I receive, I have individuals in my life to thank for being brutally honest and helping me to become the person I am today.

Summary

By now, it is evident that quality and frequent feedback is part of the foundational matrix critical to becoming an effective leader in the healthcare world. There are multiple ways to go about gathering, delivering, and scheduling feedback to and from others. In a perfect world, feedback would be gathered from both leaders and employees on a continual basis. The delivery of feedback would be presented in a way that makes sense, depending on the context of the organization and the relationship between the rater and the ratee. Based on the culmination of the information presented in this chapter, feedback in leadership is an area that is dynamic with more to be learned to optimize this activity that is frequently dreaded by all parties involved. It is also important to realize how the "right way" to provide feedback continues to change as society changes. Hopefully this chapter gives some insight on where feedback started and the strides that have been made to improve it, as well as dispenses pearls of wisdom to incorporate into daily life. While criticism is sometimes necessary, do NOT forget to provide the absolutely necessary positive feedback that motivates others to keep going and to do more; to be more creative, more passionate, more dedicated to the overarching goal. Positive reinforcement and demonstration of appreciation are the keys to a motivated future (at least for now).

Special Thank You

A chapter on feedback would not be complete without a special thank you to those who have individually touched each of our lives and contributed to our success today with the feedback they have provided over the years:

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Lastly, the two of us have each other to thank for continued support over the years; from pharmacy school, to residency, to our current occupations, graduate school, and personal lives…we are always there for one another and continue to provide the much-needed support and feedback for one another. This chapter would not be possible without the trust, respect, and openness we have for each other.

Leadership Guide to Conflict and Conflict Management

Fadi Smiley

"A part of effective leadership is caring for and supporting one another, even when there is conflict or a difference of opinion." -Ty Howard

Introduction

Conflict may occur between people or within groups in all kinds of situations. Due to the wide range of differences among people, the lack of conflict may signal the absence of effective interaction. Conflict should not be considered good or bad, rather it may be viewed as a necessity to help build meaningful relationships between people and groups. The means and how the conflict is handled will determine whether it is productive or devastating. Conflict has a potential to create positive opportunities and advancement towards a common goal, however, conflict can also devastate relationships and lead to negative outcomes ((Kazimoto, 2013; Fisher, 2000; Evans, 2013).

Today's healthcare leaders are taught to lead change, development, and transformation in organizations. Leadership may be described as the ability to emphasize the pursuit of goals and motivate others to pursue them as well. Northouse states that leadership is a process whereby an individual influences a group of individuals to achieve a common goal (Northouse, 2016). Others characterize **leadership** as the ability to *inspire trust, build relationships, encourage followers*.

An under-reported aspect that is not commonly discussed among leadership qualities is the ability to handle conflict (Guttman, 2004). Guttman explains that there might be two reasons as to why there is little recognition of conflict management in leaders. One is called rationalistic fallacy, and Guttman explains that most of the literature available focuses on arming leaders with all necessary leadership concepts and success will just follow, almost as if it is assumed that leaders will automatically know how to manage conflict. Secondly, Guttman explains that leaders may have a fatalistic attitude towards conflict. Leaders may look at conflict as situation that will never be resolved, so why bother addressing it? We should focus on what can be addressed and changed (Guttman, 2004).

Conflict management is a skill that leaders must be able to employ when needed to help foster a productive working environment (Guttman, 2004). There is a realization that conflict management should be a skill that leaders need to give priority to learning and mastering (Kazimoto, 2013). The inability of a leader to deal with conflict will not only lead to negative outcomes but may also undermine the credibility of the leader (Kazimoto, 2013). Whereas if a leader is able to establish an atmosphere of cooperation and foster teamwork, making it clear that this is his/her value system, there is a likelihood that this value system will be adopted by the entire organization (Guttman, 2004). Therefore, it is very important that we discuss and address conflict management as a leadership skill.

This chapter will discuss the definition of conflict and its sources, describe conflict management and resolution, and discuss a guide for leaders to use to help them effectively manage and resolve conflict. We discuss the different types of conflict that can exist and describe the different conflict management modes that can be used to address them. Lastly, we will analyze the relationship between leadership and conflict management through a literature review. By reading this chapter, I hope that readers will understand conflict, the role it plays within teams and organizations, and the importance of developing conflict management skills for leaders.

Defining Conflict

What is conflict? The answer to this question varies, depending on the source. The Webster Dictionary

defines conflict as *"the competitive or opposing action of incompatibles: an antagonistic state or action."* For some, the definition of conflict may involve war, military fight, or political dispute. For others, conflict involves a disagreement that arises when two or more people or parties pursue a common goal. Conflict means different things to different people, making it very difficult to come up with a universal or true definition. To complicate this even further, when one party may feel that they are in a conflict situation, the other party may think that they are just in a simple discussion about differing opinions (Fisher, 2000; Evans, 2013; Conflict, 2011).

To fully understand conflict and how to manage it, we first need to establish a definition that will allow us to effectively discuss conflict management and its use by today's leaders. Conflict can be described as a disagreement among two entities that may be portrayed by antagonism or hostility. This is usually fueled by the opposition of one party to another to reach an objective that is different from the other, even though both parties are working towards a common goal (Fisher, 2000; Evans, 2013). To help us better understand what conflict is, we need to analyze its possible sources. According to American psychologist Daniel Katz, conflict may arise from 3 different sources: economic, value, and power. (Evans, 2013)

- **Economic Conflict** involves competing motives to attain scarce resources. This type of conflict typically occurs when behavior and emotions of each party are aimed at increasing their own gain. Each party involved may come into conflict as a result of them trying to attain the most of these resources. An example of this is when union and management conflict on how to divide and distribute company funds (Fisher, 2000; Evans, 2013).
- **Value Conflict** involves incompatibility in the ways of life. This type of conflict includes the different preferences and ideologies that people may have as their principles. This type of conflict is very difficult to resolve because the differences are belief-based and not fact-based. An example of this is demonstrated in international war in which each side asserts its own set of beliefs (Fisher, 2000; Evans, 2013).
- **Power Conflict** occurs when each party tries to exert and maintain its maximum influence in the relationship and social setting. For one party to have influence over the other, one party must be stronger (in terms of influence) than the other. This will result in a power struggle that may end in winning, losing, or a deadlock with continuous tension between both parties. This type of conflict may occur between individuals, groups, or nations. This conflict will come into play when one party chooses to take a power approach to the relationship. The key word here is "chooses." The power conflict is a choice that is made by one party to exert its influence on the other. It is also important to note that power may enter all types of conflict since the parties are trying to control each other (Fisher, 2000; Evans, 2013).

According to Ana Shetach, an organizational consultant in team process and development, *conflict can be a result from every aspect such as attitude, race, gender, looks, education, opinions, feelings, religion and cultures.* Conflict may also arise from differences in values, affiliations, roles, positions, and status. Even though it seems that there is a vast array of sources for conflict, most conflict is not of a pure type and typically is a mixture of several sources (Shetach, 2012).

Conflict is an inevitable part of life and occurs naturally during our daily activities. There will always be differences of opinions or disagreements between individuals and/or groups. Conflict is a basic part of the human experience and can influence our actions or decisions in one way or another. It should not be viewed as an action that always results in negative outcomes but instead as an opportunity for learning and growth which may lead to positive outcomes. We can reach positive outcomes through effective

conflict management and resolution, which will be discussed in more detail later in the chapter (Evans, 2013).

Since conflict can result in emotions that can make a situation uncomfortable, it is often avoided. Feelings such as guilt, anger, anxiety, and fear can be a direct result of conflict, which can cause individuals to avoid it all together. Conflict can be a good thing and avoiding it to preserve a false impression of harmony can cause even more damage (Loehr, 2017a). If we analyze the CPP Global Human Capital Report, we see evidence that conflict can lead to positive outcomes within the workplace environment. This research project asked 5000 individuals about their experiences with conflict in the workplace environment. They reported, that as a result of conflict:

- 41% of respondents had better understanding of others
- 33% of respondents had improved working relationships
- 29% of respondents found a better solution to a problem
- 21% of respondents saw higher performance in the team
- 18% of respondents felt increased motivation (CPP Global Human Capital Report, 2008)

Based on this report, we can conclude that conflict can lead to positive outcomes and increased productivity, depending on the conflict itself (Loehr, 2017a). Approximately 76% of the respondents reported that conflict resulted in some type of positive outcome. This speaks volumes to the ideology that conflict within the workplace is something that should be welcomed and not avoided (CPP Global Human Capital Report, 2008).

Conflict can occur in various ways in the human experience, whether it is within one-self between differing ideas or between people. Even though this chapter will focus on the conflict at the social level, it is important that we review all the different levels of conflict that may exist. The levels of conflict that we will discuss include interpersonal, intrapersonal, intergroup, and intragroup conflict (Loehr, 2017a; Fisher, 2000; Evans, 2013).

Levels of Conflict

- **Interpersonal Conflict**. This level of conflict occurs when two individuals have differing goals or approaches in their relationship. Each individual has their own type of personality, and because of this, there will always be differences in choices and opinions. Compromise is necessary for managing this type of conflict and can eventually help lead to personal growth and developing relationships with others. If interpersonal conflict is not addressed, it can become destructive to the point where a mediator (leader) may be needed (Loehr, 2017a; Fisher, 2000; Evans, 2013).
- **Intrapersonal Conflict.** This level of conflict occurs within an individual and takes place within the person's mind. This is a physiological type of conflict that can involve thoughts and emotions, desires, values, and principles. This type of conflict can be difficult to resolve if the individual has trouble interpreting their own inner battles. It may lead to symptoms that can become physically apparent, such as anxiety, restlessness, or even depression. This level of conflict can create other levels of conflict if the individual is unable to come to a resolution on their own. An individual who is unable to come to terms on their own inner conflicts may allow this to affect their relationships with other individuals and therefore create interpersonal conflict. Typically, it is best for an individual dealing with intrapersonal conflict to communicate with others who may help them resolve their conflict and help

relieve them of the situation (Loehr, 2017a; Fisher, 2000; Evans, 2013).

- **Intergroup Conflict.** This level of conflict occurs when two different groups or teams within the same organization have a disagreement. This may be a result of competition for resources, differences in goals or interests, or even threats to group identity. This type of conflict can be very destructive and escalate very quickly if not resolved effectively. This can ultimately lead to high costs for the organization. On the other hand, intergroup conflict can lead to remarkable progress towards a positive outcome for the organization if it is managed appropriately (Loehr, 2017a; Fisher, 2000; Evans, 2013).
- **Intragroup Conflict**. This level of conflict can occur between two individuals who are within the same group or team. Similar to interpersonal conflict, disagreements between team members typically are a result of different personalities. Within a team, conflict can be very beneficial as it can lead to progress to accomplishing team objectives and goals. However, if intragroup conflict is not managed correctly, it can disrupt the harmony of the entire team and result in slowed productivity (Loehr, 2017a; Fisher, 2000; Evans, 2013).

Regardless of the level of conflict that takes place, there are several methods that can be employed to help manage conflicts. And with the seemingly infinite triggers for conflict, management of conflict is a constant challenge for leaders. To help address this, we will next discuss what conflict management is and then later examine the role of leadership in conflict management and resolution.

Conflict Management

Conflict Management may be defined as *the process of reducing negative outcomes of conflict while increasing the positive*. Effectively managed conflicts can lead to a resolution that will result in positive outcomes and productivity for the team and/or organization (Loehr, 2017b; Evans, 2013). Leaders need to be able to manage conflict when it occurs, and their ability to manage them is critical to the success of the individuals and/or teams involved (Guttman, 2004). There are several models available for leaders to use when determining their conflict management behavior. So where do leaders begin when they want to recognize their own conflict management styles? In this section, we will cover a popular method of conflict management styles, the Thomas-Kilmann Conflict Mode Instrument, that will help us answer this question (Loehr, 2017b; Evans, 2013).

The Thomas-Kilmann Conflict Mode Instrument (TKI)

The Thomas-Kilmann Conflict Mode Instrument is an assessment tool that helps measure an individual's behavior in conflict situations. The assessment takes less than 15 minutes to complete and provides feedback to an individual about how effectively they can use five different conflict-handling modes. TKI helps leaders understand how individual or team dynamics are affected by each of the modes, as well as helping leaders decide on which mode to employ in different conflict situations (Kilmann & Thomas, n.d.).

The TKI is based on two dimensions of behavior that help characterize the five different conflict-handling modes. The first dimension is assertiveness, and this describes the extent to which a person will try to fulfill their own concerns. The second is cooperativeness, and this describes the extent to which a person will try to fulfil others' concerns. The five conflict-handling modes fall within a scale of assertiveness and cooperativeness as shown in the figure below. They include: *avoiding, accommodating, competing, collaborating, and compromising* (Loehr, 2017b; Kilmann & Thomas, n.d.).

(source:killmanndiagnostics.com)

The TKI Five Conflict-Handling Modes (Avoiding, Accomodating, Competing, Collaborating, and Compromising)

Avoiding

This mode is low assertiveness and low cooperative. The leader withdraws from the conflict, and therefore no one wins. They do not pursue their own concerns nor the concerns of others. The leader may deal with the conflict in a passive attitude in hopes that the situation just "resolves itself." In many cases, avoiding conflict may be effective and beneficial, but on the other hand, it prevents the matter from being resolved and can lead to larger issues. Situations when this mode is useful include: when emotions are elevated and everyone involved needs time to calm down so that productive discussions can take place, the issue is of low importance, the team is able to resolve the conflict without participation from leadership, there are more important matters that need to be addressed, and the benefit of avoiding the conflict outweighs the benefit of addressing it. This mode should not be used when the conflict needs to be resolved in a timely manner and when the reason for ignoring the conflict is just that (Loehr, 2017a; Mediate.com; Kilmann & Thomas, n.d.).

Accommodating

This mode is low assertiveness and high cooperation. The leader ignores their own concerns in order to fulfill the concerns of others. They are willing to sacrifice their own needs to "keep the peace" within the team. Therefore, the leader loses and the other person or party wins. This mode can be effective, as it can yield an immediate solution to the issue but may also reveal the leader as a "doormat" who will accommodate to anyone who causes conflict. Situations when this mode is useful include: when an individual realizes they are wrong and accepts a better solution, when the issue is more important to the other person or party which can be seen as a good gesture and builds social credits for future use, when damage may result if the leader continues to push their own agenda, when a leader wants to allow the team to develop and learn from their own mistakes, and when harmony needs to be maintained to avoid trouble within the team. This mode should not be used when the outcome is critical to the success of the team and when safety is an absolute necessity to the resolution of the conflict (Loehr, 2017b; Mediate.com; Kilmann & Thomas, n.d.).

Competing

This mode is high assertiveness and low cooperation. The leader fulfills their own concerns at the expense of others. The leader uses any appropriate power they have to win the conflict. This is

a powerful and effective conflict-handling mode and can be appropriate and necessary in certain situations. The misuse of this mode can lead to new conflict; therefore, leaders who use this conflict-handling mode need to be mindful of this possibility so that they are able to reach a productive resolution. Situations when this mode is useful include: an immediate decision is needed, an outcome is critical and cannot be compromised, strong leadership needs to be demonstrated, unpopular actions are needed, when company or organizational welfare is at stake, and when self-interests need to be protected. This mode should be avoided when: relationships are strained and may lead to retaliation, the outcome is not very important to the leader, it may result in weakened support and commitment from followers, and when the leader is not very knowledgeable of the situation (Loehr, 2017b; Mediate.com; Kilmann & Thomas, n.d.).

