

**The Effect of Military Experience on Civilian And Military Healthcare  
Facility CEO Leadership Development, Behaviors, and Outcomes**

by  
**Lawrence M. Johnson**

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**THE EFFECT OF MILITARY EXPERIENCE ON CIVILIAN  
AND MILITARY HEALTHCARE FACILITY  
CEO LEADERSHIP DEVELOPMENT,  
BEHAVIORS, AND OUTCOMES**

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## CHAPTER 1

### INTRODUCTION

This investigation focused on the key leadership role in United States healthcare facilities, that of the chief executive officer (CEO) who directs the facility's overall management. In the United States, health services are offered by both civilian and military facilities, which have entered a phase of increasing collaboration. The CEOs of these two different sets of healthcare facilities share similar occupations and responsibilities but experience significantly different organizational cultures, career environments, and leader-development opportunities.

This study examined whether the leadership experiences and leadership behaviors of healthcare facility CEOs in the United States are affected by military or civilian status and background. The study also investigated whether differences in leadership outcomes, as perceived by key subordinates, were affected by the CEO's leadership development experiences or leadership behaviors. Considered in the study were cognitive, behavioral, and environmental leadership development strategies and their effects on outcomes. Thus, this study was designed to enrich our understanding of the leadership qualities of healthcare facility CEOs and to point to factors through which these qualities can be improved to help health care leaders meet future requirements.

## Challenges Confronting Health Care Executives

In a world in which the only constant is exponentially increasing change (Huey, 1994), health care executives face extraordinary challenges. The upcoming century promises striking changes for the health care industry in terms of organizational financing associated with the globalization of markets (Stewart, 1993). Moreover, an unprecedented expansion of information technologies is hastening shifts in system organization: the current model of hierarchy is being dismantled and managerial roles and relationships are changing rapidly (Stewart, 1993).

If the history of the past decade can be used as an indicator of future trends, the outlook for the ability of health care executives to adapt to the rapid changes affecting the United States health care system is not good. Although the twentieth century saw dramatic improvement in health care as the result of applied knowledge, the past decade has witnessed serious levels of organizational decline in hospital facilities (Sherman, 1999). In addition, as Batalden and Nolan (1993) pointed out, the rate at which recent health care leaders have been able to improve health care and the nature of the improvements that they have been able to make have not been adequate. According to Fottler and Smith (1994), the organizational decline of United States healthcare facilities cannot be attributed solely to the environmental changes taking place or to mismanagement *per se*. Rather, Fottler and Smith (1994) maintained that during the past decade health care executives failed to modify their strategies and tactics in response to the

environmental changes facing them.

Government, industry, and consumer groups have been pressuring health care executives to make a variety of improvements at a faster rate than ever before. Some of the most pressing demands made on military and civilian healthcare facilities have been for improved customer service and patient clinical outcome reports, demands that keep escalating even as labor costs continue to rise. In short, healthcare facilities are being called upon to provide better health care outcomes at lower cost, and they have been struggling to comply with mandates to improve performance, customer service, and accountability while simultaneously striving to reduce staff size (Abramson, 1996). This is true even for military healthcare facilities, where about half of employees are civilian. In a climate of ongoing workforce reduction and attempts to build greater organizational effectiveness, the maintaining of employee satisfaction in the healthcare workforce takes on a high degree of importance.

The responsibilities of military healthcare facilities differ somewhat from civilian healthcare facilities. As is well known, military healthcare facilities provide active-duty and retired military men and women and military dependents access to quality health care. In addition, the military health care system is engaged in a unique readiness mission in which it must commit resources to produce prompt responses to peacekeeping (as in Bosnia) as well as to natural disasters (such as Hurricane Mitch). Despite these obligations, military healthcare facilities have been closing or reducing services. In this climate of downsizing, military health care networks face financial competition from the civilian health

care sector: in 49 of the 50 states, managed care contracts offer military beneficiaries options for civilian medical care.

