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The relationship between leadership styles and performance success in hospitals

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2010

ABSTRACT

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M.S., New York University, 1991
B.S., Hunter College, 1989

Dissertation Submitted in Partial Fulfillment
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ABSTRACT

Upheavals in the health care landscape threaten the sustainability of contemporary hospital organizations. Yet there is limited research regarding the characteristics of leaders within successful hospitals. The problem is the leadership styles needed to effectively run hospital organizations have not been identified and/or established. The purpose of this study was to develop a model of congruent leadership styles linked to the success of hospitals in one metropolitan city. The research questions sought to uncover (a) consistent leadership styles within successful hospitals, and (b) what, if any, relationship exists between leadership styles and measures of success. Examination of the literature uncovered the value of leadership to organizations through theoretical frameworks of organizational development, organizational culture, leadership, and change strategies that supported the need for hospital organizations to foster leadership practices associated with successful outcomes. Correlational analyses were used to examine the relationship between leadership styles and successful hospital outcomes. Primary data for this research were collected from 109 hospital leaders via the Multifactor Leadership Questionnaire (MLQ) Form 5X. Results from this study indicated an increased likelihood of performance success with the application of transformational characteristics. These findings support positive social change as results may serve as a model for leadership practices within 21st century hospitals. Results should further heighten social consciousness to spawn the development of related college curricula, scholarship programs, and leadership alliances that weave transformational characteristics into the leadership fabric of contemporary hospital organizations.

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Dedication

This work is dedicated to the memory of my parents, Joseph and Elizabeth Little, whose life examples, encouragement, and sacrifices helped shape my values and beliefs. It was upon their shoulders I stood and dared to dream the boldest of dreams. To my children Seth and Ysatis, to whom I pass this academic torch, may you never let it grow dim but choose to enlighten your generation. Finally, to my husband, the love of my life, our twined spirits have endured this journey together and the sweetness of this victory is as much yours as it is mine.

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CHAPTER 1: INTRODUCTION TO THE STUDY

Introduction

The twenty-first century health care industry is not a gentle environment. Indeed the delivery of effective health care is increasingly characterized by fundamental and turbulent change leading to the emergence of practices that have hindered the administration of quality care. The ubiquitous nature of change within health care has in high costs associated with the delivery of care (Kilpatrick & Holsclaw, 1996). Though the proliferation of transformative acts have been abundant in many twenty-first century organizations, no segment of contemporary business industry has been more challenged by profound, unflagging transition than the health care environment. More emphatically, Hagenow (2001) stated that changes experienced within the modern health care industry were more profound than those compelled by the second industrial revolution.

The endemic nature of change within health care has been effectively chronicled over the last three decades (Bigelow & Arndt, 2000). This period was marked by change due to regulatory mandates, unparallel demands for privacy, extensive fiscal responsibility, staff shortages, and aggressive litigation, with the consequent need to redefine and reinvent methods of delivering contemporary health care. According to Morgan (1997) "Leadership ultimately involves the ability to define the reality for others" (p. 189). That being said, the hostile landscape and immense challenge presented by 21st century health care will require a form of leadership that can embed new realities and redefine the direction of quality health care delivery within hospital organizations. The 1980s were particularly hallmarked by competition within the health care industry. Investor owned and nonprofit health care systems favored the adoption of entrepreneurial

practices (Kaiser, 1992). Consolidations to decrease debt and leverage capital in the hope of re-capturing financial profit led to the health care industry functioning as institutions of commerce (Kaiser, 1992). Mergers, acquisitions, failures, and re-alignments resulted in an unprecedented period of tension and transition within the industry as adopted practices from the business sector met with repeated failures. The health care environment described several decades ago holds a unique resemblance to today's twenty-first century environment as repainted challenges and new tensions emerge and confront hospital organizations and other health care systems.

Hospitals once fortresses of the health care system are significantly impacted by the extraordinary changes in health care. Questionable managed care programs, changes in payment processes, speed of emerging technologies, ability to attract capital, new competitors, increased consumer demands in the face of staff shortages, and pressures related to cost containment threaten the foundational practices of contemporary hospital organizations (Bigelow, & Arndt, 2000). Federal incentives to drive accountability, specialty services and specialty hospitals further attack the sustainability of conventional acute care environments (Shortell, Gillies, Anderson, Erickson, & Mitchell, 2000).

The offshoots of a consistently transforming health care landscape have repeatedly attacked the core of the health care industry, the hospital setting. Multiple transitions and past failed efforts leave contemporary hospitals in need of recovery. From industrialism through postmodern organizational environments, leadership constructs have influenced social, cultural, and organizational change (Bass, 1990; Schein, 1997; Shafritz & Ott, 2001). Successful reinvention of twenty-first century acute care

environments requires leaders that are master change agents, a form of leadership that is transparent and comfortable with uncertainty. The state of twenty-first century hospital organizations remains in need of effective, visionary, transformational leaders who understand, value, and model renewal (Quinn, 1996).

Based on the literature, leadership styles from trait to transformation identify leadership as a critical factor in organizational success (Bass, 1990). Thus, investigating the relationship between leadership and the application of effective operational strategies within 21st century acute care environments is important to diminish the threat of instability and increase the likelihood of survival. Manion (1988) indicated that hospital settings would continue to require exemplary forms of leadership to survive turbulent change. This line of thinking is substantiated by others who have suggested that periods of great transitions, such as are common to hospital organizations, force the emergence of leadership styles and selected practices that promote successful outcomes within hospital organizations (Alexander, 1993; Porter-O'Grady, 1992).

Statement of the Problem

A multiplicity of negative tendencies present severe leadership challenges to contemporary hospital organizations. Stricter regulatory requirements, escalating cost, an increased number of uninsured, and the lack of fiscal responsibility are among the concerns that threaten the existence of 21century hospital organizations. The problem is the leadership styles needed to effectively run hospital organizations have not been identified and/or established. The transforming health care environment lies in need of recovery and the survival and sustainability of contemporary hospitals requires proactive,

visionary, and inventive acts, of the kind associated with transformational leadership. Leadership has been identified as critical to the successful development of organizational culture and change efforts (Kirkbride, 2006; Kotter & Heskett, 1992; & Schein, 1999). Yet, surprisingly the hospital management literature has produced little regarding the necessary leadership skills, styles, and practices that can contribute to the success strategies of hospital organizations.

Remedial treatment for the countless ailments abundant within acute care hospital environments requires the application of leadership strategies as a prescription for accountable, meaningful, and successful change. Effective leadership has been positively linked to high performance hospital organizations (Alexander, 1993; Kaiser, Hogan, & Craig, 2008; Kotter & Heskett, 1992). Yet, the distillation of specific tools, characteristics, and behaviors employed by leaders of successful hospital organizations remain obscure. Perhaps a correlational study that investigated the leadership styles found consistently among leaders of successful hospitals might uncover a model of leadership practices that may prove beneficial to the performance success of hospital organizations.

What leadership styles are found consistently among leaders of successful hospital organizations? What is the relationship between MLQ scores of hospital personnel compared to a normative group? What, if any, relationship exists between leadership styles and standard measures of success? The problem was to determine the relationship between leadership styles and performance success of hospital organizations in Metro Atlanta.

Background

Twenty-first century hospital organizations are faced with immense challenges. Failed past initiatives related to health care reform and managed care along with the speed of technological advancements resulting in massive change has spawned a chaotic health care environment. Continuous transformation within the last two decades beset hospital organizations with challenges related to competition, rising conflict, and unprecedented consumer demand (Bigelow & Arndt, 2000; Herzlinger, 2004). The turbulence and tension within 21st century hospital organizations has created a culture of crisis wrought with financial instability and performance inabilities that threaten the very survival of many contemporary hospitals. It is within this complex period of health care history that the need for effective leadership becomes more pronounced (Buyjak, 1999).

Leadership theorists and authors have demonstrated the utility and significance of transformational leadership in a multitude of fields inclusive of politics, religion, commerce, and educational and health care settings (Bass, 1990; Dering, 1998; Johns & Moser, 2001). The rapids of change, rising conflicts, and economic fragility faced by 21st century hospital organizations require a form of extraordinary leadership rooted in intent, vision, direction, and goal attainment because the elements driving change are powerful. Rapid technological advances and financial instabilities within hospital environments require contemporary leaders to rethink strategies, reengineer work practices, and reinvent themselves in order to stay solvent on the global horizon (Hesselbein, Goldsmith, & Beckard, 1997). The critical need for exemplary, visionary leadership practices is evident in numerous diverse challenges faced by leaders of local hospitals

who must grapple with unparalleled change, conflict, and the unflagging politics of health care in order to compete and survive the demands of the 21st century hospital environment (Bigelow & Arndt, 2000; Hagenow, 2001).

Reports on the current state of hospitals in the Atlanta Metropolitan area convey many concerns over the unique leadership challenges faced by local hospital leaders. Growing public demand for greater accountability within the hospital systems of metro Atlanta has prompted imperatives for new, creative, leader-driven initiatives. These initiatives are related to:

1. The rapid, continuous expansion of the indigent care pool that increases the need for funding to treat those financially challenged individuals requiring care (Whalen, 1999).
2. The increasing number of registered nurse vacancies, reportedly up by 38 % while allied health vacancies simultaneously challenge hospital performance with a vacancy increase of 40% (American Hospital Association, 2002).
3. The use of information technology has been identified as a strategic leadership tool for the provision of safe and efficient care delivery. Yet an alarming survey by Culler (2006) reported concerns with available functional computerized applications within many Georgia Hospitals.
4. Hicks (2001) documented the need for greater leader-driven accountability regarding eliminating medical errors while cogent arguments have been created regarding the need for proactive leadership involvement to achieve successful

outcomes of critical initiatives such as end of life care, and community education (Cooney, Landers, & Williams, 2002).

These concerns along with the need for greater fiscal responsibility, shifting costs, and changing consumer markets present enlightenment with respect to the acute need for leadership imperatives within Atlanta Metropolitan Hospitals that generate successful outcomes. Surprisingly, little has been documented in the health care management literature regarding leadership styles that generate successful results in hospital settings. The results of such an investigation may fill a noticeable gap in the health care leadership literature and prove beneficial to leaders within contemporary hospital organizations. This study addressed the urgent need to uncover congruent leadership styles found among leaders of successful hospital organizations in the Atlanta Metropolitan area.

Leadership trends across time not only identified leadership as critical to organizational success, but also inferred that its absence almost always resulted in failure (Bass, 1990; Cooney, Landers & Williams, 2002). The literature has expanded from notions of perceived inborn traits to fascination with personal characteristics and concepts of leadership as a reciprocal process among workers with common goals (Bass, 1990; Burns, 1978; Dering, 1998). Further, perspectives on the leadership phenomena have concentrated on leader-ability to obtain results. As behavioral scientists delved more into what leaders do, they presented a view of leadership as a discrete set of behaviors and skills that can be observed, evaluated, and developed (Dering, 1998; Wren, 1995). However, little was documented regarding specific evidence-based leadership styles that promote the success of hospital environments.

The understanding of leader induced organizational change warranted an investigation into leadership strategies defined as successful within hospital organizational structures. What leadership styles and/or characteristics are found consistently among leaders of successful hospitals? How is success measured within hospital environments? What, if any, relationship exists between leadership styles and these success measures? How might one create and teach a leadership model of best practice guidelines to would-be leaders? This research identified this gap in the literature and invited an understanding of the unique leadership styles that influence the success of hospital organizations.

Purpose

The purpose of this research was to develop a model of congruent executive leadership styles that would promote the success of acute care hospitals in the Atlanta metropolitan area. This study assessed the unique leadership styles found among executive leaders to determine whether there was a relationship between leadership styles and the success of acute care hospitals in the greater Atlanta region. Through this research it was possible to identify relationships between key leadership characteristics and successful outcomes. Results from this study will serve as a model for leadership practices within contemporary hospitals. The isolation of evidence-based leadership styles that promote successful practices in acute care environments will contribute to the body of leadership literature and serve as a prescription to correct ailments and champion change within contemporary hospital organizations.

Theoretical Framework

Change is a transformational process within organizations that requires inventive ways of thinking and behaving. More recently, organizational leaders recognize the need for a paradigm shift because previously held assumptions have either lost their relevance or have become outmoded. The current bias toward organizational change is based on the premise that the inability to change will result in the demise of the organization (Quinn, 1996). The acceleration and velocity of change forces contemporary leaders to be ready for new realities and new realities mandate new leadership approaches (Harper, 1998). Twenty first century hospital organizations require leaders who are willing to explore and challenge existing norms, beliefs, and cultures present within contemporary acute care environments. Even those hospitals and other organizations that are doing well require a leadership culture of flexibility toward renewal that will allow them to transition toward trends and stay ahead of the competition (Collins, 2001; Schein, 1999; Tichy, 1997).

It is possible for an organization to transform itself and become something better than what it was when it started (Jones, 2001). Schein's theory of culture change supports this line of thinking and indicates that successful cultural transformation within an organization revolves around the leader and is created and embedded by leadership practices within the organization (Schein, 1997). An in-depth review of the literature supports the central role of culture in channeling human behavior and how it can be skillfully manipulated by leaders to create, shape, and adopt new operational mechanisms that sustain or improve the functionality and overall success of the organization (Schein, 1997, 1999). Moreover, transformational leadership theory presents a view of leadership

that is inspirational, visionary, and performance oriented. These traits resonate well with what is needed to promote renewal within 21st century hospital settings.

Successful management of change efforts within organizations has been widely associated with transformational leadership (Collins, 2001; Dawson, 2003; Hesselbein, Goldsmith & Beckherd, 1997; & Schein, 1999). Transformational leadership Has been characterized by change, innovation, risk-taking and the ability to maximize resources. Moreover, transformational leaders have been described as leaders who are proactive rather than reactive in their thinking, and they inspire enthusiastic commitment from subordinates towards high performance acts because they give others vision to see opportunities. The moral convictions and motivational quality embraced by these agents of change give followers a strong sense of meaning and value that inspires trust, creates confidence, and establishes loyalty. Such leadership is critical to contemporary hospitals where there is an absence of vision and where leadership disconnects between hospital leaders and followers must be bridged. Among the many skills of a transformational leader is the ability to use effective, engaging communication that strengthens commitment to high performance goals and bridge leader/follower gaps.

The significance of leadership to organizational success has undeniably arrested the interest of many theorists and investigators across time (Bass, 1990). History demonstrates that no social endeavor is more fascinating, more difficult, or more complex than leadership (Bass, 1990; Johns & Moser, 1989; O'Toole, 1996; & Wren, 1995). Man's preoccupation with leader-initiatives that have impacted the social environment can be traced for thousands of years through the work of philosophers, historians, and

social scientists that contemplated the phenomenon. Scholars on the subject refer to Aristotelian eras and/or biblical history for indications of how the deep roots of leadership influenced social structures and organizational existence (Shafritz & Ott, 2001).

The exploration of leadership across time provided a historical framework that positioned leadership roles at the heart of human existence and therefore critical to the sustainability of organizations (Bass, 1990; Johns & Moser, 1989). Leadership practices that influence social constructs cannot be ignored and could be examined and explored to determine the level of influence leaders exert upon organizational practices and outcomes within our society.

The process of leadership is described as the ability to influence followers to achieve organizational objectives through change (Lussier, 2001). Change involves moving from traditional ways of doing things to a new one that brings positive outcomes. Leaders influence the change process through communicating ideas, gaining follower support for communicated values, and through purposeful, leader-driven acts that motivate actors to implement new ideas and new processes (Bolman & Deal, 1997; Burdette, 1998; Carr, Hard, & Tranhant, 1996).

From a review of the literature one conceived change within organizations as the historical reconstruction, transformation, invention, and reinvention of work systems, philosophies, patterns of authority and social partnerships that frame the social interaction landscape of the organization (Eisenstadt, 1990; Sharfritz & Ott, 1997; Summers et al, 1997). Historical data confirmed a societal change pattern that presents leadership as an

undeniable catalyst of organizational change and societal development (Bass, 1990; Van Seter and Field, 1990). While the hospital segment of the health care industry is confronted with the need for change strategies and extraordinary leadership vision, astonishingly little was documented about the unique leadership styles found among those hospitals that have been successful.

Leader-driven success of contemporary hospitals in the United States is tempered by two major influences: (a) Internal organizational mission, vision, and values that shape policies and practices embedded by those who lead and (b) External official sources with regulatory requirements and recommendations that structure performance practices (Cooney, Landers, & Williams, 2002). Hospital organizations are investigated and judged regarding exemplary measurements of high performance. Three well known and respected sources of performance success in hospital settings were used in this study. They are (a) Joint Commission, (b) Thomson (Solucient) 100 Top Hospital ratings, (c) Press Ganey Patient Satisfaction Scores. Four assumptions were identified for the study.

Assumptions

1. It was assumed that appreciable Press Ganey patient satisfaction scores indicated high performance in service quality success.
2. It was also assumed that identification among Thomson Healthcare (Solucient) 100 Top U.S. Hospitals was a valid indicator of high performance success.
3. A basic assumption was that accreditation and approval from Joint Commission adequately demonstrated successful quality patient care.

4. Another fundamental assumption was that study participants would agree to and be capable of honest responses to the questionnaire instrument.

Scope and Delimitations

This study was confined to two hospital organizations within a specific geographic location within a metropolitan city. That said, the transcendence of key leadership characteristics beyond cultural and geographic locations have been adequately discussed in the literature (Hillier, 2000; Weiss, 2000). No attempt was made in the study approach to define ethnicity and gender of the participants or the internal management and style of participating hospital organizations. Though the study is confined to two hospitals the researcher anticipated an adequate leader sample obtained from different levels of leaders. The study target population was confined to managers, directors, vice presidents, and chief executive officers of two hospitals. The hospitals are located in the Atlanta metropolitan area and are both acute care settings.

In order to positively affect the generalizability of the results, the researcher applied methods of triangulation to further increase confidence in the findings of the study. The Multifactor Leadership Questionnaire, an extensively used, reliable instrument was applied to capture a broad range of leader behaviors. Consequently, emergent data from this study maybe valuable to hospital leaders and leader-practitioners in their quest to embrace and duplicate leadership practices that promote successful outcomes. The information gap between leadership styles and successful outcomes within hospital organizations implied the need for inquiry. Hence the study results can be used as a

prescriptive model of leadership styles essential for successful hospital organizations. The four limitations listed below were identified for the study.

Limitations

1. The emergent results were based on data collected within a specific time period and were therefore representative of findings within the timeframe of the study.
2. The sample size was also small, non random, and restricted to two high performing hospital organizations in Atlanta Georgia. As such, the results were not generalizable to all hospitals in the United States or Atlanta.
3. The dynamic nature of leadership cannot be thoroughly uncovered by a single instrument.
4. Joint Commission accreditation, Press Ganey scores, and Thomson's Healthcare (Solucient) 100 Top hospital status are not flawless measures of effective, exemplary hospital performance and this may impacted the validity and reliability of the findings.

