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A Preferred Interpersonal Leadership Style: Perceived by a Chief Board Officer as Compared to a Chief Executive Officer in a Hospital Setting

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A PREFERRED INTERPERSONAL LEADERSHIP STYLE: PERCEIVED
BY A CHIEF BOARD OFFICER AS COMPARED TO A CHIEF
EXECUTIVE OFFICER IN A HOSPITAL SETTING

by

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CHAPTER I

INTRODUCTION

The purpose of this study was to review and evaluate individual leadership styles in the health care field as well as to establish and provide an awareness and reflect the variation in leadership styles as viewed by hospital management. In this instance, the study explored leadership perspectives through board officers and compared that degree of style to that of administrative officers within a hospital setting. This empirical study was limited in scope to the state of Ohio inasmuch as the intensity and transition of health care action varies from state to state. The purpose of limiting the project to the state was to have the individuals tested experience similar external influences and time frame reaction pressures.

Background

In the United States there are just over 7,000 hospitals containing more than 1.5 million beds. They employ more than 2.5 million persons and admit over 33 million patients annually for inpatient care and provide over 200 million outpatient visits per year (Fuchs, 1974).

In this era of rapid change, escalating health care costs, and growing pressures from business, government, and consumers as well, the role of the hospital chief executive officer is a subject worthy of a disciplined and focused study. A review of the professional

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positions would be in order.

The genesis of hospital management began following the civil war in the 1870s. During that period, hospitals finally began to grow and flourish. Prior to that time, the public viewed general hospitals with fear and suspicion. The reasons were: the mortality rates were high and hospitals were intended primarily for the care of people without families or for the poor. With the popularity of hospitals, volumes grew and hospital trustees entered into hospital operations, deciding which patients to admit and determining what type of patients would be rendered care and what type of physicians and staff would be involved in that care. The need was identified to have a chief executive officer who would manage the basic responsibilities of the hospital operations. This included: cleanliness, ventilation, heating, and basic services that were required to provide basic hospital care at that time (Starr, 1982).

Davis (cited in Weil, 1984), considered a pioneer in the development of the hospital administrative profession, in his writings of 1929, viewed the role of the hospital administrator as growing out of need for capital and specialized personnel management. He pointed out that the function of the administrator was to execute organizational policy, established by the governing board. The term administrator evolves from the need to reflect the implied initiative referring to leadership as well as coordinator.

The need of health care as well as the role of administrator continued to grow until the time of the great social legislation of medicare and medicaid which were passed in the mid 1960s. The

hospital administrator had established an agreed upon role in this new organization. He was in charge of all internal management (Starr, 1982).

Starr (1982), in his study, was able to examine the role of the hospital administrator and detected a growing trend toward more administrative control and structure within the hospital organization. In Starr's view, trustees and medical staffs continued to maintain their authority and the organization of hospitals remained loosely coordinated (Weil, 1984).

This brief organizational evolution has traced the shift and power relationships among trustees and administrators. The trend has been to move away from a monolithic approach of power toward a pluralistic view of power relations based on current issues and stress factors brought on by external forces.

Health care makes up the largest growth industry in the United States with expenditures hovering around 10% of the gross national product (GNP). With all this expense, many hospitals are finding themselves in financial straits and further competition for survival is becoming overwhelming (Betjemann, 1984).

The American society has decided that health care is a right not a privilege and will increasingly call upon the federal government to make that concern a reality by whatever effort is necessary (Torrens, 1978).

Although there are some variations along states and geographic regions, the hospital industry has come to be heavily regulated as well as exposed to free enterprise, not unlike the banking and auto

industries of the United States. Two major pieces of legislation which were recently passed are profoundly affecting the hospital industry: The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and Title VI of the Social Security Amendments of 1983 (Prospective Payment for Medicare Inpatient Hospital Service); they became effective October 1, 1982, and October 1, 1983, respectively. This legislation has created the atmosphere that any operating cost that exceeds the stipulated amount paid by the government must be absorbed by the hospital. On the other hand, any surplus of funds are retained by the hospital. This creates tremendous pressures on management and the board to promote productivity. The degree to which team management now must be developed is overwhelming as well as compelling. Assurance that the hospital maintains viability relies heavily on the staff, board, and administrative cooperation (Weil, 1984).

Johnson (1984) also outlined the evolution of authority and responsibility involving the chief executive officer and that particular relationship with the board of trustees. In the article he indicated that from around 1900 until the mid 1940s, hospital chief executive officers typically held the title simply of superintendent with the responsibilities and the emphasis being placed on the solving and involvement of the day-to-day operational challenges. This resulted in an occasional meeting with the board of trustees to review financial matters. In the mid 1940s and early 1950s, the superintendent became the administrator. He not only involved himself with internal operational problems but frequently left the

facility to attend state and local meetings. By the 1960s, the administrator had acquired the title of executive director, the word director reflecting the ever-growing complexity of the health care industry and the hospital itself. Cost reimbursement was the state-of-the-art with hospital payments being determined by the cost plus concept, a small profit which was identified with the medicare legislation. By the 1970s the executive director had become the executive vice president. The chief executive officer was still a facilitator, but more of the time was taken up with regard to representing the facility off the premises. With the introduction of the 1980s, the title of the chief executive officer had changed once again to the now popular term of president and with this new term the industry was changing as well.

The Congressional Record (1965) indicates that during the mid 1960s Congress passed medicare which initiated health care support to all U.S. citizens who were 65 and over. In that same legislation, medicaid was passed which has to do with the redistribution of federal money to the states for health care support to the needy. With this deluge of state and federal money to help the aged and needy, the U.S. Federal Government became the largest single purchaser of health care in the world (Somers, 1971).

This interest brought about a whole new myriad of laws promulgated to change the health care delivery system. Hospitals were placed under heavily controlled federal regulations. From the mid 1960s to present, federal and state health legislation has put hospitals in a complex economic and regulatory environment. This is

reflected by Public Law 93-641--the National Health Planning and Resources Development Act of 1974. This particular act initiated and established health systems agencies and coordinating councils that provided for district and regional, as well as state, regulations and controls of health care. Following that legislation, in 1979, Public Law 96-79 was enacted in the form of the Health Planning and Resources Development Amendments to control the spending of all capital expenses and the future planning for hospitals involving expansion, renovation, and modernization (Congressional Record, 1979).

Apparently, the federal government has now drawn the conclusion that regulation does not contribute to cost containment and has contributed little toward the quality of care to the American people. Following years of federal regulations, the federal government has now turned its direction toward competition in the health care industry (Starr, 1982).

This can be best illustrated with the introduction of reimbursement by disease or diagnosis. In 1982, Congress passed Public Law 97-248--the Tax Equity and Fiscal Responsibility Act (TEFRA). This new approach to hospital reimbursement is referred to as diagnostic related groups (DRGs). In this instance, each hospital is paid a specific amount of money for each patient it treats regardless of the time the patient is in the building. If the particular patient costs the hospital more money than it will get for the DRG, the institution would experience a loss for that patient. On the other hand, if the patient can be discharged early, the hospital is able to retain the

funds between its actual cost and the amount of money reimbursed through the DRG. This new concept places a tremendous amount of emphasis on productivity and competition within hospitals (Congressional Record, 1982).

Hospitals have now entered an entrepreneurial era. It is a time of opportunity, a time of uncertainty, a time when fiscal consideration becomes more prominent among our medical and social responsibilities. Healing at any cost is no longer feasible nor totally acceptable as a result of the congressional action. Caring must now be justified financially as well as ethically. It is an era of rapid challenges and new choices for hospital leadership.

There is a need to balance the material wonders of technology with the spiritual demands of our human nature. A consideration toward the concept of a high tech-high touch environment is that the principle symbolizes the need for a delicate balance between our physical and spiritual realities (Naisbitt, 1982).

A new network style of leadership and management is now emerging. Its values will be routed in informality and equality. Its communication style will be not only lateral and diagonal, but vertical as well, and its structure will be cross-disciplinary. Only now are the hierarchies that worked well in the centralized industrial era beginning to be abandoned. In their place, the network model of organization and communication is being substituted (Naisbitt, 1982).

Today, health care facilities are being run more like commercial traditional businesses. The industry needs physicians, chief executive officers, and trustees who are wise in the way of marketing and

managing, as well as strategic planning. The need for these qualified people begins with the governing board itself. The role of the trustee will change with the role of the health care executive. Today's top hospital management needs interpersonal skills in order to develop interrelationships with each other as well as with the medical staff.

Flory and Wesbury (1984) indicated that in the years to come interpersonal skills will be even more valuable to the institution as the need for close cooperation between trustees and chief executive officers (CEOs) become more demanding and the results more important. "The health care system has changed dramatically and permanently. Both trustees and administrators are performing according to a new set of rules" (p. 33).

Gregory (1984) confirmed the rapid growth and numerous changes that are being experienced by the health care industry. Competition penetrates the entire marketplace and with it hospital executives will be exposed to criticism. In the past, chief executive officers have been shielded from scrutiny; but as new health care delivery strategies develop to confront this volatile marketplace, the actions of the chief executive officer will be more clearly evaluated (Gregory, 1984).

Competitive and regulative forces maneuver for control in the health care market. Federal laws governing health care planning pull in a less regulatory direction while state of Ohio officials seek more controls and restrictions. This is documented by the certificate of need legislation and what the hospital leadership must seek

to provide in needed services without sacrificing the quality of care. As a result of this competition, compounded with the realization that hospitals are being given less dollars to function with, these facilities are looking for new opportunities to generate funds in order to sustain their existence (Starr, 1982).

When the economy is growing and the organization's bottom line is strong, administrative work is relatively easy and enjoyable. However, when unlimited growth is not in the forecast and it becomes clear that revenues will not keep up with expenditures, administrative decisions need to be made that will likely result in disagreements, conflicts, and intraorganizational warfare (Veninga, 1984).

The health care environment in this country, during the period of 1963 to 1978, could be labeled as either turbulent or at least disturbed, but hardly placid to use environmental descriptors. Since 1978, the environment of health care delivery organizations has continued to change. There has been a perceived intensification of the problem involving the cost of health care. With this change in perception there has also been a major change in the role and responsibilities of the administrator from one of a simple manager to the role of a chief executive officer (Berry, 1984).

Both opportunities and problems arise as hospitals view new services outside their traditional purview--home health care, health maintenance organizations, and hotel-type accommodations for patients' families, to name a few. Each new opportunity creates new challenges and time frames. These challenges place a greater need for cooperation and interrelationship between the top management

leaders of the organization. The direction that a hospital takes is far more diversified than it was several years ago and the options available are limitless. Accordingly, the scrutiny and evaluation of the chief executive officer of a hospital in today's environment is looked at with far more versatile criteria (Kinzer, 1982).

The hospital and other health care institutions by definition are concerned with problem solving. Georgopoulos' (1972) description is appropriate:

> The hospital is a problem-solving system whose principal components are purposive human beings who have the ability to act, interact, and communicate at will, to think and feel in both conscious and unconscious ways, to reason and solve problems, and to make decisions that may be rational or nonrational, correct or incorrect, self oriented or altruistic, and organizationally relevant or irrelevant. (p. 14)

The hospital function is concerned with clinical problem solving as well as administrative problem solving. Administrative problem solving is specifically a task of the chief executive officer and other executives within a hospital or complex health service organization. Administrators devote most of their time to this process. Simon preferred the term decision-making process to describe this central administrative function, but indicates that decision making and problem solving are essentially interchangeable (Simon, 1977).

The publication University Education for Hospital Administration (Association of University Programs in Hospital Administration, 1954) reflects that the review of hospital chief executive performance is viewed as a governing board responsibility. However, current practices vary widely among hospitals.

Hospital administration varies from business and industry in five major areas:

1. The services produced and their consumers.

2. The producers of the services to the consumers.

3. Education and training responsibilities.

4. The accountability of the administrator.

5. Unique public relations problems.

These challenges have led to a greater need for understanding the interreaction of top leaders in a hospital setting.

Agreement between the governing board and the chief executive officer about expectations is an important ingredient in the success of the institution. This type of understanding ensures that all parties are thinking on the same wavelength and are committed to the same goals as well as similar methods of achieving them (Adams, 1984).

Definition of Terms

A number of terms have been used in the pursuit of this review and survey. This survey was intended for an audience which included lay board members and others who may not be totally familiar with health care vocabulary and terms. Therefore, identification of some terminology would be in order at this point.