Collaborating

This mode is high assertiveness and high cooperation. In this mode both individuals or teams win the conflict. The leader works with the team to ensure that a resolution is met that fulfills both of their concerns. This mode will require a lot of time, energy and resources to identify the underlying needs of each party. This mode is often described as "putting an idea on top of an idea on top of an idea" to help develop the best resolution to a conflict that will satisfy all parties involved. The best resolution in this mode is typically a solution to the conflict that would not have been produced by a single individual. Many leaders encourage collaboration because not only can it lead to positive outcomes, but more importantly it can result in stronger team structure and creativity. Situations when this mode is useful include: the concerns of parties involved are too important to be compromised, to identify and resolve feelings that have been interfering with team dynamics, improve team structure and commitment, to merge ideas from individuals with different viewpoints on a situation, and when the objective is to learn. This mode should be avoided in situations where time, energy and resources are limited, a quick and vital decision needs to be made, and the conflict itself is not worth the time and effort (Loehr, 2017b; Mediate.com; Kilmann & Thomas, n.d.).

Compromising

This mode is moderate assertiveness and moderate cooperative. It is often described as "giving up more than one would want" to allow for each individual to have their concerns partially fulfilled. This can be viewed as a situation where neither person wins or losses, but rather as an acceptable solution that is reached by either splitting the difference between the two positions, trading concerns, or seeking a middle ground. Leaders who use this conflict-handling mode may be able to produce acceptable outcomes but may put themselves in a situation where team members will take advantage of the them. This can be a result of the team knowing that their leader will compromise during negotiations. Compromising can also lead to a less optimal outcome because less effort is needed to use this mode. Situations when this mode is effective include: a temporary and/or quick decision to a complex issue is needed, the welfare of the organization will benefit from the compromise of both parties, both parties are of equal power and rank, when other modes of conflict-handling are not working, and when the goals are moderately important and not worth the time and effort. This mode should be avoided when partial satisfaction of each party's concerns may lead to propagation of the issue or when a leader recognizes that their team is taking advantage of their compromising style (Loehr, 2017b; Mediate.com; Kilmann & Thomas, n.d.).

Personal Reflections on the Thomas-Kilmann Conflict Mode Instrument

I chose the TKC Instrument because I felt it encompassed all aspects of conflict behavior and does a thorough job of explaining those behaviors. When compared to other models, the TKI model is more specific in the description of conflict behaviors as well. The TKI model has been around for well over 30 years, and I feel it does a very good job of breaking down a complex theory of conflict styles into a format that is easily understood and can be used by anyone.

Leaders should be capable of using all five conflict-handling modes and should not limit themselves to using only one mode during times of conflict (Loehr, 2017b). Leaders must be able to adapt to different conflict situations and recognize which type of conflict-handling mode is best to employ given the conflict at hand (Mediate.com). The use of these modes can result in positive or negative resolutions and it is imperative that today's leaders understand how to effectively employ them (Loehr, 2017b; Mediate.com; Kilmann & Thomas, n.d.).

Leadership and Conflict Management

The leader's role in managing conflict can have a significant impact on how they are resolved within the workplace or organization. Leaders spend about 24% of their time resolving conflicts, however the process to approaching conflict management relates to a great extent to their leadership style (Guttman, 2004). Leaders who use conflict management skills can provide guidance and direction towards conflict resolution. A common trait of leaders is they are able to build teams that work well together and help to set the tone for the organization. They must be able to facilitate the resolution of conflicts through effective conflict management (Guttman, 2004; Doucet, Poitras & Chenevert, 2009).

Leaders exhibit a variety of characteristics and traits that allow them to be great leaders, but does it help them when it comes to conflict management? I believe that it does. These same traits can help leaders dealt with conflict. The ability to recognize one's own leadership style will ultimately help describe how a leader handles conflict. Peter Northouse states that *"it is up to the leader to assess what action, if any, is needed and then intervene with the specific leadership function to meet the demand of the situation."* To be an effective leader, one needs to respond with the action that is required of the situation" (Northouse, 2016). I feel this demonstrates that the job of a leader is to analyze a conflict and facilitate the situation to produce a resolution that can be positive and productive. Northouse reassures us that any leader can draw on his/her leadership skills to employ appropriate conflict management strategies (Northouse, 2016).

A study conducted by Zhang et al. analyzed the relationship between *transformational leadership and conflict management.* Zhang et al. looked at how transformational leadership affects team coordination and performance through conflict management. What they found was that transformational leaders who used conflict management methods were able influence their teams to establish stronger identities, discuss their disagreements and frustrations outwardly, and work out solutions that benefited the team (Zhang, Cao, Tjosvold, 2011). I feel that this study helps to confirm that leaders must be able to possess conflict management skills to effectively run a productive team and organization. This study also shows us that there may be a possibility that certain leadership styles are more effective at conflict management. This is not definite but hopefully there will be more studies done to determine this.

Earlier in the chapter, we discussed the different types of conflict-handling modes that leaders may possess, but it is also necessary to briefly discuss the leadership skills and behaviors needed to effectively manage conflicts. Leadership skills needed to be effective at conflict management can be categorized to show which skills match up with five of the TKI conflict-handling modes. The avoiding mode requires leadership skills such as: *to be able to withdraw from a conflict or sidestep issues, have the ability to leave issues unresolved, and to have a sense of timing*. The accommodating mode requires skills such as: *being able to obey orders, set your own concerns aside, selflessness, and the ability to yield for the greater good.* The competing mode requires skills such as: *standing your ground, debating, using influence, stating your position clearly, and stressing your feelings.* The collaborating mode requires skills such as: *active listening, identifying concerns, analyzing input, and confrontation.* The compromising mode requires skills such as: *negotiating and finding the middle ground, making concessions, and assessing value* (Kilmann & Thomas, n.d.; Understanding Conflict and Conflict Management, n.d.). Behaviors that allow leaders to be effective at conflict management include (Guttman, 2004):

- **Be Candid**. Leaders cannot hesitate to put issues on the table to be discussed
- **Be Receptive**. Leaders need to make sure that team members understand that it is ok for conflict to exist and that everyone's opinion will be discussed
- **Depersonalize**. Leaders must be able to remove personal feeling from the mix and view conflict as a team issue
- **Learn to Listen**. Leaders must listen carefully and make sure that they provide feedback as well
- **Be clear**. Leaders need to make sure that all team members understand how decisions will be made to resolve the conflict
- **Out-law Triangulation**. Leaders must prevent team members from "ganging-up" on others that they may disagree with
- **Be Accountable**. Leaders must make sure that they follow through on their actions but also hold others to their actions as well
- **Recognize and Reward**. Leaders must be able to recognize successful conflict management and then reward it

Effective leaders know how to bring conflict situations out into the open so that all parties involved can begin to work towards a resolution that will benefit everyone. They manage conflicts in way that it is seen as an opportunity to build productive relationships (Guttman, 2004; Kazimoto, 2013).

Conclusion

The means in which conflict is managed will determine whether the outcome will be positive and productive, or negative and destructive. Leaders are taught to lead change, development, and transformation in organizations. One way leaders can accomplish their goals is through effective conflict management. Conflict can be described *as a disagreement among two parties that is usually portrayed as antagonism or hostility.* Conflict can arise from three different sources: economic, value, and power conflicts. Conflict can also occur at different levels of the human experience, which include: interpersonal, intrapersonal, intergroup, and intragroup conflict levels.

Conflict management is the process of reducing negative outcomes while increasing the positive. Leaders must be able to utilize conflict management skills to provide direction and guidance towards a resolution. Leaders can use the Thomas-Kilmann Conflict Mode Instrument to help them recognize and understand their own conflict handling modes. The TKI model also helps leaders understand which conflict handling modes are most appropriate for each particular conflict situation.

Zhang et al. shows us that transformational leaders are able to effectively influence their teams to workout solutions to their conflicts. This shows us that transformational leaders are able to utilize conflict management effectively. Peter Northouse also tells us that an effective leader needs to be able to respond to a situation with an action that is required of that particular situation. Therefore, leaders must be able draw on their leadership skills to effectively employ conflict management strategies.

Conflict is certain to occur regardless of the setting and individuals involved. For conflict to result in a positive outcome, leaders and teams must recognize that conflict not only exists but is a necessity. Understanding conflict allows leaders to manage it more effectively and can provide a path to accomplishing positive outcomes. Conflict management can be an active force that will allow leaders grow healthy relationships within their organizations which can ultimately result in effective productivity.

Conflict management must be a part of a leader's toolbox and be deployed when conflict arises within

a team or organization. If conflict is not addressed in a timely manner, it can not only affect the moral of the team/organization but can create larger issues later. Once this happens it may be more difficult to resolve then it would have been if the conflict was addressed immediately and effectively. Leaders must be able to recognize that conflict can cause negative issues within their team or organization. If they are able to pull on their leadership skills and recognize which conflict-handling mode is required for each situation, they can create an opportunity to improve team structure and dynamics, and ultimately achieve their goal of changing, developing, and transforming organizations.

Leadership and its Effects on Employee Wellness and Morale

Haley Griffin

Introduction

Employee wellness should be a priority for effective healthcare leaders. A commitment to anticipating employee's needs can go a long way in promoting employee wellness and building morale. Leaders must be cognizant and ready to act upon physical and emotional needs of their employees. Doing so can increase employer commitment to their employees which in turn can increase staff morale and loyalty. It is also important for employees to be encouraged to stay healthy on a personal level in order to optimize personal health. There are a number of cost-effective benefits associated with having a healthier workforce due to decreases in both insurance costs and less worker's compensation claims for example. Focusing on the healthcare setting where the employees care for patients, a commitment to wellness must be taken seriously in order to ensure a safe environment for both patients and providers. The purpose of this chapter is to discuss some implications to aid in the health of employees and different ways in which leadership can increase employee support. An emphasis will be placed on the health of staff working in a hospital organization.

Employee Wellness Programs

Many employers have opted to engage the organization's employees into wellness programs. These programs are widely varied depending on the needs and limitations of the organization. Six common themes work site wellness programs may include are: *dietary and physical activity interventions, smoking cessation interventions, health-risk appraisal and tailored health advice (stress reduction and coping), comprehensive wellness programs, integration of workplace health and safety policies and practices, and economic programs* (Shaw et al., 2012). In order to gauge the needs of an organization's employees, it may be beneficial to administer surveys in order to make the most impact in terms of programs to make available to staff. For example, if a survey finds that a large percentage of the workforce suffers from obesity, nutrition and physical activity initiatives should be emphasized as part of the program. Another integral part of the survey includes asking what kind of barriers employees foresee as those that would prevent them from participating (Kohler, 2015). This is important in making wellness programs the most meaningful for employees and to try and preventively correct barriers of participation.

Another aspect to consider is what is going to motivate the work force to use the program. Some different motivators that have been assessed to increase participation are monetary rewards and increased time off (Kohler, 2015). Huang et al. (2016) also found an increased participation rate among programs that offered incentives. The two main program types in this study that had the highest participation rate due to incentives were prevention based programs and comprehensive programs that offered a mix of screening, lifestyle, and disease management.

Surveying employees to gauge what would be the most motivating reward for them would aid in the implementation of such a program and the best chance of buy in for participation and sustainability. Contrary to Kohler and Huang, Galinsky et al. (2014) finds that if employees are in a wellness program exclusively for monetary rewards and benefits, this does not prove to be sustainable. Offering incentives to employees pose ethical and economical risks if not used cautiously. Offering incentives based on results or improvements could be helpful in ensuring that employees are utilizing the programs. On the contrary, those employees that are healthy and have no major improvements to be made may be

demotivated to utilize programs due to no incentive to do so, so this should be considered when thinking about the diverse health needs of an employee population. Another aspect is the efficacy of programs and ensuring that they are reliable ways to best help employees attain desired results. As in the quality improvement approach of Plan, Do, Check, Act (PDSA) cycles of process improvement, plans can be flexible to employees of an organization and modifications can be made in order to ensure goals are being reached.

The initiation of an employee wellness program is often new and exciting and needs to receive attention and build participation by offering incentives. This so called "action" phase as described by Dr. Steve Aldana is a needed step before the "maintenance" step is achieved which is where maximum benefits of both employee health and employer cost cutting benefits are seen. Therefore incentives, if managed appropriately, are crucial in attracting participants to maximize future benefits.

Any kind of organizational change, such as implementing a new program, should involve staff at all levels of the organization. Buy-in from organizational leadership is important for several reasons. First, the commitment and prioritization of such a program as part of the guiding missions of the organization make it known to staff that their health matters (Reeleder 2006). Leaders who were dedicated to the wellness of their employees and not just focused on economic benefits were found to be the most effective in the implementation of an employee wellness initiative (Kaspin et al., 2013, Brennan, 2013).

Next, these leaders should act as champions for the initiative, such as being the spokespeople to roll-out the program and be committed to its stability. While the executive board is important to a program, the middle managers, front-line staff, and professionals with a background in reaching these health goals (such as dieticians, those specializing in cardiology and endocrinology, money management, psychologists, and occupational health nurses) should all be part of the "wellness committee" when formulating the roll out of such a program. Wellsteps, a research based wellness program initiative, describes this group of employees as a "wellness committee." Employees are able to participate and feel ownership and buy in. Doing so can aid in proper thought by hospital leadership in order to make sure all stakeholder's needs are met.

Organizational leadership's realization of the *obesity crisis*, the *prevalence of heart disease*, and other *preventable health conditions* shows the staff that these leaders are behind the program and are confident in its success for its employees (Kohler et al., 2015). A benefit to employee wellness is that those front-line staff that have the knowledge to get a plan on the ground are integral in the creation of the plan and have the ability to co-create the program and increase their own leadership skills. They are also going back out into the work force to be champions for a more successful wellness program and are able to communicate the program across the organization's network.

The sustainability of an effective program is one that comes from alignment of the organization's mission and vision combined with top leadership support in all developmental stages (Marinescu, 2007). Clear guidelines and explanations of links are helpful in how the program aligns in the organization's values. Decisions will need to be made and communicated to different levels of management as to what their role should or could be with a program. Central organization of a program should be maintained for consistency, but involvement and promotion of a program by all levels of management could be helpful in the longevity of a program as opposed to no direct involvement with the program at all.

Accessibility, simplicity, and adaptability should be part of how the wellness program is constructed (Kaspin, 2013). There are some key points to keep in mind when creating an employee wellness initiative. The first is lead with values. This means starting from the top and leading by example (Kaspin et al.). The next is to keep the program convenient. Resources like on-site clinics staffed by physician's assistants or nurse practitioners can save paid time off and can lead to reductions of copayments and medical savings for an organization by using these mid-level providers (Galinsky, 2014). Another aspect is to keep it personal and to focus on the employee as a whole and not just physical wellness. A final

habit is to share success stories and make it communal so others may relate and see examples of how the program has helped fellow employees.

The more user-friendly a program is, the more the staff will utilize it to reap the benefits. Technology has been studied for utilization in aiding in health risk awareness and education (Kaspin, 2013). Some examples of technologies used are apps, a website with a dashboard of progress, and fitness tracker syncing (ex. Fitbit data uploads to the employees' profile). However, the use of technology should be something that is used with multiple stakeholders in mind. While some employees would seamlessly adapt to a new employee wellness program platform and be able to easily navigate around it, others may not adjust as easily.

Results achieved after implementing employee wellness programs were studied in a systematic review and some main outcomes of both economic and health-related factors were observed by employers (Kaspin et al., 2013). Economic outcomes that were seen include reduced costs, return on investment, and reduced absenteeism. There was a 1.6 to 3.9 dollar saved compared to dollars spent on average in this large group of organizations studied.