Research Design

Leedy and Ormrod (2005) suggested that the selection of a research method and design should be guided by the specific question, hypothesis, or problem. Simon and Francis (2001) supported the application of correlational studies to examine the relationship between variables in their natural environment without researcher- imposed treatments. Hence, a quantitative correlational method of investigation was applied to address the problem of determining the extent to which a relationship existed between

leadership styles and measures of successful hospital outcomes. This research design was most appropriate because it sought explanations of trends, attitudes, opinions, and predictions from which generalizations could be made regarding a population with the need to further authenticate the validity of relationships and generalizations that contribute support to a theory (Creswell, 2003; Leedy, Newby & Ertmer 1997). The use of quantitative methodology further assisted in understanding the relationship between leadership styles and successful strategies within hospital organizations offering revolutionary opportunities to extract, educate, and model these leadership styles toward building more successful hospital organizations of the future.

Definitions of Terms

Managed care: A form of health care insurance in which the insured pays a pre-established premium in exchange for the health services provided by hospitals, physicians, and other health care professionals within a designated network of resources.

Success: The ability of a hospital organization to achieve and maintain established merits or rewards associated with high performance practices.

Quality care: Individual and team practices related to the consistent provision of safe, efficient, and effective health care evidenced by positive outcomes and the capacity to meet or exceed established performance standards.

Evidenced-based: Practices embraced within a hospital organization as a result of tested actions that support or increase confidence in the utility and functional capacity of the selected practice or action.

Laissez-Faire: An extreme form of permissive, nondirective, passive leadership. Laissez-Faire leaders are not proactive; rather they are inactive, withdrawn, and uninvolved. As a result employees virtually do as they please (Bass, 1998; Curtin, 1995).

Transactional leadership: Defined as a leadership style based on meaningful exchanges between leaders and followers. Leaders enter a contractual agreement in which followers perform duties that meet specified objectives. In exchange the leader rewards followers with benefits that satisfy their needs and desires (Lussier, 2001).

Transformational leadership: Leadership based on empowerment and shared vision that embraces the transcendence of self interests. The transformational leader is an agent of change who has the capacity to motivate and influence followers towards high performance acts that meet or exceed organizational objectives.

Multifactor Leadership Questionnaire (MLQ): The MLQ short form 5X is an established, valid, and reliable instrument constructed to evaluate Transactional, Transformational, and Laissez-Faire leadership traits. This full range structured leadership assessment tool has twelve scales: Idealized influence (attributes), Idealized influence (behaviors), Inspirational motivation, intellectual stimulation, individual consideration, contingent reward, management by exception (active), management by exception (passive), Laissze-Faire leadership, extra effort, effectiveness, and satisfaction (Bass & Avolio, 1995).

Research Questions

1. What leadership styles are found consistently among leaders of successful hospital organizations?

2. What is the relationship between the MLQ scores of hospital personnel compared to a normative group?
3. What, if any, relationship exists between leadership styles and patient satisfaction scores, joint commission accreditation, and achievement of Thomson's healthcare's 100 Top Hospital rating?
4. What differences exist between personnel in Hospital A compared to Hospital B in terms of MLQ scores?

These questions were significant to the research focus because they attempted to investigate the relationship between variables such as leadership styles and known measures of success within hospital organizations. The MLQ (an established, valid instrument) was used to collect data regarding non-independent variables: transactional, transformational, and laissez-faire leadership styles. Acheivement of Thomson Healthcare (Solucient) 100 Top Hospital status, Joint Commission accreditation, and Press Ganey patient satisfaction ranking within the top 10 to 15 percent are the dependent variables employed as success measures of hospital organizations.

Significance of the Study

Successful organizational leaders champion change initiatives that significantly affect societal development (Dawson, 2003; Kotter & Heskett, 1992). Perhaps having an evidenced-based model of successful leadership styles can influence the leadership content of college curricula, certification processes, and best practice guidelines as an initial significant contribution to mending the ailments of many hospital organizations. The profound benefits of such a purposeful health care leadership model will be evident

in more effective, efficient care delivery to the communities served. Moreover, the isolation of evidence-based leadership styles that promote successful practices in hospital organizations will significantly contribute to this information gap in the health care management literature.

Organization of the Remainder of the Study

This dissertation study was presented in five chapters in keeping with Walden University dissertation recommendations. Chapter one contained an introduction to the study, statement of the problem, background, purpose, theoretical support, assumptions, study approach limitations, definition of terms, research questions, and significance of the study. As a preliminary to the discussion focusing on the relationship between leadership styles and success within hospital settings, the author emphasized the problem and introduced the need for investigation. Chapter two presented an overview of the pertinent literature structured and framed by key concepts that logically and thematically weave the foundation of the research. This chapter is also the initial introduction to the research method appropriated for the study. Chapter three provided a description of the research design and the elements used in this study to investigate the research questions. It discussed the instrumentation, target population, data collection and method of analysis. Chapter four provided an interpretation of the findings and carefully addressed. inconsistencies related to the data findings while Chapter five presented the research summary, conclusions, and recommendations.

CHAPTER 2: LITERATURE REVIEW

Introduction

Chapter 2 is divided into four distinct segments related to leadership as it affects organizational endeavors. Examination of the literature related to each segment served to uncover the consistent value of leadership to organizational strategies and support the critical need for hospital organizations to embrace specific leadership practices that are more likely to promote successful outcomes. The essential issues and composite segments addressed in this review of the literature are as follows:

1. Historical Overview of Leadership
2. Fundamentals of Pertinent Leadership Styles
3. Leadership as a Predictor of Positive Organizational Outcomes
4. Leadership within Contemporary Hospital organizations

Completion of the literature review involved a systematic search of the following electronic data bases: EBSCO and ProQuest, these permitted access to Academic Search Premier, Business Source Premier, Medline, and PubMed. A variety of key words and a combination of phrases were sequentially used including: history and leadership, leader behavior, leadership styles, leadership and health care, leadership and culture, leadership and success, and success strategies. Thus, the reference list is comprised of peer reviewed articles identified as relevant to the research questions posed. In this chapter the body of the literature selected begun with a historical overview of leadership. This chronological representation of the leadership literature supported by respected theorists was presented to demonstrate the consistent influence of leadership on organizational practices since antiquity. In this section, commentators on the history of the leadership role within

organizations included an examination of works by Stogdill (1975), Burns (1978), Johns & Moser (1989), and Bass (1990).

The focus of the second section surrounded an exploration of distinct leadership styles and the distinguished messages they convey within contemporary organizations. The three leadership styles examined and discussed were: laissez-faire leadership, transactional leadership, and transformational leadership. Critical works inclusive of works by Bass and Avolio (1990a, 1990b), Burns (2003), and Lussier (2001) were connected to uncover the complex characteristics of leadership styles and the influence each one exerts within 21st century organizations.

Subsequent segments weaved a selection of representative literature to focus discussion on specific elements and/or characteristics of leadership that positioned the leadership phenomenon as a predictor of positive organizational outcomes. The crucial need for an examination of the leadership styles found within successful hospitals becomes more apparent as the multiplicity of challenges and the state of leadership within contemporary hospitals is investigated and elaborated.

Historical Overview of Leadership

Leadership is a riveting subject that has demanded center stage throughout its extensive, fascinating, and influential history. The historical account of leadership is inextricably interwoven with such complexity and controversy that a detailed understanding of leadership history is not only a significant undertaking, but also a scholarly challenge. Through the years, both early scholars and modern thinkers have regarded the leadership phenomenon as the nucleus of organizational societies and the

significant force for change. Seminal works presenting leadership philosophy identified it either as a product of circumstance relegated to group activities (the environmentalists perspective) or as an enabling trait that influenced followership (the personalists perspective). Regardless the position taken, scholars of both schools agree that the significance of leadership to organizational development is undeniable (Bass, 1990; Stogdill, 1975; Wren, 1995).

The remarkable chronology of leadership theory has generated enthusiasm and interest among scholars since ancient times (Lussier, 2001). History demonstrates no social endeavor to be more fascinating, more difficult, or more complex than leadership (Bass, 1990; Johns & Moser, 1989; O'Toole, 1996; Wren, 1995). Man's preoccupation with leadership initiatives that have impacted organizational societies can be traced for thousands of years through the work of philosophers, historians, and social scientists that contemplated the phenomenon. Scholars on the subject refer to Aristotelian eras and/or biblical history for indications of how the deep roots of leadership influenced organized societies (Bass, 1990; Johns & Moser, 1989). The exploration of leadership across time provides a historical framework that presents leadership as one of the most observed but least understood concepts of the human experience (Bass, 1990; Johns & Moser, 1989; Van Seters & Field, 1990). Therefore, leadership practices that influence organizational structures cannot be ignored, and could be examined and explored to determine the level of influence leaders exert upon successful developmental processes within organizations.

Views on leadership have changed over time. An in-depth review of the literature revealed that leadership philosophies have expanded from notions of perceived inborn

traits and characteristics, to fascination with personal characteristics and concepts of leadership as a reciprocal process among workers with common goals (Burns, 1978; Dering, 1998). An especially interesting approach to leadership emerged from behavioral scientists. Rather than investigating what leaders are like, they primarily focused on what leaders do (Dering, 1998). This led to an understanding of leadership as a discrete set of behaviors and skills that can be observed, evaluated, and developed (Dering, 1998; McCauley, Moxley, & Van Velsor, 1998; Wren, 1995).

The fascinating historical positioning of leadership revealed it as a multifaceted phenomenon that has demonstrated utility and significance in a multitude of fields, inclusive of politics, religion, commercial, and educational settings (Johns & Moser, 1989). Additionally, the application of leadership to a variety of human endeavors may well account for its ubiquitous quality, for its fascination, and for the mystique it holds. Moreover, leadership trends from trait to transformation, not only revealed leadership as the most critical factor for organizational development, but also inferred that its absence almost always results in failure (Cooney, Landers & Williams, 2002).

Theoretical concepts of leadership from industrialism through postmodern environments have demonstrated the critical role of leadership to a variety of constructs within the society. The role of leadership within organizations has been historically well defined. From systematic mass production and vertical hierarchical arrangements to scientific revolutions that linked science and technology to significant reinvention of work practices and more circular, permeable, contemporary work designs, leadership has been central to the organizational experience (Dawson, 2003; Kuhn, 1996; Shafritz &

Ott, 2001). Commentators on the history of leadership position the phenomenon at the heart of the change efforts deemed essential to the life cycle of the organization and to its ultimate survival (Dawson, 2003; Kanter, 1989; Morgan, 1998' Schein, 1997). Moreover, an intense review of the leadership literature revealed that the contemporary bias towards organizational change was a product of strong visionary leadership practices. These contemporary leader-driven practices favor renewal and rewards inventive acts that increase the solvency of the organization (Bass, 1990; Burnes, 2004; Dawson, 2003; Shafritz & Ott, 2001).

There has been considerable interest in the concepts, cultures, change strategies, and organizational arrangements of high performing organizations. This has served to also heighten and focus interest in understanding the relationship between leadership and performance strategies within contemporary organization environments (Berson & Linton, 2005). In line with the desire to better comprehend leadership as it relates to performance is the inherent need to identify forms of leadership linked to high performance. To this end, using a selection of representative literature further discussion focused on pertinent fundamental leadership styles that served as distinct predictors and indices of organizational work performance.

Fundamentals of Pertinent Leadership Styles

The connection between leadership and the human condition has been of interest since antiquity. Evolutionary one-dimensional personality trait theory assumed individuals born to be leaders exhibited recognizable personality characteristics and physical traits that distinguished them from non-leaders (Bass, 1990; McCauley et al.,

1998). Dyadic, situational, and contingency eras evolved as leader-involvement transitioned from a unidimensional approach to a multi-focused function that linked leadership to place, condition, and situation. As understanding of this complex phenomenon progressed the literature further expanded the scope of leadership from notions of leadership as defined within group interactions to leadership as a critical interactive process within the entire organization (Dering, 1998; Van Seters & Field, 1990). More emphatically, contemporary works suggested that leadership behavior profoundly impacts team characteristics and organizational outcomes (Bass, 1990; Bass, Avolio, Jung, Berson, 2003; & Flood et al., 2000).

Commentators on contemporary leadership practices further concede the complexity of leadership suggesting that it has advanced to embrace a wider range of voice. This diversity of voice is analogous to compelling differences in leadership styles. Each leadership style presents distinguished messages that are not the same, but rather conjured such differences in organizational behavior that business outcomes are significantly impacted. Consequently, contemporary organizations have demonstrated convergence regarding the relevance of identifying and harnessing effective leadership styles that promote success strategies resulting in desirable organizational performance (Avolio, 1999; Berson and Linton, 2005). Subsequent paragraphs within this section focused discussion on three distinct leadership styles: Laissez-faire, Transactional, and Transformational styles of leadership and their effect upon organizational practices.

Laissez-faire

These leaders tend to abdicate their responsibility allowing subordinates a high degree of independence and freedom of action over their designated work groups. Such leaders avoid decision making, lack the power to influence employees, shirks supervisory responsibilities, and fails to give essential guidance when needed. Laissez-faire leaders depend on subordinates to set their own goals, establish the means of achieving those goals, and offer little or no participation in the process. Rather, these leaders aid operations through the provision of information and assume the role of conduit the followers' external environment (Bass & Stogdill, 1990; Bass & Avolio, 1994; Flood, Hannan, Smith, &Turner, 2000). This passive leadership style is viewed as ineffective because such leaders offer little direction and exerts little or no authority or influence on the team. Poor work quality, diminished clarity, inefficiencies, disorganization, and a high level of employee dissatisfaction associated with a decreased sense of accomplishment trademark this leadership approach. Such characteristics are detrimental to the success strategies and overall performance goals of the organization.

The laissez-faire leader may be effective when dealing with highly skilled self-starters and motivated individuals such as a team of health care experts. Once such a leader has identified and established a group of motivated, independent, competent subordinates, such a work group is allowed to complete tasks in the manner they think is best. In such instances interference from the leader may divert effectiveness and/or harness resentment at leadership intrusion in the process (Bass & Stogdill, 1990; & Gillies, 1993). Expert observation of the characteristics of this style has resulted in the title of 'non-leadership' (Bass & Avolio, 1990a, 1990b).

Transactional

In this style of leadership transactions between the leader and follower occur to maintain the status quo and promote stability within the organization. The transactional leader exchanges rewards, recognition, and other valued services to promote desired behaviors and influence subordinate performance. One might regard the leader/follower relationship as a series of reciprocal economic and social exchanges that help accomplish goal attainment while meeting the needs of the follower (Flood et al., 2003; Lussier, 2001). Stated differently, leaders use rewards as a source of power in a contractual agreement. Compliance/performance is obtained when the rewards satisfy the needs of the follower. MacGregor Burns (2003) described the transactional leader as one who participates in simple and complex exchanges with subordinates to promote performance activities that contributes to fulfilling organizational objectives.

Transactional leadership is a dominant leadership system based on (a) contingent reward that is associated with mutually agreeable contractual agreements between leaders and followers and (b) management by exception in which leader intervention occurs when the desired standard is not met. As such these leaders routinely intervene only after a problem has occurred and has been presented to them (Antonakis, Avolio, & Sivasubramaniam, 2003). Leadership that is transactional in the most positive sense allows leaders and followers to progress toward respective goals. When the established performance action is achieved and/ the goals fulfilled, the relationship may end, a new contract maybe established, or elect to redefine goals (Bass, Jung, Avolio, Berson, 2003; Flood et al., 2000). Such leaders relate well to subordinates within organizations because

they understand what subordinates want, are able to respond to the self-interest of the subordinate, and exchanges rewards and recognition for achieving performance goals and in so doing attempts to satisfy organizational objectives. Recent studies suggest that a combination of transactional and transformational leadership styles may provide the most effective leadership outcomes (Bass & Avolio, 2003).

Transformational

Whereas transactional leadership seeks to maintain organizational stability through rewarding the self interest of subordinates, transformational leaderships serves to motivate subordinates to performance acts that transcend self interest and exceed performance expectations often inspiring change efforts through a clearly articulated vision (Berson & Linton, Burns, 1978; 2005; Flood et al., 2000). This type of leadership raises follower consciousness, elevating morality and motivation toward what is good and what is important for the organization. Rather than a reciprocal exchange, leaders who are transformational engage in interactions based on values, beliefs, and common goals and in so doing raise the ethical aspirations of both leader and subordinate (Bass, 1985; Burns, 1978; Flood, 2000; MacGregor Burns, 2003). For these reasons experts addressing the challenges and conditions of 21st century work environments endorse transformational leadership as effective quality management and as a dynamic predictor

of positive organizational indices (Bass, 1985; Burns, 1978; Flood, 2000; MacGregor Burns, 2003).

Contemporary organizational theorists have documented the essential need to identify leadership styles that enhance performance (Berson & Linton, 2005). Supportively, leadership theory experts have placed leadership styles on a continuum in terms of effectiveness and pro-activity placing laissez-fair leadership at the bottom end, transactional in the middle of the continuum, and transformational at the top. The implication is that transformational leadership is decidedly more proactive and more effective than the laissez-faire or transactional styles of leading (Avolio, 1994; Bass, 1985, Berson & Linton, 2005; Burns, 1978). Proponents in support of the transformational leadership paradigm have provided empirical data that associate this model with visionary, charismatic, value-driven, motivational practices and clearly articulated goals that result in creative acts within organizations (Judge & Bono, 2000; Berson & linton, 2005; & Keller, 1992).

The transformational leadership process was described by Bass (1985) as a demonstrated series of leader behaviors associated with three distinct factors: intellectual stimulation, charisma/inspiration, and individual consideration. Inherent in these characteristics is the ability to influence change, inspire meaning and value, and motivate and harness intellectual capital toward innovative acts that support organizational survival. These factors associated with transformational leadership were foundational to research endeavors that ultimately yielded the Multifactor Leadership Questionnaire

(MLQ) a validated instrument that is widely used as a research tool for leadership (Bass & Avolio, 1995).

Transformational leadership is among the most prominent leadership theories represented in the organizational leadership literature within the last two decades. A review of the literature seems to indicate that the transformational leadership style is more closely associated with positive organizational outcomes (Berson & Linton, 2005, Lussier, 2001; MacGregor Burns, 2003). As a leadership philosophy and style it is of interest because it can conjure strong emotion in support of a compelling vision that inspires subordinates to transcend self interests in order to achieve the overall organizational objective. Lussier (2001) concluded that there is still much to learn about transformational leadership, but offers the convergence of many years of observation as sufficient to formulate common attributes of this leadership style. Lussier (2001, P. 383) offered the following as common characteristics among transformational leaders:

> They see themselves as powerful agents of change
>
> They are visionary individuals who have a high level of trust in their intuition.
>
> They take risks, but they are not reckless.
>
> They capably and clearly articulate core values that govern their behavior within the organization.
>
> They possess incredible cognitive skills and they carefully deliberate before taking action.
>
> They believe in people and demonstrate sensitivity to their needs and concerns.

