A PHENOMENOLOGICAL STUDY: LEADERSHIP COMPETENCIES OF ACADEMIC MEDICAL CENTER CLINICAL DEPARTMENT ADMINISTRATORS

by

Ronald Dearinger

A Dissertation Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Business Administration

UNIVERSITY OF PHOENIX

July 2011

UMI Number:

A PHENOMENOLGICAL STUDY: LEADERSHIP COMPETENCIES OF ACADEMIC MEDICAL CENTER CLINICAL DEPARTMENT ADMINISTRATORS

by

Ronald Dearinger

July 2011

Approved:

Darlene Hess, Ph.D., Committee Chair

Sharon Fountain, Ph.D., Committee Member

David Gary Tucker, Ed.D., Committee Member

Accepted and Signed: Darlene Hess 08/02/2011
Darlene Hess Date

Accepted and Signed: Sharon Fountain PhD 08/02/2011
Sharon Fountain Date

Accepted and Signed: 08/02/2011
David Gary Tucker Date

08/26/2011
Jeremy Moreland, Ph.D. Date
Dean School of Advanced Studies
University of Phoenix

ABSTRACT

Academic medical centers (AMCs) require department administrators to work not only within the university environment but also run a clinical practice. This qualitative, phenomenological study specifically asked the question to AMC clinical department administrators of what competencies are most relevant to successful job completion as the administrators meet the dual missions of the university and clinical practice. The Healthcare Leadership Alliance (HLA) listed almost 300 competencies in five domains that leaders in health care often possess. Emotional intelligence and social intelligence were also discussed as factors influencing leadership success. Clinical department administrators with at least eight years experience in the AMC environment participated from AMCs in Florida and Texas. Exploration of their perceptive responses was meant to facilitate further academic understanding of leadership competencies and may guide future hiring practices of health care administrative leadership. The results of the research concluded that AMC clinical department administrators rely heavily on social "soft skills." Soft skills are not as easy to measure as concrete business skills and many institutions disregard the importance of these competencies when choosing effective clinical department administrators. A new model should be created emphasizing social competencies that helps organizations hire effective leaders and helps individuals seeking such positions develop the competencies necessary for the leadership position.

DEDICATION

I would like to thank my wonderful wife for her support and devotion during the last few years as I pursued my dream of a doctorate in the field of business administration. I dedicate this dissertation to her sacrifice and unconditional love as she encouraged and championed my efforts.

ACKNOWLEDGMENTS

First, I would like to thank my dear friend, Steve Soboroff, who guided me on a journey of educational exploration. Without his direction I would never have pursued an intellectual path. Second, I would like to thank my family, children and stepchildren. Without the support of family, a man is nothing. I hope they learn from my experience and do not put off the pursuit of higher education until the end of their careers. Third, I would like to thank my mentor, Dr. Darlene Hess and committee members, Drs. David Gary Tucker and Sharon Fountain, who have guided me through this dissertation process. Their knowledge has been invaluable. Fourth, I thank the University of Phoenix for its selection of intelligent, competent instructors who taught the many leadership courses in which I learned more about myself and the subject of leadership than I thought possible. Fifth, thank you to my peers who have been on this sojourn with me. Finally, thanks to the men and women who participated in this research study. I learned many valuable lessons from all of them that I hope to carry into my own practice of health care administration.

Table of Contents

LIST OF TABLES

CHAPTER 1: INTRODUCTION

Factors determining organizational success include strategic planning, investments, product development, and marketing (Larrson & Vinberg, 2010). An organization's success also is related to the competency of the organizational leadership (Larrson & Vinberg, 2010). Quality leadership can promote effective outcomes of delivery and support organizational stability (Larrson & Vinberg, 2010). The health care environment has become increasingly complex (Stefl, 2008). Health care leadership must demonstrate sophisticated management talent. Outcomes of administrative and clinical management relates to competencies of workplace effectiveness (Stefl, 2008). The following pages explored leadership competencies relevant to academic medical center (AMC) clinical department administrators. Chapter 1 introduced observations identifying the need for the study, formulated the strategies of research method and design, and explained the study's contributing significance to social science. A conceptual framework, assumptions, and scope of the study were elaborated to promote deliberation of the importance of the study to the knowledge bases of academia and the health care communities.

Background

Academic medical centers require department administrators to work not only within the university environment but also run a clinical practice. Executing the two duties heightens the degree to which administrators must excel in proficiency. Froedtert and the Medical College of Wisconsin (2011) defined academic medical centers as partnerships between a medical school and its affiliated teaching hospital working in unison to provide patients and the community with high quality patient care, a place to conduct medical research, and a place to teach future physicians. Swedish (2009) said that academic medical centers perform service to the community by generating value and investing resources that advance the state of health care.

Academic medical centers are responsible for bringing together talented health care professionals (nurses, physicians, and support staff) who are the drivers of a sustainable health system (Swedish, 2009). Administrators may consider developing and refining leadership competencies to meet the dual commitments to the missions of academic medical centers. The dual commitments of a clinical administrator within an academic medical center are to educate, conduct research, and operate clinical centers, and to manage a clinical department.

Academic medical center clinical department administrators fulfill a leadership role in academic health care. The medical center's missions are to educate physicians, conduct meaningful research, and provide clinical services to the community (Christmas, Kravet, Durso, & Wright, 2008). Stakeholders in academic health care facilities include faculty and staff, students, state, and federal officials (Hall & Baker, 2003). Brouwers, Stacey, and O'Connor (2010) added that clinical practice stakeholders include not only clinicians, researchers, funders, and policy-makers but also patients. Academic medical center clinical department administrators, henceforth referred to as department administrators, are responsible for meeting the missions of the academic medical center and operating a clinical practice that meets the needs of all stakeholders.

Effective health care leadership is the compilation of achievements of many competencies within five disciplines of leadership as defined by the Healthcare Leadership Alliance. The five disciplines were discussed as domains of leadership competencies. The blocks of competencies included the domain of leadership, the domain of communication and relationship management, the domain of professionalism, the domain of knowledge of the healthcare environment, and the domain of business skills and knowledge (HLA Competency

Directory User's Guide, 2005). A list of the domains and competencies can be found in Appendix G.

Clinical health care administration is a specialized field of administration, requiring knowledge of health care and business duties and responsibilities. Leadership skills such as those of professionalism, communication, and relationship management are also components of health care administration (Bureau of Labor and Statistics, 2009; HLA Competency Directory User's Guide, 2005). The academic medical center is a specialized environment of health care with administrative responsibilities to the academic institution to meet the threefold missions of the university: education, research, and clinical practice (Meyer, 2006). Possession of general leadership competencies does not guarantee administrator success in the environment of an academic medical center. Tasked with expertise in both business acumen and clinical practice administration, a successful clinical department administrator and leader in an academic setting is likely knowledgeable of the nuances associated with the university and teaching hospital. Health care leadership must also be aware of responsibilities in communication, missions of research and education, and clinical care offered to the community (Plochg, Delnoij, & Klazinga, 2006).

Problem Statement

The problem on which this qualitative phenomenological study was based was one of hiring the wrong person for the job. The consequences of incorrect hiring decisions when filling upper management positions can be financially costly. Incorrect hiring decisions may also affect the organization from a production and customer service perspective (G. E. Calvasina, Calvasina, & Calvasina, 2007; Cohen, 1996). The general problem consisted of the costs of re-hiring, re-training, and acclimating new employees to organizational structure after a poor hire is replaced.

Costs associated with poor hiring decisions can be three times the annual salary of the employee in relation to work performance, client service, and legal issues (G. E. Calvasina, Calvasina, & Calvasina, 2007). Mitchell, Schaap, and Groves (2010) and Johnson (1995) stated that two major costs associated with employee turnover are the direct cost of termination (which may be between 93% and 200% of an employee's salary) and the recruiting and training of the hired replacement. Blencoe (2005) stated that poor hires cost companies in many ways such as the costs of severance packages, recruitment and assessment efforts (including the cost of re-advertising), and training the new hire. Other under-realized costs are associated with loss of production, sales, and customer satisfaction. Possible morale issues may also arise when competent employees have to increase each individual's workload to compensate for the poor hire (Blencoe, 2005).

The specific problem targeted academic medical center clinical department administrators who may be hired without proper evaluation of leadership competencies needed for effective leadership in both the academic medical center and the clinical practice. Clinical department leadership in academic medical centers can make the same hiring errors as other types of health care organizations or other industries (Thrash, 2009). The specific problem isolated two areas that may contribute to the general problem concerning appointment of clinical administration leadership to avoid making an incorrect hiring decision. One, clinical administrators hired from within are often promoted from lower level administrative positions that do not require the broader set of competencies needed for leadership at the higher ranks of academic medical centers. Charan (2005) stated that employees from specific operative areas are not necessarily equipped to lead the entire business. Two, as is often the case in chief executive officer (CEO) selection, clinical administrators hired from outside the organization often come

from health care or business backgrounds other than academic medicine. Individuals from outside the realm of health care are often ineffective in discharging the missions of the academic medical center (Charan, 2005). Employees hired from outside the organization are often chosen based on the individual's ability to do a specific job such as take companies in new directions or reconstruct the portfolio. Skilled restructuring abilities do not necessarily lead to the broader competencies needed for long-term leadership (Charan, 2005). The best approach to secure the most desirable person for the job is through examination of personal qualities and behavioral traits and judgment of the individual's decision-making abilities (Hiring the Wrong Person, n.d.). Competencies such as leadership style, communication style, and interaction techniques should also be considered (Hiring the Wrong Person, n.d.).

A gap in knowledge exists regarding the specific competencies clinical department administrators believe important to successful leadership of clinical department administration within academic medical centers. A search within the University of Phoenix Library for pertinent literature produced no existing peer-reviewed article in the ProQuest advanced search engine with the phrase "clinical department administrator" or "department administrator." The word "administrator" when combined with the phrase "leadership competencies" elicited four peer-reviewed article selections, none of them pertaining to administration within academic medical centers.

The current study was a qualitative study employing a phenomenological methodology. Qualitative research differs from quantitative research. When conducting quantitative research, research questions are narrowly focused and specific. The data is gathered and analyzed numerically "to test hypotheses, look at cause and effect, and make predictions" (Xavier University Library, 2009). When conducting qualitative research, the questions are broad-

spectrum questions and data consist mostly of words gathered from communications with participants. The inquiry of qualitative research is subjective (Creswell, 2002). Phenomenological research is a method of investigation attempting to describe a personal phenomenon from the perspective of the person experiencing the phenomenon. The current study was based on examination of how individual academic medical center clinical department administrators perceived the competencies needed to fulfill the role successfully. A phenomenological method and research design were appropriate because of the approach taken to garner understanding of individual perspectives of current leadership roles.

Purpose

The mission of a clinical department within an academic medical center is to educate and train future physicians, conduct meaningful research, and provide quality clinical care (Christmas, Kravet, Durso, & Wright, 2008). An academic medical center clinical department administrator's duty is to ensure that the mission of the clinical department is carried out in the most cohesive and successful way possible. When a department administrator cannot synthesize or coordinate the intricacies of this mission, the mission is not met and therefore unsuccessful. Plochg, Delnoij, and Klazinga (2006) explicitly discussed the need for academic medicine leadership to merge patient care, scientific research, and education instruction with community-wide clinical services.

The purpose of the current qualitative phenomenological study was to explore leadership competencies academic medical center clinical department administrators perceived as contributing to the success of the administrator to meet the dual obligations to the university's missions and the deliverables of a clinical practice. The specific population under investigation was clinical department administrators within academic medical centers in the United States.

Academic medical centers were any one of the 133 health centers in the United States accredited by the Association of American Medical Colleges (AAMC) (AAMC, 2010a). Demographic data among study participants included type and length of education, number of years in academic center administration, and number of years in one department within the academic medical center. Candidates with general competencies in business or health care administration cannot always function as leaders in clinical departmental administration in an academic medical center setting; therefore, exploration of specific competencies increases the knowledge base that can be applied to avoid future poor hiring decisions. This study was a vehicle of discovery to observe what current clinical administrators in leadership roles viewed as significant competencies important to academic medical administration.

Significance of the Study

Creswell (2002) offered a suggestion when exploring the significance of a qualitative study. Creswell advised ensuring the proposed study was designed for purposes of obtaining a deeper understanding of the problem. The National Science Foundation asked several questions when evaluating the scientific merit of qualitative studies. First, did the proposed study exhibit intellectual merit by advancing knowledge and understanding in the study's field? Second, did the proposal explore an original, innovative concept? Third, did the proposal promote or enhance the foundation for research and education? And fourth, did the proposal offer any benefits to society (NSF Proposal Processing and Review of Grant Proposal Guide, 2008, para. 4-5)?

Identification of leadership competencies necessary to department administrators could benefit executives in the executive's search for the most qualified department administrators. Identification of leadership competencies was meant to discover drivers of administrative

success that lead to fulfillment of the academic medical community's missions of higher education, research, and clinical practice. Outcome-based (or competency-based) education studies are supported as approved methods of discovery by the health care community's accreditation boards and professional certification institutions (Calhoun et al., 2008).

Exploration of leadership competencies necessary to department administrators enriched the scholarly community. Exploration provided a current record of competencies clinical department administrators in academic medical centers distinguish as leadership competencies essential for success in the role of department administration. The competencies studied were found beneficial in exercising responsibilities to the practice of medicine, research, and educational aspects of an academic medical center as well as the operations of a clinical practice. The competencies studied promised the greatest reward to stakeholders including patients.

Nature of the Study

A qualitative research design with phenomenological methodology was appropriate to explore leadership competencies found useful by clinical administrators in many of the 133 medical schools accredited by the Liaison Committee on Medical Education (LCME) (Liaison Committee on Medical Education Directory of Accredited Medical Education Programs, 2010). Creswell (2002) defined qualitative research as educational research dependent on the views of participants. Inquiry in the form of broad spectrum questions and collection of primarily textual data elicited data analyzing and thematically describing the words of study participants. Inquiry was conducted realizing that the interpretation cannot be separated from the person conducting the research. Ereaut (2007) added qualitative research is used to increase perception of individual or group "attitudes, behaviors, value systems, concerns, motivations, aspirations,

culture, or lifestyles" (para. 2). Qualitative insights facilitate informed business decisions, policy development, more accurate communication, and furthers research inquiry and endeavors.

The current study employed a phenomenological methodology. Morrissey and Higgs (2006) defined phenomenology as "the study of human phenomena, of things or events in the everyday world" (p. 162). The study of phenomenology as a science was introduced by the mathematician, Husserl (1859-1938) (Faÿ & Riot, 2007). The book the German philosopher wrote was called *Logische Untersuchungen* (1900-1901) (Sokolowski, 2007). Faÿ and Riot (2007) described phenomenology as a method aspiring to establish an authentic connection with the perception of consciousness, or life-view, which each person experiences in daily life. The sociologist, Habermas (1987) described a person's life-view, as one's life experiences that create one's competencies, attitudes, and practices. Creswell (1998) defined a phenomenological study as a researcher chronicling the perceptions of individuals about a phenomenon, attempting to describe the meaning of the lived experiences. Moustakas (1994) asserted that describing the participant's point of view as the person engages in the phenomenon is a principle goal of phenomenology (Wood, n.d.). Trochim (2006a) described phenomenology as a school of thought emphasizing and focusing on personal experiences. Phenomenology is the manner individuals employ to interpret the experienced phenomena (Trochim, 2006).

Ciborra and Willcocks (2006) pondered two phenomenological concepts. First, one phrase originally coined to describe the observer was 'I-Situation' (Ciborra & Willcocks, 2006). This phrase was supposed to signify the observer's relationship to the situation and subject; that the point of view of the observer could not be removed from the research. Hence, Ciborra and Willcocks (2006) argued that objectivity is nearly impossible to determine. To compensate for the inability to view phenomena objectively, the observations must be viewed from the

perspective of the person conducting the research. The second concept questioned, with regard to assessing research, was the concept of the 'situation' or 'state of mind' of the participant. 'Situatedness' was meant to account for the ongoing and emerging situations of both the environment and the inner position of the participant (Ciborra & Willcocks, 2006).

Phenomenologists are those researchers who study how people perceive reality and how people interact with environments, attempting to comprehend situations witnessed from the subjects' perspective. Webster's On-Line Dictionary states that most phenomenologists believe reality consists of objects and events as understood within the human consciousness. Morrissey and Higgs (2006) described the role of the phenomenologist as a scientist examining the life experiences of people and what events mean to individuals experiencing them. Morrissey and Higgs (2006) alluded that an important component of perceiving phenomenology as a legitimate science is viewing this form of study as a valid and justifiable method of understanding and gathering knowledge about human experience, or phenomena. In-depth interviews are conducted as a primary instrument of collection to obtain ample, expressive, and comprehensive data on (often) elaborate cultural issues (Burns & Groves, 1997; Miles & Huberman, 1994 as cited in S. Martin, 2009, p. 119). One methodological approach developed by Giorgi in 1985 was to collect thematic and structural data of participants' experiences or phenomena (Morrissey, & Higgs, 2006). Giorgi's approach reduced the data pool to only significant data and developed a structural framework for describing themes and arguments. The culminating model was one of "structural analysis, reduction, and theoretical development" (Morrissey, & Higgs, 2006, p. 165). D. W. Smith (2008) said that phenomenology as a discipline can be defined by the area of study, the methods used, and the results obtained. A traditional, classical approach to phenomenological design was used. A traditional approach as explained by D. W. Smith (2008)

included three distinguishable methods: (a) description of the experience as seen from the observer's experience (the description of lived experience); (b) interpretation of the experience through development of relevant relational and situational context; and (c) analysis of the phenomena.

A phenomenological methodology was appropriate for this study. Creswell (2002) stated quantitative research involved identification of variables and the formulation of a theory. A qualitative phenomenological method was more appropriate than a quantitative method because the research was exploratory not analytical. The intent of this study was to identify leadership competencies used by clinical department administrators. Identification of competencies was achieved by interviewing current department administrators. Besides working in an LCME and AAMC accredited academic medical center, clinical department administrators must have portrayed the following characteristics: (a) the participants must have had an MBA, MHA or equivalent degree; (b) must have had at least eight years experience in health care administration; supervisory experience in an academic medical center environment; (c) must have held the rank of department administrator in the same department for a minimum of two years; and (d) must have been available to interview. The participants identified competencies the subjects found relevant to the job of department administrators that met the missions of the academic institution as well as the operations of a clinical practice. The administrators worked in the environments of clinical departments in academic health centers. The administrators discussed each individual's experiences related to meeting expectations and deliverables of academic institutions and clinical practices.

Triangulation of the interview was an essential process to increase validity and accuracy of research (Chen & Ozverir, 2004). Methodological triangulation was most appropriate for this

qualitative study. Shah, Habib, and Aamir (2010) remarked methodological triangulation is suitable "because it yields in-depth responses about people's experiences, perceptions, opinions, feelings and knowledge" (Shah, Habib, and Aamir, 2010. p. 237). Three methods used to validate the research were the secondary literature review; the primary source of the interview; and the primary source of review of researcher interpretation by study participants.

Data was analyzed to interpret the insights of the administrators in relation to each individual's experiences and perceptions. Participant narratives were intended to provide participants' perspectives related to the experience of acting in a leadership role, and supply detailed information about feelings and thoughts. The study investigated a living social experience, reflected on essential themes that characterizes the phenomenon, and used the art of writing and rewriting to describe the phenomenon. The study sustained an academic perspective to the phenomenon, and the research perspective was balanced by considering parts and whole (Van Manen, 1997). Results were presented in Chapter 4.

Research Questions

The purpose of this phenomenological study was to understand the perceptions, experiences, and related leadership competencies of department administrators as they met the dual roles of the job: meeting the missions of the academic medical center and operating a clinical practice. One central question was addressed. The central question was studied by researching four components of the phenomenon: the duties of the role of clinical department administrator, the competencies needed to meet the missions of the academic medical center, the administrator's role as business manager of a clinical practice, and the emotional and social elements of the role of clinical department administration.

Central Question

The central question was, "What competencies are essential for effective leadership of an academic medical center clinical department administrator?" Answering this question was achieved by breaking down the components of the question into four sub-questions.

Sub-Question One

What were the duties of the role as perceived by participants?

Sub-Question Two

What competencies were needed to meet the missions of the academic medical center?

Sub-Question Three

What was the administrator's role as business manager of a clinical practice?

Sub-Question Four

What emotional and social elements were perceived as necessary of the role of clinical department administration?

Theoretical Framework

The current study examined the leadership competencies used by clinical department administrators in academic medical centers. Academic administration crosses three broad realms of theory. Realms of theory are leadership theory, organizational structure, and leadership competencies. The theoretical framework on which this study was based included leadership theory (transformational theory and transactional theory) and organizational structure theory (administrative theory and bureaucracy). Leadership competency theory was also applied as leadership theory related to health care administration.

Leadership Theory

Leadership theory included examination of transformational theory and transactional theory; more specifically innovation-adaptation theory. Effective leaders in general appear to possess qualities of both leadership styles (Zagorsek, Dimovski, & Skerlavaj, 2009). Firestone (2010) found that leaders within health care professions also appear to possess qualities from both theories. Transformational leadership behaviors promote ideology motivating followers to commit to the goals of the institution (Bass, 1985; Nemanich, Keller, & Vera, 2007). The definition of transformational leadership was confirmed by Wu (2009) who stated that transformational leadership entails employing the dedication of employees by developing shared values and shared vision. Transformational leadership is particularly relevant in the context of managing change. Transformational leadership involves relationships of mutual trust between the leaders and the followers (Wu, 2009).

Zagorsek, Dimovski, and Skerlavaj (2009) called transactional leadership a form of contingent reward leadership. Transactional leadership refers to leadership mannerisms directed at defining employee tasks, identifying roles, and supplying physical or emotional rewards provided employees fulfill organizational commitments. Wu (2009) discussed transactional leadership as more inclined to offer employees some form of fulfillment of needs as compensation for labor and time. Need satisfaction fulfillment comes in the forms of salary increases, improved working conditions, or acknowledgment for a job performed well. The transactional leader clearly states goals and objectives, is perceptive of what motivates staff, and chooses fitting forms of compensation (Wu, 2009).

Organizational Structure Theory

The current study referred to the nature and scope of academic medical centers, universities and the state systems in which they operate. Theories of organizational structure included administrative theory and classical bureaucracy. Administrative theory is a "top-down" focus in which the emphasis is put on the occupation and not the worker. Scott (2003) stated administrative theory emphasizes managerial roles and endeavors to create general administrative beliefs to serve as guiding principles for an explanation of organizational actions. Wren, Bedeian, and Breeze (2002) defined the attributes of administration by saying that administration is responsible for verifying (a) all parts of the organization are unified to meet the same goals through action, discipline, anticipation, activity, and order, (b) staffing, systematizing and providing direction for the workforce, (c) providing means of positive communication between departments and external environment, (d) synchronizing of elements toward the common organizational goal, and (e) satisfying stakeholders including employees.

Bureaucracy theory, first realized by Max Weber (Olsen, 2006), stated that the attributes of modern bureaucracy included the theory's antiseptic approach to business with an emphasis on services and duties. This technical, impersonal approach has an equalizing effect, eliminating social and economic status through execution of an authoritarian system of control (Olsen, 2006). Olsen (2006) added that administration is founded on the principles of law and due process, accentuating conventional codes of appropriate conduct and a system based in rationality.

Leadership Competencies in Health Care

The Healthcare Leadership Alliance (HLA) is a coalition of six reputable health care professional organizations that accredit or legitimize medical schools and health care

professionals. The HLA presented a list of general leadership competencies that may be applied to health care professionals, separating the competencies under five domains: (a) Leadership; (b) Communication and Relationship Management; (c) Professionalism; (d) Knowledge of the Health care Environment; and (e) Business Skills and Knowledge. The HLA's list plus those of other academics and institutions was used to identify leadership competencies that academic medical center clinical administrators are encouraged to acquire for leadership success. Included were the inherent competencies of emotional and social intelligence.

The Healthcare Leadership Alliance defined the domain of Leadership as a list of competencies individuals portray to inspire people to excel individually or organizationally through the creation of a shared vision. Leadership competencies included managing change with the goal of attaining strategic objectives and efficacious achievement (HLA Competency Directory User's Guide, 2005). Garman, Butler, and Brinkmeyer (2006) added that in order for a health care administrator to be successful, the administrator is urged to further develop leadership skills in the areas of (a) crafting a convincing vision; (b) encouraging others to meet organizational goals; and (c) creating a positive work environment.

The Health care Leadership Alliance defined the domain of Communication and Relationship Management as a list of competencies individuals use to communicate clearly and succinctly with all stakeholders (internal and external customers). Garman, Fitz, and Fraser (2006) said the domain of communication and relationship management recognizes the need for leaders to understand the way people work and the need to efficiently and effectively use the knowledge to build high-performance working relationships. Communication competencies included establishing and maintaining relationships, and facilitating productive and practical exchanges with individuals and groups (HLA Competency Directory User's Guide, 2005). The

American College of Healthcare Executives (ACHE) added this domain includes "relationship management, communication skills, and facilitation skills" (ACHE, 2010, p. 3).

The Healthcare Leadership Alliance defined the domain of Professionalism as capable of aligning personal ethical standards with organizational professional standards. Professional ethical standards include accepting responsibility to patients and the community, orientation toward service, and understanding that learning and improvement are lifelong commitments (HLA Competency Directory User's Guide, 2005). The ACHE (2010) category added professionalism includes individual and professional ethics, expert and community involvement, and continual education, learning, and development.

The Healthcare Leadership Alliance defined the domain of Knowledge of the Healthcare Environment as an individual's capabilities of comprehending the nature of health care systems, and understanding the internal and external environments in which health care professionals work (HLA Competency Directory User's Guide, 2005). The ACHE (2010) added that knowledge of the health care environment includes understanding current trends and issues within health care. Discerning of health care personnel and command of health care standards and regulations are also important knowledge of healthcare competencies. Garman and Tran (2006) asserted knowledge of the health care environment can be organized into four areas of concentration: customers, staff, systems, and community.

The Health care Leadership Alliance defined the domain of Business Skills and Knowledge as capable of applying principles of business to include an understanding of how people and procedures interact and influence one another. This systems-thinking extends into the areas of "financial management, human resources, organizational dynamics and governance,

strategic planning and marketing, information management, risk management and quality improvement" (HLA Competency Directory User's Guide, 2005, p. 4).

The competency of emotional intelligence as defined by Goleman (1998-2004), a founding researcher of social science and emotional intelligence, is made up of five components: "self awareness, self-regulation, motivation, empathy, and social skill" (p. 94). Self-awareness is recognition of moods, emotions, and drives. Self-regulation is the element of controlling and redirecting negative impulses and thinking before acting (or not jumping to conclusions). Motivation is the force driving the need to achieve. Organizational loyalty can be a motivating factor. Empathy describes one's ability to understand and react to others in ways that demonstrate understanding. Social skill is the ability to persuade and lead change, establish communication, build and manage relationships (Goleman, 1998-2004).

Goleman and Boyatzis (2008) claimed social intelligence plays an essential role in management effectiveness. Seven categories characterize social competence. Empathy, defined as sensitivity, attunement to others, and organizational awareness are three of the seven categories. Two other competencies are knowing how to network within the organization, and influencing and appealing to others (persuading them to listen). Developing others through coaching and mentoring and providing inspiration (leading by bringing out the best in others) are important competencies. Teamwork by asking for input, building team support, and developing group cooperation is also an important social competency.

Definitions

Certain words were specific to the current study of leadership. Definitions offer background descriptions of words central to the study of competencies important to clinical department administration in academic medical centers.

Academic medical center (AMC): Any of the 133 accredited medical schools and the affiliated facilities that are affiliated with universities that make available health care services, medical education, and biomedical research (AAMC, 2010a; Deloitte, 2007, p. 3; Task force on Academic Health Centers, 2010).

Clinical department: A clinical department within an academic medical center meets the missions of the AMC. Physicians are faculty of the affiliated university; clinical services are offered to the community; education of medical students and other health care professions is conducted; and research is carried out for better understanding of health care (University of Florida Physicians' Clinics, 2009).

Clinical department administrator: Administrators have a wide range of duties. In an academic setting, a clinical department administrator reports to the chairperson of the department. Among many duties are providing leadership and supervision; developing and implementing plans (both strategic and tactical) for the betterment of clinical development, research achievement, educational excellence, productivity and community involvement; and acting as a catalyst for organizational change (Medical College of Wisconsin, 2010).

Leadership competencies: Horey and Fallesen (n. d.) described competencies as the knowledge, skills, abilities, and other traits that meet the requirements of leadership in supervisory, managerial, and leadership positions. Leadership competencies provide a depiction of responsibilities identified with leadership capacities (Fallesen et al., 2005; Horey & Fallesen, n.d.).

Missions of the academic medical center: The threefold mission of an academic medical center is to provide the community the center serves with medical education for medical and

health professions students, research, and health care service delivery (Williams, Matthews, & Hassan, 2007).

Perceived Organizational Support (POS): Rentao and Heung-Gil (2010) defined POS as the degree to which employees feel supported by the organization for which they work. The scientists found "perceived organizational support relates to organizational citizenship behavior and work performance" (p. 262). An example given by Rentao and Heung-Gil (2010) is of high POS. High POS is exemplified by harder-working employees and employees who want to help the employee's organization be successful.

Social intelligence: Green and de Ruyter (2010) used Vernon's 1933 definition to describe social intelligence. Social intelligence is one's aptitude to "get along with people in general, social technique or ease in society, knowledge of social matters, susceptibility to stimuli from other members of a group, as well as insight into temporary moods or underlying personality traits of strangers" (p. 203).

Assumptions

The first assumption was to reach the rank of department administrator many skills have already been mastered. Tavis (2007) theorized that success is built on the development and refinement of at least five competencies that give the manager a competitive advantage. These competencies can be one of eight Tavis (2007) considered important: (a) creativity; (b) dealing with uncertainty and ambiguity; (c) building effective teams; (d) innovation management; (e) motivating and inspiring others; (f) planning; (g) strategic agility; and (h) managing vision (p. 7). Management development of knowledge and skills is based on progressive job experiences and lengthy performance-based assignments that strengthen the manager's abilities.

The second assumption was to have longevity in an organization a "right fit" was probably established relating the individual and the organization. First, from the organization's perspective, Tavis (2007) said that most executives and senior managers have at least five to seven strengths on which they build careers; that these skills are seen by the companies for which they work as mission critical. Muirhead and Calvert, (2005) stated the vehicle individuals use to seek personal fulfillment and identity is work. Finding the right fit between a person's capabilities and work demands is often a challenge (Muirhead & Calvert, 2005). The organization may view the administrator as achieving the organization's vision. The administrator may finesse the strategic vision often constricted by the realities of physical limitations and transform the vision into work performance to achieve the organization's desired results (Harbour, 2009). Second, the individual may think that the organization supports his or her efforts. Rhoades & Eisenberger (2002) (as cited in Rahn, 2010) defined perceived organizational support (POS) as the employees' confidence that the organization is considering the employees' best interests. POS defines how much employees consider valued by the organization for their contributions and personal happiness. High correlations between organizational support and employee perceptions create environments encouraging feelings of trust, long-term obligations, and organizational identification among employees (Bass, 1985; Gerstner & Day, 1997; Graen & Cashman, 1975; Van Breukelen et al., 2006; Yukl, 2006 as cited in Rahn, 2010).

A third assumption was academic medical centers in the United States have similar organizational structures. Academic Medical Centers (AMCs) have multiple missions with which to contend as well as answering to the parent institution, one or more teaching and practicing hospitals, state, and local government entities (Deloitte, 2007). AMCs are

multifaceted networks structured to accommodate health sciences schools, partnered physician practices, research institutes, and other patient care enterprises (Darvies, 2010). Department administrators report to superiors, usually a department chairperson, who in turn reports to a dean or vice-president of the college of medicine within a larger university institution headed by a president and board of directors. Department administrators may also directly report to the dean's office .

Scope, Limitations, and Delimitations

The scope of the study focused on evaluating leadership competencies used by academic medical center clinical department administrators. Administration has components of leadership and management (Dubrin, 1997). Someone can be an effective leader without being a good manager because leadership involves possessing a vision of the strategic goals to determine what the organization or organizational unit can become. A very effective leader will elicit teamwork and cooperation from all of the people in the organization. Leaders have an understanding of the need to motivate people to accomplish the vision of the organization. Dubrin (1997) observed many leaders and concluded that effective leaders display a great deal of enthusiasm, are passionate, and inspire others to attain a high level of performance. Someone who is an exceptional manager is more formal and scientific. Dubrin (1997) stated a skillful manager uses a definitive set of rational instruments and procedures based on logical interpretation and analysis applicable to an assortment of circumstances. Exceptional managers often exhibit attributes such as increased emotional commitment and purposeful actions to achieve strategic goals. A major difference between leadership and management is that managers deal with the logistics and details of running a business whereas leaders deal with the human resource and customer service aspects. Organizational success relies on both forms of skills (Dubrin, 1997).

Limitations of the current research were based on the recommended general qualifications for clinical department administrators as posted by various academic institutions. First, related to education, the department administrator must have completed successfully and secured a master's degree in business, health, public administration, or related field (Job Description for Chief Administrative Officer, University of California, Irvine, n.d.) Second, related to on-the-job experience, the department administrator must have eight to ten years of health care administrative and supervisory experience in an academic medical center environment (Job Description for Administrator Department of Urology, Cornell Weil University, n.d.). Health care administration encompasses administration in academic medical centers, private practice, and private community hospitals. Many types of administration jobs are present in an academic medical center. Administration positions may be found in clinical departments, research oriented departments, the Dean's office, and other locations throughout the organization. The delimitations (boundaries) of the current study were limiting the study to clinical department administrators in academic medical centers, and exclusion of other types of administrators or locations. For purposes of this study, each department administrator was in each individual current position two or more years to demonstrate longevity of service. Erdogan, Kraimer, and Liden (2004) attempted to correlate organizational success and personal satisfaction as contributing factors of length of service. Employees are drawn to organizations that match the employee's principles and businesses are more likely to select candidates with corresponding values (Erdogan, Kraimer, & Liden, 2004). The outcome is a relationship that improves the likelihood of retention. "…individuals who are satisfied with their careers (Igbaria, 1991) and jobs (Griffeth, Hom, & Gaertner, 2000) are more likely to remain in the organization…" (Erdogan, Kraimer, & Liden, 2004, p. 322).

Summary

This phenomenological study focused on a problem in academic medicine in which clinical department administration is often incorrectly assigned to people lacking in the competencies necessary to perform the clinical department administrator's dual duties of carrying out the missions of the academic medical center and management of a clinical practice. An existing gap in knowledge about leadership competencies used by academic medical center clinical department administrators was established by a ProQuest database search obtaining zero results when using the phrase "clinical department administrator." A qualitative phenomenological research method was presented as the preferred method to conduct this study. Phenomenology allows the for discussion of a situation with a person experiencing the situation as part of his or her reality or life-view (Habermas, 1987).

The purpose of this phenomenological study was to understand the perceptions of academic medical center administrators regarding the competencies that make a successful leader in academic medicine. This study is beneficial to the health care industry by pinpointing competencies that signal success in department administration within academic medical centers. The current research study could be beneficial to the study of leadership in general as a scholarly record validating previous leadership studies and developing new insights into the study of leadership. The current study could be useful to the health care community as providing current research on AMC leadership that may further the advancement of academic medicine leadership to merge patient care, scientific research, and education instruction with community-wide clinical services (Plochg, Delnoij, & Klazinga, 2006).

The conceptual framework was developed to build a case for this study of academic medical center clinical department administrators. The discussion included the theoretical basis

for this investigation, definitions of relevant terminology, assumptions, scope of the study, limitations, and delimitations. The first part of the framework, the theoretical framework, was developed for purposes of evaluating this study's merit by grounding arguments in widely recognized leadership, organizational, and competency theories. The theoretical foundation on which this study was based is the leadership theories of transformational and transactional forms of leadership. The highly complex atmosphere of an academic medical center is confirmed by the complicated forms of organizational theories (Olsen, 2006; Scott, 2003; Wren, Bedeian, and Breeze (2002); administration theory, and classical bureaucracy. Discussed were the theories of transformational leadership (Bass, 1985; Nemanich, Keller, & Vera, 2007) and transactional leadership Zagorsek, Dimovski, and Skerlavaj, 2009; Wu, 2009).

The conceptual framework was also established by a study of leadership skills, abilities, and knowledge (competencies). The discussion revolved within the use of competencies by health care professionals. The purpose of generalized identification of competencies was to establish grounds for study as these competencies relate to academic medical center clinical administrators. Competencies targeted were those defined by the Healthcare Leadership Alliance. The Healthcare Leadership Alliance (HLA) is a coalition of six reputable health care professional organizations that accredit or legitimize medical schools and health care professionals (HLA Competency Directory User's Guide, 2005). The HLA presented a list of general leadership competencies that may be applied to health care professionals, separating the many competencies into five domains: Communication and Relationship Management; Leadership; Professionalism; Knowledge of the Health care Environment; and Business Skills and Knowledge (HLA Competency Directory User's Guide, 2005). Equally important to this

study of leadership was the identification of competencies generated by emotional and social intelligence as displayed by the successful leader (Goleman & Boyatzis, 2008).

Three assumptions presented when building the conceptual framework were based on how persons reach the rank of clinical department administrator within an academic medical center. One, the person has already developed many of the skills necessary for leadership (Tavis, 2007). Two, a "right fit" exists between the department administrator, the chairperson of the department, and the academic medical center to show continued employment within the department (Muirhead & Calvert, 2005; Tavis, 2007). Three, the 133 academic medical centers in the U.S. (AAMC, 2010a) have similar organizational structures that facilitate the multiple missions of the AMC, and the chain of command configuration (Darvies, 2008).

The scope of the study centered on an assessment of the leadership competencies evaluating leadership competencies academic medical center clinical department administrators believed important for successful completion of the administrator's duties to the missions of the AMC and the operation of a clinical department. Limitations on study participants included attainment of master's degree in business, health, public administration, or related field (Job Description for Chief Administrative Officer, University of California, Irvine, n.d.), and eight to ten years of administrative and supervisory experience.

Chapter 2 consisted of a review of literature presenting material relating to academic medical centers, the dual roles of department administrators, and leadership competencies pertinent to clinical department administrators. The literature review was made of two parts, the historical overview and current findings in research. The conceptual framework of the literature review was developed through explanation of the many duties of the department administrator and the institution and department to which the administrator reports and is accountable to

explanations of the competencies generated by leadership. The historical overview established the administrator's role as the position in an AMC clinical department. The current findings section discussed the theoretical components of leadership and identified leadership competencies. The sections provide current and germinal information about academic administration and leadership, constructing a picture of the leadership role of the academic medical center clinical department administrator and the phenomenon of academic medical center clinical department administration.

CHAPTER 2: LITERATURE REVIEW

Chapter 2 chapter provides a review of research and literature related to leadership competencies needed by clinical department administrators in academic medical centers. The historical overview offers a synopsis covering the unique environment of academic medical centers, funding sources, and the roles of the clinical department. The historical overview also focuses on the specific responsibilities and tasks of the clinical department administrator. Illustrated are the complexities of rules, regulations, and administrative flow with which clinical department administrators must adhere differentiating the AMC from nonacademic health care centers. The section of current discoveries provides applicable definitions of competencies offered by health care professional agencies based on the work of leadership and competency authors. Definitions of general leadership competencies lead to discussions of which competencies are seen as pertinent to clinical department administrators within academic medical centers. Other research specific to the nature of academic medical center leadership process is investigated. The literature review's scope encompasses the very broad academic medical center environment to the very specific roles of emotional and social intelligences to build a framework for discussion of which leadership competencies are necessary for the clinical department administrator within an academic medical center.

Documentation

The key terms within searches included *leadership, professionalism, communications, relationship management,* and *health care environment*. When combined with additional phraseology such as health care administrator, academic medical center, and competency, further searches resulted. One hundred ninety-two journal articles, books, and websites were used. One hundred sixty-five articles and websites or 86% of sources were from current literature dating

from 2005 through 2011. Twenty-seven articles and websites or 14 were from earlier studies, needed to establish a foundation of academic medical center department administrators and leadership competencies.

Title Searches, Articles, Research Documents, and Journals

Literature used in this review pertained to historical information on academic medical centers, the missions of the university, the funding sources, the role of the clinical department, and the clinical department administrator's leadership role within the clinical department. Current discoveries were gathered on leadership competencies applicable to the role of an executive administrator within an academic medical center. University of Phoenix's Library provided peer-reviewed articles, journals, and documents as the basis for the literature review. ProQuest and EBSCOhost were main databases searched for relevant material on which to build a framework for scholarly discussion. Key words and phrases were also used in search engines Google and Bing providing further websites and articles. Other sources from which information was obtained directly were university, college, or school of medicine websites.

Historical Overview

The academic medical center traditionally supports a tripartite mission (education, research, and clinical care) (Lale, Moloney, & Alexander, 2010). AMCs provide health care to underserved populations, yet maintain financial resources to stay in business (Lale, Moloney, & Alexander, 2010). Key stakeholders and decision-makers in the process ensuring the success of clinical departments are clinical administrators. The purpose of this phenomenological study was to examine the competencies necessary for a clinical department administrator within an academic medical center. The historical overview focused on the specific roles of the academic

medical center, the external support systems, the clinical department, and the administration of a clinical department within the academic medical center.

The Academic Medical Center and Its Missions

The mission of academic medical centers typically includes three distinct goals: providing patient care, educating future doctors, and acquiring new medical knowledge (Christmas, Kravet, Durso, & Wright, 2008). When asked to define an academic medical center, David Blumenthal, M.D., executive director of the Commonwealth Fund Task Force on Academic Health Centers in 2000, defined an academic health center as a medical school and related associated clinical facilities attached to an accredited university in the United States (Dentzer, 2000). Blumenthal added that the physicality of academic medical centers may include a hospital, clinical care centers throughout a community and even nursing homes owned by the clinical facility of an academic medical center. When questioned by PBS Online News Hour Host, Susan Dentzer, Blumenthal stated that the purpose of academic medical centers is to provide social goods: valued commodities that would otherwise be difficult for a community to afford because of their cost. Costly items included research (basic, clinical, and community health services research). Integral elements of medical education offered to medical students, health service and related professions, graduate physicians, and training in clinical disciplines are items not generally affordable in private health care settings (Dentzer, 2000). Included also is the provision for costly forms of technology and specialized health care with a commitment to serving all people including the indigent and poor that would likely not be able to have access to private health care (Dentzer, 2000).

Academic medical centers are affiliated to universities whose missions are scholarship, research, and service (University of Florida Mission Statement, 2010). Institutions often use a

variety of terminologies when discussing the academic medical center, the center's position within the university and community. As an example of diversity of terminologies, the University of Florida uses the phrases "school of medicine" and "health science center" (University of Florida, about the HSC, 2010, para. 1). Most academic medical centers provide educational and research opportunities for students in all facets of health care. Disciplines of study include those in "medicine, nursing, dentistry, health related professions, graduate studies and pharmacy" (University of Mississippi Medical Center Overview, 2010, para. 1).

Academic medical centers (AMCs) have a threefold mission that reflects the universities of which they are a part. M. L. Martin, Blevins, O'Connor, Pines and Srinivasan (2004) studied several organizations with members from multiple AMCs. M. L. Martin et al. (2004) defined the three general missions of academic medicine as educational support, advancement of research, and improvement of dissemination of patient care (M. L. Martin, Blevins, O'Connor, Pines & Srinivasan, 2004). Illustrating this point, the University of Mississippi Medical Center's missions are defined as the improvement of the circumstances of Mississippians through the education of future health-care professionals, directing research in the health sciences, and rendering innovative patient care (University of Mississippi Medical Center Overview, 2010). Many mission statements also mention concepts and ideals associated with the pursuit of higher education and rigorous standards of excellence. Values expressing the need to strive for professionalism, ethics, and leadership may also be identified in mission statements (University of Mississippi Medical Center Overview, 2010). These scholarly ideals are stressed within the missions of education, research, and clinical efforts to which academic medical centers are committed.

Educational mission. Teaching is a prime mission of academic medical centers. Most of the United States' 133 (Liaison Committee on Medical Education, Directory of Accredited Medical Education Programs, 2010) academic medical centers provide instruction. Instruction may be scholarly and or clinical, accorded to a broad variety of medical professional students seeking careers in fields of health care including medicine and health-related professions (University of Mississippi Medical Center Overview, 2010). Medical education normally involves a two part curriculum. The first part is academic class-room instruction and the second part is evidence-based clinical instruction (Florida State University, 2010). Academic instruction is often taught by clinical physician faculty often referred to as generalist faculty. This faculty participates in both health care delivery and teaching, filling vital roles in both the educational and clinical missions of academic medical centers. Generalist faculty often perform administratively developing curricula and pursuing medical education reform efforts (Thomas & Kern, 2004). For illustration, the NYU Langone Medical Center academic curriculum for surgical medical residents is a didactic series involving basic science lectures, service conferences, grand rounds lectures, and resident teaching development (New York University academic curriculum, 2010).

A clinical curriculum stresses technical skill development. Christmas, Kravet, Durso, and Wright (2008) noted that many academic medical centers (AMCs) present missions as equilateral triangles with sides denoting the university duties to conduct research, educate, and provide clinical care. As such, AMCs pledge to advance clinical and medical research and education, and administer medical services to the community. AMCs tend to have on faculty clinically excellent role-models that can train the next generation of health care professionals. Faculty tend to be dedicated teaching and to providing high standards of care to patients.

Christmas et al. (2008) performed a qualitative study in which they gathered data on emerging themes defining clinical excellence within AMCs. In the 24 Department of Medicine Centers for Excellence targeted in the study, eight themes were identified as portraying clinical excellence in academia. Concepts identified were "reputation, communication and interpersonal skills, professionalism and humanism, diagnostic acumen, skillful negotiation of the health care system, knowledge, scholarly approach to clinical care, and passion for clinical medicine" (Christmas Kravet, Durso, & Wright, 2008, p. 990). The themes identified by the Department of Medicine Centers correlated highly with the themes identified by the Accreditation Council for Graduate Medical Education (ACGME) as core competencies for leadership. Clinical skills such as diagnostic acumen and medical knowledge were important. To the individuals interviewed, ranking higher as components of clinical excellence were communication and interpersonal skills, professionalism and humanism Christmas et al. (2008) stated that medicine appears as an art; medicine is of high significance in benchmarking success in clinical practice. The study also revealed that emulating professionalism and humanism was the most efficient way to teach student clinical behavior. The consensus was that maintaining medicine as a public trust, preserving traditions of humanism and professionalism, and providing superior clinical care to the community, cultivation of clinically excellent faculty was crucial.

As an example of the importance of the teaching component of a clinical department, the University of California at Los Angeles, Davis School of Medicine psychiatric resident education extends up to four years. The first year's clinical educational objectives included nurturing of knowledge and skills in the areas of community health, elucidation, and authority with an emphasis on continuing education. Educational quality was achieved through an amalgamation of small group instruction, traditional lectures, problem-based, case-based, and

team-based instructional arenas (Bourgeois et al., 2008). As the physician-student (resident) progressed into year two, the curricula of clinical activities included an increasingly complex clinical load that incorporated an array of "advanced problem-based learning small group cases, subspecialty physical diagnosis sessions, high-fidelity simulator sessions, apprenticeships, physical diagnosis preceptorships, and epidemiology discussions" (Bourgeois et al., 2008, p. 251). Clinical instruction continues through year four, which is an elective year for residents interested in pursuing careers in academia, continuing the tradition of teaching and learning. Along with diagnostic and epidemiologic skills, students benefitted from the clinical curriculum. Most students benefitted from the instructional time dedicated to the development of interviewing, physician-patient communication, and physician-physician communication skills. Other skills developed throughout the fourth year instruction concentrated on growth in the areas of teamwork and problem-solving with other health care professionals. Fourth year students continued development of clinical reasoning, ethical decision making, and professionalism (Bourgeois et al., 2008).

Research mission. The research mission of academic medicine is twofold: one area is biomedical research, also called basic science or bench research; the other is clinical trials (Wang, Heinssen, Oliveri, Wagner, & Goodman, 2009). Bench research is experimental by nature and does not involve human subjects. Biomedical research is for the purposes of developing new technologies and techniques for both medical and clinical applications (Dunnick, 2000). Wang, Heinssen, Oliveri, Wagner and Goodman (2009) added that basic research brings about new understandings of disease mechanisms gained in the laboratory. To protect human subjects from exploitation when participating in experiments, the U. S. government created an ethics panel that wrote the Belmont Report (Belmont report: Regulations and guidelines, 2009).

Issues of human diversity, protection of human rights and basic ethical principles of using human subjects in research are outlined in the Belmont Report of 1974. Officially known as the National Research Act (Pub. L. 93-348), the Belmont Report was signed into law on July 12, 1974. This Act created the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. One duty of the Commission was to clarify the basic ethical principles of research involving human subjects to the community involved in biomedical and behavioral research. A second duty of the Commission was to ensure that this research was conducted ethically (Belmont Report, Office of Human Subjects, 2009).

Clinical trials are an important type of research conducted by academic medical centers and academic medical center investigators. The technology infrastructure of an AMC often supports a thousand clinical trials at a single institution (Chahal, 2009). Larson (2010) emphasized the importance of funding research as imperative to innovation and growth. Beginning in the 1980s fewer sponsors have committed financial resources to research because of a variety of challenges, among them moving clinical trials offshore and dissatisfaction of investigators with operational support by leadership (Chalhal, 2009). As a response, U. S. AMCs are becoming more competitive in the global clinical trial market by updating internal processing measures. One way to increase strategically competitive advantage is to offer increased support for clinical investigators. AMCs are implementing programs for the benefit of improving operational support for investigators in the areas of "execution time, safety, recruitment, tracking, compliance, data management, and many other aspects of a clinical trial" (Chahal, 2009, p. 42). AMCs are meeting research targets by applying strategies: one, increasing revenue support; and two, narrowing the focus of the research. As AMCs rebuild support for clinical trials and researchers, preparing for future trends is also suggested. Collaboration of

leadership and operations locally and worldwide are often instituted. Increased transparency and high standards promote ethical and safe practices (Chalhal, 2009). AMCs view clinical research as an important part of the research mission.

Clinical mission. Kelley (2009) defined academic health systems as those combining teaching, research, and clinical delivery. Academic health systems have been institutions that have provided high-quality health care to millions of Americans, including the uninsured. Most of these facilities are easily accessible to the majority of the American population (Kelley, 2009). The clinical mission of an academic medical center is providing medical care to the community the center serves (Riviello et al., 2010). The medical center provides physicians and a hospital generally provides the facilities in which the physicians medical group and the hospital acts as one entity providing patient care. The clinical experience provided by the joint instruction of the hospital and physician group is a major source for the education and practical experience to medical students. Residents, fellows, and other students benefit as well from the continuing medical education experience physicians offer as part of practicing medicine at the academic medical center (Kelley, 2009).

Sharing of clinical excellence is one component of the global clinical mission of AMCs. Universities also have a global responsibility to bring clinical care advances out of academic medical center hospitals and into the global arena of health care (Riviello et al., 2010). Many academic medical centers have partnerships with hospitals globally to provide access to western medicine for the global population and to provide a training ground for U. S. medical students. Many academic medical centers provide surgical services that rural communities would otherwise not be able to access. Such clinical experiences abroad can elicit relationship-building leading to the development of understanding, mutual trust and respect; an advocate that sustains

the partnership needs to be active at both institutions, but primarily at the western AMC; and predetermined ideas are suggested to be adapted to the needs of the host hospital dictating the course of action taken by the partner U. S. AMC. AMCs view clinical care as a mission reaching the local and global communities they serve (Riviello et al., 2010).

Funding sources. Academic medical centers produce clinical revenue, but other sources of funding come from federal, state, and private sources. Campbell (2009) discussed the various funding sources and the academic medical center's need to find alternative or supplementary funding during the recessionary period of the global economy. First, the largest source of financial support of life-sciences research in the United States is the federal government. Federal research grants constitute an average of 80 to 85% of total research revenues, and about one-third of all revenues (Campbell, 2009). A second funding source is pharmaceutical companies and the biomedical industry. Industry funds medical research, primarily clinical trials, and late phase research. Third, private families and nonprofit organizations support academic medical center research. Normally these advocacy groups are more interested in risky or research offering limited benefits to the public, such as research on lesser known diseases. Fourth, state funding supports research in academic medical centers. State funding, especially at large land-grant institutions that employ a significant part of the state's working population, provides support for research infrastructures for the biological sciences (Campbell, 2009).

Campbell (2009) warned research funding has been on the decline. Federal funding has been declining swiftly since 2007. The National Institutes of Health (NIH) saw an average annual budgetary increase of 3.4% from 1971 to 2003. From 2003 to 2009 there was no appreciable growth in the budget; in fact, taking into account the rate of inflation, there was a 13% decrease (Campbell, 2009). Industry funding is also declining as a result of several forces

including the recession and the generic drug market. Campbell (2009) offered several solutions for academic medical centers and academic medical center leadership in the face of decreased funding opportunities. To become more competitive, AMCs will have to instigate new strategic directions, and reevaluate how they conduct research. AMCs need to create new models that decrease dependence on federal dollars and increase self-sustainability while advocating for the core values of academic medicine (Campbell, 2009).

The Role of the Clinical Department

Crawford (2007) critically assessed the role of a clinical department from the point of view of the chairperson of a pathology department. Academic departments play multiple roles arising from one, the need to conduct vigorous research; two, the need to provide exceptional diagnostic expertise for all of the practicing clinical specialties and subspecialties; and three, the need to educate and train future health professionals. Hands-on instruction, or evidence-based medicine (EBM), is a long understood goal of academic clinical departments (Crawford, 2007). The goal of EBM is to advance patient care through the recognition and encouragement of clinical and educational practices that enhance quality, and purge ineffective or harmful practices (Crawford, 2007).

The Role of the Clinical Department Administrator

Srica (2008) described typical administrators as "analytical, pragmatic, rational, structured, and organized. Administrators are accustomed and trained to search for clear images, to plan, organize, control and evaluate projects in a well structured /*sic*/ and standardized way" (p. 190). Administrators plan, coordinate, direct, and supervise others (Top Executives, 2009-2010). Administrative executive positions within academic medical centers may be called many names including chief executive officer, chief financial officer, and even general manager (Top

Executives, 2009-2010). The role of a chief operating officer has several responsibilities, which may include overseeing other executives who direct the activities of various departments and implementation of the organization's guidelines on a day-to-day basis. A chief operating officer may also play a managerial role, working directly with personnel and managing daily operations. Competencies associated with administrative roles include: "communication skills; analytical skills; the ability to evaluate the relationships among numerous factors; leadership; self-confidence; motivation; decisiveness; flexibility; sound business judgment; and determination" (Top Executives, 2009-2010, para. 3).

A clinical department administrator has many functions. Among his or her responsibilities are operations, finances, human resources, facilities, information technology and security, compliance, quality control, strategic planning, fund raising, and community relations. As described by the Bureau of Labor and Statistics (2009), health care administrators are responsible for planning, directing, coordinating, and supervising the delivery of health care. Clinical administrators are specialists in charge of a specific clinical department.

Operations. The role of a clinical department administrator in an AMC often entails acting as the operations officer (Operations Administrator, 2010). Duke University Health System described the duties of the operating administrator as including policy interpretation, contingency development, decision making that directly relates to patient care, and ensuring correctness of communications between departments. The operating administrator also has responsibilities of acting as intermediary between patients and the health care system (Operations Administrator, 2010). Duke University offered a description of several specific daily activities and responsibilities performed by the operations administrator. Among specific requirements are establishment of departmental requirements such as space, equipment, supplies, and support

systems. Daily responsibilities also include problem solving during crisis situations that may include making judgment calls on direct courses of action, arbitrating conflicts, and making discerning decisions. Gathering and assessing data and presenting such data to department leadership are also a daily activity. Also critical to an operations administrator's role is the constant discovery process of ways to serve better the patient population while maintaining a healthy operating facility and personnel (Operations Administrator, 2010).

Financial. A clinical department administrator is responsible for tracking the financial viability of the department (personal e-mail from Jan Eller, Vice President's Office, University of Florida, received February 2010). Among the clinical department administrator's financial duties and responsibilities is ensuring that the department is in compliance with the university accounting rules. This also includes meeting federal and state rules and regulations. Duties also include accountability for accuracy of financial reports and information; development and maintenance of internal financing controls; implementation of all policies and procedures; meeting financial objectives; securing cash and fixed assets; ensuring a well trained fiscal staff. The administrator is accountable to the department chairperson and assists with the development of a department budget in agreement with the principles and guidelines designed by the financial services division of the institute. The administrator is often responsible for providing financial data to the department chair for strategic decision-making purposes. The clinical department administrator aids with negotiations, implementation, and monitoring of contracts with third parties (personal e-mail from Jan Eller, Vice President's Office, University of Florida, received February 22, 2010).

Personnel. One main duty of the department administrator is human resources, or personnel administration (Kelner & de Miranda, 2009). A suggestion to department

administrators is increased sensitivity to cross-cultural diversity within all areas of health care: faculty, staff, and patient populations. One challenge of leadership is to establish programs that increase awareness, understanding, and tolerance. Kelner and de Miranda (2008) performed an experiment assessing a cultural competency training program designed to improve the knowledge of health care providers and administrators on the importance of cross-cultural and diversity awareness. Cultural competency is defined as compatible skills, communication strategies, and policies delivered successfully and proficiently to diverse populations (Kelner & de Miranda, 2009). The participants in the study were assessed on improved understanding of diversity issues such as use of folk medicine, religion, attitudes on the use of science and medicine, perceptions of other cultures, culturally accepted principles and ideology, and gender-specific traditional duties. The study found that cultural training programs instituted by leadership not only improved the health care personnel's understanding and empathy for cultural diversity but also increased patient confidence in the doctor and facility (Kelner & de Miranda, 2009).

Clinical department administrators nurture the talents of staff as well. Federico and Bonacum (2010) examined the role leadership plays in the development of the talents of middle managers. This leadership role acts as a bridge supporting communications between upper management and direct contact with clinical staff. Most managers are promoted from within because of expertise in a clinical or technical field that does not necessarily give them leadership expertise. Leadership is responsible for providing the middle manager with the tools to become leaders so managers can improve safety and foster positive environments for staff. Federico and Bonacum (2010) suggested several approaches leadership can take to educate the middle

manager including working with a mentor; going to seminars; leading a smaller project within a major initiative; and using electronic media tools.

Facilities management. Facility, or space, management is a component of department administrator responsibilities. The facility is the physical space occupied by the clinic, administration, and research personnel of the department. When designing a new facility, the administrator acts as coordinator and liaison between hospital, physicians, architects, and other stakeholders. Issues of space include patient care demands and flow; crisis management; employee decisions; regulation and safety. Stansfield and Verner (2010) devised a 10 step plan that would ensure that a facility met the requirements of a department or clinic, to deliver quality care, and allow continuous growth and improvement. Collection and measurement of data are essential to all phases of the design process. The steps include (a) accounting for patient care flows; (b) understanding current performance metrics such as work measurement, asset measurement, and flow intensity; (c) assessing opportunities to increase efficiency without forcing employees to work harder or longer; (d) involving physicians in the design process; (e) driving team input via performance measurement and data; (f) facilitating execution of building or modifying existing space; (g) keeping the design simple which provides clarity of function and reduces costs, training and maintenance costs over the life of the facility; (h) designing for flexibility and growth; (i) designing for performance measurement for feedback on a timely basis; and (j) designing for future adjustments in patient flow, market trends, and other considerations.

Information technology and security. Proper interpretation of accurate data is a key component of the clinical department administrator's role. The department administrator is responsible for making decisions based on reliable data. Some data are retrieved via information

technology. Wright and Evans (2009) discussed the importance of effective management through information technology (IT) assessment. Wright and Evans (2009) applied a three-stage model to interpret and discriminate pertinent information received via IT. The initial stage called for the administrative manager to reflect on the information needed to perform effectively the management role. The second stage involved evaluation of information, and the last stage was a comparison f the other two stages. Through the appraisal of information obtained and comparing findings, the administrator can use IT data as a basis for forming managerial decisions. Wright and Evans (2009) further defined the evaluative stage by application of several criteria: (a) significance; (b) totality; (c) precision; (d) brevity; (e) correctness; and (f) capacity to take action.

Compliance. Adherence to compliance demands is a responsibility of the administration (Mellman, Jaffe & Dauer, 2009). Within a hospital and academic medical center, the administration primarily accountable for compliance is the chief executive officer, the compliance officer and the chief medical officer, and ultimately, the board. Compliance as defined by Mellman, Jaffe, and Dauer (2009) is following federal, state, certifying organizations, and payer rules and regulations. Most compliance issues are operational pertaining to lack of or incorrect documentation practices, paper flow or coding and billing practices; events within the realm of the administrator's domain. Documentation and coding issues can lead to quality of care challenges. Documentation of care not performed or provided may signify fraud, under treatment, or neglect. Inaccurate charting should be avoided as such charting can lead to misdiagnosis. Finally, insufficient documentation almost certainly leads to insufficient coordination of care (Mellman, Jaffe & Dauer, 2009, p. 23). Leadership plays a major role in

defining the organizational culture's need to create an atmosphere of compliance and integrity. A harmonious atmosphere leads to best practices and better quality of care.

One area of compliance is administrative accountability to the regulations of the Health Insurance Portability and Accountability Act (HIPAA) (Johnston & Warkentin, 2008). Administrative staff does not have direct contact with patients like medical staff, but administration is as responsible as medical staff for maintaining patient privacy and adhering to U.S. legislation. Administrators within public health care facilities are often more aware of compliance factors than private sector counterparts. Public sector employees face a large number of rules and regulations raising their awareness of high-level of organizational control. As such, public health care administrators understand the need for patient privacy and HIPAA compliance (Johnston & Warkentin, 2008).

Quality control. Raja, Deshmukh, and Wadhwa (2007) described leadership as the hospital system's driver encouraging quality management of patient care by continually offering opportunities for improvement in all areas of health care. The necessity of an organization to pursue quality delivery of products and services often requires the administration to develop quality award criteria. Practices improving quality control include "thought clarity, administrative style, motivation, trust, attitude, confidence, decision making and clinical competency" (Raja, Deshmukh &Wadhwa, 2007, p. 367). Areas in which leadership affects quality control include resource management, people management, process management, and customer satisfaction. Resource management is the management of data and information, supplies and equipment, technology, and financial affairs. Quality control can be measured by examining infrastructure and staffing. People management refers to the quantitative aspects of personnel development and management. Process management is indirectly affected by

leadership as implemented through human resources management. Quality control in the area of human resources is evident in development of skills, initiative, and attitude. Teamwork and staff training also reflect quality standards. Process management quality control issues include the management, evaluation, and improvement processes that ensure quality output. Quantitative aspects that can be examined are the design, operation, and improvement process that support the mission and stakeholders of the health care facility. The elements of customer satisfaction quality control measures include the quality of meeting customer expectations, staff responsiveness, and the relationship of the facility with the business's customers. This can be measured by considering such items as consumer confidence; word-of-mouth discourse, and complaint resolution. Quality control standards improve service quality as AMCs meet the needs and wants of patients (Raja et al., 2007).

Strategic planning. A long-term roadmap for a health care organization is evidenced by the development of an organizational strategy (Varkey & Bennet, 2010). Many tools are available for an organization to conduct a strategic analysis of the current state of affairs of the company. A SWOT (strength, weaknesses, opportunities, and threats) analysis is used to challenge assumptions and beliefs about the world inside and outside the organization. A SWOT analysis is used to (a) set reality-based assumptions and beliefs such as vision, mission, and objectives, (b) develop better or alter business strategies, (c) set priorities for operational change, and (d) improve organizational performance (Peterson, 2005). A SWOT analysis is an effective tool for any company wanting to identify strategic strengths and weaknesses and the companies effectiveness in the marketplace. Heizer and Render (2009) said use of a SWOT analysis maximizes opportunities and minimizes threats in the environment. This capitalizes on the organization's strengths and minimizing the weaknesses. The purpose of an analysis is to

evaluate what makes the company run most efficiently (strengths) and improve what is holding the company back (weaknesses). Outside threats can be turned to the company's advantage, or at least dealt with effectively. Through the use of strategic planning and development of clarity of purpose and vision, leadership can drive organizational alignment. This strategic planning can inspire employees to work together in synchronization to attain the organization's vision (Varkey & Bennet, 2010).