Major health-related outcomes observed include increased exercise level, risk reduction, and smoking cessation. Some of the risk reduction categories that improved through this systematic review include: high blood pressure, high cholesterol, poor nutrition, and obesity. This shows that with wellness programs in place, there are proven cost savings and health-related outcomes that are motivating employees to better themselves with their employer's help. In addition to what benefits wellness programs can provide, attention must be placed on other needs of employees like proper staffing and workplace safety including implications for the physical demand of a health worker's job.

When focusing on the whole person as mentioned above, mental aspects should be monitored like the amount of mental stress that is perceived from work and that staff safety is upheld in the workplace. Administrative support is needed for staff safety initiatives that may or may not be part of a formalized staff wellness program (Hooper et al., 2005).

Effects of Poor Health and Morale

On the opposite end of the spectrum, negative and harmful implications of toxic environments include reduced health and morale. The two main themes described are implications to patient care and the economic costs to employers because of low levels of wellness and morale.

The landscape of healthcare is moving towards prioritizing patient experience as hospitals compete against one another to earn business. Special considerations are made when developing hospital blueprints which keeps the patient and their families in mind in order to provide a luxury setting while receiving their healthcare (US News and World Report 2014). HCAHPS (Health Consumer Assessment of Healthcare Providers and Systems), which are surveys sent out to patients discharged from hospitals, show the perception of quality performance. Thirty percent of the decision for Medicare and Medicaid rests on these performance surveys for reimbursement to hospitals (Sherman, 2012). These are also publicly reported in order to promote transparency in the healthcare system. This puts pressure on the staff to maintain physical and mental energy to not only perform their job duties, but to do so in a manner that makes the patient's experience the best it can be (Gilbody, 2006).

Leaders should further support their staff to ensure high quality outcomes in their organization and benefit from Medicare and Medicaid reimbursements. Gilbody also studied how these pressures accumulated to lead to a decrease in morale and an increase in the amount of sick days taken. Increased numbers of sick days have the potential to lead to understaffing that further push the bounds of safe places for patients. With fewer staff to attend to their needs, patient satisfaction is not only at risk, but this may also put them at risk for adverse events. Increased length of stay was associated with these increases of sick days taken by staff (Gilbody, 2006). This not only increases risks for patients to develop

nosocomial infections, it also adds to unneeded costs to the patient and extra cost to a hospital by taking up a room for longer than was necessary (Brimmer et al., 2013).

There is a need to establish a safety culture to best prevent unneeded harm. Hooper et al. (2005) studied how an initiative was started in a hospital in order to change the safety culture. Administrative support was key in this movement. Their involvement is key when there is a need for paralleled attention for patient safety and staff safety because one cannot happen without the other. They reported an overall decrease in injury claims, lost-time injuries, and needle stick injuries because of this paralleled attention and visibility to employee safety. They also experienced claims being reported at a faster rate in order for preventative measures to be taken to ameliorate safety concerns (Hooper et al., 2005). These physical and mental demands intertwine to create the needs and wants of healthcare workers and these problems should be addressed in a preventative nature before excessive mistakes are made.

Attention for organization leaders entails budgetary dollars and administrative initiatives. A Joint Commission of Healthcare Organizations (JCAHO) report brought medical errors to the forefront that found a link between these errors and nurse understaffing (Hooper et al., 2005).

The amount of overtime worked has been found to have adverse effects in the nursing profession (Brimmer, 2013). According to Brimmer, 69% of nursing staff stated they experienced fatigue that made them feel concerned during work in a self-reported study. Sixty-five percent stated they almost made a mistake due to their fatigue, while 27% stated that they had made a mistake due to their fatigue. This model of nurse understaffing adversely effects the quality of care, patient and employee satisfaction, and increases operational costs in hospitals.

Some strategies used to support healthy mental demands in the workplace include the enrichment of clinical skills and increased psychologic support (Gilbody, 2006). A study from Galinsky also shows success from a company that supports the employee from other aspects like financial wellness and career development to further aid in caring for the employee. In Galinsky's study, each employee fills out a self-assessment and then has a one-on-one session where they set three goals for themselves out of categories like career-development, work-life fit, financial security, community involvement, and physical health. This personal goal setting has led to contained health care costs despite inflation while also maintaining a high employee engagement ranking and low turnover (Galinsky, 2014).

Some other hidden costs to employers are related to turnover and employee satisfaction. If an environment does not provide support to its employees, high turnover could be a result of these stresses (Gilbody, 2006). Those who choose to not switch jobs but continue to be dissatisfied would not promote others to apply for a job in the same organization, potentially turning away good candidates for jobs. When a hospital is in a competitive market and wants to recruit the best of the best, these programs and benefit packages from employers could tip the scale for the best prospective employees and be a draw to work for an organization.

Mandatory overtime was linked to more musculoskeletal problems in a longitudinal study by Trinkoff et al (2006). An added area that requires attention is the phenomenon of presenteeism, which describes the employee working in pain or reporting to work but contributing less to the overall lab's productivity and quality of work (Campo & Darragh, 2012). Presenteeism has been studied in other professions, and it has the potential to cause deleterious productivity or quality of work (Campo & Darragh, 2012).

Physical Job Demands and Employer Commitment

It is no secret that working in the healthcare field puts physical strains on employees. There have been many research studies reporting physical strain that is caused by caring for patients (Da Costa et al 2010). Musculoskeletal injuries of the back, shoulders, and knees result from long periods of standing, lifting patients and equipment, and other physical obligations of the job. Leadership must be aware of the issues behind these barriers and be willing to help with redesign or purchase of devices that may improve workplace safety for employees. Da Costa et al. (2010) performed a systematic review of recent

longitudinal studies on work-related musculoskeletal disorders. In their findings, they saw what types of movements and actions at work were typical for injuries in certain anatomical areas. They also studied different demographic and psychosocial risk factors that made injuries more common. There are two findings that stood out from this study. The first finding showed that risk factors working concomitantly, like high psychosocial stress and heavy lifting together, accelerated injuries. The other was that low back pain, which is the most commonly reported painful area among healthcare workers, has certain risk factors like heavy lifting, awkward and repetitive postures, and high BMI. The idea of high BMI is something that a wellness program would want to help reduce in order to also lower the risk for low back pain in this population.

Like athletes must condition themselves to best play their own sport, so must hospital employees condition themselves to best reduce injury inflicted during work. Emphasis from the employee wellness program to work on building strength could help with reducing injuries to promote a focus on strength for those employees that must transport, position patients, and use heavy equipment. Another way that leadership would be able to combat physical injuries would be to offer stretching and yoga seminars that can improve flexibility and mindfulness of the way they are moving in order to reduce injuries.

In an article from Bauman et al. (2015), a staff empowerment approach was utilized to best improve staff safety, health, and wellness. These front-line staff members were first educated about safety skills and what some workplace hazards to safety may be. Armed with this information, they went to their work environments and were able to make suggestions in order to modify their work environment. This cognizance of leadership's commitment to safety improved the safety culture of the organization and resulted in staff to demonstrate low risk behaviors. This can be contributed to leadership giving the employees ownership of their work environments in order to make a bigger impact than if leaders would have mandated a certain way to change things. A similar physical result may have been achieved, but there is an added benefit of employees stepping up and being a leader in the origination of their own staff safety initiative.

Another initiative would be for leaders to provide funding to purchase equipment to aid staff in the lifting of patients and equipment. Hoyer lifts are a popular tool that mounts in the ceiling of a patients' hospital room and are used to lift a patient out of bed. Necessary arrangements must be engineered in these patient rooms in order for the lifts to be installed. Another example is to have a robot system that is able to transport dirty linens or garbage as opposed to staff members pushing these heavy carts to their destinations.

Mental Job Demands and Employer Commitment

Leaders should be concerned for the psychosocial demands employees face while in the workplace (Martin et al., 2014). In the healthcare setting, there are many contributors to the decline of mental wellness. While an employer is not in control of how patients act or their degree of illness, they expect that the staff provides the best possible care and safety of patients. This can be extremely stressful for employees in terms of mental energy used to accomplish this in some circumstances. Supporting employees through these difficult encounters and overall mental health is paramount of leaders to be appreciable of and to offer a sounding board willing to provide support and resources.

Employees should maintain a sense of psychological safety such that if they were struggling mentally with the demands of their work, they could feel safe in going to their leader and bringing up their concern in order for it to be addressed. Instead of having concerns come to a final "breaking" point, care must be taken to prevent a health behavior crisis. Hours worked, workload, and other considerations should be managed between leaders and followers in order to best manage these working conditions. High workloads and time pressures as part of job demands have shown to be correlated with higher amounts of exhaustion and disengagement in nurses (Demerouti et al., 2000). Demerouti et al. goes on to explain how different job conditions induce stress reactions and can in turn decrease overall life satisfaction. A

way to combat this is for supervisors to create a healthy work environment and to promote a joint role in decision making. An additional way to combat this is encouraging leaders to complete frequent meetings with their followers to give and receive feedback so that they can best lead their followers. This would also allow followers to better communicate with their leaders what is working and what they think can also be improved.

Leadership Techniques and Theories for Achieving Employee Wellness

This topic reflects the ethical obligations of a leader to ensure that their staff is well taken care of and all their needs are met or excelled to achieve the highest functioning organization as possible. This can be best fortified by a leader's inherent values towards their job. Being an ethical leader means being sensitive to other's needs and caring for others (Northouse, 2016). The root of these ethics not only can promote health in employees, but these employees can in turn strengthen the organization. A well-studied approach to leadership is transformational leadership. Northouse describes transformational leadership as the ability for a leader to inspire followers and encourage them to reach their goals. There are four major components of transformational leadership which include: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration (Northouse, 2016). Followers' needs should be understood and leaders should have adaptability in order to reach their goals. This leadership type is seen as a role model to its followers and therefore followers trust the leader and want to achieve higher standards. This inherent quality of a leader that has a focus on values and morals would be beneficial in the promotion of employee health and wellness.

Barling et al. (2002) described that the four studied components of transformational leadership have been shown to align with creating a better safety climate through metrics, including perceived safety climate, safety consciousness, and safety-related events. Better results are achieved by leadership putting more focus on improving the lives of employees through workplace wellness initiatives than they do by financial savings as seen by Galinsky et al. (2014). More specifically, the concept of safety-specific transformational leadership, as studied by Mullen et al. (2009), delves more into transformational leadership as it pertains to safety and the environment for the staff.

Another leadership concept is positive organizational leadership when particular attention is being given to motivating the workforce to latch on to new ideas and initiatives. According to Oades et al. (2011) there are five routes to well-being, including positive emotions, engagement, relationships, meaning, and accomplishment. This study was used in a University setting but specifically looked at employee stress and student well-being. These techniques could be transferrable to a staff working in a hospital setting that have high performance goals as those in a university setting. Using these principles to motivate staff to actively participate in a work place wellness program or the improvement of staff safety culture could benefit an organization for things to move in a positive direction.

Summary

The ideas presented in this chapter are multifactorial in nature, with the main point being that employee wellness must be maintained for factors of personal health, mental wellness, and a reduction of injury. Leadership support is integral in the change of culture to one that's focus is this. Two major ways that this can be facilitated include employee wellness programs and initiatives to ensure employee workplace safety.

This culmination between promoting employee health, both mental and physical, and creating a safe work environment for employees are all obligations that a leader should be cognizant of and able to adapt to ensure that their employees are well taken care of. There have been research positively linking the health of the employee to the outcomes for patients. This can promote a strengthened and supported team that has the capability of promoting organizations to function at a high level.

First, Do No Harm (to Yourselves): The Role of Leadership in Creating a Culture of Employee Safety in Healthcare

Lindsay Schwartz

Introduction

As the push for improving patient safety in healthcare continues, leading healthcare systems in the United States are expanding safety initiatives to incorporate employee safety. Employee safety is both cost-effective for the organization as well as serving as a contributor to patient safety (Organizational Safety Culture-Linking Patient and Worker Safety, n.d.). In order to improve both patient and employee safety in healthcare institutions, a culture of safety is a requirement. A culture of safety may be defined as an organizational ideology, which prioritizes safety over financial gain or benefit (Creating and sustaining a culture of safety, 2004).

This chapter will explore best practices for creating a culture of safety in healthcare institutions. We examine the primary components of creating a culture of safety including a just culture, in which employees are treated in a supportive rather than punitive manner when it comes to safety concerns, a safety reporting system to capture safety concerns and therefore intervene to improve concerns, a transparent approach to safety in which all employees are made aware of safety concerns and efforts to improve these concerns, and finally engagement by both leaders and frontline staff to improve safety. Additionally, this chapter will examine the importance of extending safety practices to incorporate employee safety. To illustrate these best practices, this chapter will examine the Zero Hero Employee Safety program at Nationwide Children's Hospital in Columbus Ohio.

Background and Context for a Healthcare "Culture of Safety"

In 1999 the Institute of Medicine (IOM) published a report titled: "To err is human: building a safer health system" (Poillon, 1999). The paper reported groundbreaking statistics, which identified hospitals as one of the most dangerous places in the United States due to medical errors. The report detailed the detrimental impacts of medical errors including patient deaths, financial impacts, and loss of trust in the healthcare industry.

The IOM report identified major issues in medical systems including: *lack of communication among providers, lack of incentives for improving quality and safety, and flawed systems.* The report distinguishes that rather than individual person errors, most medical errors are a result of system issues. The report encourages national level changes including: a federal level focus on improving patient safety, mandated reporting of medical errors, improvements to standards of care on a national level, and a culture of safety across all medical institutions. As learned through the IOM report, system-wide initiatives are crucial to creating a culture of safety in healthcare institutions.

After the publication of the IOM report healthcare research related to patient safety increased. Along with an increase in safety literature, the IOM report also propelled a shift in the *kind* of safety research conducted. Whereas before the release of the IOM report most research centered on individual blame and malpractice cases, research began to focus on system-wide causes for a lack of safety (Stelfox, Palmisani, Scurlock, Orav & Bates, 2006). Although the IOM report brought attention to the issue of patient safety, much like at the time the report was published the healthcare industry continues to struggle today in improving safety (Free from harm, 2015). Later in this chapter, we discuss how

employee safety is the next crucial step in healthcare safety, a step that may improve patient safety as well (Organizational Safety Culture-Linking Patient and Worker Safety, n.d.).

Best Practices for Creating a Culture of Safety

In current literature, there are several practices identified to be contributors to producing a culture of safety. The presentation of these practices in many unique research articles demonstrates that these practices are evidenced-based and serve as best practices for improving safety. The particular practices, which will be examined here, were selected because they are broadly accepted as manners in which to improve safety. The following section address the themes found across the literature related to creating a culture of safety in healthcare institutions.

Just Culture

Literature underscores the importance of a "just culture" (Gandhi, 2018), in which healthcare workers are supported when they bring up safety concerns rather than punished. Dr. Mark Jarrett, the chief quality officer at Northwell Health in New York, points out that in order for employees to feel comfortable expressing safety concerns or reporting safety events, they must feel that their reporting will not lead to negative repercussions (Jarrett, 2017). A just culture focuses on accountability for all members of the healthcare team, from the frontline staff up to executives.

Everyone in the organization must embrace this just culture; particularly those who hold a leadership role, as they ultimately are the individuals who will (or will not) enforce punishments for involvement in safety events. Leaders must also lead by example when responding to safety events, such as responding by initiating positive change instead of reprimanding involved staff members (Conduct patient safety leadership walkrounds™ , 2018). Along with executive leaders who often do not serve in clinical roles, frontline leaders who do serve in clinical roles are crucial in implementing a just culture. Frontline leaders such as nurse managers or charge nurses are intricately involved in patient care, and thus, have a strong understanding of safety needs and barriers to safety. When frontline leaders respond in a supportive manner after safety events, they demonstrate a just culture through their actions and thus contribute toward a supportive safety culture in their clinical area (Tarantine, 2017).