They demonstrate flexibility and are open to learning from experience.

Leaders who are transformational have the mysteriously given vision of an organization conforming its culture and the work practices of its actors into relevant products, behaviors, and initiatives that satisfy emerging societal needs and trends. An in-depth review of both empirical and conceptual leadership literature suggested these leaders present a vision of a future state of the organization, can effectively and inspirationally articulate that vision to ignite new practices and behaviors from subordinates, and consistently motivate the implementation of that vision towards improved organizational outcomes (Berson & Linton, 2005; Schein, 1997; Senge, 1994; Quinn, 1996). The notion that they make things happen is linked to the meaning and value espoused by transformational leaders elevates the interest of subordinates and serves to create trust (Kouzes & Posner, 2003). It is their vision that gives sight to the organization as they articulate a mission and purpose that motivates high performance practices that satisfy organizational goals and objectives.

Leadership as a Predictor of Positive Organizational Outcomes

In the preceding paragraphs, this author discussed the significance and utility of specific leadership styles that impact contemporary organizational practices. The rapids of change, rising conflicts, and economic fragility require a form of leadership rooted in intent, vision, direction, and goal attainment because the elements driving change are powerful. The author further discussed the speed of technological advances and financial instabilities that force 21st century leaders to rethink strategies, reengineer work practices, and reinvent themselves in order to stay solvent on the global horizon (Hatch, 1997;

Hesselbein, Goldsmith, & Beckhard, 1997). This further supports the notion that effective leadership helps individuals in organizations navigate the rapids of change and steer their success endeavors.

Cogent arguments have been made that the leaders' beliefs, assumptions, and values are significantly related to the overarching leadership style they embrace (Dawson, 2001; Schein, 1998). Subordinates expect leaders to create the atmosphere in which workers can be successful and content or miserable and uncaring. Moreover, a Gallup poll positioned leadership as the guiding force behind culture creation, culture change, and inventive acts within contemporary organizations (Luthans, 2002). Dawson (2003) more emphatically stated that executive leadership has a direct impact on the success or failure of change initiatives. Principal change theorists emphasize that change is the most critical thing that leaders can bring and teach to contemporary work environments (Harper, 1998; Kanter, 1985). Change leaders within 21st century work environments understand the need to profoundly impact leader/follower relationships that foster the creation of new knowledge, inspire the transformation of cultures and the application of critical information, and create and demonstrate meaning and value for subordinates. Subsequent paragraphs outlined selected leader-driven concepts and practices proven critical to organizational survival.

Successful leaders focus on knowledge emergence

Nonaka and Nishgushi (2001) discussed the explosion and emergence of new knowledge as an important transition into the 21st century. Contemporary leaders understand the need to be able to recast roles inventively as well as the need to create

fluid relationships between leaders and followers to promote the emergence of new knowledge. These leaders generally embrace creative problem solvers, and solutions oriented people as valued contributors critical to the future success of the organization. Knowledge leaders also focus on changes in organizational design to accommodate rapid technological advancement, the speed of information, and a shrinking global market. Transformational leadership strategy seems appropriate because these leaders explore and challenge existing norms, systems, beliefs and business cultures present within contemporary work environments and utilize the acquisition of new information to drive change. The leadership literature supports the style of leadership that creates a culture of flexibility in an organizational structure that allows them to transition toward renewal and toward new trends in order to stay ahead of the competition (Collins, 2001; Schein, 1999).

Knowledge has been described as an effective tool to decipher the complexities of change (Huber, 1984). Knowledge as a tool of knowing positively impacts organizational environments. Organizational theorists and thinkers have described the creation of new knowledge as an effective leadership strategy essential for human enhancement and organizational growth (Nonaka & Nishiguchi, 2001). Leader-driven scientific inquiry continues to spawn dramatic changes in technology, significantly impacting the performance, functionality, and culture of organizations. The essential nature of leadership to organizational culture is seen as leaders are able to utilize knowledge principles to build strategies and create technologies, theories and paradigms that

influence values and strategically position the organization's present and future successes (Nonaka & Nishiguchi, 2001).

Gazzaniga (1998) posited that the brain enables the mind. Stated differently, it is the brain with its multi mechanisms that enables us to make sense of the things around us. Successful leaders use this concept in the creation of learning and teaching organizations. This leads to the emergence of successful leader-induced cultures that respect diversity in thinking styles, embrace a structured logical approach, and use values and emotions in solving organizational concerns. Senge (1990) discussed five disciplines that he positively associated with learning organizations. These disciplines include systems thinking, personal mastery, mental models, shared vision, and team learning. The five disciplines espoused by Senge (1990) reveal different learning styles framed in epistemic context critical to establishing learning cultures that engage in knowledge creation. Successful contemporary leaders consider this process vital to the survival of 21st century organizations because they view it as an opportunity for actors within the organization to engage in innovative acts that may more securely position the organization within a competitive global market.

Successful leaders create meaning and value

The speed of change, technological advancement, and a shrinking global market has lead to new philosophies of leadership framed in notions of meaning and value. Within this interactive, sensitive, inspirational model of leadership is the inherent belief that leaders create meaning and purpose. Frankle (1984) proffered that the unquenchable thirst to find meaning is the ultimate motivational force in man. This meaning sought by

actors within organizations is uniquely related to the self, as it can be satisfied and fulfilled only by those who seek it (Frankle, 1984). Hillman (1996) enlightened that it is this drive in search of meaning that provokes our initial descent into the world, as individuals intended to fulfill a secret path encoded in the heart. Frankle (1984) further stated that each human being has a life mission and a definitive assignment that demands fulfillment. He suggests that it is as unique a task as is the opportunity to implement it. The philosophy is that when effective leaders tap into this driving force by creating meaning and value it results in outstanding feats of subordinate performance. Leaders are therefore challenged to attach value to which subordinates can relate in their code of ethics.

Humans have an inherent desire to attach the self to meaningful endeavors. Leaders with powerful, positive values create meaning that impact social good, societal change and worldviews. Consider Mahatma Gandhi, Nelson Mandela, and Mother Theresa, as charismatic leaders who exhibited self-transcendence, which reflected high esteem for human dignity. Contemporary leaders who foster respect for human dignity generally develop and clearly articulate a vision, mission, and direction. They also establish a code of ethics that supports their concepts and more securely positions an organization, community, or country on the turbulent postmodern economic frontier (Giblin & Amuso, 1997; Nonaka & Nishigushi, 2001).

Change-induced 21st century leadership has embraced the transformational approach in which the leadership concept takes on inspirational meaning. Transformational leaders create a contemporary view of leadership that perceives the

leader as innovative, risk-taking, having the ability to maximize resources, serve others, and be agents of change. This contemporary view reflects an integration of concepts that link the most effective approaches (Van Seters & Fiek, 1990). Values such as truth, courage, compassion, ethics, honesty, and the need to be free are concepts that man is willing to live and die for (Frankle, 1984). Values are prized and conserved because of the multiple benefits they bring to the human/social interplay. When values are clearly articulated, trust is established and work is often accomplished.

Sound leadership practices support a moral responsibility that understands we are bound by obligation to others who depend on us to be accountable and to act responsibly because our actions depict our core ethical standards (Mccullough, 2002). Transformational leaders exhibit strong positive values create meaning and impact worldviews. Such leaders create meaning through the organizational mission they espouse, the values they embed within cultural practices, and the vision they articulate to subordinates. Schein (1997, 1999) stated that change agents who are transparent and comfortable in uncertainty are internally driven leaders who understand, value, and model renewal. Leaders embed culture through meaning, and are considered the relevant core of healthy, functional, high performance work environments (Collins, 2001). The core assumptions they hold speak of deep values and beliefs that create formal systems and shape the space for both personal lives and for existence in the workplace.

Establishing meaningful cultures that are worker-valued is also demonstrated in leaders who recognize the importance of language as a leadership tool. According to Lakoff & Johnson (2003) “Language is an important source of evidence for what a

system is like" (p.3). Such leaders embrace a style of leadership that demonstrates understanding of how words critically shape the work space, serve as repositories of organizational history, and implant the seeds of future successes or failures (Bourdieu, 1991). Successful leaders inspire subordinate commitment through selective leader-worker conversations using words that frame the positive outcomes they desire to see.

Successful leaders transform organizational cultures

Leadership roles have undergone tremendous transformation. Organizational theorists proffer how leaders create, shape, and adopt new operating systems elevate the functionality of the organization (Dawson, 2003; Schein, 1997; Trice & Byer, 1993). The rapids of change within 21st century environments lead to the emergence of new leadership philosophies more suitable for the contemporary workplace. Inferences of leadership as an instrument of cultural change are numerous. Bryson and Kelly (2001) stated that effective organizational leadership is evidenced by the ability to leverage powerful tools and important elements to achieve articulated goals. Nadler, Shaw, and Walton (1995) discussed the need for change leadership as a core organizational competency. These authors challenged contemporary leaders to create flexible, adaptive, responsive environments in order to survive in the coming decades. As organizations absorb and seek to satisfy global demands, leaders recognize that societal changes have forged new concepts of leadership to meet new demands (O'Grady & Malloch, 2002). Continuous, rapid, technological advances and financial instabilities require transformational acts from leaders who rethink existing cultural norms and strategies,

reengineer work practices, and reinvent their organizations in order to stay competitive (Hesselbein et al., 1997).

This approach to embedding culture and creating organizational change is reflective of an interactive, sensitive, communicative, and transformational style of leadership associated with successful organizational practices. Schein (1997) through extensive research proposed leadership as a vital concept in the creation and maintenance of an organization's culture. The author positioned the leadership concept as the entity that provides meaning and sense-making of symbols, events, and organizational image. More emphatically stated, the culture of an organization usually revolves around its leader (Nadler, Shaw, & Walton, 1995; Schein, 1997). Such transformational leaders are proactive rather than reactive in their approach, and they inspire enthusiastic commitment from their subordinates as opposed to unenthusiastic obedience. Schein (1997) suggested that these leaders embed the culture of an organization from a paradigm conceived in their corporate vision. Successful deployment of culture change efforts has been widely linked to patterns of transformational leadership (Schein, 1997; Hesselbein et al., 1997; Bass, 1990). Transformational leadership styles have been associated with the creation of positive culture change possibly because transformational leaders give followers vision to see opportunities.

Leaders who are charismatic and motivational influence culture creation and change as these visionaries offer sense of purpose and meaning to subordinates (Gellis, 2001). These agents of change champion the struggle for cooperative, innovative acts among leaders and followers, which counter bureaucratic resistance to change. Wren

(1995) suggested that transformational leaders impact culture through the use of effective communication that modifies subordinate behaviors and attitudes in order to achieve organizational goals. Additionally, these transformational leaders apply moral convictions to embed values, inspire trust, create confidence, and establish loyalty. The mission and vision they successfully communicate become the customary practices that act as guiding principles for all members of the organizational community (Pendleton & King, 2002).

Leaders are essential to change initiatives

Trice and Beyer (1993) discussed leaders as individuals who drive the course of an organization. These authors supported the composite work of other contemporary authors who suggested that transformational leaders can repaint an organization by embedding specific characteristics:

1. Individual qualities: Leaders have the capacity to transmit desired behaviors into the fabric of an organization an organization. A transformational leader/founder, can inspire and influence innovative acts that positions the organization in the direction desired.
2. Vision and mission: Leaders influence changes that actualize the leaders' vision and they establish the foundation, direction, and values that support organizational practices.
3. Use of tradition: Leaders assist change efforts through establishing new common values that frame traditional practices within the workplace. Schein also (1997)

stipulated that leaders embed culture changes within the organization through the customary practices they weave into the organization.

4. Performance: Leaders establish intricate systems of rewards and punishments to support relevant change efforts in keeping with the organizational direction.

The single most important part of any dynamic change revolves around leadership within the organization (Kotter & Heskett, 1992). Executive leadership has a direct impact on the triumph or collapse of any change initiative. The impetus within 21st century organizations to achieve and maintain a sustainable competitive edge propels strategic transformational acts from leaders within the organization. Leadership impacts organizational change practices regarding buying practices, domestic and international competition, and performance levels within the organization. Leaders develop strategies for their change vision and influence follower alignment through articulating the vision and empowering innovative acts (Carr et al., 1996; Dacin, Gelis, 2001; Dacin, Goodstein, & Scott, 2002).

Hesselbein, Goldberg, and Beckherd (1997) focused a compilation of readings on the foundational belief that leadership is a learned function and that it must be learned for the sake of organizational survival in a changing future. Hesselbein et al. espoused that leaders of the future would facilitate unprecedented change. Contemporary leaders further facilitated the change process by converting to cultures that reward activities which incite competition, invents global opportunities, mocks traditional boundaries, and present new demand for intellectual capital.

Additionally, leaders embedded change within contemporary organizations through adding the concept of diversity into the organizational strategy (Lussier, 2001). As part of the organizational strategy subordinates have equal opportunity to utilize skills, abilities, and talents for the stability of an organization without regard for race, gender, or ethnicity. This leader-driven initiative satisfies organizational objectives through increasing market shares, and establishing a wider, deeper base from which to resolve organizational concerns and draw creative solutions.

Examining the context and substance of change raises a number of important leadership considerations. For example it encompasses a sequence of phases that begins with the recognition of the need to change followed by, creating and communicating the new vision, mastering the transformation while decreasing resistance to change, and embedding the change into customary practices (Burnes, 2004; Hatch, 1997; Schein, 1996). This series of activities was grounded in Lewin's change model and constituted transformative acts synonymous with strategic leadership that is transformational. This type of leadership is critical to providing the direction and inspiration needed to create and sustain change efforts that work in concert with organizational objectives (Lussier, 2001).

Leadership Within Hospital Organizations

As contemporary health care organizations attempt to position themselves to meet the overwhelming and diverse needs of vast communities, they continue to do so in a chaotic environment riddled with massive change and emerging conflict. Hospital organizations in particular continue to experience tremendous upheavals and significant

restructuring (Burke, 2003; Kilpatric & Hosclaw, 1996). In fact, no segment of the business industry has been more profoundly impacted by unflagging transition than the hospital health care environment (Bigelow & Arndt; 2000; Hagenow, 2001). Growing tensions between providers and payers, higher consumer expectations, changes in cultural forces, economic fragility, and elevated costs have strained the system affecting the consistent delivery of meaningful, quality care.

Consider the recent grave, economic tragedy of Grady Hospital in Atlanta, Georgia. A combination of skyrocketing medical costs, increased patient population, and decreased payments recently forced Grady Hospital to close the doors of the only outpatient dialysis center in Georgia that accepted Medicaid. The hospital leadership model was described as flawed, outdated, and in desperate need of transformation (Atlanta Chamber Commerce Executive Health Care Summary, 2007). Moreover, as a hospital organization, Grady continues to totter on the border of insolvency and requires critical, decisive leadership initiatives to transform its governance structure, redefine, and reconfigure its operations to more effectively support long term viability. In the meantime, as Grady seeks potent, effective treatment for its wounds, the hospital continues to eliminate and/or reduce health services that threaten a trickle-down effect to other area hospitals resulting in increased admissions to the emergency rooms (Atlanta Chamber Commerce Executive Health Care Summary, 2007).

Other health care leaders are challenged across the country with a crippling convergence of negative tendencies. The executive health care summary of the Atlanta Chamber of Commerce (2007) identified them as follows:

1. Population growth, growing elderly subset, backlash from managed care, medical advances, and competing specialty groups.
2. Demanding regulatory agencies that require hospitals to provide generally unprofitable services for patients as a condition of payment and licensure.
3. Increased number of uninsured and anemically insured increases the drain on hospital finances.
4. Drastic decrease in the available pool of health care practitioners.
5. Poor or misaligned reimbursement for health care services.

The convergence of these influences within 21st century hospital organizations necessitates more effective and transformational leadership imperatives than past practices required (Morrison, 2000).

An astounding recent survey of 840 hospital leaders across the United States further uncovered the state of America's hospitals. The survey revealed leader concern regarding workforce shortages, 116,000 nurse vacancies were reported, gaps in specialty coverage, decreased employee satisfaction, and decreased patient satisfaction (American Hospital Association, 2007). These criticisms regarding current health care are often related to the need to see values in action in an environment where expertise, communication, insight, and a vision for the future is supported by extraordinary effort (Pendleton & King, 2002). Incongruity regarding what health care leadership has become and what is needed to survive the enormous need for quality care in the 21st century continues to severely impact hospital organizations (Dye, 2000).

Contemporary health care leaders struggle to identify and uncover solutions to the leadership structure essential to succeed and overcome the crisis of our current volatile hospital health care environment. The 2006 Leadership Summit Health Forum presented by the American Hospital Association explored the strategic issues and challenges facing contemporary hospital organizations. The impetus of the forum was to impress upon participants that the crippling concerns affecting the delivery of quality care must be seen as leader-driven performance imperatives. Issues critical to the survival of 21st century hospitals were identified and discussed during the 2006 Leaders Summit. The major concerns entrenched in the discussions were:

1. The Need for demonstrated Leadership commitment to quality care.
2. Embedding quality as a business and financial strategy.
3. Linking technologies to advancing patient-centered care.
4. Inspiring and engaging clinician participation in quality care initiatives.
5. Embedding a culture of service quality.

These imperatives for hospital organizations require a form of leadership that inspires inventiveness, motivates collaborative acts, influences change initiatives, and utilizes leader-vision to light a path for the organization. It requires a type of evolutionary leadership that is transformational in nature.

Sadly, while much work has been documented regarding proven success strategies used by leaders within other segments of the business industry, little could be found regarding the strategies utilized by leaders within hospital organizations that are

doing well. More emphatically, Tieman (2002) indicated that despite their experience contemporary leaders in health care environments are doing very little training, development, and/or succession planning.

The multiplicity of leadership challenges presented by contemporary hospital health care begs scrupulous consideration of the leadership style suitable to charter a complex, competitive, undulating course where few roadmaps exist and existing ones often need to be re-defined. Transformational leadership has been associated with the ability to inspire self transcendence and motivate acts of extraordinarily high performance in subordinates and as such remains a dynamic indicator of performance indices ((Bass, 1985; Burns, 1978; Flood, 2000; MacGregor Burns, 2003). Kane (2000) also indicated that leadership that is transformational appears well suited for promoting activities associated with learning organizations and leadership development. Hospitals are well known as learning organizations and transformational leadership could consequently be most suitable for this type of environment. Webb (2000) remarked that successful health care leadership in the 21st century is dependent on the ability to inspire subordinates to take a leap into the unknown. Inherent in this statement is the leaders ability to inspire trust among subordinates a characteristic widely associated with leadership that is transformational (Lussier, 2001).