The Medical Group Management Association (MGMS) provided an assessment tool for leadership to use as a guide when evaluating performance of an academic clinical department's effectiveness in meeting the three missions of the academic medical center– patient care, teaching, and research. Fabrizio (2009) stated that management of an academic practice involves two elements: the unification of diverse cultures and interests, and accomplishment of departmental goals concurrent with meeting the goals of the academic medical center. The assessment tool is arranged to evaluate four distinct areas in which opportunities for practice improvement may exist. These areas are strategy, culture, and governance; business planning and financial control; physician and provider compensation; and marketing and business development. The tool asks leadership several astute questions. As an illustration, when assessing strategy, culture, and governance leadership may ask probing questions. Queries may involve mission, vision, and values statements and how to assess correctly critical issues facing the department (Fabrizio, 2009). Within the area of marketing and business development leadership asks a series of questions designed to align strategically the clinical department with the marketplace and to ensure that marketing campaigns are measured for success and return on investment. Fabrizio (2009) also stated that using tools such as the assessment list provided by

the MGMA can help the academic department leadership keep focused on performance improvement, a vital element of strategic planning.

Fund raising and community relations. Public relations officers within research universities must oversee the needs of a variety of stakeholders including faculty and staff, students, and state and federal officials (Hall & Baker, 2003). Hall and Baker (2003) studied public relations at 11 universities. Officers' use of strategic managerial characteristics and historical technical skills were observed. Hall and Baker's conclusion was that the organization that understands the business value of stakeholder input and public relations had successful community relations programs. Organizations with excellent public relations exhibited communication supported by top management, equal opportunities for women and minorities, and take into account the voiced critical concerns. Hall and Baker (2003) also concluded that the role of the manager was characteristically strategic. The manager reports directly to senior management. Among issues with which the public relations manager can assist are "researching of how key constituent groups think about the university, advising the president about building relationships with key constituents, sharing with other top administrators in the overall management of the university, and managing issues that present potential crisis situations" (Hall & Baker, 2003, p. 133).

Current Findings

While the historical overview established a foundation for the role of the academic clinical department administrator, the current findings established a basis for leadership competencies when fulfilling the duties of the role of the academic clinical department administrator. The current findings identified the competencies of leadership, and defined the roles of emotional and social intelligences.

Leadership Theory

A person can be a good leader without being a good manager (Helliwell, 2009). Leadership involves possessing a vision of the strategic goals to determine what the organization or organizational unit can become. A genuinely inspiring leader will elicit teamwork and cooperation from all of the people in the organization. The leader will have a grasp of what it takes to motivate people to accomplish the vision of the organization. Leaders often display enthusiasm and passion, inspiring others to attain a high level of performance (Dubrin, 1997).

Although the terms leader and manager are sometimes used interchangeably managers tend to perform functional duties (Hopen, 2010). Someone who is a great manager is often more formal and scientific (Dubrin, 1997). In his book, *The 10 Minute Guide to Leadership*, Dubrin (1997) stated that a great manager uses an explicit set of intellectual "tools and techniques" based on logic and reasoning and testing that can be applied in a variety of situations. One of the attributes of a great manager is that he or she involves more emotion and more careful acting to achieve objectives after defining the objectives. The difference between leaders and managers is that managers regularly deal with the "technical" aspects of running and organization. Leaders often deal with the "people" aspects. Both kinds of skills are necessary for organizational success (Dubrin, 1997). Two forms of leadership are explored that leaders may choose to employ.

Adaptation-innovation theory. Tubbs and Jablokow (2009) stressed the importance of leadership as the influencing force that guides/maneuvers others to attain the goals of the organization. Tubbs and Jablokow encouraged leadership to use the adaptation-innovation theory of leadership to develop creativity and generate idea-growth engaging employees. Adaptation-innovation is a measurable cognitive ability. The most common measurement tool is

the Kirton Adaption-Innovation inventory (Tubbs & Jablokow, 2009). Leaders are suggested to develop, practice, and exercise several competencies to achieve this style of management: creativity; development of a creative organizational climate; utilization of no-fault problem solving; utilization of the SCAMPER method (substitute-combine-adapt-magnify-put to other use-eliminate-rearrange); avoidance of paradigm paralysis; reframing; and application of creativity for organizational renewal (Tubbs & Jablokow, 2009).

Transformational leadership theory. Transformational leaders guide organizations through an evolutionary process so the organization can grow and change with the communities it serves (Swedish, 2009). Leadership is more than giving directions and acting as an authoritarian figure; leadership is about identifying direction, acting with purpose, and above all, acting ethically. Leaders tend to demonstrate desired behaviors by acting, talking, and making ethical decisions that they want followers to practice (Toor & Ofori, 2009). Transformational leaders demonstrate honorable character, show concern for personal conduct as well as that of others, and express ethical values as they pursue organizational vision (Toor & Ofori, 2009). Neufeld, Wan, and Fang (2010) noted a positive correlation between transformational leadership theory and leader performance. Ladkin (2008) said that the "beautiful" leader possesses three qualities: confidence in self, confidence in the vision, and confidence in delivery of the message. Honesty, adhering to ethical practices, and treating employees fairly are important components of ethical leadership (van Quaquebeke, & Eckloff, 2010). Respect employees and subordinates, noticing and recognizing positive behaviors, and acting in ways that convey respect are three values of respectful leadership. Respectful treatment should be reciprocated (van Quaquebeke, & Eckloff, 2010). This type of leadership is most highly desired by employees. A leader who leads morally acts morally. At times a transformational leader may use systems of rewards and

punishments to make sure that followers are accountable for the folowers' roles in the organization (Toor & Ofori, p. 535; Dearinger, 2010, Personal Leadership Statement, DOC732r).

Measurement Tools

The question of how tangible and intangible qualities are identified, assessed, and measured is often asked. As society becomes more aware of the need to meet certain criteria of performance, an increasing number of evidence-based models are generated; many targeting skills needed in specific fields (Stefl & Bontempo, 2008). Weiner (2009), using a scientific process of discovery, generated a list of 15 elements identifying a "culture of assessment" (p. 28). The process of discovery is unbounded. As these elements are addressed, the same questions and methods can be applied as new ideas are generated and the cycle of exploration continues. The 15 components of the assessment process Weiner (2009) identified are (a) identification of core competencies and goals; (b) ensuring everyone has the same definition of vocabulary; (c) involvement of stakeholders in outcomes; (d) the need for ongoing professional development; (e) supportive administration; (f) cost-effective and practical assessment plans; (g) regular, timely methods of assessment; (h) identification of expected outcomes; (i) program review methods; (j) inclusion of supporting programs in the assessment process; (k) assessment of general institutional effectiveness; (l) sharing results of the review; (m) administrative support through planning and budgeting; (n) acknowledging success; and (o) growth of the assessment process.

Identifying Competencies of Leadership

Professionals have recognized the need to institute evidence-based performance models Byrne, Schroeter, Carter, & Mower, 2009). Many types of professional organizations within

specific occupations have engaged in creating lists of competencies. Leadership should attain those competencies deemed pertinent to each leader's field of operation (Tubbs & Jablokow, 2009). Kaciuba and Siegel (2009) discussed the core competencies that the AICPA (American Institute of Certified Public Accounts) believes important for accounting majors. A teaching program based on case studies in which students apply principles of activity-based management and cost accounting was examined. The AICPA divides competencies between Broad Business Perspective category and Personal Competency category. Core competencies of accounting decision making identified and explained within the Broad Business Perspective category are Strategic/Critical Thinking; Resource Management; Marketing/Client Focus; Decision Modeling; Measurement; Reporting; Leverage Technology to Develop and Enhance Functional Competencies. Core competencies discussed from the Personal Competency category are Professional Demeanor; Problem Solving and Decision Making; Interaction; Communication; and Project Management (Kaciuba & Siegel, 2009, pp. 567-569).

An agency that gathered competency data pertaining to health care executives in all aspects of health care practice is the Health care Leadership Alliance (Calhoun et al., 2008). These researchers discussed how the Health care Leadership Competency Model (HLCM) – a competency-based performance model was derived. This model was created by the National Center for Health care Leadership (NCHL) in cooperation with the ACT (Calhoun et al., 2008). This model (Version 2.0) includes three domains– transformation, execution, and people– and 18 behavioral competency categories or constructs and 8 technical competencies. Each competency is rated on three to six areas of performance. An example is given for finances. This competency is rated on Level 1: Explains financial metrics and reports; Level 2: Manages budgets and assets; Level 3: Understands impact of reimbursement models; Level 4: Evaluates

financial analyses and investments; Level 5: Develops long-term financial plans. The logistical components of the HCLA such as populations assessed and analysis of benchmark data are reviewed.

Another health care performance model was created by the Health care Leadership Alliance. The Health care Leadership Alliance (HLA) is a consortium of six health care professional membership associations. The six organizations are American College of Health care Executives (ACHE); American College of Physician Executives (ACPE); American Organization of Nurse Executives (AONE); Health care Financial Management Association (HFMA); Health care Information and Management Systems Society (HIMSS); and Medical Group Management Association (MGMA) and the Association's educational affiliate, the American College of Medical Practice Executives (ACMPE) (Stefl & Bontempo, 2008). The discussion was a review of the history that led to the HLAs formation. The major force driving the model's creation was the push toward evidence-based professionalism for health care managers. The HLA model has five domains identifying more than 300 competencies (Stefl & Bontempo, 2008). The domains are (a) communication and relationship management; (b) leadership; (c) professionalism; (d) knowledge of the health care environment; and (e) business skills and knowledge. The framework the HLA used to develop the leadership model is the Dreyfus Model (Stefl & Bontempo, 2008). The Dreyfus model outlined five skill development stages: novice to expert. The HLA has recognized that while an administrator may be proficient in one domain, he or she may be a novice in another. The benefits of the HLA leadership model are many. The model provides a tool that functions in three ways: individual and organizational assessment; employee selection; or team development. The model can further adapt for use in academic programs, an example of which is the joint project by health care administration

graduate programs (Stefl & Bontempo, 2008). While the HLA model is intended to identify competencies that apply to a broad spectrum of health care management, the health care management community can use this tool as a way to elevate collaboration and advancement within the community's ranks.

The Consortium for Research on Emotional Intelligence in Organizations (CREIO) (2010) recognized the importance of emotional and social intelligences to a productive work life as work plays a large factor in defining one's identity, self-esteem, and well-being. CREIO perfected an emotional competence inventory originally created by Goleman in 1998 and based on his characterization of emotional intelligence as competencies divided into four domains: self-awareness, self-management, social awareness, and relationship management. This inventory assesses emotional and social competencies of individuals and organizations. Self-awareness evaluates one's internal states including intuitions. This would include emotional awareness, accurate self-assessment, and self-confidence. Self-management assesses the management of one's internal state including impulse control. This includes emotional self-control, transparency, adaptability, achievement, initiative, and optimism. Social awareness appraises the ways in which one handles relationships and how perceptive one is of the feelings and needs of others. This includes empathy, organizational awareness, and service orientation. Relationship management measures one's abilities to induce others to perform desirably. This includes developing others, inspirational leadership, change catalyst, influence, conflict management, teamwork, and collaboration.

Leadership competencies. The domain of Leadership is an area of administrative leadership that the Health Care Alliance deems important to the study of competencies needed in health care leadership. Leadership can be defined as interpersonal skills and leadership styles

(HLA Competency Directory User's Guide, 2005). The leadership domain includes leadership styles and techniques and personal journey disciplines.

Kelner and de Miranda (2009) listed leadership competencies they believed separated outstanding leaders from good leaders by pinpointing the three most critical competencies for the human resources manager/leader. These competencies are change leadership; strategic orientation; and results orientation. Change leadership leaders accept change and adapt; they inspire others to become change leaders. Strategically oriented leaders do not just take orders; they are involved, contributing to the larger corporate strategy. Results oriented leaders go beyond meeting expectations and goals to improving processes.

Styles and techniques can be measured in four areas according to Allio (2009). Four challenges are faced by leadership: selection; training; followership; and metrics (Allio, 2009). The traits that good leaders have in common are good leaders have good character, meaning acting with integrity; there is no best way to lead, meaning that no single model is ideal for all situations; leaders are suggested to learn the art of collaboration, meaning that leaders need to listen to all stakeholders (employees, customers and suppliers); adaptability is the key to longevity (Allio identified this competency as the most important to helping businesses continue forward momentum); and leaders are self-made meaning that leadership behavior must be learned. Leadership skills can improve with practice.

Professional competencies. Professional competencies include an array of leadership skills not necessarily exclusive to health care administrators, but to public administration. The Health care Leadership Alliance includes professionalism as one of five domains of competencies on which administrative behavior can be appraised. Skills include knowledge of ethics, both personal and organizational; professional roles; responsibility and accountability;

professional norms and behaviors; professional societies and memberships; time and stress management techniques; conflict of interest situations as defined by organizational bylaws, policies, and procedures; ethics committee's roles, structure, and functions; and knowledge of patients' rights and responsibilities (HLA Competency Directory User's Guide, 2005).

Littleton et al. (2010) analyzed modern professional ethical concerns in health care. They focused mainly on provider ethics but were also concerned with administration. Ethical medical and health care issues have expanded over history as knowledge of medicine and technological improvements have advanced (Littleton et al., 2010). Some current issues of medical care ethics include abortion, euthanasia, human cloning, stem cell research, AIDS, and in vitro fertilization. Health care ethical issues include the application of electronic medical records, relationships between pharmaceutical companies and physicians, the use of financial incentives, and the growing costs of health care. Littleton et al. (2010) asserted that generosity, kindness, respect, and justice should be the guiding principles that all health care providers and administrators pursue as a comprehensive moral framework. This model should guide the medical and administrative staff's actions clinically and administratively while ensuring fair, just and ethical health care delivery to the public.

Addressing one of the oldest ethical practices of medicine, Littleton et al. (2010) defined the purpose of the Hippocratic Oath and how the oath has expanded to include the ethical requirements of a contemporary society. The authors said the oath is a sacred and ritualistic vow in which novice physicians swear to uphold professional ethical standards. In today's modern medicine, the best well-known element to this oath is to avoid committing harm to patients (Littleton et al., 2010). Today's health care professionals, including administration, expect

contemporaries to exhibit the ethical traits of "truthfulness, responsibility, personal integrity, and competence" (Littleton et al., 2010, p. 33).

Addressing the role of public administrators, Littleton et al. (2010) referred to the ethical standards set forth in the Bill of Rights and the U.S. Constitution. The code of ethics upheld by the American Society for Public Administration (ASAP) asserts "professional administrators must provide services in the public interest, demonstrate respect for the constitution and law, maintain personal integrity, promote ethical organizations, and demonstrate professional excellence" (ASPA, 2006, in Littleton et al., 2010, p. 36). Littleton et al. (2010) concluded by stating that ethical issues in health care evolve as society advances and should be constantly evaluated.

One regulation for which health care professionals are responsible is upholding the policies and procedures set forth by HIPAA and the agency's concurring guidelines. Ethical conformity to HIPAA regulations is a professional and organizational obligation of leadership as well as an understanding of the regulations of health care administration (HLA Competency Directory User's Guide, 2005). The Health care Information Portability and Accountability Act sets standards of care with regard to patient privacy and governance of medical records and other personal information (Wartenberg, & Thompson, 2010). HIPAA security concerns are becoming more valid as information technology makes access to patient information easier for the unscrupulous to commit identity theft and breach medical record confidentiality. Serious consequences may arise from breaches in the privacy of medical record information. Unfortunate and unfounded employment termination as well as loss of individual health insurance may be negative consequences of improper treatment of medical records. Another harmful effect may be illegal use of a patient's identity, from charges on credit cards to passport

fraud (Wartenberg & Thompson, 2010). As scientists within the field of epidemiological research, Wartenberg and Thompson (2010) addressed concerns to scientists and administrators, cautioning them failure to protect patient rights could impede or exclude further advancements in science. Wartenberg and Thompson (2010) make the case that studies of scientific nature often need access to population-based data. Important resources for explanatory and analytic epidemiology include information from nationwide birth and death records and data in disease-specific registries. These data can also provide insight into the state of the nation's health. Wartenberg and Thompson (2010) stated that while they agree with the need to protect health and personal information, they believe cumulative data pools should be available to those committed to research. Professional societies and scientists are encouraged to lobby federal and state regulatory agencies for easier access to pertinent data for the purposes of improving public health. Health care administrators are encouraged to be aware of conflict of interest issues involving medical personnel and protection of personal health information.

Communication and relationship management competencies. The professionals of the Health care Leadership Alliance compiled asserted the competencies of communication and relationship management as important to health care leadership. Competencies included in this domain were (a) labor relations strategies, (b) organizational structure and relationships, (c) principles of communication and specific applications (e.g., crisis communication, alternative dispute resolution, etc.), and (d) public relations (HLA Competency Directory User's Guide, 2005). Hernandez (2009) exemplified principles of communication when he discussed the four cores of trust described by Covey as integrity, intent, capabilities, and results. Leaders are reminded that being respected is more important than being nice; the leader should probably develop a mature perspective and high emotional intelligence to effectively listen, give others

credit, and accept responsibility for failure. Leadership is encouraged to communicate the needs and expectations of the project or task to employees as well as accept orders from superiors. Effective employment of communication competencies includes "demonstrating appropriate emotional intelligence, active listening, non-defensiveness, appropriate and skillful use of language, and body language, effective interviewing, effective negotiation, rumor control, techno-etiquette, and presentational skills" (Tubbs & Moss, 2003, in Tubbs & Schulz, 2005, p. 8).

A specific application of communication within the field of nursing leadership was presented by Moye and Swan (2009). Leadership needs to engender feelings of loyalty to the organization. Nurses in leadership positions often work to retain nurses to train for future leadership positions. Current ambulatory care nurses in leadership positions have an obligation to train the nursing staff of the future through leadership development and succession planning. Techniques are offered to leadership nursing staff to connect to younger, Generation X and Generation Y ambulatory care nurses who need to be mentored by older nurses to develop leadership skills. Moye and Swan (2009) proposed such techniques as using technology knowledge, encouraging multi-tasking and working independently, and creating structured environments as promising ways to attract and retain younger nurses as strategies to build relationships.

Knowledge of the health care environment competencies. The Health care Leadership Alliance recognizes the importance of knowledge of the health care environment when defining the competencies of health care administrators. Garman and Tran (2006) defined knowledge of the health care environment as proven understanding of the health care system of the environment in which health care managers and providers function. Among competencies the

HLA professionals thought health care administrators should demonstrate are: funding and payment operations and procedures; role of non-clinical leadership; the relationship and connections of the clinical practice to include admission, value, cost, resource distribution, answerability, and populace; legislative, governmental, professional groups, and accreditation agencies (e.g., CMS; JCAHO; NCQA); managed care models, structures, and environment (e.g., group, staff, IPA, PPO); and staff perspective in organizational settings (e.g., frame of reference by discipline and role; orientation) (HLA Competency Directory User's Guide, 2005). According to Garman and Tran (2006), knowledge of the health care environment from leadership's perspective entails understanding of four elements: "customers, staff, systems, and community/environment" (p. 152). First, recognition of the needs of customers as diverse individuals instead of ethnic or age-related stereotypes promotes a realistic outlook of patient requirements (Garman & Tran, 2006). Second, a valuable tool for leadership is to understand the interrelationships of professionals and staff. Leadership needs to develop interpersonal trust and collaboration at the same time meeting the goals of the organization. One is less likely to experience discord if one understands the organization's structure and chain of command. Third, health systems differ greatly from other systems such as banking because leadership is responsible for the well-being of people, not "things" (Garman & Tran, 2006). Leaders in health care are encouraged to understand the complexities of the health care system because the product (improving health in people) is so precious. Last, leadership must be aware of the community and the environment (Garman & Tran, 2006). Health care delivery is affected by environmental changes in the nature of the population, the neighborhood economy, attentiveness, and feelings toward health. Two approaches Garman and Tran (2006) suggested to build

proficiency in the arena of knowledge of the health care environment are firsthand experience and creation of communities of learning.

Business knowledge and skills competencies. The domain of business knowledge and skills covers many competencies that the health care professional administrator needs to manage the business aspects of running an enterprise and accomplish desired outcomes in administrative duties. Competencies range from financial analysis and planning methodologies to strategic planning processes development to issues involved with risk management, quality control, and security elements of business (HLA Competency Directory User's Guide, 2005). Tennent (2008) called the underlying ability to complete required business and financial tasks "Business Acumen" skills (p. 24). According to Tennent, a business manager should be able to demonstrate skills in six areas: a) business strategy engagement to include possessing a broad sense of the mission, objectives, and strategy of the organization; b) perception of key indicators of job performance including "knowing the portfolio of metrics that are used to monitor business performance at total company, department and project levels" (p. 25); c) reading and correct interpretation of financial reports; d) budgetary involvement including actively participating in the budgetary process; (e) using variance analysis to understand the causes of deviation from budget predictions; (f) forecasting end-of-year projections that the organization can expect to meet; g) identification of financial implication when making decisions and understanding how financial decisions impacting the business; and h) continually seeking ways to improve performance and service to customers while discovering ways to eliminate excess and wasteful spending. Tennent (2008) thought of business acumen or the attributes of successful managers as an underlying skill that is not as easy to define or measure as core skills such as people management or leadership.

Tubbs and Jablokow (2009) declared the importance of leadership to an organization's success is supported by a sizeable body of research. A good leader often demonstrates attributes ranging from communication skills to creativity to problem-solving capabilities. Tubbs and Schulz (2005) said that leadership should demonstrate knowledge of the entire organization through efficient use of technology (the Internet and intranet within the organization); demonstrating global awareness and providing effectual compensation plans increases the likelihood of organizational accomplishment. Measureable demonstrables were listed as (a) knowledge of the entire organization; (b) systems theory use; (c) technology utilization; (d) global sensitivity; (e) effective compensation; and (f) ethical practices. Other business acumen competencies include the ability to focus; employment of no-fault problem-solving; development of a team-oriented culture; development of team-based incentive and reward systems; management of one's direct superior; navigation of organizational politics; support of others on the team; utilization of empowerment; development of self-directed work teams; and improvement of organizational effectiveness through effective utilization of process improvement teams (Kirkman et al., 2004, Tubbs, 2004, in Tubbs and Schulz, 2005).

Role of Emotional Intelligence

Riggio and Reichard (2008) believed the components of emotional intelligence (EI) key to leadership were emotional expressiveness, regulation and control of one's emotional displays, and sensing follower's needs and feelings. Eason (2009) thought an essential for leaders to develop is emotional and social competence. Eason (2009) listed three components of EI to include impulse control and delay of immediate gratification; mood regulation and preservation of motivation in frustrating situations; and empathy for others (Goleman, 1995, in Eason, 2009).

By exhibiting EI, leaders can remain in control of emotions while focusing on and accomplishing goals. High EI also can promote trust in employees and patients.

Polsfuss and Ardichvili (2009) presented additional material on the ability to manage one's surroundings, especially people, through development of state-of-mind competency. Polsfuss and Ardichvili (2009) mentioned the other types of competencies (namely, behavioral, cognitive, and emotional-based competencies) but were adamant in the assertion that a master competency exists that merges mind, consciousness, and thought. This master competency called state-of-mind (SOM) can be initiated before behavioral, cognitive, or emotional competencies. The leader who can engage the SOM competency looks for triggers of insecurity and discontent and objectively and consciously uses an inner calm and creativity to change negative energy into positive energy through wise and effective decision-making. The SOM can be developed through leadership development and coaching.

Role of Social Intelligence

Srica (2008) defined social intelligence as the "ability to exercise complex social skills such as teamwork, communication, conflict resolution, harmony, consensus, multiculturalism etc." (p. 190). Social intelligence has been connected to effective leadership. Riggio and Reichard (2008) defined social intelligence as acting and thinking wisely in social environments. Important social skills reflected in one's social intelligence abilities are expression of oneself during social situations, reading, and comprehension of different types of social situations. Interpersonal problem-solving skills and social role-playing skills are key social skills. Understanding of accepted social roles, norms, and scripts are also important social skills.

Hoffman and Frost (2006) defined social intelligence as one's capabilities to grasp and adapt to different social interactions. Characteristics of social intelligence are the identification

of skills necessary for task completion, attunement to complex social cues, and management of one's behaviors that positively influence group member perceptions. Socially intelligent leaders are alert to the work environment and socially perceptive. They possess an innate understanding and exhibit flexibility to respond to diverse social situations. "Traits characteristic of individuals with strong social intelligence include good oral communication skills, self-confidence, sociability, capacity for status, stress tolerance, and an understanding of the social dynamics of organizational problem-solving (Bass, 2001; Hoffman & Frost, 2006, p. 39).

Conclusion

The role of a clinical department administrator in an academic medical center is complex and the administrator uses a variety of competencies to fulfill the leadership position. The mission of academic medical centers typically includes three distinct goals: providing patient care, educating future doctors, and acquiring new medical knowledge (Christmas, Kravet, Durso, & Wright, 2008). The actions of the academic medical center clinical department administrator tend to reflect the missions of the medical center as the administrator meets daily responsibilities and completes daily tasks. The clinical department administrator probably ensures the operational and financial 'health' of the department while meeting compliance guidelines set forth by university, state, and federal agencies. The clinical department administrator demonstrates many competencies as challenges are met and tasks completed. The Healthcare Leadership Alliance, a cohort of six professional health care organizations listed competencies in five categories. Leadership should attain those competencies deemed pertinent to each leader's field of operation (Tubbs & Jablokow, 2009). Innate traits of emotional and social intelligences are important leadership components as well (Hoffamn & Frost, 2006). A clinical department

administrator uses many of these competencies in completion of duties as well as a reliance on intangible qualities of emotional and social intelligences expressed by most leaders.

Summary

Through exploration of the purpose of the academic medical center and the importance of meeting the center's three missions of education, research, and clinical practice, the environment of the clinical department administrator was described (Christmas, Kravet, Durso, & Wright, 2008). A detailed description of duties and responsibilities of the clinical department administrator was investigated including the clinical department administrator's roles in operations (Operations Administrator, 2010), financial, personnel (Kelner & de Miranda, 2009), and facilities management (Stansfield & Verner, 2010). The clinical department administrator is also responsible for overseeing information technology and support (Wright & Evans, 2009), compliance (Mellman, Jaffe & Dauer, 2009), quality control (Raja, Deshmukh &Wadhwa, 2007), and strategic planning issues (Varkey & Bennet, 2010). The clinical department administrator is responsible for providing the chairperson with the data and tools necessary for leadership to make educated decisions with regard to community and public relations (Fabrizio, 2009).

Historical data defined the role of the clinical department administrator. Current research focused on the role of leadership as the clinical department administrator met daily duties and responsibilities. In response to the question of what competencies are essential to effective leadership for a clinical department administrator in an academic medical center, general competencies were analyzed. The competency selection was based on the ruling professional bodies of health care and the organizations combined efforts in the formation of the Health care Leadership Alliance model of general leadership competencies (HLA Competency Directory

User's Guide, 2005). The five domains of competencies as described by the HLA model are leadership, professional, communication and relationship management, knowledge of the health care environment, business skills, and knowledge (HLA Competency Directory User's Guide, 2005). Also discussed as an underlying element of the individual's abilities to perform duties requiring mental acuity and social coordination were the roles of emotional and social intelligences (Riggio & Reichard, 2008; Eason, 2008; Polsfuss & Ardichvili, 2009; Srica, 2008; Bass, 2001; Hoffman & Frost, 2006).

Chapter 3 expanded on the scientific and academic methodology and reasoning for conducting this research. The central concept of Chapter 3, the current phenomenological study and the method with which research will be performed, was described. Comprehensive examinations of the research method and design appropriateness of this phenomenological study were elucidated. Elaboration of population, sampling technique, and data collection procedures, rationale, and data analysis systems were investigated.

CHAPTER 3: RESEARCH METHODOLOGY

The purpose of the current qualitative phenomenological study was to explore leadership competencies academic medical center clinical department administrators perceived as contributing to the success of the administrator to meet the dual obligations to the university's missions and the deliverables of a clinical practice. The logistical and strategic planning of the study's primary research method (a qualitative phenomenological method) to organization and clarity of research was discussed. The conceptual framework of the study was developed including design appropriateness, population under investigation, sampling criteria, data collection procedures and rationale, instrumentation, and data analysis.

Research Method

This study used a qualitative phenomenological design for reasons of exploration of competencies relevant to the clinical administrator in an academic medical center. Use of phenomenological research was appropriate because this was the study of a phenomenon of interest to the leadership of the healthcare community and the academic medical center leadership community. The study investigated a living social experience, reflected on essential themes that characterized the phenomenon, and used the art of writing and rewriting to describe the phenomenon. The study sustained an academic perspective to the phenomenon, and the research perspective was balanced by considering parts and whole (Van Manen, 1997). Golafshani (2003) described qualitative research as a naturalistic approach seeking to understand a phenomenon by not attempting to influence or manipulate conditions. Qualitative research seeks understanding of a phenomenon in which results can be extrapolated to similar situations (Golafshani, 2003, p. 600). Interviews and observations are primary methods of qualitative research. Quantitative research involves identification of variables and the formulation of a

theory (Creswell, 2002). As this study was an exploration of the experience of participants from their perspectives, a qualitative phenomenological study was warranted rather than a quantitative study.

Design Appropriateness

Phenomenological research design differs from that of the classic case study, the ethnographic study, or the grounded theory method, and was more appropriate for this study. Vogel, Burt, and Church (2010) defined a case study as an empirical inquiry investigating a phenomenon in the context of authentic life progression. Godfrey and Parker (2010) said case study research reveals multiple factors of one instance or action as the elements interrelate to reveal a specific trait of the study's subject. Case studies can be used to study events too complex for survey or experimental research methods.

Ethnography is generally conducted in the field or by emersion into a particular culture. An important component of ethnographic research is to conduct the study with ethical sensitivity for the subjects of the study and the subjects' environments (V. Smith, 2009). Christou and Saveriades (2010) stated an ethnographic study is usually associated with anthropological or social research. "The ethnographic method… firstly includes participant observation (researchers joining the culture being studied), secondly, observational research (watching users/participants in users/participants environment) and finally, contextual inquiry (asking the participants questions in the natural setting" (Christou & Saveriades, 2010, p. 92).

Should research be conducted using a grounded theory method, the person conducting the research gathers data that generate a new theory, effectively reversing the creation of a hypothesis until after data are collected. Grounded theory "entails simultaneous data collection and analysis, together with systematic efforts to check and refine developing data categories.

The ongoing process of data collection and analysis informs the interview questions" (McConigley, Halkett, Lobb, & Nowak, 2010, p. 474). Grounded theory entails creation of a new theory from researcher observation and participant interviews of a given phenomenon.

Rationale

This study was of perceived competencies performed by a select few individuals. The purpose of this study was to gain insight into the selected individuals' thoughts on the specific competencies used by clinical department administrators. Phenomenology was appropriate for this study because the subjective perspective and meaningful experiences of the participant (Amundson, Borgen, Iaquinta, Butterfield, & Koert, 2010) were the focus. A phenomenological design was optimum for this research study. Unlike quantitative designs often using forms of descriptive and inferential statistics such as regression analysis and analysis of variance (Waitoller, Artiles, & Cheney, 2010, p. 36), phenomenological design is explorative, "identifying essential themes that characterize the experience; articulating the phenomena through a process of writing and rewriting;…and analyzing the parts and the whole of the study" (Butcher & McGonigal-Kenney, 2010, p. 150). The phenomenological method stresses how participants see the socially constructed reality in which they are involved. The person conducting the research listens respectfully and endeavors to describe the phenomenon as participants openly relate individual experiences. Using the phenomenological method the person conducting the research "attempts to put aside preconceptions and empathically enter, free of value judgment, the life world of the participants, through interview transcripts, to understand a phenomenon of interest" (Amundson et al., 2010, p. 86).

Population

The population studied in this research was academic medical center clinical department administrators. The department administrators were in academic medical centers accredited by the Association of American Medical Colleges (AAMC, 2010b). A list of medical colleges accredited by the AAMC is in Appendix E. Clinical department administrators are those in executive administration within clinical departments. A comprehensive list of clinical departments within the University of Florida's AMC is provided in Appendix F (University of Florida's departments in the College of Medicine, 2010). This list is intended to represent the types of clinical departments at most AMCs in which a clinical administrator may be practicing.

Assumptions were made that three similarities exist in the working conditions for most department administrators. One, similar skill sets were evident to attain the rank of department administrator (Tavis, 2007). Two, a "right fit" existed for the department administrator, the organization, and the administrator's direct superior (Muirhead & Calvin, 2005). Three, the organizational structures of most academic medical centers, and therefore working environments, were similar (Darvies, 2010). Study participant qualifications included the educational component of a master's degree in business, health, public administration, or related field (Job Description for Chief Administrative Officer, University of California, Irvine, n.d.), eight to ten years of healthcare administrative and supervisory experience, and at least two years held in the current department administrator position.

Sampling

Bless, Higson-Smith, and McGee (2007) explained that a nonrandomized or non-probability judgmental sampling technique is used when the criteria are predetermined. Routio (2007) defined a nonrandomized sample as deliberate identification of exacting criteria to select

study participants. Routio (2007) listed the reasons to use nonrandomized studies. First, the population may be too large to interview everyone. Second, obtaining access to all people in a target population may not be possible. Third, "the objectives of the study do not require exact results" (para. 9). Last, efficient control procedures that control bias are part of the future research process. This study used a purposeful convenience technique (Mugo, n.d.) as part of the nonrandomization. Convenience sampling is based on ease of meeting with study participants (Routio, 2007). This technique has problems with bias. Convenience sampling may be biased because the targeted participants may not be representative of the whole population. Purposeful sampling identifies samples that meet specific criteria (Siemens, 2007). Patton (1990) said, " The purpose of purposeful sampling is to select information-rich cases whose study will illuminate the questions under study….Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research…" (Patton, 1990, p. 169).

For this study of competencies used by AMC department administrators, criteria were (a) the participants must have had an MBA, MHA or equivalent degree, (b) must have had at least eight years experience in healthcare administration; supervisory experience in an academic medical center environment, (c) must have held the rank of department administrator in the same department for a minimum of two years, and (d) must have been available to interview. The sample population was be self-selected, meaning that participation was voluntary (Holah.co.uk.psychology, 2006). Volunteers who chose to participate were expected to answer questions honestly and completely. If the participant chose not to participate or to withdraw from the study at any time, the participant could do so without penalty or loss of benefit to his or her self. The results of the research study may be published but the participant's identity will remain confidential and the participant's name will not be disclosed to any outside party.

Targeted department administrators in this study were in AMCs with which prior contacts were established and maintained through the Medical Group Management Association (MGMA) membership. Targeted AMCs were the University of Florida, the University of South Florida, and Baylor University. The objective of the sampling techniques explained above was to obtain access to at least one administrator in each of the three AMCs listed. The list of department administrators can be found on the MGMA website accessed through membership login and identification. This list was used to find potential candidates for this study. Study participants were recruited from the MGMA list of administrators. Members do not need permission to use the MGMA website to locate subjects. As the researcher is a member of the MGMA permission is not necessary. Subjects were selected from those potential administrators who showed an interest in volunteering for this study by returning emails stating interest. The subjects also passed the list of requirements by filling out the demographic survey that sent to them after they showed initial interest.

Informed Consent

Informed consent from participants was obtained before interviews were arranged. Leclercq, Keulers, Scheltinga, Spauwen, and van der Wilt (2010) described informed consent as a legal procedure. Informed consent is a voluntary authorization given by a patient or research subject stating that the subject fully understands all risks involved in partaking in the research study, or in the case of patient authorization, the risks involved in a surgical procedure. The informed consent form detailed any preconditions, confidentiality, and provides a line for signature authorizing consent. Preconditions were defined as the subject's competence and voluntariness. Information provided was of the participant's role in the discovery and research process.

The informed consent form used for this study is presented in Appendix A. Participant confidentiality was assured by assigning the participant data a coded number that was used as the Study ID number throughout the study. Explanations were given regarding the risk involved in the study. There was no psychological risk greater than ordinarily encountered in daily life or psychological examinations or tests. The use of the Study ID was meant to further reduce risk that video-taped interview material could be matched with transcribed material or material presented in the dissertation. The participant was given a number which correlated with the name. The number-name correlation data is kept on an Excel spreadsheet that is housed on a separate USB key from transcribed data to ensure no linkage between name and information provided in transcription. The code was a combination of letters and numbers, and was enacted as follows. The first participant was assigned the code P01. The second participant will be given the code P02, and so on for the rest of the participants. The key containing participant names and corresponding codes is kept separate from the keys with other data, such as interview and interpretative data. The code key is kept locked in a file cabinet in the home office. Data was kept secure during the research process and will be kept for a minimum of three years after conclusion of investigation. Hard copy data is kept in a locked filing cabinet. Electronic data was password protected to ensure only appropriate the principle investigator can access data. After three years hard copy data will be shredded and electronic data will be permanently erased from USB key and computer. Direct benefits to the participants were stated as a possible clearer, more synthesized understanding of the participant's duties. Benefits to the healthcare community could be a better understanding of the complex nature of academic medical center clinical department administration (Calhoun et al., 2008).

Guidelines within the institution about the need to obtain clearance to use the premises existed. The use of the premises was obtained before initial contact was made and an administrator was committed to volunteering for the study. Appendix H holds predicted information needed to use premises. The actual to use premises is located in Appendix N. Emails from the academic medical centers validated the use of premises. Permission was obtained to follow each institution's policies and procedures for the institutional IRB in order to maintain compliance with the regulatory guidelines. Once approval was received (or no additional requirement is necessary from the institutional IRB) the appointment was be made for the interview. The participant was informed that data will be kept confidential through the Informed Consent form. Strict control was maintained over all data.

The participant was allowed withdraw from the study at any time with no penalty to the participant, the participant's, family, or institution where the participant is employed. The participant did not need to provide any reason for his or her desire to withdraw. If the participant withdrew before the interview, the participant needed to send an email from the participant's work email address stating a desire to withdraw from the study. The email was to provide hard copy documentation of the withdrawal. Should a participant have withdrawn, no data the participant provided would have been used in the construction of the dissertation. Information obtained from the withdrawn participant would have been stored for three years and then discarded. Information will never be shared with any other source.

Data Collection Procedures

This study assessed administrators' use of leadership competencies in clinical departments within academic medical centers. Data collection in qualitative research differs from quantitative research in the type of evidence gathered and the personal connection with the

subjects. Creswell (2002) best described the rationale for conducting qualitative research. Creswell listed data collection procedures that affirm the use of qualitative research as a legitimate form of scientific discovery. First, when exploring a central phenomenon, identify places and people experiencing the phenomenon. Second, get permission from appropriate sources to conduct the study. Third, go to the site to hold interviews with participants. Fourth, conduct interviews asking open-ended questions. Fifth, record the information. Conduct qualitative data collection with understanding and respect for the participants and ethical considerations (Creswell, 2002).

An interview protocol was established for this study using a standardized open-ended interview. "Participants are always asked identical questions, but the questions are worded so that responses are open-ended….Participants [then] contribute as much detailed information as they desire…allow[ing] the researcher to ask probing questions as a means of follow-up" (Turner, 2010, p. 756; Gall, Gall, & Borg, 2003). M. D. Gall, Gall, and Borg (2003) suggested that standardized open-ended interviews reduce researcher bias because sifting through the narrative responses forces full reflection of the overall interview response when coding. McNamara (2009) offered a series of suggestions for conducting a well orchestrated interview. When interviewing, check to make sure the video camera continues to tape the interview. Do not ask more than one question at a time. Present a neutral composure even when a comment stirs strong emotions. Do not move too quickly when taking notes as this may influence the participant's responses to future questions. Be encouraging; nodding the head can promote continued responses. Introduce new topics with a transition, such as, "Let us move on to discuss…" Finally, stay in control of the interview. Be careful not to let the participant stray from the topic or ask questions of the interviewer (McNamara, 2009). A potential weakness in

the standardized open-ended interview form as suggested by Creswell (2007) may be difficulty coding data.

In this study, the initial step was to send letters of solicitation to study participants. This email letter can be found in Appendix C. After interest was established, a demographic survey was sent to potential participants by email to assess participant qualifications. The demographic survey can be found in Appendix B. Should the candidate be interested and possess the correct qualifications, the next step was to arrange a face-to-face interview at the participant's location. An informed consent form was signed upon arrival at the interview location. An example informed consent form may be seen in Appendix A. Study procedures were communicated by the use of a form emailed to the participants after acceptance into the study. The participant acknowledged procedures and returned in email form. An example of the procedures form is located in Appendix J. Withdrawal procedures was communicated by the use of a form emailed to the participants after acceptance into the study. The participant acknowledged procedures and returned in email form. An example of the procedures form is located in Appendix K. The interview took place at the participant's place of employment, either in the office of the participant or a conference room in the same building. The interview was video-taped to ensure accuracy and for transcription purposes. The interview protocol can be found in Appendix D. The interview consisted of open-ended questions and prompts. The first two questions were intended to prompt the participant to think about the dual roles, duties, and responsibilities of clinical department administration: first the participant's leadership role within a clinical department; second the participant's role within the administration of the academic medical center. The next three questions were intended to discuss meeting the missions of the academic medical center. The sixth question pertained to the participant's perceptions of running a clinical

practice. Questions seven through nine were intended to give the participant the opportunity to explain what skills he or she found pertinent to clinical administration. Question 10 was the central question to this research study: "*What competencies are essential for effective leadership of an academic medical center clinical department administrator?"* Answering the final question gave the participant an opportunity to synthesize his or her thoughts gathered through exploration of the previous questions.

Data Collection Process

After determining and selecting candidates the data process began. The data collection process occurred in two phases, the interview phase and the transcription phase. The two phases have been explained below. The data collection process also included the geographic locations of the interviews and the time spent collecting data which has been explained in this section.

Interview Process

A research technique referred to as the in-depth interview was used to gather primary source data. Individual, comprehensive interviews were conducted with a small number of participants exploring the participants' perspectives on leadership competencies (Boyce & Neal, 2006). In-depth interviews can provide detailed data providing a greater level of detail than other questioning methods such as surveys. A possible problem may be subject bias. The individual interviewed may want to prove the validity of a program and attempt to make the program appear more successful than reality may suggest (Boyce & Neal, 2006). An effort will be made to prevent bias by designing a data collection process and conducting interviews that allowed for minimal bias. The interview protocol was designed to protect the interests of the participants while eliciting the greatest response to the questions posed.

The goal of the structured, in-depth interview was to gather data from the participant's perspective about leadership competencies used in the job of AMC clinical department administrators. To preserve the integrity of the phenomenological interview process, the interviewer maintained interest in participants' dialog, did not use any leading or yes or no questions, and avoided generalization. An interview protocol was designed before interviewing participants. The protocol contained dialog the interviewer used to introduce the topic of the interview and included a dialog conversation about informed consent, confidentiality, and withdrawal procedures. The protocol contained dialog about what the interviewer was to say at the conclusion of the interview. The interview was composed of 10 open-ended questions. Probes were used when necessary to engender deeper consideration of questions. Appendix L contains a full script of each participants' responses. The interview protocol included the preferred venue of the interviews. Interviews were conducted at the place of business of each participant, in an assigned conference room or the participant's office. Groenewald (2004) warned that environmental conditions may affect the quality of the interview. Temperatures were pleasant, ambient lighting was used, and noises were kept to a minimum.

Transcription Process

The process of transcription of oral data is an important component of qualitative research (Witcher, 2010). The transcription process, therefore, must provide accuracy in order to be considered trustworthy. Challenges include unfamiliar terminology, unfamiliar accents, and colloquialisms. No transcript can completely represent the contact between interviewer and interviewee with one hundred percent accuracy (Witcher, 2010). "Transcripts that remain faithful to the aural record contribute to data quality and subsequently to the rigor of data

analysis"(Witcher, 2010, p. 130). Common transcription errors include missing words, misinterpreted words, or miss-heard words.

A professional transcriptionist was used to transcribe interview data. The use of a seasoned transcriptionist increased the likelihood that the aural record had been preserved. Use of a transcriptionist may be perceived as a limitation to the researcher's analysis as the researcher often immerses himself when transcribing aural data. The researcher compensated for the lack of immersion during the transcription process through the process of reading and re-reading the professionally transcribed data. This technique allowed the researcher to become deeply engaged and involved in the research. Interviews were video-taped. A second, tape-recorder device was used for two reasons: (a) in case of video failure and, (b) as the preferred method of transcription of the transcriptionist. Equipment failure may seriously threaten the research (Groenewald, 2004). Recording equipment was ensured to be functioning by preparing spare batteries and secondary recording devices. The transcriptionist never viewed the video tapes, further preserving the identity of participants. The data was transcribed within a week of the interview.

Data Collection Sites

Three academic medical centers were sites of interviews. Five people were interviewed at one institution; two people were interviewed from the second institution; and three people were interviewed at the third institution. The purpose of obtaining multiple geographic sites was to secure a broader range of samples that could bring new information to the subject before reaching saturation. The original protocol allowed for the possibility of four geographic locations. Three institutions were used for data collection. Saturation was reached after interviewing ten participants from the three institutions, so no added participants from additional geographic locations was necessary.

Time Spent Collecting Data

Time for interviews was expected to take no more than 45 minutes. Proper time was allowed for interviews lasting up to 45 minutes. Interviews ranged from approximately 15 minutes to over one half hour. The average length of the sessions was approximately 20 minutes. The interviews got longer over time as proficiency was gained asking prompting and probing questions to elicit more thorough responses. Each participant received a completed transcript for review and returned the edited (or unedited) transcript via email within one week. After the interview data was coded and interpreted, the participant again reviewed the data. This process achieved triangularity to verify the correctness of the researcher's interpretations. The entire process took approximately 8 weeks.

Population Selection Criteria

Twenty-six potential candidates were solicited for the current study. Sixteen candidates did not return the qualification questionnaire, were not eligible to participate in the study, or declined to participate. Ten candidates met all criteria. Limitations of this research were based on the recommended general qualifications for clinical department administrators as posted by various academic institutions. First, the department administrator must have completed successfully and secured a master's degree in business, health, public administration, or related field (Job Description for Chief Administrative Officer, University of California, Irvine, n.d.). Second, the department administrator must have had eight or more years of health care administrative and supervisory experience in an academic medical center environment (Job Description for Administrator Department of Urology, Cornell Weil University, n.d.). Health care administration encompasses administration in academic medical centers, private practice,

and private community hospitals. Third, each department administrator was in each individual current position two or more years.

Question Construction

The development of the interview questions evolved from questions pertaining to achievement of the missions of the academic medical center to questions alluding to competencies required for health care business to the final question of leadership competencies. The interview consisted of 10 open-ended questions. After giving initial thoughts on the subject of each question, the participants were encouraged to expand on the question with prompting questions such as "Is there any more you would like to add?", or "Can you provide an example?"

Interview Questions 1 and 2

Interview question 1. How do you perceive your leadership role within the department?

Interview question 2. What do you perceive as your leadership role within the administration of the academic medical center?

Questions 1 and 2 were general questions intended to provide description of the leadership roles of an academic medical center clinical department administrator. The intent of questions one and two was to present an introductory line of questioning intended to help the individual focus on the issue of leadership. Questions one and two were generated as an initial inquiry phase leading to in depth questions of organizational and clinical leadership.

Interview Questions 3, 4, and 5

Interview question 3. What do you perceive as your leadership duties to the educational mission of the organization and department?

Interview question 4. What do you perceive as your leadership duties to the research mission of the organization and department?

Interview question 5. What do you perceive as your leadership duties to the clinical mission of the organization and department?

Questions 3, 4, and 5 were related to the mission of a clinical department within an academic medical center to educate and train future physicians, conduct meaningful research, and provide quality clinical care (Christmas, Kravet, Durso, & Wright, 2008). Questions 3, 4, and 5 were specific questions concerning one aspect of the administrator's duties working in a university environment with obligations to the organization.

Interview Question 6

Interview question 6. What do you perceive as your role as business manager in the operation of a clinical practice?

This question concerned the administrator's role as business manager running an operating clinical facility. This was a specific question regarding the second aspect of the administrator's duties to the operation of a profitable, self-sustaining business. Question 6 gave the respondents an opportunity to isolate a segment of the job that may require a different set of skills than the previous questions about the administrator's role within the organization.

Interview Questions 7, 8, and 9

Interview question 7. If you were interviewing someone for your position what knowledge, skills and abilities would you look for?

Interview question 8. If you were interviewing someone for your position what emotional skills would you look for?

Interview question 9. If you were interviewing someone for your position what social skills would you look for?

Questions 7, 8, and 9 were designed to give the participant an opportunity to express thoughts about what he or she believes important knowledge, skills, and abilities, emotional intelligences, and social intelligences to clinical department administration. The intent of these questions was to have respondents evaluate and consider elements of the administrative role that when working in synchronicity produce successful leaders.

Interview Question 10

Interview question 10. What competencies are essential for effective leadership of an academic medical center clinical department administrator?

The final question specifically targeted the research question; the current study's chief inquiry. The central question allowed the participant to synthesize and summarize the previous nine questions into one focused response.

Developing Themes

The purpose of the current qualitative study was exploration of competencies used by clinical department administrators. Competencies were arranged by core theme as amassed from the thematic clusters discovered through analysis of the 10 interview questions. The core themes coincided with the themes of the Healthcare Leadership Alliance and the research conducted during the literature review process for the emotional and social intelligences. The core themes were: (a) Communication and Relationship Management, (b) Leadership, (c) Professionalism, (d) Knowledge of the Healthcare Environment, (e) Business Knowledge and Skills, (f) Emotional Intelligence, and (g) Social Intelligence. The HLA identified two aspects of social intelligence as Communication and Relationship Management. While these themes are segments of Social Intelligence, the HLA expressed these social skills in specific terms. Social Intelligence encompasses a broader spectrum of social skills.

After delineating textual evidence by question, clusters of competencies were determined by question. Development of themes included four processes that often occur simultaneously: isolation of thematic statements, applying heuristic methodology, reduction and elimination, and clustering. The computer program NVivo 9 was used in thematic development.

Isolating Thematic Statements

Ten individuals participated in the study. The question then was how to separate pertinent data from the body of information. Van Manen (1990) suggested three techniques for isolating thematic statements. The techniques were (a) the wholistic or sententious approach, (b) the selective or highlighting approach, and (c) the detailed or line-by line approach. A selective approach to theme development was used for the current analysis. A selective approach focuses on words, phrases, or sentences that are prominent. After each interview was transcribed into written word by the transcriptionist, and reviewed by participants, the statements were arranged by question. The text was read and re-read.

Heuristic Methodology

Heuristic measures were used to explore the text for words, phrases, and sentences that may explain the respondents' perceptions to each question. Brooks and Howie (2008) stated that heuristic enquiry is a valuable form of qualitative investigation. Phenomenological enquiry expects the researcher to express a personal interest in the phenomenon studied (Brooks & Howie, 2008). "The heuristic process requires the researcher to undertake profound self-searching to discover the essence of the phenomenon in question" (Brooks & Howie, 2008, p. 15). Creative synthesis is the final phase of a structured heuristic frame (Nuttall, 2006). Creative synthesis is putting the themes into words on paper. The researcher uses tacit and intuitive

powers to develop a comprehensive expression of the essences of the participants' lived experiences (Nuttall, 2006).

Reduction and Elimination

Reduction is an important phase of discovery. The process of selecting key words and phrases eliminates extraneous dialog allowing focus on words and phrases related to the topic. Reduction is a method in which scientists have a direct experience in the studied phenomenology. Phenomenological reduction moves from a general enquiry to specific elements. The premise for the study plays the guiding role in the research. The specific elements include ontology and meaning (Marcelle, 2010). The textual research of the current study isolated words, phrases, and sentences. Clusters of words, phrases, and sentences emerged through the elimination of divergent extraneous text.

Clustering

Discovery of emerging words, phrases, and sentences were analyzed according to the list of leadership domains and competencies compiled by the Healthcare Alliance Leadership and competencies of emotional and social intelligences gathered through research during the Literature Review process. The HLA domains and the categories of emotional intelligence and social intelligence were considered the core themes. The textual data was evaluated according to the competency the data most closely represented. Clusters of competencies emerged describing competencies used by AMC clinical department administrators. The processes of reduction and elimination and clustering were approached from two different directions: summaries by question; and summaries by participant interview. The resulting findings are discussed below.

Using NVivo 9 as a Method of Coding and Analyzing Transcripts

NVivo 9 is a computer program designed to facilitate discovery when working with research data. NVivo 9 was one tool used in the detection process, mainly used in the organization and clustering of data. Transcripts were input into NVivo 9 and examined for textual constructs which helped in the reduction and elimination phase of thematic development.

Instrumentation

Butcher and McGonigal- Kenney (2010) remarked that phenomenological research is a "method of inquiry that develops a deeper understanding of the existential features of human experiences" (p.150). The instrument used in this study to investigate the phenomenological experience of the subject was the interview. Key (1997) suggested meeting five requirements when conducting an interview. First, remain neutral and control physical reactions. This helps toward unbiased evaluation of participant views and responses. Second, as the goal of the research is to generate the most accurate subject reaction, the research should be conducted where the participants feel most comfortable and are most likely to speak openly. Third, questions should be open-ended. "Yes" or "no" (close-ended) questions stifle detail in participant responses. Fourth, remain flexible when approaching participants. Last, "consider to what degree the interview questioning is "recursive." As applied to interviewing, what has been said in an interview is used to determine or define further questioning" (Key, 1997, para. 8).

Kenny, Lincoln, and Balandin (2010) said a narrative approach depends on listening and interpreting the participants' individual life stories. While the strength of the narrative approach is the individual life story, the weakness may be noted that life stories are subjective and continually changing. Kenny, Lincoln, and Baladin also noted narrative analysis is designed to construct and interpret meaning from the human experience. These interviews were video-taped

for transcription purposes with follow up communications for clarification and verification by e-mail and telephone. Use of these techniques allowed gathering information that informed the profession on the issues regarding leadership competencies needed in the academic medical center environment.

Triangulation of the interview is an essential process to increase validity and accuracy of research (Chen & Ozverir, 2004). Methodological triangulation is most appropriate for this qualitative study. Shah, Habib, and Aamir (2010) remarked methodological triangulation is suitable "because it yields in-depth responses about people's experiences, perceptions, opinions, feelings and knowledge" (Shah, Habib, and Aamir, 2010. p. 237). Three methods used to validate the research are the secondary literature review; the primary source of the interview; and the primary source of review of researcher interpretation by study participants.

Reliability

Quantitative experiments can be easily reproduced, supporting the reliability or the trustworthiness of the research (Seamon, 2002). Reliability in phenomenological research is not measured as easily because the subject matter does not lend itself to any predetermined set of measurements. Seamon referred to intersubjective corroboration. Intersubjective corroboration happens when the readers of the phenomenological test can understand and empathize with the life experience being described. Four elements determine the presence of reliability in phenomenological research: vividness, accuracy, richness, and elegance (Seamon, 2002). First, the writing generates in the reader a sense of realism and truth. Second, readers identify with the phenomenon in the reader's own experiences or can imagine that such situations exist. Third, the reader can interpret emotionally and intellectually the phenomenon because of the depth and quality of the account. Fourth, the test is written in a way to elicit emotion. "The most

significant test of trustworthiness for any phenomenological study is [the study's] relative power to draw the reader into the researcher's discoveries, allowing the reader to see his or her own world or the worlds of others in a new, deeper way" (Seamon, 2002, Reliability and Phenomenological Research section, para. 19).

Validity

Two concepts treated as separate elements in quantitative research are validity and reliability. Qualitative research blends these concepts. Terminology of qualitative validity is more inclusive, often referring to terms such as credibility, transferability, and trustworthiness (Golafshani, 2003). Validity can be viewed three ways according to Cano (2006). First, validity attends to whether the data gathered and explained accurately depict what is claimed the research would illuminate, which can be seen as appropriateness of method or design of the research question. Second, validity addresses the interpretations of the data. Data must be presented in a way to show the least possible subjectivity and the greatest objectivity; that research is a "product of conscious analysis" (Cano, Validity Issues, 2006, para. 2). As part of the methodological triangulation to ensure validity of research a copy of the findings was sent to participants so they may validate discoveries. Should the participant have disagreed with the perceptions expressed of the interview, the segment of incongruity would have been re-written until consensus was reached that the segment expressed the views of the participant.

Internal

Quinton and Smallbone (2005) listed three components of internal validity. First, content validity is judged by evaluation of the design of the research. Second, construct validity is a generalization of the concept of the research (Trochim, 2006b). Third, criterion-related validity (also referred to as instrumental validity (Criterion-Related Validity, 1993-2010)) is concerned

with demonstrating accuracy by comparison to a measure already established as valid. Experiment-Resources.com (2008-2010) defined internal validity as a cause and effect relationship. One is encouraged to explore all possibilities by asking, "Could there be an alternative cause, or causes, that explain [any] observations and results?" (Experiment-Resources.com, 2008-2010, para. 2).

Qualitative research in general does not have the same internal validity quality as quantitative research. Trochim (2006b) referred to internal validity as *credibility*. The results of qualitative research must be presented as "believable" from the participant's perspective. As qualitative research is described from the participant's point of view, only the participant can judge the credibility of the results. As this study was phenomenological, internal validity will be established by the participants. The final research was reviewed, member checked, establishing internal validity. Participants were given an opportunity to approve, elaborate, edit, and clarify that the interpretations of the interview dialog and interpretation were correct (Carlson, 2010). The participant was able to conduct member checking of the interpreted material before the dissertation was completed. Each participant was given an opportunity to review researcher interpretations of the interview.

External

Quinton and Smallbone (2005) explained external validity as how easily a study's research could be generalized to other similar experiences; how representative the study's sample is to the larger population. Among types of external validity are population validity, ecological validity, and statistical validity. Many qualitative researchers reject the idea of external validity in qualitative research. The researchers rebuff the "basic realist assumption that there is a reality external to our perception of it" (Trochim, 2006c, para. 3). Instead, these researchers employ the

idea of transferability. Transferability refers to how qualitative research can be generalized to other contexts and settings. By doing a methodical job of describing context and assumptions central to the research, other researchers should be able to apply the same framework to similar phenomena, thus "transferring" methodology. The external validity of this study can be gauged by the population of healthcare administrators in general, and other types of administrators within academic medical centers.

Data Analysis

Analysis of qualitative data is interpretive (Creswell, 2002). The material is examined several times with an impartial, unbiased eye. "There is no single, accepted approach to analyzing qualitative data, although several guidelines exist for this process (Dey, 1993; Miles & Huberman, 1994 in Creswell, 2002). Creswell (2002) described data analysis as involving an eclectic process including organization, transcription, analysis by hand or computer, and coding. The method of collection and analysis for this study was recording every comment so as not to miss nuances or emerging patterns of individual user sessions (Kanter, Solvo, & Anshuetiz, 2005, p. 3). The interview process was continued until the data reached a saturation point. Saturation occurs when no new evidence is forthcoming from continued interviews and is contingent on concurrent analysis and collection (Tuckett, 2004). Five to a maximum of 10 clinical department administrators were interviewed to reach data saturation. Interviews were conducted using open-ended questions. Interviews lasted from 30 to 45 minutes. The method of recording was the videotaped personal interview. Participant narratives were intended to provide participants' perspectives related to the experience of acting in a leadership role, and supply detailed information about feelings and thoughts.

> Narratives give us both an identity and the consciousness of belonging to a society and a setting. They yield a better description of life and experience than that provided by figures, tables and concepts. Narratives touch us in a manner that is different from factual knowledge, and thus give us a greater understanding of actual experiences. (Jakobsen, & Sørlie, 2010, p. 290)

After collecting data via interviews and transcribing the data, interrelated themes and developing patterns were looked for. NVivo 9 software was used to identify themes. NVivo 9 software assisted by making many manual tasks easier; tasks related to the functions of analysis including classifying, sorting and arranging information (NVivo 9, Overview, 2007). Campo and Darragh (2010) described the steps taken in phenomenological data analysis that will be used in this study. First, code the transcripts looking for comparisons, similarities and differences. Second, compare data during the interview process looking for emerging themes until saturation is achieved. "Systematically identify codes (key words or phrases summarizing comments), collapse them into larger categories (groups of related codes), and finally identify larger emergent themes (larger concepts representing the codes and categories associated with the topics covered during the interviews (Campo & Darragh, 2010, p. 909). This highly-structured process of documentation also provides an auditable trail until identification of final themes. Further steps employed in this study will be writing analytical memos. Pontin and Lewis (2009) referred to the necessity of writing analytical memos. Analytical memos will be written immediately after the interviews to capture initial ideas and thinking. Analyzing data immediately after collection allows the development of codes used in the systematic analysis of data (Pontin & Lewis, 2009). Phenomenological studies are not based in preconceptions, meant

only to "uncover and describe the structure, the internal meaning, and the essence of the everyday lived experience" (Butcher & McGonigal-Kenney, 2010, p. 150) of the participants.

Organization and Clarity

The material in Chapter 1 provided a general explanation of the need for the current study. Chapter 2 provided literature relevant to the topic of clinical health care leadership. The framework for the current qualitative research study on the leadership competencies relevant to academic medical center clinical department administrators has moved from a general explanation of the need for the study to the specific logistical aspects of conducting the study with research subjects as presented in Chapter 3. The generalized problem was inaccurate hiring practices. The specific problem was overlooking the importance of possessing the necessary competencies, emotional and social intelligences when hiring people as AMC department administrators. The material presented in the literature review constructed a picture of the working environment and duties of AMC department administrators, clarifying the competencies, social and emotional intelligences necessary to act as successful department administrators. The third chapter presented material about how the process of discovery continued as the research progressed to present new evidence from direct interviews with AMC department administrators. This phenomenological research was intended to gather information on the leadership competencies that people currently acting in AMC department administrator positions believe most represents each individual's working identities.

Summary

Chapter 3 tied together the arguments made for the importance of this qualitative exploration while clearly describing the process of conducting a phenomenological study. The purpose of the study was reiterated. The purpose of this paper was exploration of the leadership

competencies relevant to academic medical center clinical department administrators. The design appropriateness of using a qualitative approach to answer the research question was defended. A qualitative phenomenological design was chosen because academic medical center leadership is a social issue discussed by administrators currently employed in the field. Qualitative research seeks understanding of a phenomenon in which results can be extrapolated to similar situations (Golafshami, 2003). The department administrators provided firsthand accounts of the phenomenon from each participant's perspectives. These narrations were intended to elicit information that was then interpreted and presented to benefit the healthcare leadership community and academic inquiry. The face-to-face interview was used. The interview was video-taped and later transcribed, analyzed, and cataloged for themes (Creswell, 2002). Credible and transferable data was presented to present an honest interpretation of the data (Creswell, 2002).

After acceptance of the proposal by the Academic Review Board and the Institutional Review Board, Chapter 4 was designed to present the findings of this study.

CHAPTER 4: ANALYSIS AND RESULTS

Effective managerial leadership is an essential component in the business environment (Botha, & Claassens, 2010). Facing the many challenges of business requires the study of the developmental qualities of business leaders. Development of business competencies adds to the value and success of organizations (Botha, & Claassens, 2010). The purpose of the current qualitative phenomenological study was to explore leadership competencies academic medical center clinical department administrators perceived as contributing to the success of the administrator to meet the dual obligations to the university's missions and the deliverables of a clinical practice. The posed research question reflected the intent of the research: what competencies are essential for effective leadership of an academic medical center clinical department administrator? The purpose of data collection and analysis was revealing the perceptions of administrators as the administrators examined the knowledge, skills, and abilities used meeting daily obligations within clinics and AMCs. The results of the study provided a depiction of competencies used in clinical hospital administration.

Chapter 1 introduced the purpose of the study and relevance to the study of leadership and health care administration. Chapter 2 contained a literature review. A historical overview provided information on academic medical centers and the roles of clinical administrators. Current findings held a discussion of leadership theory and leadership competencies. Chapter 3 comprised a detailed methodology applied to the study. The data collection process was explained in detail. The data collection process included (a) interview protocol, (b) data collection process, (c) data collection sites, (d) time spent collecting data, (e) question construction, (f) using NVivo 9 as a method of coding and analyzing transcripts, (g) reduction and elimination, and (h) clustering, Chapter 4 is an analysis and explanation of results of

research. Demographic results are presented. The manifested themes are discussed and applied to the research question. Themes are presented by participants' interview summaries and by question. Structural discussion of questions is discussed. Core themes discovered through analysis, applying predominant themes to research questions, validity and reliability, and results are presented in Chapter 4. A summary transitions the discovery phase to Chapter 5.

Demographic Data Results

Convenience nonprobability sampling is used when the research sample is predetermined (Trochim, 2006d). A nonrandomized or non-probability judgmental sampling technique was used to establish standards for participant eligibility. Non probability sampling was used in the current study because the population is small, the difficulty and cost of travel, and time constraints to gather data. Bias may be a challenge with the use of non probability sampling, but non probability sampling is an often used qualitative sampling technique (Trochim, 2006d). Participants were from academic medical centers in Florida and Texas. A sample of two women and eight men were involved in the study. All ten of the participants were Caucasian and held master's level degrees. Table 1 represents the distribution of research participants according to age. Table 2 represents the distribution of research participants according to gender. Table 3 represents the distribution of research participants according to length of time in current clinical administrative departments. Table 4 represents the participants according to total years of healthcare administrative experience.