Safety Reporting Systems

Additionally, literature emphasizes the importance of implementing safety reporting systems to achieve a culture of safety. Dr. Mary Gregg, the chief medical officer of MAG Mutual Insurance, reported the importance of learning from safety incidences reported through safety reporting systems (Gregg, 2013). Dr. Gregg emphasizes the importance of documenting "near misses," (Gregg, 2013) which are circumstances in which a negative safety event could have happened but was avoided. A safety reporting system alone is not enough; leaders who review safety data must act quickly to make changes after safety events. By responding quickly, leaders demonstrate their focus on safety as well as provide encouragement to employees to report safety events (QAPI leadership rounding guide, n.d.). Leaders who respond efficiently to safety concerns reported will demonstrate to employees that reporting can lead to positive outcomes. Additionally, it is crucial that leaders continue to assess the data in order to avoid complacency and to move toward continued improvement (The essential role of leadership in developing a safety culture, 2017).

Transparency

Further, literature discusses the benefits of transparency (Creating and sustaining a culture of safety, 2004). In order for a widespread culture of safety, leaders must be transparent regarding safety occurrences and initiatives. In conjunction with the previously discussed safety reporting systems, transparency allows for all members of the healthcare team, from frontline staff to executives, to be aware of safety events. Transparency has a two-fold benefit. The initial benefit may seem rather obvious: transparency provides all staff members with information regarding safety events. While it may seem overly simplistic, knowledge of safety events is crucial for all staff members. When

armed with knowledge regarding the number and types of safety occurrences, all members of the healthcare team can be aware of potential safety issues and therefore act to reduce safety incidences. Additionally, transparency encourages accountability among all employees related to safety occurrences. When safety data is regularly shared, everyone shares the responsibility of improving safety at the institution (The essential role of leadership in developing a safety culture, 2017). Shared responsibility and accountability go hand-in-hand with the ever-important just culture, as all within the institution share the burden of improving safety rather than pointing fingers at individuals. Along with transparency about the type and number of safety events, transparency also includes sharing information about initiatives made toward improving safety at the institution. Information regarding safety improvement efforts again encourages everyone to be accountable and responsible for implementing improvement initiatives (Creating and sustaining a culture of safety, 2004).

Leadership and Frontline Staff Engagement

A just culture, a safety reporting system, and transparency are all requirements for a safety culture; however, without leadership engagement, a culture of safety is impossible to attain. The Joint Commission, a national accreditation organization for healthcare organizations, implores healthcare leaders to focus on a culture of safety just as much as a focus on any other leadership topic such as finance or business growth (The essential role of leadership in developing a safety culture, 2017). While human errors may occur, the literature emphasizes that the majority of safety issues stem from systematic issues. From their vantage point, leaders are in a unique position to approach safety from a whole systems approach (Gandhi, 2018).

It is necessary that leaders focus on separating human errors from systematic errors to allow for appropriate interventions (Gandhi, 2018). A culture of safety must be a conscious effort on the part of employees, and leaders are encouraged to incorporate safety into all daily activities. It is essential that leaders utilize an adaptive leadership approach. **Adaptive leaders** conduct themselves in a manner in which their behaviors reflect their goals for the organization and motivate followers to conduct themselves in a manner that will achieve these goals (Northouse, 2016). Additionally, adaptive leaders encourage their followers to think for themselves to create positive change (Northouse, 2016). In healthcare, the leaders' behaviors must reflect a mission toward improving safety, so they can encourage followers to participate in safety measures and feel empowered to accomplish safety goals. As leaders incorporate safety into all activities, this behavior serves as a model to followers (Creating and sustaining a culture of safety, 2004).

In order to demonstrate active engagement in safety efforts, literature encourages leaders to have regularly scheduled time to interact with and shadow frontline workers.

The literature describes an emphasis on the importance of leaders engaging frontline staff in order to gain the best understanding of safety concerns in all areas of work. It is recommended that this interaction with frontline workers be systematic and regularly scheduled. The Institute for Healthcare Improvement (IHI) calls regularly scheduled interactions with staff "leadership walkroundsTM" (Conduct patient safety leadership walkrounds™ , 2018). **Leadership walkroundsTM** provide an opportunity for leaders to directly interact with frontline staff to discuss important safety topics. Other institutions such as the Center for Medicare and Medicaid Services (CMS) and local healthcare systems engage in similar rounds with a variety of names including "rounding to influence" (Rounding to influence, 2008) and "leadership rounding" (QAPI leadership rounding guide, n.d.).

In addition to rounding by leaders, regularly scheduled safety briefings should be conducted. During conversations with executives, any identified issues should be discussed. However, the staff member who identified the issue should remain anonymous, another essential component to creating a just culture (Conduct patient safety leadership walkrounds™ , 2018). As previously discussed, it is necessary for

leaders to quickly address and respond to concerns that are identified, which serves as another manner to demonstrate to frontline staff that leaders are receptive and responsive to safety feedback.

Next Steps: Employee Safety

As advancements in patient safety continue, this goal of a culture of patient safety can be expanded to incorporate employee safety. The Federal Occupational Safety and Health Administration (OSHA) reported a strong relationship between a culture of safety and employees following appropriate infection control precautions, which is a contributor to both patient and employee safety (Organizational Safety Culture-Linking Patient and Worker Safety, n.d.). Along with safer patient care, the literature shows that safer employees have higher morale and therefore create a stronger and more motivated workforce (Barr, Miller, Principe, Merandi, & Catt, 2016). Additionally, safer employees are more cost-effective as they require fewer days off, reduce healthcare costs, and may have fewer turnovers due to their higher morale (Barr, Miller, Principe, Merandi, & Catt, 2016).

Case Study: Nationwide Children's Hospital Zero Hero Employee Safety Program

The following case study will examine the Zero Hero program at Nationwide Children's Hospital, beginning from the program's inception as a patient safety program and the expansion to incorporate employee safety. The reader will gain understanding of the actions and steps taken to create this successful safety program. Additionally, a comparison is made between the literature on best practices and the Zero Hero program.

Zero Hero Program Background

Nationwide Children's Hospital in Columbus, Ohio is a nationally ranked, freestanding children's hospital, which services patients and families from all 50 states of the United States and patients and families from 52 countries (Nationwide Children's Hospital-About Us., n.d.). In 2009 under the leadership of Chief Medical Director Dr. Richard Brilli, Nationwide Children's Hospital created the "Zero Hero" program (Zero Hero, n.d.). The Zero Hero program aimed to create a culture of patient safety at the hospital. The goal of Zero Hero was simple yet incredibly complex to achieve: *zero instances of preventable harm to patients at the hospital* (Zero Hero, n.d.). While leaders at the hospital knew that zero instances of harm was a very lofty goal, they believed that the hospital needed to aim high as the ultimate goal is to avoid all preventable patient harm. This type of goal follows a quality improvement method of creating *"big hairy audacious goals" (BHAG)* (Collins, 2018)3, which can serve as motivators for change as they serve as *"clear and compelling"* (Collins, 2018) goals for the organization.

Incorporating Employee Safety

While a leader in patient safety following the initiation of the Zero Hero program in 2009, Nationwide Children's senior leaders determined that to truly reduce preventable harm, employee safety must also be prioritized (D. Barr personal communication, February 9, 2018). In 2012, the hospital had 179 OSHA reportable incidents; these incidents caused 846 days of lost employee work time and cost the hospital approximately $1.2 million (Barr, Miller, Principe, Merandi, & Catt, 2016).

In order to reduce these negative effects, beginning in 2012, hospital senior leaders expanded the Zero Hero program to include employee safety (Barr, et al., 2016). Tackling employee safety at Nationwide Children's was no easy task, particularly due to the magnitude of employees; nearly 13,000 employees work for the organization (D. Barr personal communication, February 9, 2018). The priority of the hospital to encourage safety is evident as the Zero Hero program is introduced during hospital orientation for new employees and new employees are required to attend a Zero Hero training course during their on-boarding process (D. Barr personal communication, February 9, 2018).

Through the patient safety initiatives, a safety reporting system called CS Stars was implemented. The CS Stars system provides a simple process for employees to directly report safety occurrences, including occurrences in which staff members correctly intervene to avoid potential harm. In order to hold safety

at the forefront of all employees' minds, all hospital computers have a direct link to the CS Stars form on the desktop. To begin the employee safety component of the Zero Hero program, baseline data related to employee safety was collected through the CS Stars reporting system. Leaders took this data to create a preventable harm index for employee safety. The preventable harm index allowed leaders to prioritize safety initiatives in order to have the most effective impact on reducing employee harm. The preventable harm index is reassessed annually to realign safety priorities and to assess the previous year's progress (D. Barr personal communication, February 9, 2018).

The employee safety initiatives incorporate frontline staff members to ensure that all perspectives are included. One component of engaging frontline staff members is through assessing CS Stars entries. When a CS Stars report is entered, the report is shared with the employee safety team as well as with the department manager. In order to remedy systematic issues associated with the reported event, hospital leaders respond within one week to begin steps toward improving the issue. If events are severe, however, leaders will respond to the event immediately in order to quickly work toward reducing future such incidences. Additionally, safety initiatives are regularly shared with employees thorough a variety of channels. Electronic signage in the hospital is regularly updated to report messages regarding continuing safety initiatives as well as to remind staff members of steps they can take to improve safety (D. Barr personal communication, February 9, 2018).

Frontline staff members are also incorporated through the hospital's safety coach program. Departments within the hospital identify certain staff members to serve as their representative in the safety coach program. Safety coaches serve as leaders for improving safety among the staff members in their departments. These coaches receive training on ways in which to notice, report, and intervene when safety events could or do arise. Additionally, safety coaches participate in monthly meetings to discuss best practices related to improving safety within the hospital (D. Barr personal communication, February 9, 2018).

Frontline staff members are encouraged to participate in "focus effort teams" (D. Barr personal communication, February 9, 2018) related to safety topics. These focus effort teams allow for frontline staff members to have autonomy and leadership in creating safety solutions. These teams are formed when staff members identify a safety concern and work together to create a solution. The focus effort teams typically consist of an executive level sponsor, frontline staff members who either work in an area with a high-level of the type of harm being addressed or have a passion for the topic, and members of the hospital's Business Process Improvement (BPI) team (D. Barr personal communication, February 9, 2018).

Daniel Barr serves as the Vice President of Operations for the Hematology, Oncology, and Bone Marrow Transplant program as well as serves as the Co-Director of Employee Safety at Nationwide Children's Hospital. Mr. Barr played a crucial role in the expansion from patient safety initiatives to include employee safety initiatives. Mr. Barr reported that leaders initially considered creating new tools and procedures for improving employee safety, however, leaders decided that hospital employees were already familiar with and appropriately utilizing the Zero Hero tools. Therefore, leaders decided to expand current Zero Hero programs and initiatives to incorporate issues assessed from the preventable harm index for employees.

To gain a system-wide awareness of all safety concerns at the hospital, leaders at the hospital participate in a daily organizational safety phone call each morning. The daily safety call allows leaders to assess any safety events from the previous day. During the call, leaders assess if the harm event was preventable and how to best intervene to prevent similar future occurrences. Mr. Barr reported that one of the most important benefits of this phone call is that it forces safety issues to "stay at the top of the mind" of leaders (D. Barr personal communication, February 9, 2018).

Case Study Example: Reducing Employee Harm with Combative Patients

With the rising numbers of patients seen at the hospital for behavioral health diagnoses, the number of injuries to staff members due to combative patients also increased. Utilizing the preventable harm index, the employee safety team determined the importance of reducing staff member injuries due to combative patients. Patients admitted with behavioral health diagnoses are serviced in the hospital's Emergency Department, in-patient behavioral health unit, and in-patient crisis stabilization unit. In addition to these areas with a dedicated behavioral health focus, patients with other health conditions along with their behavioral health diagnosis may be serviced on other medical units. Due to the large range of locations where patients with these diagnoses are admitted, it was necessary to provide expansive training and services to reduce employee injuries (Barr, Miller, Principe & Milliken, 2017).

In order to reduce the number of injuries by combative patients, the hospital created a focus effort team with this goal in mind. The focus effort team utilized data from the CS Stars reporting system to ascertain where to focus their safety interventions. Through the data, the team learned that it is necessary to improve employees' knowledge in how to keep themselves safe and to improve how employees utilize de-escalation techniques. To remedy these issues the team worked to change the culture and mindset, as it was noted that many employees felt that injuries from patients was simply a part of the job when working with behavioral health patients (Barr, et al., 2017).

Additionally, the team noted that incidences with combative patients occur in an unpredictable manner. Therefore, preventative actions must be used to reduce staff injuries. For any patient or caregiver who becomes escalated or violent, staff members are able to activate a "Code Violet" (Barr, et al., 2017).

During a Code Violet, mental health professionals, as well as security officers, assist in de-escalating the patient and keeping the patient and staff members safe. In order to proactively support patients with a history of Code Violets, the team created an update to the hospital's electronic medical record (EMR) system. This update causes a purple banner to appear at the top of the screen in any patient's medical record when the patient has a history of a Code Violet. Through this identification, staff members are able to be prepared for the patient's potential triggers and behaviors and can anticipate potential incidents. Additionally, every week hospital leaders and the security team review the previous week's Code Violets and prepare for upcoming outpatient appointments for patients with a history of a Code Violet. A similar conversation occurs for inpatient unit managers related to hospitalized patients with a Code Violet history (Barr, et al., 2017).

In order to better respond to Code Violet situations, the team also implemented Code Violet simulations. During these simulations, employees are able to practice de-escalation techniques and safety interventions. By allowing staff members to practice in advance, they are better armed and more confident when interacting with patients during a true Code Violet (Barr, et al., 2017). Following the implementation of a new behavioral health unit, the hospital saw an increase in about 30% of harm incidents for staff working with behavioral health patients. After about one year of utilizing these initiatives, however, the hospital saw a 60% decrease in harm due to combative patients (D. Barr personal communication, February 9, 2018).

How Does Zero Hero Line Up?

In comparison to the best practices identified by the literature, the Zero Hero Employee Safety program implements many of the suggested activities and behaviors. The below section will discuss the Zero Hero program in relationship to best practices learned from the literature.

Creating a Just Culture at Nationwide Children's Hospital

Daniel Barr, who serves as the co-director of employee safety at Nationwide Children's Hospital, identified that the hospital's rate of safety incidents reporting demonstrates the hospital's just culture. According to Mr. Barr, at the beginning of the hospital reporting system, the program received approximately 30-40 reports per month. Currently, however, CS Stars receives up to 120 reports per

month (D. Barr personal communication, February 9, 2018). Mr. Barr believes that if staff members felt there was a punitive component to reporting safety concerns, these reports would not continue to increase over time and would instead slow down. The hospital incorporates a "200 percent accountability" (Barr, et al., 2016) mindset. This mindset means that all employees are responsible not only for their own engagement in safe behaviors, but also are responsible for their peers engaging in safe behavior.

This accountability is created through a culture of utilizing what has been coined a "questioning attitude" (L. Kappy, personal communication March 12, 2018). The questioning attitude is a philosophy in which staff members are expected to intervene when they notice a safety concern. Beginning from the new employee Zero Hero training, this idea is reinforced and encouraged. Staff members are taught that regardless of the hierarchy of professionals in the hospital, everyone is expected to provide and accept a questioning attitude.

A frontline registered nurse is expected to intervene when an attending physician does not correctly complete a safety procedure. The attending physician is expected to be gracious and accept the feedback provided. Alternatively, when the situation is reversed, the attending physician is also expected to question the registered nurse, and he or she is expected to respond graciously and implement the feedback. The questioning attitude philosophy encourages accountability and responsibility among all staff members and assists in creating a culture in which it is an expectation that safety concerns are identified and addressed (Zero Hero, n.d.).