The competitive challenges of the past decade for cost-effective, high-quality performance have forced United States health care organizations to rethink how they organize and manage. One result has been increased collaboration between military and civilian health care systems, which has reduced the number of differences between them. Recent examples of this collaboration are shared responsibility for citywide trauma care and graduate medical education programs (Goodspeed, 1997).

To summarize, rapid external changes have been forcing United States healthcare facilities, both civilian and military, to cope with pressures that have strained their capacity to react efficiently and well. The result has been a decline in organizational effectiveness, reductions of healthcare staff, the closing of military and civilian healthcare facilities, and inadequate health care improvements. Increasingly, civilian and military healthcare facilities are finding avenues for collaboration in the provision of health care services. The following section provides a discussion of the purpose of this study, which is to investigate differences in the leadership development experiences and leadership behaviors of civilian versus military CEOs of healthcare facilities, as well as the performance outcomes of their leadership as perceived by their direct subordinates.

#### Purpose of the Study

In light of the increasing collaboration between the military and the

civilian health care systems of the United States and the distressing organizational decline of United States healthcare facilities, this study was designed to examine possible leadership differences between military and civilian healthcare facility CEOs. Specifically sought was data concerning leadership development experiences, leadership behaviors, and performance outcomes as perceived by high-ranking subordinates of the CEOs. The performance outcome variables of interest to this study were leader effectiveness, satisfaction with the leader, and willingness of subordinates to put forth extra effort (Gasper, 1992), variables which are correlated with a wide range of leader behaviors (Avolio, Bass, & Jung, 1996). These outcomes were of interest to this study because they address the effectiveness of leader behavior. To show the complex interrelationships of these performance outcomes with behavioral, developmental and situational variables, a theoretical leadership model was adapted for this study from a conceptual framework developed by Yukl (1989). Although health care leadership exists throughout a facility's staff and at various organizational levels, this study focused on the role of the CEO because the responsibility for directing the overall management of the hospital lies with this person, who is appointed by the hospital governing body. In the military, a board appointed by each Service's Surgeon General selects hospital CEOs. Thus, the hospital CEO provides an important leadership role in determining the effectiveness of the institution that he or she leads.

As indicated by the Joint Commission on the Accreditation of Health care Organizations (1992), the hospital CEO usually serves as the healthcare facility's

catalyst for change, and thus the CEO's leadership behavior is crucial to the healthcare facility's success. According to Heidrick and Struggles (1993), most CEOs believe that their role is to provide visionary leadership, to build consensus and a strong management team, and to develop skilled operations and financial expertise. Indeed, prior research suggests that executive leadership is critical to achieving the strategic, cultural, and technical changes required to improve quality and reduce costs (Godfrey, Berwick, & Roessner, 1992).

In sum, then, the goal of this study was to investigate how occupationally similar, yet experientially diverse, military and civilian hospital CEOs differ in significant leadership experiences, behaviors, and three performance outcomes, namely perceived effectiveness, follower satisfaction with the leader, and willingness of subordinates to put forth extra effort. The following section provides a discussion of the core problem of this study: How can we improve the leadership qualities of hospital CEOs?

### Statement of the Problem

For reasons described previously, health care for Americans might be improved if healthcare facilities were able to obtain better outcomes during times of turbulence. Key to better outcomes for a hospital, as the literature suggests, are the type, qualities, and experiences of its leadership (Kotter, 1990; Conger, 1992). A 1995 longitudinal study of 60 health care facilities by Rohles, Baker, and Donaho underscored the vital role of leaders in transforming a health care organization. The leader creates the vision, aligns people in that chosen direction,



and motivates and inspires others to meet the challenges of providing quality care within current and future economic constraints (Dunham-Taylor and Klafehn, 1995).

Leadership has been defined in terms of individual traits, influence over others, interaction patterns, and perceptions of others regarding the legitimacy of influence (Yukl, 1989). This study adopted a definition by Conger (1992) that broadly captures the important manifestations of leadership.