Table 1

Distribution of Participants by Age

Age Range	Number of Participants in Age Range
21-31	0
32-42	4
43-53	4
54-64	2
65+	0

Table 2

Distribution of Participants by Gender

Gender	Number of Participants
Male	8
Female	2

Table 3

Distribution of Participants by Length of Time in Current Clinical Department

Range of Years as Administrator in Current Department	Number of Participants
2	3
3-5	1
6-9	2
10-15	3
›15	1

Table 4

Distribution of Years of Total Healthcare Administrative Experience

Range of Total Years of Healthcare Experience	Number of Participants
8	0
9-12	1
13-15	1
16-20	3
›20	5

Thematic Development Through Analysis

Ten participants answered 10 questions during the interview process. Two approaches were undertaken to analyze extracted data. The first was an examination of themes through scrutiny of the interview questions. The second was analysis of themes through the exploration of the participant dialogue. The dual approach added a level of interpretative clarity to thematic discovery.

Findings: Thematic Development Through Analysis of Interview Questions

The participants' interviews were analyzed by response to each question. The participants responses were analyzed through the qualitative techniques of reduction and elimination. Key words and phrases were clustered together thematically. Examining words and phrases led to interpretation of themes and competencies participants were expressing. The competencies were clustered by core theme. The emergent core themes (a) communication and relationship management, (b) leadership, (c) professionalism, (d) knowledge of the healthcare environment, and (e) business knowledge and skills, (e) emotional intelligence, and (f) social intelligence. Analysis of the core themes was meant to provide discovery of themes and competencies participants perceived as necessary to answer each function of their roles as AMC clinical department administrators.

Interview Question 1

How do you perceive your leadership role within the department?

Within the theme of Communication and Relationship Management two competencies appeared most relevant to the participants: organizational structure and relationships; and, principles of communication and their specific applications. Participant 10 (P10) stated that supporting staff to the best of one's abilities was a key tool in the achievement of specific goals in the operational, financial, research, and administrative realms. Participants 02(P02), 04(P04), and 21(P21) perceived leadership styles and techniques as important to clinical administrative leadership. Skills such as making others believe in the leadership's direction, acting as a facilitator, and leading by example were discussed as relevant to success.

Within the theme of professionalism, two competencies were perceived as important: organizational and business ethics; and professional roles, responsibility and accountability. Representing the department's best interests, representing the chairman [within the university, college, and department], and responsibility for administration were deemed important to Participant 12(P12). Participant 24 (P24) stated the department administrator role includes "full accountability of [the department when meeting] all the missions of the college." P10 and P04 discussed the relevancy of knowledge of the healthcare environment. Healthcare technological research and advancements and knowledge of global healthcare issues, trends, and perspectives were perceived as pertinent to clinical department administration. Participant 26 (P26) asserted knowledge of nursing, physicians, and allied health professionals' roles and practice was an important asset in the health care environment, saying one skills the administrator must exert is deciding which physicians work best together and capitalizing on the patterns that best serve the department.

Ten business knowledge and skills were discussed. The competencies referred to were (a) management functions, (b) broad systems connections, (c) comparative analysis strategies, (d) financial analysis, (e) financial planning methodologies, (f) characteristics of strategic decision support, (g) implementation planning, (h) strategic planning, (i) characteristics of administrative systems and programs, and (j) organizational mission, vision, objectives and priorities. Discussing the need to understand the organizational mission, P26 remarked, "you have to understand how all the missions of an academic department at a medical school or college are intertwined."

Serving as a decision-making party and thinking strategically with a long range vision of where the department was heading were two skills discussed. P04 described himself as an "institutional library." The participant's knowledge of the health care system and business skills are a predominant part of what this participant considers important to a well-rounded clinical department administrator. P12 believed the social intelligence competency of interpersonal problem-solving and social role-playing was relevant. The participant's answer to the first question discussed his willingness to get involved in intradepartmental conflicts between individuals. Table J1 in Appendix J is a list of competencies identified in IQ1. Figure J1 is a visual representation of the clusters discovered through analysis of IQ1.

Table 5

Number of Core Themes and Competencies Expressed by Participants in Response to IQ1

Core Theme	Number of Competencies Elicited Within Theme
Communication and Relationship Management	2
Leadership	1
Professionalism	2
Knowledge of the Healthcare Environment	4
Business Knowledge and Skills	10
Social Intelligence	3
Total Number of Competencies Referred to in Response to IQ1	22

Interview Question 2

What do you perceive as your leadership role within the administration of the academic medical center?

Nineteen competencies were thought to be applicable to the answer of this question as perceived by the participants. Under the theme of Communications and Relationship Management, P04 and P20 felt that public relations was an important competency. P04 said that he was "the voice" of the department outside of the department within the academic medical center. P20 said he developed relationships outside of the department acting as "liaison" for the department. Personal journey disciplines, is a competency within the domain of leadership. P20 discussed building credibility and reputation as a successful clinical department administrator though past experiences.

Within the theme of Knowledge of the Healthcare Environment five competencies were perceived as pertinent to the leadership role within the administration of the academic medical center. Two of the competencies identified through participants' dialogue were (a) the interrelationships among access, quality, cost, resource allocation, accountability, and community, and (b) organization and delivery of healthcare. P20 stated [understanding the] integration in an academic center is vital between the hospital, between the university, [and] between the Dean's office. Referring to the delivery of health care. P02 said the administrator was "engaged" or involved in the operations of the main inpatient facility.

Seven business skills competencies were listed as relevant to the leadership role within the academic medical center. The participants' dialogue related to (a) organizational vision, mission, and value objectives, (b) strategic planning processes development, and (c) workforce planning for a physician office. Related to the organization's mission, P10 said a relevant

competency was the ability "to balance the core missions of the academic department within the College of Medicine." P22 remarked, "It's my job to take [the] macro vision [of top leadership within the AMC]and put it on a micro level [within the department]." This statement brings to light a previously unidentified competency, the ability to integrate, merge, link, marry the department and hospital perspectives. When discussing the need for the competency of contingency planning when predicting budgetary requirements, P24 stated, "we have to make allowances for education in our clinical operations, not allowances that ever cost us anything but we have to consider it."

Social intelligence competencies were perceived as important to the leadership role of the clinical department administrator. The competencies named were (a) expression of oneself during social situations, reading, and comprehension of different types of social situations, (b) interpersonal problem-solving skills and social role-playing, (c) understanding of accepted social roles, norms, and scripts, (d) skills necessary for task completion, and (e) management of one's behaviors that positively influence group member perceptions. Participant 22 (P22) discussed the need to be able to express of oneself during social situations, reading, and comprehension of different types of social situations when communicating strategically with the chairperson. "[One duty is to] give feedback as I can to the top leadership on how it's going and where we might look at going another direction." Serving on committees and involving oneself in mentoring programs was significant to participants P12 and P20. Referring to management of one's behaviors, P20 suggested when ideas are sequestered, using tact helps get one's ideas heard. Table J2 in Appendix J is a list of competencies identified in IQ2. Figure J2 is a visual representation of the clusters discovered through analysis of IQ2.

Table 6

Number of Core Themes and Competencies Expressed by Participants in Response to IQ2

Core Theme	Number of Competencies Elicited Within Theme
Communication and Relationship Management	11
Leadership	1
Professionalism	1
Knowledge of the Healthcare Environment	4
Business Knowledge and Skills	7
Social Intelligence	5
Total Number of Competencies Referred to in Response to IQ2	29

Interview Question 3

What do you perceive as your leadership duties to the educational mission of the organization and department?

Discussing the educational mission as related to the role of clinical department administrators prompted the participants to list 14 competencies within four of the HLA domains. One competency referred to under the theme of Communication and relationship Management was principles of communication and their specific applications. P12 believed "conflict resolution" to be an noted competency. Within the theme of Professionalism a topic emerged that was unidentified by the Healthcare Leadership Alliance. P02 stated that the administrator was often called upon to educate new residents in the general points of administration. The new competency was named "instructor within residency program." A second clinical department administrator, P10, said "training the next generation of physicians" was part of his duties.

Four competencies within the theme of Knowledge of the Healthcare Environment were identified as (a) role of non-clinical professionals in the healthcare system, (b) corporate compliance laws and regulations, (c) educational funding for healthcare personnel, and (d) funding and payment mechanisms of the healthcare system. Four participants (discussed funding

and payment mechanisms. P12 stated it was his responsibility to "provide equipment for the program to run smoothly." P20 and P21 talked about the need to understand funding mechanisms for residency slots and programs. P10 stated in order to procure the highest quality medical students into the residency program, he must "provide the resources for the residents to have the most fruitful and rewarding and educational experience…during their tenure of residency."

Fourteen business knowledge and skills competencies were discussed by the participants. First, broad systems connections was an identified competency. P12 asserted performance at a wide variety of tasks to keep the residency program "running smoothly" including making hiring decisions of personnel to support the program and conflict resolution when such issues arose. Second, project management was discussed. P04 set up the residency program in his department and was responsible for the program's management. Cost accounting was a third competency listed. P02 highlighted billing basics and activities driven by money to build and maintain the infrastructure of the educational mission. Human resources laws and regulations was a listed competency. Residents are allowed by law to work a certain number of hours per week. P10 declared ensuring compliance was the clinical department administrator's responsibility. Workforce planning for a physician practice was recognized as another competency. P04 stated the administrator was responsible for hiring the staff for the residency program. P21 declared that even though the educational mission did not generate profit for the department, the mission was an important part of the role of an academic clinical administrator because of the effect the mission has on the faculty and responsibility of the department. A sixth identified competency was marketing plan development. The participating clinical department administrator, P20, was responsible for oversight of the website used for medical student recruitment purposes. Another

business knowledge and skills competency identified was understanding of the organizational mission, vision, objectives, and priorities. P20 felt part of his leadership duties was to support the college's and the department's obligations to the educational vision and mission of the academic medical center and the university. P24 noted the educational component of the college was "the primary reason" the academic medical center was in place. Table J3 in Appendix J is a list of competencies identified in IQ3. Figure J2 is a visual representation of the clusters discovered through analysis of IQ3.

Table 7

Number of Core Themes and Competencies Expressed by Participants in Response to IQ3

Core Theme	Number of Competencies Elicited Within Theme
Communication and Relationship Management	1
Leadership	1
Professionalism	1
Knowledge of the Healthcare Environment	5
Business Knowledge and Skills	14
Total Number of Competencies Referred to in Response to IQ3	22

Interview Question 4

What do you perceive as your leadership duties to the research mission of the organization and department?

A Communication and Relationship Management competency discussed by two participants (P04 and P12) was the competency of principles of communication and their specific applications. P04 talked about the discussions of research from an administrative perspective with his chairman. P12 spoke about discussions with the primary investigators (PIs) about the financial details of research programs. Four competencies in the theme of Knowledge of the Healthcare Environment were thought to hold relevance. P02 and P04 discussed the competency of knowledge of corporate compliance laws and regulations. The ability to follow procedures

and policies applicable to research grants, funding agencies, and research programs was desirable. Understanding the funding payment mechanisms of research, basic and clinical was a second desirable competency. How to spend grant dollars and assign people to grants was a skill set P02, P12, and P21 thought clinical department administrators should understand. Health care technological research and advancements was the third competency discussed. P20 talked about his role reviewing manuscripts before the manuscripts are sent to agencies such as the IRB (Institutional Review Board) "to get a better understanding of what [the researchers] are doing, what types of drugs they're bringing in, [and] what they're trying to prove." A competency not identified by the HLA was discussed by P18, P20, and P24; the need to understand and support research, research personnel, and grants. P24 said of this competency, "We have to be able to support our research faculty and give them a little different administration. I mean they need assistance in other administrative areas than you would think of in day-to-day clinical operations. They're out getting the grants and trying to find funding and they're trying to complete studies and sometimes the studies are clinical and sometimes they're not and we need to incorporate that in our regular strategy for the department."

The participants considered nine competencies listed under the theme of Business Knowledge and Skills were applicable to administration of the research mission. When discussing inventory systems, P12 said knowing grant end dates and keeping the end dates in mind when making research related decisions was important to research maintenance. P12 explained the significance of asset management when administering the research mission. Two aspects of the competency were discussed. First, managing the research accounts for the PIs, and second, knowing how much is available [in each grants account] for bridge funding if necessary. Financial planning methodologies such as operational, budgeting, and strategic planning were

thought relevant by Participants 02 and 21. P26 regarded the competency of knowledge of quality planning and management necessary to meeting the research mission. On this subject, P26 asserted, "I see the primary research duty as recruiting the right faculty."

Understanding reimbursement principles and techniques was another perceived competency as well as organizational dynamics and political realities. P02 related that while the administrator might be proud of a physician or scientist for procuring a research grant, the administrator could not allocate funds until the granting agency released the funds to the primary investigator. In some cases the money has been slow to arrive to the department's account which has been a source of irritation to the investigator and administration. Staffing methodologies was another competency P12 felt necessary to accurate research administration. The clinical department administrator needs to be able to allocate the correct number of people to the grant and provide the staffing support necessary to maintain the grant and the research. P04 discussed his role in principles and practices of management. "I see my role as helping very much to lead the development of the critical research infrastructure." P10 discussed his role in the characteristics of strategic management support. "I view my role as a support mechanism for [the other people involved in research] to advance throughout the department and the institute.

One social intelligence competency was mentioned by P26. P26 remarked one leadership duty of administrators was to work with researchers and listen to what the investigator and secondary researchers' interests were. Listening to the researchers explain the needs and concerns of research helped better serve the research mission. The social skill applied was interpersonal problem-solving skills and social role-playing skills. Table J4 in Appendix J is a list of competencies identified in IQ4. Figure J4 is a visual representation of the clusters discovered through analysis of IQ4.

Table 8

Number of Core Themes and Competencies Expressed by Participants in Response to IQ4

Core Theme	Number of Competencies Elicited Within Theme
Communication and Relationship Management	1
Knowledge of the Healthcare Environment	4
Business Knowledge and Skills	10
Social Intelligence	1
Total Number of Competencies Referred to in Response to IQ4	16

Interview Question 5

What do you perceive as your leadership duties to the clinical mission of the organization and department?

The five themes participants thought germane to a discussion of duties to the clinical mission of the organization and department were the theme of Communication and Relationships Management, Leadership, Professionalism, Knowledge of the Healthcare Environment and the theme of Business Knowledge and Skills. P26 talked about the need for the competencies of public relations knowledge and knowledge of the interrelationships among access, quality, cost, resource allocation, accountability, and community within the theme of Communications and Relationship Management. Discussions of the prospect of expanding the department's clinical practice requires effective communication skills. Discovered through discussion with one clinical department administrator was a theme not recorded in the HLAs list of Knowledge of the Healthcare Environment competencies. P04 emphasized the ability to integrate, merge, link, and marry the department, hospital, and academic medical center perspectives was a desired competency. P10 discussed the competency of community standards of care by highlighting his department's involvement in community outreach programs. P10 related the competency of understanding the interrelationships among access, quality, cost, resource allocation, accountability, and community to the experience of juggling multiple balls. He described the

importance of maintaining a balance between the missions of the academic medical center and the administration within the department and within the AMC.

All participants identified competencies included in the domain of Business Knowledge and Skills as fundamental to meeting the clinical mission of the AMC. P10 perceived the clinical mission as making sure his department provides good access for patients to engage with physicians and provide evidence based medical care. Regarding the competency of asset management, P02 perceived clinical department administrators as needing to be "good managers of expenditures." P02 emphasized management functions competencies. When planning, the administrator uses modeling techniques and tools to efficiently plan and direct department activities. P02 talked of percentages of time, effort, and funds accrued from programs and sources, exemplifying the competency of financial analysis. P02 also identified the need to create a budget, a competency of financial planning. P02 and P12 discussed having a need for knowledge of compensation and benefits. P04 related the need for the competency of knowledge of organizational policies and procedures and their functions. Within his department are weekly meetings to make sure the department's clinical staff adhere to the policies and procedures of the AMC and other agencies. P02 and P20 believed workforce planning to be a necessary skill. P20 stated one duty of the administrator was to keep constant watch on the physicians to ensure the physicians met all of their clinical obligations in a timely manner. P20, P21, and 24 regarded knowledge of customer satisfaction principles as tools necessary to meet the clinical mission of the department. P20 stated the need to keep patients satisfied with care. P21 said, "Patients have to be treated as number one…so I take a lot of time to ensure that our practices in the department are good, that our customer service is good, that we're giving patient care the best we can, and that …the patients know [the clinic is] here." P24 stated good operational practices leads to

good customer service, and retaining clients is primary as clinical income is a vital source of departmental revenue. Participant 04 perceived knowledge of organizational dynamics, political realities, and culture to be a necessary skill. The alignment and facile (smooth) working relationships between staff and faculty (medical personnel) assured a capable clinical operation. Participant 02 perceived knowledge of the components of effective succession planning a crucial competency. Physicians enter and leave the organization. The administrator needs to rapidly integrate or replace the medical staff without causing disruption to the clinic or patients. Participant 10 asserted a clinical department administrator needs to have knowledge of the various roles and responsibilities of physicians in a medical practice. P10 stated, "You need to understand the business from a purely clinical standpoint; understand the politics from a faculty standpoint." The competencies of knowledge of the characteristics of strategic decision support and implementation planning were discussed as relevant to meeting the mission of the clinical practice. Participant 10 discussed the need for proficiency in strategic planning and management. P02 discussed the need to implement new [clinical] enterprises. Knowledge of characteristics of administrative systems and programs was offered. P20 pronounced little direct involvement in the clinical mission accept when administering or managing a program driven task. Finally, Participant 10 discussed physician practice management IT systems. The administrator oversees billing and accounts receivable activities and other financial systems. Table J5 in Appendix J is a list of competencies identified in IQ5. Figure J5 is a visual representation of the clusters discovered through analysis of IQ5.

Table 9

Number of Core Themes and Competencies Expressed by Participants in Response to IQ5

Core Theme	Number of Competencies Elicited Within Theme
Communication and Relationship Management	1
Leadership	2
Professionalism	1
Knowledge of the Healthcare Environment	6
Business Knowledge and Skills	20
Total Number of Competencies Referred to in Response to IQ5	30

Interview Question 6

What do you perceive as your role as business manager in the operation of a clinical practice?

Four themes were emphasized in the participants answers to this question. First, under the domain of Communication and Relationship Management, P12 believed an effective competency to be principles of communication and their specific applications. Although this clinical department administrator did not view the duties of the administrator as a clinic manager, P12 believed the administrative leadership role was communication and coordination of others who were more directly involved in clinical affairs. Within the theme of Professionalism, P10 saw his role within the clinical arena as all activity starting and ending under his supervision. The competency met by P10s philosophy is the understanding of professional roles, responsibility, and accountability. Within the core theme of Leadership, P24 articulated consciousness of personal leadership styles allows the administrator to take advantage of opportunities to increase visibility within the clinic. P24 said, "I think I'm very involved because clinical, there's operations to this department in all the missions of the college and so I'm not necessarily a hands-off manager."

Knowledge of the Healthcare Environment was perceived as a valuable trait in the administration of the clinical arena. Participant 04 continued the theme of the importance of being able to integrate departmental functions with the missions and goals of the medical center and hospital. P02 and P04 discussed the competency of interrelationships among access, quality, cost, resource allocation, accountability, and community. Participant 02 commented on being able to view the department as a whole and break down the various components in an effort to better utilize departmental and hospital resources. Participant 10 discussed the need "to make sure that the financial resources are there to meet [the department's] year to year goals on [the department's] operational budget, [and to assure the department's] capital goals [meet] the long term objective." A final competency perceived as relevant to clinical department administration within the theme of Knowledge of the Healthcare Environment is a knowledge of nursing, physician's, and allied health professionals roles and practice. P21 discussed the need to be involved in the decisions to better understand the direction that the faculty chooses to steer the department.

All participants perceived Business Knowledge and Skills as substantive to the success of their roles as administrators in clinical services. In all, 19 competencies discussed including (a) purchasing procurement, (b) cost accounting, (c) financial analysis, (d) financial planning methodologies, (e) fundamental productivity measures, (f) the relationship between physician productivity and the cost structure of a medical practice, (g) revenue cycle and accounts receivable processes, (h) workforce planning for a physician practice, (i) implications of a group verses a solo mentality as a cultural driver in a physician practice, (j) implementation planning, and (k) customer satisfaction principles and tools. Relating to the competency of cost accounting, P04 said the administrator was responsible for designing, implementing, and

maintenance of all of the accounting procedures for the department. Speaking in reference to the competency of knowledge of financial planning methodologies, P10 discussed the need to be well versed in budgeting as designing the operational budget for a clinical department for a fiscal year is challenging. P20 imparted the one duty the administrator has on a daily basis is examining the volumes [of patients] flowing through the building; a function of the competency of knowledge of workforce planning and implementation planning. P20 also feels responsible for ensuring patient satisfaction, a statement correlating to the competency of customer satisfaction tools and principles. P18 added five competencies in discussions of importance to clinical operations. The competencies P18 discussed were (a) Data collection, measurement and analysis tools and techniques (e.g., root-cause analysis; process analysis; workflows) (b) Comparative analysis strategies (e.g., indicators; benchmarks; systems; performance), (c) Organizational mission, vision, objectives and priorities, (d) Organizational dynamics, political realities, and culture, and (e) Asset management, including investments, equipment, etc . The competency of Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external was discussed by P18 and P22.

P02 perceived Social Intelligence to be part of the competency arsenal of a clinical department administrator. P02 illustrated the need for understanding of accepted social roles, norms, and scripts. P02 related that recruitment and retention of residents versus staff requires different sets of social skills and knowledge. P02 explained, "Residents come here and expect to do 3, 4 or 5 years in training, you pretty much point them in the direction and its hands off. Managing 40-50 nurses is a little different, so and you know they're more of an employee where residents are more of a trainee obviously and the management needs are different in that

environment." Table J6 in Appendix J is a list of competencies identified in IQ6. Figure J6 is a visual representation of the clusters discovered through analysis of IQ6.

Table 10

Number of Core Themes and Competencies Expressed by Participants in Response to IQ6

Core Theme	Number of Competencies Elicited Within Theme
Communication and Relationship Management	1
Leadership	1
Professionalism	1
Knowledge of the Healthcare Environment	5
Business Knowledge and Skills	21
Social Intelligence	1
Total Number of Competencies Referred to in Response to IQ6	30

Interview Question 7

If you were interviewing someone for your position, what knowledge, skills, and abilities would you look for?

P02 and P21 perceived the principles of communication and their specific applications as a pertinent competency needed in clinical department administration. Both participants felt the ability to communicate effectively was important. P21 added the ability to be flexible along with effective communication affects trust between the administrator and physicians. "…if they don't trust you then you have no relationship and therefore you can't run [the clinical practice]."

Under the theme of Professionalism, three outlying competencies emerged unmentioned by the HLA. First, P04 declared an MBA or higher level degree or certification was a competency proving "the ability to work both in a detailed work environment as well as thinking more locally, and more at a macro level." Second, prior experience was deemed an important tool to P02, P04, P12, and P21. Prior experience was linked with proved mastery of a wider variety of competencies. Third, P04 explained the competency of balancing professional

responsibilities with human skills. P04 said, I believe there's a balance between being very tactically strong [administratively] and also having good human skills and so…I would try to find somebody who is knowledgeable but also has good interpersonal skills.

One competency within the theme of Leadership was mentioned. P24 explained the relevance of the competency understanding leadership styles and techniques. P24 recommended candidates possess "a level of leadership that allows the department to come together and be recognized as a leader." A clinical department administrator should have a leadership style that supports the department chair's style to bring cohesiveness to departmental decisions and actions.

Within the theme of Business Knowledge and Skills, five competencies were emphasized. First and second, P10 discussed knowledge of the revenue cycles and accounts receivable processes, and knowledge of organizational policies and procedures and their functions. Third, P04 and P20 discussed the relevancy of knowledge of the organizational mission, vision, objectives, and priorities. P04 said, You have to have some interest in what your faculty is doing and what the missions of the department are. P20 explained that understanding the three missions of the academic medical center makes it easier to prioritize immediate and long term goals for the department. Fourth, knowledge of data collection, measurement, and analysis tools was referred to by P18. P22, P24, and P26 discussed the need for the business competency of financial planning methodologies. "Fiscal skills", "financial skills", and "a strong financial core" were phrases referring to this competency.

One competency within the theme of Emotional Intelligence was highlighted, the competency of remaining in control of emotions while focusing on and accomplishing goals. P26 asserted that the clinical hospital administrator is a person who can "triage lots of different

[problems (e.g., personnel issues, financial difficulties)] and keep reprioritizing throughout a day or a week."

Social Intelligence competencies were relevant to the knowledge, skills, and abilities of clinical department administrators. The four of the five competencies discussed were (a) expression of oneself during social situations, reading, and comprehension of different types of social situations, (b) skills necessary for task completion, (c) attunement to complex social cues, and (d) interpersonal problem-solving skills and social role playing skills. An outlying competency emerged. P22 talked about the need for "good people skills" as a quality to look for in the clinical department administrative candidate.

Table 11

Number of Core Themes and Competencies Expressed by Participants in Response to IQ7

Core Theme	Number of Competencies Elicited Within Theme
Communication and Relationship Management	1
Leadership	1
Professionalism	5
Knowledge of the Healthcare Environment	2
Business Knowledge and Skills	5
Emotional Intelligence	1
Social Intelligence	5
Total Number of Competencies Referred to in Response to IQ7	22

Interview Question 8

If you were interviewing someone for your position what emotional skills would you look for?

Two participants deemed skills under the umbrella of Communication and Relationship management as relevant to emotional skills needed for a position as clinical department administrator. P10 said of the competency of knowledge of public relations, "[An administrator] has to be willing to listen and not pass judgment right away." P18 discussed need of the competency of knowledge of the principles of communication and their specific applications

(e.g., crisis communication, alternative dispute resolution, etc.). When discussing professional roles, responsibility, and accountability, a competency under the domain of Professionalism, P04 explained a clinical department administrator has to be able to separate professional and job-related activities from a personal agenda. P10 likened the administrator's office to that of the priest's quarter. What is said in confidence whether by the chairman, faculty, or staff, must remain in confidence to maintain accountability and trust.

Within the realm of Emotional Intelligence, six competencies were perceived as relevant to department administration. First was the ability to regulate one's mood and preservation of motivation in frustrating situations. P02 remarked the qualities of rationalality and prudence were desirable. P02 said, "…level-headedness. I would look for somebody who has enough confidence in themselves that they don't get flustered…they can keep their focus on the task at hand and not be overwhelmed by [that task]." P12 considered the ability to stay calm under stress a necessary skill, and P21 asserted, "…don't make decisions based on emotions…This isn't personal, it's business." Second, empathy for others was perceived as a necessary competency. P20 stated, "You have to have your heart in believing in people that you work with to make them feel that you care." P20 added that there is a fine line between being perceived in a negative sense as an authoritarian and being perceived as someone who commands with compassion. Third, the ability to manage one's surroundings was perceived as a desirable trait. P02 remarked that the duties of administration can be taxing and overwhelming. At the end of the day, the department must deliver a quality product. The administrator is responsible for task completion no matter what stresses are encountered. P04 said of the same competency maturity has taught him not to micromanage stresses outside of his control. His self image is built upon the tasks in his control such as data accumulation and analysis. Realizing his limited access has

improved his management over programs within his purview. Fifth, P22 and P26 determined the need for the competency of the ability to remain in control of emotions while focusing on and accomplishing goals. P24 also alluded to a previously unlisted emotional competency, the need to for the clinical department administrator to portray self-confidence that words, actions, and delivery of decisions affecting others are the most effective and correct choices.

Under the auspices of the Social Intelligence umbrella were three competencies viewed as significant to the emotional welfare of clinical department administrators. P02 referred to the ability to express oneself with enthusiasm during social situations, reading, and comprehension of different types of social situations as a necessary competency. P21 perceived understanding of accepted social roles, norms, and scripts as a skill clinical department administrators should contain. P21 stated through lack of emotional expression when negative consequences must be rendered, the administrator can make the chairman of the department look more approachable. The chairman is viewed by others as the "good guy" when making hard decisions such as letting go of employees because P21 delivers the details to the individuals. Six participants discussed the competency of management of one's behaviors that positively influence group member perceptions. P04 professed the ability to emotionally differentiate and maintain a perspective with passion enabled him to accomplish his duties. P10 reported a sense of maturity, discretion, trustworthiness, great listening skills, and high ethics allowed him to accomplish his job. P21 stated remaining calm when working with faculty, particularly angry faculty, helped "bring people together to see a common goal." Self-confidence was an important social skill stated by P24. When discussing the emotional qualities of an administrative candidate, P24 said, "I would expect them to be confident…" Table J8 in Appendix J is a list of competencies identified in IQ8. Figure J8 is a visual representation of the clusters discovered through analysis of IQ8.

Table 12

Number of Core Themes and Competencies Expressed by Participants in Response to IQ8

Core Theme	Number of Competencies Elicited Within Theme
Communication and Relationship Management	2
Professionalism	2
Business Knowledge and Skills	1
Emotional Intelligence	6
Social Intelligence	3
Total Number of Competencies Referred to in Response to IQ8	14

Interview Question 9

If you were interviewing someone for your position what social skills would you look for?

One emerging competency was discussed under the theme of Communication and Relationship Management. The competency alluded to was knowledge of the principles of communication and their specific applications. Speaking of this competency, P04 articulated that as cliché as his thoughts were, communicating intelligently, articulately, and effectively through verbal and written communication skills is an essential competency of the clinical department administrator. P12 said respectively, " You have to be comfortable talking to people and talking to people you don't know." Three competencies were discussed under the realm of Emotional Intelligence. First was the competency of empathy for others. P02 stated all employees have value to the clinical department. The administrator draws upon employee value and propagates and the attribute for the sake of the organization. P04 recommended administrators "always be mindful of tolerance and appreciation for medical staff…as people and as family members. P10 suggested some people may find talking to surgeons easier than talking to housekeepers. P10 stated, " I think a good administrator learns how to engage both of them." A second emotional intelligence competency noted by P12 was the ability to manage one's surroundings. A balance of an introverted personality with an extroverted personality allows the administrator to communicate more effectively, thus accomplishing more tasks. The third

competency discussed by P20 was the development of the state-of-mind. Polsfuss and Ardichvili (2009) regarded the state-of-mind (SOM) competency as encompassing other emotional intelligence competencies. P20 asserted communication, honesty, trust, and respect could be mastered with applied consistency and forethought.

A social intelligence theme not discussed in the literature review was proposed by P20. When asked the question about the social skills the administrator should look for in a clinical department administrator replacement, P20 said, "[Candidates for my job] have to be very, very people oriented. P10 revealed a need for the competency of expression of one's self in social situations, reading, and comprehension of different types of social situations. P10 said one of his responsibilities is ensuring the chairman is the department's "shining star" or charismatic personality so others perceive the chairman to be trustworthy, visible, and socially engaging. Five additional social intelligence competencies were perceived as relevant to the leadership role which can be found in Table J9 in Appendix J as a complete of competencies identified in IQ9. Figure J9 is a visual representation of the clusters discovered through analysis of IQ9.

Table 13

Number of Core Themes and Competencies Expressed by Participants in Response to IQ9

Core Theme	Number of Competencies Elicited Within Theme
Communication and Relationship Management	1
Professionalism	1
Business Knowledge and Skills	3
Emotional Intelligence	4
Social Intelligence	7
Total Number of Competencies Referred to in Response to IQ9	16

Interview Question 10

Central Question— What competencies are essential for effective leadership of an academic medical center clinical department administrator?

This was the dissertation's central question. The nine previous questions dissected the central question. Posing the central question as the last question was meant to give the participants an opportunity to synthesize previous information into one encompassing statement. Within the theme of Communication and Relationship Management, P12 discussed the competency of knowledge of principles of communication and their specific applications. P12 perceived an essential competency to be solving personnel conflicts. Within the Domain of Leadership, P20 advocated for the competency of personal journey disciplines. P20 remarked all clinical department administrators should strive for excellence in all areas of duties: meeting the education, research, and clinical missions of the AMC, and working in a leadership capacity in an active clinical practice. Under the theme of Professionalism, P04 and P10 asserted the need for professional credentialing and education. Under the Domain of Knowledge of the Healthcare Environment, a theme emerged not discussed by the HLA. P10 stated "The competencies of an academic leader at an academic medical center are a knowledge of the complexities of what makes an academic medical center unique versus a private hospital. The new competency was named "understanding the intricacies of working in an AMC versus other types of healthcare facilities." Business skills remained a predominate theme. Thirteen competencies were perceived as important to the role of clinical department administrator including the competencies of management functions, organizational dynamics, political realities, and culture, organizational mission, vision, objectives, and priorities, and customer satisfaction principles and tools. Indicating the competency of knowledge of management functions, P04 discussed "management basics like understanding basic software programs, understanding how to do some data analysis, understanding your governing structures, [and] understanding some IT types of aspects of the job." P12 added the clinical department administrator needs some basic financial

skills and an understanding of general management of people. P02 explained his understanding of one aspect of the competency of organizational dynamics. The department administrator has to be able to prioritize issues; "first comes the department, but within the organizational dynamics." Alluding to the competency of understanding the organizational mission, P04 said, "In the academic medical center, it helps…to appreciate that despite the stresses, the strains, and changes in resource allocation, there are three missions…We are not simply a patient care enterprise we're not simply a training enterprise, but [we are also committed to research]. P20 perceived the need for the competency of customer satisfaction principles and tools. P20 stated that people (patients) will be drawn to clinical enterprises that offer quality physicians and excellence in product and service. Of note were two competencies unmentioned in earlier discussions, but relevant to P22 in the summation. The competencies added were Human resources laws and regulations (e.g., labor law; wage and hour; FMLA; FLSA; EEOC; ERISA; workers compensation) and the need for knowledge of the Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting).

Four Emotional Intelligence competencies were perceived as necessary skills. First, mood regulation and preservation and preservation of motivation in frustrating situations was discussed by P02. P02 advised clinical department administrators to concentrate on the ability to listen and practice patience. Second, P02, P12, and P20 thought empathy for others was a compelling competency. P12 stated, "[In order to] get a feel for [faculty] you don't see on a day to day basis…you really need to quickly determine how they're doing. You can ask them and they'll say something, but then you read between the lines [to discover their true feelings]." P20 added, [The administrator has to have] enthusiasm, to be patient with people, there's a value in a person. Everybody has value to add in some way and you have to work toward those assets…."

P02 remarked when working with colleagues the administrator should empathize by thinking about being "in their place and at least listen fairly to their statements and their desires and their needs." P18 and P24 referred to the competency of the ability to remain in control of emotions while focusing on and accomplishing goals.

All of the participants perceived Social Intelligence knowledge and skills valuable tools to the clinical department administrator. P20 attributed effective leadership to the quality of self-confidence by saying, "You have to have confidence that you don't fear failure [in order to] win respect." Expression of oneself during social situation, reading, and comprehension of different types of social systems were included in the interviews of P02, P10, P12, P20, and P21. P02 emphasized that shyness was not a desirable trait as one could be taken advantage of in certain social settings. P10 remarked, " An effective leader would balance technical skills with a good personality to listen, be a facilitator, and a resource. P12 stated being able to "read" situations, being able to read between the lines when in a meeting was advantageous to the effectiveness of the administrator. P20 advised listen and show others that you care. Act industrially, prepare for the worst and hope for the best. P21 stated the administrator must synthesize a large amount of information in a small amount of time, often without receiving many details. Yet, the administrator's job is to make effective choices and decisions so that his message is clearly understood. P22 and P24 discussed the need for interpersonal problem-solving skills and social role-playing skills. P04 was concerned with the competency of understanding of accepted social roles, norms, and scripts. P04 encouraged getting to know of others' general orientations to understand their motivations. P21 discussed the competency of skills necessary for task completion. P21 perceived the "the ability to process a lot of information and be able to narrow it down to a smaller number of items to present to the faculty" as a skills of task completion that

focused the administrator's efforts to accomplish a goal efficiently. Other participants finding relevance in skills necessary for task completion were P18, P24, and P26. Last, the Social Intelligence competency of management of one's behaviors that positively influence group member perceptions was that a resource P02, P12, and P20 believed should be in the clinical department administrator's arsenal. P02 felt the role of the leader was to encourage success in others, thus making the department thrive and prosper. P12 counseled the administrator to work logically as a technique to evaluate and propose new options when settling personnel conflicts. Finally P20 advocated, "Add you [strength]in order to build a [successful] organization. Table J10 in Appendix J is a complete list of competencies identified in IQ10. Figure J10 is a visual representation of the clusters discovered through analysis of IQ10.

Table 14

Number of Core Themes and Competencies Expressed by Participants in Response to IQ10

Core Theme	Number of Competencies Elicited Within Theme
Communication and Relationship Management	1
Leadership	2
Professionalism	3
Knowledge of the Healthcare Environment	4
Business Knowledge and Skills	13
Emotional Intelligence	4
Social Intelligence	6
Total Number of Competencies Referred to in Response to IQ10	33

Findings: Thematic Development Through Analysis of Participant Interviews

Participant 02

The perceptions of P02 corresponded with a total of 28 competencies within six primary themes used in the categorization of health care clinical administrative leadership competencies. The core themes, or domains in which competencies were discussed were Communication and

Relationship Management, Professionalism, Knowledge of the Healthcare Environment, Business Knowledge and Skills, Emotional Intelligence, and Social Intelligence. Within the Domain of Communication and Relationship Management, P02 discussed two competencies. First, when responding to IQ1, P02 said, "I look at is being an equal partner with the senior leadership. In my perfect world, you have the chair and then you have maybe 4 people at an equal level who would share the responsibilities for the 4 main missions." This corresponds to knowledge of the organizational structure of his department and the interactions of the leadership personnel. Second, P02s response to IQ7 was clinical department administrators should have "the ability to communicate well." This statement is in direct alignment with the competency of Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.).

P02 discussed three competencies within the core theme of Professionalism. First, when replying to IQ 7 about interviewing someone for his position, P02 discussed his role as being responsible for the department's administration. The phrase is aggregate to the competency of knowledge of professional roles, responsibility and accountability. Second, one of P02s duties was lecturing to medical residents several times a year. The HLA did not categorize this duty which may be specific to clinical department administrators in academic medical centers. A new competency evolved entitled, "Training or instructing roles." The third competency discussed was a need for an advanced degree or certification. P02 stated, "If they're qualified most likely they have the skills set," implying that a candidate must meet minimum standards to be considered eligible for the position.

P02 alluded to four competencies within the core theme of knowledge of the healthcare environment. First, one of duties of a clinical department administrator is "securing money for

visiting professor lecturers and sending residents to do national presentations". This corresponds to the competency of knowledge of Educational funding for healthcare personnel. Second, P02 stated, "I think the other important part of my role in research is to make sure we are following policies and procedures whether they be federal or the state or an organization and funding agency." This statement is alignment with the competency of Corporate compliance laws and regulations (e.g., physician recruitment, billing and coding practices, antitrust, conflict of interest, etc.). Third, when discussing the competency of knowledge of funding and payment mechanisms of the healthcare system for research in response to IQ4, P02 said, "It's very important [to be knowledgeable about funding mechanisms] because if we have to assign people, if people get research money, we have to take them out of the clinical environment and so that's doubly expensive. One, I'm paying the person I'm taking out and two; I have to pay somebody to be there, so we have got to watch that." Fourth, P02 also stated that the competency of knowledge of the interrelationships among access, quality, cost, resource allocation, accountability, and community is a necessary skill. When discussing the department administrator's role as business manager in a clinical practice (IQ6) P02 discussed the importance of knowledge of the interrelationships. P02 said, "We then break down various business units within the [department] and look at what we're doing. Are we doing more cardiovascular cases or are we doing more OB? Are we doing more [pediatrics]? All of those have to go into the mix."

The core theme of Business Knowledge and Skills appeared the most important acumen to P02. P02 alluded to thirteen business knowledge and skills competencies when responding to eight out of the 10 interview questions. First, workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a

medical practice) appeared as a dominant competency, addressed in response to two questions. Second, in response to IQ2, P02 said, "my involvement [in the surgical theater] is to try to make sure that we have the right mix of providers and by that I mean the right mix is not only right aggregate number but you have to have the right people on the right days." Third, when answering IQ5, P02 said, "you take somebody out of a clinical enterprise, you have to backfill; making sure we're staff correctly." Fourth, the competency of knowledge of organizational dynamics, political realities, and culture was also perceived as a necessary competency. In response to IQ4, P02 stated, "...I'm very happy and very proud that doc x got a grant, I can't do anything until we get the NOA, until it gets here; Oh, by the way, [the researcher] didn't really get a grant but somebody in that company said they thought maybe they could fund it." When summarizing competencies for IQ10, P02 said, "First comes the department but within the organizational dynamics." The largest majority of business knowledge and skill competencies were elicited in response to IQ5, the clinical department administrator's role in the leadership of the academic medical center's mission to conduct a clinical mission. The list of additional business knowledge and skills competencies is provided in the tables and figure corresponding to the competencies expressed by P02.

P02 proposed three emotional intelligence competencies (within the theme of Emotional Intelligence) were necessary to the clinical department administrator. The first competency discussed was mood regulation and preservation of motivation in frustrating situations. The statement P02 gave that corresponded with this competency when providing feedback for IQ8 was, "…level-headedness--I would look for somebody who has enough confidence in themselves that they don't get all that flustered by that. That they can keep their focus on the task at hand and not being overwhelmed by the task at hand." When summarizing necessary competencies in

IQ10, P02 asserted, “the ability to listen and to have patience”, in other words, preservation of motivation in frustrating situations, was perceived as requisite. The second competency intimated was empathy for others. P02 said, “So what I have to do if I’m working with colleges is to kind of put myself in their place and at least listen fairly to their statements and their desires and their needs.” Third, when responding to IQ8, P02 felt conflict between the desire to show empathy for others during stressful events and task completion. In such a case, managing one’s environment (the competency of ability to manage one’s surroundings) was perceived as a crucial competency to keep moving forward with tasks. “A clinical department administrator should keep their focus on the task at hand and not [become] overwhelmed…Kind of like the catch 22 and chasing your tail instead of actually getting production. Because at the end of the day I think the people we answer to are expecting a certain amount of production. How we do that, whether we do it in by amassing data from the people underneath us or we do a lot of thought process ourselves, they really don’t care but they want a product to deliver [to the consumer.]

The theme of Social Intelligence was also perceived as necessary to the role of clinical department administrator. The three competencies P02 applied to hospital administration were (a) Understanding of accepted social roles, norms, and scripts, (b) Expression of oneself during social situations, reading, and comprehension of different types of social situations, (c) and management of one’s behaviors that positively influence group member perceptions. First, when discussing understanding of accepted social roles, norms, and scripts in response to IQ6, P02 said, “The recruiting and the retention of these folks is a little different. Residents come here and expect to do 3, 4, or 5 years in training, you pretty much point them in the direction and its hands off. Managing 40-50 nurses is a little different, so and you know they’re more of an employee

where residents are more of a trainee obviously and the management needs are different in that environment." Second, the competency of expression of oneself during social situations, reading, and comprehension of different types of social situations was referred to in response to four different questions. During the response to Q7 P02 said a candidate needed "bright eyes. I want to see enthusiasm in any level of recruiting." When replying to IQ8. The necessary emotional skills, P02 listed the ability to be involved and enthusiastic. His response to IQ9 referring to social intelligences was similar. "I guess the big [competency]…is to be able to be engaged at all levels.." In the summary of competencies in IQ10, P02 remarked, "You can't be shy or you'll get run over", implying the need to express oneself in groups of strong, outspoken healthcare leaders. Third, when summarizing desirable competencies for the clinical department administrator, P02 reflected on the competency of management of one's behaviors that positively influence group member perceptions. P02 perceived a major component of the job as influencing others. P02 said, "[I] try to see if I can actually help others to succeed. Because usually if they succeed, then we're going to succeed so there's that connected centered focus that one has to have to be sure the thing works. Table K1a in Appendix K is a summary of the P02 interview categorized by question. Table K1b is a summary of the P02 interview by core theme. Figure K1 is a visual representation of thematic clusters and competencies as presented by P02.

Participant 04

P04 expressed 32 competencies within the seven core themes of Communication and Relationship Management, Leadership, Professionalism, Knowledge of the Healthcare Environment, Business Knowledge and Skills, Emotional Intelligence, and Social Intelligence.. Three competencies were discussed in the theme of communication and relationship management. First when addressing his position within the organization, P04 considered himself

a "member of the senior management team, insinuating the competency of knowledge of organizational structure and relationships. Second, P04 discussed the competency of Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.). P04 related one of his duties as providing "council to the chair." Third, when responding to IQ9 a question of what social skills a clinical department administrator should be able to demonstrate, P04 stated, the competency of principles of communication and their specific applications was imperative. "…communication skills which you know it's almost cliché at this point but its critical both for verbal and written [communication.] [Candidates for clinical department administrator] need to be able to communicate intelligently, articulately and effectively."

Four competencies were deemed important within the core theme of Professionalism. First, referring to the competency of knowledge of professional norms and behaviors, P04 said, "[a clinical administrator should be able to] differentiate professional or job-related things from personal." Three of the competencies in the domain of Professionalism were not identified competencies by the Healthcare Leadership Alliance, the body determining competencies used by healthcare professionals. First, P04 perceived the competency of MBA, higher level degree, or certification, considering the need for professional credentials important. An additional comment was, "I'd suggest at least master's degree training….the ability to work both in a detailed work environment as well as thinking more locally and more of a macro level." Second, P04 perceived the competency of the need for prior experience. Third, the competency of being able to balance professional responsibilities with human skills was identified. P04 recommended a sense of passion combined with desire to maintain both inward and outward control in the academic medical center environment.

Three competencies were suggested under the theme of Knowledge of the Healthcare Environment. First, when responding to IQ2, perceptions of the leadership role of an administrator within the academic medical center, P04 said, ""I'm somewhat of an Institutional Library….my role has transitioned from simply kind of establishing process and procedure and policy to an extent to now really assisting the chair as a member of the senior leadership team and thinking in terms both operationally and trying to be mindful of details and working with staff but also trying to think strategically, think ahead and really get a view of what where we should be going, what are the trends in healthcare and emergency medicine in particular, locally and nationally and then make sure I'm on the same page with the chair and at least understand where our differences are." The competency most nearly related to this statement is knowledge of Global healthcare issues, trends and perspectives (e.g., aging population, insurance costs, malpractice crisis, etc). Second, a knowledge of corporate compliance laws and regulations (e.g., physician recruitment, billing and coding practices, antitrust, conflict of interest, etc.) was considered a necessary competency when discussing the educational mission of the organization (IQ3). P04 felt such a competency would be useful when "understanding residency accrediting bodies and meeting standard." The same competency was applied again when discussing the organization's research mission. P04 felt a good understanding of the policies and procedures for administering the research mission was a valuable asset. Third, a competency not identified by the HLA was noted by P04. P04 believed it is necessary to integrate, merge, link, and marry the department and hospital perspectives. Of this competency he said one of his duties was to "bridge the hospital perspective in the clinical arena with the medical staff [in the clinical practice] (IQ5).

Sixteen competencies within the core theme of Business Knowledge and Skills were presented by the participant. First, one important statement P04 made was in response to IQ2 (leadership role within the academic medical center). P041 advised "think strategically, think ahead and really get a view of what where [the department] should be going." This statement encompassed four competencies: (a) knowledge of comparative analysis strategies (e.g., indicators; benchmarks; systems; performance), (b) Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting), (c) Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting), and (d) Strategic planning processes development, and implementation (scenario planning, forecasting, etc). Then, in the final summation given by P04 during IQ10, P04 referred to two competencies felt necessary in the administration of an academic center clinical department. First, intimating the competency of knowledge of the Organizational mission, vision, objectives and priorities, P04 stated, "In an academic health center, it helps also really I think to appreciate that despite the stresses, the strains, and changes in resource allocation, there are three missions and we are not simply patient care enterprise, we're not simply the training enterprise but research is critical." Second, the competency of knowledge of Management functions (e.g., planning; organizing; directing; controlling) was vital. Clinical administrators must have in their repertoire "management basics like understanding basic software programs, understanding how to do some data analysis, understanding your governing structures, understanding some IT types of aspects of the job." A complete list of Business Knowledge and Skills competencies as expressed by P04 is presented in the tables and figures below.

P04 referred to two competencies within the core theme of Emotional intelligence as pertinent to clinical department administration. First, pertaining to the competency of the ability

to manage one's surroundings, P04 asserted, "there's a line where our responsibilities and our abilities to influence stops and whether those things happen really isn't of our concern after we've done our job to try to prove the information and analysis that will assist the chair in making whatever arguments they need to but I know a lot of times, I in the past, and my colleagues will get very caught up in those types of things."Second, P04 also believed a necessary competency to be empathy for others. "[Physicians, residents, and staff] all have value and our emotional or social ability ought to be to draw that value out and try to help regardless…"

Within the core theme of Social Intelligence, P04 perceived three competencies as necessary. First, when discussing IQ7(what are knowledge, skills, and abilities you look for when interviewing a candidate), P04 remarked, "[Besides] management and the kind of the technical and analytical skills and an ability to…multitask, you have to be able to just cover the spectrum." This statement most closely relates to the competency of skills necessary for task completion. Second, a final critical social skill addressed was an understanding of accepted social roles, norms, and scripts. When summarizing necessary competencies in his address to IQ10, P04 referred to an understanding of each person's general orientation (surroundings, circumstances, position within the organization). Third, acknowledging the competency of management of one's behaviors that positively influence group member perceptions, P04 said, an administrator should have the ability to "emotionally differentiate and maintain a perspective to be able to passionate about their work involved but to maintain a healthy perspective."

Table K2a in Appendix K is a summary of the P04 interview categorized by question. Table K2b is a summary of the P04 interview by core theme. Figure K2 is a visual representation of thematic clusters and competencies as presented by P04.

Participant 10

The six core themes, or domains in which competencies were elicited were Communication and Relationship Management, Professionalism, Knowledge of the Healthcare Environment, Business Knowledge and Skills, Emotional Intelligence, and Social Intelligence. Within the core theme of Communication and Relationship Management, P10 considered one relevant competency to by knowledge of public relations. P10 reflected on the need for restraint, the ability to listen and consider one's actions crucial to development of strong social connections.

Discussion of the theme Professionalism brought to light four competencies. First was the competency of knowledge of professional roles, responsibility, and accountability. In response to IQ8 on emotional skills necessary for clinical department administration, P10 made a strong claim when stating, "Ultimately the buck starts and stops with the department administrator. In addition, the comment made by P10 concerning the ability of the clinical department administrator to remain impartial to events around him and use discretion in political, official, and personal matters related not only to the theme of Professionalism, but also to the theme of Communication and Relationship Management. P10 commented, "I think the first thing that comes to mind with emotional skills is I've often said that the administrator's office is like the priests quarter. It is the lawyer's room and so with that comes a certain amount of accountability and trust. You have to be able to listen and not pass judgment right away." This statement reflects both the competency of knowledge of Professional roles, responsibility, and accountability; adeptness when handling issues of public relations. Second, three competencies not listed by the Healthcare Leadership Alliance (the professional society that put together the list of themes and competencies) may be related directly to the role of the clinical department

administrator. First, administrators have duties to train the next generation of physicians, a new perceived competency. Second, a balance should be maintained between professional responsibilities and human skills. When addressing IQ7, P10 remarked, "I believe there's a balance between being very tactically strong admin and also having good human skills and so I've been I would try to find somebody who is knowledgeable but also has good interpersonal skills." Third, a higher level degree and or certification proves knowledge of basic administrative skills. P10 asserted the need for "validation of technical competencies through professional certification."

Within the core theme of Knowledge of the Healthcare Environment, P10 discussed components related to six leadership competencies. First, the competency of healthcare technological research and advancements was elicited from a comment in IQ1 about the administrator's responsibility to keep "apprised of research issues and initiatives." Second, the competency of knowledge of educational funding for healthcare personnel arose from the discussion of the educational mission of the academic medical center (IQ3). P10 discussed the need to gather "philanthropic funds for unique residency items not covered by other funding sources (ex. ipads)." Third, while conversing about the educational mission, P10 added it was the administrator's responsibility to provide "resources for the residents to have the most fruitful and rewarding and educational experience they can during their tenure of residency." This closely relates to the competency of funding and payment mechanisms of the healthcare system. Fourth, the competency of understanding community standards of care was broached in the address to IQ5 when the participant said, "[The department has] a very large outreach program that I'm involved in quite a bit." Fifth, the participant was concerned with the competency of the interrelationships among access, quality, cost, resource allocation, accountability, and

community. When discussing IQ5, administrative duties to the clinical mission, P10 described a working scenario. "I'll use the ball analogy to patient care, balance research, teaching, and philanthropy. I think it's fair and I hope you'd agree with me that patient care is the biggest ball in that but if the ball becomes too big and over takes over the other missions then we've become a private practice offering without fulfilling our other obligations. He continued the discussion when attending to IQ6, perceptions of the role of office manager to a clinical practice. "The administrator must ensure] that the financial resources are there to meet [the department's] year to year goals on our operational budget and then our capital goals on our long term objective. Sixth, a new competency was alluded to when summarizing the role of the clinical department administrator in IQ10. The new competency was understanding the intricacies of working in an AMC versus other types of healthcare facilities. P10 remarked, "…so the competencies are an academic leader at an academic medical center are a knowledge of the complexities of what makes an academic medical center unique versus a private hospital."

Sixteen competencies were perceived necessary in the realm of Business Knowledge and Skills. Seven of the competencies related to one encompassing statement made in response to IQ1, the role of the administrator within the clinical academic department. P10 asserted the administrator serves "as a resource, facilitator and decision making party supporting all faculty and staff to the best of [the administrator's] abilities on key operational, financial, research administrative issues and initiatives. Competencies related to this statement are (a) Management functions (e.g., planning; organizing; directing; controlling), (b) Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external, (c) Financial analysis (e.g., ratio analysis; cost-benefit analysis; cost-effectiveness analysis; vertical analysis; horizontal analysis), (d) Financial planning methodologies (e.g.,

strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting), (e) Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting), (f) Implementation planning (e.g., operation plan; management plan), and (g) Characteristics of administrative systems/programs (e.g., financial; scheduling; on-line purchasing; productivity; human resources). IQ5 evoked four business skills competencies. First, P10 discussed the department's clinical mission." So regarding the clinical mission— It is to make sure that we have department in our subspecialties and that we have good access and that we provide evidence based medicine." This statement aligns with the competency of knowledge of an evidence-based practice. Second, P10 considered the competency of understanding Various roles and responsibilities of physicians in a medical practice (e.g.,, provider; owner; managing partner; president of the board; medical director). He surmised, "you need to understand the business from a purely clinical standpoint— understand the politics from a faculty standpoint." Third, discussion of strategic planning and management related to the competency of Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting). Fourth, "watching to make sure that the clinical work is getting billed correctly, watching you're A/R" corresponded to the competency of Physician practice management IT systems (e.g., billing; referral/authorization; claims processing; electronic medical records; prescription writing; productivity; transcription) and the financial competency of Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing).

P10 expressed one competency within the theme of Emotional Intelligence relevant to a clinical department administrators' position. Of great concern to the department administrator was the ability to have and express empathy for others. P10 said, "The interest level of one the housekeepers for social conversation versus one of the surgeons reciprocally might find it easier

to talk to the housekeeper than the surgeon, might find it easier to talk to the surgeon than the housekeeper. I think a good administrator learns how to engage both of them." In addition, three Social Intelligence skills were discussed. One necessary competency alluded to was management of one's behaviors that positively influence group member perceptions. When answering IQ8, P10 responded an administrator needs the emotional skills is sense of maturity, discretion, trustworthiness, great listening skills and high ethics. A second competency stressed was understanding of accepted social roles, norms, and scripts. Discussing his role as protecting the chairman's position as department head, P10 said, "Let the chairman be the department's 'shining star' or charismatic entity."

Third, the social intelligence competency of expression of oneself during social situations, reading, and comprehension of different types of social situations was found pertinent to the conversations of IQ7, IQ8, and IQ10. First, when discussing relevant skills to look for when interviewing (IQ7), P10 stated, "I find individuals who are technically very strong but bury themselves in the office and never are engaged with the residents and the faculty and the staff and thus don't have the deeper relationship. So if I were interviewing someone for my position, I would look for somebody who has balance in those two skills sets. Personality that would be reflective of those things I already reference to you and validation of some department of technical knowhow." Second, when discussing necessary emotional skills (IQ8), P10 asserted an administrator must be "socially adept." Third, when summarizing necessary competencies (IQ10), P10 stated, "An effective leader would balance technical skills with a good personality to listen, be a facilitator and a resource." Table K3a in Appendix K is a summary of the P10 interview categorized by question. Table K3b is a summary of the P10 interview by core theme. Figure K3 is a visual representation of thematic clusters and competencies as presented by P10.

Participant 12

Nineteen competencies were expressed by P12 within the seven core themes. The seven core themes, or domains, in which competencies were elicited were Communication and Relationship Management, Leadership, Professionalism, Knowledge of the Healthcare Environment, Business Knowledge and Skills, Emotional Intelligence, and Social Intelligence. Within the theme of Communications and Relationship Management, one competency was indicated when addressing five interview questions (IQ3, IQ4, IQ6, IQ9, and IQ10). The competency of knowledge of the principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.) was prevalent in the discourse. When responding to IQ3, P12 directly discussed "conflict resolution." In the dialog for IQ4, P12 discussed the use of communication skills when working with researchers. One duty of clinical department administrators when striving toward the academic medical center's mission of research is [engaging in] "a conversation with [the department's] PI's about their research programs" in order to gauge progress and understand the financial aspects of the research. In the discussion of IQ6, the role of the administrator as clinic manager, P12 discussed his position as director to remain in constant contact with clinic personnel. "I don't see myself as the business manager. I think [my role is] more speaking to the people and more coordinating the people that are the business managers of their little areas. In his address to IQ9, the social intelligence skills a clinical department administrator needs in his repertoire, P12 remarked, "You have to be comfortable talking to people and talking to people that you don't know." The ability to communicate in various situations then becomes a social skill as well. In P12s summation of competencies for IQ10, he again stressed the importance of communication in [solving] personnel conflicts.

Three themes expressed as relevant to the administrator's role were Leadership and Professionalism and Knowledge of the Healthcare Environment. IQ1 asked about the clinical department administrator's role within the department. A pertinent competency within the core theme of Leadership was acknowledged, the competency of knowledge of leadership styles and techniques. P12 perceived one of his roles as "facilitator," overseeing all activities within the department to maximize results.

Within the theme of Professionalism two competencies were cited. First, the competency of organizational business and personal ethics was alluded to in response to IQ1. P12 contended one duty of the administrator is "representing the Department's best interests" within the department and when engaging with others within the academic medical center. Second, a competency not expressed by the Healthcare Leadership Alliance (HLA) (the professional society responsible for the creation of the list of domains and competencies) was articulated by P12 when discussing position qualifications. "[The administrator has] to have one or two of about 3 [items]. [The administrator needs] to have managerial experience, you need to have clinical experience, or you need to have research experience." The competency discussed was one of prior experience.

One competency was significant from the core theme of Knowledge of the Healthcare Environment. The competency conveyed in response to IQ3 and IQ4 was knowledge of funding and payment mechanisms of the healthcare system. IQ3 was a question of skills relevant to completion of the academic medical center's mission of education. P12 related the administrator must understand purchasing and financial departmental matters in order to "[provide] equipment for the [residency and medical student] program to run smoothly." When discussing the specialized mission of the academic medical center to fulfill the obligation of research (IQ4),

P12 asserted, "We have to fund research, it doesn't fund itself. So, from a leadership prospective in a department, we need to plan for when we will have funding and when we won't have funding."

P12 stressed eight competencies within the theme of Business Knowledge and Skills. First, the competency of broad systems connections—potential impacts and consequences of decisions was stated when the participant said, "my role in [fulfilling the educational mission] is helping it run smoothly, just like I help the rest of the department run smoothly." Second, workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice) was explained when P12 mentioned providing personnel necessary to make [the educational] program run smoothly and effectively. Third, when discussing maintenance of research grants, P12 alluded to the competency of inventory control systems, stating that one duty of the administrator is to "keep [grant] end dates in mind" when making financial decisions based on grant funded projects. Fourth, the competency of asset management, including investments, equipment, etc. was approached when P12 stated an administrative duty was management of research accounts for PIs (Principle Investigators); "knowing how much [money] is available in each account for bridge funding if necessary. Fifth, staffing methodologies and productivity management was reflected upon when P12 discussed "general management of grants staff, and the administrative staff that needs to be in place" when meeting the research mission of the AMC. Sixth, the participant related a scenario in which the clinical department administrator is responsible for understanding physician compensation and benefits through salary allocation. "On the research side, we have grants administrators who can say, all right well, "this grant that we're putting forth, we want to have 30% of a PI's salary on this (grant), plus we're going to have to cover any

salary over the cap." So you can have a staff member who can really evaluate the grants without any supervision and on the clinical side, I think there's a big gap there, that the administrator of the department is pretty much the responsible party for that." Seventh, the competency of implementation planning was intimated when expounding on IQ6, the administrator's role in clinic management. P12 stated that "[he manages] the overall picture and coordination" of clinical activities. Eighth, the competency of knowledge of management functions was emphasized. "There's some basic skills that you need as far as financial…here's the understanding of just general management of people."

Two competencies within the realm of emotional intelligence were stressed as relevant to clinical department administration. First, addressing the emotional qualities he would look for in a candidate for an administrative position, P12 stated, "I would try to evaluate the person's ability to stay calm under stress." This statement reflects closely the competency of mood regulation and preservation of motivation in frustrating situations. Second, in the summation of competencies in IQ10, P12 expressed the requisite competency of empathy for others. At times faculty and staff within the department may not be able to articulate their true feelings. "Getting a feel for people you don't' see (like faculty) necessarily on a day to day basis in a large department like this [is important.] But when you do, you really need to quickly determine how they're doing. You can ask them and they'll say something, but then you read between the lines and find out you know what is [the person's] real feeling."

P12 perceived the theme of Social Intelligence as important to the clinical department administrator's position. First, the competency of interpersonal problem-solving skills and social role playing was addressed when answering the question of the administrator's role within the department (IQ1). "When there's a personnel issue that's not directly reporting to me, I get

involved" because the administrator is supposed to help solve issues of conflict. Second, when working with faculty and staff, attunement to complex social cues is essential. P12 asserted, "The ability to dissemble a situation and read the mood of the faculty and the staff and help maneuver through what can sometimes be, with the wrong words, a very volatile situation. With the right words and the right presence, you can come to a pretty quick (not always easy but at least acceptable) solution to problems." Third, the competency of expression of oneself during social situations, reading, and comprehension of different types of social situations is a necessary skill when involved in activities in the academic medical center. P12 found the competency invaluable "being able to read the situations, being able to read between the lines when you're in a big meeting". Fourth, management of one's behaviors that positively influence group member perceptions is essential. When discussing necessary emotional skills (IQ8) P12 affirmed, "[a] person's ability to stay calm under stress and under, when dealing with angry people, in particular, angry faculty…you really have to know how to handle it...being able to remain calm and try to bring people together to see a common goal. In addition, when summarizing important leadership competencies, P12 said, "being able to logically evaluate options and propose new options because…where there's a conflict, there's got to be another option because you're not getting agreement." Table K4a is a summary of the P12 interview categorized by question. Table K4b is a summary of the P12 interview by core theme. Figure K4 is a visual representation of thematic clusters and competencies as presented by P12.

Participant 18

The seven core themes, or domains, in which competencies were elicited were Communication and Relationship Management, Leadership, Professionalism, Knowledge of the Healthcare Environment, Business Knowledge and Skills, Emotional Intelligence, and Social

Intelligence. Within the theme of Communications and Relationship Management, two competencies were identified. First, P18 talked about the role of the clinical department administrator within the administration of an academic medical center (IQ2). P18 stated an administrator needs the ability to "essentially to be a voice for your dept." This statement directly corresponds with the competency of knowledge of public relations. Second, P18 discussed the competency of knowledge of Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.) during the discussion of IQ8 (necessary emotional competencies) when P18 suggested department administrators "have to know how to talk to people" to be effective. Additionally, when discussing what knowledge, skills, and abilities to look for when interviewing candidates for a position as clinical department administrator (IQ7) P18 advised the need for what he termed as "soft skills" to accomplish goals through the application of negotiation.