Safety Reporting System at Nationwide Children's Hospital

In alignment with literature recommendations and as discussed previously, Nationwide Children's has a safety reporting system called CS Stars. In addition to employees regularly reporting concerns through CS Stars, many departments also incorporate safety discussions into team meetings. For example, Lisa Kappy, a child life specialist in the Family and Volunteer Services department, reported that at the beginning of their department meetings staff members report "safety catches" (L. Kappy Personal communication March 12, 2018). Safety catches are times in which staff members notice potential safety concerns and intervene appropriately. Managers within the department lead a brief discussion regarding the Zero Hero tool utilized when intervening, which serves as a way to assist in reporting data to the employee safety team and to assist other staff members in knowing how to respond in similar situations.

Creating Transparency at Nationwide Children's Hospital

Nationwide Children's also incorporates the previously discussed literature recommendations related to the importance of transparency. In order to maintain open lines of communication with staff members about safety occurrences, the hospital's intranet page includes a daily tracker of time since serious safety events. The intranet includes two counts one which indicates the number of days since the last serious patient harm event and one with the number of days since the last employee harm event. This transparency is intended to maintain awareness for staff members at all levels and serves as a regular reminder about engaging in safe behavior (D. Barr personal communication, February 9, 2018).

Leadership and Frontline Staff Engagement at Nationwide Children's Hospital

Nationwide Children's engages in practices in alignment with the literature cited and does so through leadership and frontline staff engagement in safety initiatives. Mr. Barr, the co-director of employee safety stated that hospital leaders aim to "lead by example" through their behaviors and actions (D. Barr personal communication, February 9, 2018). Mr. Barr stated that leadership buy-in is crucial and requires leaders to hold themselves and those around them accountable for improving safety. As recommended by the literature, Nationwide Children's leaders regularly visit with employees to assess their engagement with the Zero Hero program. These regular visits called "Rounding to Influence" (Zero Hero: Rounding to Influence, n.d.) allow managers to have an increased understanding of safety concerns and an awareness of safety needs of frontline staff. Nationwide Children's aims to incorporate

frontline staff members into safety improvement efforts through the safety coach program and focus effort teams. Through these endeavors, Nationwide Children's utilizes a multidisciplinary approach to improve employee safety.

Conclusion

Creating a culture of safety is necessary to improve patient outcomes as well as to improve safety for healthcare workers. The literature identifies several important factors for creating a culture of safety in healthcare institutions. These factors include creating a just culture in which all are accountable for safety and the response to safety concerns is to focus on problem solving rather than punishment. Another factor, which is crucial for a culture of safety, is a strong safety reporting system.

A safety culture requires hospital leaders to be transparent in their efforts for safety as well as to incorporate employees into efforts for safety improvement. Finally, leadership behavior of executive and frontline leaders is crucial to model engagement in safety. While many safety efforts are focused on patient safety, there is a great need for improvements to employee safety as well. Safer employees provide better care to their patients and also contribute to better financial outcomes for the healthcare institutions where they work.

We presented a case study of the safety program at Nationwide Children's called Zero Hero. The program was initially aimed to improve only patient safety, but later efforts were expanded to include improving employee safety. Many recommendations provided by the healthcare safety literature, including incorporating *a just culture, a strong reporting system (titled CS Stars), transparency, as well as staff and leader engagement*, were demonstrated by the Nationwide Children's Zero Hero Program.

Organizational and Team Psychological Safety within Health Care and Public Health Organizations

Hilary Metelko Rosebrook

Introduction

This chapter covers psychological safety within a group setting and explores what is meant by psychological safety – what it is, why it works, how it works, and how to build it. The role of trust in organizations, adaptive leadership impacts on safety, and leadership behaviors along with strengths and weaknesses are explored. Google will be used as a cast study example.

Why Psychological Safety is Important

Health care organizations are in the business of making people better. In order to stay competitive in this time of payment reform and heightened transparency of organizations' outcome metrics, improvement and innovation are required. But, in an effort to generate good outcomes, some organizations have created cultures and policies that inadvertently shut down improvement and innovation. Unequal power distribution and status, automatic consequences for honest mistakes, and unwillingness of leadership to consider the opinions of their employees lead to a workplace or team environment where innovation stagnates and broken systems continue. While this is never the aim of an organization, however, it may be an outcome of a culture that lacks psychological safety.

Google conducted a study of the dynamics of effective teams and found psychological safety to be the most important of the elements identified by the research team. Members of teams with high psychological safety were more likely to be successful in areas including generation of revenue, perception of effectiveness, and innovation; in addition, psychological safety was found to decrease staff turnover, demonstrating that the benefits of psychological safety are extensive and transcend discipline.

Most humans practice a behavior known as impression management: filtering words and actions in order to avoid looking ignorant, incompetent, intrusive, or negative. This serves as an effective tool to keep individuals safe. However, it is detrimental to organizations or teams whose work is both uncertain and interdependent (Edmondson, 2014). In order to innovate and learn, individuals must be willing to share their ideas and experiences and must feel that the benefits of doing so outweigh the likely consequences. In order to flip that switch from fear to assurance, leaders must make a conscious effort to cultivate and build psychological safety into the culture of their organizations and teams.

How does psychological safety work?

In Dr. Amy Edmonson's 2014 TEDx Talk, she defined psychological safety as: "… a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes." Frankel, et al outlined the key elements of psychological safety as:

- "Anyone can ask questions without looking stupid.
- Anyone can ask for feedback without looking incompetent.
- Anyone can be respectfully critical without appearing negative.
- Anyone can suggest innovative ideas without being perceived as disruptive."

Generally, psychological safety allows organization and team members to feel safe collaborating and

problem solving together. That can be particularly challenging in teams consisting of members of varying statuses. In these cases, the distribution of power often seems uneven, leading those of lower status or power to feel unsafe contributing to team activities or conversations. When this happens, teams function below their potential, regularly missing opportunities for improvements. Link to Amy Edmondson's TEDxTalk:

https://www.youtube.com/watch?v=LhoLuui9gX8

Trust vs. psychological safety

While psychological safety is closely related to trust, it differs in some key ways, for example, the focus of attention. When an individual does not trust someone, that individual might carefully monitor the other person's behavior. However, when an individual does not feel psychologically safe, they monitor their own behavior also called self-monitoring (CITE). Judgement is also affected in situations lacking psychological safety in a different way than those lacking dyadic trust. Even though a person's silence could have severe and long-term consequences, the immediate risks of speaking up feel much larger in the moment than the potential long-term consequences, preventing them from making logical choices in those situations. Another difference is that trust is usually measured at the interpersonal level, whereas psychological safety is generally defined at the group level: it is a facet of the culture of a team or organization. (Edmondson, 2004)

Adaptive Leadership and psychological safety

Among the many leadership theories, adaptive leadership as explained by Northouse 2016, focuses on facilitating change within an organization, stands out as lining up nicely with creating a culture of psychological safety. Key features of this leadership style include giving a voice to the staff and empowering them to do their jobs. Adaptive leadership is noteworthy in that it takes dependence off of the "leader". All members of the team or organization affected by the necessary adaptation are included in the work. Adaptive leaders don't exercise dominance over the team members; rather, leaders empower others to do the necessary work, facilitating the process through holding environments, providing guidance and conflict management, and by ensuring the followers are experiencing a productive level of distress: not so high that they become overwhelmed, but not so low that they can avoid the challenge altogether.

In the context of adaptive leadership, there are three categories of challenges that can arise: *adaptive, technical, and a combination of both.* Adaptive challenges are different than technical challenges in that technical challenges can be solved with current organizational knowledge and capacity. Adaptive challenges tend to be more nebulous, involve values and beliefs, and, because of this, are more difficult to address. There are also challenges that are both technical and adaptive in nature: those with a clearly defined goal, but without a solution already in existence within the organization. In these cases, the leader and followers must work together to come up with a solution. There are four main perspectives that make up adaptive leadership (Northouse, 2016):

1. **Systems perspective**: Problems are part of a complex system
2. **Biological perspective**: People are able to adapt and have been heavily influenced by past experiences that required adaptation
3. **Service orientation**: The leader serves the people by recognizing the problems they're facing and then proposing solutions to those problems
4. **Psychotherapy perspective**: People need a safe and supportive environment in which to adapt to change

Leaders encouraging psychological safety are utilizing the **psychotherapy perspective of adaptive leadership** in order to create a safe environment for innovation and improvement.

There are several behaviors which can lead to successful adaptive leadership (Northouse, 2016):

1. **Look at the forest**: The leader must step back far enough to see all of the pieces of a challenge and how they interact. Sometimes this means stepping into an observer role for a period of time.
2. **Categorize the challenges**: Are the challenges adaptive, technical, or both? A leader can generally handle a technical challenge themselves. However, adaptive challenges require involvement of those followers whose values, beliefs, and feelings are being affected.
3. **Regulate the temperature**: An adaptive leader is responsible for creating a safe environment for the followers to produce change. This means maintaining an environment with the correct amount of pressure to encourage change but also avoid burnout.
4. **Direct attention**: The leader must assist the followers in staying on task. This includes the prevention of avoidance behaviors such as blaming others for the problem, ignoring the problem, or focusing on unrelated tasks.
5. **Step aside**: While leaders must provide guidance when needed, they also need to recognize when to hand over the job of finding and implementing a solution to their followers.
6. **Give others a voice**: Be open to the ideas and opinions of those who may be not be in a position of authority or who feel unheard or disregarded. This may yield innovative ideas and solutions and can inspire additional participation.

A key feature of a psychologically safe environment is that all team members are encouraged and expected to contribute to group conversation and planning. By giving others a voice, leaders are fostering the creation of psychological safety within their team or organization.

Strengths of psychological safety in organizations and teams

Organizations with an ingrained culture of psychological safety benefit in numerous ways, including increases in innovation and improvements in patient safety. Many organizations give contradictory messages by having a benchmark of safety standards that must be met while also making error reporting of these processes a priority. Employees may fear punishment for not meeting the safety standards and, therefore, may not report the related safety errors. As expected, adverse events have been found to be under-reported by front line providers.

Both psychological safety and error reporting rates are positively associated with leader inclusiveness, defined as, “words and deeds that invite and appreciate others’ contributions”. (Applebaum, et al, 2016) When team members feel safe to report mistakes, ask questions, or make suggestions, there are more opportunities for learning. The individual gains knowledge that they can build on, and the organization gains the opportunity to explore where their systems and processes are working and where they’re not.

The created openness can function as a protective factor and a marketing asset for organizations in the age of published metrics by giving leaders an opportunity to address shortcomings sooner and with increased input from those people who know how best to solve them. Similarly, especially in health care, there will be situations involving risk that require coordination within teams. Members must feel free to talk about those risks and to get and give advice as needed in order to minimize them.

Psychological safety was also found to positively influence creativity and innovation in the group setting. A free-flowing exchange of information leads to more comprehensive brainstorming, resulting in an expansion of ideas and possible solutions to issues. And just as leader inclusiveness promotes error

reporting, it was also shown to encourage participation in quality improvement efforts (Kessel, et al, 2012).

Another benefit of psychological safety is an improvement in job satisfaction among employees. An increase in employee motivation and a decrease in turnover mean that organizations are retaining trained staff with institutional knowledge, saving money on training new employees, and increasing opportunities for process and organizational improvements (Edmondson, 2014).

Challenges for Psychological Safety

While psychological safety has many resulting benefits, there are also weaknesses.

Creating culture change is not an easy task and requires concerted effort and conscious planning to move a team or organization to a high performing psychologically safe environment. Most organizations or teams are made up of members who already have a history with each other, which can be a hindrance; members must unlearn old habits and inclinations before relearning new ways of interacting. Also, a change of culture does not happen overnight. The process can be time consuming and requires a great deal of planning and attention.

How to Create a Team or Organizational Culture of Psychological Safety

As psychological safety is a group construct, it can best be created through changes in leader behavior as well as through the establishment of ground rules, outlining the expected behavior within the team or organization. Organization or team leaders are in a uniquely powerful position to influence the behavior of their subordinates. In order to plant the seeds of culture change, leaders must ensure that all organization or team members are clear on what cultural changes are expected and how those translate to their own roles, no matter where they are in the organizational hierarchy. A key ingredient to creating psychological safety is “walking the talk”. In the context of psychological safety, that includes encouraging dialogue, inviting input and feedback, being accessible, and modeling openness and fallibility (Leroy, et al, 2012).

Encourage Dialogue and Inviting Input

Approaching a situation with the expectation that everyone will deliver flawlessly is a recipe for failure. To err is human. If team members feel like they can’t or shouldn’t ask questions, then the whole team is more likely to make a mistake. The best way to counter this is to explicitly frame the work as a “learning problem, not an execution problem”. Remind them that the only way to succeed is together, utilizing the questions, viewpoints, and opinions of *everyone* on the team. (Edmondson 2014

Group meetings can also be used as a tool to promote psychological safety. These are opportunities to demonstrate that the environment is safe. The team should be provided with the leader’s undivided attention during meetings. Demonstrate engagement by asking questions and responding both verbally and through body language. (Re:Work) Engage an organization or team member ahead of time to request that they bring up issues during the meeting. Leaders can be prepared to respond in a way that demonstrates to the other members that the unit is a safe space. Also, by asking questions of team members, leaders show interest in their opinions and promote further dialogue. Even if it hasn’t previously been a psychologically safe environment, simply modeling this new behavior can spur change.

Accessibility

Supervisors who are open, available, and have a routine presence on healthcare teams foster better psychological safety within the teams. In addition to having an open-door policy, being physically present, and getting to know staff members in all positions, leaders should also support and encourage their mid-level managers and supervisors to develop this kind of open team culture.

Modeling Openness and Fallibility

In order to foster psychological safety, leaders need to function as coaches: guiding their staff and minimizing judgement. Also, leaders should view their own mistakes as opportunities to model

psychological safety. By owning up to their own mistakes in front of them, the team will see that it's safe for them to share their mistakes as well. One of the features of the health care environment is that status and power are derived largely from position. Those in higher positions are in a place of greater default psychological safety than those in lower positions.

Power distance, defined as "the extent to which an individual perceives and accepts unequal distributions in status and power within institutions and organizations" has been shown to negatively affect psychological safety and adverse event reporting. However, leader inclusiveness can have a moderating effect on psychological safety with regard to status. So, in addition to training staff to comment and share their thoughts more freely, organizational and team leaders should also be trained in how to both invite and reward these comments, ensuring that everyone feels valued and respected.

Stacking Teams

In order to encourage culture change, leaders can stack teams with members who are more likely to see the team as safe and to build friendships amongst the team members, which has been shown to increase team psychological safety. However, managers should also be aware that the opposite can happen as well: there is a risk of decreasing team psychological safety by including members who are previously inclined to perceive low psychological safety (Shulte, et al, 2012).