Leaders are individuals who establish direction for a working group of individuals, who gain commitment from these group members to this direction, and who then motivate these members to achieve the direction's outcomes. (p. 18)

Bedard and Johnson (1984) contended that, although good leadership helps an organization achieve its goals, change has the power to make once sufficient leadership behaviors suddenly inadequate. To survive in the new era, healthcare facilities need approaches to leadership that go beyond what once was effective. Earlier models of leadership do not go far enough in building the trust of people in today's health care workforce and in developing the motivation of hospital employees to achieve their full potential in the workplace.

As health care organizations move toward flattening their structures, that is reducing hierarchical layers, the need for more effective leadership in organizations at all levels is quite evident (House, 1995). Identifying and producing a leader who can articulate a shared goal and lead diverse groups is a difficult challenge, and a number of researchers agree that the development of this new type of leadership requires a set of approaches not generally available in the

health care industry. Most of today's hospital CEOs began their careers in a cost-reimbursement environment or had mentors who did (Sherman, 1999).

Avolio et al. (1996) argued that the degree of integration and interdependency needed for the new hospital work environment will require leadership that goes beyond traditional exchange and bargaining to encompass one or more of four behavioral components which they identified as charisma, challenge and persuasion, intellectual stimulation, and consideration of other individuals. According to Avolio et al., *charismatic leadership* is such that the follower identifies with and seeks to emulate the leader. *Challenge and persuasion* can be used to provide the follower with meaning and understanding. *Intellectual stimulation* provided by the leader can help the follower expand his or her abilities. Finally, the *individually considerate* leader provides the follower with support, mentoring, and coaching.

Kotter (1990) had previously argued that leadership produces change by establishing direction, aligning people, motivating, and inspiring. According to Kotter, some emerging new forms of leadership orient followers to goals that transcend immediate self-interest and encourage followers toward greater organizational effort (1990). Cumulative evidence indicates that such leadership is likely to result in higher levels of cohesion, commitment, trust, motivation, and performance in organizational environments.

Hall (1984) observed that organizations traditionally have focused on identifying leadership talent, but that organizations desiring to attain effectiveness and efficiency, particularly in the challenging climate awaiting future CEOs, must

look ahead and invest in specific training for developing leaders. A survey conducted by The Healthcare Forum (1992) examined the relationship between current CEO leadership skills and future effectiveness requirements. The results suggest a gap between the leadership values and competencies currently practiced and those needed to lead the United States health care system into the new millennium.

As a basis for understanding leadership development, Kuhnert and Lewis (1987) proposed that the processes through which different types of leaders emerge could be examined within a framework of constructive and developmental personality theory. The effective leader, they suggested, reflects the core values and original standards consistent with mature adult development.

Several studies suggest that leadership skills can be developed. Kotter (1990) and Conger (1992), who examined the influence of heredity and childhood experiences on leadership development, stressed that individuals have the capacity to learn and change after adolescence, and that education and career experiences can effect leadership. Avolio and Bass (1991) developed comprehensive leadership training programs called the Full Range of Leadership Development. A large scale quasi-experimental pre-post evaluation of these programs was reported by Avolio and Bass (1994) that generally suggested participants show modest leadership improvements up to a year following completion of the program, particularly in areas in which participants had made plans to improve.

If leadership can be developed, what options are open to turn potential into

reality? Conger (1992) identified four approaches to leadership development that require a long-term commitment by both the organization and the participating individual. These approaches are personal growth, conceptual capacity, feedback, and skill building. To effectively develop leadership, Conger concluded, a program must combine all four of these approaches.

A hospital CEO's career can be expected to provide various combinations and sequences of Conger's (1992) four approaches, and thus Conger's leadership development framework appears to support the argument that military and civilian managers have different training experiences and hence may have different leadership behaviors and potential outcomes.

Bass (1996) concluded that much of what has already been learned about training civilians in leadership has not been fully exploited by the military. Examining the differences between civilian and military CEOs in terms of cognitive, behavioral, and environmental leadership development strategies may help us explain the variations that exist in leader behaviors and outcomes in these two groups across the individual and organizational life cycle (Hall, 1984).