One competency within the theme of Leadership and two competencies within the theme of Professionalism were emphasized as important administrative skills. The leadership competency to which P18 alluded was personal journey disciplines; the practice of lifelong learning leading to building a reputation on past successes. As a previous hospital CEO, P18 practiced the discipline of healthcare leadership, becoming an expert at physician contracting among other healthcare and leadership skills. Within the theme of Professionalism, first P18 discussed a competency unidentified by the Healthcare Leadership Alliance. The HLA is the professional society that composed the initial list of themes and competencies. The new perceived competency has been titled the need for an MBA or higher level degree or professional certification. P12 asserted a department administrator should have "an advanced degree, an MBA or an MHA. My preference always is somebody with experience [in the upper percentile

of graduates with a degree]." Second, the competency of professional roles, responsibility, and accountability was considered necessary as one duty of the clinical department administrator is the recruitment and termination of staff dispensed in a professional manner.

Two competencies were elicited from discussions within the theme of Knowledge of the Healthcare Environment. First, when summarizing the clinical department administrator's list of competencies (IQ10), the competency of knowledge of healthcare economics was perceived as vital to the role. P18 said, "You have to know the business of medicine…You have to know what a CPT (Current Procedural Terminology) code is, you have understand what RVU's (Relative Value Unit) are, you have to know how it all rolls up into a budget." Second, the administrator's duties require a competency undetermined by the HLA. Anew emerging competency entitled support of research, research personnel, and grants was obtained from a statement made by P18. This competency may be specific to clinical department administration within an academic medical center. When discussing leadership duties to the academic medical center's mission of research (IQ4), P18 stated, "…for me in particular, I feel it's more of a support role per say in that [clinical department administrators] support the ability to get grants done. [The administrators] support the ability to provide realistic financial snapshots of where the researchers stand relative to budget."

Seventeen competencies were extracted within the theme of Business Knowledge and Skills. Five competencies were discussed when addressing the question of the department administrator's duties to meet the clinical mission of the AMC (IQ5). First, P18 referred to the competency of Data collection, measurement and analysis tools and techniques (e.g., root-cause analysis; process analysis; workflows). P18 stated the role of the administrator is "more operational" [than participatory in that the administrator] actually…work[s] on process issues."

Second, the competency of knowledge of the Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing) was considered necessary. P18 responded the duties of the department administrator include setting fiscal and financial targets while addressing efficiency measures, etc. Third, the participant discussed "oversight of clinical operations." This statement reflects three administrative competencies: (a) Fundamental productivity measures (e.g., hours per patient day; cost per patient day; units of service per man hour; PMPM), (b) Management functions (e.g., planning; organizing; directing; controlling), and (c) Customer satisfaction principles and tools.

Six competencies were articulated when summarizing competencies used by effective clinical department administrators (IQ10). First, P18 maintained the competency of determining outcomes measures and management (e.g., ROI; Cost-effectiveness analysis [CEA]; cash flow analysis and testing) was important when stating "[The administrator has] to understand contractual allowances versus gross charges. Second, knowledge of funding and payment mechanisms of the healthcare system was important and especially relevant to the grant funding, NOA process. Third, understanding compliance with regulatory agencies and tax status requirements was significant. P18 remarked, "[The administrator has] to understand a local environment and how to taxes are assessed and how that is going to produce the final bottom line." Fourth, P18 referred to understanding net revenue to determine money the department has to pay for items and activities. This falls under the competency of knowledge of the revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing). Fifth, P18 advised a background in human resources would be helpful to the clinical department administrator. The competency related to this statement is knowledge of organizational policies and procedures and their functions. Sixth, the competency of knowledge

of Staffing methodologies and productivity management (e.g., acuity-based staffing; flexible staffing; fixed staffing) was alluded to as a mechanism to monitor staff behavior. A complete list of competencies within the theme of Business Knowledge and Skills as expressed by P18 is located in the tables and figure below.

P18 perceived three competencies within the theme of Emotional Intelligence as relevant to the role of the clinical department administrator. First was the competency of mood regulation and preservation of motivation in frustrating situations. P18 advised "[The administrator has] to be a good listener, you have to be able to make sure you know it's not about you, it's not about being right or being wrong, it's about what's best for the dept.." Second, the competency of delay of immediate gratification was thought significant as the administrator should reflect on decisions before administering orders instead of impulsively and arbitrarily passing judgment. Third, P18 recommended the administrator to remain in control of emotions while focusing on and accomplishing goals. In the summation of competencies used by effective clinical department administrators, P18 recommended the need for "The intestinal fortitude to provide the consequences if the behavior does not match the pace and goals of the department."

Six competencies were defined within the theme of Social Intelligence. The competency of management of one's behaviors that positively influence group member perceptions was addressed when responding to three questions, IQ1, IQ8, and IQ10. In the discussion of the role of the department administrator within the department (IQ1), P18 stated, "My role within the department is one of influence...That's both collaborative at the chair level and it's one of influence, not final decision making." When discussing relevant emotional skills (IQ8) two plausible statements referred to this competency. First, P18 said, "We have an interesting mix of individuals where we have a few seasoned people on the staff side, but we have a lot of young

people. If we push them too hard too fast, they'll leave. If we leave them without expectations, nothing will get done. I also say the ability to negotiate with the faculty members." In addition, P18 related, "[The administrator has] to be able to articulate your message in such a way that various members of the audience aren't going to be offended and lose the message that you're trying to articulate." Finally, the competency of management of one's behaviors that positively influence group member perceptions was mentioned in the summation of relevant competencies (IQ10). P18 counseled the administrator to elicit positive working relationships with staff by remembering to say "job well done." A complete list of competencies within the theme of Social Intelligence as expressed by P18 can be referenced in the tables and figure below. Table K5a in Appendix K is a summary of the P18 interview categorized by question. Table K5b is a summary of the P18 interview by core theme. Figure K5 is a visual representation of thematic clusters and competencies as presented by P18.

Participant 20

P20 discussed 25 competencies related to the seven core themes: Communications and Relationship Management; Leadership; Professionalism; Knowledge of the Healthcare Environment; Business Knowledge and Skills; Emotional Intelligence; and Social Intelligence. Within the theme of Communications and Relationship Management, two competencies were discussed. First, the competency of public relations skills were thought useful when considering the role of the clinical department administrator in the realm of the academic medical center (IQ2). P20 said of the clinical department administrator's role in the AMC, "I've really developed relationships externally as a liaison with other community hospitals, with other programs, whether they be for profit or not-for-profit." Second, discussing necessary social skills (IQ9), P20 discussed the need for communication skills as one of the four attributes of successful

administrators. This statement corresponds with the competency of knowledge of Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.).

A significant competency within the core theme of Leadership was revealed through the interview process. The competency of knowledge of leadership styles and techniques was broached when discussing the role of the clinical department administrator within the department (IQ2). P12 remarked, "[Making] people believe in the changes that I'm making are for the better and for the good of the overall, not only of the mission of providing care but for those faculty for those staff that are here as well." Another second leadership competency was discussed in the summation of skills necessary for successful clinical department leadership (IQ10), the competency of personal journey disciplines. P20 believes strongly in striving for excellence as a lifelong goal and learning from failures as well as successes.

Within the theme of Professionalism, P20 expressed the competency of organizational and business ethics. Along with communication, P20 regards honesty, trust, and respect as skills necessary to build a firm ethical foundation within the academic medical center. People who exhibit these four components garner the respect of their peers, superiors, and subordinates. In addition, P20 related a competency not expressed by the Healthcare Leadership Alliance, the competency of the need for prior experience to be able to work with others in a professional manner. P20 provided a scenario articulating the necessity of this competency. The experience took place outside of the academic medical center, but was considered just as essential to professional behavior within the AMC. "I coached soccer when I was younger. I thoroughly taught to those individuals who were very young that in order to be successful, [you must develop] those four elements (communication, honesty, trust, and respect) in you, [and] embed

[them] in the back of your mind. [Should] you cross over any one of those, like a lack of communication, [you create an atmosphere of] disrespect, that you're not honest. People will not believe in you."

Three competencies within the theme of Knowledge of the Healthcare Environment were alluded to in conversation. First the competency of knowledge of the interrelationships among access, quality, cost, resource allocation, accountability, and community was discussed in IQ2 and IQ5 proving this competency necessary to the skills set of the clinical department administrator. When answering IQ2 (the role of the administrator within the AMC) P20 stated, "[Understanding the] integration between in an academic center is vital between the hospital, between the university, between the Dean's office." Discussing the role of the administrator meeting the academic medical center mission of clinical care, P20 said, "the clinical mission is to provide care for all, whether it be the indigent or otherwise because we're here to teach the residents and here to make sure that we have those complex cases for them to understand." Second, the competency of funding and payment mechanisms of the healthcare system was discussed when talking about the administrator's role in meeting the educational mission of the AMC. P20 felt that understanding funding for residency slots was a important component of the administrator's job when meeting that mission. Third, understanding healthcare technological research and advancements is a necessary competency to the mission of research. P20 remarked on the duty of the administrator to "review all of the manuscripts before they go to the IRB to get a better understanding of what they're doing, what type of drugs they're bringing in, what they're trying to prove" as an approach to exercise control over research dollars.

Business Knowledge and skills competencies were perceived as relevant to the clinical department administrator's functions. Six competencies were referred to multiple times. Three

competencies were discussed in relation to interview question 6 about the administrator's duties as manager of a clinical practice. First, an administrator must understand the competency of Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing). P20 asserted, "What I do on a daily basis…is to look at the volumes that are flowing through the building and make sure that [the department(s) is/are] keeping at threshold of about 600 [beds] or so, of course everybody has vacations, but from the standpoint of down to the minute details. Second, referring to the competency of Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice), P20 stated, "I've actually set up a great model for the floor that our clinics are on. The way that I've done that is develop a clinic manager who is superb and created a navigator who is a non-clinical individual who makes sure that the through-put is consistent and constant and therefore I don't have to worry about the day-to-day ops." Third, corresponding to the competency of customer satisfaction principles and tools, P20 remarked, "…to assure, again, that we know what type of patients are coming through and to assure that the patient is very satisfied in their experience here." In addition, P20 referred to the competency of customer satisfaction principles and tools again when summarizing the competencies necessary for clinical department leadership (IQ10). "[Striving for excellence of service], people will understand you have an excellent product or service and therefore people [will] want to come to see those [physicians again]. Reference to the other Business Knowledge and Skills competencies can be accessed in the tables and figure provided below.

P20 discussed two important emotional intelligence competencies. First, empathy for others was a running theme through much of the dialogue. When answering IQ8 on necessary emotional skills, P20 related, "From an emotional standpoint, you have to have your heart in

believing in the people that you work with to make them feel that you care and to make them feel that you don't step over the fine line of what's authority and what is what will put you on the same level as them." In the summarization of IQ10, he again stressed, "[The clinical department administrator has to] have that enthusiasm, to be patient with people, there's a value in a person, everybody has value to add in some way and you have to work toward those assets or towards that person's value and work to that strength and not be very chronicle in the weaknesses of that individual." Second, alluding to what P20 considered the four key principles of effective social skills (communication, honesty, trust, and respect), P20 demonstrated the concept of the development of the Sate-of-Mind competency where the administrator discourages negativity in others by manifesting the characteristics he would like others to display.

The final theme of Social Intelligence elicited five social competencies. First, discussing skills necessary for task completion, P20 remarked on the need of the clinical department administrator to serve on committees to accomplish the larger goals set by the academic medical center (IQ2). Second, a new perceived social competency was identified when the participant said that the administrator needs to be "people oriented." Expression of oneself during social situations, reading, and comprehension of different types of social situations was a third competency confirmed by P20 in his summation of necessary competencies. "[The clinical department administrator must] "listen, [show] that you care, that you recognize everyone as you are a leader, that you prepare for the worst and hope for the best, that you are industrialist." The fourth "must have" social competency is management of one's behaviors that positively influence group member perceptions. In response to IQ2 P20 stated, "When ideas are sequestered use tact to get one's ideas heard." In the summary of leadership competencies (IQ10), P20 finished be saying, "…add [your] strength in order to build a [more successful]

organization." Fifth, the social competency of self-confidence was discussed. P20 said when discussing the position of the administrator when dealing with other leaders in the academic medical center, "you have to have the confidence that you don't fear failure [in order to] win respect." Table K6a in Appendix K is a summary of the P20 interview categorized by question. Table K6b is a summary of the P20 interview by core theme. Figure K6 is a visual representation of thematic clusters and competencies as presented by P20.

Participant 21

P21 referenced 18 competencies within the seven core themes of Communication and Relationship Management, Leadership, Professionalism, Knowledge of the Healthcare Environment, Business Knowledge and Skill, Emotional Intelligence, and Social Intelligence. Two competencies were discussed within the theme of Communication and Relationship Management. First, was the competency of knowledge of organizational structure and relationships. Addressing the question of the clinical department administrator's role within the department (IQ1), P21 said, "I really try to keep [the Chairman] abreast of what's going on and act as that advisor to him and … [direct] the staff." Second, when addressing what knowledge, skills, and abilities P21 would look for in an administrative candidate (IQ7), P21stated, "[The candidate should possess the] ability to be flexible and be able to communicate effectively with the physicians because I think that if they don't trust you then you have no relationship and therefore, you can't [direct physician activities]. This statement corresponds to the competency of principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.).

Within the theme of Leadership, P21 discussed the competency of leadership styles and techniques. "Leading by example" is the method P21 finds most effective when running a

department within an academic medical center. Leading by example implies the ethical behaviors and commitment to the organization P21 would like to have emulated by staff and faculty within the department. Closely related to the theme of Leadership is the theme of Professionalism. P21 alluded to the competency of professional role, responsibility, and accountability when responding to IQ1 (the administrator's leadership role within the department) and IQ2 (the administrator's leadership role within the academic medical center). Responding to IQ1, P21 reflected the role of the administrator is to act as "chief advisor to the Chairman [and] chief teacher to the staff. Providing feedback for IQ2, P21 stated, "[the role of the administrator within the AMC was] trying to be a good advisor again to other people and how they might learn from [P21s philosophies and input]. A new competency emerged when discussing the tools a candidate would need for a career as a clinical department administrator. P21 said, "…I think that knowledge of the clinical practice world is absolutely necessary in a very busy clinical department." This statement has been interpreted to mean the competency of professional prior experience is needed for administration of an active clinical operation.

Three competencies were confirmed as necessary under the theme of Knowledge of the Healthcare Environment. First, the department administrator must have knowledge of the role of non-clinical professionals in the healthcare system. When responding to IQ3 (the duties of the administrator to the educational mission of the academic medical center) P21 discussed the need to understand and be able to perform staff duties such as the duties of the residency program coordinator. Second, the educational funding for healthcare personnel competency was deemed a requirement, especially "understanding funding for residency program[s]. Third, an administrator has to have the competency of knowledge of Nursing, physicians, and allied health professionals' roles and practice. Regarding IQ6 (the role of the administrator in managing an

active clinical practice) P21 stressed an administrator must have some level of involvement in clinical affairs such as understanding the flow of physicians and patients to better serve the department's faculty. With regard to the research mission of the AMC, P21 asserted, "my leadership role is to tell the faculty whether [a purchase from grant funded research] is something that we can feasibly do without losing money or whether we can afford to lose money on something because [the researchers] really want to do it. This statement is an example of the usefulness of the competency knowledge of the competency of knowledge of funding and payment mechanisms of the healthcare system.

Within the theme of Business Knowledge and Skills, P21 addressed five competencies. Knowledge of fundamental productivity measures (e.g., hours per patient day; cost per patient day; units of service per man hour; PMPM) is important when working in a hospital environment. P21 said a major duty is ensuring the smoothness of day-to-day detailed activities. An example of this practice was stated in the comment, "I deal with hospital a considerable amount in allocation of OR time, giving up OR time.) Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice) was another duty discussed. When discussing the role of the administrator in the educational mission of the AMC P21 stated, "just because it's not a financial issue for an administrator, the educational piece, I think it's a really important piece to provide a good framework for the faculty to do their teaching so that your national prestige can be maintained, so that your funding doesn't get cut, so that you maintain that flow of teaching...." P21 stated little involvement in the clinical mission of the AMC (IQ4) unless a financial decision is required. This statement is reflected in the competency of knowledge of Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning;

budgeting; capital budgeting). An additional competency requiring financial decisions is the competency of purchasing procurement which was discussed in the response P21 gave for the role of the administrator as business manager for the operation of a clinical practice (IQ6). Finally, P21 emphasized the business knowledge and skill of knowledge of customer satisfaction principles and tools. P21 stated, "Patients have to be treated number one and then I'll deal with the research and the education because the patients are really very important. And so I take a lot of time trying to ensure that physician and staff practices in the department are good, that our customer service is good, that we're giving patient care the best that we can and that we make sure that the patients know that we're here.

Three competencies were highlighted in the themes of Emotional Intelligence and Social Intelligence. P21 believed the emotional intelligence competency of mood regulation and preservation of motivation in frustrating situations was a useful tool for clinical department administrators to be able to demonstrate. P21 advised the candidate for a department administrator position (IQ8), "Don't make decisions based on emotions...This isn't personal, this is business." A social skill thought necessary was understanding of accepted social roles, norms, and scripts. P21 considered one of the administrator's roles as a decision-maker to allow her department chair credit for decisions, even negative ones. When having to present negative information or decisions P21 relates the information to the chairman who dispenses the information to faculty and staff. P21 reflected, "I don't tend to focus on the emotional side of things and [I think my boss] appreciates looking like the bad guy but I'm really the bad guy." Lastly, the social competency of expression of oneself during social situations, reading, and comprehension of different types of social situations was presented when responding to two different questions. When discussing necessary social skills (IQ9), P21 thought it important that

the department administrator demonstrate god manners, good etiquette, good grammar, and the ability to adapt to different types of situations. In the summary of competencies necessary to effective administrative leadership, P21 responded the clinical department administrator must be able to "synthesize a lot of information in a small amount of time without giving too many details and yet still make it effective so that the communication is clear." Table K7a in Appendix K is a summary of the P21 interview categorized by question. Table K7b is a summary of the P21 interview by core theme. Figure K7 is a visual representation of thematic clusters and competencies as presented by P21.

Participant 22

P22 referenced 31 competencies within the seven core themes of Communication and Relationship Management, Leadership, Professionalism, Knowledge of the Healthcare Environment, Business Knowledge and Skill, Emotional Intelligence, and Social Intelligence. The core themes and competencies were those listed in a larger general list of competencies used in healthcare leadership as selected by the professional association of the Healthcare Leadership Alliance (HLA). P22 deemed one competency of importance in the theme of Communication and Relationship Management. Knowledge of the Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.) is a competency used in negotiation (IQ3)and being able to communicate [effectively] with people (IQ10). Within the theme of Leadership, P22 was most concerned with the competency of leadership styles and techniques. When responding to the interview question of the clinical department administrator's role in the clinical mission of the academic medical center (AMC) (IQ5), P22 discussed using a transformational style to get physicians involved in problem-solving clinical issues. P22 said, "I think you get a better product when you [act] as a team".

Within the theme of Professionalism, four competencies were prevalent. First, the competency of knowledge of professional roles, responsibility, and accountability was mentioned when responding to IQ1 and IQ5. IQ1 was a question of the clinical department administrator's role within the department. Giving the question some thought, P22 replied, "I think it varies depending on the different tasks that we have to do because sometimes I am an consultant, sometimes I am a visionary that kind of looks at where we're going and tries to inspire people to go along, sometimes I'm the enforcer and sometimes I am the whatever needs to be done person. It varies depending on the task." Thus P22 identified several of an administrator's roles within the department. Answering IQ5, P22 remarked his role in clinical management is more of a consultant to the clinical manager. Second, time and stress management skills were stated in direct response to IQ8, listing qualities P22 would look for when interviewing for the clinical department administrator position. Third, a new emerging competency was identified the HLA did not record, when P22 defined the administrator's role in the clinical mission of the AMC. P22 remarked on how previous clinical experience has helped when dealing with clinical issues. The new competency is the need for higher level leadership to garner exposure to healthcare management through prior experience. Fourth, a second emerging competency was identified- the need to balance professional responsibilities and human skills. P22 recommended, "I …think you have to be able to go home and forget about [work] at some point and have some [activities] outside of work that take the stress off because it can be a real stressful job."

P22 addressed four competencies within the theme of Knowledge of the Healthcare Environment. First, when referring to the understanding of resident slot funding as part of meeting the educational mission of the AMC (IQ3), P22 was referring to the competency of

knowledge of Educational funding for healthcare personnel. Second, P22 felt understanding Staff perspective in organizational settings (e.g., frame of reference by discipline and role; orientation) was an important competency when working with physicians in the clinic on a day-to-day basis (IQ5). Third, P22 believed the competency of understanding the interrelationships among access, quality, cost, resource allocation, accountability, and community played a significant part in the clinical department administrator's role. When summarizing effective competencies (IQ10), P22 advised the administrator to "have some broad knowledge of the healthcare industry and how it works." Fourth, the competency of knowledge of governmental, regulatory, professional, and accreditation agencies (e.g., CMS; JCAHO; NCQA) related to healthcare delivery was deemed an important skill. In the summary statement, P22 remarked the administrator needs to "have knowledge of clinics and how clinics operate and … what HIPAA is all about…"

Fourteen competencies were alluded to within the theme of Business Knowledge and Skills. Two new competencies were identified. First, P22 stated, "...it's my job to take [the] macro vision [of top leadership within the AMC]and put it on a micro level [within the department]," when discussing the administrator's role within the administration of an academic medical center (IQ2). The competency discussed was the integration, merging, linking, and marrying of the clinical department and hospital perspectives. Second, the participant discussed the knowledge to support research, research personnel, and grants in the response to the administrator's role in the research mission of the organization which may be unique to the role of the clinical department administrator. P22 said of maintaining valuable research personnel, "...if you have a grant that ends in 6 months, you have to look forward, and say, ok, when this grant is over, I have 3 people who are funded on this grant. What are we going to do with those 3

people? Where are they going to work after that?" A third competency addressed in discussions of questions IQ3, IQ4, and IQ10 is the requirement of the department administrator to demonstrate the competency of financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting), referred to by the participant as "fiscal competencies." Fourth, P22 discussed the competency of knowledge of characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting). In the summation of effective competencies used by the clinical department administrator, P22 said, "have to be able to look at financial reports and see where you are and what's going on and also project where you're going. The tables and figure related to the competencies expressed by P22 include the list of Business Knowledge and Skills competencies for further reference.

P22 broached competencies listed under the theme of Emotional Intelligence. First, the competency of remaining in control of emotions while focusing on and accomplishing goals was discussed when replying to IQ8 (The emotional qualities the administrator would look for when interviewing an administrative candidate). P22 stated, "I think you have to have an even keel so to speak, you can't get too excited or too frustrated because there are things that happen during the day that you just can't always control." Second, P22 advised the administrative candidate to "be able to take some hits so to speak without losing your mind over it.." This statement is reflected in the emotional competency of mood regulation and preservation of motivation in frustrating situations.

Finally, P22 addressed five competencies within the theme of Social Intelligence. First, the competency of interpersonal problem-solving skills and social role-playing skills was mentioned when responding to two interview questions (IQ9 and IQ10). When replying to IQ9 about the social skills employed by the department administrator, P22 said, "Staff

communication skills are huge, staff can make an administrator look terrible if they want to and so you've got to get the staff on board." P22 reiterated the need for interpersonal competencies in the summation of effective competencies (IQ10). Second, the new competency of expressing people oriented behaviors was suggested when P22 advised the administrative candidate to possess "very good people skills." Third, the competency of skills necessary for task completion was emphasized in the discussions of IQ7 and IQ8. In IQ7 (the knowledge, skills, and abilities desired in an administrative candidate) P22 recommended the candidate to possess, "...very strong physician relations. No administrators can survive if they can't get along with physicians." In the response to IQ9, P22 restated the importance of communication with faculty to achieve desired results. Fourth, the competency of expression of oneself during social situations, reading, and comprehension of different types of social situations was considered relevant to the clinical department administrative position. In the reply to IQ2 (The administrator's role within the AMC) P22 declared, "[One duty is to] give feedback as I can to the top leadership on how it's going and where we might look at going another direction. Fifth, P22 advised, "You have to be able to tell the physician's they're wrong when they're wrong but do it in a diplomatic way," when answering the interview question about effective clinical department administrative social skills (IQ9). This statement is a prime example of the Social Intelligence competency of management of one's behaviors that positively influence group member perceptions. Table K8a in Appendix K is a summary of the P22 interview categorized by question. Table K8b is a summary of the P22 interview by core theme. Figure K8 is a visual representation of thematic clusters and competencies as presented by P22.

Participant 24

P24 referenced 21 competencies within the seven core themes of Communication and Relationship Management, Leadership, Professionalism, Knowledge of the Healthcare Environment, Business Knowledge and Skill, Emotional Intelligence, and Social Intelligence. The core themes and competencies were those listed in a larger general list of competencies used in healthcare leadership as selected by the professional association of the Healthcare Leadership Alliance (HLA). Within the theme of Communications and Relationship Management P24 discussed one competency, principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.). P24 firmly believed clinical department administrators needed to "have the ability to communicate and speak" in order to be effective. In the realm of the theme of Leadership, P24 alluded to the competency of leadership styles and techniques when responding to IQ 6 and IQ7. IQ6 questioned the participant on the administrator's role as business manager of a clinical practice. P24 discussed involvement in terms of "hands-on leadership" in order to meet the missions of the academic medical center. IQ7 asked the participant to qualify the knowledge, skill, and abilities an administrator should look for in a clinical department administrator candidate. P24 answered, "[Administrator candidates] need to be able to have a level of leadership that allows the department to come together and be recognized as a leader" as one leadership qualification.

Two competencies were suggested within the theme of Professionalism. First, when discussing the role of the administrator within the department (IQ1), P24 said, "My leadership role is full accountability of both departments for all the missions of the college." This statement corresponds directly with the competency of knowledge of professional roles, responsibility, and accountability. Second, an emerging competency was proffered when P24 discussed the need for prior experience. P24 recommended an administrative candidate have experience in the areas

of operations and management. The competency of prior experience allows the candidate to assemble proficiencies and capabilities before attempting a complex echelon of leadership.

Six competencies were proposed within the theme of Knowledge of the Healthcare Environment. First, an emerging competency was identified from the participant's answers to IQ2 and IQ10. When responding to IQ2 (the role of the administrator within the academic medical center), P24 asserted, "Every department has things that make them unique in the overall academic medical center and it's our job to take care of that uniqueness and us it and it's what makes Baylor special." This statement reflects the competency of the ability to integrate, merge, link, and marry the department and hospital perspectives. P24 stressed the significance of this competency in the response to IQ10, the summary of competencies essential for effective leadership when restating the role of the clinical department administrator is to "integrate [the three] missions [of the AMC] and make the department work as a whole." Second, the competency of understanding nursing, physicians, and allied health professionals' roles and practice was discussed when responding to the mission to educate (IQ3). P24 stated, "Most time I think the faculty would say, it may take more time [to teach] but [teaching is] an enhancement for [physicians]as well [as medical students and residents]. Third, an emerging competency was identified possibly specific to the role of the clinical department administrator—the need to support research, research personnel, and grants. P24 discussed this competency in response to the role of the administrator serving the academic medical center's mission to conduct research (IQ4). "We have to be able to support our research faculty and give them a little different administration. I mean they need assistance in other administrative areas than you would think of in day-to-day clinical operations. They're out getting the grants and trying to find funding and they're trying to complete studies and sometimes the studies are clinical and sometimes they're

not and we need to incorporate that in our regular strategy for the department." Fourth, P24 said, "[The] key for having education for the students, you've got to have good clinic and surgery for the students to be able to participate in." This comment was made when discussing the administrator's role meeting the mission of clinical service (IQ5). P24 was remarking that providing a high quality clinical practice allows physicians to perform the mission of education. This statement reflects the competency of the interrelationships among access, quality, cost, resource allocation, accountability, and community. Fifth, knowledge of the role of non-clinical professionals in the healthcare system was mentioned when P24 discussed IQ6 and IQ9. When addressing IQ6 (the clinical department administrator's role in the management of the clinical practice), P24 said, "I need to make sure that my staff who work in [departmental] areas, be it clinic manager or research manager or educational coordinator, that they are able to perform their duties." When talking of the social skills that a candidate for administrator must have, P24 advised, "[the candidate needs] to be willing to understand all the staff in their departments and their jobs." Sixth, P24 considered the competency of organization and delivery of healthcare (e.g., acute care, ambulatory care, medical practice, ancillary services) relevant to an administrator's duties.

P24 listed five competencies as primary concerns of the clinical department administrator within the theme of Business Knowledge and Skills. First, the competency of knowledge of Organizational mission, vision, objectives, and priorities was referred to when answering IQ1, IQ3, and IQ10. When responding to IQ1, the administrator's role in the department, P24 stated, "There are three main missions of the college in research, education and clinical operations and I have to be accountable to all three of those in my three departments." When addressing IQ3, the administrator's role in meeting the educational mission of the AMC, P24 said, "[Education] is

the primary reason why we're here." In the summarization of competency related to effective clinical department administration, P24 reminded, "[bring] together 3 unique missions that are all related but they all have whole different goals and strategies." Second, knowledge of organizational dynamics, political realities, and culture was considered necessary in the role of the department administrator within the academic medical center (IQ2). P24 stated, "We have to play our part as a department in a much larger medical school in carrying out [the three] missions. So we are each a unit and we operate, hopefully, cohesively." Third, contingency planning was viewed as a required competency. When discussing the administrator's role in the fulfillment of the educational mission of the AMC (IQ3), P24 believed, "we have to make allowances for education in our clinical operations, not allowances that ever cost us anything but we have to consider it." Fifth, the competency of customer satisfaction principles and tools was discussed. P24 said, "We have to have great customer service in all areas of clinical operations and we need to be able to maintain good clinical operations day-today," when discussing the duties of the administrator to the clinical mission of the AMC (IQ5). Sixth, the most relevant business competency discussed by 24 was knowledge of Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting). This competency was referred to in the answers to IQ6, IQ7, and IQ10. IQ6 was the interview question of the role of the administrator in management of the clinical practice. The administrative function was "the day-to-day operations." P24 said, "I have to be involved in them in order to make good leadership decisions." When responding to IQ7 (what knowledge, skills, and abilities to look for in the potential clinical department administrator candidate), P24 referred to this business competency twice. First P24 said, "I think that [the candidate has] to have a good financial competency core." Next P24 asserted, "[The candidate needs] to be able to

set goals and strategies for their department and see them through." Lastly, in the summarization of effective clinical department administrator competencies, P24 emphasized, "[The administrator as to] think at a higher level, go beyond what's happening today, think about a little bit in the future."

Within the theme of Emotional Intelligence, P24 thought one competency essential. In the summation of IQ10, P24 alluded to the competency of remaining in control of emotions while focusing on and accomplishing goals. P24 thought it compulsory the clinical department administrator have the ability "to adjust" as situations and conditions demanded in a fast paced healthcare environment.

Finally, five competencies were referred to within the theme of Social Intelligence. First, the competency of skills necessary for task completion was spoken of in responses to IQ7 and IQ10. In response to IQ7, P24 affirm the need for the ability to multi-task. In response to IQ10, P24 asserted the clinical department administrator must be "a flexible person," meaning the individual must be able to carry out the duties within many activities and see the activities through to completion. Second, management of one's behaviors that positively influence group member perceptions was a recommended competency submitted in replies to IQ 8 and IQ9. When discussing the social intelligence qualities preferred for the role, P24 advised the clinical department administrator, "You need to be able….build relationships, it's very important to the success." Citing the same competency in the response to emotional qualities a clinical department administrator should express in IQ8, P24 said, "[The administrator needs] to recognize that being a great leader might mean that you make decisions that aren't popular sometimes but it's how you present things." Third, P24 expressed the competency of the Ability to exercise complex social skills such as teamwork, communication, conflict resolution,

harmony, consensus, multiculturalism etc. In response to IQ9 (desirable social skills) P24 remarked on the need for the clinical department administrator to have a "team player personality." Last, in the summarization of essential leadership competencies, P24 reinforced the role of effective clinical department administrators is as administrative decision-maker for the department. The competency expressed was the ability for Interpersonal problem-solving skills and social role-playing skills. Fifth, the competency of self-confidence was identified. When listing necessary emotional components in answer to IQ8, P24 responded, "[Clinical department administrators are expected] to be confident, strong in their decision-making skills...When I say confidence, I think they need to be secure enough in themselves that they can makes decisions and take the good and the bad that comes with the decision." Table K9a in Appendix K is a summary of the P24 interview categorized by question. Table K9b is a summary of the P24 interview by core theme. Figure K9 is a visual representation of thematic clusters and competencies as presented by P24.

Participant 26

P26 referenced 31competencies within the seven core themes of Communication and Relationship Management, Leadership, Professionalism, Knowledge of the Healthcare Environment, Business Knowledge and Skill, Emotional Intelligence, and Social Intelligence. The core themes and competencies were those listed in a larger general list of competencies used in healthcare leadership as selected by the professional association of the Healthcare Leadership Alliance (HLA). Within the theme of Communications and Relationship Management P26 discussed the clinical department administrator's success related to the competency of public relations. When responding to IQ5 (the question of the role of the administrator completing the mission of clinical service), P26 related an account of when being able to communicate ideas

effectively helped a case presentation to faculty, upper leadership, and community leaders. "I had an idea about 15, 16, 17 years ago and pitched an idea to the college of growing [a] community hospital based practice." Because of public relations skills, P26 got the point across and the results have increased the size and revenue of the department. Within the theme of Leadership, P26 identified one competency used by successful department administrators, the competency of knowledge and application of leadership styles and techniques. When responding to IQ10 the summarization of effective leadership competencies used by clinical department administrators, P26 discussed the technique of mentoring saying, "I think you can enhance people's careers by just pulling them and moving them and teaching them different skills and then watching them grow."

Three competencies were discussed within the theme of Professionalism. First, P26 mentioned one duty of the clinical department administrator is working with and for the chair of the department. This duty falls within the competency of knowledge of professional roles, responsibility, and accountability. Second, P26 discussed the competency of personal journey disciplines, or concentrating on lifelong learning to become expert in a particular acumen. Addressing IQ2 (the administrator's role within the administration of the academic medical center), P26 discussed how the department has become "number 1" referring to the pursuit of excellence and how the pursuit of excellence plays an important role as other department administrators seek advice. "I see [the ability to get and retain grant funding, make the biggest profit for the College of Medicine, and be a desirable location for residency education] as the leadership role because people come to our department and they want to know how are we doing it." Third, the competency of time and stress management techniques was emphasized as the

participant accentuated the clinical department administrator (IQ10) profess "good time management skills."

Five competencies were alluded to within the theme of Knowledge of the Healthcare Environment. First, the competency of understanding nursing, physicians, and allied health professionals' roles and practice was mentioned when discussing the role of the administrator within the department (IQ1). P26 stressed the need to "[identify and develop] who are the personalities and how they fit together" in order to recruit the best physicians. The physicians in turn help meet the missions of the AMC to educate, conduct research, and provide clinical service to the community. Second, P26 discussed the competency of knowledge of the organization and delivery of healthcare (e.g., acute care, ambulatory care, medical practice, ancillary services). In response to IQ1, P26 proffered, "the leadership role in the department is trying to find people that are interested in fulfilling each one of the academic missions and hopefully you'll find somebody who also fulfills the third mission, research," acknowledging an understanding of not only delivery of healthcare, but the other components of working in an academic medical center. Third, referring to the idea of increasing productivity through additional channels of community access in response to IQ5, P26 was talking about the competency of understanding the interrelationships among access, quality, cost, resource allocation, accountability, and community. The department operates in 29 community hospitals with general and sub-specialty physicians in the community. P26 discussed the need to understand how residency slots are funded when addressing IQ7, the knowledge, skills, and abilities one should look for in the clinical department administrator candidate. Fifth, also responding to IQ7, P26 identified a competency unrecorded by the HLA, the competency of knowledge of and support for research, research personnel, and grants stressing that the potential

candidate understand how "grant funding works." This competency may be unique to the role of the clinical department administrator.

Within the theme of Business Knowledge and Skills, P26 referred to demonstrating strength in eight competencies. First, the competency of knowledge of the organizational mission, vision, objectives and priorities was discussed in response to IQ1. P26 stated, "[The clinical department administrator must] understand how all the missions of an academic department at a medical school or college are intertwined." When meeting the mission of education (IQ3), P26 reminded, "being a medical school, the primary educational duty is to teach the undergraduate medical students." Second, the competency of knowledge of financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting) was considered a primary competency in reference to IQ3, IQ7, and IQ10. Discussing meeting the mission of education (IQ3) P26 said, "[The college has] ...6 or 7 committees that [discuss educational objectives] every month. [The department administrators] talk about the teaching and who's going to be teaching what courses, and do we have the right people in the right places. What were their course evaluations for the last year, were they well received by the students or would there be a better spot?" Responding to IQ7 (qualities sought in a potential candidate), P26 asserted the necessity for "good financial skills." In the summarization of effective leadership competencies (IQ10), P26 reiterated, "[The successful administrator has] a basic understanding and knowledge of finances, financial performance, financial spreadsheets." Third, responding to IQ10, the competency of knowledge of cost accounting was recommended. Fourth, the competency of knowledge of the characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting) was seen as relevant to the clinical department administrator's role within the department (IQ1).

Using this competency, the administrator can best "recruit the right kind of faculty" that can meet the missions of the AMC to teach, participate in research, and or provide clinical service at a hospital." A list of additional Business Knowledge and Skills competencies is included in the following tables and figure.

Within the theme of Emotional Intelligence, P26 recognized the necessity of one primary competency. The clinical department administrator must remain in control of emotions while focusing on and accomplishing goals. In response to IQ7, the qualities sought in an administrative candidate, P26 said, "[The quality candidate would be] someone that can triage lots of different things and keep reprioritizing throughout a day or throughout a week." P26 also suggested the ideal candidate is "somebody [who remains] relatively calm because there's just so much, so many interruptions that happen throughout a day." Second, P26 touched on the competency of mood regulation and preservation of motivation in frustrating situations. P26 asserted the administrator has to handle many different tasks and personalities that are stress inducing and at times unpleasant. When facing these challenges, P26 stated the effective administrator has to be able "to have a lot hit you" and still accomplish tasks professionally.

P26 deemed five competencies essential within the theme of Social Intelligence. First, the competency of interpersonal problem-solving skills and social role-playing skills was discussed as a quality needed when conversing and supporting research personnel (IQ4). P26 advised working with and listening to research personnel. Discovering the faculty's motivations helps the administrator understand the level of support and involvement needed to complete the research mission. P26 also suggested the competency helps when dealing "with lots of different types of people" and situations. Second, the competency of skills necessary for task completion was broached. In the summation of effective leadership competencies P26 directed the administrator

to demonstrate "good organizational skills" leading to task achievement. When suggesting skills P26 would look for in the administrative candidate (IQ7), P26 stated, "I think somebody has to be able to handle lots of different things at a time because you can be working on one agreement with a doctor or with a hospital and you could get interrupted and you might have to take a residency question or you might…" implying prioritization as necessary for task completion. Third, a social competency used by clinical department administrators expressed by P26 is the ability to express oneself during social situations, reading, and comprehension of different types of social situations. P26 suggested this skill is critical to "fitting in [presented with] almost any type of social situation." Fourth, management of one's behaviors that positively influence group member perceptions is a competency perceived as necessary by P26. P26 insisted, "It's not all good news all the time, so…you [must be able to] take it and triage everything that comes at you and still have a positive attitude when you're walking down the hall, no matter what person you run in to." Finally, when summarizing leadership competencies used by P26, P26 described the ideal administrator as asserting the competency of being people oriented, being able to demonstrate "good people skills." Table K10a in Appendix K is a summary of the P26 interview categorized by question. Table K10b is a summary of the P26 interview by core theme. Figure K10 is a visual representation of thematic clusters and competencies as presented by P26.

Validity and Reliability

Roberts, Priest and Traynor (2006) described validity as a subtle concept, the essence of which is if the research is 'believed' to measure the subject the research is 'intended' to measure. "The researcher [must attempt] to minimize bias in the data collection, interpretation and presentation of findings." (Roberts, Priest, & Traynor, 2006, p. 44). Measures were taken to avoid bias. The validity of the interview process, transcription process and data collection have

been explained within Chapter 4. To increase the validity of the research, the technique of triangulation was applied. First, secondary sources were examined during the literature review process. Second, primary research was conducted. Third, the participants reviewed data interpretations to ensure the accuracy with which their thoughts were interpreted. "Reliability describes how far a particular test, procedure or tool, such as a questionnaire, will produce similar results in different circumstances, assuming nothing else has changed" (Roberts, Priest, & Traynor, 2006, p. 41). The well documented procedures conducted for the current research study are believed to ensure that the study could be duplicated.

Summary

A thorough examination was conducted to explore the leadership competencies used by academic medical center clinical department administrators. Data from interviews with 10 research study participants was extrapolated by interview question and by participant. Aural interviews were transcribed to print for analysis. An exercise of reduction and elimination was engaged to isolate key words, phrases, and sentences. The key words, phrases, and sentences were translated into competencies and arranged according to theme. A total of seven core themes and 87 competencies emerged from analysis.

Chapter 5 is a summary of the analysis of data presented in Chapter 4. After determining relevant themes and competencies, the data is further mined to elicit clinical department administrative leadership significance as compared to the set of competencies generated by the Healthcare Leadership Alliance and other research. Examination of the emerging data will reveal the competencies participants felt most germane to the leadership roles clinical department administrators practice within their respective organizations of academic healthcare.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

The purpose of the current qualitative phenomenological study was to explore leadership competencies academic medical center clinical department administrators perceived as contributing to the success of the administrator to meet the dual obligations to the university's missions and the deliverables of a clinical practice. A purposeful non-random selection process was used to obtain quality candidates for study. The qualifications included advanced level academic degrees, a minimum of eight years experience in health care administration, and a minimum of two years in the candidate's current administrative position. Ten clinical department administrators from three academic medical centers were selected to participate in the study. The number of participants allowed for adequate gathering of information to conduct a detailed analysis of data. The geographic distances between academic medical centers allowed further exploration as participants in different institutions may express a wider array of experiences. The study was conducted using a structured interview approach involving 10 open-ended questions. The interviews were conducted in-person to increase potentially the shared knowledge of the participants. Key (1997) stated as the goal of the research is to generate the most accurate subject reaction, the research should be conducted where the participants feel most comfortable and are most likely to speak openly.

Five of the seven themes emerged relative to the inventory of general leadership competencies assembled by the Healthcare Leadership Alliance, a professional alliance of six highly respected healthcare organizations. Two of the seven themes emerged relative to the two themes of emotional and social intelligences were derived from the research conducted during the literature review phase of the study. Key words, phrases, and sentences were arranged as competencies expressed by participants addressed the seven themes. Findings from the study

were intended to explore the leadership competencies used by a specific group of individuals within the health care industry. The findings could be used to aid department chair people in the conveyance of targeted interviews for candidates for clinical department administrator. The findings could enlighten and enhance academic medical center human resource departments as the departments search for clinical department administrator candidates. The current examination of effective leadership competencies used by clinical department administrators could improve the overall success of the department as the department meets the missions of the institution to provide top quality education, growth of research enterprises, and increased efficiency of the delivery of health care to the community. Chapter 5 contains the interpretation of the findings presented in Chapter 4. Chapter 5 starts with a demographic analysis and interpretation. The seven themes are further discussed as specific competencies become predominant. The chapter also contains implications to the study of leadership, a discussion of the limitations of this study, and recommendations for future study.

Demographics

Twenty-six clinical department administrators were solicited to participate in the current research. Fourteen possible candidates were women (53%), two women out of the 10 participants were women (20%). All of the participants were Caucasian. Eight participants (80%) were between 32 and 53 years of age. Two participants (20%) were 54 years of age or older. To qualify for this study, a minimum of a college master's degree was required. All participants held master's level degrees. To qualify for this study, the minimum number of required years of healthcare administration experience was eight years. The average number of total years of experience within healthcare was approximately 17 years. The minimum number of required years in the current clinical department administrative position was two years service.

The average number of years within the participants' current positions was approximately eight years.

A number of speculations could be made concerning the demographics of the population studied. First, more men than women have over eight years of health care administrative experience. Second, more Caucasians reach administrative leadership positions than other ethnic groups. Third, in order to achieve higher ranking positions within the organization, one probably has proven aptitude toward leadership acquired through achievement of higher education and years in lower-level administrative positions. Age then becomes a factor as age relates to experience. The demographics of the population was not the focus of this paper. Future studies could be realized to study the causal relationship between the age, gender, years of experience and higher-level degrees to the effectiveness of the clinical department administrator.

Results: Themes Presented by Significance

The purpose of the current phenomenological research study was exploration of competencies critical to academic medical center clinical department administrators in pursuit of effective leadership within a clinical practice and an academic medical center. Ten practicing clinical department administrators from three academic medical centers participated in the explorative research. General health care leadership competencies were previously compiled by the Healthcare Leadership Alliance. Emotional and Social Intelligence competencies were accumulated through research during the literature review phase. One hundred sixty-three competencies were identified by the HLA and other research. The competencies expressed by the participants were compared to the lists generated by a leading health care authority and in-depth research. Data in the form of words, phrases and sentences was extrapolated from interviews with the participants. Participants asserted reliance on 79 competencies, or 51% of

the competencies identified by professionals. An additional eight competencies which proved unidentified in the lists of competencies compiled by professionals were deduced from the extrapolated data. In total, the participants perceived 87 competencies within seven core themes as primary to the leadership roles of clinical department administrator.

Reliance on core themes and competencies within the themes were ranked according to importance as compared to the themes and competencies accumulated through research. One hundred percent of the competencies listed within the themes of Social Intelligence, Communication and Relationship Management, and Leadership were identified through analysis. Seventy-five percent of competencies within the theme of Emotional Intelligence were employed by the administrators. The participants discussed 68% of the competencies within the theme of Knowledge of the Healthcare Environment. Four out of nine competencies, or 44%, were identified from the theme of Professionalism, and 40% of competencies from Business Knowledge and Skills.

Eight competencies not recorded by the leading authority emerged through discussion. Four emerging competencies identified in the theme of Professionalism were training or instructing roles of administrators, the call for prior experience, a higher level academic degree and or professional certification, and the need to create a balance between professional responsibilities and human skills such as compassion and consideration of others' feelings. In the theme of Knowledge of the Healthcare Environment, three emerging competencies were identified: (a) knowledge of the need to integrate, merge, link, and marry the department and hospital perspectives, (b) the need to support research, research personnel, and grants, and (c) understanding of the intricacies of working in an AMC versus other types of health care facilities. One emerging competency was elicited in discussions of Social Intelligences. The new

theme was called "people oriented."A graphic representation of competencies discovered as compared to competencies in the HLA general list is presented in Appendix M.

Table 15

Competencies as Expressed by Participants

Core Theme	Total Number of Competencies	Competencies Used by Participants	Percent of Competencies Expressed by Participants
Social	9	9	100%
Communication and Relationship Management	4	4	100%
Leadership	2	2	100%
Emotional	8	6	75%
Knowledge of the Healthcare Environment	25	17	68%
Professionalism	13	8	62%
Business Knowledge and Skills	102	41	40%

Table 16

Total Number of Competencies Expressed by Participants

The 7 Core Themes	Total Number of Competencies	Competencies Used by Participants	Percent of Competencies Expressed by Participants
Totals	163	87	53%

Core Theme Conclusions: Findings and Interpretations

In Chapter 4 the themes and related competencies were analyzed by question and participant. The themes and competencies can be further analyzed by comparing competencies used by academic medical center clinical department administrators to the general list of competencies proposed by the Healthcare Leadership Alliance and the emotional and social intelligence competencies amassed through the literature review. Concentration on predominate themes is intended to further isolate specific competencies used in the specialized area of

healthcare leadership and administration. The core themes were ranked according to perceived relevance of the clinical department administrators' leadership roles to achieve the three missions of the AMC and running a functioning clinical practice. Findings and interpretations were arranged according to core theme and perceived importance.

Core Theme: Social Intelligence

Findings. Nine social intelligence competencies were compiled from the literature review of social intelligence. The participants used 100% of the competencies in their daily transactions with people in the department and in the larger organization. First, the ability to express oneself during social situations, reading, and comprehension of different types of social situations was perceived as a significant competency by eight out of ten clinical department administrators. P02, P10, P12, P20, and P21 stressed the need for this social skill in the summarizations (IQ10) of the interviews. Second, management of one's behaviors that positively influence group member perceptions was seen as important by nine of the ten participants (P02, P04, P10, P12, P18, P20, P22, P24, P26). Most of the nine participants directly stated that tasks were easier to accomplish when using of positive reinforcement techniques and approaching personnel with a positive attitude. P20, P22, and P26 identified the emerging theme of the need for the administrator to be "people oriented" in order to obtain the greatest quality product from staff and faculty. The summaries of the competencies within the core theme of Social Intelligence as expressed by the participants are recorded in Table I7 in Appendix I. Figure I7 offers a visual representation of the competencies as expressed by the 10 participants.

Interpretation. Social intelligence is the ability to act and think wisely in social environments (Riggio & Reichard, 2008). Social intelligence can be defined as one's

capabilities to grasp and adapt to different social interactions (Hoffman & Frost, 2006). Riggio and Reichard (2008) asserted a link exists between emotional and social skills and effect leadership. Two significant themes arose from the interviews. The 10 research participants ranked social intelligence as the number one necessary tool a clinical department administrator needs to complete the dual roles of the position effectively. Using a weighted average scale, Social Intelligence was the most valued characteristic of clinical department administration. Refer to Table I7. The ability to manage one's environment and express one's self in many different forums was considered the most relevant tool in the clinical department administrator's arsenal. Riggio and Reichard (2008) posited the social control is associated with a sense of assurance and understanding of oneself. Without the cooperation of others the administrator would be unable to complete tasks. Administrators have to be able to direct activities. Administrators must be careful not to alienate themselves or others. Their messages must be delivered clearly and positively. Their ability to effectively operate a clinical practice and meet the missions of the academic medical center would be severely inhibited should they have weak, negative, or alienating social skills.

Core Theme: Communication and Relationship Management

Findings. "The communication and relationship management competency is about how clearly leaders understand the people they work with and how effectively they use that knowledge in building high-performance working relationships" (Garman, Fitz, & Fraser, 2006, p. 291). Three competencies were listed under the core theme of Communication and Relationship Management, (a) Organizational structure and relationships, (b) Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.), and (c) Public relations. Each of the ten participants referred to at least one

competency within the domain. Three participants perceived the competency of knowledge of organizational structure and relationships relevant. All three referred to the competency when addressing the question of the clinical department administrator's role within the department (IQ1). The competency of principles of communication and their specific applications was expressed by eight participants. Four participants discussed the competency in relation to necessary social skills (IQ9). P12 discussed the competency when answering five of the ten interview questions. No participants listed the competency when discussing IQ1 (the role of the administrator within the department), IQ2 (the role of the administrator within the AMC), or IQ5 (the role of the administrator as manager of a clinical practice). The third competency, public relations was perceived by four participants as relevant to leadership qualities need in academic medical center administration. The summaries of the competencies within the core theme of Communication and Relationship Management as expressed by the participants are recorded in Table I1 in Appendix I. Figure I1 offers a visual representation of the competencies as expressed by the 10 participants.

Interpretation. The core theme of Communication and Relationship Management was ranked as the second most important theme to clinical department leadership. One hundred percent of the competencies within this theme were discussed by the participants. Communication played a major role in the functioning of the department administrator. Boxwell (2011) stated that communication included the skills of listening and talking, and understanding and interpreting. Leadership often requires leaders to use a diverse set of communication techniques (Gilley, Gilley, & McMillan, 2009). Communication processes were used in every aspect of administration in which the administrator had contact with another individual: when working with the department chair, directing staff, and discussing aspects of clinical

management and delivery with faculty, and solving and issues involving people. The relationship with the leadership of the academic medical center was often tenuous; public relations was used to keep lines of communication open between the department and leadership of the academic medical center. Following directions from superiors ensured that the department fulfilled its missions to education, research, and clinical practice. Communication competencies and social intelligence competencies were linked.

Core Theme: Leadership

Findings. The HLA listed two competencies within the core theme of Leadership; (a) leadership styles and techniques, and (b) personal journey disciplines. Six participants (P12, P20, P21, P22, P24, and P26) expressed awareness of personal leadership styles and techniques. Personal journey disciplines are lifelong pursuits that have led to excellence within a certain field or activity. Three participants (P18, P20, and P21) practiced the competency of quest of personal journey disciplines. Participants P02, P04, and P10 made no reference to personal leadership styles or personal journey disciplines in the interviews. The summaries of the competencies within the core theme of Leadership as expressed by the participants are recorded in Table I2 in Appendix I. Figure I2 offers a visual representation of the competencies as expressed by the 10 participants.

Interpretation. "Leaders at the highest organizational levels have the greatest opportunity, as well as responsibility, to foster a climate conducive to leadership practice and development" (Garman, Butler, & Brinkmeyer, 2006, p. 361). One hundred percent of the competencies within this theme were discussed by participants and was ranked third on a weighted scale of competencies necessary to effective leadership. Seven participants expressed understanding of the leadership role as fundamental to the practice of leadership. Consciousness of the effect

leaders have on followers is important to effectiveness. Making others believe and buy in to the leadership's vision was a major leadership goal. "Ethical leadership reduce[s] unethical behavior and deviance…By setting an example for others, employees know what is expected from them and which behavior will be accepted as appropriate and which will not" (Stouten, Baillien, Van den Broeck, Camps, De Witte, & Euwema, 2011, p. 24). Through facilitation and leading by example messages were presented so that others could understand the direction of the department and the organization. Transitions, even simple ones, could be made smoother through consciousness of what the leader's role was in the transition phase.

Core Theme: Emotional Intelligence

Findings. Six competencies were expressed by participants as predominate under the theme of emotional intelligence. Eight competencies were listed under the theme of Emotional Intelligence (refer to Appendix G). The eight competencies were assembled through the study of emotional intelligence during the literature review process. The competency of impulse control was not included in any of the interviews, but in order to attain some of the other competencies such as delay of immediate gratification, impulse control is implied. Of note is the competency of mood regulation and preservation of motivation in frustrating situations. Six participants (P02, P12, P18, P21, P22, and P26) directly stated or eluded to the necessity of this emotional competency. The higher-level emotional competency of development of state-of-mind was expressed by P20. Empathy for others was a competency expressed by five participants. The summaries of the competencies within the core theme of Emotional Intelligence as expressed by the participants are recorded in Table I6 in Appendix I. Figure I6 offers a visual representation of the competencies as expressed by the 10 participants.

Interpretation. The theme of Emotional Intelligence was perceived as the fourth leading competency required for effective clinical department administration with 75% of the eight competencies applied by the 10 research participants. Anand and UdayaSurivan (2010) found "emotional intelligence has a significant relationship with the leadership practices of executives (p. 70).

The high-level department leader may be exposed to high-levels of stress. Stress can effect work performance, may have physical or emotional manifestations, or trigger burn-out (Quick, et al., 2006). Being able to remain in control of one's mood and emotions helped administrators keep lines of communication open with others. This behavior allowed them to effectively complete assigned tasks. Empathy for others permitted administrators to view conditions from other people's points of view, giving them compassion when having to give reports that may have had negative impacts on others lives. Leadership may benefit from the magnetic and engaging aspects of emotional intelligence that enables leaders to analyze, organize, and utilize information in an effective manner (Anand & UdayaSurivan, 2010).

Core Theme: Knowledge of the Healthcare Environment

Findings. The Core theme of Knowledge of the Healthcare Environment as documented by the HLA consists of 22 competencies. Fourteen of the competencies listed by the HLA were expressed by the 10 study participants. The summaries of the competencies within the core theme of Knowledge of the Healthcare Environment as expressed by the participants are recorded in Table I4 in Appendix I. Figure I4 offers a visual representation of the competencies as expressed by the 10 participants. Three competencies appeared important to five or more participants. First, five participants (P02, P10, P21, P22, and P26) expressed the relevance of the competency of knowledge of educational funding for healthcare personnel. This competency was

discussed primarily in terms of meeting the academic medical center's mission of education. Second, five participants acknowledged the need for knowledge of funding and payment mechanisms of the healthcare system, referring to the administrator's role meeting the institutional missions of education and research. Third, six participants (P02, P10, P12, P20, P24, and P26) recognized the administrator's requirement for the competency of the interrelationships among access, quality, cost, resource allocation, accountability, and community. The competency was targeted especially in discussions of the administrator's role meeting the clinical service mission of the AMC.

Three emerging competencies were perceived important by several participants. These competencies were not listed in the inventory list provided by the HLA. First, P04, P22, and P24 cited the administrator's need for knowledge of the integration, merging, linkage, and marriage of the department and hospital perspectives. Second, P10 acknowledged the need to understand the intricacies of working in an AMC versus other types of healthcare facilities. Third, when discussing the role of the clinical department administrator meeting the AMC mission of research, P18, P22, P24, and P26 believed the role of the administrator was support of research, research personnel, and grants.

Interpretation. Knowledge of the Healthcare Environment was ranked fifth in importance of competencies needed by clinical department administrators. Fundamental differences can be noted between health care systems and other types of services (Garman & Tran, 2006). Differences were noted in the delivery of health care in an academic medical center versus other health care facilities. Administrators seemed most concerned with the financial aspects of meeting the missions of education, research, and clinical delivery. Health care is a tightly regulated industry (Garman & Tran, 2006). Education of medical students is also closely

regulated. Research, especially through the National Institutes of Health (NIH) is closely monitored (NIH Compliance and Oversight, 2011). Armstrong (2006) urged enlightened, inspired, and transformative academic health care leadership to benefit the complexity, costs, and human elements of the healthcare system. Understanding the uniqueness of the academic medical center environment, such as how to fund medical students, how to support medical research in an academic university, and how to define the financial parameters of clinical practice in terms of the AMC were essential tools to effective management of the nuances of meeting the three missions. These competencies may be unique to the position of the clinical department administrator.

Core Theme: Professionalism

Findings. The HLA listed eight competencies within the theme of Professionalism. Four competencies from the HLA inventory were expressed by the study participants. The complete list of Professional competencies is located in Appendix G. The competencies on which participants concentrated were (a) Organizational business and personal ethics, (b) Professional roles, responsibility and accountability, (c) Professional norms and behaviors, and (d) Time and stress management techniques. Participants P12 and P20 perceived the competency of organizational business and personal ethics important to increasing effectiveness of an administrator's leadership abilities. Professional norms and behaviors was discussed by P04, and time and stress management techniques were discussed by P22 and P26. The professional competency most often expressed was knowledge of professional roles, responsibility, and accountability. Seven out of ten participants discussed this competency when addressing the administrator's role; five participants (P02, P21, P22, P24, and P26) relied upon the competency when addressing roles within the department (IQ1).

Four competencies not listed by the HLA were noted in the participants' responses. First, P02 and P10 declared the roles of department administrator include the necessity to instruct or train medical student and residents in basic hospital administration practices. The participants discussed the duty to teach when answering the question of the clinical department administrator's role in meeting the academic medical center's mission of education (IQ3). Second, seven participants professed the need for prior experience to be successful in the administrative capacity. Some skills and knowledge of business and the healthcare environment take years to develop. The participants stressed that an individual could not attempt a level of leadership such as clinical department administration without honing basic competencies in previous lower-level positions. Third, three administrators (P04, P10, and P18) stated the need for higher level educational degrees and or professional certifications. Fourth, three participants (P04, P10, and P22) affirmed a need to strive for balance between professional responsibilities and human skills. The summaries of the competencies within the core theme of Professionalism as expressed by the participants are recorded in Table I3 in Appendix I. Figure I3 offers a visual representation of the competencies as expressed by the 10 participants.

Interpretation. The 10 participants believed that professionalism was achieved through pursuit of higher education and or continuing education. Shah, Anderson, and Humphrey (2008) suggested that business leaders should exhibit an ethic of professionalism, conforming to social standards of behavior. As such, many business schools offer courses in leadership, social responsibility, and nonprofit management. In addition, the participants believed professional skills could only be developed through years of experience in lower-level leadership positions. Garman, Butler and Brinkmeyer (2006) suggested some of those earlier opportunities may have included leadership roles on committees, in service organizations, and in special projects at the

medical center. The role of the administrator within the department took was important especially when managing the clinical practice. The administrators took their roles seriously with respect to offering guidance to the department chair and ensuring personnel and faculty were kept informed of the departmental actions. The role of the administrator within the larger organization was as follower; taking directions and ensuring completion of projects that met the requests of the AMC leadership. Professionalism was viewed as disseminating knowledge, decisions, and judgments with personal dignity and consideration for others' feelings.

Core Theme: Business Knowledge and Skills

Findings. One hundred-two competencies were listed by the HLA under the theme of Business Knowledge and Skills. Participants in the current study recognized 41 competencies, or 40%, as of primary importance to clinical department administrations. The competencies were divided into subthemes for easier identification. The HLA list of subthemes and competencies can be located in Appendix G. The first subcategory was general applications. The participants recognized the importance of eight out of 14 competencies in this category. Table I5a in Appendix I represents the list of general competencies identified by the participants. The second subcategory listed financial competencies. Seven financial competencies out of the 14 identified by the HLA were recognized as necessary to the performance of an administrator. Of note are the competencies of (a) financial analysis (e.g., ratio analysis; cost-benefit analysis; cost-effectiveness analysis; vertical analysis; horizontal analysis), and (b) financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting). Eight out of ten participants (P02, P04, P10, P20, P21, P22, P24, and P26) expressed a need for the administrator to have financial analysis abilities, and the same eight out of ten participants perceived the need for the administrator to have knowledge of

financial planning methodologies. Table I5b represents the list of financial competencies identified by the participants. The third subtheme was human resources competencies. Six competencies were discussed by the participants. Five out of ten participants suggested a heavy emphasis on the human resources competency workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice). Table I5c lists the human resources identified by the participants. The fourth subtheme as classified by the HLA was organizational governance and dynamics. The ten research participants discussed four of the 10 competencies listed within the subcategory. Participants P02, P04, P18, P22, and P24 stressed the need for understanding organizational dynamics, political realities, and culture as a primary organizational governance and dynamics competency. The summary of this subset of Business Knowledge and Skills competencies is listed in Table I5d. The fifth subtheme was strategic planning and marketing. Table I5e lists the strategic planning and marketing competencies identified by the participants. Six competencies were highlighted by the research participants. The most significant strategic planning and marketing competency was knowledge of organizational mission, vision, objectives and priorities. Eight out of ten participants stressed the need for the competency when discussing various components of the clinical department administrator's roles and duties. The six subcategory was information management. Two out of 17 competencies were listed by the HLA. P10 discussed the need for the competencies knowledge of the characteristics of administrative systems/programs (e.g., financial; scheduling; on-line purchasing; productivity; human resources) and physician practice management IT systems (e.g., billing; referral/authorization; claims processing; electronic medical records; prescription writing; productivity; transcription). P20 confirmed the need for the administrator to understand the characteristics of administrative

systems/programs. Table I5f lists the information management competencies identified by the participants. The participants considered three of the 13 competencies listed under the subtheme of risk management important to administrative practice. Table I5g lists the risk management competencies identified by the participants. The seventh subset of competencies under the theme of Business Knowledge and Skills was quality improvement competencies. Two out of 10 competencies were referred to by individual participants. Four out of the 10 participants conceded the importance of knowledge of customer satisfaction principles and tools as a major component of operating a clinical practice. Table I5h lists the quality improvement competencies identified by the participants.

Interpretation. Although all of the themes identified were important to the effectiveness of the administrative leader, Business Knowledge and Skills competencies were ranked the least important. The clinical department administrator should have knowledge of business practices such as those listed by the HLA: "project management, organizational business and personal ethics, facilities planning, purchasing procurement, evidence-based practice, inventory control systems, proposal analysis and contract negotiation, critical thinking and analysis, needs analysis for and/or desirability of outsourcing, and outcomes management implementation" (Garman, Burkhart, & Strong, 2006, p. 82). Business knowledge and skills was pervasive in every aspect of the administrator's job. A sustainable competitive advantage and the importance of leadership for the success if information and knowledge management have been stressed in recent organizational knowledge literature (Lakshman, 2009). Finance skills were thought especially important as the administrator often did a majority of financial tasks for the department. But, relatively speaking, the job of leadership of a department relies less on the

business skills and more on the nuances of working well with others to accomplish the overall goals of the academic medical center.