American College of Hospital Administrators: The American College of Hospital Administrators (ACHA) is a national organization made up of chief executive officers and assistant administrators, planners, and other administrative representatives of hospitals and

related health organizations. The American College of Hospital Administrators is viewed as an organization that represents professionals inasmuch as member status requires a written and oral examination. The prime purposes include: national legislative action and lobbying, administrative educational programs and seminars, and data process offerings that include data base and survey techniques.

Behavioral science: A knowledge that the existence of certain describable conditions in the human being and/or in his or her environment are followed by certain describable consequences in his or actions (Rogers & Skinner, 1978).

Chief board officer: An individual who holds the position of leader of the board of trustees or board of directors. The position commonly is referred to as chairman of the board. The position usually includes presiding over board meetings, often chairing the board executive committee, and assigning board members to board committees (Wilson & Neuhauser, 1982).

Chief executive officer: Various titles are also used, such as: administrator, executive director, executive vice president, and president. The chief executive officer has the planning, corporate coordinating, and day-to-day responsibilities for managing and directing the hospital or facility (Wilson & Neuhauser, 1982).

Governing board: The governing and legal responsible body of the hospital. Also referred to as the board of governors or board of overseers. Board membership ranges typically from 5 to 15 members and meets monthly, functions with bylaws, and elects its own officers. The responsibilities include the appointment and selection of

an administrator and approves the appointments of physicians and other professionals to the hospital medical staff (Wilson & Neuhauser, 1982).

<u>Hospital-beds</u>: The average number of beds, cribs, and pediatric bassinets regularly maintained, set up, and staffed for use for inpatients.

<u>Leadership</u>: Leadership is a process or series of actions in which one or more persons exert influence, authority, or power over one or more others in moving a social system toward one or more of four primary goals. These goals are the satisfaction of wants of system members, innovation, productivity, and maintenance of the system (Boles, 1980).

<u>Leadership style</u>: Leadership style describes a characteristic manner of behavior. Weber (cited in Boles & Davenport, 1975), in 1922, indicated that leadership style is a personality characteristic rooted in the leader's perception as to the source of his or her authority.

<u>Medicaid</u>: Medicaid is a mutually funded state and federal comprehensive health service provided to the indigent. In many states known as medical welfare. Referred to as Title XIX of the 1965 Social Security Amended Act (Coe, 1978).

<u>Medical staff</u>: The medical or professional staff consists primarily of physicians, but may include dentists, podiatrists, and psychologists. The organized staff usually has an elected president or chief of staff (Wilson & Neuhauser, 1982).

<u>Medicare</u>: A federally funded, comprehensive, medical health insurance program passed by Congress in 1965 offering comprehensive medical support to all people 65 and over. Also known as Title XIII as amended to the Social Security Act (Coe, 1978).

<u>Ohio Hospital Association</u>: This association represents the hospitals in the state of Ohio. Each hospital is a member in the association for the purposes of education, lobbying, representation with the state legislature, and being actively involved with ongoing in-service and educational programs for all levels of management. The state association carries a full-time staff in order to coordinate all functions required to maintain education, political contact, and educational services to the hospitals as well as to provide a data base for determination of legislative and reimbursement references.

<center>Statement of the Problem</center>

Toffler (1980) indicated that in the third wave environment (the coming society), corporate results will include many different facets. That concern toward social, environmental, informational, political, and ethical factors will contribute to desired corporate performance.

Hospitals in the United States have moved from what was referred to as a cottage industry, individual hospitals operating independently of each other, into a mass health care delivery system that is under the influence and direction of the federal and state governments. From the 1960s through the 1970s and into the 1980s, the

federal government has placed more and more emphasis on free enterprise of health care to U.S. citizens. The government has also placed in competition physicians, clinics, laboratories, and hospitals each vying and competing for a share of the market. To compound this challenge, time frames have been compacted allowing very short lead time in order for management to make reasonable and long-range plans.

These external pressures, placed on hospitals, will continue to increase over the course of the decade. Hospital leaders will have to work in a closer relationship in order to ensure success throughout the 1980s. This forthcoming relationship can contribute to a more effective facility; however, these interreactions will place new concerns and strains on the interpersonal relationships of individuals.

Hospital administrative staffs are trained with a keen awareness of operational and medical responsibilities coupled with public expectations. Board of trustee input includes business, government, and industry expertise. A successful outcome is dependent upon talents, taking into account individual leadership techniques and styles, to ensure harmony and communication between hospital board members and the administrative staff.

Hospital administrators and board members must respond with leadership guidance and influence in order to rearrange or redirect hospital operations to meet changing health care demands. Hospital leadership must recognize that the most aggressive changes in the health care field in decades have suddenly emerged and are compounded

with a higher degree of frequency.

The hospital administrator holds a unique leadership role in two contexts: in the governance function of goal setting and policy format and in the executive management of ongoing internal operations. The challenges of leadership style and application are evident when consideration is given to the responsibilities of the chief executive officer in offering guidance, direction, and leadership to the board of trustees while on a status basis remains subordinate to that forum.

As a result of this turbulent environment, it is important that chief executive officers (CEOs) and chief board officers (CBOs) work in confluence toward the goals of the institution. Because of the compressed time frames that influence responses to current challenges, it is imperative that these individuals be sensitive and aware of the techniques--in this instance, individual leadership style that is applied toward attaining the agreed upon organizational goals. It was not the intent of this research study to change or to influence these leaders, but to identify the variations in their leadership styles.

The concerns of this study center around identification and comparison, but do not necessarily allude to any corrective action. The concept is expressed with the following thought, that fortunately, science does not demand that bias be eliminated, but only that our judgment take it into account (Kaplan, 1964).

Boles and Davenport (1975) indicated that leadership is a process rather than a simple personal attribute. Further, the

leadership process requires that the leader be able to understand as well as interpret his or her and others' behaviors involving those responsibilities.

It is important to point out that there is no one model of successful leadership that will fit all situations or institutions; however, leaders are alike in their ability to bring together the different types of people for a common goal or mission (MacCoby, 1981).

This study attempted to substantiate that the size of hospitals, age of the CEOs and their formal education, as well as their years of experience affect the hierarchy of the management form and contributes to an individual's attitude toward interpersonal leadership style. It should be kept in mind that the CEO of larger institutions serves more in the role of the staff functions than in the day-to-day operations. That staff position places the CEO in a similar setting with the CBO. Therefore, this study specifically addressed the following points that established five hypotheses. To determine whether administrators of smaller facilities, dealing with the day-to-day operations, perceive their interpersonal leadership style differently than that of CEOs of larger hospitals.

Further, the study attempted to identify whether the age of the chief executive officer is a factor with regard to differences within interpersonal leadership style (relationship behavior versus task behavior).

Another characteristic that could be of significant importance is the duration of time involving the degree of formal education that

the chief executive officer has obtained. Finally, a consideration was given to years of experience that the chief executive officer has acquired and if that influencing factor contributes to the difference in interpersonal leadership style.

The following information contributes to that concern.

CHAPTER II

A REVIEW OF THE LITERATURE

Hospital Boards and CEO's Concerns
and Challenges

Board attitudes toward greater active involvement in the organization have been generally beneficial for the organizations concerned; however, they have created a number of coordination and control problems for management. An increasing amount of the administrator's attention must be directed toward problems associated with proper functioning of his or her board and as a direct result problems associated with governing boards have become more important for administrators (Carper, 1982; Hickey, 1972).

"Sitting on a board of directors, as little as 15 years ago, was similar to attending a men's club" (Miller, cited in Koepp & Zagorin, 1985, p. 69). He indicated that currently the director's job has become much more challenging. Government regulations have begun taking directors to task for failing to perform their duties properly. Boards now are being forced into a sharper awareness of their responsibilities. Board members are beginning to take a more active role in their responsibilities. Further, these directors are spending more time on board activities in order to meet that obligation. The typical board member of a large corporation puts in approximately 196 hours a year. This is up 40% from only 6 years ago (Koepp & Zagorin, 1985).

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The trustees of the community hospitals are very important in the control and operation of the facility. It can be assumed that most, if not all of them serving as board members, serve voluntarily and seek to serve well. Unfortunately, most of them have very little personal experience with the operation of a hospital or any type of health care organization. This contributes to administrative concern and involvement (Weeks & DeVries, 1978).

The relationship between a hospital board and a chief executive officer today is an unusual challenging assignment. On one hand it is a unique organizational relationship and, on the other, a pronounced personal relationship (Umbdenstock & Hageman, 1984b).

Mickey (1984), in her article published by the American College of Hospital Administrators, indicated that a major difficulty that exists in the field of hospital administration, when compared with business and industry, is the lack of adequate bases or standards for evaluating the performance of top management or the success of the institution in achieving its objectives.

"The hospital CEO has been cast in a leadership role, the principal agent of the board of trustees in both external relations and internal management" (ACHA, 1984a, p. 13). This expectation was confirmed by the role study conducted recently by the American College of Hospital Administrators (1984a).

In 1973, a special task force of the College (ACHA) revealed the position that, the hospital's role in the new health care environment is one of transition, as is the conventional role of a chief executive officer in the top level organizational structure (ACHA, 1984b).

Therefore, the CEO has responsibility and accountability for all leadership functions including management policy making and planning.

Alexander (1984) reflected his opinion on trustee relations in his article in <u>Modern Healthcare</u>. The author pointed out that, "Trustees are the final judges of a CEO's performance" (p. 204). However, the CEO's position in a not-for-profit hospital does not necessarily parallel that of a CEO in the business or industry world in that, in many instances, the scope of the CEO's role depends directly on the activity of the board of trustees itself. The author also pointed out the very important aspect of the working relationship. The new CEO must establish a productive working relationship with the chairman of the board. The key elements in the relationship must include interpersonal style, availability, method of communication, and meeting frequency.

Weil and Wesbury (1984) also voiced some major concerns and focused attention on the relationship of chief executive officers and boards of trustees in their article, "The Shifting Roles of CEOs and Trustees." They reflected the following salient points.

The chief executive officer's agenda has become more and more demanding in the 1980s. In addition to the many decisions involving balancing budgets, related costs with needed services, the CEO must now manage human resources and build a dynamic as well as a cohesive organization. They indicate further that more than 97% of chief executive officers in not-for-profit, free-standing hospitals report to a board of trustees or its executive committee. The attitude that is reflected in the article by the chief executive officers is

basically the hope and desire to create a partnership with the board in pursuit of the success of the organization (Weil & Wesbury, 1984).

The degree of challenge and cooperation between board representatives and hospital administration is reflected further in the article which appears in _Trustee_ entitled "Why Boards Need Fresh Information, Not Warmed-Over Management Reports" (Bader & Beneman, 1983). The authors indicated a major change in the environment of the hospital industry and revealed that indeed major environmental forces involving pricing, competition, and aging population, compounded with expensive medical technology, places a heavy burden and tight timetable on hospital management. The article also reveals that today's hospitals, to be managed effectively, need timely information and timely response in order to remain competitive.

Johnson (1984) pointed out that trustees need to learn a "second language," not really the language of hospitals or health care, but rather the language of "boardsmanship." This includes the art of asking the proper questions, interpreting data, and making governing decisions on a timely basis. CEOs and boards are only now beginning to recognize that they must adopt and organize an efficient process for channeling meaningful information into timely outcomes that contribute to their competitive position. Phrases used for over 80 years, such as dedication, public service, and charity, have now been replaced with common terms known in economics as market share, profitability, productivity, and the concern for bond ratings and efficiency. The relationship of the board of trustees to the chief executive officer today has changed. The author indicated that the

governing board members must now formally acknowledge the CEO as the head of the entire organization. Further, he voiced a concern with regard to the ability of this new chief executive officer role to meet all the needs and characteristics of the position of leader (Johnson, 1984).

Bays's (1984) article in Trustee Magazine entitled "A Common-sense Approach to Productivity," offers another perspective involving board input to the direction and goals of the institution. "Historically, hospital trustees have often believed that it was their duty to minimize uncertainty and risk" (p. 32), but the future holds a greater challenge inasmuch as the trustees will have to assume more risk on behalf of the hospital as it enters a more competitive era. What this points out is the greater challenge to the institution and realignment and close alliance that must exist between board involvement and CEO activity.