Leadership is about managing change (Kotter, 1999). As repainted challenges and new tensions emerge within contemporary hospital environments frame-breaking changes occur requiring an extraordinary form of visionary leadership. Hospital organizations will require leaders that can rebuild trust, establish efficient and effective processes, and

ensure sustainability of quality initiative in the face of hostile transitions (Dye, 2000). The inspirational, charismatic, value-driven, qualities of transformational leadership have been purported as the optimum leadership style for managing change and boosting quality performance (Judge & Bono, 2000; Keller, 1992; Berson & Linton, 2005). Leaders who are transformational are more likely to understand the evolutionary culture of contemporary hospital environments and embed appropriate values, apply relevant technologies to navigate change, and select inventive strategies to more securely position the hospital organization.

Leadership development has been described as a teachable process (McCauley, Moxley, & VanVelsor, 1998; Wren, 1995). Given the state of contemporary hospital organizations it is critical to identify leadership styles and characteristics at work in successful hospitals and utilize these to establish developmental processes. The relationship between leadership styles and successful hospitals outcomes has received minimal attention. A study of this nature could significantly contribute to the pool of available health care leaders needed to navigate the turbulent, uncertain terrain that shapes contemporary health care. Such a process would be relevant and valued because it would facilitate the emergence of new knowledge that could fill the gaps regarding leadership characteristics and styles at work within successful hospital environments. The value and relevance of such a study is also evident in the need to develop appropriate content for leadership training programs as well as for making important decisions for promoting and hiring leaders within hospital environments. The isolation of evidence-based leadership styles that promote successful practices in hospital settings will

significantly contribute to this information gap in the health care literature. Since there is limited research in this area of health care as a whole and practically none found to address the specific leadership styles that are found in successful hospitals, this topic should be addressed.

Measurement of Leadership Styles and Hospital Success

The competitive nature of 21 century hospital organizations paved the way to a significant increase in the development and use of performance success indicators as determinants of competitive advantage (Schacht and Hines, 2003). In support of the need to identify leadership styles that promote successful outcomes, Kotter and Heskett (1992) cited competent forms of leadership as the most distinguishing factor between organizations that succeed and those that fail (p. 84). The following paragraphs focus on three well known measures of high performance success within hospital organizations: Press Ganey patient satisfaction scores, Joint Commission accreditation, and Thomsons Healthcare 100 Top Hospital status. Measurement methods of leadership styles are also elaborated.

Measurement of leadership styles

The Multifactor Leadership Questionnaire (MLQ) will be used in this study to measure leadership styles. The MLQ has been extensively used to measure leadership styles and outcomes since its inception in 1985. The efficacy of the MLQ as a valid, reliable leadership assessment tool has been repeatedly established in the literature (Avolio & Bass, 1999; Antonakis, Avolio, & Sivasubramanium, 2003; MacGregor Burns, 2003). Founded on the full range of leadership theory, this instrument evaluates and

differentiates both transactional and transformational leadership styles and allows inquiry into the connection between leader styles, performance effectiveness, and satisfaction. The MLQ form consists of forty-five descriptive question statements and this tool will be applied to adequately collect, measure, and identify data regarding leadership styles. The measurement process includes indicators of organizational outcomes making the MLQ instrument most appropriate for this investigation.

Tracey and Hinkin (1998) measured the extent to which the MLQ assessed distinct leadership constructs compared to the Managerial Practice Survey (MPS). The authors concluded that the MLQ assessed clearly distinguishable leadership traits compared to the management traits assessed by the MPS. A variety of established studies have tested the MLQ and have documented support for its validity and reliability (Barbuto, John, Fritz, matkin, & Marx, 2007; Barbuto & John, 2005; Parry & Proctor, 2002). Antonakis, Avolio, and Sivasubramanium (2003) also supported the use of the MLQ as a valid, reliable instrument that adequately measures the intended leadership factors. Other instruments contemplated could not adequately address particulars related to the study and consequently were not selected.

Measurement of success: patient satisfaction

Patient satisfaction is frequently used as an efficient proxy measure of quality of care. A considerable body of evidence exists regarding how patient satisfaction influences patient return and increased referrals (Corviano, 2005; Garman et al, 2005; Otani & Harris, 2004). Therefore, competitive uncertain markets, regulatory standards, and rival institutions have forced leaders of hospital organizations to cite patient

satisfaction as critical to competitive advantage. Patient satisfaction, as measured by Press Ganey, is now considered the primary tool for retaining relationships with providers and increasing patient loyalty.

Leaders of contemporary hospital organizations exhibit intense interest in a comprehensive view of the determinants of patient satisfaction as measured by Press Ganey. These determinants served as key identifiers of patient expectations that identify and define their inner measures of quality care. Moreover, these key determinants of patient satisfaction allow caregivers to learn about the patients' perception of the service they received and make critical adjustments to services offered.

Measurement of success: Joint Commission

The Joint Commission offers accreditation and certification to more than 15,000 health care organizations and programs in the United States. Joint Commission is an independent, not-for-profit, global, knowledge-based organization that circulates information regarding accreditation, best practice guidelines, development of standards and compliance, and health care quality improvement that is widely valued by hospital leadership in Atlanta and across the country. Joint Commission (JC) is committed to helping health care organizations improve the quality of patient care and achieve peak performance through vigorous, detailed monitoring processes. The mission of this organization is to "continuously improve the safety and quality of health care in the United States and in the international community through the provision of education, publications, consultation, and evaluation services (JCR, 2007). The comprehensive

rigors of the JC accreditation survey process allow accredited hospitals the *coveted* recognition of high performance success.

Measurement of success: Thomsons Healthcare 100 Top Hospital status

Thomson Healthcare (previously Solucient Corporation) 100 Top Hospital status is associated with higher survival rates, decrease in medical complications, ability to attract more patients, and a good history of financial accountability (Thomsons, 2007). Hospital organizations are bestowed this honor for demonstrating superior organization-wide performance in critical areas of health care practice. Hospitals are scored on core performance measures centered on Clinical service excellence, financial stability, operating efficiency, and responsiveness to community health needs. The analysis was conducted by Thomson Healthcare the corporate sponsor of this benchmark 100 Top Hospital listing.

Selection of the Research Method

Through this research was possible to determine whether or not an influential relationship exists between key leadership characteristics and successful hospital outcomes. For this reason the quantitative research approach was considered most appropriate as discussed further in chapter 3. The basic purpose of quantitative correlational studies is to identify, examine, and determine the relationship between variables and/or the extent to which these variables impact each other in some predictable fashion (Leedy & Ormrod, 2005; Simon & Francis, 2001). Several researchers support the application of quantitative correlational studies to identify trends, attitudes, opinions, and predictions from which generalizations can be made regarding a population with the

need to further authenticate the validity of relationships and generalizations that contribute support to a theory (Creswell, 2003; Leedy, Newby & Ertmer 1997). Since a qualitative research design would not identify relationships between variables it was not considered appropriate for this study (Leedy and Ormrod, 2005).

Summary

Chapter 2 was an examination and review of the literature related to the critical need for hospital organizations to embrace specific leadership practices that are more likely to promote successful outcomes. The examination of the literature began with a historical representation of the leadership literature presented by respected theorists in order to understand the consistent influence of leadership on organizational practices over time. Some discussed the idea of leadership as the nucleus of organizational societies, the enabling trait that critically influences organizational societies, and/or the undeniable force behind fruitful change efforts (Bass, 1990; Stogdill, 1975; Wren, 1995). The resounding significance of leadership to successful organizational endeavors remained consistent among respected commentators on the history of the subject. This historical examination positioned the leadership phenomenon as a critical factor for organizational development, with strong inference that its absence almost always results in failure (Cooney, Landers & Williams, 2002).

Further examination of the literature uncovered extensive interest in the concepts, cultures, change strategies, and the organizational arrangements of high performing work environments. Moreover, contemporary organizations have demonstrated confluence surrounding the relevance of identifying, harnessing, and understanding the link between

critical forms of leadership that promote success strategies resulting in high performance and consequent organizational solvency (Avolio, 1999; Berson & Linton, 2005). The revelatory application of representative literature allowed discussion and focus on pertinent fundamental leadership styles that appears to serve as distinct predictors and indices of organizational work performance. The literature review indicated that transformational leaders use their vision to give sight to the organization as they clearly articulate a mission and purpose that motivates high performance practices that meet organizational objectives.

This review of the literature funneled to identify the multiplicity of leadership challenges presented by contemporary hospital health care. Key to this discussion was the need to identify and give scrupulous consideration of the leadership styles suitable to charter a complex, competitive, undulating course where few roadmaps exist and existing ones often require a structural overhaul as in the case of Grady Hospital. Well-known methods of measuring hospital performance and leadership styles were identified and elaborated. The selected research methodology for this study was also reviewed and discussed. Given the state of 21st century hospital organizations was critical to identify leadership styles and characteristics at work in successful hospitals and utilize these to create winning performance improvement strategies. Yet as the literature indicated the relationship between leadership styles and successful hospitals outcomes have received minimal attention and beg further attention. This is attributed to a gap in the literature that supported the need for more inquiry into evidence-based leadership styles that promote successful practices in hospital settings.

This investigation explored the relationship between leadership styles and successful outcomes in two distinct hospital settings. Such a critical undertaking can significantly contribute to the pool of available health care leaders needed to navigate the turbulent, volatile, uncertain terrain of 21st century hospital organizations. Chapter 3 detailed the proposed methodology of the study. In chapter 3 a quantitative correlational method of investigation was applied to address the problem of determining the extent to which a relationship exists between leadership styles and measures of successful hospital outcomes.

CHAPTER 3: METHODS

Introduction

The pursuit of inquiry is evoked by the desire to observe and/or understand phenomena that few have recognized, investigated, or understood previously. Such discovery is a communal achievement as the investigator both draws from and contributes to an existing body of knowledge (Committee on Science, Engineering, and Public Policy, 1995). While there are several methods available for conducting meaningful inquiry, these methods all involve essential research processes of collecting, analyzing, and interpreting information in order to better understand an occurrence (Leedy & Ormrod, 2005). This chapter features the proposed methodology for the study. The purpose of this study was to assess the unique leadership styles found among executive leaders to determine whether leadership styles have a relationship on the success strategies of acute care hospitals in the greater Atlanta region. Through this research it is possible to identify relationships between key leadership characteristics and successful outcomes. Chapters 1 and 2 contain the core intent and value of the study. In chapter 3 a review and discussion of the selected research method, design, and appropriateness of the approach is elaborated.

Description of the Research Method and Design

A graphic rendering of the essence of the research project is pictured in Figure 1. Discussion is focused on the research design, population, instrumentation, data collection, data analysis, the appropriateness of the research design chosen, and a summary of the methodology. Leedy and Ormrod (2005) suggested that the selection of a research method and design should be guided by the problem, specific question, and/or

hypothesis. Simon and Francis (2001) supported the application of descriptive correlational studies to examine the relationship between variables in their natural environment without researcher- imposed treatments. This quantitative correlational

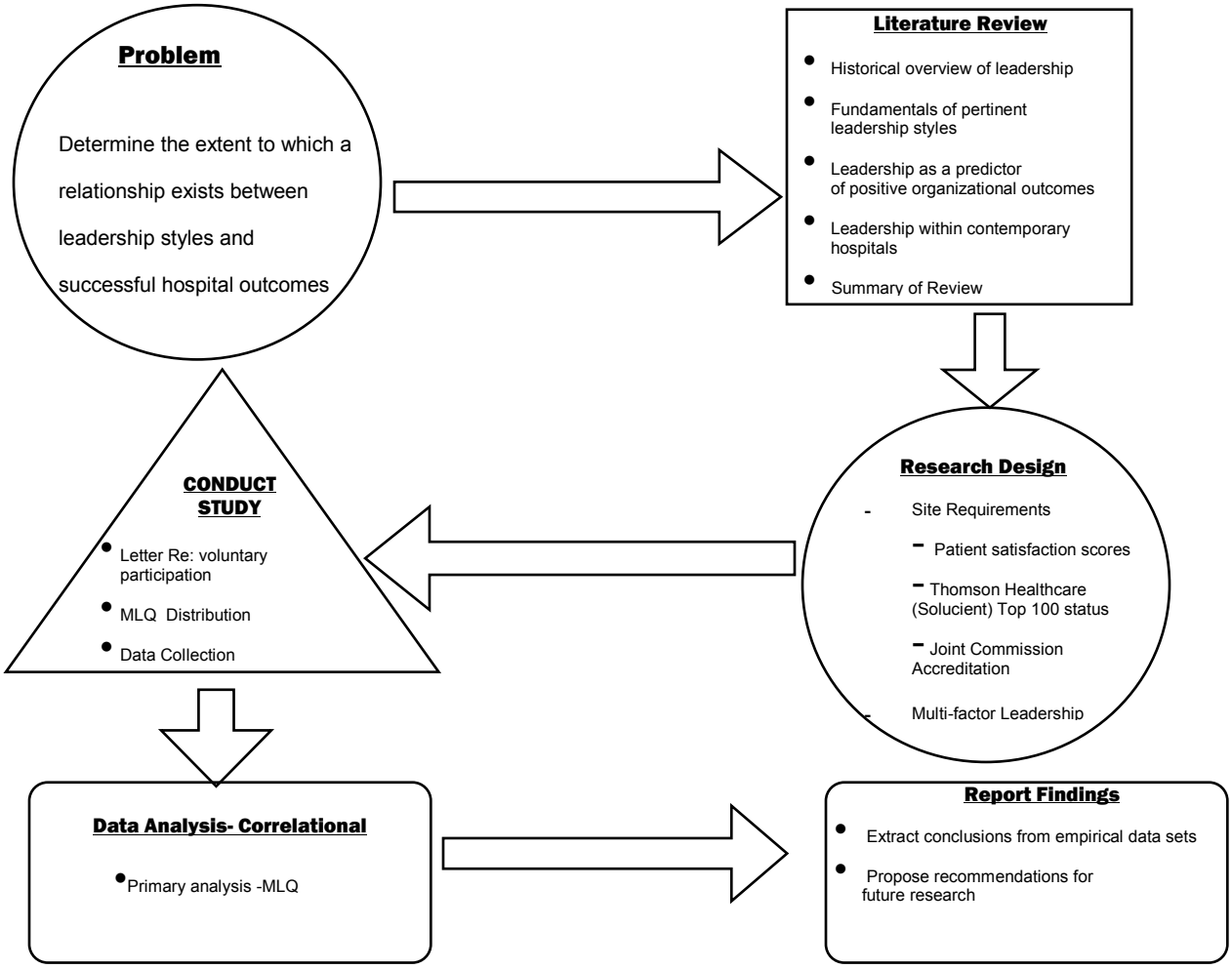

Figure 1. Graphic illustration of research process (Tufte, E.R.,1990, & 1997).

method of investigation is applied to address the problem of determining the extent to which a relationship exists between leadership styles and measures of successful hospital outcomes.

The quantitative research approach is deemed most appropriate because the basic purpose of this type of study is to determine the relationship between variables and/or the extent to which these variables relate to each other in some predictable fashion (Leedy & Ormrod, 2005; Simon & Francis, 2001). The application of the quantitative research method allows the researcher to test and verify theories through the identification of variables, relating variables to the research questions or hypotheses, and useful application of analytical validity and reliability. The application of this research method is most appropriate because it seeks explanations of trends, attitudes, opinions, and predictions from which generalizations can be made regarding a population with the need to further authenticate the validity of relationships and generalizations that contribute support to a theory (Creswell, 2003; Leedy, Newby & Ertmer 1997). Since a qualitative research design would not identify relationships between variables it was not considered appropriate for this study. Moreover, a correlational design was appropriate to this study to uncover surface relationships without establishing underlying causal explanations (Leedy & Ormrod, 2005; Simon & Francis, 2001). Rather "a correlation exists if when one variable increases, another variable either increases or decreases in a somewhat predictable fashion" (Leedy & Ormrod, 2003, P. 193).

This quantitative correlational research method of investigation is applied to address the problem of determining the extent to which a relationship exists between leadership styles and successful hospital outcomes. The application of this research design will potentially assist in the identification of leader behaviors that are found most consistently within successful hospital organizations in the Metro Atlanta Region. The

use of quantitative methodology will further assist in understanding the relationship between leadership styles and successful strategies within hospital organizations offering revolutionary opportunities to extract, educate, and model these leadership styles toward building more successful hospital organizations of the future. In order to identify and detail possible correlations a summary of recognized leadership styles and accepted measures of success in hospital organizations will be examined. Identified leadership styles will serve as the nonmanipulated independent variables while successful outcome measures will serve as the dependent variables. The categories for the dependent variables are based upon three known measures of success in hospital settings: Press Ganey patient satisfaction scores, Joint Commission accreditation scores, and achievement of Thomson Healthcare (Solucient) 100 Top Hospitals status.

Population

Among numerous ailments that threaten the longevity of 21st century hospital organizations in Atlanta is the unwavering need to provide quality care at all service levels. There are approximately 40 hospitals in the metro Atlanta region with a combined total of 8,697 inpatient beds that range in size from the smallest consisting of 40 beds to the largest that consists of 587 beds. Atlanta hospitals greatly contribute to the economic well-being of the region and are among the largest employers in their respective communities. Metro Atlanta hospital organizations supply an annual revenue impact of 7.8 billion with a profit margin of 4.3% (Georgia Department of Community Health Division Services, 2004; Georgia Hospital Association Membership Directory, 2006).

Hospital leaders of the region and local health officials express grave concern over the rising cost of quality health care. Like other hospitals nationwide, Atlanta hospitals are challenged by low occupancy rates, staffing shortages, decreased reimbursement, competition for a shriveling pool of private payers, population diversity, and multiple closures. Since 1980 approximately 39 metro Atlanta hospitals have closed their doors. Of these closures four hospitals were purchased, reopened, or replaced. Increased uncompensated charity care, indigent care, and bad debt additionally threaten the stability and economic impact of Atlanta hospitals as leaders struggle to maintain solvency and deliver quality care (AHA, 2006; GHA Membership Directory, 2006).

Leaders within local Atlanta hospital organizations are challenged to create cultures, practices, and strategies associated with reputed success and quality services that meet the health care needs of the surrounding communities. Thus, leadership within Atlanta based hospital organizations view quality service as pivotal to survival efforts of local hospitals. Patient satisfaction, as measured by Press Ganey, is frequently used as a proxy measure for quality of care in most acute care hospital environments in the Atlanta Metro area. Additionally, Joint Commission accreditation and certification is highly recognized nationwide as a mark of quality reflecting the commitment of an organization to meeting rigorous performance standards. Further, achievement of 100 Top Hospital status is an honor awarded to hospital organizations demonstrating superior organization-wide performance in critical areas of health care practice. Hospitals selected to participate in this study were required to have attained these three known measures of success: Press Ganey rankings within the top 10 to 15 % for overall inpatient satisfaction, Joint

Commission accreditation, and achievement of Thomson Healthcare (Solucient) 100 Top Hospitals status within the last three years.