Psychological Safety through the establishment of ground rules

Ground rules can be a helpful method of encouraging team members to feel a sense of ownership and buy-in to the key concepts of psychological safety. Cave, et al conducted a 2016 study of CENTRE, a framework of ground rules which was developed to encourage psychological safety. The study suggested that Confidentiality, Equal Airtime, Non-Judgemental listening, Timeliness, Right to Pass, Engagement) (CENTRE) was useful for participants, although it did not establish details of what made it useful. Regardless, it can be used to create a pre-defined agreement on interaction and expectations within the team. Please keep in mind that setting effective ground rules requires buy-in from the team members prior to implementation, which means they must be informed and allowed to give feedback and request changes. CENTRE includes the following rules:

1. Confidentiality – Team members are expected to share only what the team agrees can be shared outside of the team, and are expected to speak from an individual point of view only (do not speak for the group);
2. Equal airtime – All members are to be given equal opportunities to attend, speak, and present at meetings, which, while under the management of the group leader, is the responsibility of all of the members;
3. Non-judgmental listening – Starting out listening to understand rather than listening to respond; one person speaks at a time; team members speak in "I" statements and trust that others' are speaking their own personal truths; members respond with only constructive feedback that focuses on behaviors and never personal character; and mobile devices are either turned off or other members of the team are notified of the possibility of receiving an important notification prior to the start of the meeting;
4. Timeliness – All team members are provided with set start and end times for each meeting beforehand, those start and end times are respected, and all members arrive for the meetings on time;
5. Right to pass – All members have the right to pass up an opportunity to speak any time they are invited to do so;
6. Engaged – All team members should take note of what may be distracting them and are

encouraged to engage as much as is possible for them

Google's Psychological Safety Toolkit: https://rework.withgoogle.com/guides/understanding-team-effectiveness/steps/foster-psychological-safety/

Summary

Psychological safety is a group construct in which members feel that they "…will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes." (Edmondson, 2014) Members of teams with high psychological safety are more likely to report mistakes and to be successful in areas including generation of revenue, perception of effectiveness, and innovation. Psychological safety can also result in significant benefits to teams and organizations, such as improved patient safety and decreases in staff turnover.

In order to cultivate a culture of psychological safety, leadership must create an environment where members feel that the personal benefits outweigh the risks or consequences of speaking up with ideas, concerns, or mistakes. By encouraging dialogue from all team members, inviting input and feedback on leader behavior, being accessible and developing relationships with team members, and modeling openness and fallibility by sharing personal examples of failures and lessons learned, leaders can model psychological safety for their teams and help promote culture change. While culture change can be a long, challenging process, the benefits of psychological safety can facilitate successful teams and organizations in growing and adapting to ever-changing environments.

The Power of Resilience: How Stewards in Palliative Healthcare Settings Can Leverage Resilience to Combat Staff Burnout

Nicholas Fowler

Introduction

Burnout is no stranger to the palliative healthcare industry. Day in and day out palliative healthcare staff are faced with stressors that are both common to the healthcare industry as a whole and unique to palliative healthcare alone. These stressors can often lead to chronic burnout among the palliative healthcare staff members. The good news is that there are steps that can be taken to help mitigate and potentially alleviate the symptoms of burnout. One could argue that stewards within palliative healthcare teams are not only in a position to use this knowledge to help their teams but are actually obligated to do so. Throughout the rest of the chapter we will explore the palliative healthcare field through a Positive Organizational Scholarship (POS) lens to investigate how stewards can use resilience training as a tool to combat the negative effects of burnout within their teams.

Burnout, in simple terms, is a loss of energy. This sense of energy loss can manifest itself in both physical and psychological forms. We have all probably experienced burnout in some way, shape, or form. One may feel a sense of physical burnout after a long day of helping a friend move into their new home, continually working muscles that you may have not used in that way in years for an entire day. A sense of psychological burnout could occur after hours and hours of cramming for a big test that you have been procrastinating for weeks. We are fortunate in that our burnout is usually temporary and only occurs a few times throughout the course of our life. However, for some, burnout is an everyday occurrence, and can have potentially negative outcomes for those experiencing this phenomenon.

For those working in palliative healthcare, burnout, in some shape or form, is nearly a certainty. Individuals working in palliative healthcare settings have been found to experience similar levels of stress as their non-palliative healthcare working peers, and there is some evidence that those working in healthcare settings in general experience much more stress relative to the general working population (Ablett & Jones, 2007). The emergence of Positive Organizational Scholarship offers an opportunity to explore how palliative healthcare staff can combat burnout and have more reasons to smile.

One key concept in Positive Organizational Scholarship (POS) is “resilience.” According to Shawn Murphy, in his book *The Optimistic Workplace*, resilience is the ability to recover from, adapt to, and grow from setbacks. As noted above, working in palliative healthcare can lead to a multitude of setbacks that might test one’s resilience. These setbacks may be viewed as stressors. In fact, these are the same stressors that lead one to burnout. Shawn Murphy, says the good news is that resilience can indeed be developed and that positive emotions such as joy, interest, and pride help individuals to build resilience (Murphy, 2016).

Due to their unique positioning, middle managers have the capacity to make for very large, and substantial change in palliative healthcare. Middle managers are oftentimes in the loop with the goals and initiatives that senior leadership hope to push but also have rapport and influence with those on the ground level, giving them great opportunity to influence change within an organization (Hagland, 2005).

Although most are familiar with the term “manager,” for the sake of this chapter the word steward will be used in its place. The words “manager” and “management” may have negative connotation for some. Inherently, these words may raise issues of “management” being in control over or dominating

subordinates. This chapter changes the language of manager to steward in order to explore the positive aspects of leadership (Murphy, 2016). This chapter is about capitalizing on the foundations that POS has created to help people and organizations within the palliative healthcare field flourish and thrive. This cannot be accomplished unless there is a shift in the way in which people view the role of mangers, and instead think of them as "stewards."

Stewards operate from a place of caring for individuals. Rather than using their position to dominant or impose their will upon others, they use their position to inspire, motivate, and support the members of their team. Stewards view it as their responsibility to coach, guide, mentor, and motivate people to be the best version of themselves, facilitating team members to achieve greatness through their actions and their words (Murphy, 2016).

This subtle change of jargon may seem trivial, so why even bother? The answer, language matters. We do not have to search very hard to find an example of this play out in real life. Let us look at the opioid epidemic that has taken so many lives and has impacted nearly every corner of the United States. Stigma is one problem that has been perpetuating this epidemic, and much of this stigma has to do with the language that is used to describe the people that have an addiction, a disease, that may lead them to use either prescriptions, illicit opiates, or both. For example, are people going to put in the time and effort to help change the culture for a junkie or an addict? Probably not. But they may be willing to work toward a culture where a person with a substance use disorder is able to access the resources that they need to live a happier healthier life.

As shown above, when trying to change a culture, language really does matter. So, in order to perpetuate the culture that this chapter is advocating for, it is important that language is used that reflects the culture to be instilled. Therefore, to stay true to the more modern discipline of POS, it is important that one uses language that illustrates a more modern view on management. Hence, the importance of using the term steward/stewardship as opposed to the term manager/management.

With this new vocabulary and vision of stewardship put in place, the foundation is set for the pages that will follow. The remaining pages of this chapter will outline the importance of resilience in the battle against burnout that palliative healthcare staff are all too familiar with. As we have already established, resilience may be developed, and it is the responsibility of stewards within the palliative healthcare field to empower individuals to develop resilience to help defend themselves from the stressors that come along with working in such a line of work.

Palliative Healthcare

First, it is important to understand what palliative care is and why it is such an important part of the healthcare system. The World Health Organization, whose goal is to "build a better, healthier future for people all over the world," defines palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." The WHO breaks down the role purpose of palliative healthcare providers into the following practices:

- Provides relief from pain and other distressing symptoms
- Affirms life and regards dying as a normal process
- Intends neither to hasten nor postpone death
- Integrates the psychological and spiritual aspects of patient care
- Offers a support system to help patients live as actively as possible until death
- Offers a support system to help the family cope during the patient's illness and in their own bereavement
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated

• Will enhance quality of life, and may also positively influence the course of illness
• Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications (Sepúlveda, Marlin, Yoshida & Ullrich, 2002)

Thus, palliative healthcare is unique from other forms of healthcare work. Many people seek out typical healthcare services in hopes of healing and getting better. However, in a palliative healthcare setting, as noted above, there is typically no hope of getting better. Quite the contrary is actually true. Those seeking out palliative healthcare do so because there is no "getting better," as death is imminent. This unique situation presented by palliative healthcare, a focus on quality of life until their dying day rather than a focus on the quantity of days left, makes for an incredibly high risk of stress, depression, and burnout for palliative healthcare workers (Hulbert & Morrison, 2006).

Due to this disconnect, those working in a palliative healthcare setting could potentially experience a unique type of stress. Oftentimes, professional training for healthcare workers involves a curative focus, however, this is not the reality for those working in a palliative healthcare setting. This disconnect could lead to a sense of helplessness and dissatisfaction that staff in other healthcare staff do not have to cope with as regularly in their work (Ablett & Jones, 2007).

After understanding all that palliative healthcare staff must do, this reality should come to no surprise to anyone. Because of this, it is critical that palliative healthcare organizations do all that they can to not only minimize these negative outcomes, but to work day in and day out to help their employees build resilience to overcome such stressors which may come with the role of working in palliative healthcare. Not only will this have a positive impact on the palliative healthcare staff but improve the outcomes of the patients and their families as well.

Positive Organizational Scholarship

Throughout the entirety of this chapter, we will be exploring resilience through a lens of Positive Organizational Scholarship (POS). Therefore, it is important that time is taken to understand what POS is, and how it came to be. According to Kim Cameron and Arran Caza, POS is "is a new movement in organizational science that focuses on the dynamics leading to exceptional individual and organizational performance such as developing human strength, producing resilience and restoration, and fostering vitality" (Cameron & Caza, 2004). To fully understand POS we will first take a delve into its foundation: positive psychology.

Dr. Martin E. P. Seligman is often accredited as the pioneer of the positive psychology movement. As the story goes, Seligman and his daughter were pulling weeds in the garden, but his daughter could not stop playing and singing as they tried to complete the chore. Seligman snapped, yelling at his daughter. She snapped back, stating that she had given up whining because he had asked her to, and if she could stop that, he could stop being such a grouch. It was in that moment that Seligman realized that raising his daughter was not about stopping her from whining, but rather nurturing her strengths, enabling her to flourish and thrive (Seligman & Csikszentmihalyi, 2000).

Seligman, the president of the American Psychological Association at the time, noticed, like the way he had been raising his daughter, the field of psychology had been focusing far too much on fixing what was wrong with people rather than focusing on the aspects of people's lives that made life worth living. This deficit approach had taken hold shortly after World War II, focusing on disease model and healing the mental deficits that people were experiencing.

Although focusing on the pathology of mental health is very important, this mindset neglected to consider those individuals and communities that were thriving, and failed to help them build upon those skills to enable them to live the life that they wanted to live.7 Due to the work of Seligman and other

colleagues in the field, positive psychology has become more and more present in many fields of work. However, many doctors still operate under the deficit model that Seligman had been trying to abandon.

For example, in an article written by The Atlantic on March 21, 2018, Helen Mayberg, an American neurologist known for her studies of using deep-brain stimulation for the treatment of severe chronic depression, said “It’s not my job as a neurologist to make people happy. I liberate my patients from pain and counteract the progress of disease. I pull them up out of a hole and bring them from minus ten to zero, but from there the responsibility is their own” (Lone, 2018). The field of positive psychology has come a long way from the time that Seligman had his revelation near the turn of the 21st century, however, it is easy to see from this quote the remnants of a deficit based model are still seen today. This notion of only being concerned with getting patients from a state illness to state of okay can be illustrated on a continuum.

Another way to frame this is by looking at the Illness-Wellness Continuum, created by Dr. John Travis (Figure 1-1). Psychologists seemed to spend a great deal of time on the left-hand side of the continuum, working within the treatment paradigm. Although this was helpful, it only got patients to a neutral point. What Seligman was calling for was a shift in perspective, helping patients that were already beyond the neutral point. In other words, he wanted to focus on how psychologists can help patients thrive rather than simply survive. This model of thinking, however, is not unique to healthcare. Businesses and organizations, too, can be bogged down by thinking only of curing the illnesses of bad business practices, fixing troubled employees, or putting a bandage on the wounds that bleed profits and productivity out of organization. Shifting the focus from trying to fix all that can go wrong in a business to a focus on the conditions that allow for great businesses to thrive is the essence of POS.

Figure 1-1

Now that there is a clearer understanding of the foundations of POS, it is time to dive deeper into POS. In the book titled *Positive Organizational Scholarship: Foundations of a New Discipline* by Kim Cameron and Jane Dutton, POS is further explained by breaking down the three words that make up POS: positive, organizational, scholarship (Cameron, Dutton & Quinn, 2003). POS focuses on positive states, rather than focusing disproportionately on fixing what has been going poorly in the past. Within POS, there is an aim to focus on patterns of excellence, and in particular, phenomena that tend to deviate from the norm in a positive manner. These positive phenomena of focus are phenomena that tend to give organizations the ability to flourish and thrive, not simply survive as observed in the organizational scholarship of the past (Cameron, Dutton & Quinn, 2003).

The organizational aspect of POS is highlighted by the focus on phenomena that occur within organizations, as well as the context of the organization itself, bringing the oftentimes overlooked positivity to the forefront of focus. Subscribers of POS look to focus on how performance can be driven by promoting meaningful work for employees, aligning work toward employee strengths, and empowering those employees in a manner that promotes inclusion within, and with stakeholders outside

of, the organization. This is a far cry from the typical focus on mitigating negative consequences that lead to poor performance (Cameron, Dutton & Quinn, 2003).

Unlike many of the self-help books that have been published that tout the power of positive thinking or the parables of perseverance, POS is deeply rooted in the scientific method. In a way, it takes the self-help literature to another level, focusing on a desire to "develop rigorous, systematic, and theory-based foundations for positive phenomena" (Cameron, Dutton & Quinn, 2003).

What causes burnout?

In the introduction, burnout was defined simply as a loss of energy that can manifest itself either psychologically or physically. However, what needs to be explored further is what causes burnout, and in particular, what causes burnout in individuals working within the palliative healthcare setting. Research has shown that palliative healthcare staff face a unique set of stressors. These stressors include, but are not limited to: constant exposure to death, inadequate time with dying patients, growing workload, inadequate coping with their own emotional response to the dying, increasing number of deaths, communication difficulties with dying patients and families, and feelings of grief, depression and guilt (Slocum-Gori, et al., 2011).

One major cause of burnout that is commonly noted in palliative healthcare is "compassion fatigue," otherwise known as, 'the cost of caring'. Although not unique to palliative healthcare settings, this phenomenon is unique to helping professions, making it a great concern for palliative healthcare workers. Such stress has been known to show signs with little warning and can lead to helplessness, depression, and stress-related illness (Slocum-Gori, et al., 2011).

Resilience

"Resilience" was first explored when trying to better understand children that were maltreated and is a core aspect of the POS paradigm. "Resilience" applications have been used far beyond the realm of understanding its role in the lives of children that have been treated poorly. A myriad of diverse fields, including psychology, psychiatry, sociology, business, and biological sciences, have started to further explore resilience. Because of this there is no single definition of what resilience is, but, for the context of this chapter, we will define resilience as the "positive adaptation, or the ability to maintain or regain mental health, despite experiencing adversity" (Murphy, 2016).

The term "Grit" has also gained a lot of traction and has been used interchangeably with the term "Resilience." This has been fueled even more by the release of Angela Duckworth's book *Grit: The Power of Passion and Perseverance*. Although similar, there are some differences between the two that make them not so interchangeable. As described earlier, resilience is an optimistic mindset that motivates one to continue going on in the face of adversity. Grit, however, is a term that describes one's passion and perseverance toward a long-term goal (Duckworth, 2016).

Although these two concepts tend to intertwine a lot they are not interchangeable. One may have to exhibit a lot of resilience along the path to long-term goals. For example, a future hospice nurse may have to show a lot of resilience to bounce back after receiving a C score on his or her first epidemiology exam, but the deliberate practice to learn the skills necessary to obtain the nursing degree may require a lot of grit. Although not synonymous, these two words are both valuable in deterring burnout, and seem to dance together a lot within the same ballroom.