Umbdenstock and Hageman (1984a) also contributed to the new managing responsibilities of board and CEO activities in their article entitled "Governance and Management: Where Do You Draw the Line?" Their opening question is, "Is there a clear-cut division between the responsibilities of governance and management? Or, will the role of both parties vary depending on the issue and the circumstances" (p. 19)? In the competitive environment that now exists, the industry has moved away from issues that are clearly handled at a board level as compared to issues that were addressed solely by administration. The fact is that there is no longer one point where you can draw the line and apply that attitude. Rather, there is a

need to view governing boards and administration as a related function as well as a continuum of corporate leadership. The functions, therefore, cannot be in isolation one from the other.

The principles of management to plan, lead, organize, and control the operations of an organization with its staff is familiar to all hospital executives; but board trustees and administrators have fuzzy perceptions concerning what constitutes their individual involvement. Many of these problems can be minimized through an appreciation by each party of the other's proper role.

The article (Umbdenstock & Hageman, 1984a) goes on to indicate that many trustees seldom seem to view the hospital executive in the same way that they view the bank president or the manufacturing tycoon and this reinforces the concern that the governing board and administration must blend together to direct a highly sophisticated service such as a hospital.

Finally, they (Umbdenstock & Hageman, 1984b) indicated,

Frustrated observers might be tempted to ask, where do you draw the line between governance and management? But that's the key issue, the fact that there is no one point where you can draw the line and apply to all issues. Governance and management are two functions within the same sphere, namely, corporate leadership. (p. 5)

Almost all hospitals share a common characteristic which complicates the administration and obstructs the orderly process of change. That single characteristic is the administrative powers and responsibilities which are shared among several individuals in such a way that no single individual or group can act decisively to set goals or induce the change of the organization. Simply stated, power does not

reside in any one individual.

The board of trustees of a hospital is commonly composed of businessmen and community leaders with authority over both hospital administration and the medical board, but unfortunately not having the background or the technical knowledge to exercise the power wisely. It appears they have the legal responsibility for medical care, but in reality have limited influence because of lack of background and knowledge. For these reasons, the hospital may be realistically viewed as a rather loose affiliation of hierarchies of power (Rushmer, 1978).

Summers (1984) indicated that leadership is more than just administration. The mission of the new hospital falls to the chief executive officer and he or she must rise to the occasion. The administrator must not only take but also earn the right to a leadership role. Openness instead of manipulation seems to be highly valued as an ingredient in building the confidence base for recognition and acceptance as a leader.

Livinson (1979), a noted management consultant in organizational theory, motivation, and the management of change, pointed out that value concerns have also been related to top management of hospitals. In order for the administrator to succeed, he or she must build a values consensus with the board of trustees, the medical staff, and other employees. It is necessary for the chief executive officer to establish his values by achieving a consensus on the mission of the health service facility and seek to exemplify the ethical ideals of that mission and personal conduct.

Summers (1984) pointed out that this incredible diversity of conflicting responsibilities, which puts the chief executive officer in a position of authority to be leader, is necessary in order to pull together a value consensus and how the institution shall represent itself internally and externally. It is important that this value system be in accord with board members in order to identify values, remove role conflicts, and ensure shared goals. Or, as the author put it, "encouraging a sense of common goals resting on a foundation of common values between the board and the chief executive officer" (p. 87)

Values are not the only factor contributing to a top management relationship. Decisions as well as strategies and plans are molded by the individuals who constitute the institutions, governing board, and top management. This not only reflects the personal values, preferences, and beliefs of the individuals, but often are the direct relationship or reflection of the individuals themselves, the hierarchical positions, and their influence with the organization (J. P. Peters & Wacker, 1982).

> The real issue then is institutional leadership--how to
> define it, how to organize it, how to coordinate it, and
> how to develop it. Leadership begins and ends with the
> individuals involved and the degree to which their under-
> standings and expectations are shared. (Umbdenstock &
> Hageman, 1984a, p. 22)

The author believed that what separates effective leadership from simple turmoil is the mutual respect between the board and the administration. He pointed out further, "There is an infinite variety in the leadership structures and styles in our nation's hospitals.

Despite those differences, the basic principles of leadership are applicable to all" (Umbdenstock & Hageman, 1984a, p. 24).

Prior Studies and Research

No major studies describing the actual services of administrators were performed until 1945 when, in February of that year, the American College of Hospital Administrators (ACHA) and the American Hospital Association (AHA) created a Joint Commission on Education. With financial support from the Kellogg Foundation, they attempted a special study outlining the role of the administrator. This empirical effort was prepared and reported by Prall (1948) and has proven to be the best documentation of hospital administration activities through the mid 20th century (Weil, 1984).

Wentz and Moore (1981) reflected that the majority of assistant and associate administrators aspire to be CEOs; however, very little is documented in what contributes to the success of that goal. They identified a study performed by Fiedler and Chemers (1974) that offers some guidance to this subject.

Fiedler and Chemers (1974) developed a questionnaire that involved 10 factors contributing to administrative success. To apply the factors to the health care industry, a survey was conducted involving chief executive officers of hospitals of varying sizes in Kansas, Wisconsin, and Minnesota. The number totaled 180 participating applicants. The 10 factors were delineated reflecting what would determine their success in the field. The 10 factors were put into priorities including very strong affect, moderate affect, or no

significant affect.

The study revealed that the single most important factor contributing to individual success was the support of superiors or board officers. The participants had indicated that the strong support of their boards had been of great significance in their career goals. It would be appropriate here to point out that the second most important item surveyed proved to be support of subordinates which again has a direct bearing on leadership relationship and style. The third and fifth items of importance proved to be speaking skills and writing skills which are directly related to effective communication and paramount in leadership effectiveness.

Another perspective of the relationship between board of trustees and top administrator positions is illustrated with a study that was performed by the New Jersey Hospital Association documenting that there were 46 top administrator job changes in 103 hospitals over a 5-year period. The time frame involved 1975 through 1980. The external forces which include big government and competition from the chains of profit making hospitals have made the boards of these hospitals painfully insecure and as a result the boards are having difficulty in making a determination on how to accurately assess the effectiveness of the chief executive officer (Kinzer, 1982).

Kinzer (1982) pointed out further that board insecurity is a major factor and although insecurity is a concern, the boards in the past had a great deal of influence on the direction and operation of the facility and that the profile of the board was to select an administrator who was easy to direct. Now, however, all this is

changing with the realization that hospital management has become so complex that boards cannot handle the mainstream governance, but need the direction and coordination of a dynamic CEO. There is "a new desire for strong leadership" (Kinzer, 1982, p. 17).

Kinzer (1982) identified the ascending complexity and challenge of hospital administration by identifying the first phase or first wave of chief executive officer positions with something that was filled by a minister or a nun or possibly an aging physician, certainly someone who was a respected citizen in town. The second phase was that of a trained individual as distinguished from the educated administrator. Education and training were a mandate in the second phase of hospital administration, but now what is emerging is the third phase. As the author indicates, the new wave of CEOs are better educated individuals, but not nearly so well prepared. This new group is being shaped and developed out of an on-the-job experience that may have nothing in particular to do with their formal education.

The article indicates that the dominating model of a successful chief executive officer includes the following characteristics:

1. He or she will be systems oriented, more than institutionally oriented. This is a key to the marketplace.

2. He or she will have more in common rather than less with the business leaders who serve on the hospital board. There certainly will be an interreaction far greater than it was experienced in the past.

3. The new CEO will have much more authority because of the capacity to exercise authority and will be one of the main attributes a board search committee will now be seeking.

4. The individual will have to be much stronger in communication skills, both speaking and writing.

The characteristics reflect a strong need for interrelationship between the board and the administrator.

The article closes with the emphasis that a need to reduce the attrition and turnover of chief executive officers must include the exposure of the leadership of the board to an intensive orientation with regard to the close proximity of the CEO and the challenges in which he is facing. In other words, the message that must be sent through to the hospital board is that they have an obligation to support the main risk taker, that of their leader--the chief executive officer (Kinzer, 1982).

The American College of Hospital Administrators (1984b) in 1982 compiled a comprehensive study involving 651 individuals with an 81% response rate. The purpose of this study was to interview hospital chief executive officers with regard to their role as the facility's top executive officer. This study was able to reveal that only 25% of the CEOs think they should adopt a passive role of deferring to the board in charting the course of the hospital. The majority of the CEOs in the study see a partnership relationship in hospital governance between the board of trustees and the CEO. It should be kept in mind that the leadership style as it applies between the board and the CEO is not limited to the relationship between them,

but should be considered in the operation and direction of the hospital itself with the understanding that a hospital is a service oriented organization and that over 60% of the operating budget involves manpower concerns.

The summary of the study revealed that CEOs believe that their role requires: (a) a strong leadership relationship with the board, as well as, (b) attention to long range plans for the hospital, and (c) constructing a budget which must be strongly adhered to. Leadership style would have a direct relationship with the first and third of these concerns.

The 1982 American College of Hospital Administrators' (1984b) summary also concluded with a very strong opinion by the chief executive officer's role to include the selection and identification of potential new members to the board of trustees. This interest clearly identifies the close relationship of management application involving the board and the chief executive officer. The study also asked the individual CEOs to compare their activities conducted with their board chairman today with similar activities of only 5 years ago. The majority of the CEOs reported that more time is currently spent in discussing strategy with board chairmen today than in the past. The conclusion—most CEOs have been drawn closer to the governance of their hospital in recent years.

The study also revealed a growing relationship, specifically between the two individuals, that of the CEO and the CBO. In recent years, CEOs have developed closer ties to their boards and board chairmen. Together they plan strategy and attend social functions.

Chief executive officer relationships have grown to the point that overall 38% are voting members on the board in which they serve. The CEOs reported in the study that a strong working relationship with the board with neither the CEO nor the board as a dominant factor best describes the CEOs ideal of hospital governance. The question- naires responded further with, in fact, CEOs and their boards act as partners in devising the hospital strategies and futures.

The American College of Hospital Administrators' (1984b) study made the following suggestions with regard to the successful hospital chief executive going into the end of the 1980s. Their 10-point recommendations will not be discussed in their entirety for the purpose of this study. However, focus should be placed on the fol- lowing. The Point 3 recommendation illustrates the importance of the ability not only for decision making, but also for the opportunity and effectiveness of convincing and persuading others of the validity of their ideas. "Boards and medical staffs will look to CEOs for qualified evidence as they face critical decisions to initiate or expand profitability" (p. 90). This clearly reflects a growing and challenging interrelationship of activities and rapport between the board, medical staff, and CEO. Further, Point 8, CEOs will need to consider the human side of the organization as well in order to affect change, another way of emphasizing interpersonal leadership needs.

The CEO will indeed have to give new meaning to the role of communicator. He or she will have to listen, meditate, motivate, probe, and respond to changing conditions. Today, American health

care providers and purchasers alike find themselves with an emerging health care crisis due in part to a complex combination of factors; such as, inflation, recession, increased utilization of services, and declining industrial productivity with less dollars to spend for health care. These and a variety of other factors have led to the point where health care is a major concern and consumes 10% of the gross national product which totals close to $280 billion in expenditures. Even the federal government is beginning to stagger under the burden which approaches 11% of the federal budget (Betjemann, 1984).

As was outlined earlier, the Prall (1948) report, a study performed in 1948 under the auspices of the Joint Commission on Education of the American College of Hospital Administrators and the American Hospital Association, interviewed approximately 100 practicing hospital administrators. It should be pointed out that the sampling procedure was anything but random; however, Prall did not feel that this bias severely compromised the goal of his overall project.

In that study, "governing board problems" were identified as 8th in an order of 1 to 10 reflecting the 10 categories of administrative concern to the well renowned practicing administrators.

A second study of administrative problems was conducted as part of Cornell University's 1963 comprehensive analysis of the field of hospital administration. The 1963 investigation used a random selection of administrators that yielded over 200 responses. Again reviewing the rank order, the "governing board challenges and problems" moved from eighth to seventh as viewed by the chief executive

officers (Dolson, 1965).

Following these two studies, a contemporary hospital administra--tor's view was explored. The study was conducted by the American College of Hospital Administrators during the fall of 1978. The 1978 edition of the American Hospital Association's "Guide to Health Care Field" was used to identify and obtain the relevant population in a random national sample of 200 hospital administrators. The survey was accomplished through a mailed questionnaire. One follow-up mailing was made to the nonrespondents after a 2-week period--an autonomy was guaranteed. A total of 66 usable responses were returned--a 33% response rate. The 1978 survey reflecting the 10 priorities moved the "governing board problem" area to 5th in the categories (Carper, 1982).

