PREFACE

It is an honor to write a preface for this special issue of *Advances in Health Care Management*, with its important and timely focus on leadership. The topic of leadership is of vital importance in healthcare management today primarily because of the need for large-scale organizational change throughout the sector. Organizational change is needed to overcome the pressing cost and quality challenges that plague the industry, and change is inherently a leadership issue. Consistent with this, in our interactions with physicians, nurses, pharmacists, managers, and administrators in hospitals, physician practices, community health centers and insurers, we have found that leadership has suddenly become a topic that captures and holds their attention. The demand for knowledge about leadership – what its effects are, how to exercise it – has never been greater. This special issue takes an important step toward addressing some of this growing need and interest.

Why is the need for change, and for leadership, so intense? To begin with, healthcare costs have been rising at four percent for the last three years and are predicted to rise seven percent in the next year (Morgan, 2013). Meanwhile, concerns about quality and safety have risen in recent years throughout the industry. Similarly, access to care is an issue receiving growing attention, and difficult decisions lie ahead. Clearly, the pressure for change is great. Yet, despite the need for change, many in healthcare inevitably will resist making the changes that are needed (Carey & Weaver, 2010). These changes can take many forms – new processes, new discipline, new levels of coordination and teamwork, to name a few – some of which are addressed in the excellent papers in this special issue. To overcome resistance to change, to achieve ambitious cost and quality goals, leaders throughout the industry have work to do. The first leadership task under such conditions starts with the imagination and courage to envision new possibilities for their organizations. Next, they must inspire and engage others in doing the work of change to help achieve these new possibilities. This calls for innovation and leadership in equal measure.

KEY LEADERSHIP ISSUES IN HEALTH CARE ORGANIZATIONS

To lead health care organizations in ways that enable their continued viability in terms of both health and economic outcomes, health care leaders often feel drawn to take a pragmatic managerial perspective – with its emphasis on day-to-day production pressures and its need to respond to small and large problems. Yet, this tendency can limit their ability to engage in the visionary leadership activities that may help transform their organizations for the future. For example, health care workers face an increasing multitude of job demands: patient care but also administration, cost-efficiency, optimal staffing, leading to role ambiguity, and even role conflict (Katz-Navon, Naveh, & Stern, 2009). Facing role conflict, most people experience stress and may be less effective in both primary and secondary role responsibilities. For this reason, conflicting role demands increase the importance of leadership as a means of helping managers and providers make thoughtful and consistent choices between competing values (Leroy et al., 2012).

As health care becomes increasingly advanced and more complex (Katz-Navon, Naveh, & Stern, 2005, Hofmann & Mark, 2006), dealing with that complexity requires a willingness from leaders as well as followers to learn (Edmondson, 2003, 2004). More specifically, health care leaders are increasingly faced with "adaptive challenges" (DeRue, 2011). Adaptive challenges are problems where those creating the solution are part of the problem (Heifetz, 1994), off the shelf solutions are absent, and leaders often must work in a piecemeal fashion to move from an old to a new situation in an organic, iterative manner (Edmondson, 2012; Tucker, Edmondson, & Spear, 2001).

Increasing complexity is not only related to medical knowledge, but also to how leadership in health care is organized. As a professional bureaucracy (Mintzberg, 1983), health care organizations house professional experts with considerable autonomy in executing their job. In these types of organizations, leadership is distributed and ideally shared across different people (Carson, Tesluk, & Marrone, 2007). Having technical experts share leadership requires not only good teamwork (Edmondson, 2003; Schulte, Cohen, & Klein, 2012) but also a model of collaborative governance and networked leadership (Barsade et al., forthcoming).