Significance of the Study to Leadership

The current qualitative phenomenological study is significant to leadership because the study fills a gap in the knowledge of competencies directly related to effective leadership of academic medical center clinical department administrators. The significance to the study of leadership can be discussed as related to three noteworthy elements: the individual, the organization, and the industry. First, the significance to the individual might involve personal edification and enlightenment. The individual striving for a position as an AMC clinical department administrator might endeavor to develop competencies revealed as important to leadership within the specific position. Ulrich (2007) stated developing attributes that align with achievement creates results (p. 3). The individual might be able to concentrate on developing a body of experience and résumé clearly identifying competencies effective to clinical department administrative leadership. Second, the significance to the organization might be development of better selection criteria for hiring purposes. "Selecting and hiring the most qualified employees is at the root of effective organizations" (Segrest, 2009, p. 1). Isolation of competencies specific to clinical department administration may increase the chances effective administrative leaders are hired. Garman and Johnson (2006) said identification of competencies can be used as performance tools, building a framework of parameters important to health care leadership. Developing competency models "can help articulate the behavioral implications of a strategic vision" (Garman & Johnson, 2006, p. 14). Competency models can elucidate individual roles and clarify performance expectations (Garman & Johnson, 2006). Third, the significance to leadership might be extended to the health care industry. One hundred thirty-three academic

medical centers are accredited by the AAMC in the U.S.(AAMC, 2010a). Defining the role of the clinical department administrator may have a larger impact on how the industry identifies the importance of the role of the clinical department administrator when measuring the success of the department or institution. Investment in leadership development can increase the odds that the desired effects by ensuring that individuals with the correct skills sets are in place (Ulrich, 2009).

Recommendations to Leadership

The purpose of this study was exploration of competencies used by effective clinical department administrators. The problem from which the current study evolved was the hiring of the ineffective clinical department administrator. Incorrect hiring decisions may be made because under qualified people are promoted from within the organization that have not attained the necessary business or leadership competencies to meet the higher-level leadership role of the clinical administrator. Incorrect hiring decisions may be made because individuals hired from outside of the organization do not have sufficient background in health care although they may be strong in business knowledge and skills. Often, social and emotional skills are not even targeted in the interview process although communication skills may be.

Clinical department administrative leadership effectiveness seems to stem from seven core themes. Ranked in order of necessity the themes are Social Intelligence, Communication and Relationship Management, Leadership, Emotional Intelligence, Knowledge of the Healthcare Environment, Professionalism, and Business Knowledge and Skills. Noting the thematic order is important. One recommendation to organizations would be to interview candidates according to these themes. Social Intelligence should not be underestimated, nor should too much emphasis be given to Business Knowledge and Skills. A second

recommendation to organizations may be to implement developmental programs to enhance the leadership qualities of current clinical department administrators and develop the essential competencies in personnel within the organization that would like to be involved in clinical department administration. At an individual level, persons seeking clinical department administration should expand upon competencies expressed as largely relevant to the position, stressing social development, communication skills, and advancement of leadership competencies. Current clinical department administrators should work to improve or augment competencies that may offer effective leadership guidance.

Recommendations to Higher Education

"Governments and important social groups, such as students, industry and labour, are vitally interested in and benefit from the services and outputs of the higher education systems" (UNESCO (United Nations Educational, Scientific, and Cultural Organization), Preamble, para. 4, 1997-2011). Higher education is instrumental in the "pursuit, advancement and transfer of knowledge" (UNESCO, Preamble, para. 3, 1997-2011). The goals of higher education include human development and the progression of society while promoting the opportunity for lifelong learning (UNESCO, 1997-2011). Two recommendations are made to the institutions supporting higher education. First, provide the infrastructure to continue the process of academic research for purposes of personal, industry, and community edification. Second, maintain the researcher's academic freedom and freedom of thought to pursue research in facets concerning the researcher and the community.

Recommendations for Future Research

The current study has initiated opportunities for future studies into academic medical center clinical administration. The demographic evidence in this study poses interesting

questions for future study including a study of gender related topics such as why fewer women met this study's qualifications of higher-level academic degrees or attainment of years of experience in health care administration. Studies could be conducted on the success of clinical department administrators promoted from within the organization as compared to those hired from outside the organization. Studies could be done on the reasons social intelligence competencies were found more necessary than business knowledge and skills in clinical department administration. Examining the possibility for future research on a broader scale, the recommendation would be to create a competency model directed at clinical department administration leadership.

Closing Comments

The current qualitative phenomenological study involved the exploration of effective competencies employed by academic medical center clinical department administrators. The intention of the current study was not to create a new set of themes or competencies, but to explore which themes and competencies clinical department administrators considered the most effective within the practice of clinical department administration. The leadership themes coincided with the themes inventoried by the Healthcare Leadership Alliance and the additional themes of emotional intelligence and social intelligence. The exploratory evidence amassed during the current research study concluded the clinical department administrator relies more on the soft skills (personal qualities, attitudes, and, social graces (Lorenz, 2009)) of social, emotional, professional, and communication skills than on tangible, quantitative business skills.

One reason may be a paradigm shift in the way the culture views the role of the leader. Scott (2003) stated traditional administrative theory emphasized managerial roles. A traditional bureaucracy applied an impersonal approach to management, removing social status through

execution of an authoritarian system of control (Olsen, 2006). Health care leadership today must be interactive and dynamic (Garman & Johnson, 2006). The role of the clinical department administrator is participatory; constantly evolving as personnel demand a larger presence in the decision making process. Zagorsek, Dimovski, and Skerlavaj (2009) claimed today's effective health care leaders use a combination of transformational and transactional leadership styles. The study of the specific role of the AMC clinical department administrator supports this supposition. The clinical department administrator often exhibits sets of complex social skills that include flexibility, problem-solving skills, and the ability to manage others that positively impact the intent of the organization. The study of effective competencies employed by practicing clinical department administrators has filled a gap in the knowledge of this phenomenon that leads to possibilities for future research. Most notably, a model should be generated that individuals, organizations, and the health care industry can apply to construct the most effective academic medical center clinical department administrators for today's leadership environment.

Personal Reflection

As an academic medical center clinical department administrator the qualities of leadership are of great interest at a personal level. Through the years as a lower level administrator to my current position, I have witnessed people who have been successful in the administrator position and people who have struggled and eventually failed. Working for or with a struggling administrator that does not earn the respect of employees or colleagues, seems to commit one social blunder after another, and fails to emit an aura of trust and competence can be a challenge. When executive leadership finally realizes that the struggling administrator does not motivate employees to the degree necessary for superior output, the price to the organization

may be costly. This kind of administrator leads one to question what qualities executive leadership saw in the candidate that they felt would make a good administrative leader. Years of experience working with different personalities and different skill levels have led to the question of what qualities must one possess to be not only efficient and competent at the physical aspects of the job, but also what are the intangible behaviors that make an administrator able to move people in positive directions and withstand the pressures that come with the position.

Through the phenomenological process, I was able to meet and discuss leadership competencies of the administrative position with ten very intelligent, scholarly, and competent people currently practicing clinical administration in academic medical centers. From interviews with these people I was able to isolate characteristics they felt pertinent to successful leadership. Comparing the competencies they described to a general list of competencies previously established as relevant to health care leadership, I further targeted the specific competencies used by clinical department administrators.

The role of the academic center clinical department administrator has not been the object of much scholarly attention. Scrutinizing this specific form of executive leadership has led to two important discoveries. First, the phenomenological process has led to a greater understanding on a personal level the broader spectrum of the qualities of leadership and a more narrow focus of leadership competencies applicable to the position of clinical department administrator. Second, this critical leadership position has been under-studied. Clinical department executive leadership has not been privy to a study that depicts the qualities needed for successful clinical department administration. If executive leadership better understood the qualities to look for in administrative candidates perhaps fewer people who do not fit the specific profile would be selected for the position.

I have enjoyed the phenomenological research process. One reason for scientific exploration is to de-bunk assumptions that may be formed through personal experience. This was certainly the case with the current research. Scientific results were obtained countering my personal assumptions that knowledge, skills, and abilities were the aptitudes separating clinical department administrators from other health care professionals. Through phenomenological discovery and analysis the more pertinent competencies to clinical administration within academic medicine are the softer skills such as emotional and social intelligence. The dissertation process has been a tremendous learning experience leading to deeper understanding of myself and other leaders. The most valuable lessons I have learned are introspective, making me a stronger leader and person.

References

AAMC (Association of American Medical Colleges). (2010a). *Medical school*. Retrieved from http://www.aamc.org/medicalschools.htm

AAMC (Association of American Medical Colleges). (2010b). *Member medical schools*. Retrieved from http://services.aamc.org/memberlistings/index.cfm?fuseaction=home.search&search_type=MS&state_criteria=all

ACHE (American College of Health care Executives). (2010). *Health care executive competencies assessment tool.* Retrieved from http://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdfhttp://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf

Allio, R. J. (2009). Leadership - the five big ideas. *Strategy & Leadership, 37*(2), 4-12. Retrieved from ABI/INFORM Global. (Document ID: 1880664681)

Amundson, N., Borgen, W., Iaquinta, M., Butterfield, L., & Koert, E. (2010). Career decisions from the decider's perspective. *The Career Development Quarterly, 58*(4), 336. Retrieved from ABI/INFORM Global. (Document ID: 2060379321)

Anand, R. & UdayaSuriyan, (2010). Emotional Intelligence and Its Relationship with Leadership Practices. *International Journal of Business and Management, 5*(2), 65-76.

Armstrong, P. W. (2006). A time for transformative leadership in academic health sciences. *Clinical and Investigative Medicine (Online), 30*(3), E127-32.

Bass, B. M. (1985). *Leadership and Performance Beyond Expectations*. New York: The Free Press.

Bass, B.M. (2001). Cognitive, social, and emotional intelligence of transformational leaders. In R. E. Riggio, S. E. Murphy, & F. J. Priozzolo (Eds), *Multiple Intelligences and Leadership.* Mahwah, NJ: Lawrence Earlbaum and Associates.

Belmont report: Regulations and guidelines. (2009). Washington, DC: Office of Human Subjects Research, NIH. Retrieved from http://ohsr.od.nih.gov/guidelines/belmont.html

Blencoe, G. (2005). Replace unproductive employees. Retrieved from http://www.tpisearch.com/newsletter/Turning%20Point%20Employer%20Newsletter%20Nov%202005%20v.2.htm

Bless, C., Higson-Smith, C., & Kagee, A. (2007). *Fundamentals of social research methods: An African perspective* (4th ed.). Retrieved from http://books.google.com/books?id=7aKGSIsNk-IC&pg=PA99&lpg=PA99&dq=definition+of+%22population+under+investigation%22&source=bl&ots=Bn6RWTlpF-&sig=Ku5iFrVLU4A6rGUis2PoL28WFLo&hl=en&ei=ET66S4SUCYTG8wTXz8nqAw&sa=X&oi=book_result&ct=result&resnum=1&ved=0CAUQ6AEwADgK#

Botha, S. & Claassens, M. (2010). Leadership competencies: The contribution of the bachelor in management and leadership (BML) to the development of leaders at First National Bank, South Africa. *International Business & Economics Research Journal, 9*(10), 77-87.

Bourgeois, J., Ton, H., Onate, J., McCarthy, T., Stevenson, F., Servis, M., & Wilkes, M. (2008). The doctoring curriculum at the University of California, Davis School of Medicine: Leadership and participant roles for psychiatry faculty. *Academic Psychiatry, 32*(3), 249-54. Retrieved from ProQuest Health and Medical Complete. (Document ID: 1483127581)

Boxwell, M. (2011, March 24). The art of communicating. *Arrow Lakes News.* p. 5.

Boyce, C., & Neal, P. (2006). *Conducting in-depth interviews: A guide for designing and conducting in-depth interviews for evaluation input.* Pathfinder International. Retrieved from http://www.esf-agentschap.be/uploadedFiles/Voor_ESF_promotoren/Zelfevaluatie_ESF-project/m_e_tool_series_indepth_interviews.pdf

Brooks, S., & Howie, . (2008). Therapist as researcher; Using heuristic methodology in a study of spoken language in the therapeutic relationship. *Gestalt Journal of Australia & New Zealand*, 5(1), 13-31.

Brouwers, M., Stacey, D., & O'Connor, A. (2010). Knowledge creation: synthesis, tools, and products. *Canadian Medical Association Journal, 182*(2), E68-72. Retrieved from Research Library. (Document ID: 1976388531)

Byrne, M., Schroeter, K., Carter, S., & Mower, J. (2009). The professional portfolio: An evidence-based assessment method. T*he Journal of Continuing Education in Nursing, 40*(12), 545-52. Retrieved from ProQuest Health and Medical Complete. (Document ID: 1925655701)

Butcher, H., & McGonigal-Kenney, M. (2010). Living in the doldrums: The lived experience of dispiritedness in later life. *Research in Gerontological Nursing, 3*(3), 148-161. Retrieved from ProQuest Health and Medical Complete. (Document ID: 2099020071)

Bureau of Labor and Statistics. (2009). *Occupational outlook handbook, 2010-11 edition* Medical and Health Services Managers. Retrieved from http://www.bls.gov/oco/ocos014.htm

Calhoun, J., Dollett, L., Sinioris, M., Wainio, J., Butler, P., Griffith, J., Warden, G., & Rice, T. (2008). Development of an interprofessional competency model for health care leadership/Practitioner application. *Journal of Health care Management, 53*(6), 375-89; discussion 390-1. Retrieved from ABI/INFORM Global. (Document ID: 1607949941)

Calvasina, G. E., Calvasina, R. V., & Calvasina, E.J. (2007). Making more informed hiring decisions. *Proceedings of the Academy of Legal, Ethical and Regulatory Issues, 11*(1), 9-14. Retrieved from http://sbaer.uca.edu/research/allied/2007/Legal,%20Ethical,%20and%20Regulatory%20Issues/3.pdf

Campbell, E. (2009). The future of research funding in academic medicine. *The New England Journal of Medicine, 360*(15), 1482-3. Retrieved from Research Library. (Document ID: 1676868301)

Campo, M., & Darragh, A. (2010). Impact of work-related pain on physical therapists and occupational therapists. *Physical Therapy, 90*(6), 905-20. Retrieved from Career and Technical Education. (Document ID: 2073626131)

Cano, V. (2006). Reliability & validity in qualitative research. *Study Notes, Online*. Retrieved from http://www.qmu.ac.uk/psych/rtrek/study_notes/web/sn5.htm

Carlson, J. (2010). Avoiding traps in member checking. *The Qualitative Report, 15*(5), 1102-1113. (Document ID: 2159013371).

Chahal, A. (2009). Letting investigators lead. *Applied Clinical Trials, 18*(2), 42-45. Retrieved from ProQuest Health and Medical Complete. (Document ID: 1668431191)

Charan, R. (2005). Ending the CEO succession crisis. (Cover story). *Harvard Business Review, 83*(2), 72-81. Retrieved from Business Source Complete database.

Chen, R. & Ozverir, A. (2004). Interviews. Retrieved from http://www.uow.edu.au/~/thc685/interviews/critique.htm

Christmas, C., Kravet, S., Durso, S., & Wright, S. (2008). Clinical excellence in academia: Perspectives from masterful academic clinicians. *Mayo Clinic Proceedings, 83*(9), 989-94. Retrieved from ProQuest Health and Medical Complete. (Document ID: 1545608881)

Christou, P., Saveriades, A. (2010). The use of ethnography to explore tourist satisfaction antecedents. *Tourismos*, *5*(1), 89-100. Hospitality and Tourism Complete. (ISSN: 17908418)

Ciborra, C., & Willcocks, L. (2006). The mind or the heart? It depends on the (definition of) situation. *Journal of Information Technology, 21*(3), 129-139. Retrieved from ABI/INFORM Global. (Document ID: 1121746201)

Consortium for Research on Emotional Intelligence in Organizations. (2010). *Emotional competence inventory.* Retrieved from http://www.eiconsortium.org/measures/eci_360.html

Crawford, J. M. (2007). Original research in pathology: Judgment, or evidence-based medicine? *Laboratory Investigation, 87*(2), 104-14. Retrieved from ProQuest Health and Medical Complete. (Document ID: 1221410321)

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. London: Sage Publications.

Creswell, J. W. (2002). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research.* Upper Saddle River, NJ: Pearson.

Creswell, J. W. (2007). *Qualitative inquiry &research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Criterion-related validity. (1993-2010). Writing @ CSU. Retrieved from http://writing.colostate.edu/guides/research/relval/com2b3.cfm

Darvies, B. (2010). Understanding the impact of organizational structure and market forces on academic medical centers. MedCenter Today.com. Retrieved from http://medcentertoday.com/article.php?id=46&chapter_id=1

Dearinger, Ronald. (2010). Personal Leadership Statement, DOC732r.

Deloitte Center for Heath Solutions. (2007). *Academic medical centers: The tipping point*. Retrieved from http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_AcademicMedicalCentersTheTippingPoint_062109.pdf

Dentzer, S. (2000). Online News Hour transcript: online focus David Blumenthal, M.D. PBS News Hour with Jim Lehrer. Retrieved from http://www.pbs.org/newshour/bb/health/july-dec00/amc_blumenthal.html

Dubrin, A. (1997). *10 Minute guide to effective leadership*. 10 minute guides. New York, NY: Macmillan Spectrum/Alpha Books.

Dunnick, N. R. (2000). Health care legislation: FDCH Congressional Testimony. MasterFILE Premier (*AN 32Y20009200004436*)

Eason, T. (2009). Emotional intelligence and nursing leadership: A successful combination. *Creative Nursing, 15*(4), 184-185. Retrieved from ProQuest Health and Medical Complete. (Document ID: 1923234831)

Erdogan, B., Kraimer, M. L., & Liden, R. C. (2004). Work value congruence and intrinsic career success: The compensatory roles of leader-member exchange and perceived organizational support. *Personnel Psychology, 57*(2), 305-332. Retrieved from ABI/INFORM Global. (Document ID: 659326101)

Ereaut, G. (2007).What is qualitative research? *QSR International*. Retrieved from http://www.qsrinternational.com/what-is-qualitative-research.aspx

Experiment-Resources.com. (2008-2010). Internal validity. Retrieved from http://www.experiment-resources.com/internal-validity.html

Fabrizio, N. (2009). *Academic practice self-assessment tool*. Medical Group Management Association (MGMA). Retrieved from http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=10366

Fallesen, J., French, M. R., Goodwin, G. F., Haplin, S. M., Lafitte, L., & Zbylut, M. L. (2005). Competency modeling in military education. *Parameters: U.S. Army War College, 35* (1), 109-112. Database Search Complete. (ISSN: 00311723)

Faÿ, E., & Riot, P. (2007). Phenomenological approaches to work, life, and responsibility. *Society and Business Review, 2*(2), 145-152. Retrieved from ABI/INFORM Global. (Document ID: 1364976221)

Federico, F., & Bonacum, D. (2010). Strengthening the core. *Health care Executive, 25*(1), 68-70. Retrieved from Business Source Complete. (ISSN: 0883-5381)

Felder, P. (2010). On doctoral student development: Exploring faculty mentoring in the shaping of African American doctoral student success. *The Qualitative Report, 15*(2), 455-474. Retrieved from Research Library. (Document ID: 2022025961)

Firestone, D. (2010). A study of leadership behaviors among chairpersons in allied health programs. *Journal of Allied Health, 39*(1), 34-42. Retrieved from Career and Technical Education. (Document ID: 2016016751)

Florida State University. (2010). College of Medicine 2009-2010 Graduate Bulletin. Retrieved from http://registrar.fsu.edu/bulletin/grad/colleges/medicine.htm

Froedtert and the Medical College of Wisconsin. (2011). Retrieved from http://www.froedtert.com/AboutUs/Academic/Academic.htm

Gall, M. D., Gall, J. P., & Borg, W. R. (2003). *Educational research: An introduction* (7th ed.). Boston, MA: A & B Publications.

Garman, A. N., Burkhart, T., & Strong, J. (2006). Business knowledge and skills. *Journal of Healthcare Management*, *51*(2), 82-85.

Garman, A. N., Butler, P., & Brinkmeyer, L. (2006). Leadership. *Journal of Health care Management. Chicago, 51*(6), 360-364.

Garman, A. N., Fitz, K. D., & Fraser, M. M. (2006). Communication and relationship management. *Journal of Healthcare Management, 51*(5), 291-294.

Garman, A. N., & Johnson, M. P. (2006). Leadership competencies: An introduction. *Journal of Health care Management, 51*(1), 13-15.

Garman, A. N., & Tran, L. (2006). Knowledge of the health care environment. *Journal of Health care Management, 51*(3), 152-155.

Gilley, A., Gilley, J., & McMillan, H. S. (2009). Organizational change: Motivation, communication, and leadership effectiveness. *Performance Improvement Quarterly, 21*(4), 75-94.

Godfrey, E., & Parker, L. (2010). Mapping the cultural landscape in engineering education. *Journal of Engineering Education, 99*(1), 5-22. Retrieved from Research Library. (Document ID: 1950593631)

Golafshami, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report, 8*(4), 597-607. Retrieved online from http://ace.upm.edu.my/~lateef/Handouts%20-%20dce%205920/golafshani%20-%20reliability%20and%20validity%20in%20qual%20research.pdf

Goleman, D. (1998-2004). What makes a leader? *Harvard Business Review, 76*(6), 93-102. https://www.mercy.edu/faculty/Georgas/inbs640/files/WhatMakesaLeader.pdf

Goleman, D., & Boyatzis, R. (2008). Social intelligence and the biology of leadership. *Harvard Business Review, 86*(9), 28-32. Retrieved from Medline. (ISSN: 00178012)

Green, W., & de Ruyter, B. (2010). The design and evaluation of interactive systems with perceived social intelligence: Five challenges. *AI & Society, 25*(2), 203-210. Retrieved from ProQuest Computing. (Document ID: 2011723011)

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods, 3*(1), 1-26.

Habermas, J. (1987). *The philosophical discourse of modernity*. MIT Press.

Hall, M. R., & Baker, G. F. (2003). Public relations from the ivory tower: Comparing research universities with corporate/business models. *The CASE International Journal of Educational Advancement, 4*(2), 127-154. Retrieved from ProQuest Education Journals. (Document ID: 1200158021)

Harbour, J. (2009). Integrated performance management: A conceptual, system-based model. *Performance Improvement, 48*(7), 10-14. Retrieved from ABI/INFORM Global. (Document ID: 1893304321)

Heizer, J., & Render, B. (2009). *Operations management* (9th ed.). Upper Saddle River, NJ: Pearson Prentice Hall.

Helliwell, C. (2009). Leader or manager? Retrieved from http://www.management-issues.com/2009/10/21/opinion/leader-of-manager.asp

Hernandez, J. (2009). Crossing the leadership bridge. *Physician Executive, 35*(5), 92-94. Retrieved from ABI/INFORM Global. (Document ID: 1867686441)

Hiring the wrong person costs you three times their annual salary. (n.d.). Personnel Policy Service, Inc. Retrieved from http://www.instanthrpolicies.com/dp/18212.htm

HLA Competency Directory User's Guide. (2005). Health care Leadership Alliance. Retrieved from http://www.health careleadershipalliance.org/HLA_Competency_Directory_Guide.pdf

Hoffman, B. J., & Frost, B. C. (2006). Multiple intelligences of transformational leaders: An empirical examination. *International Journal of Manpower: Leadership in organizations, 27*(1), 37-51. Retrieved from ABI/INFORM Global. (Document ID: 1073422031)

Holah.co.uk.psychology. (2006). *Self-selected sampling*. Retrieved from http://www.holah.karoo.net/glossary.htm#Self_selected_sampling

Hopen, D.(2010). The Changing role and practices of successful leaders. *The Journal for Quality and Participation, 33*(1), 4-9. Retrieved from ABI/INFORM Global. (Document ID: 2033993861)

Horey, J., & Fallesen, J. (n.d.). Leadership competencies: Are we all saying the same thing? Retrieved from http://www.drtomlifvendahl.com/Leadershipcompetencies.pdf

Jakobsen, R., & Sørlie, V. (2010). Dignity of older people in a nursing home: Narratives of care providers. *Nursing Ethics, 17*(3), 289-300. Retrieved from Research Library. (Document ID: 2027463561)

Job description for administrator department of urology, Cornell Weil University. (2010). Ithaca, NY: Cornell University. Retrieved from http://hr.cornell.edu/jobs/

Job description for chief administrative officer, University of California, Irvine. (2010). University of California, Irvine. Retrieved from http://www.health care.uci.edu/jobs.asp

Johnson, A. A. (1995). The business case for work-family programs. *Journal of Accountancy*, 180(2) 53-52.

Johnston, A. C., & Warkentin, M. (2008). Information privacy compliance in the health care industry. *Information Management & Computer Security, 16*(1), 5-19. Retrieved from ABI/INFORM Global. (Document ID: 1464231211)

Kaciuba, G., & Siegel, G. (2009). Activity-based management in a medical practice: A case study emphasizing the AICPA's core competencies1. *Issues in Accounting Education, 24*(4), 553-577. Retrieved from ABI/INFORM Global. (Document ID: 1910056581)

Kanter, L., Sova, D., & Anshueitz, L. (2005). Organizing qualitative data from lab and field: Challenges and methods. Retrieved from http://www.teced.com/PDFs/upa2005_lk.pdf

Kelley, W. (2009). Academic medicine and real health care reform. *Journal of Clinical Investigation, 119*(10), 2852. Retrieved from ProQuest Health and Medical Complete. (Document ID: 1880063541).

Kelner, S., & de Miranda, M. (2009). The good and the great: Definable differences. *People and Strategy, 32*(2), 8. Retrieved from ABI/INFORM Global. (Document ID: 1889781001)

Kenny, B., Lincoln, M., & Balandin, S. (2010). Experienced speech-language pathologists' responses to ethical dilemmas: An integrated approach to ethical reasoning. *American Journal of Speech - Language Pathology (Online), 19*(2), 121-134. Retrieved from ProQuest Health and Medical Complete. (Document ID: 2064623661)

Key, J. P. (1997). Research design in occupational education. Retrieved from http://www.okstate.edu/ag/agedcm4h/academic/aged5980a/5980/newpage21.htm

Lakshman, C. (2009). Organizational knowledge leadership: An empirical examination of knowledge management by top executive leaders. Leadership & Organization Development Journal, 30(4)., 338-364.

Ladkin, D. (2008). Leading beautifully: How mastery, congruence, and purpose create the aesthetic of embodied leadership practice. *The Leadership Quarterly 19*, 31–41. (doi:10.1016/j.leaqua.2007.12.003)

Lale, A., Moloney, R., & Alexander, G. C. (2010). Academic medical centers and underserved communities: Modern complexities of an enduring relationship. *Journal of the National Medical Association, 102*(7), 605-613.

Larson, C. (2010). Needed–an R&D and innovation stimulus. *Research Technology Management, 53*(3), 8-9. Retrieved from ABI/INFORM Global. (Document ID: 2063390601)

Larsson, J., & Vinberg, S. (2010). Leadership behavior in successful organizations: Universal or situation-dependent? *Total Quality Management & Business Excellence, 21*(3), 317-334.

Leclercq, W., Keulers, B., Scheltinga, M., Spauwen, P., & van der Wilt, G. (2010). A review of surgical informed consent: Past, present, and future. A quest to help patients make better decisions. *World Journal of Surgery, 34*(7), 1406-15. Retrieved from ProQuest Health and Medical Complete. (Document ID: 2076770691)

Liaison Committee on Medical Education. (2010). *Directory of Accredited Medical Education Programs.* Retrieved from http://www.lcme.org/directry.htm

Littleton, V., Meemon, N., Breen, G., Seblega, B., Paek, S., Loyal, M., Ellis, N., & Wan, T. (2010). An ethical analysis of professional codes in health and medical care. *Ethics & Medicine, 26*(1), 25-48. Retrieved from Research Library. (Document ID: 1950198791)

Lorenz, K. (2009). Top 10 soft skills for job hunters. Retrieved from http://jobs.aol.com/articles/2009/01/26/top-10-soft-skills-for-job-hunters/

Marcell, D. J. (2010). Aron Gurwitsh's incipient phenomenological reduction: Another way into phenomenological transcendental philosophy. *Studia Phaenomenologica, 10*,119-134.

Martin, M. L., Blevins, T., O'Connor, V., Pines, J., & Srinivasan, R. (2004). Society for Academic Emergency Medicine survey of the association of American Medical Colleges Council of Academic Societies. *Academic Emergency Medicine, 11*(8), 844-7. Retrieved from Career and Technical Education. (Document ID: 678451501)

Martin, S. (2009). Illness of the mind or illness of the spirit? Mental health-related conceptualization and practices of older Iranian immigrants. *Health & Social Work, 34*(2), 117-26. Retrieved from Research Library. (Document ID: 1701896421)

McConigley, R., Halkett, G., Lobb, E., & Nowak, A. (2010). Caring for someone with high-grade glioma: A time of rapid change for caregivers. *Palliative Medicine, 24*(5), 473-9. Retrieved from ProQuest Health and Medical Complete. (Document ID: 2065655541)

McNamara, C. (2009). *General guidelines for conducting interviews*. Retrieved from http://managementhelp.org/evaluatn/intrview.htm

Medical College of Wisconsin. (2010). Clinical department administrator. Retrieved from https://tbe.taleo.net/NA3/ats/careers/requisition.jsp?org=MCW&cws=1&rid=3658

Mellman, D., Jaffe, R., & Dauer, E. (2009). Quality and compliance: The dual responsibilities of the chief medical officer. *Physician Executive, 35*(3), 22-25. Retrieved from ABI/INFORM Global. (Document ID: 1723112271)

Meyer, R. (2006). The tripartite mission of an academic psychiatry department and the roles of the chair. *Academic Psychiatry, 30*(4), 292-7. Retrieved from ProQuest Health and Medical Complete. (Document ID: 1093577621)

Mitchell, T., Schaap, J., & Groves, M. (2010). Maintaining the integrity of turnover measurements when there are layoffs. *Journal of Business & Economics Research, 8*(1), 79-85. Retrieved from ABI/INFORM Global. (Document ID: 1957481081)

Morrissey, G., & Higgs, J. (2006). Phenomenological research and adolescent female sexuality: Discoveries and applications. *The Qualitative Report, 11*(1), 161-181. Retrieved from http://www.nova.edu/ssss/QR/QR11-1/morrissey.pdf

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Moye, J., & Swan, B. (2009). Growing ambulatory care nurse leaders in a multigenerational workforce. *Nursing Economics, 27*(6), 408-11, 415. Retrieved from Research Library. (Document ID: 1929055781)

Mugo, F. W. (n.d.). Sampling in research. Retrieved from http://www.socialresearchmethods.net/tutorial/Mugo/tutorial.htm

Muirhead, R., & Calvert, J. (REVIEWER). (2005). Just work. *Labour*, (56), 353-355. Retrieved from CBCA Complete. (Document ID: 984209871)

National Institutes of Health (NIH). Compliance and Oversight. Retrieved from http://grants.nih.gov/grants/compliance/compliance.htm#glance

Nemanich, L. Keller, R., & Vera, D. (2007). Managing the exploration/expoiltation paradox in new product development: How top executives define their firm's innovation trajectory. *International Journal of Innovation and Technology Management, 4*(3), 351–374. Retrieved from Business Source Complete.

Neufeld, D., Wan, Z., & Fang, Y (2010). Remote leadership, communication effectiveness and leader performance. *Group Decision and Negotiation, 19*(3), 227-246. Retrieved from ABI/INFORM Global. (Document ID: 1987353871)

New York University academic curriculum. (2010). New York University Langon Medical Center. Retrieved from http://surgery.med.nyu.edu/education/residency/curriculum

NSF Proposal Processing and Review of Grant Proposal Guide. (2008). *National Science Foundation.* Retrieved from http://www.nsf.gov/pubs/policydocs/pappguide/nsf08_1/gpg_3.jsp

Nuttall, J. (2006). Researching psychotherapy integration: a heuristic approach. *Counselling Psychology Quarterly, 19*(4), 429-44.

NVivo 9 overview. (2007). QSR International. Retrieved from http://www.qsrinternational.com/products_nvivo.aspx

Nwokah, N. G., & Ahiauzu, A. I. (2010). Marketing in governance: emotional intelligence leadership for effective corporate governance. *Corporate Governance, 10*(2), 150-162. Retrieved from ABI/INFORM Global. (Document ID: 2010833271)

Olsen, J.P. (2006). Maybe it is time to rediscover bureaucracy. *Journal of Public Administration Research and Theory, 16*(1), 1-24. Retrieved from ABI/INFORM Global database. (Document ID: 947224311)

Operations administrator. (2010). Durham, NC: Duke University Health System; Duke University. Retrieved from http://hr.duke.edu/jobs/descr_duhs/select.php?ID=5488

Patton, M. (1990). *Qualitative evaluation and research methods.* Beverly Hills, CA: Sage. Retrieved from http://www.oise.utoronto.ca/field-centres/ross/ctl1014/Patton1990.pdf

Peterson, C. (2005). *Strategic analysis workbook.* East Lansing: Michigan State University. Retrieved from https://www.msu.edu/course/aec/857/STRATanal2.pdf

Plochg, T., Delnoij, D. M., & Klazinga, N. (2006). Linking up with the community: A fertile strategy for a university hospital? *International Journal of Integrated Care (IJIC), 6*, 1-19. Retrieved from EBSCOhost Database.

Polsfuss, C., & Ardichvili, A. (2009). State-of-mind as the master competency for high-performance leadership. *Organization Development Journal, 27*(3), 23-33. Retrieved from ABI/INFORM Global. (Document ID: 1851849291)

Pontin, D., & Lewis, M. (2009). Maintaining the continuity of care in community children's nursing caseloads in a service for children with life-limiting, life-threatening or chronic health conditions: A qualitative analysis. *Journal of Clinical Nursing, 18*(8), 1199-1206. Academic Search Complete. (doi. 10.1111/j.1365-2702.2007.02022.x)

Quick, J. C., Saleh, K. J., Sime, W. E., Martin, W., Cooper, G. L., Quick, J. D., & Mont, M. A. (2006). Stress management skills for strong leadership: Is it worth dying for? Journal of Bone & Joint Surgery, American Volume, *88*(1), 217-225. (doi: 10.2106/JBJS.E.0092)

Quiton, S., & Smallbone, T. (2005). The troublesome triplets: Issues in teaching reliability, validity and generalisation to business students. *Teaching in Higher Education, 10*(3), 299-31. Academic Search Complete. (doi: 10.10801356251050012099)

Rahn, D. (2010). *The role of follower self-concept and implicit leadership theories in transformational leadership and leader-member exchange* (Doctoral dissertation). Retrieved from Dissertations & Theses. (Publication No. AAT 3396741)

Raja, M. P., Deshmukh, S. G., & Wadhwa, S. (2007). Quality award dimensions: A strategic instrument for measuring health service quality. *International Journal of Health Care Quality Assurance, 20*(5), 363-378. Retrieved from ABI/INFORM Global. (Document ID: 1369356731)

Riggio, R. E., & Reichard, R. J. (2008). The emotional and social intelligences of effective leadership: An emotional and social skill approach. *Journal of Managerial Psychology, 23*(2), 169-185. Retrieved from ABI/INFORM Global. (Document ID: 1440864031)

Riviello, R., Ozgediz, D., Hsia, R., Azzie, G., Newton, M., & Tarpley, J. (2010). Role of collaborative academic partnerships in surgical training, education, and provision. *World Journal of Surgery, 34*(3), 459-65.

Roberts, P., Priest, H., &Traynor, M. (2006). Reliability and validity in research. *Nursing Standard, 20*(44), 41-45.

Routio, P. (2007). *Sampling*. Retrieved from http://www.uiah.fi/projekti/metodi/152.htm

Scott, W. R. (2003). *Organizations: Rational, natural, and open systems* (5th ed.). Upper Saddle River, NJ: Prentice Hall.

Seamon, D. 2002. *Phenomenology, place, environment, and architecture: A review of the literature.* Retrieved from http://www.phenomenologyonline.com/articles/seamon1.html

Segrest, S. L. (2009). Rater error bias training in the employment interview and racioethnicity biased perceptions. *Journal of Academic and Business Ethics*, (3), 1-18.

Shah, F., Habib, M., & Aamir, A. (2010). A critical evaluation of the issue of gender inequality in Pakistan's labor market. *Interdisciplinary Journal of Contemporary Research In Business, 2*(1), 237-256. Retrieved from ABI/INFORM Global. (Document ID: 2067156771)

Shah, N., Anderson, J., & Humphrey, H. J. (2008). Teaching professionalism: A tale of three schools. Perspectives in Biology and Medicine, 51(4), 535-546.

Siemens, L. (2007). Challenges faced by rural/remote tourism businesses on Vancouver Island: an exploratory study. *Journal of Enterprising Communities, 1*(4), 308-320. Retrieved from ABI/INFORM Global. (Document ID: 1526077671)

Smith, D. W. (rv.2008). Phenomenology. *Stanford encyclopedia of philosophy on-line*. Retrieved from http://plato.stanford.edu/entries/phenomenology/

Smith, V. (2009). Ethical and effective ethnographic research methods: A case study with Afghan refugees in California. *Journal of Empirical Research on Human Research Ethics, 4*(3), 59-72. Retrieved from ProQuest Health and Medical Complete. (Document ID: 1984541481)

Sokolowski, R. (2007). Logische Untersuchungen Ergänzungsband. Zweiter Teil. Texte für die Neuaffassung der VI Untersuchung. Zur Phänomenologie des Ausdrucks und der Erkenntnis (1893/94-1921). *The Review of Metaphysics, 61*(2), 425-426. Retrieved from ProQuest Religion. (Document ID: 1422144281)

Srica, V. (2008). Social intelligence and project leadership. *The Business Review, Cambridge, 9*(2), 189-199. Retrieved from ABI/INFORM Global. (Document ID: 1617904951)

Stansfield, T. & Verner, D. (2010). Designing better performance. *Industrial Engineer, 42*(2), 26-31. Retrieved from Business Source Complete.

Stefl, M., & Bontempo, C. (2008). Common competencies for all health care managers: The Health care Leadership Alliance model/PRACTITIONER APPLICATION. *Journal of Health care Management, 53*(6), 360-373; discussion 374.

Stouten, J., Baillien, E., Van den Broeck, A., Camps, J., De Witte, H., & Euwema, M. (2011). Discouraging Bullying: The Role of Ethical Leadership and its Effects on the Work Environment. *Journal of Business Ethics, 95*, 17-27.

Swedish, J. (2009). Leadership: Meeting the demands of the times. *Frontiers of Health Services Management, 26*(2), 31-3. Retrieved from ABI/INFORM Global. (Document ID: 1935138091)

Task force on academic health centers. (2010). The Commonwealth Fund. Retrieved from http://www.commonwealthfund.org/Content/Program-Areas/Archived-Programs/Task-Force-on-Academic-Health-Centers.aspx

Tavis, A. (2007). Point/counterpoint. HR. *Human Resource Planning, 30*(4), 6-13. Retrieved from ABI/INFORM Global. (Document ID: 1484185081)

Tennent, J. (2008). Helping managers to be financially literate. *The British Journal of Administrative Management: Manager*, 24-25. Retrieved from ABI/INFORM Global. (Document ID: 1605905871)

Thomas, P., & Kern, D. (2004). *Internet resources for curriculum development in*

medical education: An annotated bibliography. New Orleans: Tulane University. Retrieved from http://www.som.tulane.edu/ome/helpful_hints/Internet_JGIM.pdf

Thrash, A. (2009). *Leadership in higher education: An analysis of the leadership styles of academic deans in Ohio's 13 state-supported universities*. (Doctoral dissertation) Retrieved from Dissertations & Theses. (Publication No. AAT 3378893)

Toor, S., & Ofori, G. (2009). Ethical leadership: Examining the relationships with full range leadership model, employee outcomes, and organizational culture. *Journal of Business Ethics, 90*(4), 533-547. Retrieved from ABI/INFORM Global. (Document ID: 1913218371)

Top Executives. (2009-2010). Bureau of Labor statistics: Occupational outlook handbook, 2010-11 edition. Retrieved from http://www.bls.gov/oco/ocos012.htm

Trochim, W. (2006a). *Qualitative approaches*. Research Methods Knowledge Base.com. Retrieved from http://www.socialresearchmethods.net/kb/qualapp.php

Trochim, W. (2006b). *Construct validity*. Research Methods Knowledge Base.com. Retrieved from http://www.socialresearchmethods.net/kb/constval.htm

Trochim, W. (2006c). *Qualitative validity*. Research Methods Knowledge Base.com. Retrieved from http://www.socialresearchmethods.net/kb/qualval.php

Trochim, W. (2006d). *Non-probability sampling*. Research Methods Knowledge Base.com. Retrieved from http://www.socialresearchmethods.net/kb/sampnon.php

Tubbs, S., & Jablokow, K. (2009). Leadership development and adaption-innovation theory. *The Business Review, Cambridge, 13*(1), 53-59. Retrieved from ABI/INFORM Global. (Document ID: 1778504641)

Tubbs, S. L., & Schulz, E. (2005). Leadership competencies: Can they be learned? *The Business Review, Cambridge, 3*(2), 7-12. Retrieved from ABI/INFORM Global. (Document ID: 1023778361)

Tuckett, A. (2004). Qualitative research sampling: the very real complexities. *Nurse Researcher, 12*(1), 47-61. Retrieved from ProQuest Health and Medical Complete. (Document ID: 701915981)

Turner, D. (2010). Qualitative interview design: A practical guide for novice investigators. *The Qualitative Report, 15*(3), 754-760. Retrieved from Research Library. (Document ID: 2073543361)

Ulrich, D. (2007). Leverage competency. *Leadership Excellence, 24*(7), 3-4.

Ulrich, D. (2009). Leadership insights. *Leadership Excellence, 26*(12), 5.

United Nations Educational, Scientific, and Cultural Organization (UNESCO): Preamble. Retrieved from http://www.unesco.org/new/en/unesco/

University of Florida, About the HSC. (2010). Gainesville: University of Florida. Retrieved from http://www.health.ufl.edu/about_the_hsc.shtml

University of Florida mission statement. (2010). Gainesville: University of Florida. Retrieved from http://www.registrar.ufl.edu/catalogarchive/01-02-catalog/mission/

University of Florida physicians' clinics. (2009). Gainesville: University of Florida. Retrieved from http://www.med.ufl.edu/about/depts.shtml

University of Florida's departments in the College of Medicine. (2010). Retrieved from http://www.med.ufl.edu/patients/ufclinics.shtml

University of Mississippi Medical Center overview. (2010). Oxford: University of Mississippi. Retrieved from http://www.umc.edu/about_us/index.html

van Quaquebeke, N., & Eckloff, T. (2010). Defining respectful leadership: What it is, how it can be measured, and another glimpse at what it is related to. *Journal of Business Ethics, 91*(3), 343-358. Retrieved from ABI/INFORM Global. (Document ID: 1941120381)

Van Manen, M. (1997). *Researching the lived experience: Human science for an action sensitive pedagogy.* London, ON: Althouse.

Varkey, P., & Bennet, K. (2010). Practical techniques for strategic planning in health care organizations. *Physician Executive, 36*(2), 46-48. Retrieved from ABI/INFORM Global. (Document ID: 1979903551)

Vogel, E., Burt, S., & Church, J. (2010). Case study on nutrition labeling policy-making in Canada. *Canadian Journal of Dietetic Practice and Research, 71*(2), 85-92. Retrieved from ProQuest Health and Medical Complete. (Document ID: 2045900301)

Waitoller, F., Artiles, A., & Cheney, D. (2010). The miner's canary: A review of overrepresentation research and explanations. *The Journal of Special Education, 44*(1), 29-49. Retrieved from Research Library. (Document ID: 2005429681)

Wang, P., Heinssen, R., Oliveri, M., Wagner, A., & Goodman, W. (2009). Bridging bench and practice: Translational research for schizophrenia and other psychotic disorders. *Neuropsychopharmacology, 34*(1), 204-12. Retrieved from ProQuest Health and Medical Complete. (Document ID: 1610999501)

Wartenberg, D., & Thompson, W. (2010). Privacy versus public health: The impact of current confidentiality rules. *American Journal of Public Health, 100*(3), 407-12. Retrieved from ABI/INFORM Global. (Document ID: 1979013041)

Weiner, W. (2009). Establishing a culture of assessment. *Academe, 95*(4), 28-32, 3. Retrieved from Research Library. (Document ID: 1952131851)

Williams, J. R., Matthews, M. C., & Hassan, M. (2007). Cost Differences between Academic and Nonacademic Hospitals: A Case Study of Surgical Procedures. Hospital Topics, 85(1), 3-10. Retrieved from Research Library. (Document ID: 1238822821)

Witcher, C. S. (2010). Negotiating transcription as a relative insider: Implications of rigor. *International Journal of Qualitative Methods, 9*(2), 122-132.

Wood, B. (n.d.). *A phenomenological investigation of client perceptions of their relationships to co-leaders in process groups*. (Doctoral dissertation). Virginia Commonwealth University, United States -- Virginia. Retrieved from Dissertations & Theses. (Publication No. AAT 3403991)

Wren, D., Bedeian, A., & Breeze, J. (2002). The foundations of Henri Fayol's administrative Theory. *Management Decision, 40* (9), 906-918. Retrieved from ABI/INFORM Global Database. (Document ID: 277240001)

Wright, S. (2009). The real skills. *Nursing Standard, 24*(15-17), 24-5. Retrieved from Career and Technical Education. (Document ID: 1942124041)

Wright, W., & Evans, C. (2009). The "how to..." series 15: How to evaluate your information needs. *The British Journal of Administrative Management: Manager*, (66), 14-15. Retrieved from ABI/INFORM Global. (Document ID: 1793403951)

Wu, F. Y. (2009). The relationship between leadership styles and foreign English teachers job satisfaction in adult English cram schools: Evidences in Taiwan. *Journal of American Academy of Business, Cambridge, 14*(2), 75-82. Retrieved from ABI/INFORM Global database.

Xavier University Library. (2009). Qualitative versus quantitative research. Retrieved from http://www.xavier.edu/library/help/qualitative_quantitative.pdf

Zagorsek, H., Dimovski, V., & Skerlavaj, M. (2009). Transactional and transformational leadership impacts on organizational learning. *Journal for East European Management Studies, 14*(2), 144-165. Retrieved from ABI/INFORM Global. (Document ID: 1732390631)

APPENDIX A: INFORMED CONSENT– PARTICIPANTS 18 YEARS OF AGE AND OLDER

UNIVERSITY OF PHOENIX

INFORMED CONSENT: PARTICIPANTS 18 YEARS OF AGE AND OLDER

Dear ,

My name is _____ and I am a student at the University of Phoenix working on a DBA degree. I am conducting a research study entitled *A PHENOMENOLGICAL STUDY: LEADERSHIP COMPETENCIES OF ACADEMIC MEDICAL CENTER CLINICAL DEPARTMENT ADMINISTRATORS*. The purpose of the research study is to explore leadership competencies used by academic medical center clinical department administrators that may enhance the success of the administrator to meet the dual obligations to the university's missions and the deliverables of a clinical practice.

Your participation will involve a thirty to forty-five minute video-taped interview where you describe your activities and share your thoughts about your role as a clinical department administrator within the academic medical center. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, you can do so without penalty or loss of benefit to yourself. The results of the research study may be published but your identity will remain confidential and your name will not be disclosed to any outside party.

To ensure confidentiality of all of your responses, you will be assigned a coded number that will become your Study ID number throughout this study.

Your participation in this evaluation involves no physical risk. There is the possibility of psychological risk if your answers to surveys and interviews were made public at any point. Because of that risk we are maintaining strict control over all data. The reason for assigning you a Study ID and using that number to code all of your answers is to reduce the risk that any answer you give can be traced back to you. The master list of Study ID numbers will be kept in a password-protected electronic file.

A probable benefit to you is a better understanding of your introspective self. A possible benefit of your participation to the health care community is better understanding of the complex nature of your job and the competencies needed to be successful in clinical health care administration that can be used to promote better hiring practices in your field.

If you have any questions concerning the research study, please call me at insert phone number and email address.

As a participant in this study, you should understand the following:

1. You may decline to participate or withdraw from participation at any time without consequences.
2. Your identity will be kept confidential.
3. _____, the researcher, has thoroughly explained the parameters of the research study and all of your questions and concerns have been addressed.

4. As the interviews are to be recorded, you must grant permission for the researcher, _____, to digitally record the interview. You understand that the information from the recorded interviews may be transcribed. The researcher will structure a coding process to assure that anonymity of your name is protected.
5. Data will be stored in a secure and locked area. The data will be held for a period of three years, and then destroyed.
6. The research results will be used for publication.

By signing this form you acknowledge that you understand the nature of the study, the potential risks to you as a participant, and the means by which your identity will be kept confidential. Your signature on this form also indicates that you are 18 years old or older and that you give your permission to voluntarily serve as a participant in the study described.

Signature of the interviewee _____ Date _____

Signature of the researcher _____ Date _____

APPENDIX B: DEMOGRAPHIC SURVEY INSTRUMENT

The purpose of this survey is to gather demographic information on the sample of academic medical center clinical department administrators who voluntarily participate in this study and the demographic information on the academic medical center represented.

Name (optional) _____

Name of Academic Medical Center employed by (optional) _____

Age	☐ 21-31 ☐ 32-42 ☐ 43-53 ☐ 54-64 ☐ 65+
Sex	☐ Male ☐ Female
Education	☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate ☐ No response
Ethnic Background	☐ American Indian ☐ Asian American ☐ African American ☐ Caucasian ☐ Hispanic/ Latino ☐ Other
Length of Time in Current Clinical Department Administrator Position	☐ 2 years ☐ 3-5 years ☐ 6-10 years ☐ 10-15 years ☐ >15 years
Total Years of Health care Administrative Experience	☐ 8 years ☐ 9-12 years ☐ 13-15years ☐ 16-20 years ☐ >20years
Researcher USE ONLY Code #	

APPENDIX C: EMAIL INVITATION LETTER

Dear _____ (Potential Study Participant),

I am a doctoral candidate at the University of Phoenix working on a Doctorate of Business Administration dissertation and I am conducting a research study entitled: *A Phenomenological Study: Leadership Competencies of Academic Medical Center Clinical Department Administrators.* The purpose of this qualitative phenomenological study is to explore leadership competencies used by academic medical center clinical department administrators that may enhance the success of the administrator to meet the dual obligations to the university's missions and the deliverables of a clinical practice.

As an administrator in a clinical department, your participation is an important source of discovery. Your participation would involve providing demographic information about yourself and your college. Sharing your views about the leadership competencies needed to be successful in your position is a key component of participation. The initial step will be to complete a demographic survey by email to gauge your interest and assess your qualifications. The next step would be to arrange a face-to-face interview at your location. The proposed interview will be video-taped to ensure accuracy and for transcription purposes. I am hoping to complete the study within the next four months (September – December 2010) and I would be willing to work out the interview schedule to a time convenient to you.

Your participation in this study would be strictly voluntary, and if you choose not to participate or to withdraw from the study at any time, you can do so without penalty or loss of benefit. The results of the research study may be published; however, your name will not be used and your comments will be maintained in confidence. In this research, there are no foreseeable risks to you.

As you are in the rare position of having achieved such a high degree of leadership within your department and academic medical center, I sincerely hope you would consider participating in this study. Although there may be limited benefit to you, the possible benefit of your participation is a contribution to health care leadership studies. Upon your acceptance and agreement to participate in this study, an informed consent and further details of the study will be provided to you. If you have any questions concerning the study, please do not hesitate to call me directly at (###) ###-####. I look forward to hearing from you.
Thank you for your consideration!

Sincerely,

Ron Dearinger
Doctoral Candidate, Doctorate of Business Administration, University of Phoenix

APPENDIX D: INTERVIEW PROTOCOL AND QUESTIONS

The purpose of this qualitative phenomenological study is to explore leadership competencies used by academic medical center clinical department administrators that may enhance the success of the administrator to meet the dual obligations to the university's missions and the deliverables of a clinical practice.

Project: Leadership competencies Interviewee:_____

Time of Interview:_____ Date:_____

Interviewer: Ron Dearinger, Researcher

General Questions intended to provide description of the leadership roles of an academic medical center clinical department administrator.

1. How do you perceive your leadership role within the department?
2. What do you perceive as your leadership role within the administration of the academic medical center?

Questions related to the mission of a clinical department within an academic medical center to educate and train future physicians, conduct meaningful research, and provide quality clinical care (Christmas, Kravet, Durso, & Wright, 2008).

3. What do you perceive as your leadership duties to the educational mission of the organization and department?
4. What do you perceive as your leadership duties to the research mission of the organization and department?
5. What do you perceive as your leadership duties to the clinical mission of the organization and department?

Questions related to the administrator's role as business manager running an operating clinical facility.

6. What do you perceive as your role as business manager in the operation of a clinical practice?

Questions designed to give the participant an opportunity to express thoughts about what he or she believes important knowledge, skills, and abilities to clinical department administration.

7. If you were interviewing someone for your position what knowledge, skills and abilities would you look for?

8. If you were interviewing someone for your position what emotional skills would you look for?

9. If you were interviewing someone for your position what social skills would you look for?

The Central question will allow the participant to synthesize the previous question nine questions into one focused response.

Central Question—

10. What competencies are essential for effective leadership of an academic medical center clinical department administrator?

APPENDIX E: AMERICAN ASSOCIATION OF ACADEMIC MEDICAL CENTERS (AAMC) MEMBER MEDICAL SCHOOLS LOCATED IN THE UNITED STATES

Alabama	University of Alabama School of Medicine University of South Alabama College of Medicine
Arizona	University of Arizona College of Medicine
Arkansas	University of Arkansas for Medical Sciences College of Medicine
California	Keck School of Medicine of the University of Southern California Loma Linda University School of Medicine Stanford University School of Medicine University of California, Davis, School of Medicine University of California, Irvine, School of Medicine University of California, Los Angeles David Geffen School of Medicine University of California, San Diego School of Medicine University of California, San Francisco, School of Medicine
Colorado	University of Colorado School of Medicine
Connecticut	University of Connecticut School of Medicine Yale University School of Medicine
District of Columbia	George Washington University School of Medicine and Health Sciences Georgetown University School of Medicine Howard University College of Medicine
Florida	FIU Herbert Wertheim College of Medicine Florida State University College of Medicine University of Central Florida College of Medicine University of Florida College of Medicine University of Miami Leonard M. Miller School of Medicine University of South Florida College of Medicine
Georgia	Emory University School of Medicine Medical College of Georgia School of Medicine (Name changed to Georgia Health Science University) Mercer University School of Medicine Morehouse School of Medicine
Hawaii	University of Hawaii, John A. Burns School of Medicine
Illinois	Chicago Medical School at Rosalind Franklin University of Medicine & Science Loyola University Chicago Stritch School of Medicine Northwestern University The Feinberg School of Medicine Rush Medical College of Rush University Medical Center Southern Illinois University School of Medicine University of Chicago Division of the Biological Sciences The University of Illinois College of Medicine
Indiana	Indiana University School of Medicine

Iowa	University of Iowa Roy J. and Lucille A. Carver College of Medicine
Kansas	University of Kansas School of Medicine
Kentucky	University of Kentucky College of Medicine University of Louisville School of Medicine
Louisiana	Louisiana State University School of Medicine in New Orleans Louisiana State University School of Medicine in Shreveport Tulane University School of Medicine
Maryland	Johns Hopkins University School of Medicine Uniformed Services University of the Health Sciences F. Edward University of Maryland School of Medicine
Massachusetts	Boston University School of Medicine Harvard Medical School Tufts University School of Medicine University of Massachusetts Medical School
Michigan	Michigan State University College of Human Medicine Oakland University William Beaumont School of Medicine University of Michigan Medical School Wayne State University School of Medicine
Minnesota	Mayo Medical School Mayo Clinic College of Medicine University of Minnesota Medical School
Mississippi	University of Mississippi School of Medicine
Missouri	Saint Louis University School of Medicine University of Missouri-Columbia School of Medicine University of Missouri-Kansas City School of Medicine Washington University in St. Louis School of Medicine
Nebraska	Creighton University School of Medicine University of Nebraska College of Medicine
Nevada	University of Nevada School of Medicine
New Hampshire	Dartmouth Medical School
New Jersey	University of Medicine and Dentistry of New Jersey-New Jersey Medical School University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School
New Mexico	University of New Mexico School of Medicine
New York	Albany Medical College Albert Einstein College of Medicine of Yeshiva University Columbia University College of Physicians and Surgeons

	Hofstra University School of Medicine in Partnership with North Shore-LIJ Health System
	Mount Sinai School of Medicine
	New York Medical College
	New York University School of Medicine
	State University of New York Downstate Medical Center College of Medicine
	State University of New York Upstate Medical University
	The School of Medicine at Stony Brook University Medical Center
	University at Buffalo State University of New York School of Medicine & Biomedical Sciences
	University of Rochester School of Medicine and Dentistry
	Weill Cornell Medical College
North Carolina	Duke University School of Medicine
	The Brody School of Medicine at East Carolina University
	University of North Carolina at Chapel Hill School of Medicine
	Wake Forest University School of Medicine
North Dakota	University of North Dakota School of Medicine and Health Sciences
Ohio	Case Western Reserve University School of Medicine
	Northeastern Ohio Universities Colleges of Medicine and Pharmacy
	Ohio State University College of Medicine
	The University of Toledo College of Medicine
	University of Cincinnati College of Medicine
	Wright State University Boonshoft School of Medicine
Oklahoma	University of Oklahoma College of Medicine
Oregon	Oregon Health & Science University School of Medicine
Pennsylvania	Drexel University College of Medicine
	Jefferson Medical College of Thomas Jefferson University
	Pennsylvania State University College of Medicine
	Temple University School of Medicine
	The Commonwealth Medical College
	University of Pennsylvania School of Medicine
	University of Pittsburgh School of Medicine
Puerto Rico	Ponce School of Medicine
	San Juan Bautista School of Medicine
	Universidad Central del Caribe School of Medicine
	Ramon Ruiz Arnau University Hospital
	University of Puerto Rico School of Medicine
Rhode Island	The Warren Alpert Medical School of Brown University
South Carolina	Medical University of South Carolina College of Medicine
	University of South Carolina School of Medicine

South Dakota	Sanford School of Medicine The University of South Dakota
Tennessee	East Tennessee State University James H. Quillen College of Medicine Meharry Medical College University of Tennessee Health Science Center College of Medicine Vanderbilt University School of Medicine
Texas	Baylor College of Medicine Texas A&M Health Science Center College of Medicine Health Science Center COM Texas Tech University Health Sciences Center Paul L. Foster School of Medicine Texas Tech University Health Sciences Center School of Medicine The University of Texas School of Medicine at San Antonio University of Texas Medical Branch School of Medicine University of Texas Medical School at Houston University of Texas Southwestern Medical Center at Dallas Southwestern Medical School
Utah	University of Utah School of Medicine
Vermont	University of Vermont College of Medicine
Virginia	Eastern Virginia Medical School University of Virginia School of Medicine Virginia Commonwealth University School of Medicine Virginia Tech Carilion School of Medicine
Washington	University of Washington School of Medicine
West Virginia	Marshall University Joan C. Edwards School of Medicine West Virginia University School of Medicine Robert C. Byrd Health Sciences Center
Wisconsin	Medical College of Wisconsin University of Wisconsin School of Medicine and Public Health

APPENDIX F: TYPES OF CLINICAL DEPARTMENTS

Types of Clinical Departments
Aging and Geriatric Research
Anesthesiology
Community Health and Family Medicine
Emergency Medicine
Neurological Surgery
Neurology
Obstetrics and Gynecology
Ophthalmology
Orthopaedics
Otolaryngology
Pathology, Immunology and Laboratory Medicine
Pediatrics
Psychiatry
Radiation Oncology
Radiology
Surgery
Urology

APPENDIX G: HLA LIST OF DOMAINS AND COMPETENCIES AND COMPETENCIES OF EMOTIONAL AND SOCIAL INTELLIGENCES

Communication and Relationship Management Domain

Labor relations strategies

Organizational structure and relationships

Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)

Public relations

Leadership Domain

Leadership styles/techniques

Personal journey disciplines

Professionalism Domain

Organizational business and personal ethics

Professional roles, responsibility and accountability

Professional norms and behaviors

Professional societies and memberships

Professional standards and codes of ethics

Time and stress management techniques

Conflict of interest situations as defined by organizational bylaws, policies, and procedures

Ethics committee's roles, structure, and functions

Patients rights and responsibilities

Knowledge of the Health care Environment Domain

Community standards of care

Regulatory and administrative environment in which the organization functions (e.g., antitrust; Stark I and II; accreditation; organized labor)

Role of non-clinical professionals in the health care system

The interrelationships among access, quality, cost, resource allocation, accountability, and community

The patient perspective

Workforce issues

Corporate compliance laws and regulations (e.g., physician recruitment, billing and coding practices, antitrust, conflict of interest, etc.)

Educational funding for health care personnel

Funding and payment mechanisms of the health care system

Global health care issues, trends and perspectives (e.g., aging population, insurance costs, malpractice crisis, etc)

Governmental, regulatory, professional, and accreditation agencies (e.g., CMS; JCAHO; NCQA) related to health care delivery

Health care and medical terminology

Health care economics

Health care technological research and advancements

Interaction and integration among health care sectors

Legislative issues and advocacy

Managed care models, structures, and environment (e.g., group, staff, IPA, PPO)

Nursing, physicians, and allied health professionals' roles and practice

Organization and delivery of health care (e.g., acute care, ambulatory care, medical practice, ancillary services)

Socioeconomic environment in which the organization functions

Staff perspective in organizational settings (e.g., frame of reference by discipline and role; orientation)

Standards applicable to information integration and interoperability

Business Knowledge and Skills Domain

Basic statistical analysis

Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external

Evidence-based practice

Facilities planning

Inventory control systems

Project management

Purchasing procurement

Systems theory

Systems thinking

Asset management, including investments, equipment, etc

Basic business contracts (e.g., legal and financial implications) and contract negotiation

Comparative analysis strategies (e.g., indicators; benchmarks; systems; performance)

Management functions (e.g., planning; organizing; directing; controlling)

Financial competencies

Cost accounting

Financial analysis (e.g., ratio analysis; cost-benefit analysis; cost-effectiveness analysis; vertical analysis; horizontal analysis)

Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)

Financial statements

Outcomes measures and management (e.g., ROI; Cost-effectiveness analysis [CEA]; cash flow analysis and testing)

Reimbursement principles and techniques including rate setting and contracts

Tax accounting

Capital budgeting principles

Fundamental productivity measures (e.g., hours per patient day; cost per patient day; units of service per man hour; PMPM)

How physician services are reimbursed (e.g., RBRVS; Medicare Part B; managed care negotiated fees; usual and customary charges)

Operating budget principles (e.g., fixed vs. flexible, zero-based)

Relationship between physician productivity and the cost structure in a medical practice

Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)

The system of financial checks and balances required to mitigate risk of

embezzlement in smaller, cash-intensive physician practices

Human Resources

Compensation and benefits

Employee satisfaction measurement and improvement techniques

Motivational techniques

Organizational policies and procedures and their functions

The need for and/or desirability of outsourcing

The varying work environments in which staff work

Worker safety, security and employee health issues (e.g., OSHA; workplace violence)

Components of a benefits package to attract and retain physicians (e.g., time off; CME allowance; coverage policies)

Human resources laws and regulations (e.g., labor law; wage and hour; FMLA; FLSA; EEOC; ERISA; workers compensation)

Job classification systems

Physician compensation and income distribution models

Staffing methodologies and productivity management (e.g., acuity-based staffing; flexible staffing; fixed staffing)

Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)

Organizational Dynamics and Governance

Organizational dynamics, political realities, and culture

Principles and practices of management and organizational behavior

Components of effective succession planning in a physician practice (e.g., seniority and transition of leadership responsibilities; impacts on call coverage and compensation; recruitment and developing new physicians; structuring buy-in agreement)

Corporate structures for physician practices and their legal ramifications (e.g., PC; LLC; partnerships; sole proprietorships)

Dynamics of working for physician owner/providers and their impacts on such functions as decision-making, policy formulation, disciplinary procedures, accountability, etc.