In civilian healthcare facilities, CEO leader development training experiences may include graduate school, progressive assignments, and continuing leadership assessment and development programs. Unlike the civilian sector, however, in military healthcare facilities the Fiscal Year 1996 National Defense Authorization Act mandates the hospital commander's health care management and administrative skills. According to this act, a military health care officer can obtain certification of competency to command a military hospital

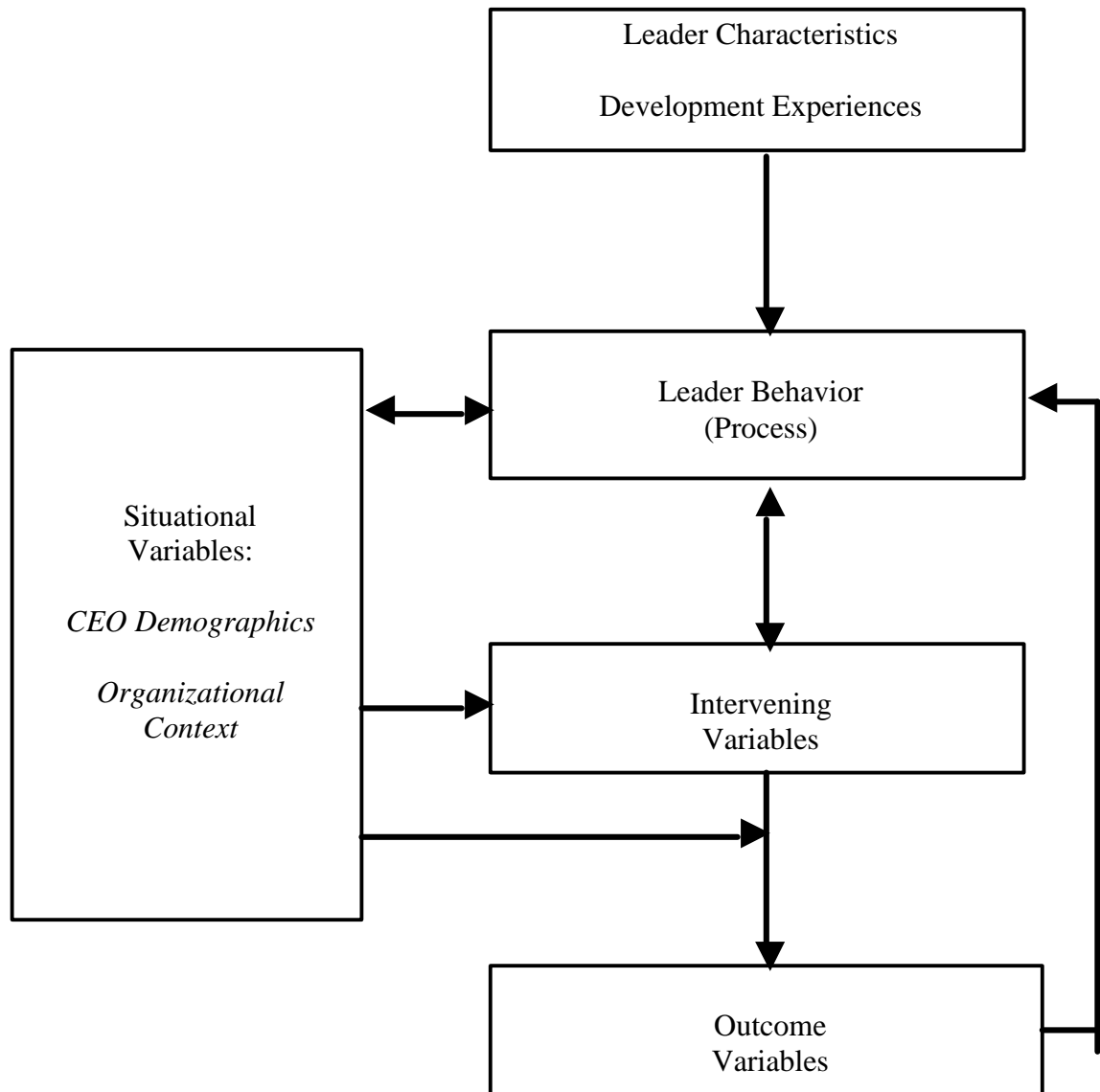
through institutional training, operational assignments, and professional development training over the course of his or her career.