A central concern of leadership is enhancing the ability of people to work collaboratively in an organization. Both a practical and a research focus

on teams and teamwork are thus on the rise (Valentine, Nembhard, & Edmondson, in press). While managerial controls are useful in ensuring adherence to standards and achievement of objective goals, they fall short in enabling collaboration among peers, who may each bring essential elements to the challenge of solving a complex problem or executing unpredictable tasks where intense coordination is needed. This kind of collaborative behavior is often at odds with the demands of formal organizational structures, which divide people by specialty and focus more of their attention on bosses than on peers (Edmondson, 2012). Leadership is needed to foster an environment of psychological safety, which enables such collaboration (Edmondson, 1996, 1999). Moreover, leaders can help people interpret the ambiguous signals that accompany organizational change in a positive and productive light, and they can facilitate their understanding of new and changing performance expectations. They also must inspire and motivate people to collaborate. Although the need for collaboration may seem obvious in patient care settings, it cannot be over-stated that people tend to focus on their own role responsibilities and tasks, failing to give adequate attention to how these fit into the larger picture of the collective care delivery. Therefore, leadership is badly needed to help people overcome these natural human tendencies.

Finally, health care organizations require a specific kind of leadership, because they face unique challenges. Working in high-reliability organizations where a small mistake can have a huge consequence (Weick & Sutcliffe, 2001), leaders in health care hold tremendous responsibility. Lives depend upon the effectiveness of their organizations' processes. With that responsibility and pressure, health care leaders may sometimes struggle to remain open to others' input and feedback. Yet, research shows that being self-aware and self-regulating (Avolio & Gardner, 2005) and maintaining honesty and humility (Leroy, Anseel, Gardner, & Sels, in press; Maltby, Wood, Day, & Pinto, 2012) can enhance leadership authenticity. This helps them make consistent choices facing value conflicts, skillfully confront adaptive challenges, and facilitates collaboration. Authenticity has been shown to be surprisingly transparent; that is, when a leader does not walk the talk others will know it (Cha & Edmondson, 2006; Simons, 2002, 2008). Yet, in stressful and fast-paced environments, leaders may feel less able to exercise transformational, charismatic, and servant models of leadership; demonstrating these kinds of leadership models requires actions rather than words, or what Simons (1999) refers to as leading by example.

OVERVIEW OF THE CHAPTERS IN THIS VOLUME

This volume is divided in three sections: (1) a contemporary exploration of leadership in health care, (2) the role of trust in fostering change and learning, and (3) leadership at and beyond the executive level. Each of the chapters in the sections is discussed briefly below. It is noteworthy that this volume combines an equal number of quantitative and qualitative papers, with one paper that combines both methods (van Dyck, Dimitrova, Korne, & Hiddema, this volume). We hope that readers will agree with our assessment that combining both methods across and within papers helps both researchers and readers develop a more in-depth understanding of the various important issues related to health care leadership (Edmondson & McManus, 2007; Edmondson & Zuzul, 2013).

Section I – Exploring Leadership in Health Care

Adding to this preface, the two chapters in the first section take stock of what is known about leadership in health care. One chapter provides a literature overview of previous research on head nurse leadership; and the other explores effective and ineffective models of leadership. The first chapter, by Verschueren, Kips, and Euwema, reviews the literature on the leadership of head nurses and patient safety and quality of care. These authors start by providing a concise overview of some of the contemporary challenges facing health care leaders, especially clinicians. They then offer a very specific review of previous research on head nurse leadership and its impact on patient safety and health care outcomes (excluding leadership research on safety climate or culture). Their discussion highlights the importance of transformational leadership, in general, and trust, more specifically. They also call for distributed leadership and team sense making as ways to better address the complex adaptive systems that characterize modern health care organizations.

The second chapter, by Gover and Duxbury, provides a layperson's view of leadership. They conducted interviews within a health care organization to identify examples of both effective and ineffective leadership, differentiated by job type and formality. Their results provide insights about lay notions that health care providers and administrators' use in identifying effective leadership. Interestingly they found that these lay views of health care leadership fit not only the classical models of task-, relation-, and change-oriented leadership, but also newer models of authentic and servant

leadership. Moreover, they identified a new category specific to health care leadership that we can most easily summarize as leading by example.

Section II – Trust in Leadership for Learning and Change

The three chapters in this section offer in-depth studies that emphasize and illuminate how trust in leaders fosters both learning and change. For both learning and change, it is important to identify the types of leader behaviors that help followers voice their concerns, whether it is to reduce resistance to change or to encourage follower-initiated change. Moreover, as the lead paper in this section highlights, trust in leaders often needs to occur at multiple levels within a health care organization.