The problems were evaluated and compared to the Prall (1948) and Cornell (Dolson, 1965) studies. A review of the comparison of the three surveys reflect only one category of ascending concern and problem to the CEO, that category being, "governing board challenges" moving from eighth in 1948 to seventh in 1963 and finally to fifth in 1978. Clearly this points out the need for greater open communication and relationship between the CEO and the governing board. This proven major challenge should be addressed and evaluated.

A recent hospital study, conducted by Arthur Anderson and Company (1984) through the cooperation of the American College of Hospital Administrators, also reveals some interesting concerns regarding CEO and board relationships. Six panels of experts were surveyed. The panels include: hospital leaders, physicians, other providers,

legislators/regulators, suppliers, and finally, payers or consumers. One thousand experts were involved in this comprehensive research evaluation. The result of this study revealed that the panels predict greater involvement for hospital boards in the coming decade. The hospital and physician panels specifically forecast substantially greater involvement for boards of hospitals. A priority ranking was provided to the hospital panel to identify the top five challenges over the course of 1984 through 1995. Two categories were clearly delineated; those of interpersonal skills and governing board relations. Further, both were identified as a concern now as well as into the mid 1990s. The implications and conclusions of the study reveal that a hospital's need for qualified management in the next decade begins at the top of the organization--the governing board. Further, the panel reflects that an organized process of governance will be required including such things as in-service training and strong, active committee structure. They predict that greater board involvement will be exercised in the areas of policy decisions regarding strategic planning, capital expenditure, and other operations normally left to the CEO. This will contribute to a need or an essential partnership between the board and the CEO. The leadership of the CEO will be critical to the effectiveness of the board. The responsibility to prepare board members for their expanded role will also be the responsibility of the CEO. A policy of performance evaluation must be developed in order to identify and determine the goals of the institution, the interest and concerns of the board, as well as the effective management involvement of the CEO (Arthur

Anderson and Company, 1984).

The study also supports the concept that the interrelationship between the CEO and board will become more critical toward the success of the organization. Further, it also indicates the importance of the evaluation of the board in the board's role toward the chief executive officer. That criteria directly or indirectly identified will include interpersonal leadership style as a behavioral condition of performance.

Schnacke (1985), in his article, "What 1985 Holds in Store for Trustees," buttresses the involvement of effective criteria for CEO performance evaluation by the board of trustees where he indicates, Trustees will find it necessary to pay close attention to their administrative team and initially to install and strengthen methods for the evaluation of the chief executive officer and related administrative staff.

The findings continue to support the significance of interrelationship of the chief executive officer to the board of trustees, specifically the chairman of the board. It is important to note that as the different approaches and concerns of board/CEO relationships are explored, leadership style itself, a major contributor to the overall outcome, has not been identified nor has it been considered by the authors as a component contributing to the success of this joint effort.

Umbdenstock and Hageman (1984b) reflected that the approach to leadership involves two basic issues, one of substance and one of style. The issue of substance has to do with organizational policy.

The issue of style; that is, how and what point does the board want to be apprised of an issue and how does a CEO best present information in order to help the board in its decision-making process. The effective situation would allow the CEO to enjoy a good and effective relationship with each of the trustees. This relationship must be based on an understanding of each other's role and a willingness to work together toward a common purpose. In order to accomplish this we must address both organizational leadership as well as individual leadership. Organizational leadership is built on a foundation of mutual trust and respect. Within that sphere, at its very core, is what is referred to as the individual leadership. Individual leadership guides and directs as well as creates the personality of the board and, in some cases, the entire organization.

The success of any human endeavor relies largely on a successful relationship of the individuals involved. The hospital, by the very nature of its mission and its history, creates greater tensions within these relationships than perhaps in many other types of organizational structure. Individuals whose leadership will determine the survival of the hospital must work harder than ever at easing these tensions and making these relationships succeed (Umbdenstock & Hageman, 1984b).

Based on the nature of the health care industry and the review of literature that reflects the need for communication and inter-reaction between board members and CEOs involving attitudes and values, this study will attempt to reveal the hidden element in the concept, that of interpersonal leadership style.

Leadership Concerns

T. J. Peters and Waterman (1982) offered dynamics to leadership in the definition of leadership being the ability to alter agendas so that new priorities get enough attention. They refined the process by pointing out that it includes the ability to be visible when things are going awry and invisible when they are working well. These characteristics, of course, would support the philosophy and concept of situational leadership behavior.

Burns (1978) also buttressed this approach by indicating in his book <u>Leadership</u> in which he refers to transactional leadership--a leadership offering that builds on man's need for meaning, a leadership that creates institutional purpose as well. Transforming leadership actually occurs when one or more persons engage with others in a way that raises the levels of motivation and mortality among the leaders and followers as well.

Zaleznick (1977), a business psychologist, pointed out the difference in the contrasting characteristics of leaders versus managers. Managers prefer working with people; leaders stir the emotion. This results in the leader arousing the confidence in his followers and the followers feel better able to accomplish whatever goals have been identified and share in the satisfaction of the results.

Bennis (1976) offered a very accurate metaphor for the transforming leader. "The leader is a social architect whc studies and shapes what is called the culture of work" (p. 15).

Selznick (1957) has advocated that the inbuilding of purpose is the greatest challenge to creativity because it involves transforming people from a different or neutral state into participants with a very particular interest of sensitivity and total commitment. The effective leader must know the meaning and master the technique of the educator. This leadership approach is important if he or she wants to contribute to the promotion and protection of values.

R. Scott (1978) offered an interesting approach to corporate leadership and the influences bearing on the decision-making process. R. Scott has formulated a matrix of four main areas of development and management practice and the influences on it. The matrix is reflected in a two dimensional grid with the vertical reflecting or indicating a "closed" to "open" approach to the environment with a horizontal indicator from "rational" to "social." The first aspect, "closed" to "open," would reflect the attitude or decision-making process of the top management as being influenced by the environment, the competition, the marketplace, or other influencing external factors. An aspect or component that was given little consideration in the earlier generations of management concept.

T. J. Peters and Waterman (1982) reflected their concerns involving strategy and structure. The concern points out that external forces do indeed influence the decision process and techniques used by management in order to cope and react to the exterior and its consequences. The authors were concerned with the major change in our culture which started approximately 1970 and continues into the present. The point being that businesses which were insulated from

the outside world are now superseded by the business being inundated by a fast-paced and ever-changing array of external forces. They indicate that in the view of today's leading theorists, everything is influx--the ends, the means, as well as the influencing forces of external change.

R. Scott (1978) clearly pointed out that internal organization dynamics are currently shaped, influenced, and pressured by external events. As indicated in this study by state and federal government intervention, the other side of R. Scott's grid reflects "rational" to "social." This concept takes in the spectrum of clear purpose and objectives for an organization to the other end, the social view involving value choices and styles. That includes social coalitions, past habit patterns, and other dynamics that influence personal or people's individual characteristics and styles as reflected by inter-personal leadership style.

The review of literature indicates that external and internal forces are contributing to the challenges of organizations. These forces, being brought to bear, influence the direction and perform-ance of hospitals within the United States. The review has also supported the concern involving a close and harmonious relationship between top management in health care, specifically the chief execu-tive officer and board members, as well as the chief board officer.

Further, an attempt has been made to identify the elements that contribute to that successful relationship. The elements include: mission or goal, values, and social and behavioral characteristics that are harmonious between the central influencing figures. This

study attempted to focus in on the social/behavioral techniques involved with interpersonal leadership style.

Relationship of Literature to Hypotheses

Hospitals are currently under great external pressures from government and commercial payers, as well as consumers with regard to cost containment and reduction of medical services within the community. This challenge has resulted in the greatest impact on hospital boards and administrations, as well as medical staffs (Grayson, 1978).

This study will provide an identification and concern to top management and governance of the hospitals involving the inter-relationship and importance of interpersonal leadership style in an organizational setting. The review of literature has indicated and substantiated the interrelationship and need for cooperation and respect between board governance and hospital administration.

The review points out further that the time constraints and pressures that are being brought upon these management bodies will continue to increase creating a more sensitive interrelationship. This favorable relationship can result in the overall success of the hospital corporation in the current turbulent environment.

The review of literature has supported the concern for a close interrelationship between top management of hospitals in order to be competitive and successful as health care enters the 1980s and the 1990s. The purpose of this study was to address one area of concern,

namely, identifying interpersonal leadership style and how that iden-
tification serves as a benefit in the hospital's mission or goal.

The Research Hypothesis 1

As a result of interpersonal leadership style being perceived by
each individual as a unique approach based on corporation position,
the following hypothesis is indicated. There is a difference of
importance placed on interpersonal leadership style (relationship
behavior versus task behavior) as perceived by hospital administra-
tors (chief executive officers) and chief board officers (chairmen of
the board).

The Research Hypothesis 2

A second factor that can contribute to a difference involving
the attitudes of perceived leadership style has to do with the envi-
ronmental determination, that being the size of the hospital in-
volved. The day-to-day functions of an administrator or chief execu-
tive officer involved in directing a small institution can indeed
affect the characteristics of interpersonal leadership style as com-
pared to a larger institution. Chief executive officers functioning
in a larger institution have job characteristics that are more
closely aligned to that of a chief board officer. The positions
resemble each other in regard to the composition of their roles
toward planning, coordinating, and external interests. The chief
executive officer of a larger hospital finds himself removed from the
normal operations on a day-to-day basis of authority and

responsibility that are usually experienced by a chief executive officer of a smaller hospital. Therefore, the chief executive officer of a larger institution functions primarily in a staff role that concerns itself with peer and committee activity, a role similar in responsibility and authority to that of a normal chief board officer. Therefore, the second hypothesis is in order. There is a difference of importance placed on interpersonal leadership style (relationship behavior versus task behavior) as perceived by hospital administrators of small hospitals as compared to hospital administrators of large facilities.

The Research Hypothesis 3

The chronological age of an individual involving personal background, family situations, and related responsibilities will also provide a relationship to interpersonal leadership style. Management attitudes toward effective leadership style have continued to become more sophisticated with regard to motivational behavior and communication skills. As a result of this evolutionary regard for leadership style and application, the age of the individual would be a factor in perceived leadership attitude.

Because of the limited size of the survey, it would be difficult to establish graduated points of years. Therefore, in order to clarify the chronological factor, this survey attempted to establish a dichotomy in order to reflect the possible difference or variation. Therefore, there is justification to review the third hypothesis. Chief executive officers under 50 years of age perceive a greater

difference of interpersonal leadership style (relationship behavior versus task behavior) than chief executive officers at 50 years of age or over.

The Research Hypothesis 4

Leadership style concepts and theories have changed over the course of a few years. Greater emphasis has been placed on the motivational influence of management. Effective communication skills have been articulated during this same period of time. Therefore, it would appear that formal education has a relationship to management attitudes involving leadership style. Further, the time element, when that formal education was acquired, will also impact the perceived leadership style or role. Therefore, the following hypothesis addresses this concern. Chief executive officers who obtained their highest educational degree prior to 1975 will perceive a greater difference of interpersonal leadership style (relationship behavior versus task behavior) than chief executive officers who obtained their highest educational degree during or after 1975.

The Research Hypothesis 5

Many top managers in the field of health care administration have entered the field at different times throughout recent history. The evolution of the health care industry has changed dramatically over the last 20 years. It would be important to identify the characteristics and relationship of years of experience with perceived interpersonal leadership style that has resulted from that impact.

Because of the rather turbulent environment that has been outlined in the review of literature, a comparison of leadership style by longevity would be appropriate. Once again, because of the limited sample size, it would be difficult to place the chief executive officers into any continuum of tenure; therefore, the established position of 10 years to make the determination of young or short-term CEOs was used.

Accordingly, the fifth hypothesis would concern itself with the following. Chief executive officers with less than 10 years of CEO experience will perceive a greater difference of interpersonal leadership style (relationship behavior versus task behavior) than chief executive officers with 10 years or more.