Impacts of physician generational, gender and cultural orientation differences (e.g., financial; lifestyle) on the practice

Implications of a group versus a solo mentality as a cultural driver in physician practices (e.g., orientation to shared resources and aligned systems versus autonomy of practice and decision making)

Organization theories and structures (complex adaptive systems) , e.g., span of control; chain of command; interrelationship of organizational units

Role and functioning of the board of directors and other components of the governing structure

Various roles and responsibilities of physicians in a medical practice (e.g.,, provider; owner; managing partner; president of the board; medical director)

Strategic Planning and Marketing

Business plan development and implementation processes

Business planning including business case and exit strategy development

Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)

Crisis and disaster planning

Factors that contribute to successful joint ventures between physician practices and hospitals (e.g., new physician recruitment; on call coverage of specialists)

Health care system services

Implementation planning (e.g., operation plan; management plan)

Marketing plan development

Marketing principles and tools (e.g., competitive and market research and data analysis; sales; advertising)

Organizational mission, vision, objectives and priorities

Strategic planning processes development, and implementation (scenario planning, forecasting, etc)

Information Management

Application software (e.g., spreadsheets; e-mail; word processing)

Characteristics of administrative systems/programs (e.g., financial; scheduling; on-line purchasing; productivity; human resources)

Characteristics of clinical systems/programs (e.g., electronic medical records; medical decision support; diagnostic information systems)

Confidentiality principles and laws (e.g., credentialing; intellectual property; peer

review)

Data analysis including manipulation, understanding of, and ability to explain data

Electronic education and information resources and systems

Health informatics (e.g., coding; communication standards; data standards)

Information systems continuity (e.g., disaster planning; recovery; backup; sabotage; natural disasters)

Information systems planning and implementation (includes, service architecture; technology lifecycles; obsolescence)

Information technology (e.g., e-commerce; Internet; Intranet)

IT systems selection criteria and review

Physician practice management IT systems (e.g., billing; referral/authorization; claims processing; electronic medical records; prescription writing; productivity; transcription)

Principles of database and file management

Privacy, confidentiality and security requirement for information management (e.g., HIPAA; Medical Records)

Role and function of information technology in operations

Testing and evaluation activities of IT systems

The changes in information systems and technology trends

Risk Management

Compliance with regulatory agencies and tax status requirements

Components of a physician employment contract with the practice (e.g. divestiture of assets; restrictive and non-compete clauses ; buy-sell agreements)

Contingency planning (e.g., emergency preparedness)

Corporate history and record keeping procedures

Credentialing, medical malpractice, and professional liability

Personnel and property security plans and policies

Professional resource networks for risk-related activities

Risk assessments and analyses (e.g., at risk financial activities)

Risk management principles and programs (e.g., insurance; education; safety; injury management; patient complaint)

Risk mitigation (e.g., insurance; outsourcing; disaster recovery)

Risks related to personnel management

Risks related to quality management and patient safety

Specific application of federal laws (e.g., Stark and Anti-trust) to structure and manage physician-hospital relations

Conflict resolution and grievance procedures

Quality Improvement

Clinical pathways and disease management

Customer satisfaction principles and tools

Data collection, measurement and analysis tools and techniques (e.g., root-cause analysis; process analysis; workflows)

Medical staff peer review and disciplinary process

National quality initiatives including patient safety

Patient communication systems

Quality improvement theories and frameworks

Quality planning and management

Training and certification (e.g., industry standards; ISO-9000)

Utilization review and management regulations

Emotional Intelligence

Impulse Control

Delay of Immediate Gratification

Mood regulation and preservation of motivation in frustrating situations

Empathy for Others

Remain in control of Emotions while focusing on and accomplishing goals

Promote trust in employees and patients

State-of-Mind Competency

Ability to Manage One's Surroundings

Social Intelligence

Ability to Exercise Complex Social Skills such as Teamwork, Communication,

Conflict resolution, Harmony, Consensus, Multiculturalism, etc.

Expression of Oneself During Social Situations, Reading, and Comprehension of

Different Types of social situations

Interpersonal Problem solving Skills and Social Role Playing

Understanding of Accepted Social Norms, Roles, and Scripts

Skills Necessary for Task Completion

Attunement to Complex Social Cues

Management of One's Behaviors that Positively Influence Group Member

Perceptions

Self-Confidence

APPENDIX H: INSTITUTIONAL REQUIREMENTS NEEDED BEFORE PERMISSION IS GRANTED TO USE PREMISES

Institutions may require ARB/IRB approval before granting permission to use premises. Below is a list of documents of which one or more may be required by an institution in order to use premises.

- IRB-approved protocol
- Consent documents
- Recruiting materials
- IRB determination/approval letter

APPENDIX I: SUMMARIES AND GRAPHS REPRESENTING PREDOMINANT THEMES OF THE RESEARCH QUESTION

Table I1

Participants Expressing Competencies within Core Theme of Communication and Relationship Management

Emerging Competencies	Expressed by Participant	Discovery Question
Organizational structure and relationships	P02, P04, P21	IQ1
Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	P12, P22	IQ3
	P04, P12	IQ4
	P12	IQ6
	P02, P18, P21	IQ7
	P18	IQ8
	P04, P12, P20, P24	IQ9
	P12, P22	IQ10
Public relations	P18, P20	IQ2
	P26	IQ5
	P10	IQ8

Figure I1

Competencies Expressed in Core theme of Communication and Relationship Management

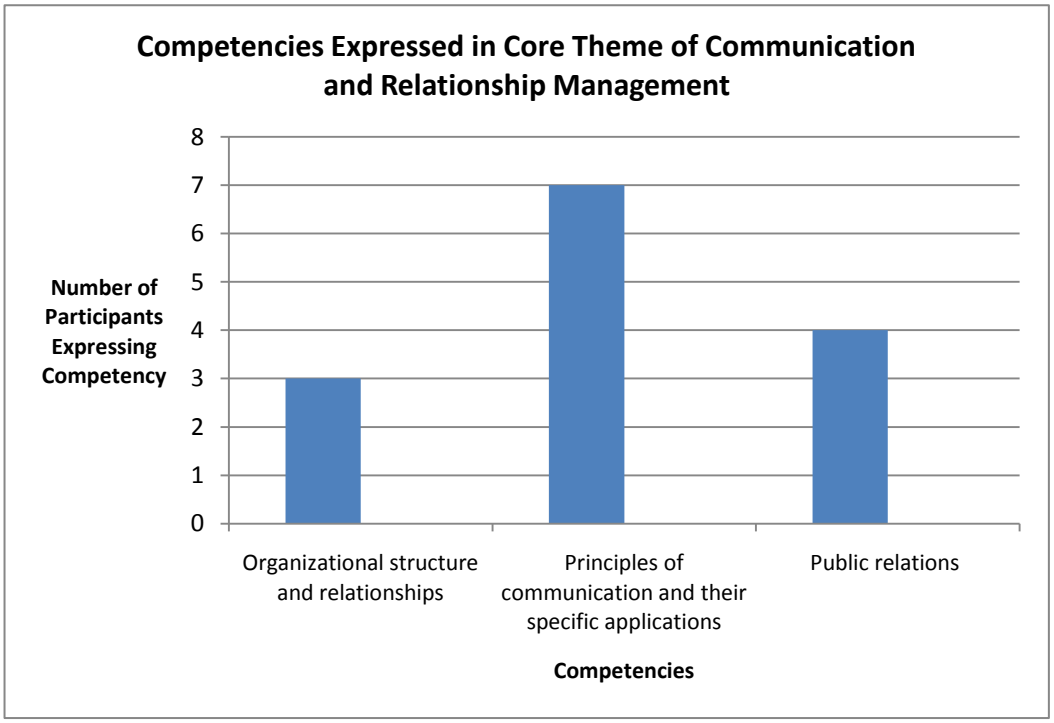


Table I2

Participants Expressing Competencies within the Core Theme of Leadership

Emerging Competencies	Expressed by Participant	Discovery Question
Leadership styles/techniques	P12, P20, P21	IQ1
	P22	IQ5
	P24	IQ7
	P24	IQ6
	P26	IQ10
Personal journey disciplines	P20, P21	IQ2
	P18	IQ3

Figure I2

Competencies Expressed in Core theme of Leadership

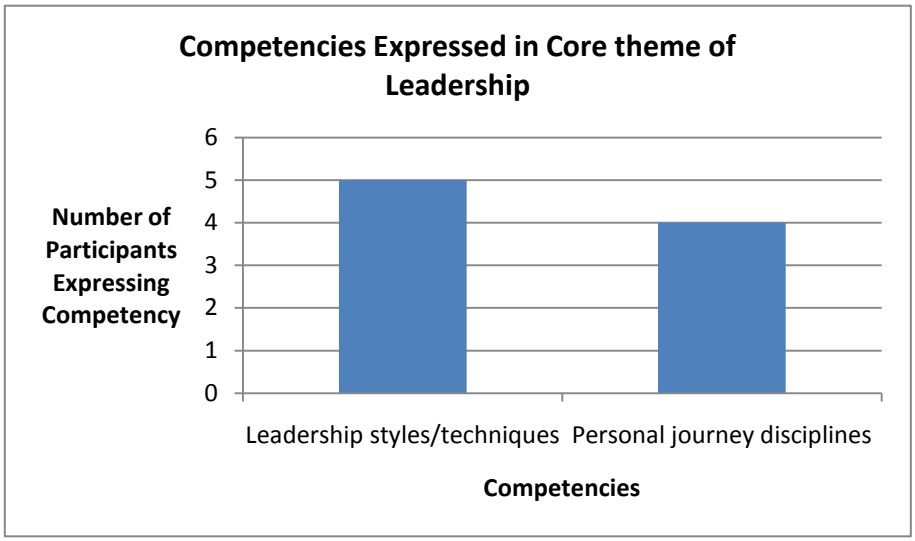


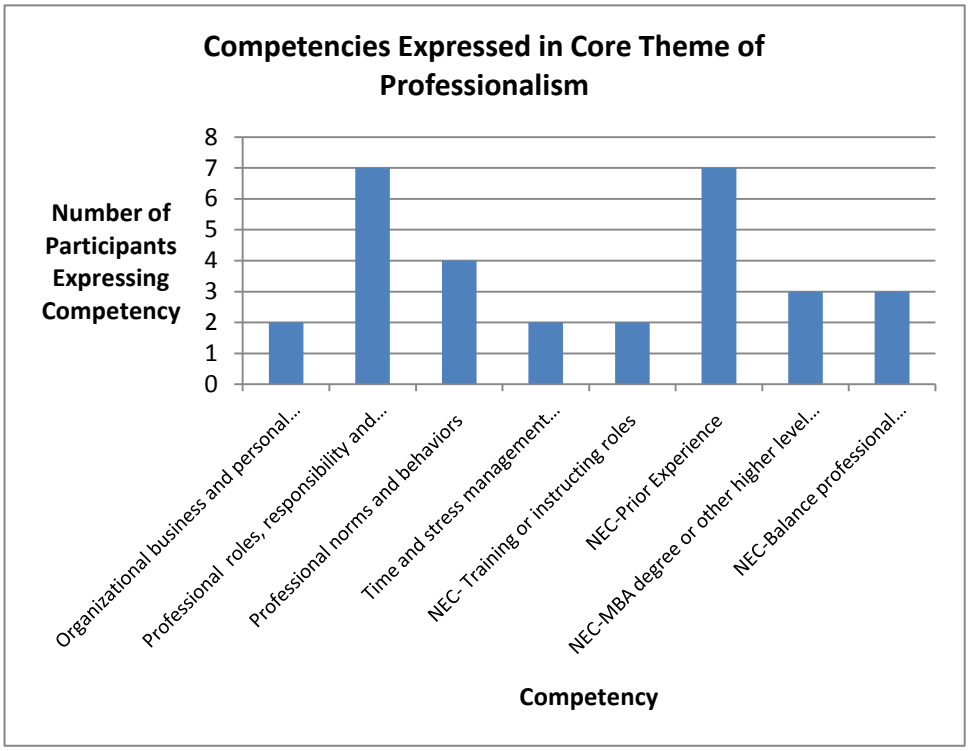
Table I3

Participants Expressing Competencies within the Core Theme of Professionalism

Emerging Competencies	Expressed by Participant	Discovery Question
Organizational business and personal ethics	P12	IQ1
	P20	IQ9
Professional roles, responsibility and accountability	P02, P21, P22, P24, P26	IQ1
	P21	IQ2
	P22	IQ5
	P10	IQ6
	P10	IQ8
	P18	IQ10
Professional norms and behaviors	P04	IQ8
Time and stress management techniques	P22	IQ7
	P26	IQ10
New Emerging Competency Identified- Training or instructing roles	P02, P10	IQ3
New Emerging Competency Identified-Prior Experience	P22	IQ5
	P02, P04, P12, P21, P24	IQ7
	P20	IQ9
New Emerging Competency Identified--MBA degree or other higher level degree	P04, P18	IQ7
	P04, P10	IQ10
New Emerging Competency Identified--Balance professional responsibilities and human skills	P04, P10	IQ7
	P22	IQ8

Figure I3

Competencies Expressed in Core theme of Professionalism



Note: NEC is the acronym for 'New Emerging Competency'

Table I4

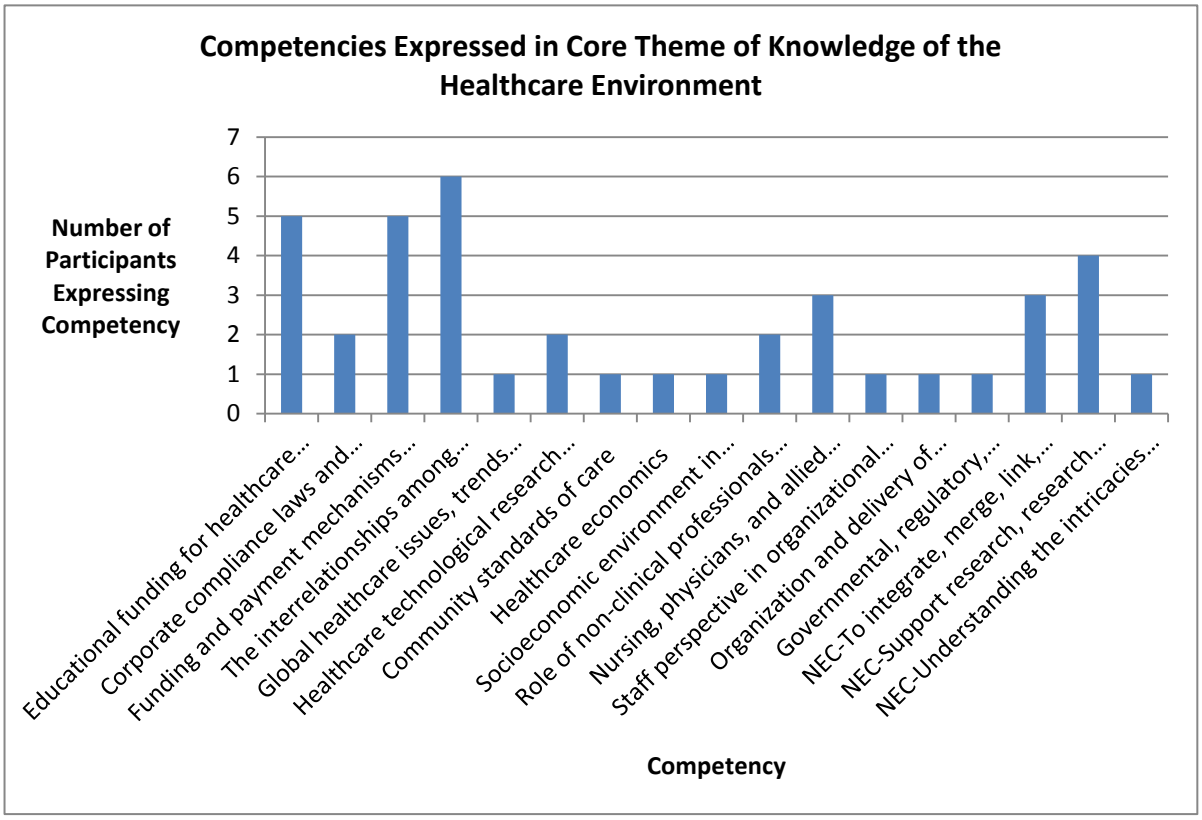
Participants Expressing Competencies within the Core Theme of Knowledge of the Healthcare Environment

Emerging Competencies	Expressed by Participant	Discovery Question
Educational funding for healthcare personnel	P02, P10, P21, P22	IQ3
	P26	IQ7
Corporate compliance laws and regulations (e.g., physician recruitment, billing and coding practices, antitrust, conflict of interest, etc.)	P04	IQ3
	P02, P04	IQ4
Funding and payment mechanisms of the healthcare system	P10, P12, P20	IQ3
	P02, P12, P21	IQ4
The interrelationships among access, quality, cost, resource allocation, accountability, and community	P20, P24	IQ2
	P10, P20 P24, P26	IQ5
	P02, P10	IQ6
	P22	IQ10
Global healthcare issues, trends and perspectives (e.g., aging population, insurance costs, malpractice crisis, etc)	P04	IQ2
New Emerging Competency Identified- To integrate, merge, link, marry the department and hospital perspectives	P22	IQ2

	P04	IQ5
	P24	IQ10
	P04	IQ6
Healthcare technological research and advancements	P10	IQ1
	P20	IQ4
Community standards of care	P10	IQ5
New Emerging Competency-Understanding the intricacies of working in an AMC versus other types of healthcare facilities.	P10	IQ10
Healthcare economics	P18	IQ10
Socioeconomic environment in which the organization functions	P18	IQ10
New Emerging Competency Identified--Support research, research personnel, and grants	P18, P22, P24, P26	IQ4
	P26	IQ7
Role of non-clinical professionals in the healthcare system	P24	IQ6
	P21	IQ3
	P24	IQ9
Nursing, physicians, and allied health professionals' roles and practice	P26	IQ1
	P24	IQ3
	P21	IQ6
Staff perspective in organizational settings (e.g., frame of reference by discipline and role; orientation)	P22	IQ5
Organization and delivery of healthcare (e.g., acute care, ambulatory care, medical practice, ancillary services)	P26	IQ1
	P24	IQ6
Governmental, regulatory, professional, and accreditation agencies (e.g., CMS; JCAHO; NCQA) related to healthcare delivery	P22	IQ10

Figure I4

Competencies Expressed in Core theme of Knowledge of the Healthcare Environment



Note: NEC is the acronym for 'New Emerging Competency'

Table I5a

Participants Expressing Competencies within the Core Theme of Business Knowledge and Skills (General Applications)

Emerging Competencies	Expressed by Participant	Discovery Question
Asset management, including investments, equipment, etc	P12, P26	IQ4
	P02	IQ5
	P18	IQ6
Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	P10	IQ1
Comparative analysis strategies (e.g., indicators; benchmarks; systems; performance)	P26	IQ3
	P04	IQ2
	P18	IQ6
Evidence-based practice	P10	IQ5
Inventory control systems	P12, P22	IQ4

Management functions (e.g., planning; organizing; directing; controlling)	P10	IQ1
	P02, P18	IQ5
	P04, P12	IQ10
Project management	P04	IQ3
Purchasing procurement	P21	IQ6

Figure I5a

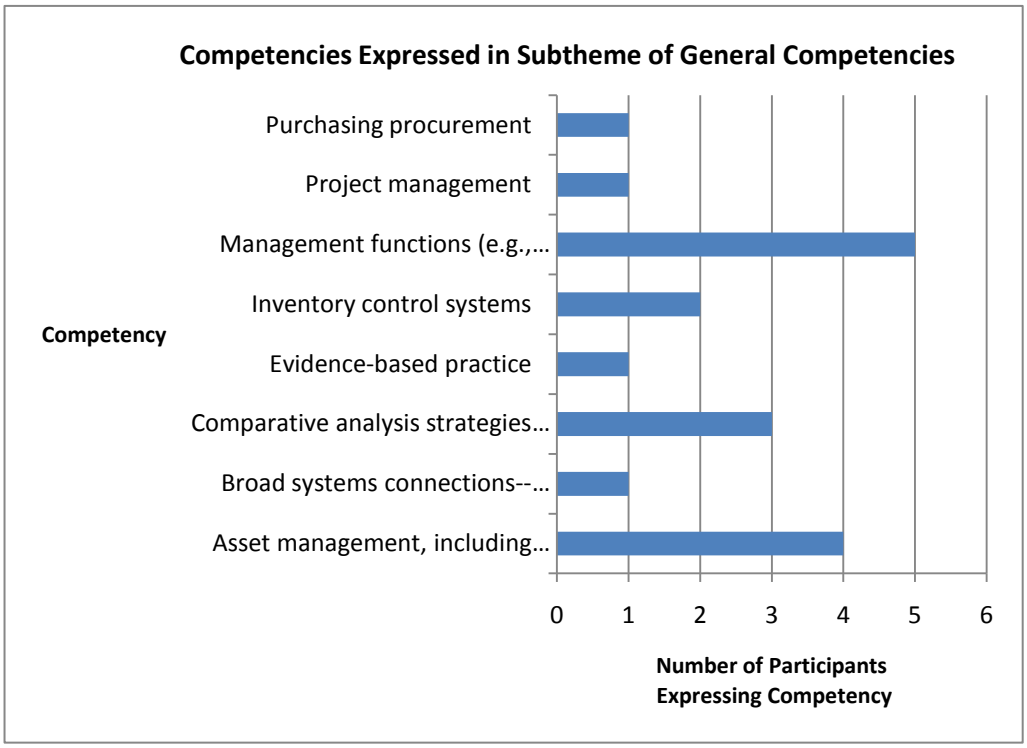


Table I5b

Participants Expressing Competencies within the Core Theme of Business Knowledge and Skills (Financial Applications)

Emerging Competencies	Expressed by Participant	Discovery Question
Cost accounting	P04	IQ6
Financial analysis (e.g., ratio analysis; cost-benefit analysis; cost-effectiveness analysis; vertical analysis; horizontal analysis)	P10	IQ1
	P04	IQ2
	P22, P26	IQ3
	P02, P21, P22	IQ4
	P02	IQ5
	P04, P10, P24	IQ6
	P22, P24, P26	IQ7

	P26	IQ9
	P22, P24	IQ10
Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	P04, P10	IQ1
	P22, P26	IQ3
	P02, P21, P22	IQ4
	P02	IQ5
	P10, P24	IQ6
	P22, P24, P26	IQ7
	P22, P24, P26	IQ10
Fundamental productivity measures (e.g., hours per patient day; cost per patient day; units of service per man hour; PMPM)	P18	IQ5
	P21	IQ6
Reimbursement principles and techniques including rate setting and contracts	P02	IQ4
Relationship between physician productivity and the cost structure in a medical practice	P04	IQ6
Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	P10, P18	IQ5
	P02, P04, P20	IQ6
	P10	IQ7
	P18	IQ10

Figure I5b

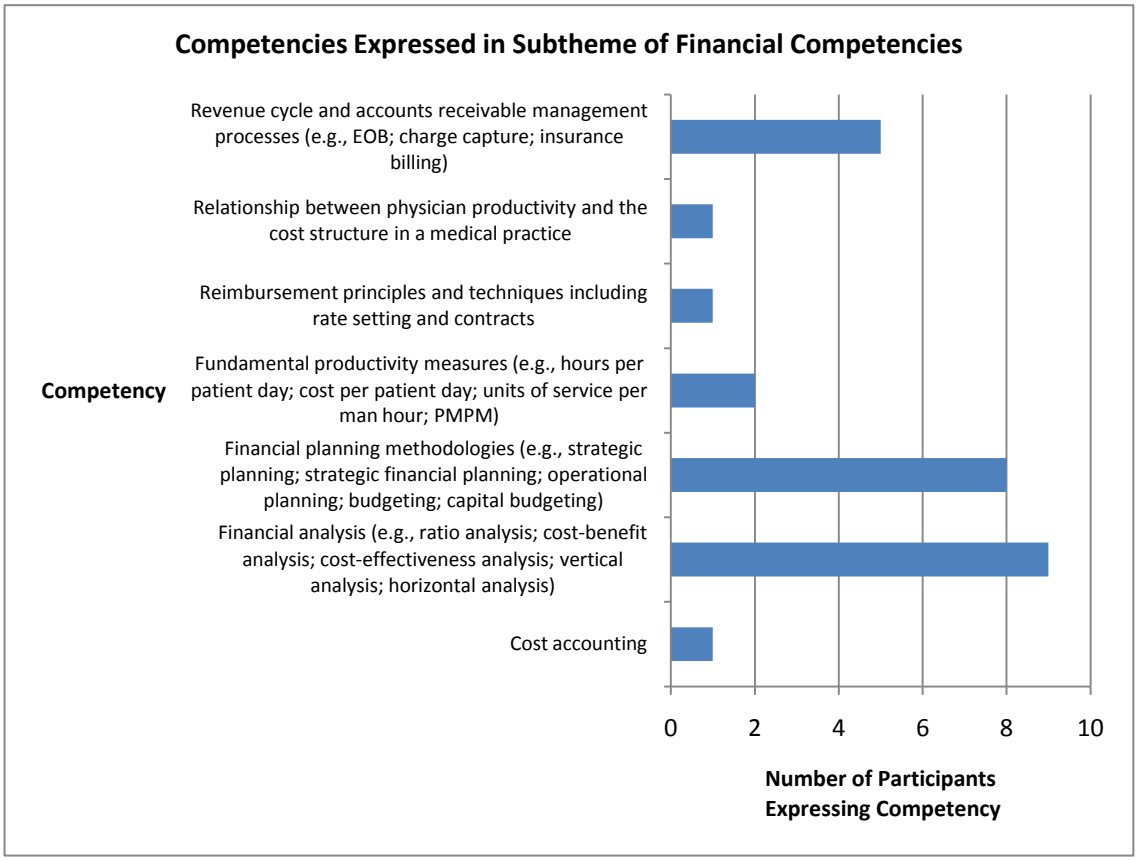


Table I5c

Participants Expressing Competencies within the Core Theme of Business Knowledge and Skills (Human Resources Applications)

Emerging Competencies	Expressed by Participant	Discovery Question
Compensation and benefits	P02, P12	IQ5
Human resources laws and regulations (e.g., labor law; wage and hour; FMLA; FLSA; EEOC; ERISA; workers compensation)	P10	IQ3
Motivational techniques	P22	IQ5
Organizational policies and procedures and their functions	P22	IQ4
Staffing methodologies and productivity management (e.g., acuity-based staffing; flexible staffing; fixed staffing)	P12	IQ4
Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	P02	IQ2
	P04, P12, P21	IQ3
	P02	IQ5
	P02, P20	IQ6

Figure I5c

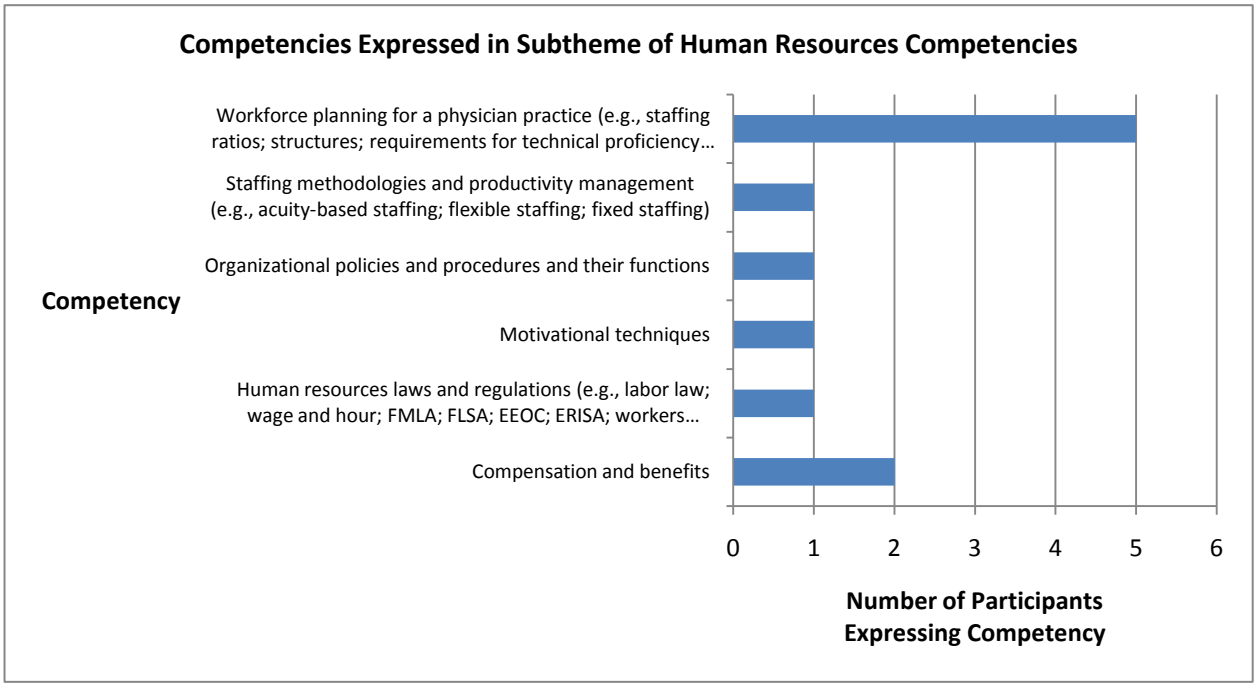


Table 5d

Participants Expressing Competencies within the Core Theme of Business Knowledge and Skills (Organizational Dynamic and Governance Applications)

Emerging Competencies	Expressed by Participant	Discovery Question
Components of effective succession planning in a physician practice (e.g., seniority and transition of leadership responsibilities; impacts on call coverage and compensation; recruitment and developing new physicians; structuring buy-in agreement)	P02	IQ5
Organizational dynamics, political realities, and culture	P24	IQ2
	P02	IQ4
	P04	IQ5
	P18, P22	IQ6
	P02	IQ10
Principles and practices of management and organizational behavior	P04	IQ4
Various roles and responsibilities of physicians in a medical practice (e.g.,, provider; owner; managing partner; president of the board; medical director)	P10	IQ5

Figure 5d

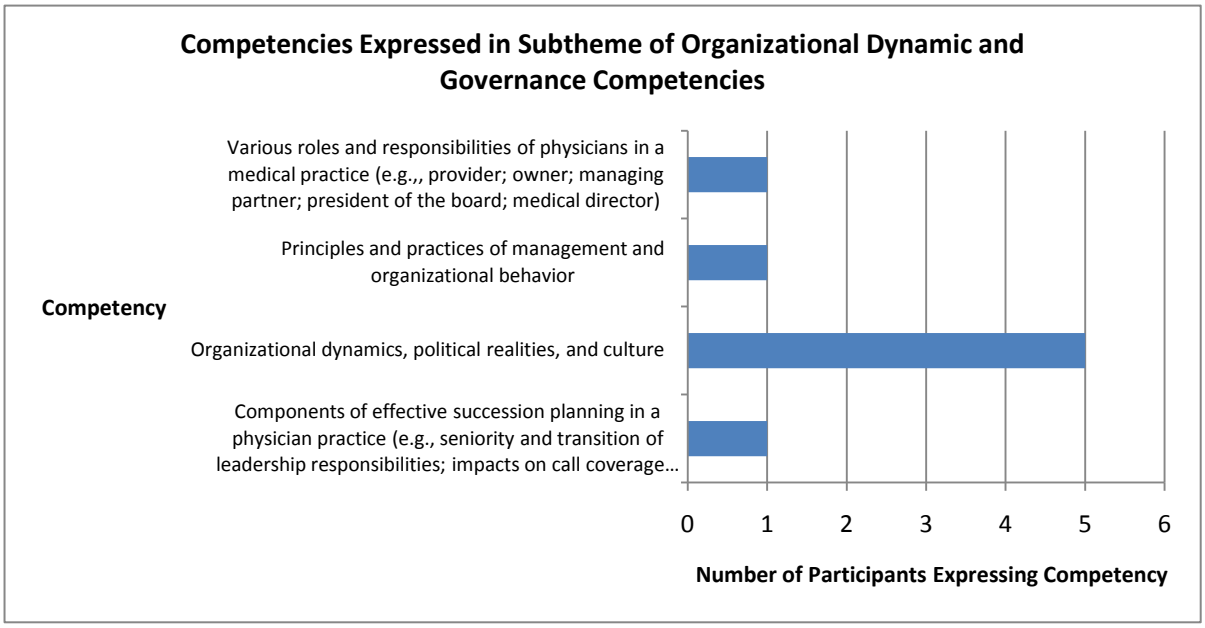


Table I5e

Participants Expressing Competencies within the Core Theme of Business Knowledge and Skills (Strategic Planning Applications)

Emerging Competencies	Expressed by Participant	Discovery Question
Business plan development and implementation processes	P22	IQ6
Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	P10, P26	IQ1
Implementation planning (e.g., operation plan; management plan)	P10	IQ1
	P02	IQ5
	P02, P12	IQ6
	P02	IQ8
Marketing plan development	P20	IQ3
Organizational mission, vision, objectives and priorities	P24, P26	IQ1
	P10, P22	IQ2
	P20, P24, P26	IQ3
	P18	IQ6
	P04, P20	IQ7
	P04, P24	IQ10
Strategic planning processes development, and implementation (scenario planning, forecasting, etc)	P02, P04	IQ2

Figure I5e

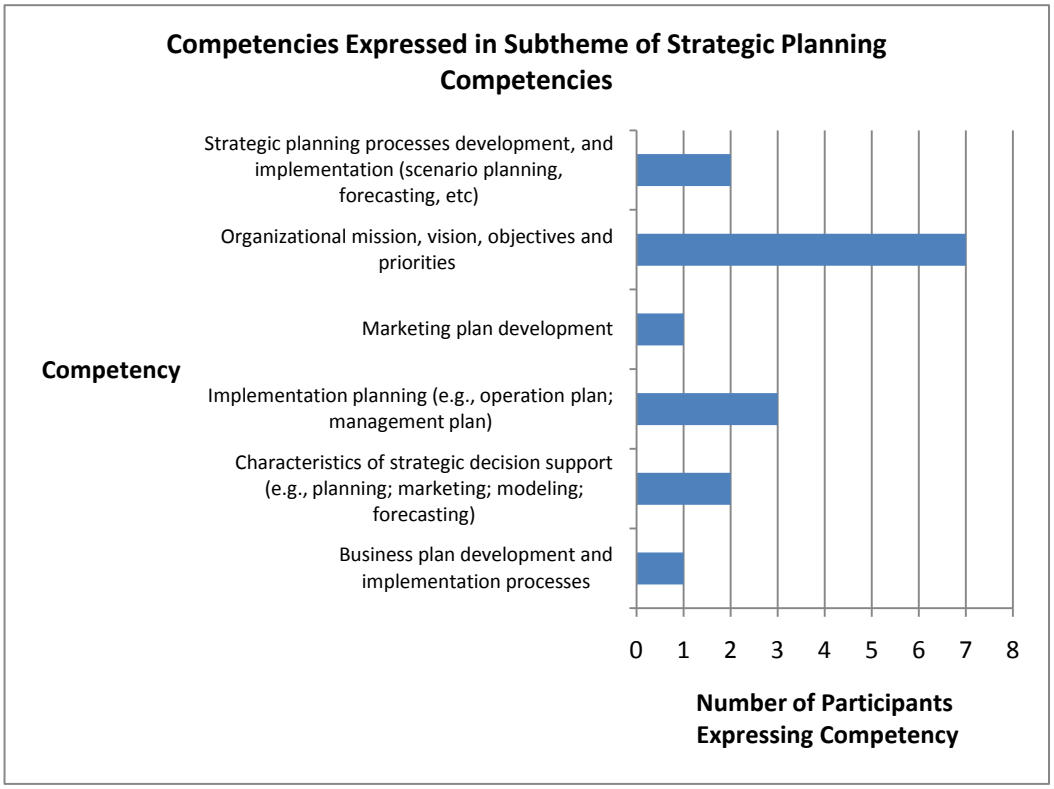


Table I5f

Participants Expressing Competencies within the Core Theme of Business Knowledge and Skills (Information Management Applications)

Emerging Competencies	Expressed by Participant	Discovery Question
Characteristics of administrative systems/programs (e.g., financial; scheduling; on-line purchasing; productivity; human resources)	P10	IQ1
	P20	IQ5
Physician practice management IT systems (e.g., billing; referral/authorization; claims processing; electronic medical records; prescription writing; productivity; transcription)	P10	IQ5

Figure I5f

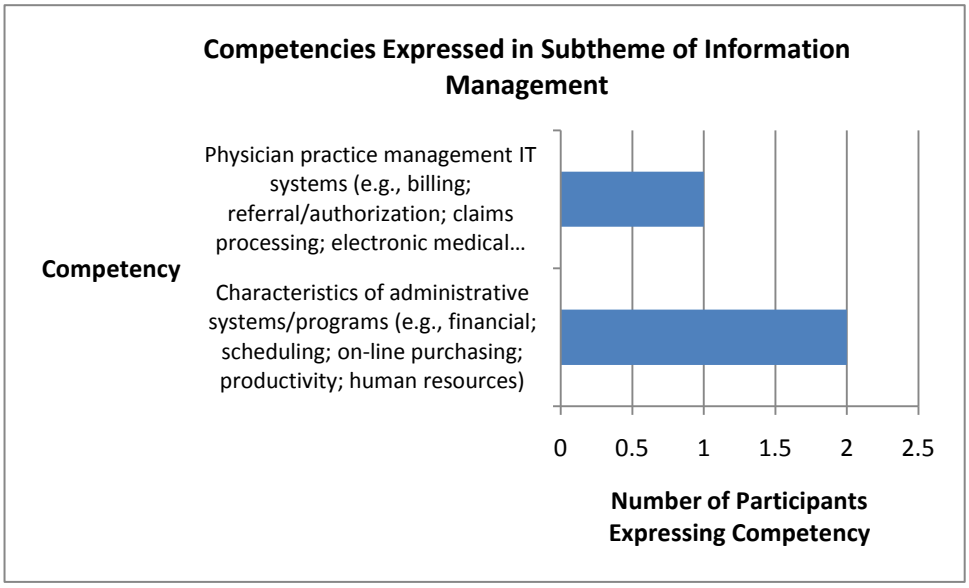


Table I5g

Participants Expressing Competencies within the Core Theme of Business Knowledge and Skills (Risk Management Applications)

Emerging Competencies	Expressed by Participant	Discovery Question
Compliance with regulatory agencies and tax status requirements	P18	IQ10
Components of a physician employment contract with the practice (e.g. divestiture of assets; restrictive and non-compete clauses ; buy-sell agreements)	P18	IQ3
Contingency planning (e.g., emergency preparedness)	P24	IQ3

Figure I5g

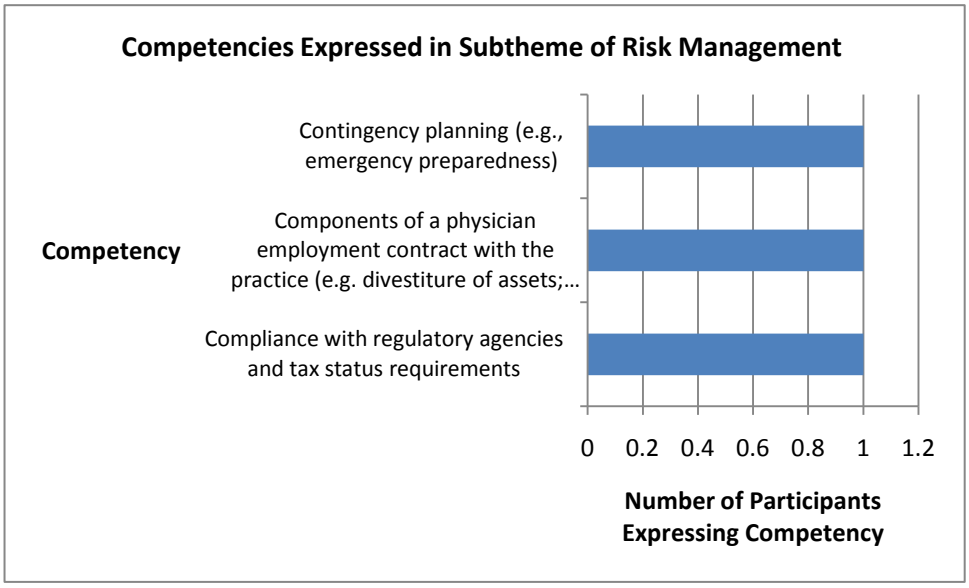


Table I5h

Participants Expressing Competencies within the Core Theme of Business Knowledge and Skills (Quality Improvement Applications)

Emerging Competencies	Expressed by Participant	Discovery Question
Customer satisfaction principles and tools	P18, P20, P21, P24	IQ5
	P20	IQ6
	P20	IQ10
Data collection, measurement and analysis tools and techniques (e.g., root-cause analysis; process analysis; workflows)	P18	IQ5

Figure I5h

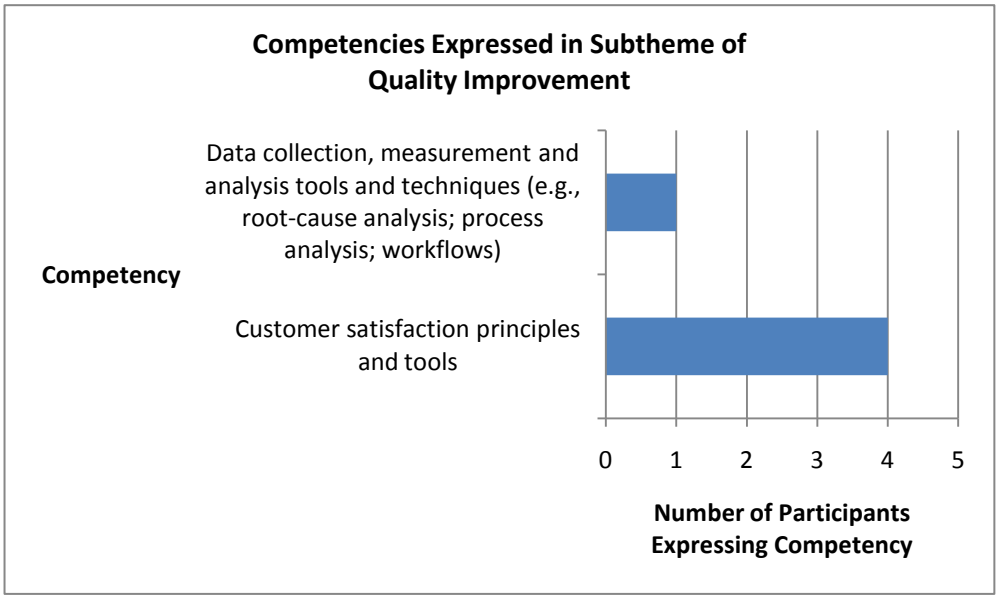


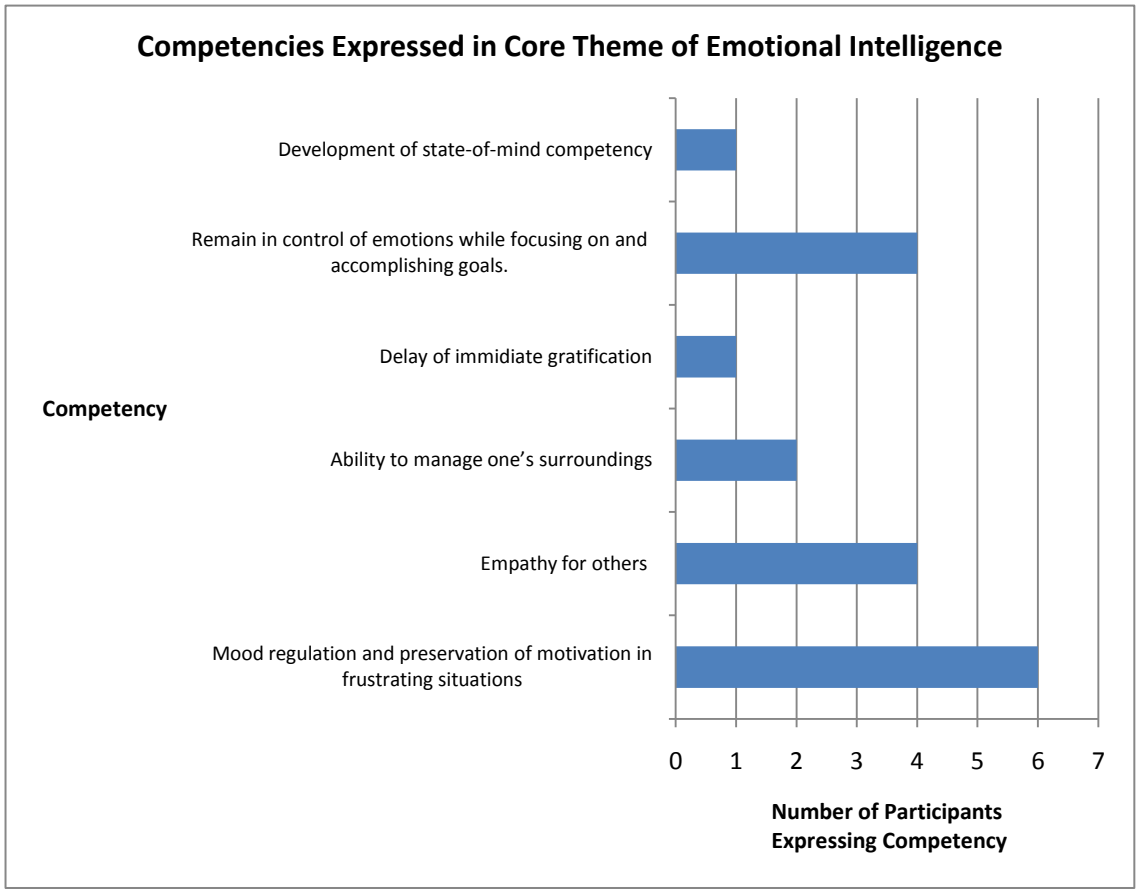
Table I6

Competencies Expressed in the Core Theme of Emotional Intelligence

Emerging Competencies	Expressed by Participant	Discovery Question
Mood regulation and preservation of motivation in frustrating situations	P02, P12, P18, P21, P22, P26	IQ8
	P02	IQ10
Empathy for others	P20	IQ8
	P10, P04	IQ9
	P02	IQ10
	P12, P20	IQ10
Ability to manage one's surroundings	P02, P04	IQ8
Delay of immediate gratification	P18	IQ8
Remain in control of emotions while focusing on and accomplishing goals.	P26	IQ7
	P22, P26	IQ8
	P18, P24	IQ10
Development of state-of-mind competency	P20	IQ9

Figure I6

Competencies Expressed in Core Theme of Emotional Intelligence



Note: NEC is the acronym for 'New Emerging Competency'

Table I7

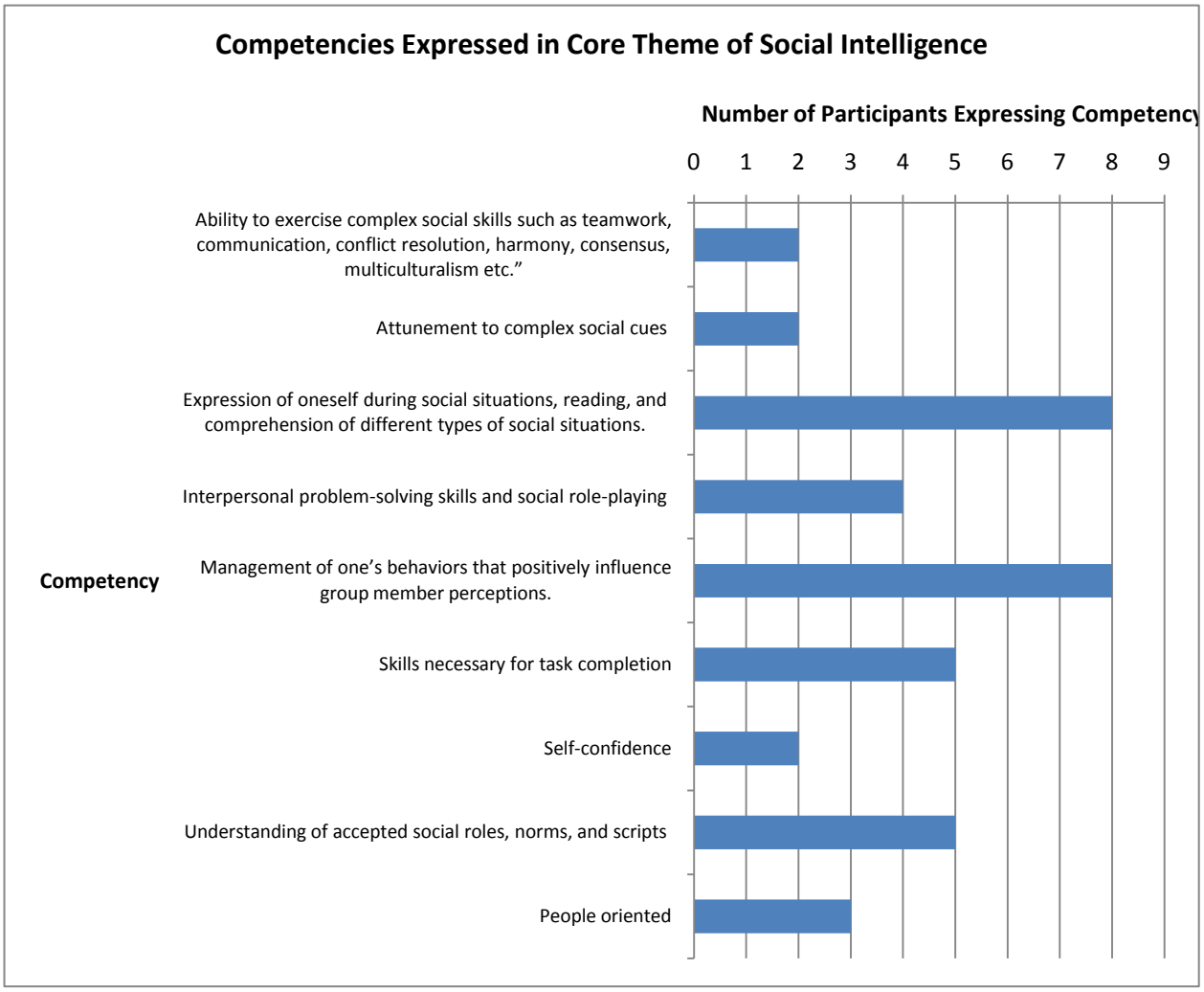
Competencies Expressed in the Core Theme of Social Intelligence

Emerging Competencies	Expressed by Participant	Discovery Question
Ability to exercise complex social skills such as teamwork, communication, conflict resolution, harmony, consensus, multiculturalism etc.	P18, P24	IQ9
Attunement to complex social cues	P12, P18	IQ7
Expression of oneself during social situations, reading, and comprehension of different types of social situations.	P12, P18, P22	IQ2
	P02, P10	IQ7
	P02	IQ8
	P02, P10, P21, P26	IQ9
	P02, P10, P12, P20, P21	IQ10
Interpersonal problem-solving skills and social role-playing	P12	IQ1
	P12	IQ2
	P26	IQ4
	P26	IQ7
	P22	IQ9
	P24, P22	IQ10
Management of one's behaviors that positively influence group member perceptions.	P18	IQ1
	P20	IQ2

	P04, P10, P12, P18, P24, P26	IQ8
	P22, P24	IQ9
	P02, P12, P18, P20	IQ10
Skills necessary for task completion	P20	IQ2
	P04, P22, P24, P26	IQ7
	P22	IQ9
	P18, P21, P24, P26	IQ10
Self-Confidence	P20	IQ10
	P24	IQ8
Understanding of accepted social roles, norms, and scripts	P18	IQ1
	P02	IQ6
	P21	IQ8
	P10	IQ9
	P04	IQ10
New Emerging Competency Identified--People oriented	P22	IQ7
	P20	IQ9
	P26	IQ10

Figure I7

Competencies Expressed in Core Theme of Social Intelligence



Note: NEC is the acronym for 'New Emerging Competency'

APPENDIX J: TABLES AND GRAPHS REPRESENTING THEMATIC DEVELOPMENT OF INTERVIEW QUESTIONS

Interview Question1

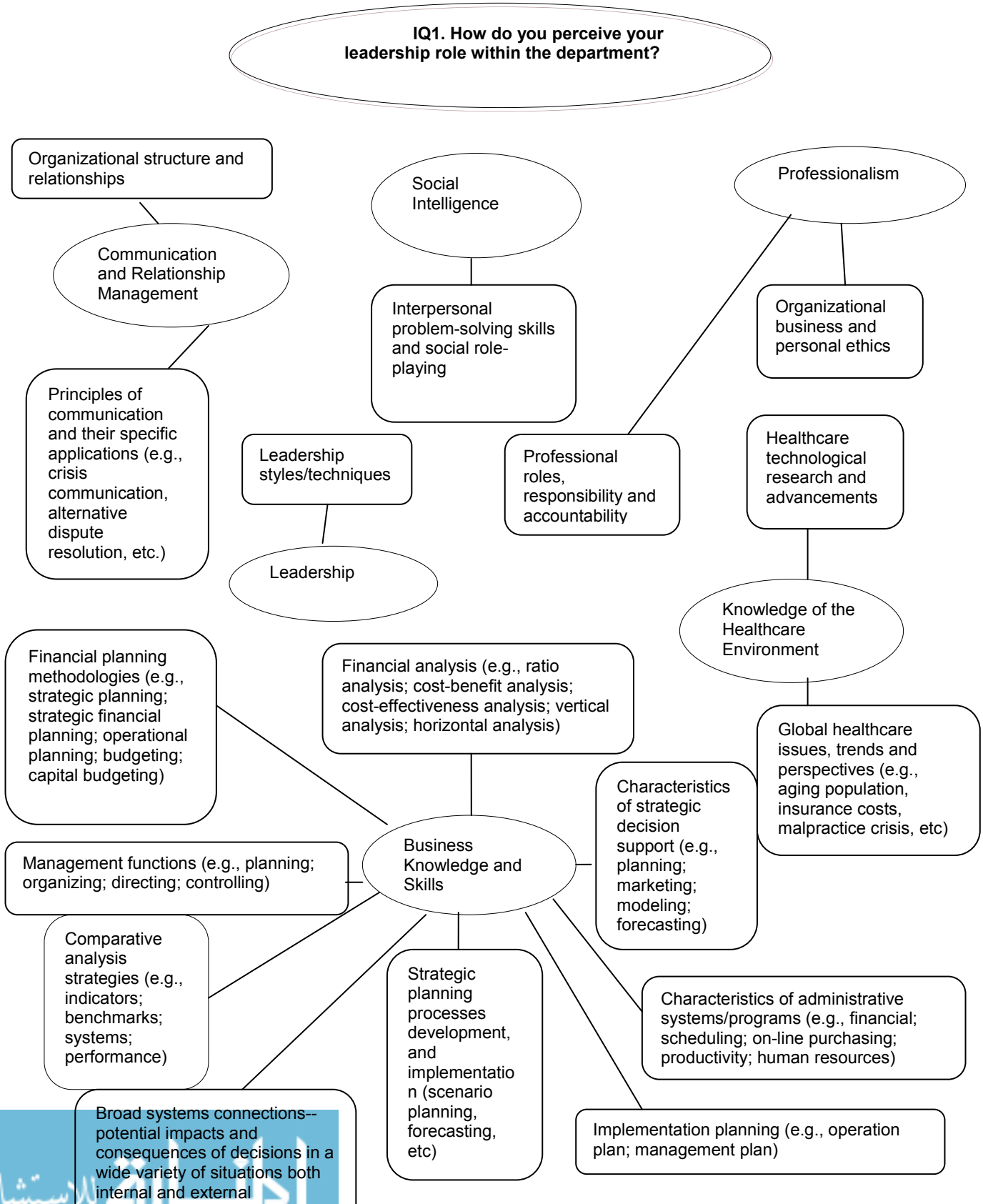
Table J1

Reduction and Elimination of Interview Question 1

Core Theme	Emerging Competency	Participants
Communication and Relationship Management		
	Organizational structure and relationships	P02, P04, P21
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	P10
Leadership		
	Leadership styles/techniques	P12, P20, P21
Professionalism		
	Organizational business and personal ethics	P12
	Professional roles, responsibility and accountability	P02, P21, P22, P24, P26
Knowledge of the Healthcare Environment		P04
	Healthcare technological research and advancements	P10
	Global healthcare issues, trends and perspectives (e.g., aging population, insurance costs, malpractice crisis, etc)	P04
	Nursing, physicians, and allied health professionals' roles and practice	P26
	Organization and delivery of healthcare (e.g., acute care, ambulatory care, medical practice, ancillary services)	P26
Business Skills		
	Management functions (e.g., planning; organizing; directing; controlling)	P10
	Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	P10
	Comparative analysis strategies (e.g., indicators; benchmarks; systems; performance)	P04
	Financial analysis (e.g., ratio analysis; cost-benefit analysis; cost-effectiveness analysis; vertical analysis; horizontal analysis)	P10
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	P04, P10
	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	P04, P10, P26
	Implementation planning (e.g., operation plan; management plan)	P10
	Strategic planning processes development, and implementation (scenario planning, forecasting, etc)	P04
	Characteristics of administrative systems/programs (e.g., financial; scheduling; on-line purchasing; productivity; human resources)	P10
	Organizational mission, vision, objectives and priorities	P24, P26
Social Intelligence		
	Interpersonal problem-solving skills and social role-playing	P12
	Understanding of accepted social roles, norms, and scripts	P18
	Management of one's behaviors that positively influence group member perceptions.	P18

Figure J1

Flow Chart of Core Theme Clusters Expressed for IQ1



Interview Question 2

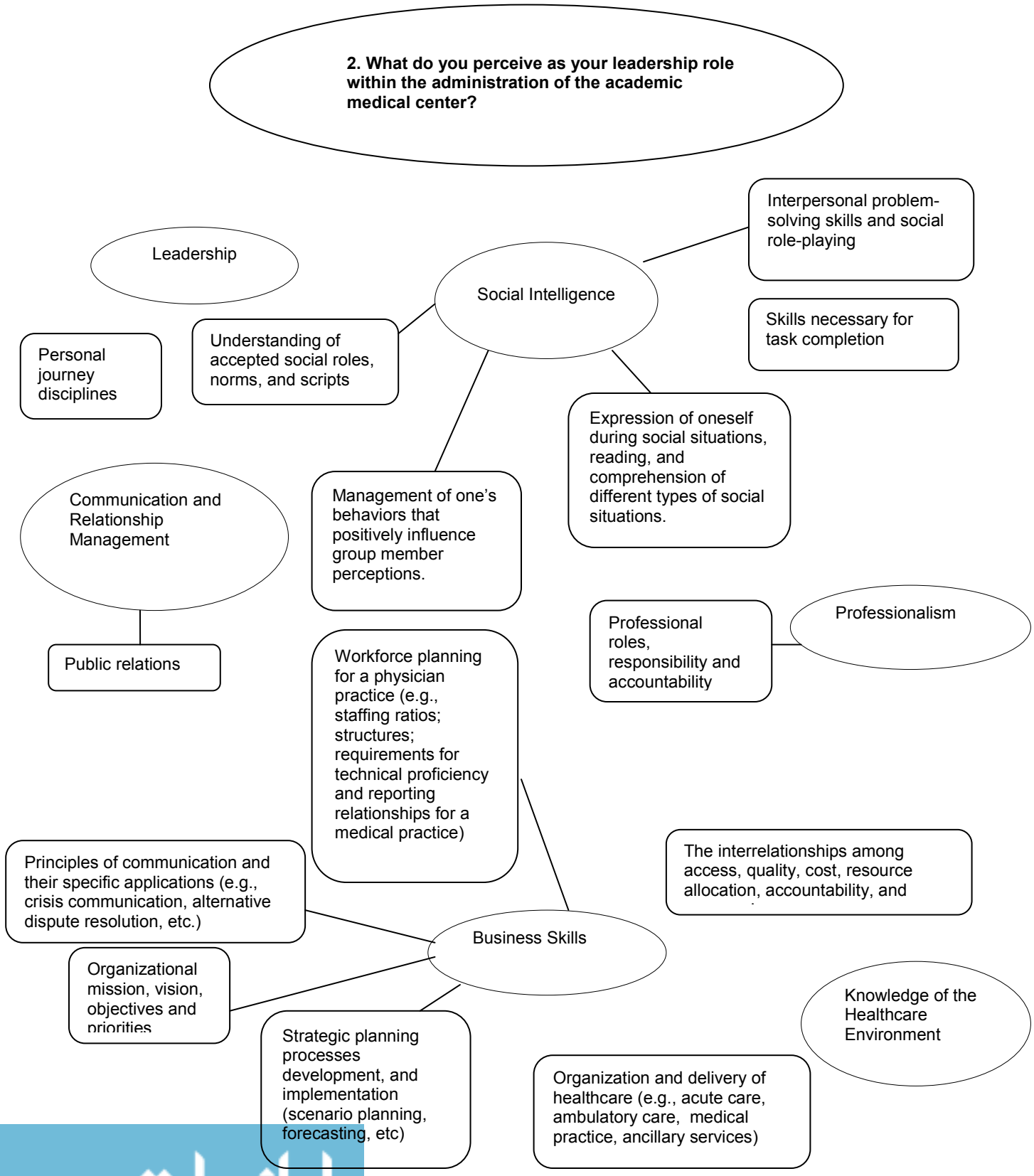
Table J2

Reduction and Elimination of Interview Question 2

Core Theme	Emerging Competency	Participants
Communication and Relationship Management		
	Public relations	P04, P20, P18
Leadership		
	Personal journey disciplines	P20, P26
Professionalism		
	Professional roles, responsibility and accountability	P21
Knowledge of the Healthcare Environment		
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	P20
	Organization and delivery of healthcare (e.g., acute care, ambulatory care, medical practice, ancillary services)	P02
	Nursing, physicians, and allied health professionals' roles and practice	P24
	New Emerging Competency Identified— To integrate, merge, link, marry the department and hospital perspectives	P24
Business Skills		
	Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	P02
	Organizational mission, vision, objectives and priorities	P10, P22, P24
	Strategic planning processes development, and implementation (scenario planning, forecasting, etc)	P02
	New Emerging Competency Identified- To integrate, merge, link, marry the department and hospital perspectives	P22
	Organizational dynamics, political realities, and culture	P24
	Contingency planning (e.g., emergency preparedness)	P24
	Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	P26
Social Intelligence		
	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	P04, P12, P18, P22
	Interpersonal problem-solving skills and social role-playing	P04, P12, P20
	Understanding of accepted social roles, norms, and scripts	
	Skills necessary for task completion	
	Management of one's behaviors that positively influence group member perceptions.	P20

Figure J2

Flowchart of Core Theme Clusters Expressed for IQ2



Interview Question 3

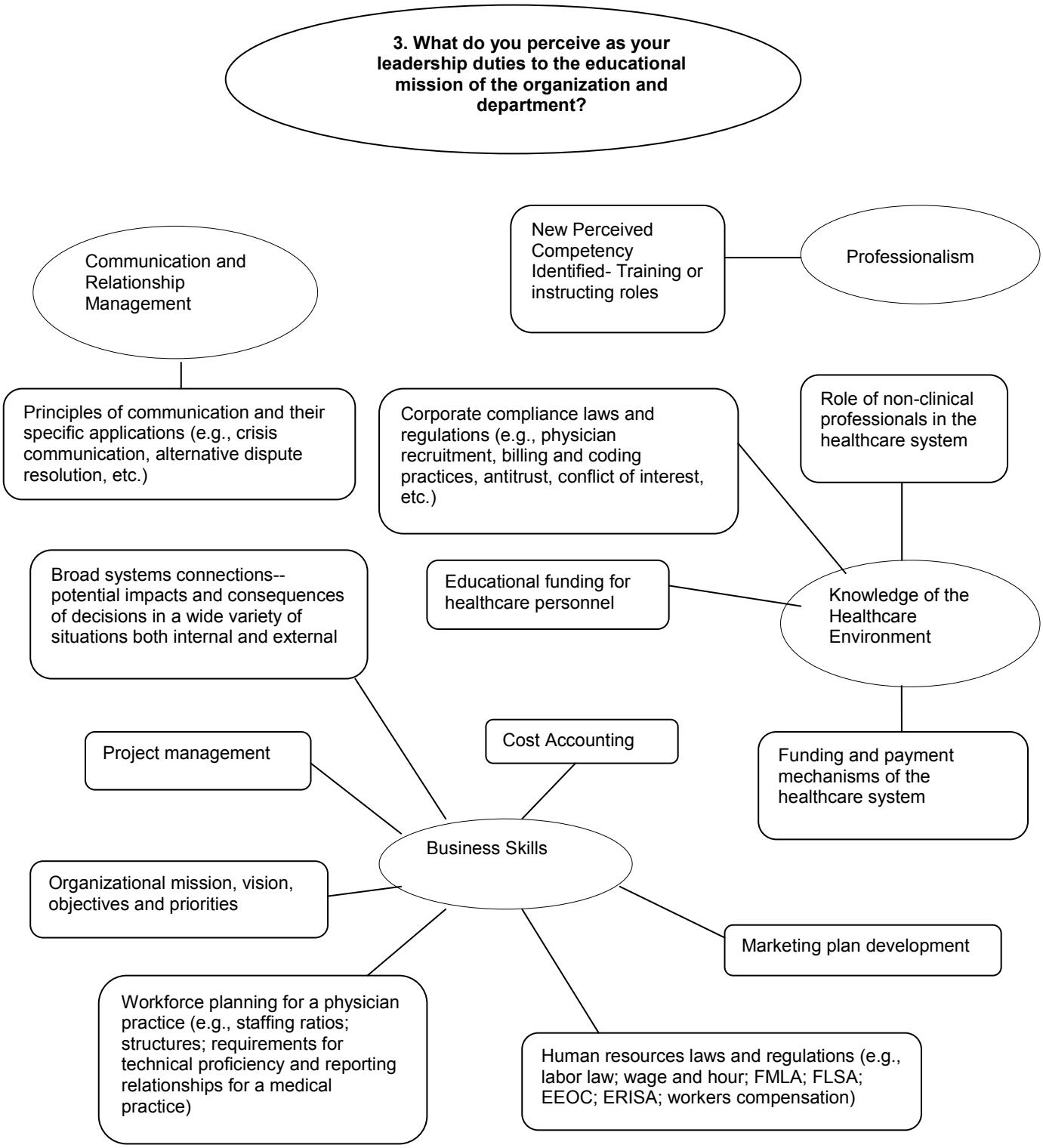
Table J3

Reduction and Elimination of Interview Question 3

Core Theme	Emerging Competency	Participants
Communication and Relationship Management		
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	P12, P22
Leadership		
	Personal Journey Disciplines	P18
Professionalism		
	New Theme Identified- Billing and finance Instructor for residency program	P02, P10
Knowledge of the Healthcare Environment		
	Role of non-clinical professionals in the healthcare system	P21
	Corporate compliance laws and regulations (e.g., physician recruitment, billing and coding practices, antitrust, conflict of interest, etc.)	P04
	Educational funding for healthcare personnel	P02, P10, P21, P22
	Funding and payment mechanisms of the healthcare system	P10, P12, P20
	Nursing, physicians, and allied health professionals' roles and practice	P24
Business Skills		
	Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	P12
	Project management	P04
	Cost accounting	P02
	Human resources laws and regulations (e.g., labor law; wage and hour; FMLA; FLSA; EEOC; ERISA; workers compensation)	P10
	Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	P04, P12, P21
	Marketing plan development	P20
	Components of a physician employment contract with the practice (e.g. divestiture of assets; restrictive and non-compete clauses ; buy-sell agreements)	P18
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	P22, P26
	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	P22
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	P22
	Organizational mission, vision, objectives and priorities	P20, P24
	Contingency planning (e.g., emergency preparedness)	P24
	Organizational mission, vision, objectives and priorities	P26
	Comparative analysis strategies (e.g., indicators; benchmarks; systems; performance)	P26