Although the career experiences of military hospital CEOs versus their civilian counterparts can reasonably be expected to be different, for the purposes of this investigation some baseline educational and occupational qualifications were controlled as all the CEO respondents to this study belonged to the same professional organization, the American College of Health care Executives (ACHE).

As discussed previously, Gasper (1992) identified three significant leadership outcome variables: leader effectiveness, satisfaction with the leader, and willingness of subordinates to put forth extra effort. These three outcome variables are correlated to varying degrees with a wide range of leader behaviors (Avolio et al., 1996), usually charisma, intellectual stimulation, individualized consideration, and contingent reward. If military hospital CEOs do indeed experience different career leadership experiences than their civilian counterparts, as is argued in this study, military and civilian hospital subordinates also can be expected to have different levels of the three outcome variables identified by Gasper. This point suggests the relevance of leader behavior to subordinate and organizational outcome.

Yukl (1989) developed a conceptual framework to encompass important sets of variables relevant for leadership effectiveness, based on the assumption that organizational effectiveness, in terms of end-result variables, is mediated by a core set of situational and intervening variables. For the present study, a

theoretical leadership model was adapted from Yukl's conceptual framework to show the complex inter-relationships of performance outcomes with behavioral, developmental, and situational variables (see Figure 1.1). A situational variable is a measurable criterion of the environment. An intervening variable can be described as one that has a potential influence between a cause and effect. In this model, an example of a *situational variable* relevant to leadership effectiveness is organizational structure (i.e. hospital bed size); an example of an *intervening variable* relevant to leadership effectiveness is follower effort. The model recognizes that leadership is only one of many determinants of the intervening variables and outcome variables; the possibility that a leader's influence may be overwhelmed by strong situational influences is explicitly acknowledged.



Conceptual Leadership Model

Figure 1.1

Adapted from Yukl, 1989

This model, which provided a guide for development of the research design, is examined fully in Chapter 2. Control of the selected variables is addressed Chapter 3. In the next section, the research questions addressed in this study are presented.

### Research Questions

To investigate the differences between military and civilian healthcare facility CEOs, this study considered the three specific research questions presented below.

1. Do military, civilian, and prior service civilian healthcare facility CEOs differ regarding their:

- a. adult leadership development experiences?
- b. full range of leadership styles and behaviors?
- c. leadership outcomes?

2. Do the relationships existing between CEO military experience and CEO development experiences, CEO leadership behaviors and outcomes occur independently of the CEO's demographic variables of gender, age, years as CEO, and ACHE affiliation level or organizational context factors of bed size or geographical region?

3. Are the differences between leader outcomes of military, civilian, and prior service civilian CEOs, as perceived by their key subordinates, affected by the CEO's: adult leadership development experiences or leadership styles and behaviors?



## Significance of the Study

The three research questions detailed in the previous section were constructed to help probe the assessment, development, and training of leadership competencies. Thus, the findings of this study are expected to add to our knowledge base concerning improvement of the organizational outcomes of United States healthcare facilities. In addition, the results of this study have potential for linkage with assessments of ongoing leader development initiatives.

## Research Design

This study was a cross-sectional analysis of the relationship of the military versus civilian background of 117 healthcare facility CEOs on outcomes related to leader behavior in an organizational context. A conceptual leadership model was adapted for this study to help provide a framework in which to analyze: leadership development; leadership behaviors; and three types of outcomes (perceived effectiveness of the leader, satisfaction with the leader, and willingness of subordinates to put forth extra effort) Yukl (1989). Chapter 3 discusses the control of moderating and situational variables important to examine healthcare facility CEO leadership outcomes.

This study's respondents were 117 military and civilian members of the American College of Health Care Executives (ACHE) who were predominately hospital CEOs. The civilian hospital CEOs surveyed in this study typically led large, general medical and surgical hospitals offering teaching programs, and thus were not representative of all United States healthcare facilities. The military healthcare facility CEOs surveyed typically led a wider range of tertiary or