Sampling Procedure

The ideal data set for an investigation involving human performance characteristics such as leadership in health care would be extracted from the entire population of health care leaders across the country. Thus, such a large, dispersed selection would render a close approximation of the entire universe of the investigated population. In reality, constraints related to time, cost, size, or inaccessibility usually prevents investigation of such a unit in its entirety (Leedy & Ormrod, 2005; Singleton & Straits, 2005). Moreover, Singleton & Straits (2005) further indicated that attempting to observe all possible cases may result in less accurate descriptions of the population compared to a judiciously selected sample.

The rationale for the sample was based on several factors (Simon & Francis, 2001). One factor was the ability to access participants in leading roles within metro Atlanta hospitals. The perspective of the researcher was that leaders of these hospitals would be disposed to participate due to their elite benchmark positions. Another key factor addressed the purpose of the study, which was to identify relationships between key leadership styles and successful outcome in acute care environments. To achieve this goal purposive sampling was applied to extract and delineate Atlanta based hospital organizations that met all three known measures of success: Press Ganey rankings within

the top 10 to 15% for overall inpatient satisfaction, Joint Commission accreditation scores, and achievement of Thomson Healthcare (Solucient)100 Top Hospitals status within the last three years.

This sampling method was also deemed applicable for the selection of the leaders who will participate in the study. Purposive sampling was considered most appropriate for this study because this sampling design supported the selection of typical participants that represent diverse perspectives on an issue (Leedy & Ormrod, 2005). For example, one might investigate a group typical of the population in important respects such as the three success measures previously identified. "The general strategy is to identify sources of variation in the population and then select a sample that reflects this variation (Singleton & Straits, p. 133)." Thus, purposive sampling is a non-probability sampling approach through which members of a population are selected for a particular purpose; and was considered an appropriate methodology for this study given the aforementioned criteria/guidelines and explanation of the rationale for using the sample (Leedy & Ormrod, 2005; Singleton & Straits, 2005).

In order to verify hospital accreditation by Joint Commission, the list of Atlanta based hospital organizations receiving Joint Commission accreditation was obtained from the Joint Commission Quality Checks/Quality Reports database and from Joint Commission's Public Information listing of accredited hospitals. Atlanta hospitals selected for this study must have received accreditation status from Joint Commission as an indication of successfully attaining high performance standards related to patient care delivery. To determine inclusion in Thomson's Healthcare (Solucient) 100 Top

benchmark hospitals, the winner's list was accessed through the 100 Top Hospital Study Abstract of the Thomson's Healthcare database. Atlanta hospitals selected for this study would have achieved listing among the nation's 100 Top Hospitals within the last 3 years as an indication of successfully achieving and demonstrating superior healthy care delivery.

The geographic location selected for the investigation was confined to the metro Atlanta region. Hospital A and Hospital B were selected due to documented Press Ganey inpatient satisfaction ranking within the top 10 to 15%, achievement of Joint Comission accreditation, and recognition within Thomson (Solucient) 100 Top Hospital ratings within the last three years. These two hospitals were the only ones in the metro Atlanta region to attain all three established measures of success. The leader-participants were comprised of all CEOs, presidents, vice presidents, executive directors, directors, and managers of services within these select hospitals. These leaders represented those who achieved the top most position in their respective fields. Two hundred and five leader-participants were anticipated from Piedmont Hospital, and 47 leader-participants were expected from Piedmont Fayette Hospital. A combined total of 251 recognized hospital leaders within the selected organizations were given the Multifactor Leadership Questionnaire (MLQ). This number represented the entire leadership pool of both facilities. Each study participant was informed that participation was voluntary. A letter of informed consent was provided to participants and required signatures obtained prior to returning the study questionnaires. . Of 251 possible participants 109 valid responses

were obtained yielding a 43% response rate. Singleton and Straits (2005) indicated that a response rate below 50% was not uncommon in mail surveys.

Sample

1. The study sample was derived from Piedmont Hospital and from Piedmont Fayette Community Hospital both located within the metro Atlanta area.
2. These two hospital organizations were the only acute care environments in the Atlanta metro area to attain all three established measures of success, thus meeting the criteria for participation in the study.
3. Hospital A is a landmark. More than a century old, this 458-bed hospital remains an integral part of the Atlanta Buckhead community. The hospital holds the reputation of being the premier provider of specialty health services throughout the metro Atlanta community. The Piedmont hospital leadership has embedded a strong service culture built of excellence in delivery of care described by actors within Hospital A as 'the Piedmont way.' Distinguished awards and ranks of distinction uniquely positions Hospital A among peer hospitals.
4. Hospital B is a tribute to teamwork. Hospital B opened in September 1997, and has since been proud to deliver quality, innovative care for patients in the metro Atlanta region and neighboring communities.
5. Hospital B embraces a tradition of medical excellence through incorporating best practice guidelines and the best ideas in every area from architecture to technology. This 100-bed, general community acute care hospital with state-of-the-art technology offers a wide range of medical and surgical services, inclusive

of an advanced diagnostic imaging department and comprehensive emergency care.

6. The leader-participants came from individuals in the top most positions in their respective fields. Therefore the leader-sample were comprised of all CEO's, presidents, vice presidents, executive directors, directors, and managers of services within these select hospitals.
7. A total of 251 recognized hospital leaders within the selected organizations formed the study sample.

Instrumentation

Corviano (2005) proposed that patients want to feel cared for by sensitive staff in an environment that inspires trust and nurtures confidentiality. A considerable body of evidence exists regarding how inpatient satisfaction influences patient return and increased referrals (Corviano, 2005; Garman et al., 2005; Otani & Harris, 2004). Therefore, competitive uncertain markets, regulatory standards, and rival institutions have forced leaders of hospital organizations to cite patient satisfaction as critical to competitive advantage. Press Ganey patient satisfaction is now considered a primary leadership tool for retaining relationships with providers and increasing patient loyalty. The assumption is that more satisfied patients are more likely to return. This increase in patient loyalty translates into increased ability to compete with providers, a stemming of the competition, while positively contributing to a hospital's bottom line and its ultimate longevity (Otani & Harris; Rahman, 2005). The Press Ganey data will be accessed and used as an instrument to extract those metro Atlanta hospitals whose reported inpatient

satisfaction positioned their hospitals within the top 10% to 15% of all hospitals across the nation that participate in Press Ganey reports.

As an independent, not-for-profit organization, Joint Commission offers accreditation and certification to more than 15,000 health care organizations and programs in the United States. Joint Commission is global, knowledge-based organization that circulates information regarding accreditation, best practice guidelines, development of standards and compliance, and health care quality improvement that is widely valued by hospital leadership in Atlanta and across the country. Joint Commission is committed to helping health care organizations improve the quality of patient care and achieve peak performance through vigorous, detailed monitoring processes. The mission of this organization is to "continuously improve the safety and quality of health care in the United States and in the international community through the provision of education, publications, consultation, and evaluation services (JCR, 2007)." The Commission Quality Checks/Quality Reports database of this instrument was accessed to identify all accredited hospitals in the Atlanta metropolitan region.

Achievement of Thomson Healthcare (Solucient)100 Top Hospital status is associated with higher survival rates, decrease in medical complications, ability to attract more patients, and a good history of financial accountability. This honor is awarded to hospital organizations demonstrating superior organization-wide performance in critical areas of health care practice. Hospitals are scored on core performance measures centered on Clinical service excellence, financial stability, operating efficiency, and responsiveness to community health needs. The analysis is conducted by Thomson

Healthcare, the corporate sponsor of this benchmark 100 Top Hospital listing. The researcher used this instrument to access the winners' list through the 100 Top Hospital Study Abstract of the Thomson's Healthcare database.

The questionnaire instrument used in this study is the Multifactor Leadership Questionnaire (MLQ) Form 5X. The MLQ was created by Bass and Avolio (1995/2000). The Multifactor Leadership Questionnaire has been used in leadership research since its inception in 1985. The MLQ Form 5X is the most current version of the instrument was developed to address researcher issues related to concerns surrounding validity, and reliability. The utility of the MLQ as a valid, reliable leadership assessment tool has been repeatedly established in the literature (Avolio & Bass, 1999; Antonakis, Avolio, & Sivasubramanium, 2003; MacGregor Burns, 2003). This instrument is founded on the full range of leadership theory and evaluates and differentiates both transactional and transformational leadership styles while allowing inquiry into the relationship between leader styles, performance effectiveness, and satisfaction. The measurement process includes indicators of organizational outcomes making the MLQ instrument most appropriate for this investigation. The application of the MLQ in this study allowed analysis of leader participant self-reported styles from 12 distinct points of interest: Idealized influence (ascribed to individuals and behaviors displayed by individuals), inspirational motivation, intellectual stimulation, individualized consideration, contingent reward, management by exception (active/passive), and laissez faire leadership, extra effort, effectiveness, and satisfaction are measured by the MLQ.

The MLQ has been extensively used as a reliable, valid instrument across multiple professional disciplines since its inception in 1985, and has confirmed ability to capture a broad range of leader behaviors. Tracey and Hinkin (1998) measured the extent to which the MLQ assessed distinct leadership constructs compared to the Managerial Practice Survey (MPS). The authors concluded that the MLQ assessed clearly distinguishable leadership traits compared to the management traits assessed by the MPS. The validity and reliability of the MLQ has been further tested and widely supported by multiple users in a variety of established research studies (Barbuto, John, Fritz, matkin, & Marx, 2007; Barbuto & John, 2005; Parry & Proctor, 2002). Antonakis, Avolio, and Sivasubramanium (2003) also supported the use of the MLQ as a valid, reliable instrument that adequately measures the intended leadership factors. Other instruments contemplated could not adequately address particulars related to the study and consequently were not selected. The MLQ form consists of forty-five descriptive question statements and the tool will be applied to adequately collect, measure, and identify data regarding leadership styles.

Data Collection

Permission was required from the Institutional Review Board (IRB) at Walden University to conduct the research. Full compliance with the IRB regulations from these organizations regarding human subjects was maintained. Through letters of request, hospital based participants that meet the criteria of attaining the top most positions in their respective fields such as CEOs, presidents, vice presidents, executive directors,

directors, and managers were asked to participate in the survey. Each of the 251 study participants was informed that participation was voluntary. A letter of informed consent was provided to participants and required signatures obtained prior to returning the questionnaires, as detailed in the sampling procedures. Due to the nature of the study no risks to participants were anticipated.

A combination of existing data and new data was gathered and reviewed. To determine patient satisfaction ranking, the extensive Press Ganey data base was reviewed to extract those metro Atlanta hospitals who placed within the top 10% to 15% of all hospitals across the nation that participate in Press Ganey reports, including hospitals in the metro Atlanta area. Placement within the top 10% to 15% of overall inpatient satisfaction is an indication of successful contribution to the patient care delivery process. These data are consistent with those reported to the Centers for Medicare and Medicaid reimbursement and represent responses from patients who were at the respective hospitals during the calendar year of 2007.

The researcher emailed the letter of informed consent along with an embedded link to the MLQ designated research website to the administrative assistants of the CEOs, executive vice presidents, and vice presidents with request for completion within 10 to 14 days. Similarly, directors and managers received the MLQ and letter of consent via email with the request for completion within 10 to 14 days. Participants at both Piedmont hospital and Fayette community Hospital received the MLQ with consent form in a similar manner. Thus, the researcher securely and confidentially accomplished the distribution and collection of the research instrument. Weekly email reminders to the

executive forum, the directors' forum, and the managers' forum were forwarded until the due date of the questionnaire. Only fully completed instruments were accepted for the study. The researcher was available via phone contact and email to answer any questions that arose. Thus, the researcher's contact information, phone number and email address, were provided for each participant. This researcher availability helped to decrease any anxiety and/or confusion arising and promoted more timely completion of the questionnaire. No adverse effects to study participants were anticipated from the investigation.

Data Analysis

Simon & Francis (2001) emphasized the importance of organization, management, and analysis of the data to better uncover the existence of any correlations. Authentication and validation of the MLQ instrument is well documented (Antonakis, Avolio, & Sivasubramanium, 2003; Bass,1995, 2000). The use of correlation was applied to analyze data from the MLQ. Leedy and Ormrod (2005) support the application and utility of simple linear regression and multiple regression techniques in predicting relationships between variables. The Pearson r correlation was applied to test the strength of the linear relationship between leadership factors of the MLQ and success measures. Statistical analyses were conducted to calculate and relate the mean scores of variables for each leadership factor. The research questions and corresponding data analysis method are detailed for clarity in table 1.

Table 1

Research Questions and Corresponding Data Analysis Method

Research Questions	Questionnaire	Data Analysis Method
1. What leadership styles are found consistently among leaders of successful hospital organizations?	MLQ	1. MLQ Rater scores 2. Statistical analysis: Measures of central tendency
2. What is the relationship between MLQ scores of hospital personnel compared to a normative group?	MLQ	1. MLQ Rater Scores 2. Pearson Correlation Coefficient
3. What, if any, relationship exists between leadership styles and patient satisfaction, Joint Commission Accreditation, and Thomson's healthcare's 100 Top	MLQ	1. MLQ Rater scores 2. Pearson Correlation Coefficient

	Hospital rating?	
4.	What differences exists between personnel in Hospital A compared to Hospital B in terms of MLQ scores?	1. MLQ rater scores 2. Pearson Correlation Coefficient

These questions are significant to the research focus because the answers to them showed the relationship between variables such as leadership styles and known measures of success within hospital organizations. Pearson's r correlation coefficient was used to test the strength of the relationships between hospital personnel and a normative group as well as the relationship between leadership components of the MLQ and factors related to success outcome. Thus, the MLQ leadership factors were compared to Press Ganey patient satisfaction ranking, achievement of Joint Commission accreditation, and achievement of Thomson Healthcare 100 Top Hospital status. The MLQ was used to collect data regarding the independent variables: transactional, transformational, and laissez-faire leadership styles. Press Ganey patient satisfaction ranking, achievement of Joint Commission accreditation, and achievement of Thomson Healthcare 100 Top Hospital status were the dependant variables employed as success measures of hospital organizations. Content relevant to the dependant variables: Press Ganey patient

satisfaction ranking, achievement of Joint Commission accreditation, and achievement of Thomson Healthcare 100 Top Hospital status, was previously discussed in the instrumentation section of this paper. Table 2 provides a graphic summary and depiction of the research variables and how they interact.

Table 2

Explanation of Variables

Variables	Independent/Dependent	Measurement
Transactional Leadership	Independent	MLQ
Transformational Leadership	Independent	MLQ
Laissez-faire Leadership	Independent	MLQ
Joint Commission	Dependent	Archival Data Review
Press-Gainey	Dependent	Archival Data Review
Thomsons Healthcare 100 Top Hospital Status	Dependent	Archival Data Review

Summary

The overarching goal of this study design was to assess the unique leadership styles found consistently among executive leaders to determine whether leadership styles influence the success of acute care hospitals in the greater Atlanta region. Leedy &

Ormrod (2005) suggested that the selection of a research method and design should be guided by the specific question, hypothesis, or problem. Simon & Francis (2001) supported the application of correlational studies to examine the relationship between variables in their natural environment without researcher- imposed treatments. This quantitative correlational method of investigation was applied to address the problem of determining the extent to which a relationship exists between leadership styles and measures of successful hospital outcomes. The MLQ has been extensively used as a reliable, valid instrument across multiple professional disciplines, to capture a broad range of leader behaviors. This tool was applied to collect data regarding leadership styles.

CHAPTER 4: RESULTS

Introduction

The purpose of this quantitative correlational research was to develop a model of congruent executive leadership styles that promote the success of acute care hospitals in the Atlanta metropolitan area. Thus, the objective of this investigation was to obtain real-world data regarding leadership styles to determine their association to known measures of success. A total of 109 leaders from two hospitals participated in this study. For these hospitals, Hospital A had 89 participants and Hospital B had 20 participants. This chapter contains response rates and description of the research population, analysis of the data, a review of the research questions, and the chapter summary.

The leader-participants were comprised of all CEOs Presidents, vice presidents, executive directors, directors, and managers of services within the selected hospitals. Of 251 possible participants 109 valid responses were obtained yielding a 43% response rate. The Multifactor Leadership Questionnaire (MLQ Form 5X) a validated, reliable instrument was used to assess the leadership styles of study participants. In chapter 4 the researcher first presented and interpreted findings and descriptive statistics related to each of the 4 research questions outlined in the study. Additional information related to demographic data is presented followed by a concluding statement.

Demographic Data

The geographic location selected for the investigation was confined to the metro Atlanta region. Hospital A and Hospital B were the only two metro Atlanta hospitals to meet the study criteria at the time of the investigation. Twenty-one men from Hospital A completed the survey; while 7 men from Hospital B completed the survey. The men

comprised 26% of the leader-participants . A total of 68 women completed the survey at Hospital A and 13 women completed the survey at Hospital B. Female leaders comprised 74% of the entire research population.

Analysis of Data

Research Question One

Research Question One asked: What leadership styles are found consistently among leaders of successful hospital organizations? To answer this question, Table 1 is a display of 15 MLQ leadership style ratings: individual consideration, effectiveness, inspirational motivation, intellectual stimulation, satisfaction, transformational, contingent reward, idealized influence (behavior), idealized influence (Attributed), extra effort, transactional, management-by-exception (active), management-by-exception (passive), passive/avoidant, and laissez-faire. The 15 MLQ leadership style ratings were sorted by the highest mean score. These ratings were based on a five-point metric ranging from (0 = *Not at all* to 4 = *Frequently, if not always*). Ten of 15 scores had mean ratings of at least 3.00. The table data indicated highest mean scores were for individual consideration (M = 3.4), effectiveness (M = 3.31), inspirational motivation (M = 3.31), and intellectual stimulation (M = 3.30). Table data indicated lowest mean scores were for laissez-faire (M = 0.38), passive / avoidant (M = 0.50), and management-by-exception (passive) (M = 0.61) (Table 1).

Statistical analyses were conducted and Table 1 reports mean scores with standard deviations for all 109-study participants. The findings indicated no appreciable difference between Hospital A and Hospital B for their MLQ scores. Stated differently, MLQ scores

for both hospitals were equally favorable suggesting the existence of high-level leadership within these two successful hospital organizations.