CHAPTER III

RESEARCH DESIGN AND PROCEDURE

The research was conducted in a field setting in order to provide a realistic environment in which to test for the effects predicted by the theory. All the facilities included in the study are engaged in providing acute care institutional services to patients in their geographic locations. The purpose of focusing on short-term acute care facilities, specifically hospitals involved in health care and geographic locations restricted to state influences as well as the random selection involving 50 institutions out of 200, are determined for the purpose of providing a natural control of extraneous variables. Considerable attention was given to sample selection in order to meet and fit within the characteristics sought as common criteria and base line characteristics.

Population

The chief board officers and chief executive officers were selected for the study in facilities located throughout the state of Ohio. These individuals are responsible for the governing and management of 50 acute care facilities. The selection was drawn on the basis of size of the hospital as outlined. The population contained two subgroups for each hospital; specifically, chief executive officers and chief board officers. Geographic location was not a factor with regard to the random sampling selection.

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Currently, there are 200 acute care hospitals functioning within the state. The sample groups were determined by establishing a dichotomy consisting of hospitals of 200 beds and less and those of 300 beds and greater. From those two categories, a random sampling was used to select 25 facilities from each grouping. Hospitals of 201 to 299 beds were removed from the study for the purpose of more accurately reflecting the two categories to be tested. Primarily, the sampling consisted of chief board officers and chief executive officers, all who are currently involved in directing hospitals in the state of Ohio. The responses reflect the viewpoints of administrators and chief board officers in all types of settings: regional medical centers, rural hospitals, and teaching hospitals, as well as small and large facilities.

Sampling Technique

Currently there is a total of 200 hospitals functioning within the state of Ohio. The research proposal was processed with a random sampling technique.

The Ohio Hospital Association, located in Columbus, Ohio, served as a reference for the profiling of the institutions. The hospitals in each category were selected on a random sampling basis in order to determine the candidate facilities to be interviewed. A total of 25 hospitals in the 200 bed or less category was selected from a possible 68 institutions. The 25 hospitals for 300 beds or greater were selected from a base of 35.

The hospital profile information used was received from the Ohio Hospital Association identifying Ohio hospitals from a 1984 American Hospital Association handbook. It was used as the basis for the hospital selection. The hospitals that were involved in the population base had the following characteristics. First, it fell into one of two categories, that of 200 beds or under or 300 beds or greater. Second, the facility was a not-for-profit institution. Third, it was an institution that was not state sponsored nor had a religious affiliation. The reason for this consideration was in order to ensure consistency with regard to the selection and relationship between the chief executive officer and the chief board officer. After the facilities had been identified as possible candidates based on the above criteria, the facilities were then numbered in order. The random sample selection process was obtained from a technique outlined in Foundations of Behavioral Research (Kerlinger, 1973). After the candidates were selected using the random table, each of the facilities were identified and listed into the two categories of under 200 beds and 300 beds and over.

Therefore, this study encompassed 50 hospitals out of a total population base of 200. The two top management positions were contacted at each facility. The response activity totaled 72%.

Instrumentation

Two instruments were used to collect the needed data and test the research hypotheses. The first is the Leader Adaptability and Style Inventory-Leader Effectiveness and Adaptability Description

(LASI-LEAD) used to classify managerial behavior into one of four leadership styles. The second, the Individual Profile Instrument, a self-developed questionnaire, was used to identify individual characteristics about each respondent.

Leader Adaptability and Style Inventory-Leader Effectiveness and Adaptability Description

The first instrument used is the Leader Adaptability and Style Inventory-Leader Effectiveness and Adaptability Description (LASI-LEAD), a proven technique that compiles results on an interval level data base. The Hersey and Blanchard (1974) survey questionnaire provides a reliable document in order to test and evaluate the participants and removes the need for any major revision for the purpose of this study. Further, it is economical, easy to use, and score.

The questionnaire consists of a series of 12 scenarios. In each, the respondent has the option to choose one of four suggested answers. The dilemma or situation always requires an action or decision thus forcing the respondent to reflect an opinion of his or her value structure on that particular problem.

Green (1980) verified that the leadership model instrument, developed by Hersey and Blanchard (1974), classifies managerial behavior into two categories:

1. Task behavior: The extent to which a manager engages in basically a one-way communication or conversation by explaining what a subordinate should do as well as when and where and how the tasks are to be completed.

2. Relationship behavior: The extent to which a manager engages in a two-way discussion or communication with his subordinate by providing social and emotional support as well as psychological support and motivation.

The categories are subdivided into four leadership styles. The four styles are delineated into low task and high relationship, low task and low relationship, high task and high relationship, and high task and low relationship. These four categories are compared on a matrix of four quadrants that reflect either a low or high relationship behavior as compared to a low or high task behavior.

Reliability

Reliability is the degree to which a test consistently measures whatever it was intended to measure. Therefore, the term reliability reflects a durable outcome of test results from experiencing similar or like conditions in a retesting situation (Gay, 1981).

The stability or reliability of the style scores was determined by administering the LASI-LEAD twice to 88 managers enrolled in graduate classes. The two administrations were approximately 6 weeks apart. The results reflected the following: 65 managers, or 75%, maintained their dominant style across the 6-week interval. The strength of the relationship between the two administrations was moderately strong. The contingency coefficient was .71.

The stability of the alternate style for the same manager respondents were found to have a distinctive alternate style at both administrations. Of these 79 respondents, 56 managers, or 71%,

maintained the same alternate style across the 6-week interval. The strength of the relationship was moderate. The contingency coefficient was .71 (Green, 1980).

Xerox Corporation has also found this instrument to be highly effective in the application of middle management evaluations. Xerox Corporation has used this instrument in the evaluation of their management team since 1974 and found it to be effective in evaluating the attitude and identification of leadership styles (Gumpert & Hambleton, 1979).

Validity

Validity, simply defined, is the degree to which a test actually measures what it is supposed to measure (Gay, 1981).

Validity may best be analyzed by considering two distinct classification categories: logical and empirical. Logical validity includes face and content validity. Empirical validity represents the most critical dimension of the technical characteristics of an instrument. The following supports the logical and empirical validity of the LASI-LEAD instrument.

Logical validity. The face validity of the LASI-LEAD is best established by directly reviewing the items. In each item the description aptly depicts one of four maturity states and requires the respondent to select a course of action which most closely describes his or her behavior. The conclusion, of course, is then analyzed and scored with regard to the style type and effectiveness. The content

validity of the LASI-LEAD emanates from the procedures employed to create the original set of items. Several prime interest groups were contacted to provide meaningful input. Structure interviews and discussions were conducted by organizational development experts with managers, expert managerial consultants, and followers. The item eliminations and revisions were based upon the appropriateness of item content and the extent to which the item represented the corresponding aspect of the Situational Leadership Model (Green, 1980).

Empirical validity. The instrument was evaluated with the correlations involving the demographic/organismic variables. The Pearson product-moment and point-bi-serial coefficients were used in the evaluation. The results indicated the relationship between the LASI-LEAD scores and the demographic/organismic variables were generally low, indicating the relative independence of the scales with respect to these variables (Green, 1980).

The dimensions of the LASI-LEAD were examined using a modified approach to factor analysis. The survey instrument was carefully constructed as a training instrument to measure four styles, a confirmatory approach was utilized rather than the conventional exploratory approach.

In light of the complexity of the construct being measured, the modified factor analysis findings are deemed to be satisfactory. The responses of the managers clearly supported the four purported style dimensions of the instrument and, as a result, the LASI-LEAD is characterized by established factorial validity (Green, 1980).

The LASI-LEAD provides a succinct and easy to follow format. The briefness of the questionnaire, coupled with the accuracy, lends a form to be easily responded to by the participants--an important feature that is required in order to promote a desirable response rate.

Self-Developed Questionnaire

An individual questionnaire was attached to each survey instrument and asked for the participant's personal profile. The areas of concern addressed age, experience, and formal educational background. The specific categories in the individual profile questionnaire reflect: "under 50 years of age" and "50 years of age and over," "less than 10 years" and "10 years or more" of experience in the position of a CEO/CBO, and "highest degree obtained prior to 1975" and "highest degree obtained in 1975 and after."

In order to determine the clarity of the self-developed questionnaire, a pilot study was administered. This pilot study involved 10 randomly selected hospitals following the above format. The pilot study offered two purposes. First, the study helped the researcher to determine if the instrument could be easily read and understood. Second, it enabled the investigator to interpret the data and prepare formats for the tabulation to be presented in the study. The questionnaire, with a cover letter, was sent to each of the facilities identified in the pilot effort. The results of the 10 pilot hospitals were used in the final computation of data as the data collection system had been validated.

Design and Procedure

The Ohio Hospital Association provided the proper name and mailing address of each chief executive officer and chief board officer of the selected hospitals. The acceptable response rate was produced by an initial telephone contact with the executive secretary at each facility to identify the credibility and purpose of the study. Following the initial telephone contact, a cover information letter (Appendix A or B) along with the survey instrument was mailed separately to each CEO and CBO in order to remove any influence one may have on the other. One cover letter (Appendix A) was sent to the CBOs selected for the study and the other (Appendix B) sent to all CEOs selected for the study. The cover letter indicated that the information would be held "confidential" and the results would be published in an aggregate comparison only and would be made available to each of the participating locations upon completion of the study. The letter indicated that each survey instrument would be coded in order to ensure the identification of participating facilities. Further, it emphasized the need for cooperation and participation by the key positions of the management team and closed with an offering to share the aggregate results with each of the participants. Enclosed with the letter was the instrument developed by Hersey and Blanchard (1974) entitled Leader Effectiveness and Adaptability Description as well as the Individual Profile Questionnaire. A stamped, self-addressed envelope was provided for the convenience of the participant.

Follow-up Procedures

A follow-up telephone request was made to each of the CBOs and CEOs of the hospitals who had failed to respond within the time frame of 1 month. After the expiration date, as a result, phone calls were made to encourage participation by each of the selected participants.

The proposed survey time frame was over the course of 3 months. The follow-up telephone request followed in approximately 4 weeks from the original mailing as a result of compiling the returning questionnaires and identifying the locations of individuals who had not responded. The follow-up telephone request urged each individual to complete the questionnaire that had been mailed.

Survey Process

The survey feedback process included the following considerations and enhancements.

1. The process provided a way in which top management members could examine their leadership style in an organized manner.

2. The survey assessment provided the individuals an opportunity to analyze and evaluate their function in a way that is characterized by low threat inasmuch as the results do not indicate a proper or improper approach to leadership style.

3. The process resulted in identification of a specific leadership style and offered each individual the opportunity to identify with or to determine a similar or dissimilar style in the tandem positions of management.

4. Base line data and analysis were generated that could be employed at a future time for comparison with future studies.

Data Analysis

The LASI-LEAD produces an assessed preferred leadership style and alternate styles. Respondents were classified by a leadership approach concept, being one of four basic leadership styles: low task/low relationship, high task/low relationship, high task/high relationship, and low task/low relationship.

The LASI-LEAD scoring instrument is characterized with 12 leadership style situations. Each question or situation provides four alternatives. Each alternative reflects an individual leadership style as identified in the four approaches or concepts mentioned prior.

The leadership style mean scores are derived from scores produced by the LASI-LEAD instrument. Each response is classified by numerical value in each of the four possible leadership styles. Group mean scores are calculated by averaging the leadership style values for each respondent in each subgroup: CEO, CBO, and CEO demographic subgroups. Style mean scores are then compared across subgroups for each leadership style.

The LASI-LEAD scores are determined predicated on interval level data and, as a result, the t test for independent mean scores was used in order to statistically analyze the following hypotheses. A matching technique was considered for the study. However, as a

result of the lack of dual (CBO-CEO) responses from each location, the process could not be applied.

Research Hypothesis 1

The first research hypothesis as stated in Chapter II is: There is a difference of importance placed on interpersonal leadership style (relationship behavior versus task behavior) as perceived by hospital administrators (chief executive officer) and chief board officers (chairmen of the board). This hypothesis is operationalized by using the LASI-LEAD mean score to identify each interpersonal leadership style. The leadership style preferences for the CBO group is compared to the CEO group. The dichotomy of CBO versus CEO is operationalized by analysis of responses to the demographic information and by job description. Data analysis of this hypothesis tested the mean score for CEOs versus the mean score for CBOs using a t test for independent means. An alpha level of .10 was used to determine statistical significance. Following the research procedure, when the data produced fall within the region of rejection, the null hypothesis that there is no difference between the mean scores of CEOs and mean scores of CBOs would be rejected and the research hypothesis would be accepted. Otherwise, the null hypothesis would not be rejected.