Figure J3

Flow Chart of Core Theme Clusters Expressed for IQ3



Interview Question 4

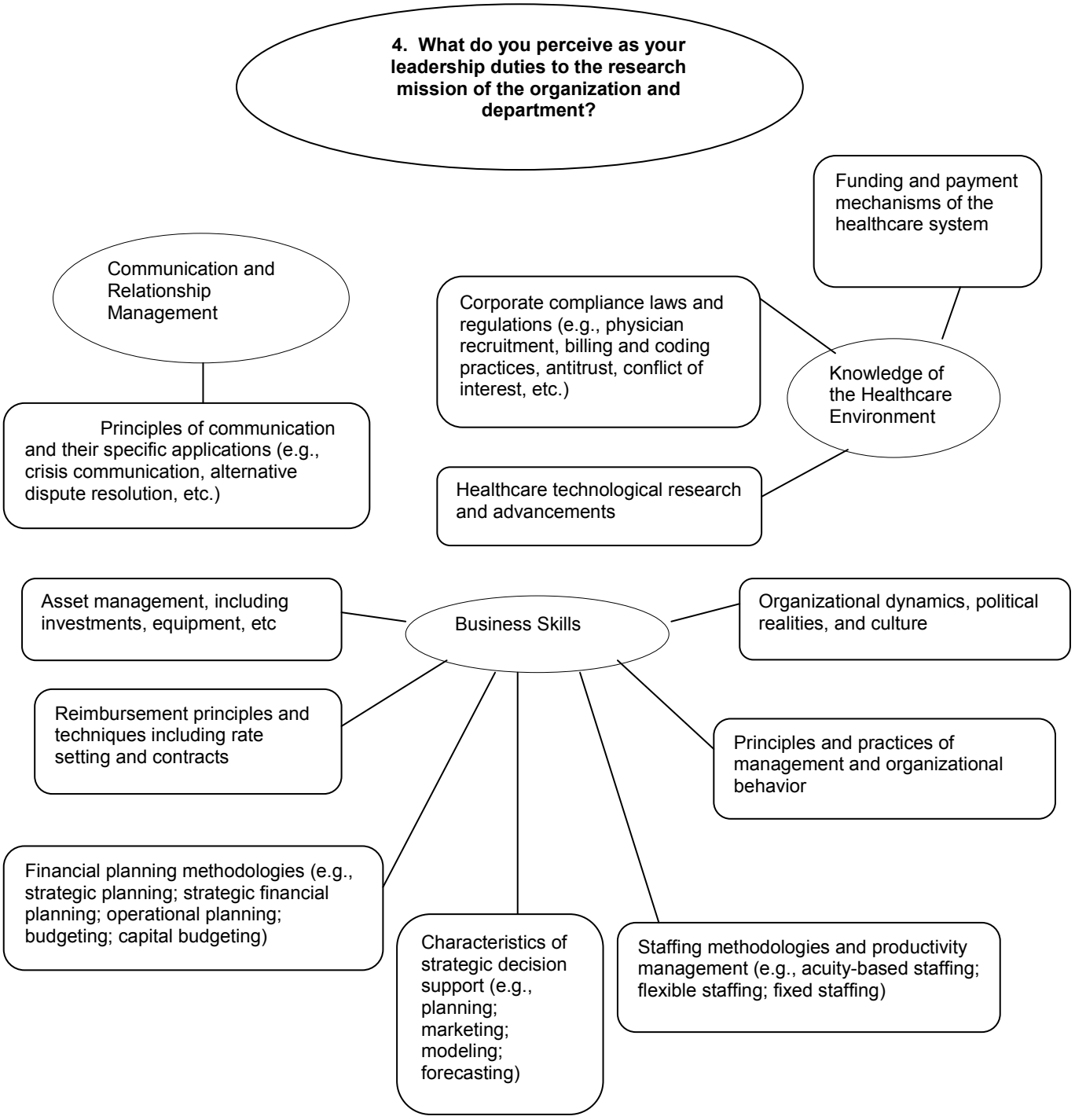
Table J4

Reduction and Elimination of Interview Question 4

Core Theme	Emerging Competency	Participants
Communication and Relationship Management		
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	P04, P12
Knowledge of the Healthcare Environment		
	Corporate compliance laws and regulations (e.g., physician recruitment, billing and coding practices, antitrust, conflict of interest, etc.)	P02, P04
	Funding and payment mechanisms of the healthcare system	P02, P12, P21
	New Emerging Competency Identified--Support research, research personnel, and grants	P18, P22, P24
	Healthcare technological research and advancements	P20
Business Skills		
	Inventory control systems	P12
	Asset management, including investments, equipment, etc	P12, P26
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	P02, P21, P22
	Reimbursement principles and techniques including rate setting and contracts	P02
	Staffing methodologies and productivity management (e.g., acuity-based staffing; flexible staffing; fixed staffing)	P12
	Organizational dynamics, political realities, and culture	P02
	Organizational policies and procedures and their functions	
	Principles and practices of management and organizational behavior	P04
	Quality planning and management	P26
	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	P10
Social Intelligence		
	Interpersonal problem-solving skills and social role-playing skills	P26

Figure J4

Flow Chart of Core Theme Clusters Expressed for IQ4



Interview Question 5

Table J5

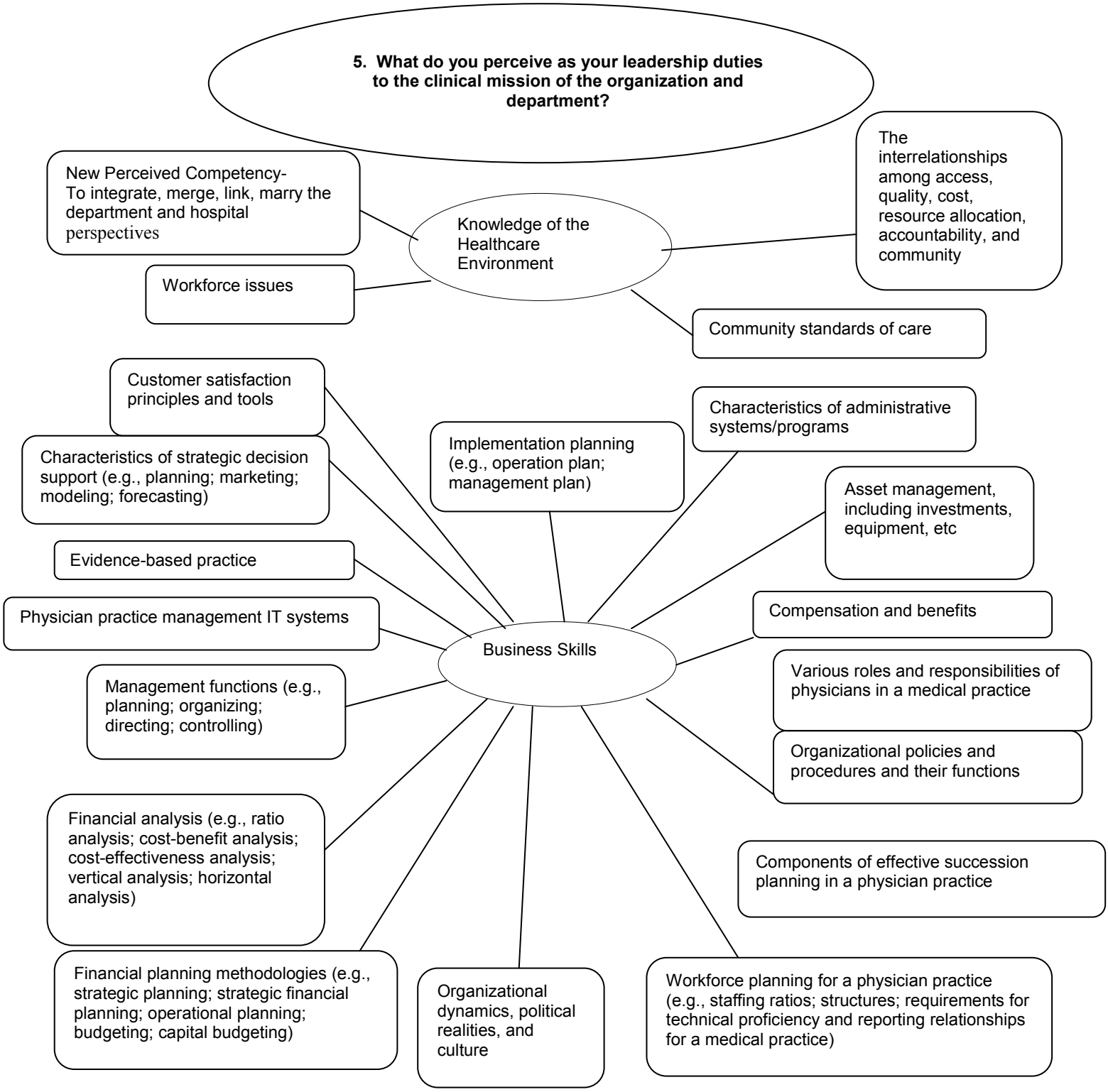
Table 5
Reduction and Elimination of Interview Question 5

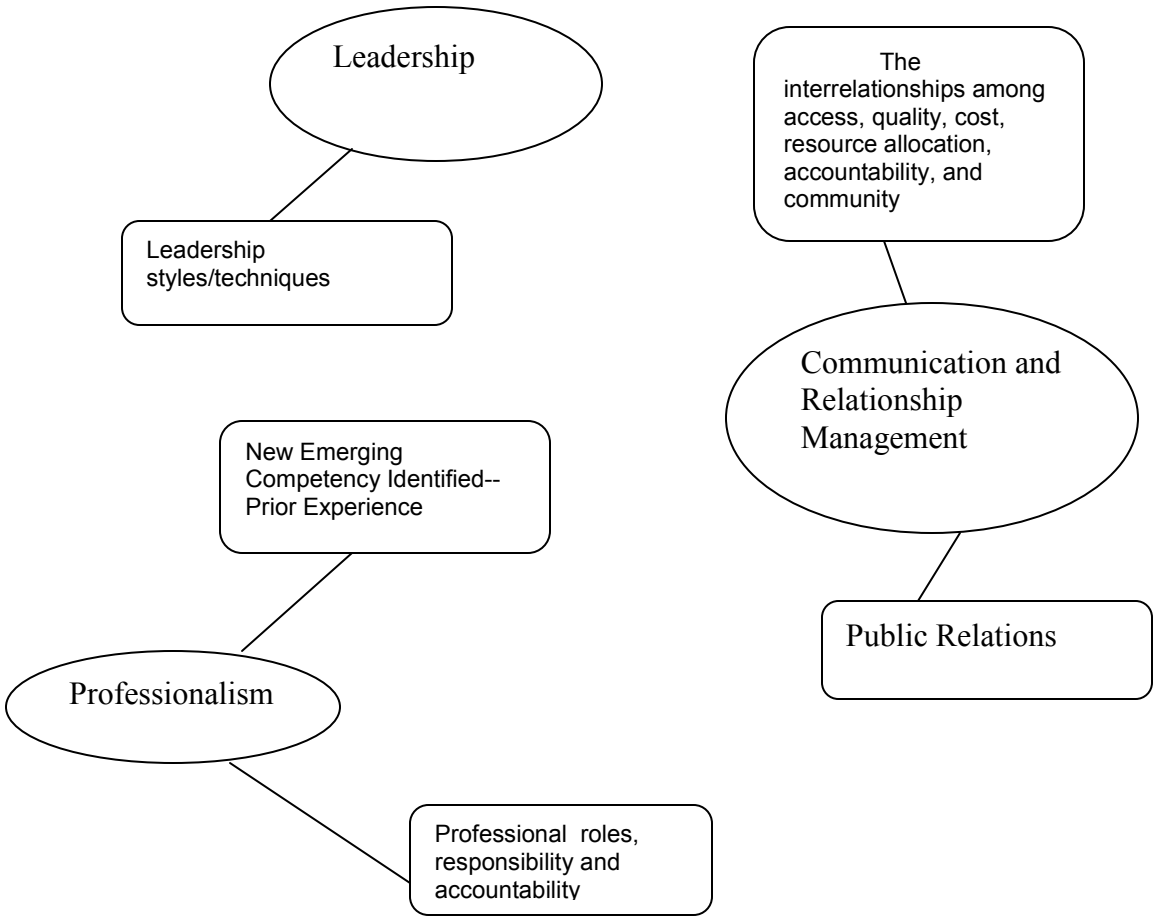
Core Theme	Emerging Competency	Participants
Communication and Relationship Management		
	Public relations	P26
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	P26
Leadership		
	Leadership styles/techniques	P22
Professionalism		
	New Emerging Competency Identified--Prior Experience	P22
	Professional roles, responsibility and accountability	P22
Knowledge of the Healthcare Environment		
	New Theme- To integrate, merge, link, marry the department and hospital perspectives	P04
	Community standards of care	P10
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	P10, P20
	Workforce issues	
	Staff perspective in organizational settings (e.g., frame of reference by discipline and role; orientation)	P22
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	P24
Business Skills		
	Evidence-based practice	P10
	Asset management, including investments, equipment, etc	P02
	Management functions (e.g., planning; organizing; directing; controlling)	P02
	Financial analysis (e.g., ratio analysis; cost-benefit analysis; cost-effectiveness analysis; vertical analysis; horizontal analysis)	P02
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	P02
	Compensation and benefits	P02, P12
	Organizational policies and procedures and their functions	P04
	Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	P02, P20
	Customer satisfaction principles and tools	P20, P21, P24
	Organizational dynamics, political realities, and culture	P04
	Components of effective succession planning in a physician practice (e.g., seniority and transition of leadership responsibilities; impacts on call coverage and compensation; recruitment and developing new physicians; structuring buy-in agreement)	P02
	Various roles and responsibilities of physicians in a medical practice (e.g.,, provider; owner; managing partner; president of the board; medical director)	P10
	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	P10
	Implementation planning (e.g., operation plan; management plan)	P02
	Characteristics of administrative systems/programs (e.g., financial; scheduling; on-line purchasing; productivity; human resources)	P20
	Physician practice management IT systems (e.g., billing; referral/authorization; claims processing; electronic medical records; prescription writing; productivity; transcription)	P10

Data collection, measurement and analysis tools and techniques (e.g., root-cause analysis; process analysis; workflows)	P18
Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	P18
Motivational techniques	P22
Principles and practices of management and organizational behavior	P22

Figure J5

Flow Chart of Core Theme Clusters Expressed for IQ5





Interview Question 6

Table J6

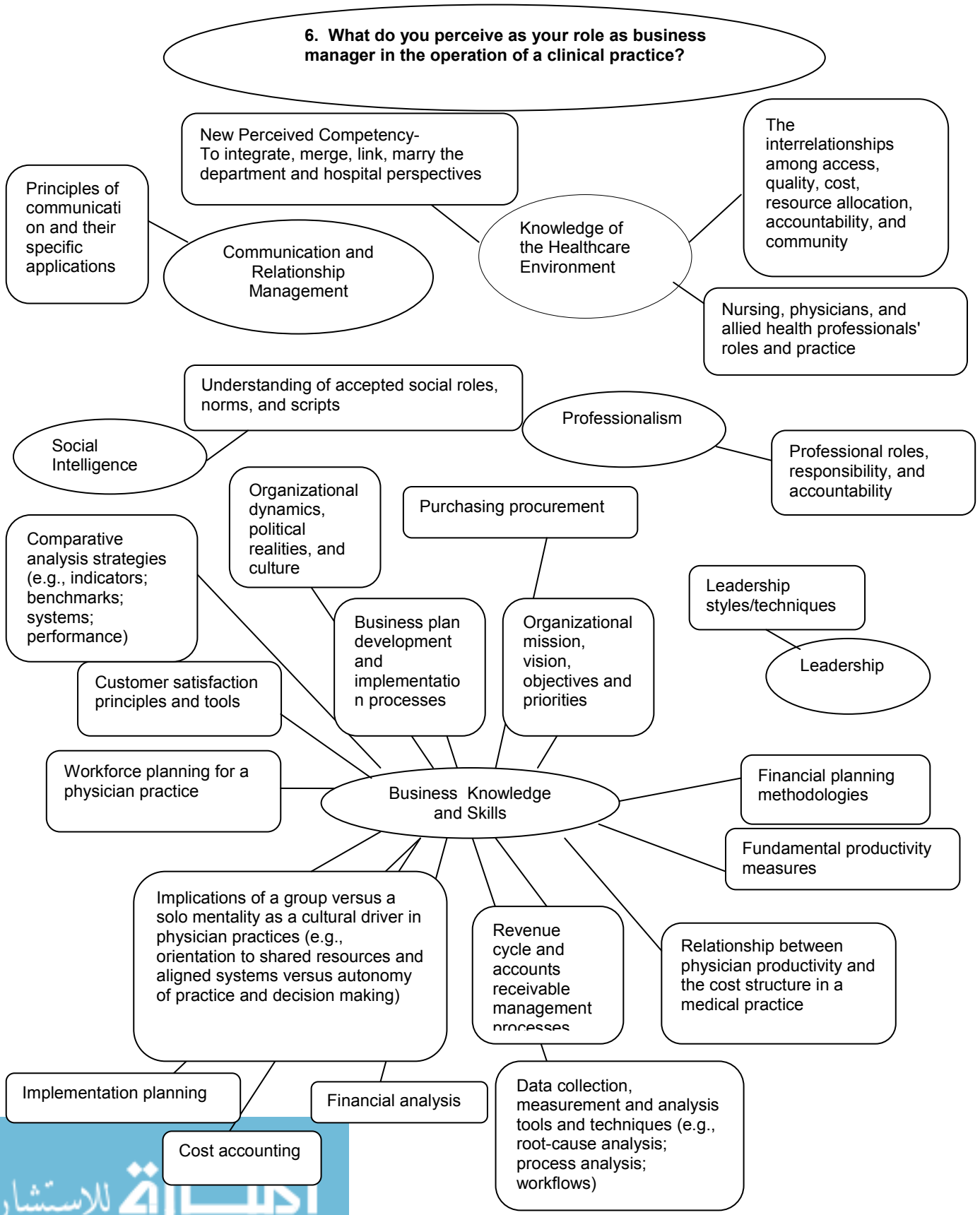
Table 6
Reduction and Elimination of Interview Question 6

Core Theme	Emerging Competency	Participants
	Competency	
Communication and Relationship Management		
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	P12
Leadership		
	Leadership styles/techniques	P24
Professionalism		
	Professional roles, responsibility and accountability	P10
Knowledge of the Healthcare Environment		
	New Theme- To integrate, merge, link, marry the department and hospital perspectives	P04
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	P02, P10
	Nursing, physicians, and allied health professionals' roles and practice	P21
	Role of non-clinical professionals in the healthcare system	P24
	Organization and delivery of healthcare (e.g., acute care, ambulatory care, medical practice, ancillary services)	P24
Business Skills		
	Purchasing procurement	P21
	Finance Skills	
	Cost accounting	P04
	Financial analysis (e.g., ratio analysis; cost-benefit analysis; cost-effectiveness analysis; vertical analysis; horizontal analysis)	P04
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	P10, P24
	Fundamental productivity measures (e.g., hours per patient day; cost per patient day; units of service per man hour; PMPM)	P21
	Relationship between physician productivity and the cost structure in a medical practice	P04
	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	P02, P04, P20
	Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	P02, P20
	Implications of a group versus a solo mentality as a cultural driver in physician practices (e.g., orientation to shared resources and aligned systems versus autonomy of practice and decision making)	P21
	Implementation planning (e.g., operation plan; management plan)	P02, P12, P20
	Customer satisfaction principles and tools	P20
	Data collection, measurement and analysis tools and techniques (e.g., root-cause analysis; process analysis; workflows)	P18
	Comparative analysis strategies (e.g., indicators; benchmarks; systems;	P18

	performance)	
	Organizational mission, vision, objectives and priorities	P18
	Organizational dynamics, political realities, and culture	P18, P22
	Asset management, including investments, equipment, etc	P18
	Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	P18, P22
	Business plan development and implementation processes	P20
Social Intelligence		
	Understanding of accepted social roles, norms, and scripts	P02

Figure J6

Flow Chart of Core Theme Clusters Expressed for IQ6



Interview Question 7

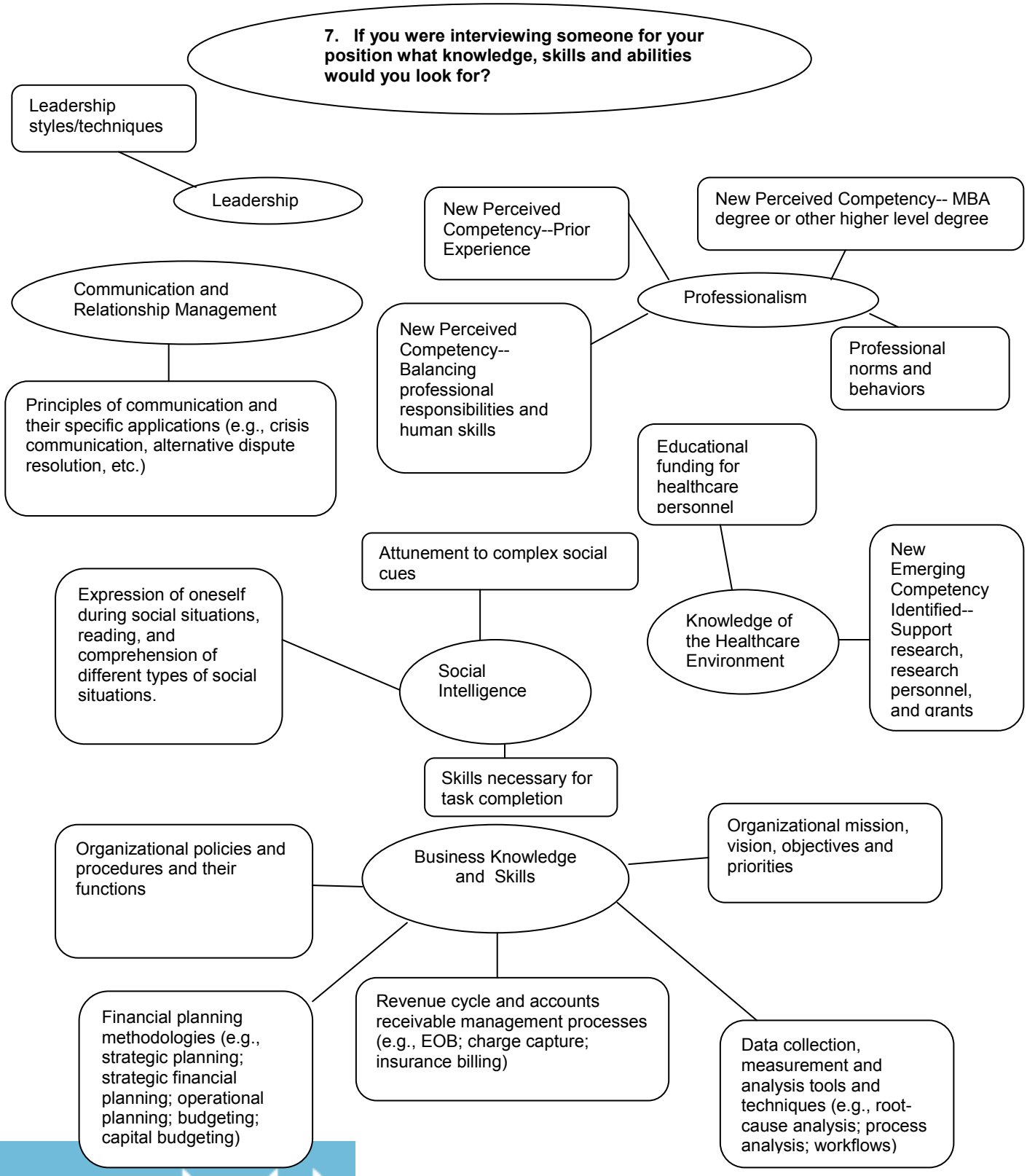
Table J7

Reduction and Elimination of Interview Question 7

Core Theme	Emerging Competency	Participants
	Competency	
Communication and Relationship Management		
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	P02, P21, P18
Leadership		
	Leadership styles/techniques	P24
Professionalism		
	New Emerging Competency Identified--MBA degree or other higher level degree	P02, P04, P18
	New Emerging Competency Identified--Prior Experience	P04, P12, P21, P24
	New Emerging Competency Identified--Balance professional responsibilities and human skills	P10
	Professional norms and behaviors	P04
	Time and stress management techniques	P22
Knowledge of the Healthcare Environment		
	Educational funding for healthcare personnel	P26
	New Emerging Competency Identified--Support research, research personnel, and grants	P26
Business Skills		
	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	P10
	Organizational policies and procedures and their functions	P10
	Organizational mission, vision, objectives and priorities	P04, P20
	Data collection, measurement and analysis tools and techniques (e.g., root-cause analysis; process analysis; workflows)	P18
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	P22, P24, P26
Emotional Intelligence		
	Remain in control of emotions while focusing on and accomplishing goals.	P26
Social Intelligence		
	New Emerging Competency Identified--People oriented	P22
	Interpersonal problem-solving skills and social role-playing skills	P26
	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	P02, P10
	Skills necessary for task completion	P04, P22, P24, P26
	Attunement to complex social cues	P12, P18

Figure J7

Flowchart of Core Theme Clusters Expressed for IQ7



Interview Question 8

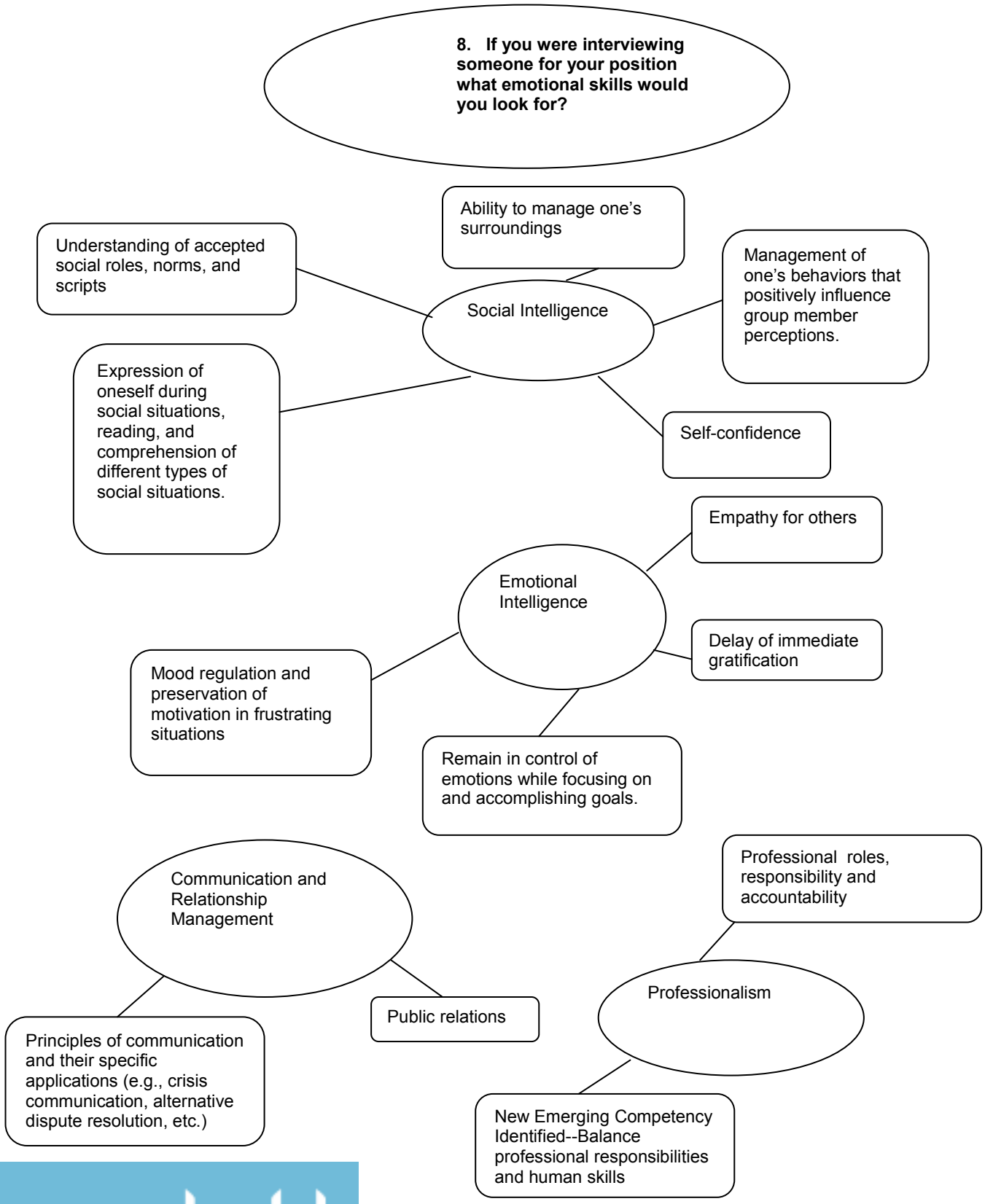
Table J8

Reduction and Elimination of Interview Question 8

Core Theme	Emerging Competency	Participants
	Competency	
Communication and Relationship Management		
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	P18
	Public relations	P10
Professionalism		
	New Emerging Competency Identified--Balance professional responsibilities and human skills	P22
	Professional roles, responsibility and accountability	P04, P10
Business Skills		
	Implementation planning (e.g., operation plan; management plan)	P02
Emotional Intelligence		
	Mood regulation and preservation of motivation in frustrating situations	P02, P12, P21, P18, P22, P26
	Empathy for others	P18, P20
	Delay of immediate gratification	P18
	Remain in control of emotions while focusing on and accomplishing goals.	P22, P26
	Ability to manage one's surroundings	P02, P04
Social Intelligence		
	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	P02
	Understanding of accepted social roles, norms, and scripts	P21
	Self-Confidence	P24
	Management of one's behaviors that positively influence group member perceptions.	P04, P10, P12, P18, P24, P26

Figure J8

Flowchart of Core Theme Clusters Expressed for IQ8



Interview Question 9

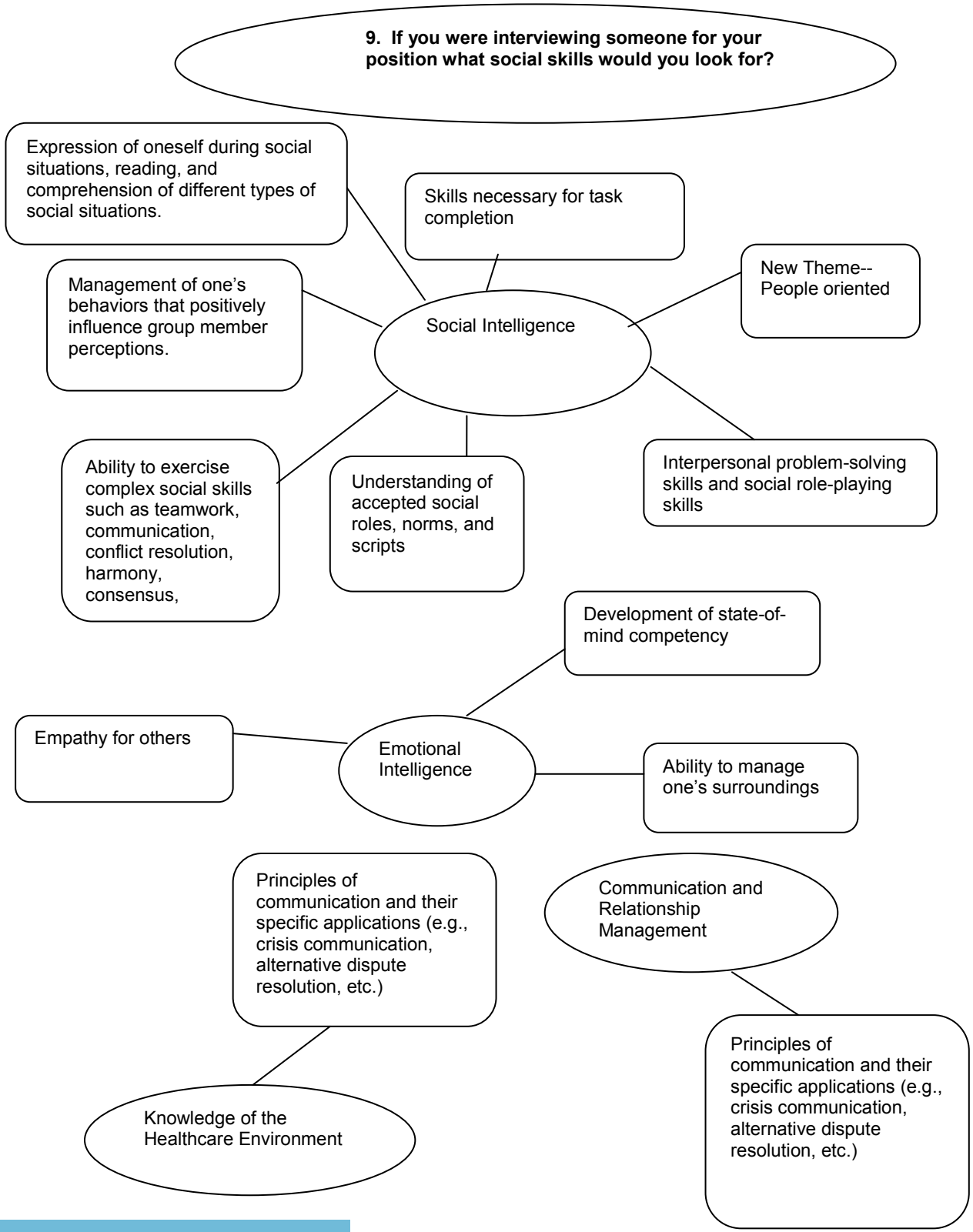
Table J9

Reduction and Elimination of Interview Question 9

Core Theme	Emerging Competency	Participants
Communication and Relationship Management		
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	P04, P12, P24
Knowledge of the Healthcare Environment		
	Role of non-clinical professionals in the healthcare system	P24
Emotional Intelligence		
	Empathy for others	P02, P04, P10
	Ability to manage one's surroundings	P12
	Development of state-of-mind competency	P20
Social Intelligence		
	New Emerging Competency Identified--People oriented	P20
	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	P02, P10, P21, P26
	Understanding of accepted social roles, norms, and scripts	P10
	Ability to exercise complex social skills such as teamwork, communication, conflict resolution, harmony, consensus, multiculturalism etc."	P18, P24
	Skills necessary for task completion	P22
	Management of one's behaviors that positively influence group member perceptions.	P22, P24
	Interpersonal problem-solving skills and social role-playing skills	P22

Figure J9

Flowchart of Core Theme Clusters Expressed for IQ9



Interview Question 10

Table J10

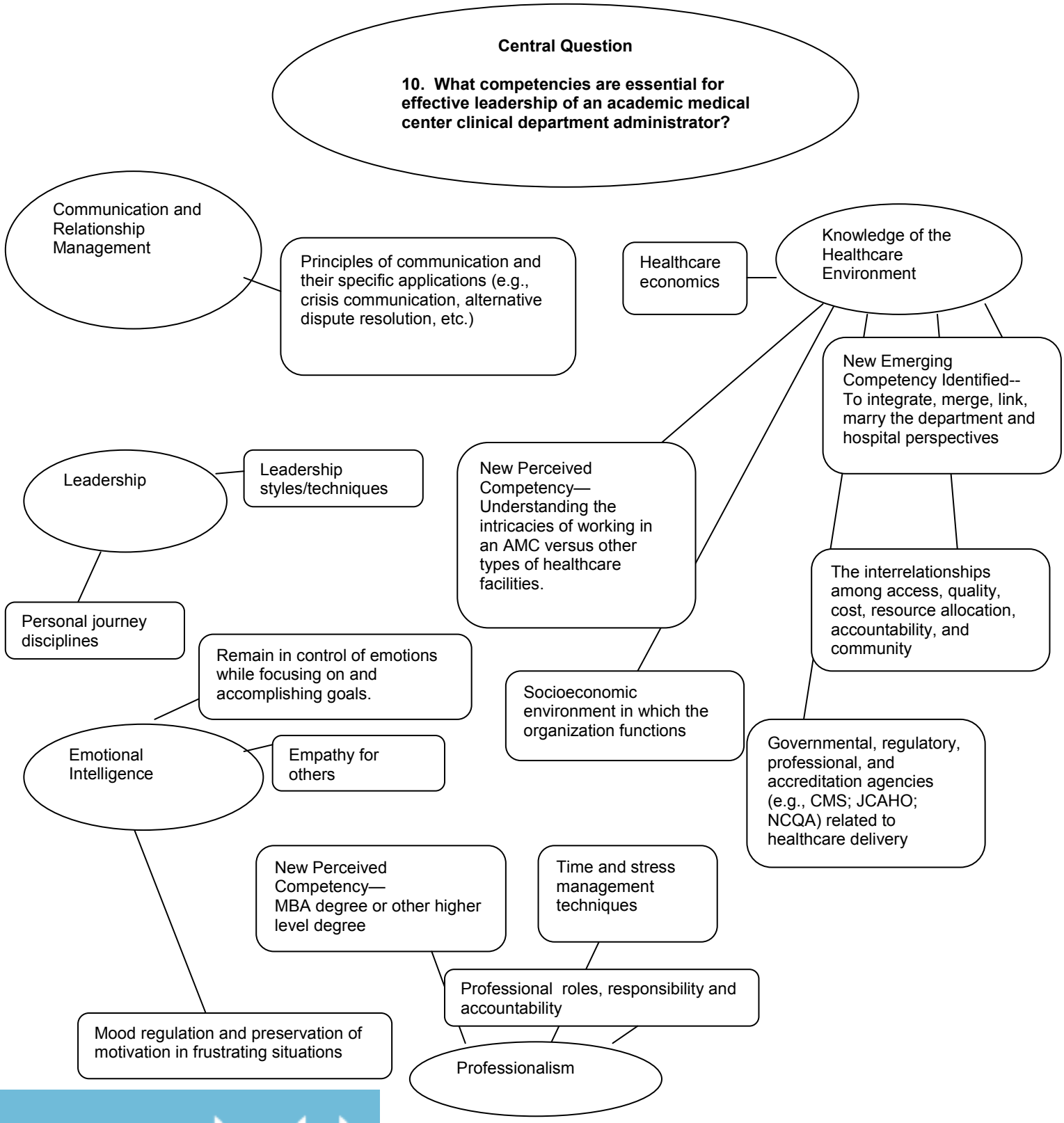
Reduction and Elimination of Interview Question 10

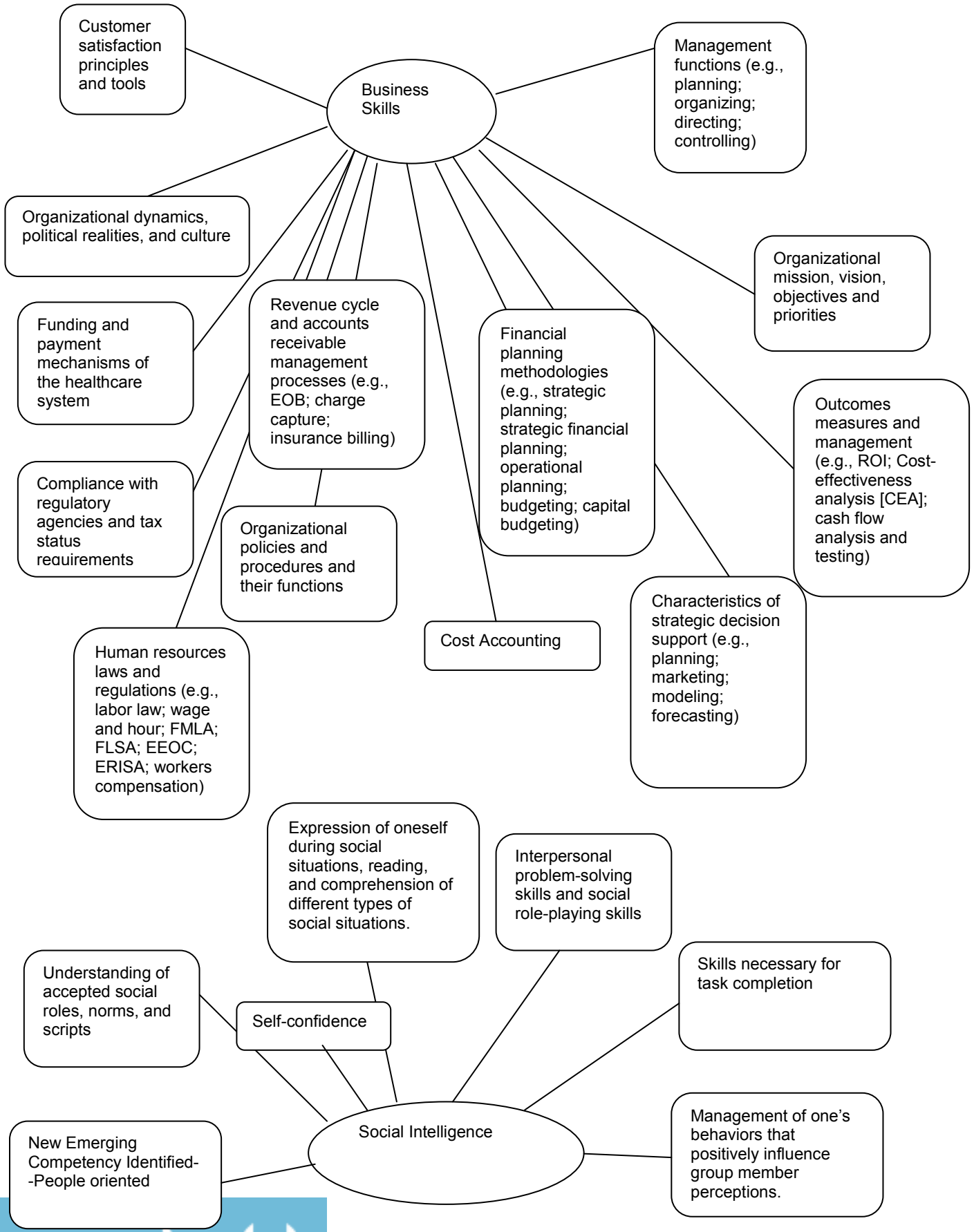
Core Theme	Emerging Competency	Participants
	Competency	
Communication and Relationship Management		
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	P12, P22
Leadership		
	Personal journey disciplines	P20
	Leadership styles/techniques	P26
Professionalism		
New Theme	MBA degree or other higher level degree	P04, P10
	Professional roles, responsibility and accountability	P18
	Time and stress management techniques	P26
Knowledge of the Healthcare Environment		
	New Emerging Competency Identified--understanding the intricacies of working in an AMC versus other types of healthcare facilities.	P10
	Healthcare economics	P18
	Socioeconomic environment in which the organization functions	P18
	Governmental, regulatory, professional, and accreditation agencies (e.g., CMS; JCAHO; NCQA) related to healthcare delivery	P22
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	P22
	New Emerging Competency Identified-- To integrate, merge, link, marry the department and hospital perspectives	P24
Business Skills		
	Management functions (e.g., planning; organizing; directing; controlling)	P04, P12
	Organizational dynamics, political realities, and culture	P02
	Organizational mission, vision, objectives and priorities	P04, P24
	Customer satisfaction principles and tools	P20
	Outcomes measures and management (e.g., ROI; Cost-effectiveness analysis [CEA]; cash flow analysis and testing)	P18
	Funding and payment mechanisms of the healthcare system	P18
	Compliance with regulatory agencies and tax status requirements	P18
	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	P18
	Organizational policies and procedures and their functions	P18
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	P22, P24, P26
	Cost Accounting	P26
	Human resources laws and regulations (e.g., labor law; wage and hour; FMLA; FLSA; EEOC; ERISA; workers compensation)	P22
	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	P22
Emotional Intelligence		
	Mood regulation and preservation of motivation in frustrating situations	P02
	Empathy for others	P02, P12, P20
	Remain in control of emotions while focusing on and accomplishing goals.	P18, P24
Social Intelligence		
	Self-confidence	P20
	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	P02, P10, P12, P20, P21

Understanding of accepted social roles, norms, and scripts	P04
Skills necessary for task completion	P18, P21, P24, P26
Interpersonal problem-solving skills and social role-playing skills	P22, P24
Management of one's behaviors that positively influence group member perceptions.	P02, P12, P18, P20
New Emerging Competency Identified--People oriented	P26

Figure J10

Flowchart of Core Theme Clusters for IQ10





APPENDIX K: TABLES AND GRAPHS REPRESENTING THEMATIC DEVELOPMENT OF PARTICIPANTS

Participant 02

Table K1a

Summary of P02 Interview by Question

Interview Question	Core Theme	Related Competency	Textual Descriptors
IQ1	Communication and Relationship Management	Organizational structure and relationships	"I look at is being an equal partner with the senior leadership. In my perfect world, you have the chair and then you have maybe 4 people at an equal level who would share the responsibilities for the 4 main missions [of education, research, clinical practice, and administration]"
	Professionalism	Professional roles, responsibility and accountability	Responsibility for administration of the department
IQ2	Business Skills	Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	my involvement [in the surgical theater] is to try to make sure that we have the right mix of providers and by that I mean the right mix is not only right aggregate number but you have to have the right people on the right days.
		Strategic planning processes development, and implementation (scenario planning, forecasting, etc)	long range planning and recruiting
IQ3	Professionalism	New Perceived Competency Identified-Training or instructing roles	I lecture about 4 or 5 times a year on the business of [health care about]...the billing basics for the new guys coming in….
	Knowledge of the Healthcare Environment	Educational funding for healthcare personnel	Securing money for visiting professor lecturers and sending residents to do national presentations
	Business Skills	Cost accounting	Billing basics; activities driven by money; once we invest in the infrastructure,it's really not all that expensive.
IQ4	Knowledge of the Healthcare Environment	Corporate compliance laws and regulations (e.g., physician recruitment, billing and coding practices, antitrust, conflict of interest, etc.)	I think the other important part of my role in research is to make sure we are following policies and procedures whether they be federal or the state or an organization and funding agency
		Funding and payment mechanisms of the healthcare system	it's very important because, um, if we have to assign people, if people get research money, we have to take them out of the clinical environment and so that's doubly expensive. One, I'm paying the person I'm taking out and two; I have to pay somebody to be there, so we have got to watch that.

	Business Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	an important role is to help them develop a budget, a realistic budget so they have an opportunity to get the grant.
		Reimbursement principles and techniques including rate setting and contracts	I'm very happy and very proud that doc x got a grant, I can't do anything until we get the NOA, until it gets here
		Organizational dynamics, political realities, and culture	...I'm very happy and very proud that doc x got a grant, I can't do anything until we get the NOA, until it gets here; Oh, by the way, he didn't really get a grant but somebody in that company said they thought maybe they could fund it.
IQ5	Business Skills	Asset management, including investments, equipment, etc	we have to be good managers of the expenditures
		Management functions (e.g., planning; organizing; directing; controlling)	we do a lot of modeling, like how many beds do we need to take care of to cover the workload
		Financial analysis (e.g., ratio analysis; cost-benefit analysis; cost-effectiveness analysis; vertical analysis; horizontal analysis)	If you take out the research component, which I feel we wouldn't spend the money if we didn't have the research, about 97% of our dollars come from the clinical environment.
		Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	budgeting
		Compensation and benefits	our clinical work is driven by labor and labor translates to salaries
		Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	you take somebody out of a clinical enterprise, you have to backfill; making sure we're staff correctly
		Components of effective succession planning in a physician practice (e.g., seniority and transition of leadership responsibilities; impacts on call coverage and compensation; recruitment and developing new physicians; structuring buy-in agreement)	when you have 65-70 clinicians, you have a constant coming and going. Some leaving, some retiring, some moving, promoting to other places, etc… So, it's, I keep my hand on that wheel a lot.
		Implementation planning (e.g., operation plan; management plan)	implementation of new enterprises

IQ6	Knowledge of the Healthcare Environment	The interrelationships among access, quality, cost, resource allocation, accountability, and community	we then break down various business units within the anesthesia whole and look at what we're doing. Are we doing more cardiovascular cases or are we doing more OB, are we doing more peds, all of those have to go into the mix
	Business Skills	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	the business part of a clinical enterprise is the kind of the return on our investment or on our labor and that's the revenue cycle
		Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	a lot of the time and effort that I see myself in the clinical arena is doing staffing or projecting for staff
		Implementation planning (e.g., operation plan; management plan)	implementation of new enterprises
	Social Intelligence	Understanding of accepted social roles, norms, and scripts	The recruiting and the retention of these folks is a little different. Residents come here and expect to do3, 4 or 5 years in training, you pretty much point them in the direction and its hands off. Managing 40-50 nurses is a little different, so and you know they're more of an employee where residents are more of a trainee obviously and the management needs are different in that environment
IQ7	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	the ability to communicate well
	Professionalism--New Theme	Prior Experience	If they're qualified most likely they have the skills set
	Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	bright eyes. I want to see enthusiasm in any level of recruiting.
IQ8	Business Skills	Implementation planning (e.g., operation plan; management plan)	implementation of new enterprises
	Emotional Intelligence	Mood regulation and preservation of motivation in frustrating situations	level-headedness--I would look for somebody who has enough confidence in themselves that they don't get all that flustered by that. That they can keep their focus on the task at hand and not being overwhelmed by the task at hand.

	Emotional Intelligence	Ability to manage one's surroundings	getting production because at the end of the day I think the people we answer to are expecting a certain amount of production. How we do that, whether we do it in by amassing data from the people underneath us or we do a lot of thought process ourselves, they really don't care but they want to product to deliver
	Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	enthusiasm is an emotional skill
IQ9	Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	I guess the big thing would be is to be able to be engaged at all levels.
IQ10	Business Skills	Organizational dynamics, political realities, and culture	First comes the department but within the organizational dynamics
	Emotional Intelligence	Mood regulation and preservation of motivation in frustrating situations	the ability to listen and to have patience.
		Empathy for others	So what I have to do if I'm working with colleges is to kind of put myself in their place and at least listen fairly to their statements and their desires and their needs.
	Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	You can't be shy or you'll get run over
		Management of one's behaviors that positively influence group member perceptions.	try to see if I can actually help others to succeed. Because usually if they succeed, then we're going to succeed so there's that connected centered focus that one has to have to be sure the thing works.

Table K1b

Summary of P02 Interview by Theme

Core Theme	Related Competency	Textual Descriptors	Interview Question
Communication and Relationship Management			
	Organizational structure and relationships	"I look at is being an equal partner with the senior leadership. In my perfect world, you have the chair and then you have maybe 4 people at an equal level who would share the responsibilities for the 4 main missions [of education, research, clinical practice, and administration]"	IQ1

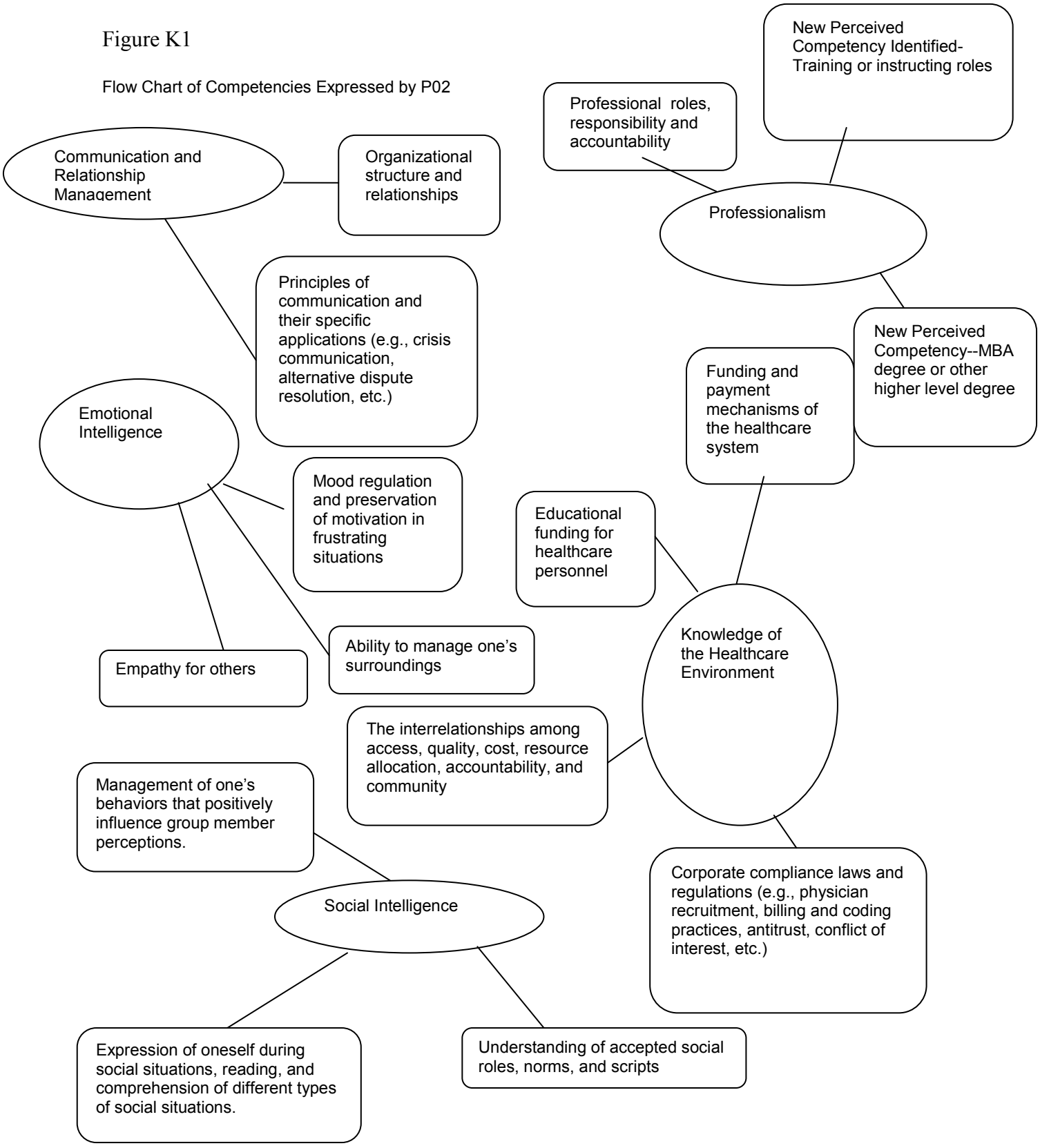
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	the ability to communicate well	IQ7
Professionalism			
	Professional roles, responsibility and accountability	Responsibility for administration of the department	IQ1
	New Perceived Competency Identified- Training or instructing roles	I lecture about 4 or 5 times a year on the business of [health care about]...the billing basics for the new guys coming in….	IQ3
	New Perceived Competency Identified-Prior Experience	If they're qualified most likely they have the skills set	IQ7
Knowledge of the Healthcare Environment			
	Educational funding for healthcare personnel	Securing money for visiting professor lecturers and sending residents to do national presentations	IQ3
	Corporate compliance laws and regulations (e.g., physician recruitment, billing and coding practices, antitrust, conflict of interest, etc.)	I think the other important part of my role in research is to make sure we are following policies and procedures whether they be federal or the state or an organization and funding agency	IQ4
	Funding and payment mechanisms of the healthcare system	it's very important because, um, if we have to assign people, if people get research money, we have to take them out of the clinical environment and so that's doubly expensive. One, I'm paying the person I'm taking out and two; I have to pay somebody to be there, so we have got to watch that.	IQ4
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	we then break down various business units within the anesthesia whole and look at what we're doing. Are we doing more cardiovascular cases or are we doing more OB, are we doing more peds, all of those have to go into the mix	IQ6
Business Skills			
	Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	my involvement [in the surgical theater] is to try to make sure that we have the right mix of providers and by that I mean the right mix is not only right aggregate number but you have to have the right people on the right days.	IQ2
		you take somebody out of a clinical enterprise, you have to backfill; making sure we're staff correctly	IQ5
		a lot of the time and effort that I see myself in the clinical arena is doing staffing or projecting for staff	IQ6
	Strategic planning processes development, and implementation (scenario planning, forecasting, etc)	long range planning and recruiting	IQ2
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	an important role is to help them develop a budget, a realistic budget so they have an opportunity to get the grant.	IQ4

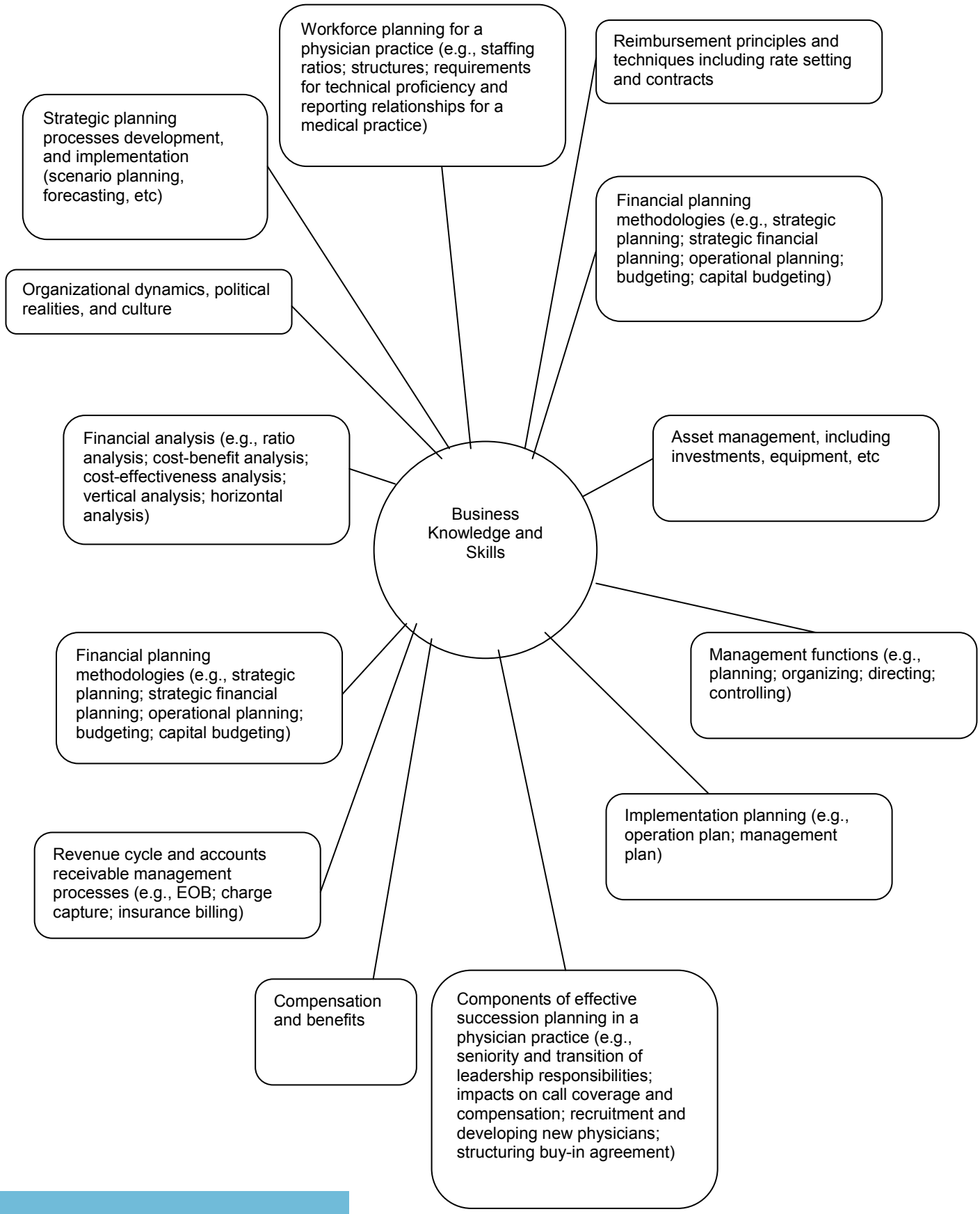
	Reimbursement principles and techniques including rate setting and contracts	I'm very happy and very proud that doc x got a grant, I can't do anything until we get the NOA, until it gets here	IQ4
	Organizational dynamics, political realities, and culture	...I'm very happy and very proud that doc x got a grant, I can't do anything until we get the NOA, until it gets here; Oh, by the way, he didn't really get a grant but somebody in that company said they thought maybe they could fund it.	IQ4
		First comes the department but within the organizational dynamics	IQ10
	Asset management, including investments, equipment, etc	we have to be good managers of the expenditures	IQ5
	Management functions (e.g., planning; organizing; directing; controlling)	we do a lot of modeling, like how many beds do we need to take care of to cover the workload	IQ5
	Financial analysis (e.g., ratio analysis; cost-benefit analysis; cost-effectiveness analysis; vertical analysis; horizontal analysis)	If you take out the research component, which I feel we wouldn't spend the money if we didn't have the research, about 97% of our dollars come from the clinical environment.	IQ5
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	budgeting	IQ5
	Compensation and benefits	our clinical work is driven by labor and labor translates to salaries	IQ5
	Components of effective succession planning in a physician practice (e.g., seniority and transition of leadership responsibilities; impacts on call coverage and compensation; recruitment and developing new physicians; structuring buy-in agreement)	when you have 65-70 clinicians, you have a constant coming and going. Some leaving, some retiring, some moving, promoting to other places, etc… So, it's, I keep my hand on that wheel a lot.	IQ5
	Implementation planning (e.g., operation plan; management plan)	implementation of new enterprises	IQ5
		implementation of new enterprises	IQ6
		implementation of new enterprises	IQ8
	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	the business part of a clinical enterprise is the kind of the return on our investment or on our labor and that's the revenue cycle	IQ6
Emotional Intelligence			
	Mood regulation and preservation of motivation in frustrating situations	level-headedness--I would look for somebody who has enough confidence in themselves that they don't get all that flustered by that. That they can keep their focus on the task at hand and not being overwhelmed by the task at hand.	IQ8
		the ability to listen and to have patience.	IQ10
	Empathy for others	So what I have to do if I'm working with colleges is to kind of put myself in their place and at least listen fairly to their statements and their desires and their needs.	IQ10

	Ability to manage one's surroundings	getting production because at the end of the day I think the people we answer to are expecting a certain amount of production. How we do that, whether we do it in by amassing data from the people underneath us or we do a lot of thought process ourselves, they really don't care but they want to product to deliver	IQ8
Social Intelligence			
	Understanding of accepted social roles, norms, and scripts	The recruiting and the retention of these folks is a little different. Residents come here and expect to do3, 4 or 5 years in training, you pretty much point them in the direction and its hands off. Managing 40-50 nurses is a little different, so and you know they're more of an employee where residents are more of a trainee obviously and the management needs are different in that environment	IQ6
	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	bright eyes. I want to see enthusiasm in any level of recruiting.	IQ7
		You can't be shy or you'll get run over	IQ10
		enthusiasm is an emotional skill	IQ8
		I guess the big thing would be is to be able to be engaged at all levels.	IQ9
	Management of one's behaviors that positively influence group member perceptions.	try to see if I can actually help others to succeed. Because usually if they succeed, then we're going to succeed so there's that connected centered focus that one has to have to be sure the thing works.	IQ10

Figure K1

Flow Chart of Competencies Expressed by P02





Participant 04

Table K2a

Summary of P04 Interview by Question

Interview Question	Core Theme	Related Competency	Textual Descriptors
IQ1	Communication and Relationship Management	Organizational structure and relationships	Member of the senior leadership team
	Knowledge of the Healthcare Environment	Global healthcare issues, trends and perspectives (e.g., aging population, insurance costs, malpractice crisis, etc)	"I'm somewhat of an Institutional Library….my role has transitioned from simply kind of establishing process and procedure and policy to an extent to now really assisting the chair as a member of the senior leadership team and thinking in terms both operationally and trying to be mindful of details and working with staff but also trying to think strategically, think ahead and really get a view of what where we should be going, what are the trends in healthcare and emergency medicine in particular, locally and nationally and then make sure I'm on the same page with the chair and at least understand where our differences are.
IQ2			
	Business Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	
	Business Skills	Comparative analysis strategies (e.g., indicators; benchmarks; systems; performance)	think strategically, think ahead and really get a view of what where we should be going
	Business Skills	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	
	Business Skills	Strategic planning processes development, and implementation (scenario planning, forecasting, etc)	
IQ3	Business Skills	Project management	Developing and setting up a residency program and the detail work involved
	Knowledge of the Healthcare Environment	Corporate compliance laws and regulations (e.g., physician recruitment, billing and coding practices, antitrust, conflict of interest, etc.)	Understanding residency accrediting bodies and meeting standards
	Business Skills	Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	Hiring staff to maintain residency program
IQ4	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	provide a lot council to the chair. We have a lot of very involved discussions about how proceed there.