Mean MLQ scores of all 109 respondents were sorted from high to low. Interestingly, the highest MLQ leadership style ratings obtained within the study sample were observed as individual consideration, effectiveness, inspirational motivation, and intellectual stimulation, as displayed in Table 1 data. Such leadership characteristics have been linked to transformational leadership, a style of leadership associated with successful organizational outcomes. Thus, these findings present a response to Research Question 1 and proffer initial insight into the leadership styles present within these two successful hospitals. The related relevance of these data is further described in chapter 5 (Table 1).

Table 1

MLQ Leadership Style Ratings Sorted by Highest Mean Rating (N = 109)

MLQ Rating	*M*	*SD*	Low	High
Individual Consideration	3.44	0.46	2.50	4.00
Effectiveness	3.31	0.41	2.00	4.00
Inspirational Motivation	3.31	0.53	2.00	4.00
Intellectual Stimulation	3.30	0.43	2.25	4.00
Satisfaction	3.30	0.50	2.00	4.00
Transformational	3.28	0.36	2.20	3.95
Contingent Reward	3.22	0.45	1.75	4.00
Idealized Influence (Behavior)	3.21	0.49	1.75	4.00
Idealized Influence (Attributed)	3.12	0.46	1.50	4.00
Extra Effort	3.05	0.56	1.67	4.00
Transactional	2.52	0.46	1.63	4.00
Management-by-Exception (Active)	1.83	0.86	0.00	4.00
Management-by-Exception (Passive)	0.61	0.50	0.00	2.50
Passive / Avoidant	0.50	0.38	0.00	1.63
Laissez-Faire	0.38	0.49	0.00	2.00

Note. Ratings based on five-point metric: 0 = *Not at all* to 4 = *Frequently, if not always.*

MLQ = *Multifactor Leadership Questionnaire*

Research Question Two

Research Question Two asked: What is the relationship between the MLQ scores of hospital personnel compared to a normative group? To answer this question, Table 2 is a display of the *t* test comparisons for 12 MLQ scores from the current sample ($N = 109$) against a normative sample of $N = 3{,}375$ (Bass & Avolio, 2004). Thus, all data includes both hospitals. The descriptive statistical information gives indication of the leader-behavior of the study participants. Statistical analyses were conducted and Table 2 contains the mean scores with standard deviations and t-test comparisons along with levels of significance. Results indicated that Hospital A and Hospital B had appreciably more favorable scores across all dimensions of the MLQ subscales compared to the normative sample. Results indicated significant differences between the current research sample compared to the normative sample for their MLQ scores. For all 12 comparisons, the current research sample of respondents had significantly more favorable leadership scores at least at the $p = .003$ level (Table 2).

The findings suggested that there were no significant differences in leadership scores between these two successful hospitals. Therefore, in Table 2 these scores were compared against a normative sample of 3, 375 leaders from various organizations across the country to determine how they compared against leaders in general. Results indicated that the leaders within the research population had the self-perception that they were better leaders and scored more favorably on all measures except they were less passive

and less laissez-faire. Thus, compared to the normative sample, the research population scored higher on 10 of the 12 MLQ measures. Lower scores were noted in only two areas: management-by-exception (passive) and laissez-faire leadership. Management-by-exception (passive) is characteristic of leaders who intervene only when standard operating procedures are not performed and/or performance expectations are not met. Laissez-faire leadership is characteristic of those who avoid discussing and clarifying expectations, abdicates decision-making, avoids conflict and is characteristically known as non-leaders (Kirkbride, 2006; Muenjohn & Armstrong, 2008). Thus, the two lower ratings obtained from participants of Hospital A and Hospital B for these measures were considered more favorable compared to the higher scores achieved by the normative sample on the same two subscales. For all other MLQ dimensions the higher scores achieved for the research population were deemed more favorable compared to the normative group.

Contingent reward, management-by-exception (active), and management-by-exception (passive) represents 3 subscales on the MLQ that are characteristic of transactional leadership (Muenjohn & Armstrong, 2008). Contingent reward is the classic type of transactional leadership that offers reward in exchange for meeting or exceeding performance expectations. These leaders give focus to communicating and clarifying goals, objectives, and performance targets as well as providing the essential resources and follow-up needed to satisfy requirements. Management-by-exception (active) refers to leaders who establish efficient quality controls used to monitor and detect problems, errors, and/or deviation from best practice guidelines (Kirkbride, 2006). The research

population scored more favorably on two of the three transactional factors. Compared to the normative sample the research populations scored lower on management-by-exception (passive) indicating that they were more proactive leaders.

Three leadership outcome factors listed as subscales on the MLQ are extra effort, effectiveness, and satisfaction. These three desirable leadership outcome measures have been positively associated with subordinates of transformational leaders (Kirkbride, 2006; Muenjohn & Armstrong, 2008). The research population scored significantly higher on each of these 3 MLQ measures compared to the normative group at least at the $p = .001$ level. Conversely, the research sample scored less favorably on the subscale laissez-faire leadership compared to the normative group indicating that they did not consider themselves as non-leaders.

Transformational leadership was not indicated on the scale presented in Table 2 because it was not a part of the normative sample given (Avolio and Bass, 2004). Idealized influence attributed, idealized influence behavior, inspirational motivation, intellectual stimulation, and individualized consideration are the first 5 points on the MLQ scale and they represent behaviors characteristic of transformational leadership (Muenjohn & Armstrong, 2008). Idealized influence attributed describes leaders who serve as role models to subordinates. These are purposive visionaries who demonstrate uncanny competence and positive use of authority. Inspirational motivation represents leaders whose exciting communication compels and motivates employees to superior performance. These charismatic leaders succeed in elevating employee performance

through creating meaning and value as well as shaping an optimistic view of the future (Kirkbride, 2006).

Intellectual stimulation describes leaders who challenge and stimulate follower ideas, beliefs, assumptions and thinking styles. In so doing, these leaders establish a readiness for change. Individualized consideration refers to leaders who promote self-development through coaching, teaching, and listening to subordinates. These leaders demonstrate personal concern for employees and seek to develop follower abilities through appropriate assignments and tasks (Kirkbride, 2006; Muenjohn & Armstrong, 2008). The research population scored significantly higher than the normative group on the first five points of the scale at least at the $p = .001$ level. Thus, it is safe to surmise that if transformational leadership were a point on the scale it would be high as well given the favorable scores of the first five dimensions of the scale. The related relevance of this data is further elaborated in chapter 5 (Table 2).

Table 2

Comparison of MLQ Scores for Current Sample with MLQ Normative Sample Using t Tests for Independent Means

	Current		Normative			
	N = 109		*N* = 3,375			
MLQ Score	*M*	*SD*	*M*	*SD*	*t*	*p*
Idealized Influence (Attributed)	3.12	0.46	2.95	0.53	3.31	.002
Idealized Influence (Behavior)	3.21	0.49	2.99	0.59	3.85	.001
Inspirational motivation	3.31	0.53	3.04	0.59	4.72	.001
Intellectual Stimulation	3.30	0.43	2.96	0.52	6.75	.001
Individual consideration	3.44	0.46	3.16	0.52	5.55	.001
Contingent Reward	3.22	0.45	2.99	0.53	4.48	.001
Management-by-Exception (Active)	1.83	0.86	1.58	0.79	3.11	.003
Management-by-Exception (Passive) [a]	0.61	0.50	1.07	0.62	7.67	.001

Laissez-Faire	0.38	0.49	0.61	0.52	4.55	.001
Extra Effort	3.05	0.56	2.79	0.61	4.39	.001
Effectiveness	3.31	0.41	3.14	0.51	3.44	.001
Satisfaction	3.30	0.50	3.09	0.55	3.93	.001

Note. Ratings based on five-point metric: 0 = *Not at all* to 4 = *Frequently, if not always.*

MLQ = *Multifactor Leadership Questionnaire*

Table 2 (*Continued*)

[a] Lower MLQ rating was deemed to be more favorable and for all other ratings, a higher score was more favorable.

Research Question Three

Research Question Three asked: What, if any, relationship exists between leadership styles and patient satisfaction scores, joint commission accreditation, and achievement of Thomson's healthcare's 100 Top Hospital rating? Success was conceptually defined as the capability to fulfill these 3 criteria: (a) patient satisfaction as measured by Press Ganey (top 10-15% inpatient satisfaction), (b) Joint accreditation, and (c) achievement of Thomson's Healthcare's 100 Top Hospital ratings. A correlation between the MLQ subscale means and these measures could not be accomplished since the related scores of these measures are general and could not be associated with individual employees. More specifically, patient satisfaction scores are not formatted in a manner that makes comparisons possible. Additionally, the study was confined to the only 2 hospitals that met these 3 criteria. Since only two leading hospitals participated in

this investigation similar correlations were indicated regardless of the metrics. Thus, this research could not directly compare these measures to the MLQ scores given that the correlations would be exactly the same because only two hospital sites were represented in the study.

Remarkably, both Hospital A and Hospital B achieved exceptional ranking related to each of the three measures. For example these hospitals ranked as follows: patient satisfaction (overall rating of care) 92% and 97 % respectively. They both received a score of two, which is the highest level of satisfactory compliance that can be achieved from The Joint Commission. Additionally, a rank within the 90th percentile gained these two successful hospitals listing in Thomson's 100 Top hospitals across the country. Interestingly, the MLQ means of Hospital A and Hospital B were also higher when compared to the normative group made up of general leaders from organizations across the nation. This finding was critical to this study considering that leadership has been purported as an essential for managing change and boosting quality performance (Judge & Bono, 2000; Keller, 1992; Berson & Linton, 2005). Moreover, a variety of established studies have tested the MLQ and have documented support for its validity and reliability in measuring leadership styles and organizational outcomes (Barbuto, John, Fritz, matkin, & Marx, 2007; Barbuto & John, 2005; Parry & Proctor, 2002). The related relevance of these findings is further discussed in Chapter 5.

Research Question Four

Research Question 4 asked "what differences exist between personnel in Hospital A compared to Hospital B in terms of MLQ scores?" To answer this question, Table 3 is

a correlation comparing both Hospital A and Hospital B. It contains the Pearson product-moment correlations for each of the 15 MLQ scores with the respondent's hospital. Table 3 displays a correlation between which hospital participants belonged to with all 15 MLQ scores. Thus, mean scores were compared along each MLQ subscale, to observe differences between personnel of hospital A and Hospital B. Results revealed a similar profile between these high performing hospitals and yielded no significant differences on this measure. None of the fifteen correlations were statistically significant at the $p < .05$ levels. No significant differences in responses were noted from respondents between the two hospitals for their leadership scores (Table 3). The related relevance of this data is further described in chapter 5.

Table 3

Pearson Product-Moment Correlations for MLQ Scores with Hospital (N = 109)

MLQ Score	N = 109	
	M	P
Idealized Influence (Attributed)	3.12	.06
Idealized Influence (Behavior)	3.21	.10
Inspirational motivation	3.31	.14
Intellectual Stimulation	3.30	.10
Individual consideration	3.44	.03
Contingent Reward	3.22	.02
Management-by-Exception (Active)	1.83	.07

Management-by-Exception (Passive)	.61	.18
Laissez-Faire	.38	.02
Transformational	3.28	.10
Transactional	2.52	.07
Passive / Avoidant	.50	.13
Extra Effort	3.05	.03
Effectiveness	3.31	.04
Satisfaction	3.30	.02

Table 3 (*Continued*)

Note. $p < .05$.

MLQ = *Multifactor Leadership Questionnaire*

Additional Findings

To observe differences based on gender, Table 4 is a comparison of the percentage of female leaders in Hospital A compared to Hospital B. A similar correlation was conducted for male leaders. Table 4 displays the chi-square test of significance for the association of hospital and the respondent's gender. No significant association was found ($p = .29$) (Table 4). However, both hospitals had a higher percentage of female leaders. These results were not surprising since women comprise 80% of the Piedmont Hospital workforce and 65% of the Fayette Hospital workforce.

Table 4

Association of Hospital and Respondent Gender (N = 109)

Gender	Hospital A		Hospital B	
	n	%	*n*	%
Male	21	23.6	7	35.0
Female	68	76.4	13	65.0
Total	89	100.0	20	100.0

X^2 (1, N = 109) = 1.11, p = .29. Cramer's V = .10.

Table 5 contains the *t*-test comparisons for the 15 MLQ scores based on the gender of the respondent. None of the 15 resulting *t*-tests were significant at the $p < .05$ level. The results for this measure seem to indicate that there were no significant differences related to gender and MLQ scores. Results suggest that the leadership styles of women equaled that of their male counterparts. These data findings are further elaborated in Chapter 5 (Table 5).

Table 5

Comparison of MLQ Scores Based on Gender of the Respondent (N = 109)

	Males		Females			
	n = 28		*n* = 81			
MLQ Score	*M*	*SD*	*M*	*SD*	*t*	*p*
Idealized Influence (Attributed)	3.08	0.41	3.13	0.47	0.52	.60
Idealized Influence (Behavior)	3.26	0.48	3.20	0.49	0.57	.57
Inspirational motivation	3.35	0.41	3.29	0.56	0.48	.64
Intellectual Stimulation	3.35	0.42	3.28	0.43	0.68	.50
Individual consideration	3.35	0.42	3.48	0.47	1.27	.21
Contingent Reward	3.13	0.47	3.25	0.45	1.17	.24
Management-by-Exception (Active)	1.96	0.87	1.78	0.86	0.92	.36
Management-by-Exception (Passive)	0.74	0.54	0.57	0.48	1.60	.11
Laissez-Faire Leadership	0.43	0.43	0.37	0.51	0.57	.57
Transformational Leadership	3.28	0.33	3.28	0.37	0.00	1.00
Transaction Leadership	2.54	0.42	2.52	0.48	0.29	.77
Passive / Avoidant	0.58	0.42	0.47	0.37	1.41	.16
Extra Effort	2.94	0.54	3.09	0.56	1.23	.22
Effectiveness	3.30	0.45	3.31	0.40	0.12	.90
Satisfaction	3.32	0.46	3.29	0.51	0.29	.77

Table 5 (*Continued*)

Note. Ratings based on five-point metric: 0 = *Not at all* to 4 = *Frequently, if not always.*

MLQ = *Multifactor Leadership Questionnaire*

Summary of Results

This study was an examination of the leadership styles of 109 leaders within 2 high performing hospitals in the metro Atlanta region. Thus, fundamental points presented in this chapter systematically and logically reported findings obtained from 109 leader-participants within Hospital A and Hospital B. The study was to develop a model of congruent executive leadership styles that promote the success of acute care hospitals in the Atlanta metropolitan area. Data were gathered to respond to 4 specific research questions. The MLQ an established instrument was used to collect emergent data. The findings were summarized and interpreted in relation to their significance to the research questions posed.

Chapter 5 concludes the research study and details the study summary, conclusions, and recommendations. Implications for future research are discussed along with practice and policy recommendations. The impact of its relationship to positive social change is elaborated.

CHAPTER 5: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this dissertation research was to determine the relationship between leadership styles and performance success strategies in high performing

hospitals in the metro Atlanta area. The objective was to create a model of congruent leadership styles that promote success in hospital organizations. This investigation was considered both timely and relevant due to the tumultuous nature of our current healthcare landscape that demands the application of proven leadership behaviors consistent with service quality and organizational sustainability.

This quantitative correlational investigation produced empirical data regarding the relationship between leadership styles and recognized measures of success employed by high performing hospitals in the metro Atlanta region. Success was conceptually defined as Press Ganey inpatient satisfaction ranking within the top 10-15%, achievement of Joint Commission accreditation, and achievement of Thomson Healthcare 100 Top Hospital ranking. The study population was derived from the two metro Atlanta hospitals that attained all three of these recognized success measures.

The questionnaire instrument used in this study was Bass and Avolio's (2000) Multifactor Leadership Questionnaire (MLQ) Form 5X. The MLQ has been extensively used in the area of leadership research and was used to collect data regarding the independent variables transactional, transformational, and laissez-faire leadership styles. Letters of request were submitted to hospital based participants who met the criteria of attaining the top most positions in their respective fields such as: CEO's, presidents, vice presidents, executive directors, directors, and managers to solicit their participation in the survey. Only fully completed instruments were accepted for the study. The research questions sought to uncover pertinent issues related to hospital leadership.

Findings revealed the existence of high-level leadership within the research population based on all subsets of the MLQ. The research population received exceptional ranking related to each of the 3 established success measures and the MLQ means of the research group were considerably more favorable compared to a normative sample of leaders from across the country. Moreover, similar leadership styles were found present among leaders of both successful hospital organizations.

Chapter 5 contains an interpretation of the findings to these research questions, discusses the implications of the results found in Chapter 4 related to the key findings, presents recommendations for action, and final conclusion.

Conclusions

Research Question One

1. What leadership styles are found consistently among leaders of successful hospital organizations?

The purpose of Research Question 1 was to uncover the leadership styles among individuals in the top most positions of their respective fields within successful hospitals. Research Question One sought to identify critical forms of leadership consistent among leaders within two metro Atlanta hospitals, considered successful based on the research criteria. No significant differences were found among leaders of these two highly successful hospitals for their MLQ scores. Initial findings were consistent with the idea of a positive association between leadership styles and hospital success.

One strength of the study was the unveiling of the different styles of leadership found among leader participants. In order to reveal the leadership styles present among

study participants it was imperative to extract the data obtained in Table 1. Statistical analyses were conducted and mean scores with standard deviations for all 109-study participants were documented as indicated in Table 1. The data illustrated in Table 1 revealed mean MLQ scores of all 109 respondents were sorted from high to low. All 15 MLQ leadership style ratings were sorted by the highest mean score. Table 1 data indicated that the lowest mean scores were for laissez-faire ($M = 0.38$), passive / avoidant ($M = 0.50$), and management-by-exception (passive) ($M = 0.61$), while the highest mean scores were indicated for individual consideration ($M = 3.4$), effectiveness ($M = 3.31$), inspirational motivation ($M = 3.31$), and intellectual stimulation ($M = 3.30$).

MLQ ratings of all 109 respondents were sorted by the highest mean scores. Interestingly, the highest MLQ leadership style ratings obtained by leaders within the study sample were observed as: individual consideration, effectiveness, inspirational motivation, and intellectual stimulation, as displayed in Table 1 data. Such leadership characteristics have been linked to transformational leadership, a style of leadership associated with successful organizational outcomes. These findings are considered relevant because Table 1 unequivocally acknowledges a full range of leadership styles, but narrows in on those forms of leadership that were found more consistently among participants. Kirkbride (2006) admonishes “Any attempt to develop transformational leaders must recognize the organizational realities of other leadership styles.” As indicated in Chapter 4, Research Question 1 revealed no appreciable differences between Hospital A and Hospital B for their MLQ scores. MLQ scores for both hospitals were equally favorable suggesting the existence of high-level leadership within these two

successful hospital organizations. Accordingly, leaders within these two hospitals had the self-perception of a superior level of leadership based on the MLQ. These findings are consistent with the idea of a positive association between leadership styles and hospital success.