So, why exactly is grit important in developing resiliency amongst palliative healthcare staff? As stated earlier, grit is a combination of passion and perseverance. It is in this perseverance that one may see resilience shine the most, particularly perseverance over adversity. In Duckworth's book, mentioned above, she cites the work of Carol Dweck. Dweck, earned her PhD in psychology and has focused her attention on mindset and the impacts that it has on perseverance. In particular, the benefits of a growth mindset over a fixed mindset. Over her years of studies, she has determined that having a growth mindset leads to a more optimistic view of adversity. In other words, individuals with a growth mindset tend to be

more optimistic, viewing adversity as a challenge that is temporary and within their control (Duckworth, 2016). It is this connection between the perseverance of grit and the ability to overcome adversity that we find the connection between resilience and grit. This is further demonstrated below in Figure 1-2.

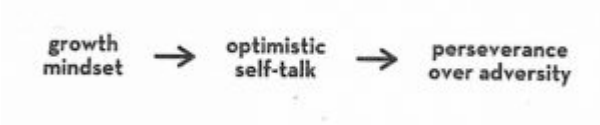


Figure 1-2

Putting the Pieces Together

Now that we have all of this knowledge about burnout, palliative healthcare, and resilience, it is time to explore how all of these pieces of the puzzle fit together. How might middle management in palliative healthcare settings measure resilience be good stewards of resilience amongst members of their team and ultimately use resilience as an asset to combat all of the negative side effects that come with burnout? At this point in the reading, readers may have come to some of these answers on their own. However, in this section we will continue to explore the practical application of resilience in palliative healthcare settings and how it can lead to a happier and healthier workforce.

First, stewards must understand how to measure resilience among team members. In 2011, a group of researchers published a systematic review of resilience measurement scales. Through this review, they were able identify 15 measures that were intended to measure resilience in various populations. However, not all of these assessments are geared towards adults; in fact, more than half were not. When looking at the scales geared toward adults, the population most likely to be working in palliative healthcare setting, there were a few that were found to be of higher quality than the rest. Even the highest rated resilience assessments seemed to be of moderate quality at best (Windle, Bennett & Noyes, 2011).

There is a growing body of research that suggests there are ways in which resilience can be developed. One such way that evidence seems to support is the practice of mindfulness. Mindfulness is defined by some as “a state in which one is able to give uninterrupted attention over a period of time in a nonjudgmental way to ongoing physical, cognitive and psychological experience, without critically analyzing or passing a judgment on that experience” (Bajaj & Pande, 2015). Put simply, mindfulness is the ability to be present in the moment, and experience events and sensations for what they are. This may seem to some as a form of pseudoscience, but there is more and more research that is being published every day that points to mindfulness as an effective tool for people of nearly all walks of life. If looking for ways to incorporate mindfulness into professional development, staff meetings, or training, the Positive Psychology Toolkit can be a great place to start.

For those who still do not believe in the benefits of mindfulness, look no further than the United States Military. There are not many higher stress events that one may experience than live combat. According to an article posted on the United States Army website, mindfulness was shown effective to build not only cognitive resilience, but the brain’s ability to pay attention during training as well.

Mindfulness has shown so much promise that the military’s STRONG Project, standing for Schofield Barracks Training and Research on Neurobehavioral Growth, which has been granted over $1.7 million to continue researching the impacts of pre-deployment mindfulness and resiliency training (Myers, 2015). It is not only pre-deployment military personnel that is benefitting from the benefits of mindfulness; military veterans that have been diagnosed with posttraumatic stress disorder (PTSD) have also seen benefits of mindfulness in their treatment.

Similar to palliative healthcare staff members, military personnel are oftentimes exposed to high stress environments and the reality of death. This can lead to high rates of PTSD and depression. Mindfulness exercises have been shown to significantly decrease both PTSD and depression severity in military veterans (Boden, et al., 2012). This is just one more example of the benefits of mindfulness exercises

and the need for further mindfulness research. It seems as if mindfulness is powerful, but it is not the only way in which one can develop resiliency.

Angela Duckworth cites a study done by Steve Maier in her book. This study showed that it is not adversity alone that builds resilience in individuals. The old adage "what doesn't kill you makes you stronger," is true to a point. It is the sense of having some sort of control over one's circumstances that has been shown to "make you stronger." Those who have a sense of no control over the adversity that plagues them will often fall into this state of learned hopelessness, destroying resilience. It is not the adversity that tends to build resilience, rather the way in which people are able to and equipped to respond the adversity that comes their way (Duckworth, 2016). This means that stewards can build resilience in employees by fostering hope and providing ways for individuals to overcome adversity in a positive way.

Individuals that have been shown to have high hope often view adversity differently than those with low hope. Adversity, otherwise known as goal blockages, can lead to negative emotions in individuals with low hope, but those with high hope often view this adversity as a challenge to overcome. Studies have shown a correlation between high hope and higher achievement and lower levels of depression, while their low hope peers demonstrated a decreased sense of well-being among other negative outcomes (Hanson, 2009).

Adult Dispositional Hope Scale

The Adult Dispositional Hope Scale, a twelve question self-assessment graded on an eight-point Likert scale, has shown to be reliable and valid, and is used in people 15 years of age and older.16 This is yet another test that stewards can use in palliative healthcare onboarding or professional development conversations in order to assess and discuss an employee's sense of hope in the workplace and in their lives.

Snyder divides hope theory into four distinct categories: goals, pathway thoughts, agency thoughts, and barriers (Hanson, 2009). One way to develop hope in individuals may be to engage in dialogue that involves these four areas. Establishing "goals" for an employee can give them an endpoint to view in their hopeful thinking (Hanson, 2009). Therefore, it is important that stewards take time to work with their employees to establish meaningful goals, and check in regularly on how the goal attainment is coming along.

"Pathway thoughts" are the ways in which people hope to explore in order to achieve their goals. This means it is not only important for stewards to help employees set meaningful goals, but explore with them how they might go about achieving those goals. Agency thoughts refer to the motivation one might have to undertake the route needed to be explored in order to achieve those goals.16 In this context, it is essential for stewards to know the purpose of the organization and the team member. It is worth exploring the strengths and passion of the team member to help them realize how their goals can be fulfilling to them.

Palliative nurses may feel a great sense of connection to their work because they feel their purpose is to offer relief to people in some of their most trying times. Setting goals that orient toward a nurse's purpose will most likely lead to the greatest sense of motivation to pursue the paths needed to achieve his or her goals. Finally, barriers are the things that hinder individuals from attaining their goals. These can either cause someone, typically with a low sense of hope, to give up on their goals or motivate individuals, usually those with a high sense of hope, to find new routes to take on their way to their goals (Hanson, 2009). Stewards that are experienced and forward-thinking may be able to use some foresight to identify future barriers, or even challenge team members to look ahead and see what barriers there may be, preparing them to face such adversity shall it arise.

Although hope and mindfulness are only a couple of things that stewards can do to build resilience within their teams, it is a start in the right direction. What is important to takeaway is that resilience

is not fixed; it can be developed and fostered through meaningful intervention. This not only provides palliative healthcare workers on the front line the ability to grow as individuals, but give stewards and organizations the opportunity to provide protective factors to their teams against burnout.

Challenges and Future Exploration

Although researchers have been studying the impacts of Organizational Scholarship (OS) for decades, the field of Positive Organizational Scholarship (POS) is a fairly new frontier of exploration. As more POS research floods the field of OS, we are learning how impactful POB can be in the workplace. From the limited studies, it seems as if the palliative healthcare field is no different, but more research needs to be done. POS consists of many factors other than resilience, and focusing research on resilience alone is far too narrow. I would encourage more research on the implementation of a fully immersive culture of POS in healthcare settings. With the great deal of overlap, it is also natural to expect that there would be a synergistic relationship between all of the POB pillars. These synergies deserve much more research in the future in order to fully unlock the potential of resilience and POS as a whole.

Nearly all of the research thus far seems to focus on the palliative healthcare staff or patients that are terminally ill. However, with the expansion of the WHO's definition of palliative, it is important that researchers take into account the impacts on the families whose loved ones are ill. Resilience is oftentimes viewed as a characteristic or trait of an individual in much of the research that has been conducted. This focus may erroneously lead people to believe that resilience is the sole responsibility of the individual developing it. When we hear stories of resilience we oftentimes hear parables of overcoming incredible amounts of adversity in order to accomplish great feats. For example, the football player that overcomes cancer and is still able to play in the National Football League, or the child that grows up in a zip code that is well below the poverty line and raised by two parents that were constantly in and out of jail but is able to overcome these obstacles to earn a PhD. In both of those examples we see individuals accomplishing amazing things, but what we do not see is the role that others played in this journey to success.

Regardless of the journey and the amount of resilience demonstrated, there is more to the picture that we often see. This is important to keep in mind. When it comes to developing resilience in palliative healthcare staff, or anyone for that matter, it is important to realize that organizations and other people played a role in the success of that individual. It is irresponsible for organizations to solely rely on individuals to develop their own resilience in order to overcome adversity and battle burnout. Organizations and middle management–stewards operating in the middle–need to view burnout as a threat to the workforce and give teams the tools that they need in order to overcome this affliction. It is critical that a proactive approach is taken.

Another important factor to keep in mind is that one does not have to overcome incredible odds or accomplish a great feat to be a paragon of resilience. In palliative healthcare, adversity is part of the job description. Just because it is the job of a palliative healthcare worker to provide services to an individual and their families during the dying process, it does not mean that bouncing back from the death of patient or helping a family through the grieving process is not a demonstration of great resilience.

Conclusion

No matter what field of work one might choose to pursue, there will be stressors. If left unattended these stressors can lead to a myriad of negative consequences, and if they persist long enough without any defense or interventions, they can lead to chronic burnout. Although this is a threat to anyone in the workforce, we have seen that healthcare workers tend to experience burnout at much higher rates than that of the average working American. In a palliative healthcare setting, staff members tend to experience roughly the same amount of stress and burnout at other healthcare staff, but the stressors they tend to experience are very unique to the field of palliative care. The good news is that resilience can act as a tool to combat the ill effects of burnout.

It is important that stewards in palliative healthcare settings use all the information at their disposal to create an organization that truly embraces the POS model. This means creating an environment that promotes the building of resilience in order to defend against burnout. First and foremost, it is important that stewards in palliative healthcare settings take time to get to know their team members. This may include performing nontraditional assessments such as measuring resilience, strengths, and burnout. Using one-on-one staff meetings and trainings as an opportunity to be intentional about building resilience can greatly benefit the staff and quality of care. Such activities may be exploring purpose, nurturing hope, and mindfulness-based activities.

Burnout is a serious issue that impacts far too many in palliative healthcare settings, however, it is an ailment that can be combatted. Through careful coaching and the implementation of POS pillars into the palliative healthcare setting, it is possible that stewards can help to eliminate, or at least lessen, the impact that burnout makes. As the future stewards of the healthcare industry, it is up to you how you will protect your team from the ill effects of burnout and help them become the best that they can be. Hopefully, after reading this chapter your course of action will be a little easier.

Burnout in Addiction Treatment: Implications for Leadership and Public Health

Trevor Moffitt

Introduction

Coined the "opioid epidemic," the United States' public health crisis of rising opioid-related overdoses and overdose deaths has finally garnered medical, social, and political attention and focus. In October of 2017, President Trump declared the opioid crisis a "public health emergency," potentially paving the way for more national resources to be allocated to opioid-related treatment and research (Davis, 2017). Some states have been affected more than others by the epidemic, although all of them have at least 2.4 opioid-related overdose deaths per 100,000 people per year (NIDA, 2018). Ohio ranks third in states with most of these overdose deaths and has 36.8 such deaths per 100,000 people (Columbus Public Health, 2018). Franklin county, Ohio's second most populous county, has seen its rate of unintentional drug overdose deaths rise by 423% since 2003 (Columbus Public Health, 2018).

While more research studies are underway and are being funded as the crisis continues, more work is needed to answer basic questions. What are best practice guidelines for delivering treatment to those with Opioid Use Disorder (OUD)? How can opioid users be effectively linked to treatment during a crisis? How can users avoid relapse or further need for intensive treatment? At the center of each of these questions is the individual "OUD treatment experience." Even critics of the government's handling of drug epidemics, past and present, see the need for treatment as a vital focus moving forward (Stobbe, 2017). It appears the nation is primed for a great influx of addiction treatment centers to treat the rise in drastic number of Americans dying of opioid-related overdoses. However, the data show a low level of engagement among opioid users with treatment centers. In 2016, only 18% among those needing treatment for an illicit drug use problem received treatment at a specialized facility (Park-Lee, Lipari, Hedden, Copello, & Kroutil, 2016). With such a low treatment engagement level, it is essential that addiction treatment leaders prioritize quality for both staff and clients. This may or may not dictate a surge in new treatment center construction but does impact the quality of treatment offered during treatment interventions.

Focusing on the healthcare providers specifically, like counselors, social workers, or nurses, treatment center staff encounter a breadth of occupational stressors: *resistance from clients, poor treatment outcomes, coworker turnover, and pressure to meet company goals.* In addition to these barriers, which several other professions could reasonably face, addiction treatment center providers are confronted with overwhelming client workloads, emotional stories of loss and devastation, and the uncertainty of final outcomes of treatment (Volker et al., 2010). Healthcare providers, specifically addiction treatment providers, may thus face a higher risk of burnout compared to other professions.

An Overview of "Burnout"

Burnout is broadly defined as the interaction of the stresses of work and the ways in which a person copes or, more accurately, fails to cope (Lacoursiere, 2001). As the pressures and stressful experience of a job increase, the employee may begin to feel burnt out as their coping skills deteriorate. According to Maslach (2001), a leading figure of job burnout research and developer of a popular burnout instrument, the burnout experience can be deconstructed into three dimensions: [1] overwhelming exhaustion, [2] feelings of cynicism and detachment from the job, [3] and a sense of ineffectiveness and lack

of accomplishment (p. 160). We can imagine how an opioid use counselor may experience each of these facets. If the counselor has more clients than hours in the workday, he/she could easily become exhausted. Counseling multiple clients that may have been through treatment multiple times could lead to cynicism about the effectiveness or benefits of treatment. Finally, when counselors experience a lack of closure as clients leave the center and are never heard from, accomplishments are difficult to conceptualize.

Job burnout as a conceptual model and theory has been driven predominantly by Leiter and Maslach (1999). While incorporating the basic three-dimension framework of *exhaustion, cynicism, and ineffectiveness*, the authors expanded their theory to include the organizational, contextual, or environmental aspects of burnout.

Six organizational risk factors for job burnout were identified and modeled into the "Areas of Worklife:" workload, control, reward, community, fairness, and values. Leiter and Maslach argue that organizational burnout antecedents, may be categorized into one of these areas. A survey, the Areas of Worklife Scale (AWS), was constructed to measure the predictors of burnout on an organizational level (Leiter and Maslach, 2004). Whereas the Maslach Burnout Inventory (MBI) (Maslach, Jackson, & Leiter, 1986) was created to assess burnout in individuals based on the three dimensions, exhaustion, cynicism, and inefficacy, the AWS can be used by organizations or leaders to assess for systematic contributions to employee burnout. As Leiter and Maslach concluded (2008), "it is more likely that signs of impending problems… will tend to cluster within particular units or organizational groups" (p. 509). For leaders in addiction treatment settings, one question concerns, "Where are the problem clusters and what can be done to alleviate and prevent this?"