Research Hypothesis 2

The hypothesis that the variable of hospital size will reflect a relationship to the interpersonal leadership style of CEOs is

operationalized by calculation of separate mean score of inter-personal leadership style for CEOs of large and small hospitals as defined by Chapter II.

The dichotomy of CEOs of large hospitals versus CEOs of small hospitals was operationalized by analysis of responses to the demographic information and by job description. The leadership style preferences are compared to subgroups involving CEOs of 200 bed hospitals and smaller/CEOs of 300 bed hospitals and larger. Data analysis of this hypothesis tested the mean score for CEOs of large hospitals to the mean score for CEOs of small hospitals using a t test for independent means. An alpha level of .10 was used to determine statistical significance. When the data produced fall within the region of rejection, the null hypothesis that there is no difference between the mean score of CEOs of large hospitals and the mean score of CEOs of small hospitals would be rejected and the research hypothesis would be accepted. Otherwise, the null hypothesis would not be rejected.

Research Hypothesis 3

The American College of Hospital Administrators (1984), through their chief executive officer survey results, reflect that the median age of a CEO is 49.5 years old. Therefore, the following hypothesis would be appropriate. CEOs under 50 years old will have a leadership style different from that of CEOs of 50 years of age or more. The CEO mean score was calculated for each CEO subgroup.

The dichotomy of CEOs under 50 years versus CEOs 50 years and older is operationalized by analysis of responses to the demographic information and by job description. The leadership preferences are compared to subgroups involving CEOs under 50 years old/CEOs 50 years of age and older. Data analysis of this hypothesis tested the mean score for CEOs under 50 years of age to the mean score for CEOs 50 years of age and older using a t test for independent means. An alpha level of .10 was used to determine statistical significance. When the data produced falls within the region of rejection, the null hypothesis that there is no difference between the mean score of CEOs under 50 years of age as compared to the mean score of CEOs 50 years of age and older would be rejected and the research hypothesis would be accepted. Otherwise, the null hypothesis would not be rejected.

Research Hypothesis 4

The American College of Hospital Administrators' (1984) survey of number of years in the role as a CEO have been identified at approximately 8.5 years. The impact of education over this approximate period of time can also be a factor. Rather than challenge an individual's thoughts to the exact 8.5-year period, this study has selected a 10-year span to determine the possible educational relationships. Therefore, the following hypothesis is presented. CEOs receiving their highest degree before 1975 would exhibit a different leadership style than CEOs receiving their highest degree during or after 1975. The dates of highest degree were assessed from the demographic questionnaire.

The dichotomy of CEOs receiving their highest degree before 1975 as compared to CEOs receiving their highest degree during or after 1975 is operationalized by analysis of responses to the demographic information and by job description. The leadership preferences are compared to subgroups involving CEOs obtaining their highest degree before 1975/CEOs obtaining their highest degree during or after 1975. Data analysis of this hypothesis tested the mean score for CEOs receiving their highest degree before 1975 compared to the mean score for CEOs receiving their highest degree during or after 1975 using a t test for independent means. An alpha level of .10 was used to determine statistical significance. When the data produced fall within the region of rejection, the null hypothesis that there is no difference between the mean CEOs receiving their highest degree before 1975 and mean CEOs receiving their highest degree during or after 1975 would be rejected and the research hypothesis would be accepted. Otherwise, the null hypothesis would not be rejected.

Research Hypothesis 5

As indicated in Hypothesis 4, the American College of Hospital Administrators (1984) reflected that CEOs are currently experiencing a tenure of approximately 8.5 years. With those data available, it is appropriate to present the hypothesis as follows: CEOs with less than 10 years of CEO experience will perceive a difference in leadership style than those CEOs with 10 or more years of CEO experience.

The dichotomy of CEOs with less than 10 years of CEO experience compared to CEOs with 10 or more years of CEO experience is

operationalized by analysis of responses to the demographic information and by job description. The leadership preferences are compared to subgroups involving CEOs with less than 10 years of CEO experience/CEOs with 10 or more years of CEO experience. Data analysis of this hypothesis tested the mean score for CEOs with less than 10 years of CEO experience compared to the mean score for CEOs with 10 or more years of CEO experience using a t test for independent means. An alpha level of .10 was used to determine statistical significance. When the data produced fall within the region of rejection, the null hypothesis that there is no difference between the mean score for CEOs with less than 10 years of CEO experience compared to the mean score for CEOs with 10 or more years of CEO experience would be rejected and the research hypothesis would be accepted. Otherwise the null hypothesis would not be rejected.

RESULTS AND DISCUSSION

This chapter presents and discusses the results from the empirical investigation of this study. Five hypotheses, derived from the theoretical perspective on leadership style perception, were tested. Data were obtained from the original sampling of 50 hospitals located in the state of Ohio. The sampling process included 25 hospitals of 200 beds and less as well as 25 hospitals of 300 beds and larger. In that sampling, the chief executive officers (hospital administrators) and the chief board officers (chairmen of the board) were asked to participate.

The cooperation of the participants resulted in a 72% participation level. The response by chief board officers was equally distributed on the basis of 30 total responses to the survey request. This is reflected with 15 chief board officers of hospitals of 200 beds and under responding to the request, a 60% response rate. Further, 15 chief board officers of 300 and over bed facilities completed the questionnaires in their entirety, also a 60% response rate. This contributed to a total response of 60% with 30 chief board officers complying and cooperating in the study. Chief executive officers, contributing to the outcome of this survey, is reflected with 20 chief executive officers in 200 beds or less complying with the survey activity. This results in an 80% response rate. An 88% response was incurred with 22 chief executive officers

in 300 bed and more hospitals also cooperating in this effort. The total chief executive officer activity proved to be 84%, resulting in 42 chief executive officers involved in the research study.

The acceptable response rate was produced by an initial telephone contact with the executive secretary at each facility to identify the credibility and purpose of the study. Following the initial telephone contact, the cover letter (Appendices A and B) was mailed with an attached Leader Adaptability and Style Inventory-Leader Effectiveness and Adaptability Description (LASI-LEAD) questionnaire form as well as an individual profile form (Appendices C and D). This procedure resulted in an initial 65% response activity result. Six weeks into the study, all the candidates for participation who had not responded were contacted with a second telephone request. This supplemental activity contributed to another 7% of participation. The two efforts contributed to the over 70% response performance.

The amount of nonparticipating chief board officers totaled 20 (40%) out of the 50 candidates that were selected to participate in the research survey. In the subgroup of 300 beds or greater, 10 chief board officers failed to respond as well as 10 chose not to cooperate in the 200 bed and under subgroup. It should be noted that there appears to be no characteristic, whether it be size or geographic location, that lend any pattern to the nonparticipants in the category of chief board officers. Nonparticipants in the area of chief executive officers reflected a far smaller impact. This is documented with only 5 members of chief executive officers in 200

beds and under failing to respond with 3 members of 300 beds and over not participating. This results in, out of the 50 candidates that were selected to participate in the study of chief executive officers, only a total of 8 chose not to cooperate. Once again, the characteristics with regard to size of the facility and geographic location reflected no pattern and, therefore, appear to have had minimal involvement on the outcome of the study.

The LASI-LEAD instrument used in this study measured the four aspects of leadership behavior by producing scores for each leadership style. This was accomplished by having each of the participants complete the testing instrument. The instrument compiled an individual preferred leadership style profile by having 12 situations with four alternatives offered. Each of the alternatives reflected a leadership style as outlined in Figure 1. The total of the 12 situations in each instance provide a preferred leadership style in one of the quadrants.

Leadership style mean scores are derived from compiling the scores produced by the LASI-LEAD survey instrument. Each response is classified by numerical value in each of the four possible leadership styles. Group mean scores are calculated by averaging the leadership style values for each respondent in each subgroup: CEO, CBO, and CEO demographic subgroups. Style mean scores are then compared across subgroups for each leadership style.

Style 3 low task/ high relationship	Style 2 high task/ high relationship
Style 4 low task/ low relationship	Style 1 high task/ low relationship

Figure 1. Effective Leadership Styles.
From "So You Want to Know Your Leadership Style?" by
P. Hersey and K. Blanchard, 1974, Training and Development
Journal, 28(2), p. 28.

Demographic Categories

The primary purpose of this study was to research elite leaders in a hospital setting within the state of Ohio involving perceived leadership behavioral patterns. This effort proved worthwhile in identifying perceptual affects predicated on the basis of hierarchical context of the managerial position, size of the facility, time of formal education, age of the individual, and years of experience as a CEO.

A matching technique was considered for statistical purposes. However, it was not obtainable because of a lack of dual (CBO-CEO) responses from the individual facilities.

Findings for Hypothesis 1

The review of the data reveals the following. The first hypothesis test: There is a difference of importance placed on interpersonal leadership style (relationship behavior versus task behavior) as perceived by hospital administrators (chief executive officers) and chief board officers (chairmen of the board). The response to the LASI-LEAD survey instrument indicated no major differences in leadership style predominance between the responding CEOs and CBOs. Each group responded to the instrument resulting in Style 2 being indicated as the predominant style for each group with mean scores of 5.54 for the CBO group and 5.81 for the CEO group. The predominant leadership style is defined by the LASI-LEAD as that leadership style with the greatest score result. The remaining style groupings reflected a similar degree of agreement.

Using a t test for independent means to statistically test for intragroup differences, the resulting analysis indicates no support for the hypothesis. The null hypothesis was that no difference would be found between means of the style selections as derived by the LASI-LEAD. The resulting analysis by t test indicates a t value of 0.62 for differences in means for Style 1. The t values of -0.68, -0.19, and 0.78 were derived for Styles 2, 3, and 4, respectively. Since an alpha level of .10 with a critical value of 1.645 for a two-tailed test was chosen, the null hypothesis for all style mean score differences between CBOs and CEOs was retained. This research project did not support a conclusion of a difference between these two

groups. Specifically, the results reflect that chief board officers indicate a greater preference within the Leadership Styles of 1 and 4 than those of chief executive officers. Further, chief executive officers reflect a greater degree of preference for Leadership Styles 2 and 3 than chief board officers. However, the differences in each leadership style category did not exceed the critical value of 1.645.

The conclusions have been reflected in a composite form in Table 1.

Table 1

CBOs Versus CEOs, Mean Scores on LASI-LEAD
Leadership Styles

Group	Leadership Styles			
	HT/LR Style 1	HT/HR Style 2	LT/HR Style 3	LT/LR Style 4
CBO mean scores	2.07	5.54	3.75	0.64
Standard deviations	1.51	1.52	1.68	0.81
CEO mean scores	1.86	5.81	3.83	0.50
Standard deviations	1.25	1.84	1.76	0.66
t ratio	0.62	-0.68	-0.19	0.78
Null hypothesis rejected	No	No	No	No

Note. Alpha = .10. Critical value of 1.645.

Findings for Hypothesis 2

The second research hypothesis studied was that a difference in interpersonal leadership style of CEOs for large versus small hospitals would be found. Again, the LASI-LEAD instrument was used to determine the mean scores for the four style groupings. A t test for independent means was used with an alpha level of .10 to determine intragroup differences. For Styles 1 and 3 the t score did not exceed the critical value of 1.645. However, for Style 2, the predominant style found for both subgroups, the value of -2.38, did exceed the critical value. With regard to Style 4, the value of 1.90 also exceeds the critical value of 1.645. This represents a secondary leadership style and therefore is not a factor contributing to the hypothesis.

The results of the data review supports the research hypothesis with regard to preference within the leadership styles. This difference in degree, however, is supported only for Styles 2 and 4. The over 300 bed CEOs appear to perceive a greater degree of Style 2 characteristics than does the under 200 bed CEOs.

The conclusions have been reflected in a composite form in Table 2.

Findings for Hypothesis 3

The third research hypothesis predicted a difference in degree of interpersonal leadership style between CEOs under 50 years of age and those CEOs 50 years old or greater. The LASI-LEAD survey

Table 2

Under 200 Bed CEOs Versus Over 300 Bed CEOs, Mean Scores on LASI-LEAD Leadership Styles

Subgroups--CEOs	Leadership Styles			
	HT/LR Style 1	HT/HR Style 2	LT/HR Style 3	LT/LR Style 4
Under 200 beds	1.95	5.15	4.20	0.70
Standard deviations	1.32	1.56	1.94	0.71
Over 300 beds	1.77	6.41	3.50	0.32
Standard deviations	1.17	1.87	1.50	0.55
t ratio	0.46	-2.38	1.30	1.90
Null hypothesis rejected	No	Yes	No	Yes

Note. Alpha = .10. Critical value of 1.645.

questionnaire was used to determine the style and degree of style between the subgroups.