The findings related to Research Question One are consistent with contemporary theoretical assumptions that suggest leaders who scored high on the MLQ transformational characteristics also perform better as leaders within the work environment thus promoting successful outcomes within organizations (Antonakis, Avolio, & Sivasubramanium, 2003; Kirkbride, 2006; Ozaralli, 2003). Contemporary researchers argue that transformational leaders coach, mentor, and empower subordinates. Such concepts increase subordinate effectiveness and heighten opportunities for organizational success. An in-depth review of the related literature also supports the notion that transformational leadership style is more closely associated with positive organizational outcomes (Berson & Linton, 2005, Lussier, 2001; & MacGregor Burns, 2003). Based on the existing supportive body of research and the findings cited in Table 1 it is difficult to deny an association between the success of these two hospitals and the prominent transformational leadership style that seemed to exist among study participants.

Research Question Two

2. What is the relationship between the MLQ scores of hospital personnel compared to a normative group?

The purpose of Research Question 2 was to compare the MLQ data obtained from the research group with the MLQ scores of leaders within other organizations across the country. Initial findings suggests that participants had the self-perception that they were better leaders and scored more favorably on all subsets of the MLQ compared to the normative group. Chapter 4 results also indicated that the success of these hospitals was closely associated with transformational leadership styles found in existence among leaders within these two high-performing organizations. Berson & Linton (2005) extensively documented the essential need to identify leadership styles that enhance performance. Antonakis, Avolio, and Sivasubramanium (2003) supported the use of the MLQ as a valid, reliable instrument that adequately measures the intended leadership factors. This exploration of interrelationships between the study group and a normative sample uncovered patterns of leadership characteristics displayed among the two successful hospitals that were distinct from the body of leaders within other industries.

Table 2 displayed the *t*-test comparisons for 12 MLQ scores from the current sample ($N = 109$) against a normative sample of $N = 3{,}375$ (Bass & Avolio, 2004). Results indicated that Hospital A and Hospital B had appreciably more favorable scores across all dimensions of the MLQ subscales when compared to the normative sample obtained from industries across the country. Significant differences between the current research group compared to the normative research sample MLQ scores were observed. For all 12 comparisons, the current research sample of respondents had significantly more favorable leadership scores at least at the $p = .003$ level (Table 2). These findings

further support the idea that specific leadership styles within these two exceptional hospitals generate practices that ensures success of the hospital organizations.

Results (as cited in Table 2) indicated that the leaders within the research population had the self-perception that they were better leaders and scored more favorably on all measures except they were less passive and less laissez-faire. For this reason they scored higher on 10 of the 12 MLQ measures. Lower scores were noted in only two areas: management-by-exception (passive) and laissez-faire leadership. Scores on these two measures were significantly lower at least at the $p = .001$ level. As referenced in Chapter 4, management-by-exception (passive) is characteristic of leaders who intervene only when standard operating procedures are not performed and/or performance expectations are not met. Laissez-faire leadership is characteristic of those who avoid discussing and clarifying expectations and abdicates decision-making. The lower scores achieved by the research population on these measures support the notion that research participants within these successful hospitals had clearly defined roles, vision and direction, as well as excellent performance monitoring systems. These characteristics are consistent with high performing organizations (Kirkbride, 2006; Muenjohn & Armstrong, 2008).

Contingent reward, management-by-exception (active), and management-by-exception (passive) represents 3 subscales on the MLQ that are characteristic of transactional leadership (Muenjohn & Armstrong, 2008). Contingent reward is the classic type of transactional leadership that offers reward in exchange for meeting or exceeding performance expectations. These leaders give focus to communicating and clarifying

goals, objectives, and performance targets as well as providing the essential resources and follow-up needed to satisfy requirements. Management-by-exception (active) refers to leaders who establish efficient quality controls used to monitor and detect problems, errors, and/or deviation from best practice guidelines (Kirkbride, 2006). The research population scored significantly higher on these two measures compared to the normative sample at least at a $p = .001$ and $p = .003$ level respectively. Thus, the research group scored more favorably on two of the three transactional factors. Compared to the normative sample the research populations scored lower on management-by-exception (passive) indicating that they were more proactive leaders. The latter finding is critical to this study since hospital organizations must consistently adhere to established best standards of practice in order to realize successful health outcomes. Such standards require leaders who engage in continuous monitoring versus providing intervention only when standards are not achieved.

The fact that positive forms of transactional leadership were found present among leaders within the research group suggests use of rewards in exchange for compliance and high performance. Kirkbride, 2006 stated that "these styles are useful for stable state situations" (p.23). Findings of chapter 4 (as presented in Table 2) confirms prior arguments and offer further insight into the combination of leadership styles used within these hospitals that promoted successful outcomes. The underlying philosophy supportive to this line of thinking is grounded in the leadership literature. Transactional leadership, in the most affirmative sense allows leader and follower to progress toward respective goals (Avolio, Bass, Berson, Jung, 2003; Flood et al., 2000). Such leaders relate well to

subordinates within hospital organizations because they understand what subordinates want, are responsive to the self-interest of the subordinate, and exchanges rewards and recognition for achieving performance goals. In so doing organizational objectives are often satisfied. The study uncovered the application of fundamentals associated with transactional leadership along with forms of transformational leadership among hospital respondents that contributed to the overall performance success of these hospitals. Recent studies suggest that a combination of transactional and transformational leadership styles may provide the most effective leadership outcomes (Bass & Avolio, 2003).

As previously stated in Chapter 4, transformational leadership was not indicated on the scale presented on Table 2. However, idealized influence (attributed), idealized influence (behavior), inspirational motivation, intellectual stimulation, and individualized consideration are the first 5 points on the MLQ scale and they represent behaviors characteristic of transformational leadership (Kirkbride, 2006; Muenjohn & Armstrong, 2008). Remarkably, the research sample scored significantly higher than the normative group on the first five points of the scale with idealized influence (attributed) at least at the $p = .002$ level and idealized influence (behavior), inspirational motivation, intellectual stimulation, and individualized at least at the $p = .001$ level.

The significantly higher MLQ scores, obtained for the research sample, for transformational leadership characteristics is considerably important because leadership theories consistently associate transformational leadership with high-level performance that results in successful organizational outcomes ((Berson & Linton, 2005; Burns, 1978; Kirkbride, 2006; Flood et al., 2000). For these reasons experts addressing the challenges

and conditions of 21st century work environments endorse transformational leadership as effective quality management and as a dynamic predictor of positive organizational indices (Bass, 1985; Kirkbride, 2006; Flood et al., 2000; Muenjohn & Armstrong, 2008).

Kirkbride (2006) stated "ideally a leader's profile should show higher scores on the transformational styles and lower scores on the management-by-exception and laissez-faire" (p. 27). The high transformational leadership scores of leaders in these two hospitals suggest that the success of these hospitals could be attributed to the transformational leadership characteristics embraced by their leaders. This assumption is deeply rooted in the leadership literature. Proponents of the transformational leadership paradigm have provided empirical data that associate this leadership model with high performance resulting from visionary, inspirational practices, and clearly articulated goals creative acts within organizations (Judge & Bono, 2000; Keller, 1992; Berson & Linton, 2005). More profoundly, the literature indicates that the transformational leadership style is more closely associated with positive organizational outcomes (Berson & Linton, 2005, Kirkbride, 2006; Lussier, 2001).

Research Question Three

3. What if any, relationship exists between leadership styles and patient satisfaction scores, joint commission accreditation, and achievement of Thomson's 100 Top Hospital rating?

Kaiser, Hogan, and Craig (2008) discussed the benefit of evaluating leadership in terms of organizational performance. These authors highlighted the critical need to highlight the styles and characteristics of leaders within high performing work

environments. The purpose of Research Question 3 was to determine the extent to which a relationship existed between the leadership styles and three established measures of hospital success: (a) Patient Satisfaction as measured by Press Ganey (top 10%-15% inpatient satisfaction), (b) Joint accreditation, and (c) achievement of Thomson's Healthcare's 100 Top Hospital ratings. Chapter 4 findings indicated that a correlation between the MLQ subscale means and these measures could not be accomplished since the related scores of the success measures are general and could not be associated with individual employees. More specifically, patient satisfaction scores are not formatted in a manner that makes such comparisons possible. Additionally, the study was confined to the only two hospitals that met these three success criteria. Since only two leading hospitals participated in this investigation similar correlations were indicated regardless of the metrics. Thus, this researcher could not directly compare these measures to the MLQ scores given that the correlations would be exactly the same because only two hospital sites were represented in the study.

Chapter 4 findings indicated that both Hospital A and Hosptial B achieved exceptional ranking related to each of the 3 success measures. As indicated in Chapter 4, these hospitals ranked as follows, patient satisfaction (overall rating of care) 92% and 97 % respectively. Interestingly, individual consideration and inspirational motivation are the MLQ subscales that most closely relate to patient satisfaction. These points demonstrate leader ability to listen to concerns and ideas, increase readiness to change, and inspire superior performance (Kirkbride, 2006). The latter points are critical to patient satisfaction as they serve to empower sensitive, frontline staff to exceed patient

expectations through inventively meeting their needs in a way that alleviates fears, and inspires trust in the care given. This suggests that the high patient satisfaction scores are reflective of the exceptional MLQ ratings associated with customer satisfaction.

They both received a score of two, which is the highest level of satisfactory compliance achievable from The Joint Commission Accreditation process. A rank within the 90th percentile gained these two successful hospitals listing in Thomson's 100 Top hospitals across the country. Interestingly, the MLQ means of Hospital A and Hospital B were also higher when compared to the normative group made up of general leaders from organizations across the nation. These results lend further support to the link between the leadership styles present and the high scores achieved on these standard measures of success. The latter finding is critical to this study and is inextricably grounded in research in which leadership has been purported as an essential for managing change and boosting quality performance measures (Judge & Bono, 2000; Keller, 1992; Berson & Linton, 2005).

Moreover, a variety of established studies have tested the MLQ and have documented support for its validity and reliability in measuring leadership styles and organizational outcomes (Barbuto, John, Fritz, Matkin, & Marx, 2007; Barbuto & John, 2005; Parry & Proctor, 2002). The leadership styles found present among respondents of both hospitals were consistently associated with high performance measures and positive outcomes in the contemporary literature (Flood et al, 2000; Kirkbride, 2006; Muenjohn & Armstrong, 2008). The observation of a convergence between the three measures of performance success and the transformational leadership characteristics found among

respondents is compelling and bounded to existing research. Thus, this sufficiently supported the idea of a positive relationship between the performance success of these two hospitals and the leadership style of their superiors.

Research Question Four

4. What differences exist between personnel in Hospital A compared to Hospital B in terms of MLQ scores?

The purpose of Research Question 4 was to uncover differences in leadership style between the two high performing hospital organizations. No significant differences in responses were noted from respondents between the two hospitals for their leadership scores. Chapter 4 results (illustrated in Table 3) revealed a correlation comparing both Hospital A and Hospital B. Table 3 contains the Pearson product-moment correlations for each of the 15 MLQ scores with the respondent's hospital. Thus, Table 3 exhibited a correlation between which hospital participants belonged to with all 15 MLQ scores. The mean scores were compared along each MLQ subscale, to observe differences between personnel of hospital A and Hospital B. Results revealed a similar profile between these high performing hospitals and yielded no significant differences on this measure. None of the fifteen correlations were statistically significant at the $p < .05$ levels. These results further infer a positive relationship between transformational leadership style performance success within these two hospital organizations.

The similar leadership profile between these two high performing hospital organizations is undeniable based on Chapter 4 results. These findings are complementary and help buttress conclusions drawn from the other research questions

within this study that positions leadership style as a crucial component of performance success within contemporary hospital environments. Results (as indicated in Chapter 4, Table 3) supporting similarities in leadership styles from leaders within these two successful hospitals are further underscored by consistent theoretical arguments that thread throughout this dissertation research. The contemporary literature supports the inspirational, charismatic, value-driven, qualities of transformational leadership as the optimum leadership style for managing change and boosting performance success within 21st century organizations (Berston & Linton, 2005; Judge & Bono, 2000; Keller, 1992).

To further observe differences between respondents within Hospital A and Hospital B, chapter 4 results contained differences based on gender. Table 4 was a comparison of the percentage of female leaders in Hospital A compared to Hospital B. A similar correlation was conducted for male leaders. Table 4 also contained the chi-square test of significance for the association of hospital and the respondent's gender. No significant association was found ($p = .29$). However, both hospitals had a higher percentage of female leaders. These results were not surprising since women comprise 80% of the Piedmont Hospital workforce and 65% of the Fayette Hospital workforce.

Table 5 contained the *t* test comparisons for the 15 MLQ scores based on the gender of the respondent. Interestingly, none of the 15 resulting *t* tests were significant at the $p < .05$ level. The results for this measure seemed to indicate that there were no significant differences related to gender and MLQ scores. Chapter 4 results (as contained in Table 5) presented respondents as two similar groups of leaders regardless of gender. Results further suggested that the leadership styles of women equaled that of their male

counterparts. These findings are supported in the literature that position executive females as intellectually, psychologically, and emotionally equal to their male counterparts (Wren, 1995). More emphatically, Wren (1995) stated that "the bulk of evidence on managerial behaviors shows few differences between men and women" (p. 161). These findings suggested that transformational leadership (and elements of transactional leadership) may help promote organizational success regardless of gender. In this study, male and female leaders within two successful organizations used similar leadership styles that contributed to the overall performance success of the organization.

Consequently, many findings were extracted from the research questions posed in chapter 4. Albeit, findings related to each question hold merit, it is together in relationship with each other that they exert significant influence and supplied critical evidence that inextricably links leadership style to performance success within acute care hospitals in the Atlanta Metro area. Moreover, the collective evidence arising from this study is supported by theoretical propositions, interwoven from the literature, which proffers transformational leadership as a predictor of success in acute care environments.

Recommendations

This research was conducted in order to uncover and develop a model of congruent executive leadership styles that promote the success of acute care hospitals in the Atlanta metropolitan area. Investigating the relationship between leadership and the application of effective operational strategies within 21st century acute care environments

is critical to diminish the threat of instability and increase the likelihood of survival. This investigation assessed the unique leadership styles found consistently among leaders within two successful hospitals in the Atlanta region to determine whether there was a relationship between leadership styles and the success attributed to high performing hospitals. Through this research it was possible to identify and infer relationships between key leadership characteristics and successful practices. This study identified the transformational leadership style as the leadership profile most pronounced within the two successful hospitals participating in the research.

Results from this study can serve as a model for leadership practices within contemporary hospitals. The profound benefits of such a purposeful health care leadership model will be evident in more effective, efficient care delivery to the communities served. Consequently, findings arising from this study may potentially catalyze change actions related to leadership development within contemporary hospitals. This section details the recommendations for practitioners as well as recommendations intended for future research.

Recommendations for Practice

The results obtained from this study suggest that elements of transactional leadership and the strong presence of transformational leadership styles profoundly impact the success of hospital organizations. The isolation of evidence-based leadership styles that promote successful practices in acute care environments will contribute to the existing body of leadership literature and serve as a prescription to correct leadership ailments and champion change efforts within contemporary hospital organizations.

Recommendations offered herein, are based on data collected from 109 leaders found within two high performing hospitals. The collective evidence obtained indicated the existence of transformational leadership as the dominant leadership style within these high performing hospitals along with elements of transactional leadership (contingent reward and management-by-exception -active). The data supports existing theories that purport a combination of transactional and transformational leadership styles as a means of obtaining the most effective leadership outcomes within organizations (Bass & Avolio, 2003). Establishing methods of developing transformational characteristics in emerging leaders at every level of the organization holds the promise of extraordinary benefit to the performance strategies of contemporary hospitals. Tichy (1997) stated "winning organizations win because they have good leaders that develop other leaders at all levels of the organization" (p. 3).

The utility of these findings is evident in the ability to apply the results to create an evidence-based leadership model that combines transformational characteristics along with the positive attributes of transactional leadership in order to achieve positive outcomes within hospital environments. Moreover, the literature supports the teachable characteristics of the transformational leadership style (Tichy, 1997; Wren, 1995). Given the findings arising from this study, contemporary hospitals could begin leadership development at new employee orientation and establish its connection to high performance. The creation of mandatory leadership development programs that emphasize transformational leadership characteristics may prove beneficial to new and would-be managers within acute care hospital settings. The related relevance of this was

initially discussed in the literature review where leadership was expounded as the most critical factor for organizational success the absence of which almost always results in failed efforts (Cooney, Landers & Williams, 2002).

Contemporary organizations have demonstrated convergence regarding the relevance of identifying and harnessing effective leadership styles that promote success strategies resulting in desirable organizational performance (Avolio, 1999; Berson & Linton, 2005). Based on evidence provided via this study, it may be prudent to create related course-work that integrate essential components of the leadership styles found most frequently in these high performing hospitals into the health care administration curricula of local colleges and universities. As the 21st century health care environment continues to grapple with massive change, the need for strong leaders within hospitals becomes more pronounced. Results arising from this study offer a basis for recommending the establishment of education departments with a leadership development emphasis or a department of organizational development with leadership training and certification processes within contemporary hospitals. This form of leadership development was previously discussed in the literature review where transformational leaders were seen as those who utilized knowledge principles to strategically position the organization's present and future successes (Nonaka & Nishiguchi, 2001).

Recommendations for Related Research

An in-depth review of the literature identified the multiplicity of leadership challenges presented by contemporary hospital health care (Bigelow & Arndt, 2000; Hagenow, 2001). The literature indicated that the relationship between leadership styles and successful hospitals outcomes have received minimal attention and beg further attention. This attributed to a gap in the literature that supported the need for more inquiry into evidence-based leadership styles associated with successful practices in hospital environments. This investigation explored the relationship between leadership styles and successful outcomes in two distinct hospital settings. The study provided empirical data that positions transformational leadership as a predictor of success in acute care environments.

Given a review of the related literature and the results arising from this study, much has been learned regarding the relationship between leadership and the leadership profile within high performance hospitals in the metro Atlanta region. Although this study provided the basis for creating a leadership model for hospital success, the study was confined to two hospitals both of which were successful. Thus, the leadership characteristics of leaders within less successful hospitals environments were not examined. Future studies may give focus to the comparison of leadership styles and patient satisfaction scores found between leaders of high performing hospitals as compared to those that are lower performing hospital organizations. Since both of these hospitals were privately run institutions, this study also raised questions for future research regarding the leadership styles in private versus government run hospitals as well as unionized versus non unionized hospitals.