Challenges in Addiction Treatment

Burnout aside, substance use treatment centers face a breadth of unique challenges, at both the individual provider and organizational levels. As discussed, the personal stress counselors face can be formidable, much like that of other healthcare delivery workers (Oser, Biebel, Pullen, & Harp, 2013). Outside of the individual effects of this profession, characterized as "compassion fatigue" though recent literature suggests discontinuing the term (Biebel, 2012), are organizational factors. In order to stimulate research that could lead to improving the national substance use treatment network, D'Aunno (2006) briefly summarized the current state of organization and management in substance addiction treatment. D'Aunno argued that best practices are commonly not used in substance abuse treatment centers because clients are not in position to demand them. Additionally, and more applicable in this context, since treatment providers often use the practices they prefer or see fit, managers cannot expect for all staff members to adopt a current best practice merely because they show efficacy. Furthermore, D'Aunno described an inherent conflict between substance use counselors and their leadership; counselors desire to use what they believe works best for them individually, while leadership exerts pressured to follow best practices standards and guidelines. This fits in the control area of Leiter and Maslach's (1999) organizational burnout risk model while also touching on fairness. Counselors and social workers may perceive it unfair that they, the trained professionals who interface with clients, do not get to choose the method or framework implemented during treatment.

Similar to the D'Aunno (2006) study, Leiter and Maslach intended to fuel further research in the organizational behavior and leadership of substance use treatment. The longitudinal study utilized data from the National Treatment Center Study at the University of Georgia from public and private sector treatment centers (n = 766). The authors used this data to highlight differences of substance use treatment delivery between public and private sectors. While these findings would no longer be accurate as 12 years have passed, the general pattern of findings may be. In every medically assisted treatment (MAT) the public-sector counselors were more familiar with the effectiveness of the listed treatment. This could be helpful for directors and counseling managers in private sectors who may need to ensure staff are

familiar and trained on best practices. Counterintuitive findings showed that private sector treatment centers consistently offered more MAT.

During their national study of implementing evidence-based treatment in community addiction treatment providers (excluding specially identified programs in the NIDA Clinical Trial Network (CTN)), Lundgren et al. (2011) analyzed the organizational and leadership factors of directors (n = 212) for correlation with perceived attitudes of their staff's resistance to organizational change. The authors' linear regression model found that those directors with less staff cohesion and autonomy who also saw their organization as needing more guidance displayed higher levels of staff resistance to organizational change. The authors recommended that more funds are needed to properly train staff in evidence-based practices, though this may result in unwanted effects in employee burnout regarding control. Additionally, these results may show a need for addiction treatment leaders to strengthen their staff's cohesion, which will be discussed later with other protective factors.

Contributing Factors

Before considering protective factors against job burnout and how organizations may implement or strengthen them, it is important to understand the factors contributing to this psychological syndrome following Maslach & Leiter (2016). The literature classically established a multitude of individual factors (Pines & Maslach, 1978) and researchers later sought to describe organizational contributors (Leiter & Maslach, 1999).

Individual Contributing Factors

Two of the three dimensions of the burnout experience, exhaustion and cynicism, could be considered solely on the personal level. True, the workplace environment moderates these, but individual feelings of exhaustion and cynicism exist primarily at the individual level. In other words, there can be no tangible workplace expression of exhaustion or depersonalization, whereas with reduced accomplishment there can be, for example, a lack of annual raises or no reinforcement from management. Lacoursiere (2001) suggested that there could be certain work events or environments in which a feeling of burnout might be a normal response. This contrasts with the conceptualization of burnout as a disease-model. Regardless, in response to individuals experiencing unhealthy levels of burnout components like exhaustion or cynicism, Lacoursiere (2001) purports that employers ought to demonstrate the same effort as when dealing with other problems like quality, style and performance levels of work.

Corroborating these two primary, individual contributing factors Knudsen, Ducharme, and Roman (2009) applied burnout principals to measure other job-related individual factors. The authors, recognizing a lack of research on emotional exhaustion and turnover intention for organizational leaders, completed research on leaders of addiction treatment organizations and focused on the leader turnover intent and emotional exhaustion. Turnover intention, rather than actual turnover, was chosen since true turnover data requires longitudinal research. The authors used two job demand related independent variables, performance demand and centralization (making more day-to-day decisions), and two job resource related independent variables, innovation in decision-making and long-range strategic planning. The researchers' hypotheses were mostly confirmed; higher levels of emotional exhaustion were significantly associated with larger turnover intention ($p < .001$) and the two job demands were also significantly associated with emotional exhaustion (both $p < .01$).

As opposed to reduced accomplishment, the third primary component of burnout, Volker et al. (2010) analyzed job satisfaction in relation to risk of burnout. Job satisfaction could be considered the individual form of the third primary dimension, inefficacy; job satisfaction is parallel in many ways with perceived inefficacy. The researchers gathered treatment provider data from six different opioid treatment centers across Europe: Athens, London, Padua, Stockholm, Zurich, and Essen. The study is part of the larger Treatment-systems Research on European Addiction Treatment study (TREAT). The participants (n = 902) were only required to be health care workers delivering therapy or counseling to primarily

opioid users. Participants completed, in addition to other batteries, the Maslach burnout inventory (MBI) and a job satisfaction scale. As mentioned, the MBI covered three constructs: emotional exhaustion, depersonalization, and reduced personal accomplishment. The authors' regression model, however, only included a subset of persons from Essen, Stockholm, and Zurich (n = 142). Health care workers with low job satisfaction had 13.2 the odds of experiencing burnout compared to those with higher job satisfaction. Opioid treatment providers with high levels of burnout view their work situation as out of their control and try to avoid their negative emotions.

In addition to these causes, Kulesza, Hunter, Shearer, and Booth (2017) used provider stigma as a predictor of job satisfaction and burnout. The secondary data analysis tested whether provider stigma predicted three primary outcomes at a community-based addiction treatment facility: job satisfaction, burnout, and workplace climate. The authors argued that previous burnout studies on substance use disorder (SUD) treatment providers were conducted in either medical settings or resource-rich facilities, thus limiting generalizability. A 2014 and 2015 survey of Los Angeles treatment providers at publicly-funded centers (N = 38) were used to measure job satisfaction, workplace climate, burnout, and provider stigma.

Using stepwise linear regression, the authors concluded that higher provider stigma was significantly related to lower job satisfaction and low ratings of workplace climate. Burnout, however, did not show evidence of being significantly related to provider stigma. A small sample size likely hindered this study and prevented findings similar to previous studies that significantly associated provider stigma and burnout. Still, the study was helpful in establishing the need to study under-resourced community centers. Hopefully, more longitudinal data can be collected to build off this cross-sectional study.

Organizational Contributing Factors

Lacoursiere (2001) linked both increased work pressure and unclear work policies to burnout. Some of these factors, like work pressure, can contribute to the intrapersonal dimensions of burnout. Increased work pressure would seem to accentuate exhaustion but is still considered an organizational factor since work pressure exists on the occupational plane. Further research could explore individual perceptions of organizational factors, e.g. is an individual's perception of work pressure or unclear policies a stronger predictor of burnout than objectively, measured constructs?

Burnout and Leadership: A New Model

The six organizational risk factors as defined by Leiter and Maslach (2018) are *workload, control, reward, community, fairness, and values*. Employer-employee harmony depends on finding an agreed upon balance within each of these arenas. Conversely, issues arise when there is incongruence between the employee's expectations and the reality of workplace demands. Leiter and Maslach (2018) conclude that the, "critical point is whether the organizational control systems are consistent with the staff members' expectations for their work" (p. 473). Maslach and Leiter (2008) later defined this relationship of expectations as job-person incongruity and labeled it as an early warning sign of burnout. Using the AWS and MBI, the authors were able to identify these warning signs clustering within a specific department.

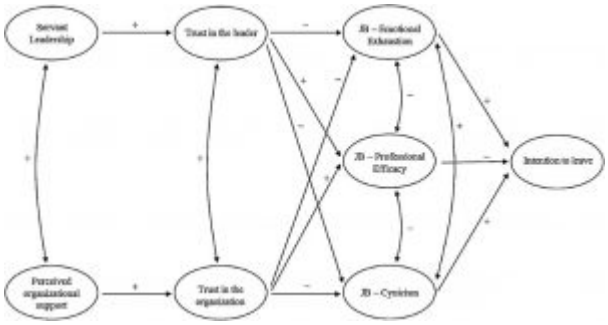
Of the six areas of 'worklife' proposed by Leiter and Maslach (1999), "fairness" appears to have the least published prior research. According to Maslach and Leiter (2008), "fairness" in burnout research refers to the, "*extent to which decisions at work are perceived as being fair and equitable"* (p. 500). There is sufficient literature establishing fairness as a critical construct in leadership; employees are less susceptible to burnout when they perceive their leaders as fair (Leiter & Harvie 1997). This leads to an important question: since fairness is both understudied and highly associated with burnout, might there be a leadership framework geared toward increasing fairness that might mediate employee burnout?

Recently, this question was addressed by Laschinger and Read (2016) who measured effects of authentic leadership burnout. This seems logical since authentic leadership values ethics, transparency

between leaders and followers, and self-awareness (Avolio & Gardner, 2005) and could have protective effects on burnout. Though authentic leadership is young in its formation and study relative to other leadership models (Northouse, 2015), there have been promising results in relation to decreasing employee burnout (Laschinger, Borgogni, Consiglio, & Read, 2015; Laschinger & Read, 2016).

Servant leadership, however, has yet to be studied in-depth as a predictor of employee burnout. Greenleaf (1970) was the first to present the servant leadership framework as an organizational theory according to the systematic review by Aij and Rapsaniotis (2017). As the name suggests, the central tenet of servant leadership is the desire to first serve others. The secondary desire to lead is seen as a calling that requires the servant leader to put others' needs and aspirations above their own. The ultimate goal in servant leadership is helping others achieve success which in turn helps the collective efficiency and production of the team (Northouse, 2016). Studying the aspects of servant leadership, it is simple to see parallels of fairness. Research has demonstrated that 1) reducing organization costs and 2) enhancing procedural justice are two tangible outputs of servant leadership (Aij & Rapsaniotis, 2017). Additionally, these outputs would exist within an organizational culture that promotes transparency. Recalling that fairness on the AWS relates to employee perception of work decisions being equitable, effective servant leadership may strengthen employee fairness, perhaps even burnout.

Searches using PubMed and EBSCO databases (Academic Search Complete, CINAHL, and PsycINFO) revealed only one study for "servant leadership and burnout." Bobbio and Manganelli (2015) studied nursing staff in two large Italian public hospitals to measure intention to leave. Intent to leave a job has been used in other studies as a predictor of burnout and is commonly accepted in the literature as being associated with job burnout (Knudsen, Ducharme, & Roman, 2009; Vilardaga et al., 2011). Bobbio and Manganelli (2015) found that servant leadership was positively associated with trust in the leader which was then negatively associated with two primary burnout dimensions: exhaustion and cynicism. Their model is below:



Given that "fairness" is the most understudied burnout organizational risk factor provides an opportunity for new research and a new model:

Servant Leadership ⇒ ↑ *Perception of Fairness* ⇒ ↓ *Employee Burnout*

Further, counseling lends itself nicely to the tenets of servant leadership. This is important for addiction treatment directors for two reasons. First, treatment center leaders often have a professional background in substance use treatment. If the leaders were successful, perhaps as evidenced by their promotion, then their personality, the key tool in servant leadership (Aij & Raspaniotis, 2017), would be well-suited for servant leadership. Thus, counselors who may eventually be in leadership positions should consider the servant leadership model. Second, counselors and other staff may respond more positively to servant leadership compared to other less personal leadership styles.

If a key concept of servant leadership is to, "*inspire followers to achieve their own goals and meet the organization's objectives,*" then the leader's model parallels the counselor's clinical model (Aij & Raspaniotis, 2017). In other words, just as the counselor wants to inspire the client to achieve success in sobriety, the leader seeks to inspire their followers to achieve their own goals towards the company's

success. In sum, the leader of treatment addiction centers may find servant leadership to be familiar in concept to both herself and her followers.

Additional Protective Factors

In addition to the protective factors discussed above, several researchers have found relationships that may be helpful for directors and managers of addiction treatment facilities. As part of gathering baseline data for a larger burnout-prevention intervention, Vilardaga et al. (2011) studied mindfulness (relating to their Acceptance Commitment Therapy intervention), values-based processes (actions and thoughts consistent with values), and work-site factors (job control, salary, social support, workload, and tenure) among addiction counselors (n = 699). Using multiple linear regression models, the authors found stronger correlations to burnout in mindfulness and values-based processes as compared to the work-site factors (11% variance increase on average). The study also concluded, with disclaimers, that higher salary levels were predictive of higher exhaustion and depersonalization levels. The findings corroborated literature that suggests the longer a counselor stays in their position, the lower the level of turnover intent. Mindfulness and encouragement or inventory of values-based actions could be helpful constructs for addiction treatment organization leaders to employ with their team.

Using data from substance use treatment center administrators gathered in the National Treatment Center Study from 1995-1998, Knudsen, Johnson, and Roman (2003) sought to find management practices that most effectively retain staff members, specifically counselors. Interviews with administrators, clinical directors, and marketing directors were performed first (n not listed) followed by mailed questionnaires to counselors. The authors found three management practices that protect against turnover: providing job autonomy (degree to which respondents believed they had authority to do their job), enabling employees' creativity, and rewarding employees' performance, both monetarily and otherwise.

Extensive research from Maslach and Leiter (2008) has also been conducted on early predictors and subsequent protective factors of burnout. For example, a good relationship between employer and employee is helpful in resolving occasional problems that, if left unresolved, may contribute to burnout. Thus, a leadership model that values leader-follower relationship, much like authentic leadership or servant leadership, may assist in alleviating early feelings of burnout. Additionally, if an employee has high congruence between their job expectations, which can be characterized in terms of fairness (distribution of resources, rewards, and credit) or values, they are less likely to experience signs of job burnout or turnover intention. It should be noted that a significant amount of time may be needed to move from early problems of job-person incongruence to burnout.

Conclusion

Strong leadership from addiction treatment directors and managers is an essential element of combating the current opioid epidemic. It should be the goal of such leaders to empower and support their employees, thus setting up counselors to succeed in their delivery of substance use treatment. A major factor in this support, as evidenced by the bevy of research in healthcare literature, ought to be burnout prevention. As key players like Maslach and Leiter have shown, burnout is a complicated syndrome that should be approached from both the intrapersonal and organizational levels.

If directors are to succeed in lowering turnover and maintaining high quality services, a leadership framework that pairs with burnout protective factors, like job-person congruence, should be utilized. It has been demonstrated that servant leadership appears to be one such model in terms of both counselor relatability and leader experience and personality. However, more research is needed to fill the literature gap, especially regarding both employee-perceived and objective fairness. If the proposed model proves to be significant in reducing burnout, addiction treatment leaders and support staff would have a wealth of servant leadership material to utilize.

Appendix

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Kania, J., & Kramer, M. (2013). Embracing Emergence: How Collective Impact Addresses Complexity. Stanford Social Innovation Review. Retrieved from https://ssir.org/articles/entry/embracing_emergence_how_collective_impact_addresses_complexity	Collective complex, b transparenc combat tha barrier. To importance of birds flo was used; e organizatio benefit and which lead coordinated Since CI ai social issue a predetern and require players inc governmen nonprofit s Creating a agenda is a component step does n there is a c solution; it everyone h understand problem. C reduced wh collaborati common g possible ste the commo Successful projects are curious. Th uncertainty deters them destination

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Citation

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Citation	Annotatio
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Citation

Manser, T. (2008). Teamwork and patient safety in dynamic domains of healthcare: a review of the literature. Acta Anaesthesiologica Scandinavica, 53(2), 143-151. doi:10.1111/j.1399-6576.2008.01717.x

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