Using a t test for independent means with an alpha level of .10 to determine intragroup differences, t scores of 0.24, -0.31, -0.59, and 2.26 were derived for Styles 1 through 4. As with previous findings, three style differences showed no significant difference, those being Styles 1, 2, and 3. The Style 4 t score was 2.26 which exceeds the critical value of 1.645.

This analysis leads to the conclusion that the project findings do not support the research hypothesis for Styles 1, 2, and 3 with Style 2 being the preferred leadership style. However, for Style 4, not the perceived preferred leadership style, the finding indicates support for the hypothesis that CEOs under 50 years old perceive a greater degree of Style 4 characteristics than do CEOs of 50 years old or greater.

The results of this study do not indicate a relationship between age and preferred leadership style difference for the preferred leadership style, that of Leadership Style 2. The outcome did reflect a condition of preference involving CEOs over 50 years old, but that preference did not reflect a statistical difference as determined with that of CEOs of 50 years old or under.

The conclusions have been reflected in a composite form in Table 3.

<div align="center">Findings for Hypothesis 4</div>

The fourth research hypothesis indicated that there is a difference in degree of interpersonal leadership style between CEOs granted degrees prior to 1975 and those granted degrees during or after 1975. Using the LASI-LEAD survey instrument mean scores were established for each style group.

Using a t test for independent means, the following t score ratios resulted in -0.50, 1.60, -1.02, and -0.64 for Styles 1 through 4. Chief executive officers with their last degree prior to 1975 reflected a greater interest for Leadership Style 2. This is

Table 3

CEOs Under 50 Years Old Versus CEOs 50 Years Old and Over,
Mean Scores on LASI-LEAD Leadership Styles

Subgroups--CEOs	Leadership Styles			
	HT/LR Style 1	HT/HR Style 2	LT/HR Style 3	LT/LR Style 4
50 years of age or under	1.89	5.75	3.71	0.64
Standard deviations	1.21	1.86	1.62	0.67
Over 50 years of age	1.79	5.93	4.07	0.21
Standard deviations	1.32	1.79	1.98	0.56
t ratio	0.24	-0.31	-0.59	2.26
Null hypothesis rejected	No	No	No	Yes

Note. Alpha = .10. Critical value of 1.645.

reflected with a mean score of 6.08 as compared to 5.20. In the other three leadership style preferences, chief executive officers with a degree since 1975 held a greater preference than their counterparts.

As a result of each t score resulting from the t test failing to exceed the critical value of 1.645, the null hypothesis is retained for this subgrouping. There is no relationship established in this study between the date of last degree and interpersonal leadership style.

The conclusions have been reflected in a composite form in Table 4.

Table 4

CEO Last Degree Prior to 1975 Versus CEO Last Degree 1975 and After, Mean Scores on LASI-LEAD Leadership Styles

Subgroups--CEOs	Leadership Styles			
	HT/LR Style 1	HT/HR Style 2	LT/HR Style 3	LT/LR Style 4
Last degree prior to 1975	1.73	6.08	3.73	0.46
Standard deviations	1.16	1.90	1.68	0.63
Last degree 1975 and after	1.93	5.20	4.27	0.60
Standard deviations	1.29	1.56	1.61	0.71
t ratio	-0.50	1.60	-1.02	-0.64
Null hypothesis rejected	No	No	No	No

Note. Alpha = .10. Critical value of 1.645.

Findings for Hypothesis 5

The final research hypothesis stated that there is a difference between length of tenure in a CEO position and the degree of interpersonal leadership style. Subgroups were established for CEOs with less than 10 years experience and those with 10 years of experience

or greater.

A t test for independent means was used with an alpha level of .10 to determine the differences in the intraleadership style mean scores. Values of -0.46, -1.16, 1.00, and 1.45 were calculated for Styles 1 through 4. In the fifth and final hypothesis reflecting the leadership style preference of the participants, it appears that chief executive officers with less than 10 years of experience had a greater preference for categories of Leadership Styles 3 and 4. However, chief executive officers with 10 years of experience or greater reflected a greater interest in categories of Leadership Styles 1 and 2.

The null hypothesis is retained inasmuch as no t score exceeded the critical value. This study did not produce data to support any relationship between tenure in a CEO position and degree of inter-personal leadership style.

The conclusions have been reflected in a composite form in Table 5.

Summary

Seventy-two of the 100 participants responded to the study. The findings were that only two factors reflect a relationship to inter-personal leadership style; i.e., size of the facility and age of the individual. However, it should be noted that the age characteristic did not support a relationship to the preferred leadership style; i.e., a secondary leadership style preference only. The fluctuations of mean scores involving negative results are due to the scoring of

Table 5

**CEOs With 10 Years of Experience or Less Versus CEOs With
Over 10 Years of Experience, Mean Scores on
LASI-LEAD Leadership Styles**

Subgroups	Leadership Styles			
	HT/LR Style 1	HT/HR Style 2	LT/HR Style 3	LT/LR Style 4
CEOs with 10 years or less of experience	1.77	5.50	4.09	0.64
Standard deviations	1.17	1.67	1.65	0.71
CEOs with over 10 years of experience	1.95	6.15	3.55	0.35
Standard deviations	1.32	1.96	1.83	0.57
t ratio	-0.46	-1.16	1.00	1.45
Null hypothesis rejected	No	No	No	No

Note. Alpha = .10. Critical value of 1.645.

the LASI-LEAD survey instrument and does not reflect meaningful comparative results. Chapter V includes the conclusions that are drawn from these findings.

CHAPTER V

SUMMARY AND CONCLUSION

This chapter contains the review of the findings and addresses the limitations associated with the research, and considers the implications and potential applications of the theoretical perspective. It appears that the vantage point described by the CEO's and CBO's unique position in the organization hierarchy reflects a relationship to the manager's perception. However, the difference in the perceived interpersonal leadership styles could not support a statistical difference predicated on all five hypotheses as outlined. However, two areas were identified as contributing factors; i.e., size of the facility and age of the individual.

Limitations of the Study

Generalized Application

An apparent question which should be raised would be the limited application of the study's theoretical perspective of generalizing to other levels in the organizational hierarchy. As to the perception of subordinates' work attitudes; such as, CBO compared to CEO, it has been observed that in ranking work associates on attitude dimensions, managers at all levels make their determination on the basis of relative hierarchical levels (Miles, 1964).

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As in all empirical studies, additional limits arise in connection with the nature of the sample and variables used. The existence of particular significant perceptual affects in this setting do not necessarily preclude affects being different in settings with other management orientations and hierarchy philosophies. The dependent variables in this study in which the perceptual affects were demonstrated may not represent all the variables which could reasonably be expected to be affected by perception in other settings.

W. R. Scott (1972) observed differing perceptions of task. Anderson and Paine (1975) employed managerial perception of environmental uncertainty and need for change as variables in a perceptual model. The variables of this study deal with human resources and work attitudes. Task or relationship oriented variables might be more or less affected by these perceptual influences.

Survey Instrument

Hersey and Blanchard's (1974) LASI-LEAD survey instrument served as the initial test instrument. This particular instrument provides for 12 situational questions that require a multichoice answer response. The brevity of the instrument provided an attractive approach to the survey inasmuch as the challenge and time commitment was not extensive for the participant. On the other hand, the lack of comprehensive review limits the degree of information obtained from each of the participants. Therefore, future study within these categories would lend consideration to a more extensive review instrument and evaluation of the information.

Conclusions

The statistical data outlined in Chapter IV led to the following considerations and conclusions as applied to the five research hypotheses.

Research Hypothesis 1

There is a difference of importance placed on interpersonal leadership style (relationship behavior versus task behavior) as perceived by hospital administrators (chief executive officer) and chief board officers (chairmen of the board).

It appears that the statistical outcome has not reflected a difference in perception by position in order to support the hypothesis. Therefore, the results cannot support a difference between CEO and CBO interpersonal leadership styles for perceived Leadership Styles 1, 2, 3, and 4. Accordingly, this study could not support the hypothesis that an individual's position in the organization contributes to leadership style perception. As a result, the null hypothesis is retained.

As indicated in the review of literature, Chapter II, chief board officers and chief executive officers will be working in a closer relationship as a result of the turbulent health care field environment. This study reflects that interpersonal leadership style preference should prove to have a low probability of problem concern in the relationship between these two positions. The perceived leadership style of both of these critical positions in the hospital

hierarchy reflect a consistency in attitudes toward the significance of Leadership Style 2; that of, high task/high relationship. Middle management staff may derive from these findings that there is a high probability of compatibility between the CBO and CEO involving interpersonal leadership style.

Consideration must also be given to the consistency of the results being attributed to the homogeneity of the participants surveyed. Individuals who seek out hospital chief executive officer and chief board officer positions may have a preference for humanistic concerns, human services, and be people oriented as compared to holding commercial/industrial output and product oriented philosophies.

Research Hypothesis 2

There is a difference of importance placed on interpersonal leadership style (relationship behavior versus task behavior) as perceived by hospital administrators of small hospitals as compared to hospital administrators of large facilities.

In this study, the results have indicated that the perceived preferred leadership style; that of Style 2, reflects a significant statistical difference. This is indicated with a t value of -2.38, a level that exceeds the critical value of 1.645. Therefore, the research hypothesis has been supported and there is a statistical difference in Leadership Style 2.

It appears that the results of the survey indicate a documented difference in leadership style as reflected by chief executive

officers in the categories of hospitals 200 beds and under as compared to chief executive officers in hospitals of 300 beds and over. The chief executive officers of the larger institutions have substantiated a greater interest in Style 2, that of high task/high relationship.

This study points out that chief executive officers of hospitals of 200 beds and under also have placed their preference for Leadership Style 2 as well. However, the leadership style interest is more evenly distributed among the four leadership styles.

Hospital boards of trustees will find a greater probability of chief executive officers functioning in a staff position; i.e., in a hospital of 300 beds and greater viewing Leadership Style 2 with a greater preference than chief executive officers in hospitals of 200 beds or less.

This study supports the hypothesis that the size of the facility has a relationship to an individual's perception of interpersonal leadership style. Chief executive officers operating in facilities of 200 beds and under have placed less value on Leadership Style 2 than chief executive officers operating in hospitals of 300 beds and greater.

This study supports the concept that the functioning position of the CEO and the size of the facility do reflect a relationship to the preferred interpersonal leadership style. Therefore, it appears that CEOs operating in smaller facilities who are dealing with day-to-day functions as compared to CEOs operating in larger facilities who take the role of a staff responsibility, show a substantial statistical

difference of preference on interpersonal Leadership Style 2.

Accordingly, the individuals operating in the larger institutions place a greater emphasis on Leadership Style 2 than do CEOs in the smaller institutions. Style 4 of 1.90 also exceeds the critical value of 1.645. However, Style 4 has not been identified as the preferred leadership style and therefore does not contribute to the hypothesis.

This indicates that boards of trustees could very well find a high probability of difference in the intensity of interpersonal leadership style as applied by a new or incoming chief executive officer who is not currently functioning in a facility of 300 beds or higher. Further middle management personnel will also view a high probability of difference in interpersonal Leadership Style 2 as applied to the day-to-day operations of the facility by a CEO with small hospital experience.

Research Hypothesis 3

Chief executive officers under 50 years of age perceive a greater difference of interpersonal leadership style (relationship behavior versus task behavior) than chief executive officers of 50 years of age or over.

The study compared CEOs under 50 years old to CEOs 50 years and older. In the research survey results, an identified statistical difference in Leadership Style 4 was established. However, Style 4 was not the preferred perceived leadership style. Nevertheless, Style 4 reflects a difference at a t value of 2.26, one that exceeds

the critical value of 1.645. However, the preferred perceived leadership style, Style 2, did not reflect a statistical difference as a result of not exceeding the critical value. This research analysis has not been able to support a relationship between chronological age of chief executive officers and an interpersonal leadership style preference. Accordingly, the null hypothesis is retained.

It appears that the chronological age of CEOs does not reflect a relationship to preferred perceived leadership style. The study substantiates that individuals on both sides of the dichotomy value Leadership Style 2 with a similar level of preference.