In this study, success was conceptually defined as Press Ganey inpatient satisfaction ranking within the top 10%-15%, achievement of Joint Commission accreditation, and achievement of Thomson Healthcare 100 Top Hospital ranking. These success measures are widely recognized within the health care industry but a correlation between the MLQ subscale means and these measures could not be accomplished since the related scores of the success measures are general and could not be associated with individual employees. Future studies may choose to measure success based on criteria such as: financial performance and health grades or other scales that evaluate hospital performance.

No consideration was given to the level of education achieved by respondents nor was there any attempt made to investigate an association between ethnicity and leadership style in this study. Thus, differences in leadership style based on having received a higher level education or based on ethnic differences were not examined and raise additional questions to be included in future research. After a review of the literature, the MLQ was exclusively utilized and considered the best choice for this research because the efficacy of the MLQ as a valid, reliable leadership assessment tool has been repeatedly established in the literature (Avolio & Bass, 1999; Antonakis, Avolio, & Sivasubramanium, 2003; MacGregor Burns, 2003). In future studies it maybe valuable to develop and validate a leadership questionnaire instrument that can be used in conjunction with the MLQ.

Relationship to Positive Social Change

Our social construction of healthcare is under attack. As historical practices and healthcare norms are challenged it is appropriately depicted as "a tough time for absolutes: every road that appeared to lead to certainty had some genius standing in the middle of it with a 'wrong-way' sign" (Anderson, 1990, p. 37). The struggle to make sense of the tumultuous nature of our current healthcare environment is addressed in the literature review which positioned transformational leadership as critical to providing the direction and inspiration needed to create and sustain change efforts (Lussier, 2001). This research answered a call to a gap in the literature regarding the leadership styles needed to create and maintain successful hospital organizations. Empirical data obtained from this research supports the transformational leadership style as the leadership profile most pronounced within the two successful hospitals that served as sites for this investigation.

It is not surprising that the emergence of new knowledge has been historically used to decipher the complexities of change (Huber, 1984; Nonaka & Nishiguchi, 2001). Consequently, results arising from this study may catalyze action within our society related to graduate level healthcare administration. Internships in this field should apply transformational leadership concepts into practice deliverables to be completed by graduate interns. The American College of Healthcare Executives may apply these findings to the existing apprenticeship program. Colleges and universities with Masters Degrees in healthcare administration (MHA) and doctoral degrees in healthcare administration (DHA) may find value in adding course work related to hospital leadership training. The application of best practice leadership training for acute care

environments may serve as an initial significant contribution to mending the ailments of many hospital organizations.

Kotter (1999) stated that leadership is about managing change. As a social construct, healthcare has consistently been in a state of flux. Moreover, leaders within 21st century hospitals are faced with unprecedented change demands requiring a visionary form of leadership that spawns renewal. Results from this study places a call to action from health insurance companies, physician institutions, and community health organizations to create scholarship programs and leadership alliances that provides opportunity for mentoring and developing future leaders of healthcare within our society. The need for such actions is supported by the results of this research and is grounded in the research literature that indicates successful leaders champion change initiatives that significantly affect societal development (Dawson, 2003; Kotter & Heskett, 1992).

Concluding Statement

From industrialism through postmodern organizational arrangements leadership constructs have significantly influenced social, cultural, and organizational change (Bass, 1990; Schein, 1997; Shafritz & Ott, 2001). In fact, Bass (1990) identified leadership as the most critical factor in organizational success. The changes experienced within modern health care are more profound than those compelled by the second industrial revolution (Hagenow, 2001). Upheavals in the health care landscape threaten the sustainability of contemporary hospital organizations. As such, hospitals will require exemplary forms of leadership in order to survive the ravages of dramatic turbulence within 21st century hospital organizations. This investigator sought to provide experiential data related to the

relationship between leadership styles and operational strategies that promote success and increase the likelihood of the survival of contemporary hospitals.

The development of the study centered on a specific problem which stated that the leadership styles needed to effectively run hospital organizations were not identified nor established. The study attempted to determine the leadership styles present within successful hospital organizations and uncover any association between those leadership styles and success. It also sought to determine the leadership styles of the research population as compared to leaders within other industries in order to better understand the influence of leadership constructs on performance outcomes within acute care hospital environments.

The empirical data was collected from 109 respondents. Results indicated that participants obtained the highest MLQ scores for Individual consideration, Effectiveness, Inspirational motivation, and Intellectual Stimulation, all characteristics of the transformational leadership style. These findings were supported in the contemporary leadership literature that demonstrated the significance and utility of transformational leadership to successful organizational outcomes (Bass, 1990; Dering, 1998; Johns & Moser, 2001). Results arising from this study hold significance as it fills a gap in the contemporary literature providing critical evidence that inextricably links a specific leadership profile to performance success within acute care hospitals in the Atlanta Metro area. Moreover, the collective evidence reported through study results contributes to the body of literature that proffers transformational leadership as a predictor of success within contemporary environments.

Leaders within contemporary hospitals recognize the need for a paradigm shift as previously held assumptions have either lost their relevance or have become passé. It is in this uncomfortable health care climate of persistent change and unexplored paths that the installation of leadership that is compelling, visionary, and inspirational becomes vital to survival. Results from this study indicated an increased likelihood of performance success with the application of transformational characteristics. The emergence of these findings should heighten social consciousness to spawn the development of related college curricula, scholarship programs, and leadership alliances that weave transformational characteristics into the leadership fabric of contemporary organizations. Certainly, these initial findings urge ongoing research in the field to explore the depth of the concerns generated through this study. In so doing, we embrace a continuous self-transcending process that is "the dynamic management of the process of creating knowledge out of exploration." (Nonaka & Nishiguchi, 2001, p.13).

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APPENDIX A: INFORMED CONSENT: PERMISSIONTO USE PREMISES NAME, AND/OR SUBJECTS

PIEDMONT HOSPITAL
1968 Peachtree Road, N.W.
Atlanta, Georgia 30309

September 9, 2008

Lilburn Hoehn, Ph.D
Faculty Mentor
Department of Applied Management & Decision Sciences
Walden University

Dr. Hoehn:

Please be advised that Beverly Hernandez, doctoral candidate at Walden University, has been granted approval to conduct her dissertation research study entitled: The Relationship Between Leadership Styles and Performance Success in Metro Atlanta Hospitals, at Piedmont Hospital and at Piedmont Fayette Hospital.

Sincerely,

Joe Herzberg
Vice President of Human Resources
Piedmont Healthcare

October 22, 2008

Dear Piedmont/Fayette Leader:

You are invited to take part in a research study that investigates the Relationship between Leadership Styles and Performance Success within Metro Atlanta Hospitals. This research involves a brief self-administered survey instrument and is being conducted as part of a doctoral dissertation. You were chosen for the study because of your current leadership role within Piedmont Hospital or Piedmont Fayette Hospital.

The purpose of the research study is to determine the relationship between leadership styles and high performing hospitals. As a leader within Piedmont Hospital or Piedmont Fayette Hospital you are part of that determination. You are asked to complete a confidential Multi Factor Leadership Questionnaire (MLQ) within 7 – 10 business days via a secure process that ensures anonymity. While your participation is purely voluntary, it is critical to the significance of the study and to its findings.

This research is timely and relevant to Piedmont Hospital, Piedmont Fayette and their communities because the isolation of an evidenced-based model of successful leadership styles can influence leadership development initiatives, succession planning, and best practice leadership guidelines throughout the organization. More profoundly, the benefits of such a purposeful health care leadership model will be evident in more effective, efficient care delivery to the communities served.

Completion of the survey serves as your consent to participate in the study. Kindly access and complete the self-rating survey instrument directly via: http://www.mindgarden.info/mlqw/mlqs.asp?rID=137154&rKey=IYJY6VCE You will receive two (2) email reminders from invite@mindgarden.com throughout the study period. Please ignore the standard automated email reminder if you have already completed the survey as well as the request to obtain raters. Participants will not need to select raters for this survey. Questions related to the research study maybe forwarded directly to the researcher at Beverly.Hernandez@piedmont.org. Thank you for your willingness to participate.

Sincerely,

Robert W. Maynard
President & CEO
Piedmont Hospital

W. Darrell Cutts
President & CEO
Piedmont Fayette Hospital

APPENDIX B: PERMSSION TO USE AN EXISTING SURVEY

Mind Garden
853 Oak Grove Ave
Suite 215
Menlo Park, CA 94025
650-322-6300 fax 650- 322-6398 www.mindgarden.com

Date: 9/9/2008

Dear Beverly,

This is to grant permission to you, Beverly Hernandez, to use the Multifactor Leadership Questionnaire, a Mind Garden, Inc. instrument, in a study with 251 participants at Piedmont Healthcare.

Reference: Mind Garden invoice 22619

Regards,

Valerie Keller Mind Garden, Inc.
info@mindgarden.com

APPENDIX C: MULTIFACTOR LEADERSHIP QUESTIONAIRE

MLQ Multifactor Leadership Questionnaire

Leader Form (5x-Short)

Name _____ Date _____

Organization_____ _____

Five sample questions for the appendix as authorized by Mind Garden Inc.

This questionnaire is to describe your leadership style as you perceive it. Please answer all items on this sheet. **If an item is irrelevant, or if you are unsure or do not know the answer, leave the answer blank.**

Forty-five descriptive statements are listed on the following pages. Judge how frequently each statement fits you. The word "others" may mean your peers, clients, direct reports, supervisors, and/or all of these individuals.

Rating Scale

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
0	1	2	3	4

I re-examine critical assumptions to question whether they are appropriate 012 3 4

I talk about my most important values and beliefs 0 12 3 4

I spend time teaching and coaching ..... > 0 12 3 4

I avoid making decisions 012 3 4

I heighten others' desire to succeed 0 123 4

APPENDIX D: WALDEN UNIVERSITY PARTICIPANT CONSENT FORM

Dear Piedmont/Fayette Leader

You are invited to take part in a research study on the Relationship between Leadership Styles and Performance Success within Metro Atlanta Hospitals. You were chosen for the study because of your current leadership role within Piedmont Hospital or Piedmont Fayette Hospital. Please read this form and ask any questions you have before agreeing to be part of the study.

This study is being conducted by a researcher named Beverly Hernandez who is a doctoral student at Walden University.

Background Information:
The purpose of this study is to develop a model of congruent executive leadership styles that promote the success of acute care hospitals in the Atlanta metropolitan area.

Procedures:
If you agree to be in this study, you will be asked to:

- Read and demonstrate agreement to participate via this informed consent
- Know that your participation will involve the Completion of 1 leadership questionnaire
- Note that the anticipated time allotment for completion of the questionnaire is approximately 20-30 minutes
- Participants are kindly asked to complete the survey within 7 to 10 business days after initial receipt of the survey document.

Voluntary Nature of the Study:
Your participation in this study is voluntary. This means that everyone will respect your decision of whether or not you want to be in the study. No one at Piedmont Hospital and/or Piedmont Fayette Hospital will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. If you feel stressed during the study you may stop at any time. You may skip any questions that you feel are too personal.

Risks and Benefits of Being in the Study:
This research presents no foreseeable risks to you but does provide an opportunity to impact social change. The possible benefit of your participation is connected to the identification of a prospective model of leadership that could assist hospital organizations to more consistently facilitate successful outcomes.

Compensation:
Your participation in this study is voluntary and without tangible compensation.

Confidentiality:

Any information you provide will be kept strictly confidential. Moreover, participants may choose to remain anonymous for the purpose of this research. The researcher will not use your information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in any reports of the study.

Contacts and Questions:
The researcher's name is Beverly Hernandez. The researcher's faculty advisor is Dr. L. Hoehn. If you have questions, you may contact the researcher via Phone at: 404-605-1746 or email Beverly.Hernandez@Piedmont.org If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Director of the Research Center at Walden University. Her phone number is 1-800-925-3368, extension 1210.
You may keep a copy of this signed formed.

Statement of Consent:

If you agree to the terms of this page, please indicate your consent by completing the

survey via the link provided.

BEVERLY J.D. HERNANDEZ, M.S., R.D., C.D.N., L.D.

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Smyrna, GA 30082
Beverly.Hernandez

Residence: (770) 465-9231
Mobile: (404) 210-1888
Email:

SUMMARY:
Proven innovative, creative program development and monitors; Solid advocacy and community involvement in the promotion of nutritional programs for adult population. Strong community motivational leadership; Deep knowledge reservoir established through education, research, and on-going practice efforts; On-going personal growth and development through leadership seminars and workshops, clinical CEUs and research; Proven innovative program development results; Strong communication and presentation style.

SOCIAL CHANGE ACCOMPLIHSMENTS

COMMUNITY BASED NUTRITION PROGRAMS

- Georgia Cancer Foundation, *Nordstrom's Chemo Chic*
- Piedmont Hospital, *Dietary Ideas for Cancer Patients*
- Fulton County Board of Education, *Healthy Practices*
- Just Us Blind Girls, *Nutrition As Preventative Health*
- Eastside Christian School, *Healthy Eating Practices*
- Carter Associates, *Nutrition and Bone Health*
- Mt. Paran Church, *Wellness & Nutrition*
- Brighton Collectibles, *Cancer Survival and Nutrition*

HIV/AIDS NUTRITION MANAGEMENT COMMUNITY PROJECTS

- AIDs Survival Project, Atlanta, GA
- Gay Men's Health Crisis, New York, NY
- HIV/AIDs Quilt Project St. Simons Island, GA
- HIV/AIDs Quilt Project, Greensboro, SC
- AIDS Center Program, St Luke's-Roosevelt Hospital, New York, NY

MEDIA APPEARANCES:

- TBN, Atlanta, Round the Town with Nikki Taylor, *Healthy Holiday Eating*
- WSBTV, Atlanta, Safe Summer Cooking
- UpScale Magazine, *The Truth About Sugar*,
- Enliven Atlanta Magazine, Take a Drink (the Benefits of Drinking Water)

CONSULTING OPPORTUNITIES

- Cascade Clinic, *Weight Loss Program*
- Kilpatrick, Stockton, LLP, *Weight Loss and Nutrition Management*
- TransUnion Credit Bureau, *Food Nutrition Practices*

EDUCATION:

WALDEN UNIVERSITY, MINNEAPOLIS, MN
PH.D ORGANIZATIONAL LEADERSHIP AND CHANGE (5/2010)

NEW YORK UNIVERSITY, NEW YORK, NY
M. S. CLINICAL NUTRITION, 1991 (MAGNA CUM LAUDE)

HUNTER COLLEGE, CITY UNIVERSITY OF NEW YORK, NY
B. S. CLINICAL NUTRITION, 1988.
Awards: Elected student advisor of the Nutrition Department, Dean's List, Who's Who among American colleges and universities. GPA 4.0

BE HEALTHY INC. **ATLANTA, GA**
President and CEO,
Serve as chief nutrition consulting officer for this Atlanta-based Nutrition consultancy.

- Provide expert nutrition research and counsel to individuals and organizations

WLA (WOMENS LEADERSHIP ALLIANCE) PIEDMONT HEALTHCARE

- *Board member, (2008- present*
- VP, WLA *(2007- 2008)*
- Chairperson of mentoring program *(2006- 2007)*

PIEDMONT HOSPITAL **ATLANTA, GA**
Director of Clinical Nutrition 1998- Present
Responsible for developing, planning, implementing and monitoring all programs and services related to clinical nutrition for this 500 bed acute care facility.

- Pioneered fully automated diet office and new revolutionary bedside menu entry
- Direct a multi-functional clinical staff of 108
- Co-sponsored hospital-wide employee wellness program with Department of Education
- Established clinical education programs with on-site CEU availability
- Developed and fostered a pivotal open communication climate for interdepartmental relationships Established appropriate departmental policies and procedures
- Developed and implemented departmental continuous value improvement program
- Introduced revenue generating community calendar
- Established programs and expanded services to capture revenue and lower operating costs
- Served as influential and integral member of Piedmont-wide corporate committee in selecting primary vendors of enteral nutritional products
- Pioneered partnership venture with enteral vendors and local home health agencies to develop monitors and mechanisms to measure outcomes and promote continuity of care for patients on enteral nutrition post discharge
- Introduced, developed and provided content for internal departmental nutrition and wellness website for all employees
- Devised departmental objectives and standards to uphold hospital policies and regulatory standards inclusive of: HACCP, JCAHO, and OSHA
- Introduced and created essential job functions and services to improve patient

care and maximized productivity in a cost effective framework

RTC MOREHOUSE ATLANTA, GA

Consulting Dietitian 1996-1998

Served as nutrition consultant for patients of Southwest Atlanta Nephrology Group: (SWAN)

- Conducted group nutritional classes for patients, family members and staff
- Conducted and published research in conjunction with Morehouse School of Medicine
- Reviewed and provided individualized nutrition counsel on weekly lab results
- Served as critical nutrition consultant where expert intervention was required
- Created a weight-loss program for nurses and ancillary staff

ST. LUKE'S/ROOSEVELT HOSPITAL CENTER, NEW YORK, N.Y.

Assistant Director: Clinical Nutrition and Patient Services 1990 – 1996

Directed and monitored all activities related to Clinical Nutrition and patient services in this 500 bed acute care setting.

- Established as full-time consultant to all patients with AIDS/HIV, and introduced, developed and implemented the nutrition component of the AIDS/HIV outpatient clinic.
- Functioned as integral member of the Nutrition Committee of the Medical Board providing guidance on: recommendations or modifications to the enteral formulary, protocols for ordering supplements by RDs on Doctors' order form, documenting malnutrition as related to the DRG's and other related Clinical Activity.
- Served as instructor for hospital-wide interdepartmental customer service program
- Developed patient education material appropriate to the reading level of our patient population.
- Founded and served as Managing Editor for first inter-hospital sites Nutrition Newsletter (Nutrition Rx)
- Developed and implemented departmental objectives, standards, policies and procedure related to JCAHO, NYSDOH and other regulatory agencies.
- Directed clinical components and all educational requirements of the coordinated internship program in conjunction with internship director.
- Chaired on-site Nursing/Nutrition Committee.
- Served as integral member of progressive patient care redesign committee.
- Served as Corporate Quality Improvement Manager from 1992 – 1993

PROFESSIONAL MEMBERSHIPS

- AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES (ACHE)
- CLINICAL NUTRITION MANAGEMENT PRACTICE GROUP
- AMERICAN DIETETIC ASSOCIATION
- GEORGIA DIETETIC ASSOCIATION
- ATLANTA DIETETIC ASSOCIATION

CERTIFICATION

- Adult Weight Management Certification **(ADA)**

- Wellness Certification, Stanford University

PUBLICATIONS

- ESTABLISHED BI-ANNUAL NUTRITION PUBLICATION, NUTRITION RX AT ST LUKE'S/ROOSEVELT HOSPITAL, NYC
- ESSENCE MAGAZINE, NYC
- ATLANTA JOURNAL/CONSTITUTION, ATLANTA, GA
- PIEDMONT HOSPITAL PIEDMONTER