McAlearney, Hefner, Robbins, and Garman, in the third chapter, examine the role of leadership in a change initiative to eliminate healthcare-associated infections. They conducted case studies of eight hospitals pursuing central line-associated blood stream infection-prevention initiatives, interviewing leaders across levels in each of these organizations. Their results underscore the importance of having both clinical champions and visible support and commitment from top executives. They suggest that this mixture of informal and formal, multilevel leadership may be essential for large-scale change initiatives to improve health care outcomes and patient safety.

In the fourth chapter, Van Dyck, Dimitrova, Korne, and Hiddema use both open interviews and a cross-sectional questionnaire to investigate the relationship between leaders' espoused and enacted priority of safety, incident reporting, and error management. Their quantitative and qualitative data illustrate that it is not leaders' espousal of safety values that drives incident reporting and learning, but the enactment of those safety values.

Kitzmiller, McDaniel, Johnson, Lind, and Anderson, in the fifth chapter, examine leadership behavior and team sense-making during health information technology (HIT) implementation. Their study examines the premise that how teams make sense of change events is an important factor in the success of HIT implementations. And their research extends our understanding of how leaders' behaviors facilitate or impede speaking up among project teams in health care settings. Significantly, they find that, despite a leader's best efforts, subtle leader interpersonal behavior easily undermines the leader's efforts to inspire HIT implementation team members to voice issues.

Section III – Executive Leadership in Health Care

Whereas the first two sections focused on the role of individual front-line leaders, the final section of this volume looks at leadership at the executive level. One chapter looks at the role of executive administrators; the next examines the role and strategic impact of human resource management; and the last chapter in this section investigates leadership at different levels of analysis.

In the sixth chapter, Davis, Marino, and Vecchiarini evaluate whether nursing homes managed by entrepreneurially oriented administrators experience better short-term financial performance than nursing homes operated by administrators who are less entrepreneurially oriented. They surveyed nursing home administrators to assess their entrepreneurial orientation, and compared those assessments with nursing home financial performance data drawn from Medicare Cost Reports. Interestingly, while risk-taking was positively associated with better financial performance, innovativeness was negatively associated with performance.

Garman, Polavarapu, Grady, and Canar, in the seventh chapter, examine the role of strategic human resource management in health system adaptability. Their survey-based study is especially significant given the changes mandated by the U.S. Patient Protection and Affordable Care Act. Results from their study indicate that the strategic alignment of human resources, that is, involving the top HR executive as part of the senior leadership team, was positively correlated with cost control, quality improvement, and patient access. These results suggest that including the HR executive as part of the senior leadership team may positively affect an organization's capacity for adaptive response.

In the eighth chapter, McCaughey, Halbesleben, Savage, Simons, and McGhan examine the unnoticed population of support personnel, for example, sanitary and maintenance employees, in health care organizations. Their study highlights the importance of both top-level (organizational) and front-line (supervisor) leadership in emphasizing safety, validating safety climate as an antecedent that reduces the likelihood of workplace injuries. Furthermore, they identified that coworker support was an important moderator of those relationships.

Section IV – Future Directions

In the final chapter, Simons and Leroy – the guest editors for this special issue – thoughtfully discuss the contributions made by authors in this

volume and explore directions for future research. They identify trust in leadership, leading by example, and multilevel leadership as three of the recurrent themes addressed by the authors in this special volume. And, to further highlight and deepen readers' understanding of the importance of combining different methods of research, these authors conducted interviews with health care executives and used these data, together with the information in the volume's individual chapters, to provide recommendations for future research in this vitally important domain of leadership and health care.

We hope both health care researchers and leadership scholars will find this volume of interest. It extends, we believe, our understanding of what leadership means not only within health care organizations, but also within other complex organizations that provide vital services. And, as the last chapter illustrates, the multiple and diverse contributions within this special issue shape several paths for future research.

Amy C. Edmondson
Hannes Leroy

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