The results of this hypothesis indicates that boards of trustees viewing candidates for the role of chief executive officer will find a high probability of Leadership Style 2 with chief executive officers having prior CEO experience regardless of chronological age. The outcome of this hypothesis also provides middle management with statistical support involving the high probability of consistency for Leadership Style 2 regardless of the age of the CEO. The results of this hypothesis will be beneficial for orderly change in executive management and will enable aspiring middle management candidates to identify executive leadership style preferences.

The consistency of leadership style preference could be a result of the similarity of formal education. The review of literature reflects that the American College of Hospital Administrators (1984b) indicates that 76% of their membership hold graduate degrees. This study not only reinforces that figure, but also has identified 81% of the chief executive officers have obtained graduate degree status.

Further consideration toward the compatibility outcome should be directed toward the LASI-LEAD survey instrument. The survey questionnaire was selected for its succinct and convenient application by the participant. As a result, the instrument had contributed to the high response rate. However, concern with regard to comprehensive findings should be considered.

A third factor for compatibility would be the high male ratio. Ninety-six percent of the chief executive officer respondents were men. Each of these points should be considered in the outcome of the study.

Research Hypothesis 4

Chief executive officers who obtained their highest educational degree prior to 1975 will perceive a greater difference of interpersonal leadership style (relationship behavior versus task behavior) than chief executive officers who obtained their highest educational degree during or after 1975.

The fourth hypothesis indicates that chief executive officers with their last formal educational degree obtained before 1975 as compared to chief executive officers obtaining their last formal degree in 1975 or later reflect a statistical t score of 1.60 difference in Style 2 which falls just below the critical value of 1.645. This would make this particular category of some interest inasmuch as the marginal area is relatively close. However, for purposes of this study, the research hypothesis has not been supported.

In this instance, individuals who have received their degree prior to 1975 as compared to individuals who obtained their latest degree since 1975 reflect little difference in perceived preferred leadership style. Therefore, this study fails to support the hypothesis that there is a relationship with the time of formal education and a preferred interpersonal leadership style.

This study cannot support the concept that the time of formal education has contributed to change in a preferred interpersonal leadership style as perceived by CEOs. This study indicates that formal education techniques are not related to an individual's views involving preferred leadership style preference over a 10-year period.

This study has not been able to support a relationship between the baccalaureate or graduate degree with a preference toward an interpersonal leadership style. It appears that preferred leadership style is not related to formal educational techniques prior or since 1975. Formal education of the candidates surveyed continue to reflect a similar amount of interest in Leadership Style 2, high task/high relationship.

Therefore, boards of trustees may view present or future chief executive officers, who have prior CEO experience, as having a high probability of Leadership Style 2 regardless of the time the CEO has obtained their graduate degree. Middle management personnel will also experience a high probability of Leadership Style 2 with chief executive officers at their present position or at a new facility, regardless of the time that chief executive officer has earned a

graduate degree.

Once again, the consistency of leadership style preference may be attributed to the following considerations: the high activity of formal education of the participants, the brevity of the survey instrument used in the study, as well as skewed representation of male respondents.

Research Hypothesis 5

Chief executive officers with less than 10 years of CEO experience will perceive a greater difference of interpersonal leadership style (relationship behavior versus task behavior) than chief executive officers with 10 years or more.

The study compared CEOs with less than 10 years experience with CEOs of 10 years experience and greater. Once again, the study has not been able to substantiate a statistical difference. The critical value has not been exceeded in any of the four leadership styles. Therefore, the research hypothesis is rejected and the null hypothesis is retained.

The study shows no support for years of experience contributing to a change in attitude toward interpersonal leadership style. This study reflects that individuals holding CEO positions have not indicated any significant change in perceived preferred leadership style as a result of years of experience in the position of CEO.

Accordingly, this study has not been able to support that years of experience contribute to changing attitudes toward a greater degree of a preferred interpersonal leadership style.

Boards of trustees will find that individuals with prior CEO experience will reflect a high consistency of Leadership Style 2 regardless of years of experience. This study supports that boards of trustees, in evaluating current CEO performance or future candidates for the positions, will find a high probability of Leadership Style 2 in individuals regardless of their years of experience. Middle management personnel interacting with CEOs can also expect a high probability of consistency involving Leadership Style 2 regardless of the CEO's years of experience in that position. Further, middle management members whose expectations include administrative responsibilities may choose to use Leadership Style 2 for their review and consideration in determining leadership concept approaches.

Finally, the consistency of performance should address three points as outlined in the prior two hypotheses; i.e., high activity of formal education, brevity of the survey instrument, and the high population representation of male CEOs.

A point to ponder is, while desired changes in the philosophy underlying managerial behavior tends to be slow and subtle, there is the potential for more rapid and substantial change in behavior to be gained by increasing manager perceptual accuracy (Bennis, 1969).

Issues for Further Research

There are several areas which merit further research. These include: perceptual affects at other levels of the hierarchy besides top level managers and the affects of managerial perception on

managerial and organizational effectiveness. This could be viewed through a longitudinal study as well. Further, whether the emphasis is to be placed on research or simply improving applied managerial functions. It would be appropriate to indicate that greater emphasis on perception and its impact on individual behavior should be evaluated.

Summary

This study investigated the relationship of preferred interpersonal leadership style of chief board officers (CBOs) as compared to chief executive officers (CEOs) in hospital settings. Further, the study explored the comparison of preferred interpersonal leadership styles of CEOs in selected areas of position, size of facility, age of the individual, years of experience, and time of last formal educational degree. One hundred participants, 50 CEOs and 50 CBOs of hospitals, were surveyed in the study.

The interpersonal leadership style was identified using the four quadrant approach of leadership as reflected by Blake and Mouton (1964), Reddin (1980), and Hersey and Blanchard (1974).

The instruments used to collect the data were the Leader Adaptability and Style Inventory-Leader Effectiveness and Adaptability Description (LASI-LEAD) as well as a self-profile instrument. The Hersey and Blanchard LASI-LEAD survey instrument was used to identify and determine the four leadership styles. The self-profile was used to identify the participant's unique characteristics that include age, length of service, and time of last formal educational degree.

The related documents were distributed to 100 participants with a response rate of 72%. The LASI-LEAD survey instrument enabled the responses from each individual to be identified to the four leadership styles. The results were used to develop mean scores for each leadership style by groups of chief board officers and chief executive officers. Mean scores for chief executive officer subgroups involving size of facility, age of the individual, length of service, and time of last formal educational degree, were also obtained. The preferred leadership style mean scores for CBOs were then compared to the chief executive officers within the leadership style categories. The four leadership style mean score results were also compared to each of the chief executive officer subgroups.

Accordingly, five hypotheses were tested to identify a relationship between perceived interpersonal leadership style and the categories of position, size of facility, age of the individual, length of experience, and when the last formal educational degree was obtained.

A review of the study indicated no support for a relationship between interpersonal leadership style and an organizational position; i.e., chief board officers compared to chief executive officers. Further, there was no support for interpersonal leadership style relationships between chief executive officers' age, years of experience, and when last formal educational degree was obtained.

Finally, the study review revealed that there is a relationship between perceived leadership style and the size of the facility. The results support that chief executive officers in large facilities

view Leadership Style 2, identified as high task/high relationship,
as a style of greater importance than chief executive officers of
small facilities.

APPENDICES

Appendix A

Letter of Introduction to Chief Board Officer

March 26, 1985

Dr. Marcus Welby
St. Elsewhere Hospital
Willobee, Ohio   43658

Dear Dr. Welby:

I would like to ask your cooperation regarding a leadership style
survey involving chief board officers (chairmen of the board) as
well as chief executive officers of hospitals within the State of Ohio.

Enclosed you will find a survey form as well as a personal profile
questionnaire that will contribute to the survey. A similar package
has also been mailed to the chief executive officer of your facility
for his/her participation as well. I would like to point out that
the entire questionnaire and personal profile results will remain
totally confidential. You will notice that the survey document has
a code number at the bottom. That number is to identify your
participation in the survey. After the results have been tabulated,
the form will be destroyed and no reference will be made to your
individual response. Only the aggregate results will be available
and I would be happy to share that information with you upon
completion of the survey study.

I can assure you that your cooperation will only require approximately
10 minutes of your time; however, the results will be quite important
to the accuracy of the study. It is the intent of this study to
measure interpersonal leadership style. Further, I can assure you
that motivational behavior experts indicate that there is no single
best answers to this questionnaire. Rather, a preference toward an
individual style itself.

Please complete the questionnaire on an individual basis, only. Any
discussion involving your answers with others will dilute the affect
of the survey. Do not respond to the items as if they were part of
a test or in terms of what you think a leader or manager ought to do.
Respond to the items in terms of the way you think you have behaved
in the past when you were faced with situations similar to those
described or in terms of the way you think you would behave if you
were faced with each of the situations described in your position as
chief board officer. Respond to the items sequentially; that is,
do item 1 before you do item 2, and so on. Do not go back over each;
please stay with your original answer.

Thank you for your interest and cooperation.

Sincerely,

Nelson Alward
President

NA:ds

Appendix B

Letter of Introduction to Chief Executive Officer

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March 26, 1985

Mr. J. R. Hughing
St. Elsewhere Hospital
Willobee, Ohio 43658

Dear Mr. Hughing:

I would like to ask your cooperation regarding a leadership style survey involving chief executive officers as well as board chairmen of hospitals within the State of Ohio.

Enclosed you will find a survey form as well as a personal profile questionnaire that will contribute to the survey. A similar package has also been mailed to the chief board officer of your facility for his/her participation as well. I would like to point out that the entire questionnaire and personal profile results will remain totally confidential. You will notice that the survey document has a code number at the bottom. That number is to identify your participation in the survey. After the results have been tabulated the form will be destroyed and no reference will be made to your individual response. Only the aggregate results will be available and I would be happy to share that information with you upon completion of the survey study.

I can assure you that your cooperation will only require approximately 10 minutes of your time; however, the results will be quite important to the accuracy of the study. It is the intent of this study to measure interpersonal leadership style. Further, I can assure you that motivational behavior experts indicate that there is no single best leadership approach. Therefore, there is no right or wrong answers to this questionnaire. Rather, a preference toward an individual style itself.

Please complete the questionnaire on an individual basis, only. Any discussion involving your answers with others will dilute the affect of the survey. Do not respond to the items as if they were part of a test or in terms of what you think a leader or manager ought to do. Respond to the items in terms of the way you think you have behaved in the past when you were faced with situations similar to those described or in terms of the way you think you would behave if you were faced with each of the situations described in your position as chief executive officer. Respond to the items sequentially; that is, do item 1 before you do item 2, and so on. Do not go back over each; please stay with your original answer.

Thank you for your interest and cooperation.

Sincerely,

Nelson Alvard
President

NA:ds

Appendix C

**Individual Profile Questionnaire to
Chief Board Officer**

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INDIVIDUAL PROFILE QUESTIONNAIRE

Please complete the personal profile below:

The following information will be used and will remain confidential. After the results have been tabulated, the form will be destroyed and no reference will be made to your individual response.

AGE: Under 50 years of age [   ]   50 years of age and over [   ]

YEARS OF EXPERIENCE:

     In the position of
     Chairman of the Board: [   ]   [   ]

                                  Less than   10 years
                                    10 years   or more

FORMAL EDUCATION:

Highest degree obtained <u>prior</u> to 1975 [ ]	**Specify degree and/or concentration**
Highest degree obtained in 1975 or after [ ]	

Appendix D

Individual Profile Questionnaire to
Chief Executive Officer

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INDIVIDUAL PROFILE QUESTIONNAIRE

Please complete the personal profile below:

The following information will be used and will remain confidential. After the results have been tabulated, the form will be destroyed and no reference will be made to your individual response.

AGE: Under 50 years of age [   ]   50 years of age and over [   ]

YEARS OF EXPERIENCE:

    In the position of
    Chief Executive Officer: [   ]   [   ]

                          Less than   10 years
                           10 years   or more

FORMAL EDUCATION:

Highest degree obtained prior to 1975	[ ]	Specify degree and/or concentration
Highest degree obtained in 1975 or after	[ ]	

Appendix E

Leadership Adaptability and Style Inventory-Leader
Effectiveness and Adaptability Description
(LASI-LEAD) Questionnaire

Note. Questionnaire reduced to 93% of original size.

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