	Knowledge of the Healthcare Environment	Corporate compliance laws and regulations (e.g., physician recruitment, billing and coding practices, antitrust, conflict of interest, etc.)	policies and procedures for administering our research mission
	Business Skills	Principles and practices of management and organizational behavior	I see my role as helping very much to lead the development of the critical research infrastructure
IQ5	Knowledge of the Healthcare Environment	New Perceived Competency Identified--To integrate, merge, link, marry the department and hospital perspectives	helping to bridge the hospital perspective in the clinical arena and with the medical staff.
	Business Skills	Organizational policies and procedures and their functions	I now attend a weekly emergency department operations meeting where there's just a constant review of the real clinical policies and procedures and issues
	Business Skills	Organizational dynamics, political realities, and culture	the alignment and facile working relationships between the hospital staff and the medical staff
IQ6	Knowledge of the Healthcare Environment	New Perceived Competency Identified--To integrate, merge, link, marry the department and hospital perspectives	We've been encouraging a look at the emergency medicine, emergency department service line so you could really look at the whole spectrum of not a physician and separate hospital component but they are truly integrated. They function together so I have spent a lot of time thinking about these things, discussing these things with my chair and getting that orientation
	Business Skills	Cost accounting	I've established all of the accounting procedures, actually created two different accounting systems that we've evolved to for this department and very heavily, heavily involved in trying to examine, analyze, learn and enhance the revenue cycle management.
	Business Skills	Financial analysis (e.g., ratio analysis; cost-benefit analysis; cost-effectiveness analysis; vertical analysis; horizontal analysis)	I've established all of the accounting procedures, actually created two different accounting systems that we've evolved to for this department and very heavily, heavily involved in trying to examine, analyze, learn and enhance the revenue cycle management.
	Business Skills	Relationship between physician productivity and the cost structure in a medical practice	the physician influence over hospital expenditures and revenues is tremendous and probably 70-80% of expenditures are physician driven through orders and other behavior, so that extent, very mindful of those things
	Business Skills	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	the first thing I look at from the clinical business perspective would be the monthly results of what we did. How much did we bill how much did we bring in
IQ7	Professionalism	New Perceived Competency Identified--MBA degree or other higher level degree	I'd suggest at least master's degree training….the ability to work both in a detailed work environment as well as thinking more locally and more of a macro level.

	Professionalism	New Perceived Competency Identified--Prior Experience	experience
	Professionalism	New Perceived Competency Identified--Balance professional responsibilities and human skills	the sense of commitment or passion. You have to have some desire, drive to want to be in a setting like this.
	Business Skills	Organizational mission, vision, objectives and priorities	you have to have some interest in what your faculty are doing and what the missions of the department are
	Social Intelligence	Skills necessary for task completion	management and the kind of the technical and analytical skills and an ability to really, you know, we have to multitask so much and you have to be able to just cover the spectrum
IQ8	Professionalism	Professional norms and behaviors	can differentiate professional or job-related things from personal.
	Emotional Intelligence	Ability to manage one's surroundings	there's a line where our responsibilities and our abilities to influence stops and whether those things happen really isn't of our concern after we've done our job to try to prove the information and analysis that will assist the chair in making whatever arguments they need to but I know a lot of times, I in the past, and my colleagues will get very caught up in those types of things
	Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	ability for someone to emotionally differentiate and maintain a perspective to be able to passionate about their work involved but to maintain a healthy perspective.
IQ9	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	communication skills which you know it's almost cliché at this point but its critical both for verbal and written they need to be able to communicate intelligently, articulately and effectively.
	Emotional Intelligence	Empathy for others	[physicians, residents, and staff] all have value and our emotional or social ability ought to be to draw that value out and try to help regardless, you know the mentoring type thing.
IQ10	Professionalism	New Perceived Competency Identified--MBA degree or other higher level degree	professional credentials are important
	Business Skills	Management functions (e.g., planning; organizing; directing; controlling)	management basics like understanding basic software programs, understanding how to do some data analysis, understanding your governing structures, understanding some IT types of aspects of the job
	Business Skills	Organizational mission, vision, objectives and priorities	In an academic health center, it helps also really I think to appreciate that despite the stresses, the strains, and changes in resource allocation, there are three missions and we are not simply patient care enterprise, we're not simply the training enterprise but research is critical
	Social Intelligence	Understanding of accepted social roles, norms, and scripts	Understanding each person's general orientation.

Table K2b

Summary of P04 Interview by Theme

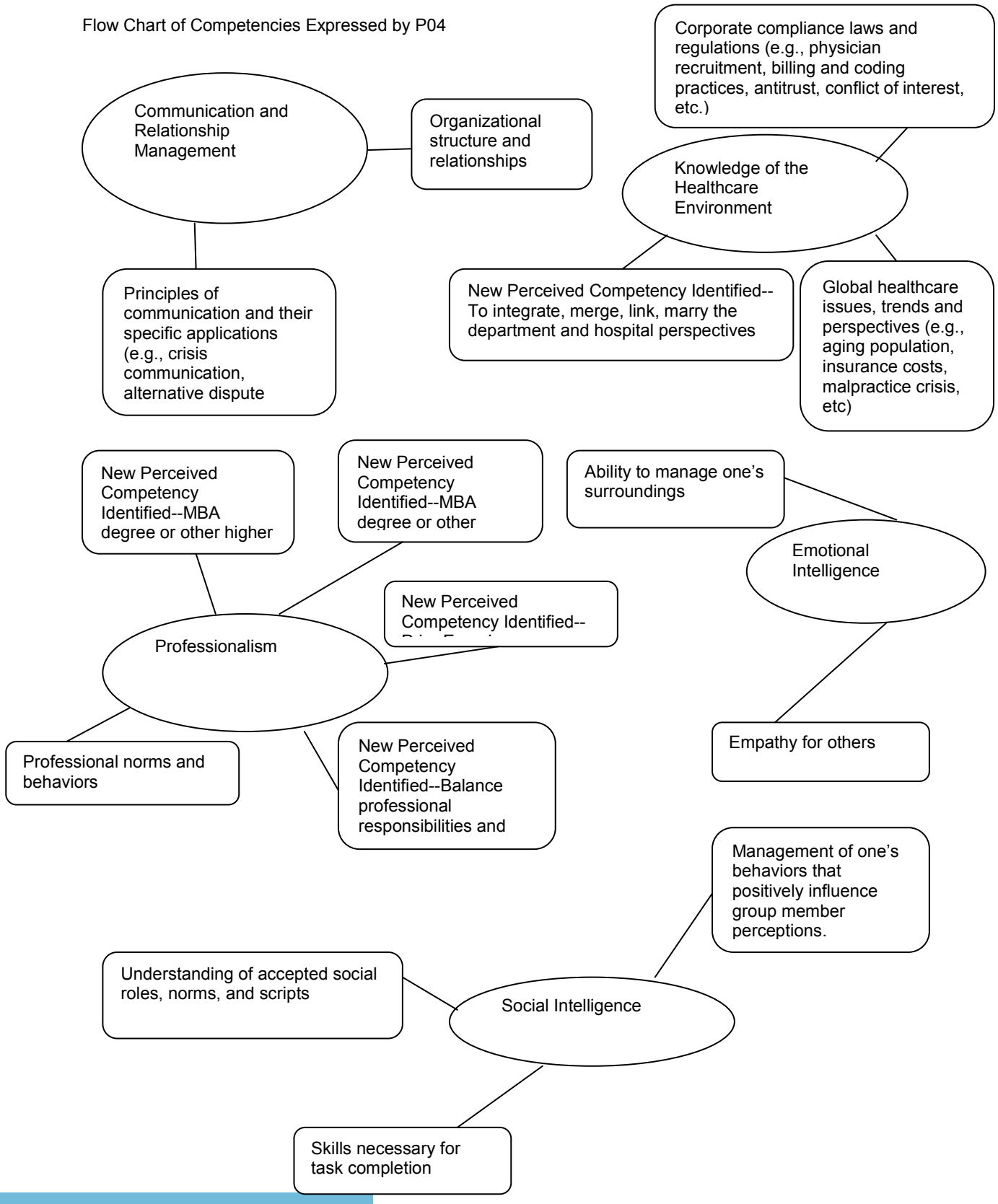
Core Theme	Related Competency	Textual Descriptors	Interview Question
Communication and Relationship Management			
	Organizational structure and relationships	Member of the senior leadership team	IQ1
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	provide a lot council to the chair. We have a lot of very involved discussions about how proceed there.	IQ4
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	communication skills which you know it's almost cliché at this point but its critical both for verbal and written they need to be able to communicate intelligently, articulately and effectively.	IQ9
Professionalism			
	New Perceived Competency Identified--MBA degree or other higher level degree	I'd suggest at least master's degree training….the ability to work both in a detailed work environment as well as thinking more locally and more of a macro level.	IQ7
	New Perceived Competency Identified--MBA degree or other higher level degree	professional credentials are important	IQ10
		experience	IQ7
	New Perceived Competency Identified--Prior Experience		IQ7
	New Perceived Competency Identified--Balance professional responsibilities and human skills	the sense of commitment or passion. You have to have some desire, drive to want to be in a setting like this.	IQ7
	Professional norms and behaviors	can differentiate professional or job-related things from personal.	IQ8
Knowledge of the Healthcare Environment			
	Global healthcare issues, trends and perspectives (e.g., aging population, insurance costs, malpractice crisis, etc)	"I'm somewhat of an Institutional Library….my role has transitioned from simply kind of establishing process and procedure and policy to an extent to now really assisting the chair as a member of the senior leadership team and thinking in terms both operationally and trying to be mindful of details and working with staff but also trying to think strategically, think ahead and really get a view of what where we should be going, what are the trends in healthcare and emergency medicine in particular, locally and nationally and then make sure I'm on the same page with the chair and at least understand where our differences are.	IQ2
	Corporate compliance laws and regulations (e.g., physician recruitment, billing and coding practices, antitrust, conflict of interest, etc.)	Understanding residency accrediting bodies and meeting standards	IQ3
		policies and procedures for administering our research mission	IQ4

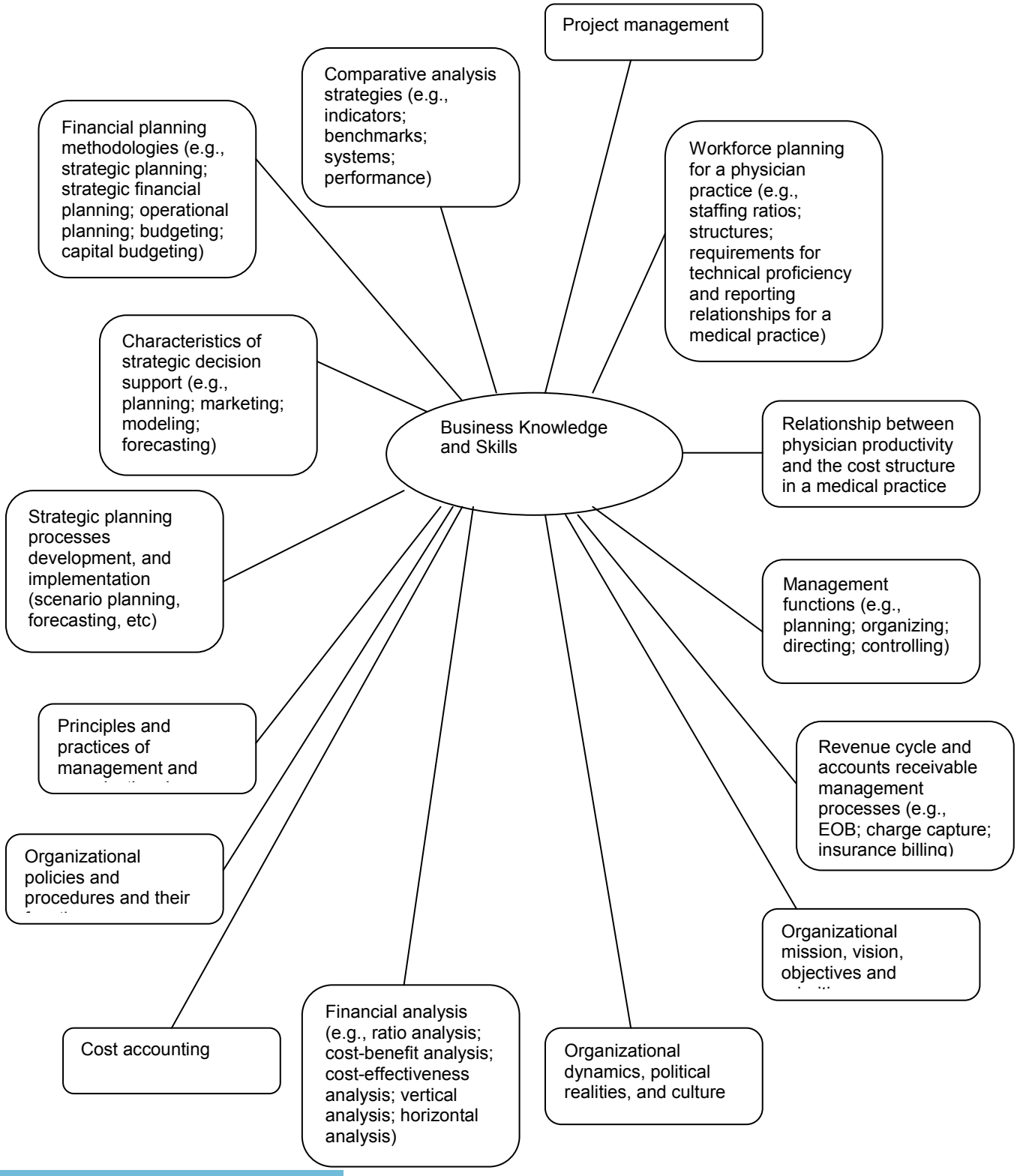
	New Perceived Competency Identified-- To integrate, merge, link, marry the department and hospital perspectives	helping to bridge the hospital perspective in the clinical arena and with the medical staff.	IQ5
		We've been encouraging a look at the emergency medicine, emergency department service line so you could really look at the whole spectrum of not a physician and separate hospital component but they are truly integrated. They function together so I have spent a lot of time thinking about these things, discussing these things with my chair and getting that orientation	IQ6
Business Skills			
	Comparative analysis strategies (e.g., indicators; benchmarks; systems; performance)	think strategically, think ahead and really get a view of what where we should be going	IQ2
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	think strategically, think ahead and really get a view of what where we should be going	IQ2
	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	think strategically, think ahead and really get a view of what where we should be going	IQ2
	Strategic planning processes development, and implementation (scenario planning, forecasting, etc)	think strategically, think ahead and really get a view of what where we should be going	IQ2
	Project management	Developing and setting up a residency program and the detail work involved	IQ3
	Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	Hiring staff to maintain residency program	IQ3
	Principles and practices of management and organizational behavior	I see my role as helping very much to lead the development of the critical research infrastructure	IQ4
	Organizational policies and procedures and their functions	I now attend a weekly emergency department operations meeting where there's just a constant review of the real clinical policies and procedures and issues	IQ5
	Organizational dynamics, political realities, and culture	the alignment and facile working relationships between the hospital staff and the medical staff	IQ5
	Cost accounting	I've established all of the accounting procedures, actually created two different accounting systems that we've evolved to for this department and very heavily, heavily involved in trying to examine, analyze, learn and enhance the revenue cycle management.	IQ6
	Financial analysis (e.g., ratio analysis; cost-benefit analysis; cost-effectiveness analysis; vertical analysis; horizontal analysis)	I've established all of the accounting procedures, actually created two different accounting systems that we've evolved to for this department and very heavily, heavily involved in trying to examine, analyze, learn and enhance the revenue cycle management.	IQ6

	Relationship between physician productivity and the cost structure in a medical practice	the physician influence over hospital expenditures and revenues is tremendous and probably 70-80% of expenditures are physician driven through orders and other behavior, so that extent, very mindful of those things	IQ6
	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	the first thing I look at from the clinical business perspective would be the monthly results of what we did. How much did we bill how much did we bring in	IQ6
	Organizational mission, vision, objectives and priorities	you have to have some interest in what your faculty are doing and what the missions of the department are	IQ7
	Organizational mission, vision, objectives and priorities	In an academic health center, it helps also really I think to appreciate that despite the stresses, the strains, and changes in resource allocation, there are three missions and we are not simply patient care enterprise, we're not simply the training enterprise but research is critical	IQ10
	Management functions (e.g., planning; organizing; directing; controlling)	management basics like understanding basic software programs, understanding how to do some data analysis, understanding your governing structures, understanding some IT types of aspects of the job	IQ10
Emotional Intelligence			
	Empathy for others	[physicians, residents, and staff] all have value and our emotional or social ability ought to be to draw that value out and try to help regardless, you know the mentoring type thing.	IQ9
	Ability to manage one's surroundings	there's a line where our responsibilities and our abilities to influence stops and whether those things happen really isn't of our concern after we've done our job to try to prove the information and analysis that will assist the chair in making whatever arguments they need to but I know a lot of times, I in the past, and my colleagues will get very caught up in those types of things	IQ8
Social Intelligence			
	Management of one's behaviors that positively influence group member perceptions.	ability for someone to emotionally differentiate and maintain a perspective to be able to passionate about their work involved but to maintain a healthy perspective.	IQ8
	Skills necessary for task completion	management and the kind of the technical and analytical skills and an ability to really, you know, we have to multitask so much and you have to be able to just cover the spectrum	IQ7
	Understanding of accepted social roles, norms, and scripts	Understanding each person's general orientation.	IQ10

Figure K2

Flow Chart of Competencies Expressed by P04





Participant 10

Table K3a

Summary of P10 Interview

Interview Question	Core Theme	Related Competency	Textual Descriptors
IQ1	Knowledge of the Healthcare Environment	Healthcare technological research and advancements	Keeping apprised of research issues and initiatives
	Business Skills	Management functions (e.g., planning; organizing; directing; controlling)	Serve as a resource, facilitator, and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues, and initiatives.
	Business Skills	Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	Serve as a resource, facilitator, and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues, and initiatives.
	Business Skills	Financial analysis (e.g., ratio analysis; cost-benefit analysis; cost-effectiveness analysis; vertical analysis; horizontal analysis)	Serve as a resource, facilitator, and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues, and initiatives.
	Business Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	Serve as a resource, facilitator, and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues, and initiatives.
	Business Skills	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	Serve as a resource, facilitator, and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues, and initiatives.
	Business Skills	Implementation planning (e.g., operation plan; management plan)	Serve as a resource, facilitator, and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues and initiatives.
	Business Skills	Characteristics of administrative systems/programs (e.g., financial; scheduling; on-line purchasing; productivity; human resources)	Serve as a resource, facilitator, and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues and initiatives.
IQ2	Business Skills	Organizational mission, vision, objectives and priorities	to balance the core missions of the academic department within the college of medicine.

IQ3	Business Skills	Human resources laws and regulations (e.g., labor law; wage and hour; FMLA; FLSA; EEOC; ERISA; workers compensation)	Residency work hours compliance
	Professionalism	New Perceived Competency Identified- Training or instructing roles	Training the next generation of physicians
	Knowledge of the Healthcare Environment	Educational funding for healthcare personnel	Gathering philanthropic funds for unique residency items not covered by other funding sources (ex. ipads).
	Knowledge of the Healthcare Environment	Funding and payment mechanisms of the healthcare system	Providing resources for the residents to have the most fruitful and rewarding and educational experience they can during their tenure of residency
IQ4	Business Skills	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	I view my role as a support mechanism for [the research administrator] to advance research throughout the department and institute.
IQ5	Knowledge of the Healthcare Environment	Community standards of care	we have a very large outreach program that I'm involved in quite a bit,
	Knowledge of the Healthcare Environment	The interrelationships among access, quality, cost, resource allocation, accountability, and community	I'll use the ball analogy to patient care, balance research, teaching and philanthropy. I think it's fair and I hope you'd agree with me that patient care is the biggest ball in that but if the ball becomes too big and over takes over the other missions then we've become a private practice offering without fulfilling our other obligations.
	Business Skills	Evidence-based practice	So regarding the clinical mission, It is to make sure that we have department in our subspecialties and that we have good access and that we provide evidence based medicine
	Business Skills	Various roles and responsibilities of physicians in a medical practice (e.g.,, provider; owner; managing partner; president of the board; medical director)	you need to understand the business from a purely clinical standpoint understand the politics from a faculty standpoint
	Business Skills	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	strategic planning and management
	Business Skills	Physician practice management IT systems (e.g., billing; referral/authorization; claims processing; electronic medical records; prescription writing; productivity; transcription)	watching to make sure that the clinical work is getting billed correctly, watching you're A/R

	Business Skills	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	watching to make sure that the clinical work is getting billed correctly, watching you're A/R
IQ6	Professionalism	Professional roles, responsibility and accountability	Ultimately the buck starts and stops with the department administrator.
	Knowledge of the Healthcare Environment	The interrelationships among access, quality, cost, resource allocation, accountability, and community	making sure that the financial resources are there to meet our year to year goals on our operational budget and then our capital goals on our long term objective
	Business Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	there is the operation budget that can be challenging to both plan for on a fiscal year and also the challenge of fulfilling that obligation
	Professionalism	New Theme---Balance professional responsibilities and human skills	I believe there's a balance between being very tactically strong admin and also having good human skills and so I've been I would try to find somebody who is knowledgeable but also has good interpersonal skills.
	Business Skills	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	well versed in the revenue cycle and accounting systems regulations
	Business Skills	Organizational policies and procedures and their functions	well versed in human resources regulations
	Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	Then I find individuals who are technically very strong but bury themselves in the office and never are engaged with the residents and the faculty and the staff and thus don't have the deeper relationship. So if I was interviewing someone for my position, I would look for somebody who has balance in those two skills sets. Personality that would be reflective of those things I already reference to you and validation of some department of technical knowhow.
IQ8	Communication and Relationship Management	Public relations	You have to be able to listen and not pass judgment right away.
	Professionalism	Professional roles, responsibility and accountability	I think the first thing that comes to mind with emotional skills is I've often said that the administrator's office is like the priests quarter. It is the lawyer's room and so with that comes a certain amount of accountability and trust.
	Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	the emotional skills is sense of maturity, discretion, trustworthiness, great listening skills and high ethics

IQ9	Emotional Intelligence	Empathy for others	The interest level of one the housekeepers for social conversation versus one of the surgeons reciprocally might find it easier to talk to the housekeeper than the surgeon, might find it easier to talk to the surgeon than the housekeeper. I think a good administrator learns how to engage both of them.
IQ10	Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	Socially adept
	Social Intelligence	Understanding of accepted social roles, norms, and scripts	Let the chairman be the department's 'shining star' or charismatic entity
	Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	An effective leader would balance technical skills with a good personality to listen, be a facilitator and a resource.
	Knowledge of the Healthcare Environment	New Theme---understanding the intricacies of working in an AMC versus other types of healthcare facilities.	so the competencies are an academic leader at an academic medical center are a knowledge of the complexities of what makes an academic medical center unique versus a private hospital. ..The education requirements as a part of the educational mission
	Professionalism	New Theme---MBA degree or other higher level degree	validation of technical competencies through professional certification

Table K3b

Summary of P10 Interview by Theme

Core Theme	Related Competency	Textual Descriptors	Interview Question
Communication and Relationship Management			
	Public relations	You have to be able to listen and not pass judgment right away.	IQ8
Professionalism			
	New Perceived Competency Identified-Training or instructing roles	Training the next generation of physicians	IQ3
	Professional roles, responsibility and accountability	Ultimately the buck starts and stops with the department administrator.	IQ6
	Professional roles, responsibility and accountability	I think the first thing that comes to mind with emotional skills is I've often said that the administrator's office is like the priests quarter. It is the lawyer's room and so with that comes a certain amount of accountability and trust.	IQ8
	New Perceived Competency Identified---Balance professional responsibilities and human skills	I believe there's a balance between being very tactically strong admin and also having good human skills and so I've been I would try to find somebody who is knowledgeable but also has good interpersonal skills.	IQ7

	New Perceived Competency Identified---MBA degree or other higher level degree	validation of technical competencies through professional certification	IQ10
Knowledge of the Healthcare Environment			
	Healthcare technological research and advancements	Keeping apprised of research issues and initiatives	IQ1
	Educational funding for healthcare personnel	Gathering philanthropic funds for unique residency items not covered by other funding sources (ex. i-pads).	IQ3
	Funding and payment mechanisms of the healthcare system	Providing resources for the residents to have the most fruitful and rewarding and educational experience they can during their tenure of residency	IQ3
	Community standards of care	we have a very large outreach program that I'm involved in quite a bit,	IQ5
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	I'll use the ball analogy to patient care, balance research, teaching and philanthropy. I think it's fair and I hope you'd agree with me that patient care is the biggest ball in that but if the ball becomes too big and over takes over the other missions then we've become a private practice offering without fulfilling our other obligations.	IQ5
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	making sure that the financial resources are there to meet our year to year goals on our operational budget and then our capital goals on our long term objective	IQ6
	New Theme---understanding the intricacies of working in an AMC versus other types of healthcare facilities.	so the competencies are an academic leader at an academic medical center are a knowledge of the complexities of what makes an academic medical center unique versus a private hospital. ..The education requirements as a part of the educational mission	IQ10
Business Skills			
	Management functions (e.g., planning; organizing; directing; controlling)	Serve as a resource, facilitator and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues and initiatives.	IQ1
	Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	Serve as a resource, facilitator and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues and initiatives.	IQ1
	Financial analysis (e.g., ratio analysis; cost-benefit analysis; cost-effectiveness analysis; vertical analysis; horizontal analysis)	Serve as a resource, facilitator and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues and initiatives.	IQ1
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	Serve as a resource, facilitator and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues and initiatives.	IQ1

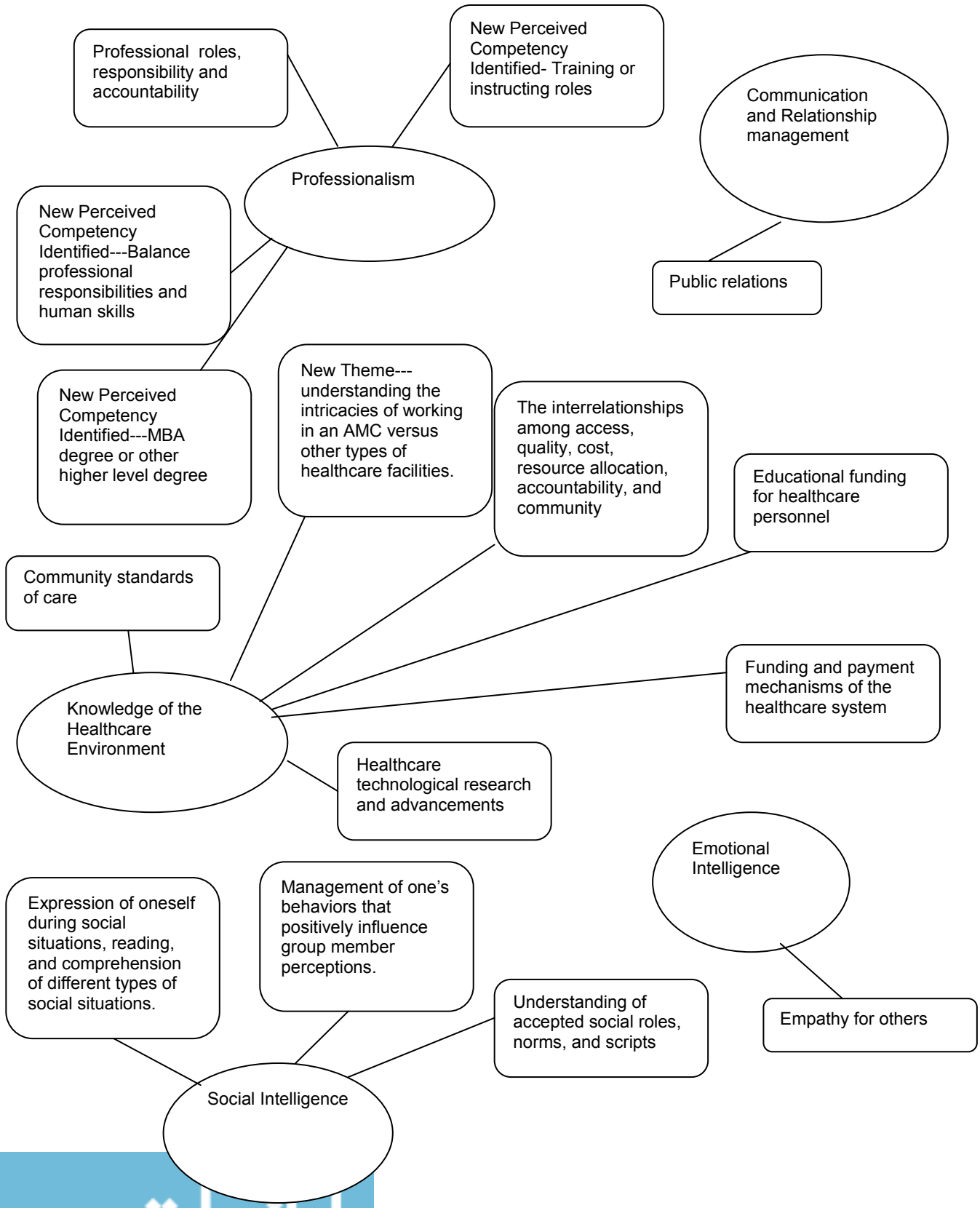
Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	Serve as a resource, facilitator and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues and initiatives.	IQ1
Implementation planning (e.g., operation plan; management plan)	Serve as a resource, facilitator and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues and initiatives.	IQ1
Characteristics of administrative systems/programs (e.g., financial; scheduling; on-line purchasing; productivity; human resources)	Serve as a resource, facilitator and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues and initiatives.	IQ1
Organizational mission, vision, objectives and priorities	to balance the core missions of the academic department within the college of medicine.	IQ2
Human resources laws and regulations (e.g., labor law; wage and hour; FMLA; FLSA; EEOC; ERISA; workers compensation)	Residency work hours compliance	IQ3
Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	I view my role as a support mechanism for [the research administrator] to advance research throughout the department and institute.	IQ4
Evidence-based practice	So regarding the clinical mission, It is to make sure that we have department in our subspecialties and that we have good access and that we provide evidence based medicine	IQ5
Various roles and responsibilities of physicians in a medical practice (e.g.,, provider; owner; managing partner; president of the board; medical director)	you need to understand the business from a purely clinical standpoint understand the politics from a faculty standpoint	IQ5
Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	strategic planning and management	IQ5
Physician practice management IT systems (e.g., billing; referral/authorization; claims processing; electronic medical records; prescription writing; productivity; transcription)	watching to make sure that the clinical work is getting billed correctly, watching you're A/R	IQ5
Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	watching to make sure that the clinical work is getting billed correctly, watching you're A/R	IQ5
Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	there is the operation budget that can be challenging to both plan for on a fiscal year and also the challenge of fulfilling that obligation	IQ6
Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	well versed in the revenue cycle and accounting systems regulations	IQ7
Organizational policies and procedures and their functions	well versed in human resources regulations	IQ7

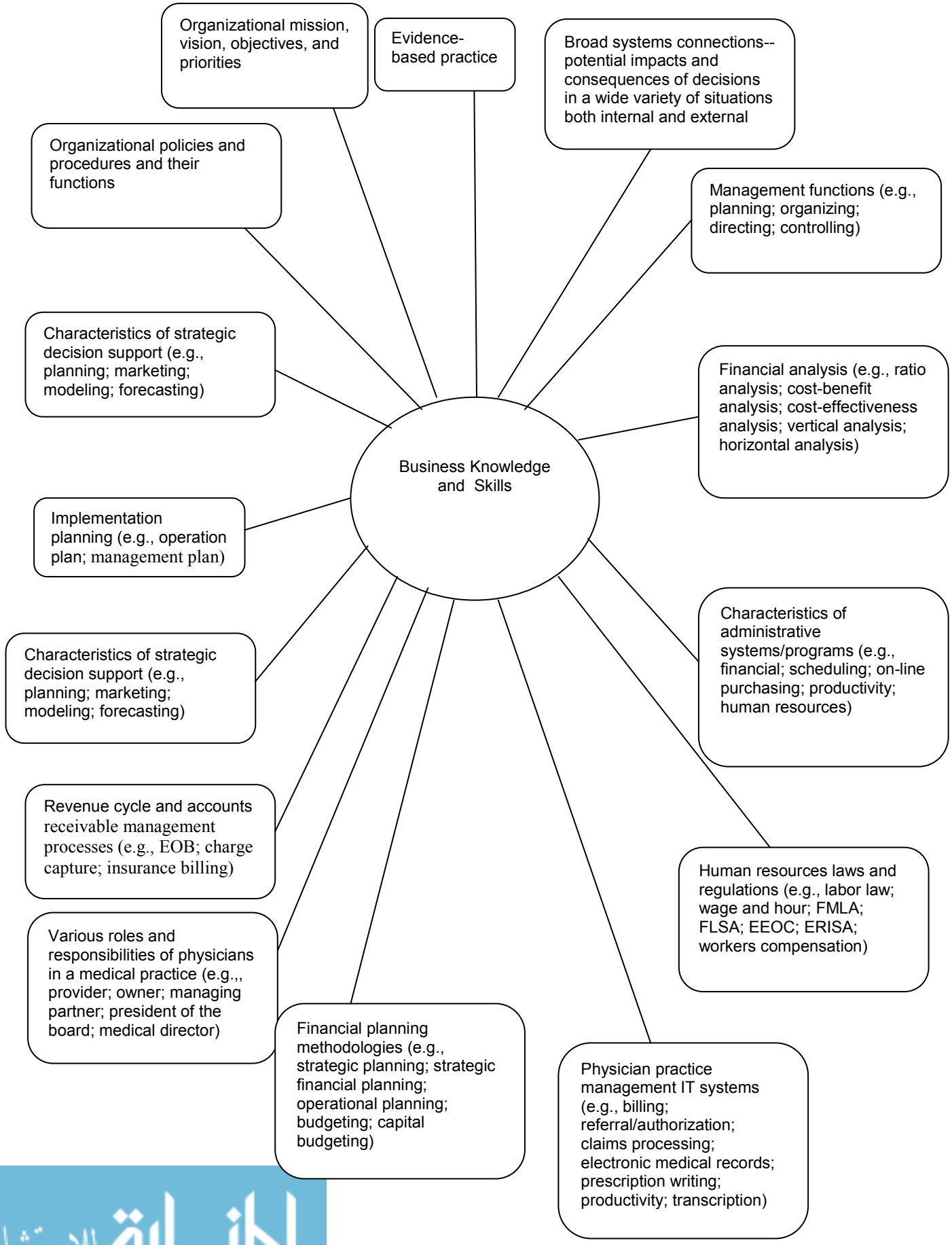
Emotional Intelligence

	Empathy for others	The interest level of one the housekeepers for social conversation versus one of the surgeons reciprocally might find it easier to talk to the housekeeper than the surgeon, might find it easier to talk to the surgeon than the housekeeper. I think a good administrator learns how to engage both of them.	IQ9
Social Intelligence			
	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	Then I find individuals who are technically very strong but bury themselves in the office and never are engaged with the residents and the faculty and the staff and thus don't have the deeper relationship. So if I was interviewing someone for my position, I would look for somebody who has balance in those two skills sets. Personality that would be reflective of those things I already reference to you and validation of some department of technical knowhow.	IQ7
	Management of one's behaviors that positively influence group member perceptions.	the emotional skills is sense of maturity, discretion, trustworthiness, great listening skills and high ethics	IQ8
	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	Socially adept	IQ9
	Understanding of accepted social roles, norms, and scripts	Let the chairman be the department's 'shining star' or charismatic entity	IQ9
	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	An effective leader would balance technical skills with a good personality to listen, be a facilitator and a resource.	IQ10

Figure K3

Flow Chart of Competencies Expressed by P10





Participant 12

Table K4a

Summary of P12 Interview by Question

Interview Question	Core Theme	Related Competency	Textual Descriptors
IQ1	Leadership	Leadership styles/techniques	Facilitator
	Professionalism	Organizational business and personal ethics	Representing the Department's best interests
	Social Intelligence	Interpersonal problem-solving skills and social role-playing	When there's a personnel issue that's not directly reporting to me, I get involved
	Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	I'm a good but younger than a lot of my colleagues, so I don't take the lead in those meetings as much, but one-on-one I think I'm good report with a number of them
IQ2	Social Intelligence	Interpersonal problem-solving skills and social role-playing	there's also mentoring programs here which I've been involved in
IQ3	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	Conflict resolution
	Business Skills	Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	my role in that is helping it run smoothly, just like I help the rest of the department run smoothly.
	Business Skills	Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	Providing personnel necessary to make program run smoothly
	Knowledge of the Healthcare Environment	Funding and payment mechanisms of the healthcare system	Providing equipment for the program to run smoothly
IQ4	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	have a conversation with our PI's about their research programs
	Knowledge of the Healthcare Environment	Funding and payment mechanisms of the healthcare system	We have to fund research, it doesn't fund itself. So, from a leadership prospective in a department, we need to plan for when we will have funding and when we won't have funding.
	Business Skills	Inventory control systems	keep end dates in mind

IQ5	Business Skills	Asset management, including investments, equipment, etc	Manage research accounts for PIs; know how much is available in each account for bridge funding if necessary
	Business Skills	Staffing methodologies and productivity management (e.g., acuity-based staffing; flexible staffing; fixed staffing)	general management of the grants staff, and the administrative staff that needs to be in place.
	Business Skills	Staffing methodologies and productivity management (e.g., acuity-based staffing; flexible staffing; fixed staffing)	On the research side, we have grants administrators who can say, all right well, “this grant that we’re putting forth, we want to have 30% of a PI’s salary on this, plus we’re going to have to cover any salary over the cap.” So you can have a staff member who can really evaluate the grants without any supervision and on the clinical side, I think there’s a big gap there, that the administrator of the department is pretty much the responsible party for that.
IQ6	Business Skills	Implementation planning (e.g., operation plan; management plan)	[I manage] the overall picture and coordination.
	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	I don’t see myself as the business manager. I think that’s, it’s more speaking to the people and more coordinating the people that are the business managers of their little areas.
IQ7	Social Intelligence	Attunement to complex social cues,	The ability to dissemble situation and read the mood of the faculty and the staff and help maneuver through what can sometimes be, with the wrong words, a very volatile situation. With the right words and the right presence, you can come to a pretty quick and not always easy but at least acceptable solution to problems.
	Professionalism	New Theme---Prior Experience	you have to have one or two of about 3 things. You need to have managerial experience, you need to have clinical experience, or you need to have research experience.

IQ8	Emotional Intelligence	Mood regulation and preservation of motivation in frustrating situations	I would try to evaluate the person's ability to stay calm under stress
	Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	person's ability to stay calm under stress and under, when dealing with angry people, in particular, angry faculty…you really have to know how to handle it...being able to remain calm and try to bring people together to see a common goal.
IQ9	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	You have to be comfortable talking to people and talking to people that you don't know.
IQ10	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	[Solving] personnel conflicts
	Business Skills	Management functions (e.g., planning; organizing; directing; controlling)	There's some basic skills that you need as far as financial…here's the understanding of just general management of people.
	Emotional Intelligence	Empathy for others	getting a feel for people you don't' see that faculty necessarily on a day to day basis in a large department like this but when you do, you really need to quickly determine how they're doing. You can ask them and they'll say something but then you read between the lines and find out you know what's the real feeling here.
	Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	being able to read the situations, being able to read between the lines when you're in a big meeting
	Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	being able to logically evaluate options and propose new options because, you know, there's, where there's a conflict, there's got to be another option because you're not getting agreement.

Table K4b

Summary of P12 Interview by Theme

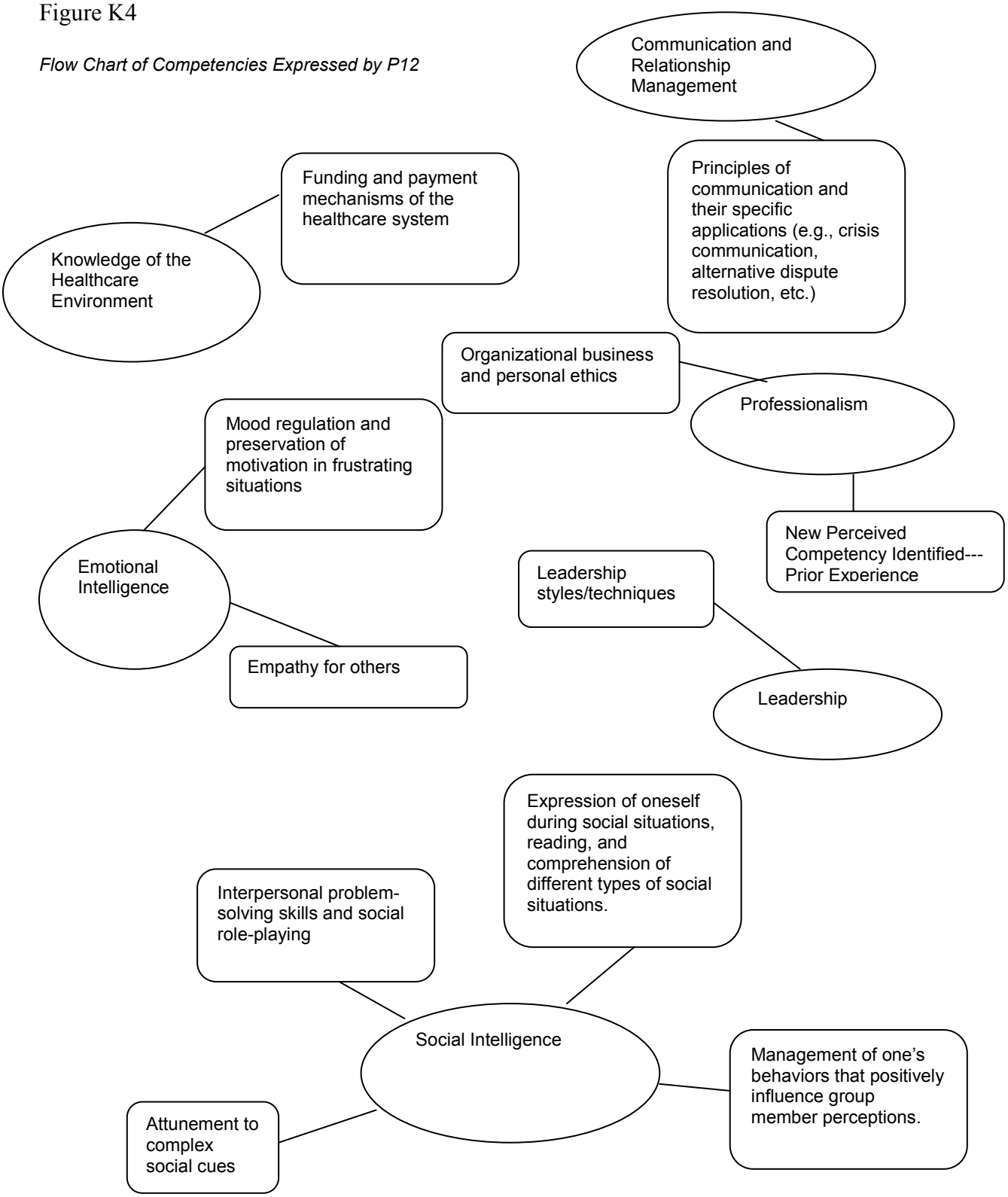
Core Theme	Related Competency	Textual Descriptors	Interview Question
Communication and Relationship Management			
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	Conflict resolution	IQ3
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	have a conversation with our PI's about their research programs	IQ4
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	I don't see myself as the business manager. I think that's, it's more speaking to the people and more coordinating the people that are the business managers of their little areas.	IQ6
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	You have to be comfortable talking to people and talking to people that you don't know.	IQ9
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	[Solving] personnel conflicts	IQ10
Leadership			
	Leadership styles/techniques	Facilitator	IQ1
Professionalism			
	Organizational business and personal ethics	Representing the Department's best interests	IQ1
	New Perceived Competency Identified---Prior Experience	You have to have one or two of about 3 things. You need to have managerial experience, you need to have clinical experience, or you need to have research experience.	IQ7
Knowledge of the Healthcare Environment			
	Funding and payment mechanisms of the healthcare system	Providing equipment for the program to run smoothly	IQ3
	Funding and payment mechanisms of the healthcare system	We have to fund research, it doesn't fund itself. So, from a leadership prospective in a department, we need to plan for when we will have funding and when we won't have funding.	IQ4
Business Skills			
	Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	my role in that is helping it run smoothly, just like I help the rest of the department run smoothly.	IQ3

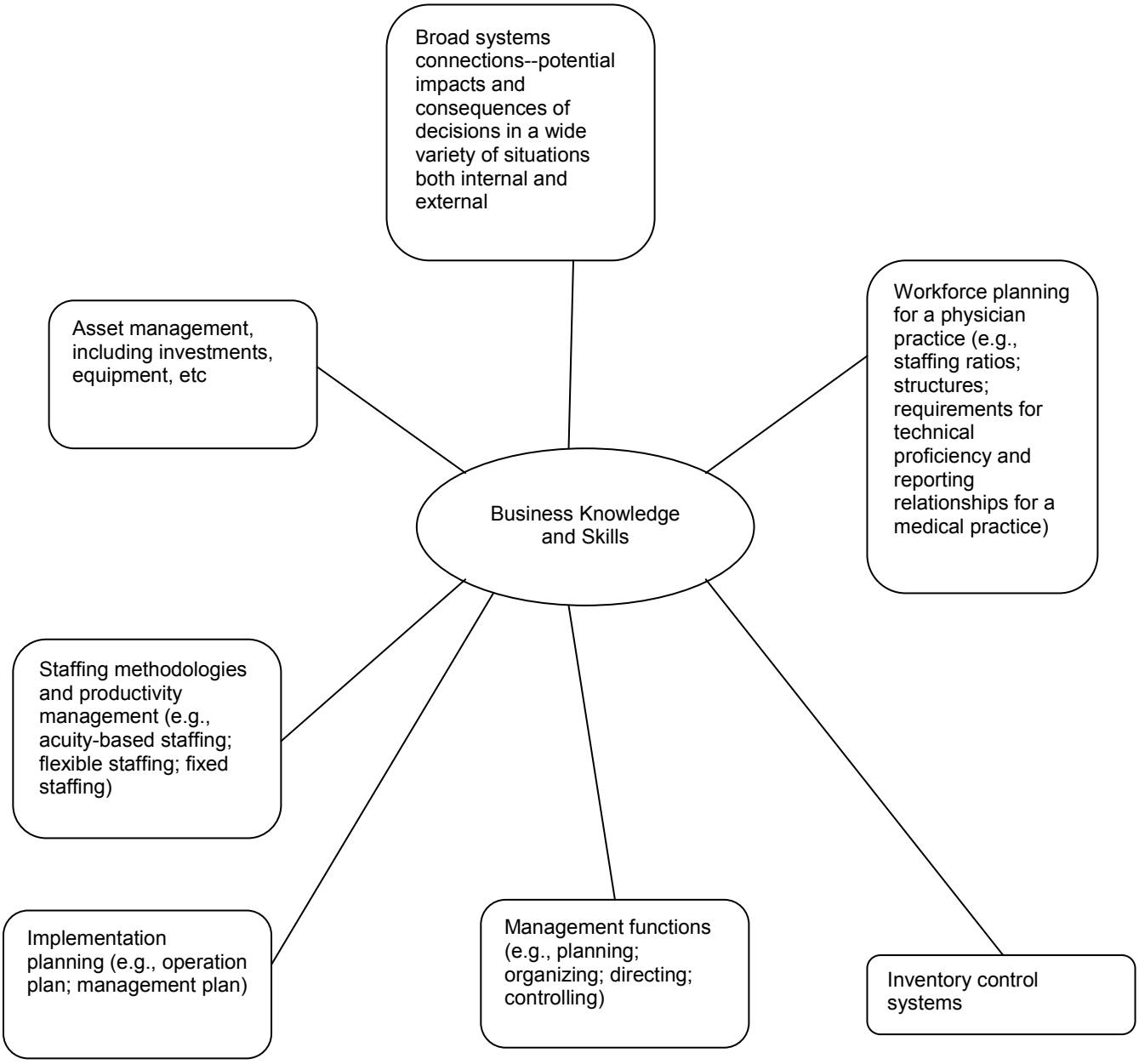
	Providing personnel necessary to make program run smoothly	IQ3
Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)		
Inventory control systems	keep end dates in mind	IQ4
Asset management, including investments, equipment, etc	Manage research accounts for PIs; know how much is available in each account for bridge funding if necessary	IQ4
Staffing methodologies and productivity management (e.g., acuity-based staffing; flexible staffing; fixed staffing)	general management of the grants staff, and the administrative staff that needs to be in place.	IQ4
	On the research side, we have grants administrators who can say, all right well, "this grant that we're putting forth, we want to have 30% of a PI's salary on this, plus we're going to have to cover any salary over the cap." So you can have a staff member who can really evaluate the grants without any supervision and on the clinical side, I think there's a big gap there, that the administrator of the department is pretty much the responsible party for that.	IQ5
Implementation planning (e.g., operation plan; management plan)	[I manage] the overall picture and coordination.	IQ6
Management functions (e.g., planning; organizing; directing; controlling)	There's some basic skills that you need as far as financial…here's the understanding of just general management of people.	IQ10
Emotional Intelligence		
Mood regulation and preservation of motivation in frustrating situations	I would try to evaluate the person's ability to stay calm under stress	IQ8
	getting a feel for people you don't' see that faculty necessarily on a day to day basis in a large department like this but when you do, you really need to quickly determine how they're doing. You can ask them and they'll say something but then you read between the lines and find out you know what's the real feeling here.	IQ10
Empathy for others		
Social Intelligence		
Interpersonal problem-solving skills and social role-playing	When there's a personnel issue that's not directly reporting to me, I get involved	IQ1
Expression of oneself during social situations, reading, and comprehension of different types of social situations.	I'm a good but younger than a lot of my colleagues, so I don't take the lead in those meetings as much, but one-on-one I think I'm good report with a number of them	IQ2
Interpersonal problem-solving skills and social role-playing	there's also mentoring programs here which I've been involved in	IQ2

Attunement to complex social cues,	The ability to dissemble situation and read the mood of the faculty and the staff and help maneuver through what can sometimes be, with the wrong words, a very volatile situation. With the right words and the right presence, you can come to a pretty quick and not always easy but at least acceptable solution to problems.	IQ7
Management of one's behaviors that positively influence group member perceptions.	person's ability to stay calm under stress and under, when dealing with angry people, in particular, angry faculty…you really have to know how to handle it...being able to remain calm and try to bring people together to see a common goal.	IQ8
Expression of oneself during social situations, reading, and comprehension of different types of social situations.	being able to read the situations, being able to read between the lines when you're in a big meeting	IQ10
Management of one's behaviors that positively influence group member perceptions.	being able to logically evaluate options and propose new options because, you know, there's, where there's a conflict, there's got to be another option because you're not getting agreement.	IQ10

Figure K4

Flow Chart of Competencies Expressed by P12





Participant 18

Table K5a

Summary of P18 Interview by Question

Interview Question	Core Theme	Related Competency	Textual Descriptors
IQ1	Social Intelligence	Understanding of accepted social roles, norms, and scripts	The ultimate decision making is made by the chair, but you have an opportunity to collaborate with the chair on issues such as budget, issue such as personnel, etc…
	Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	My role within the department is one of influence...That's both collaborative at the chair level and it's one of influence, not final decision making.
IQ2	Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	opinions are being sought
IQ3	Communication and Relationship Management	Public relations	you have the ability essentially to be a voice for your dept.
	Leadership	Personal Journey Disciplines	that as a previous hospital CEO, I've been able to carve out niche for myself with physician contracting.
	Business Skills	Components of a physician employment contract with the practice (e.g. divestiture of assets; restrictive and non-compete clauses ; buy-sell agreements)	I believe that resident physicians are ill-equipped, if you will to negotiate on their own behalf. They don't know the difference between level 1 hit and pick and level 2 hit and pick, how working at a critical access hospital builds up a provider base can negatively impact how revenue is recorded and subsequently, how they get paid. So for me, as far as education goes, it's in and around the business of medicine and preparing physicians to negotiate their first contract and how to assess ____ opportunities.
IQ4	Knowledge of Healthcare Environment	New Emerging Competency Identified--Support research, research personnel, and grants	Research mission, for me in particular, I feel it's more of a support role persay in that we support the ability to get grants done, we support the ability to provide realistic financial snapshots of where the researchers stand relative to budget
IQ5	Business Skills	Data collection, measurement and analysis tools and techniques (e.g., root-cause analysis; process analysis; workflows)	I, frankly, are more operational people in that role where we actually get to work on process issues. We get to set the fiscal targets, the financial targets; we get to work on efficiency, etc…

	Business Skills	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	set the fiscal targets, the financial targets; we get to work on efficiency, etc…
	Business Skills	Fundamental productivity measures (e.g., hours per patient day; cost per patient day; units of service per man hour; PMPM)	Oversight of clinical operations
	Business Skills	Management functions (e.g., planning; organizing; directing; controlling)	Oversight of clinical operations
	Business Skills	Customer satisfaction principles and tools	Oversight of clinical operations
	Business Skills	Data collection, measurement and analysis tools and techniques (e.g., root-cause analysis; process analysis; workflows)	analytics, which by the way is one of my favorite parts of my job
IQ6			
	Business Skills	Comparative analysis strategies (e.g., indicators; benchmarks; systems; performance)	analytics, which by the way is one of my favorite parts of my job
	Business Skills	Organizational mission, vision, objectives and priorities	From a business standpoint, it's a unique environment and understand that there are 3 missions
	Business Skills	Organizational dynamics, political realities, and culture	negotiation outside the dept.
	Business Skills	Asset management, including investments, equipment, etc	revenue coming in, whether it's grant revenue, clinical revenue, endowments, interest earned on the endowments, giving it back to everyone so that they have a realistic picture of not what they want, right, but what they need. And then can we afford what they need. How do we go about doing that?
	Business Skills	Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	Be creative in such a way that we're still fiscally prudent and responsible.

IQ7	Professionalism	New Perceived Competency Identified---MBA degree or other higher level degree	have an advanced degree, an MBA or an MHA, my preference always is somebody with experience on top of the MBA or MHA because that's when you get into the softer skills.
	Business Skills	Data collection, measurement and analysis tools and techniques (e.g., root-cause analysis; process analysis; workflows)	do the analytical pieces as far as dissecting, whether it's something as simple as this ____ code analysis to something more in-depth, which is break-even analysis based on different product lines or subspecialty lines
	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	really what you have to have in this position is some of the softer skills, so what I mean by that is that everything in this environment is in negotiation.
	Social Intelligence	Attunement to complex social cues,	It's not really in this situation about hard and fast decision making. It's about seeing things clearly, being intuitive, being reflective and being able to give, for lack of better terminology, sound advice and sound council.
IQ8	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	you have to know how to talk to people
	Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	We have an interesting mix of individuals where we have a few seasoned people on the staff side, but we have a lot of young people. If we push them too hard too fast, they'll leave. If we leave them without expectations, nothing will get done. I also say the ability to negotiate with the faculty members
	Emotional Intelligence	mood regulation and preservation of motivation in frustrating situations	You have to be a good listener, you have to be able to make sure you know it's not about you, it's not about being right or being wrong, it's about what's best for the dept.
	Emotional Intelligence	Delay of immediate gratification	You have to be reflective
	Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	you have to be able to articulate your message in such a way that various members of the audience aren't going to be offended and lose the message that you're trying to articulate.
IQ9	Social Intelligence	Ability to exercise complex social skills such as teamwork, communication, conflict resolution, harmony, consensus,	Approachability. If you're seen as approachable, you'll always be seen as someone who can solve problems. If you're not approachable, you'll be seen, quite frankly, as someone who may be part of the problem.

		multiculturalism etc."	
IQ10	Knowledge of Healthcare Environment	Healthcare economics	You have to know the business of medicine. You have to know what a hit pick is, you have to know what a CPT code is, you have understand what RVU's are, you have to know how it all rolls up into a budget.
	Business Skills	Outcomes measures and management (e.g., ROI; Cost-effectiveness analysis [CEA]; cash flow analysis and testing)	You have to understand contractual allowances versus gross charges
	Business Skills	Funding and payment mechanisms of the healthcare system	grant funding, NOA process
	Business Skills	Compliance with regulatory agencies and tax status requirements	You also have to understand a local environment and how to taxes are assessed and how that is going to produce the final bottom line
	Business Skills	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	The net revenue that you have to pay for everything
	Business Skills	Organizational policies and procedures and their functions	An HR background would be helpful
	Business Skills	Staffing methodologies and productivity management (e.g., acuity-based staffing; flexible staffing; fixed staffing)	monitor behavior
	Professionalism	Professional roles, responsibility and accountability	you have to have the ability to hire
	Social Intelligence	Skills necessary for task completion	the ability to set expectations
	Emotional Intelligence	Remain in control of emotions while focusing on and accomplishing goals.	The intestinal fortitude to provide the consequences if the behavior does not match the pace and goals of the dept.

Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	the ability to say, "job well done."

Table K5b

Summary of P18 Interview by Theme

Core Theme	Related Competency	Textual Descriptors	Interview Question
Communication and Relationship Management	Public relations	you have the ability essentially to be a voice for your dept.	IQ2
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	you have to know how to talk to people	IQ8
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	really what you have to have in this position is some of the softer skills, so what I mean by that is that everything in this environment is in negotiation.	IQ7
Leadership	Personal Journey Disciplines	that as a previous hospital CEO, I've been able to carve out niche for myself with physician contracting.	IQ3
Professionalism	New Perceived Competency Identified---MBA degree or other higher level degree	have an advanced degree, an MBA or an MHA, my preference always is somebody with experience on top of the MBA or MHA because that's when you get into the softer skills.	IQ7
	Professional roles, responsibility and accountability	you have to have the ability to hire	IQ10
Knowledge of Healthcare Environment	Healthcare economics	You have to know the business of medicine. You have to know what a hit pick is, you have to know what a CPT code is, you have understand what RVU's are, you have to know how it all rolls up into a budget.	IQ10
	New Emerging Competency Identified--Support research, research personnel, and grants	Research mission, for me in particular, I feel it's more of a support role per say in that we support the ability to get grants done, we support the ability to provide realistic financial snapshots of where the researchers stand relative to budget	IQ4

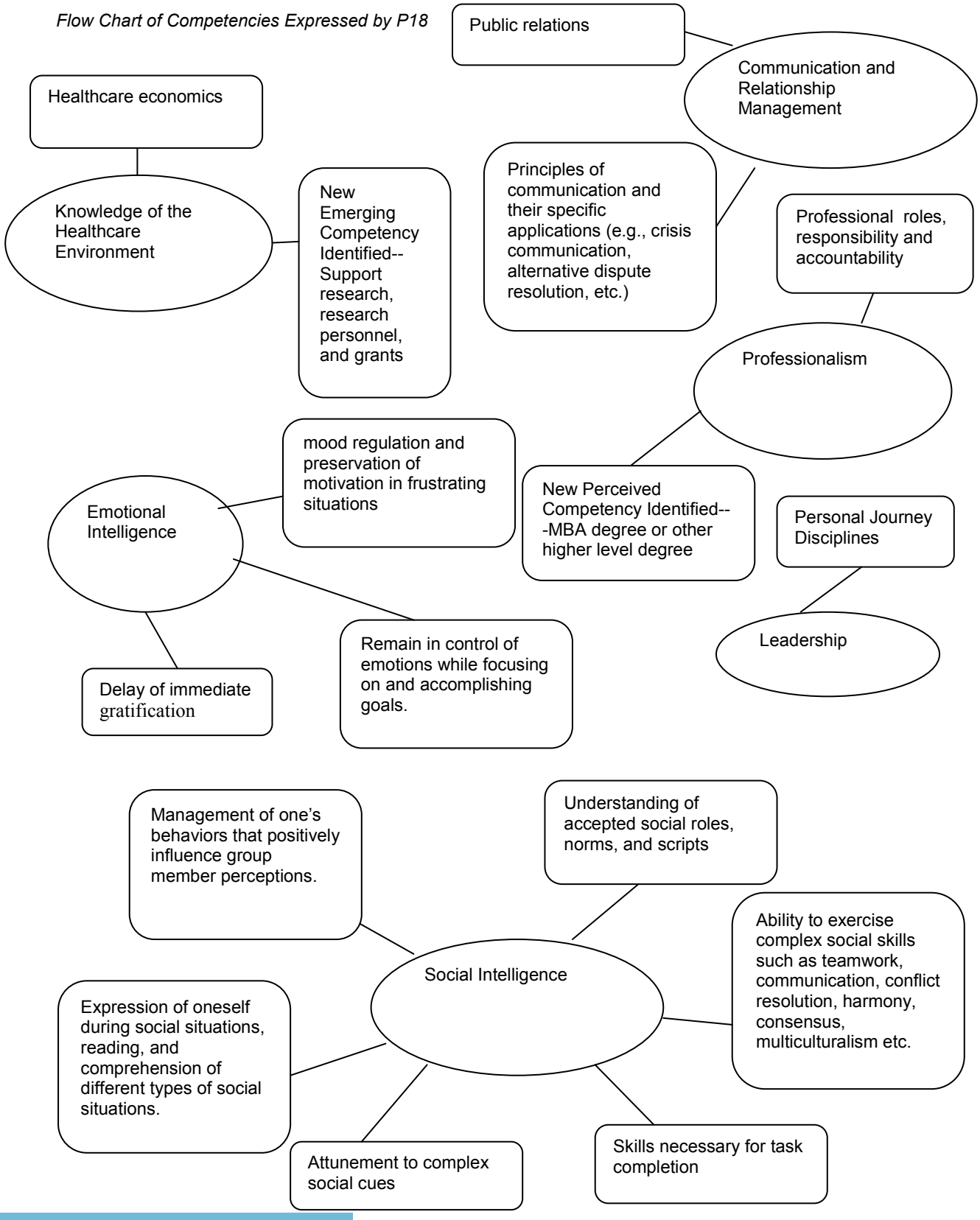
Business Skills	Components of a physician employment contract with the practice (e.g. divestiture of assets; restrictive and non-compete clauses ; buy-sell agreements)	I believe that resident physicians are ill-equipped, if you will to negotiate on their own behalf. They don't know the difference between level 1 hit and pick and level 2 hit and pick, how working at a critical access hospital builds up a provider base can negatively impact how revenue is recorded and subsequently, how they get paid. So for me, as far as education goes, it's in and around the business of medicine and preparing physicians to negotiate their first contract and how to assess ____ opportunities.	IQ3
	Data collection, measurement and analysis tools and techniques (e.g., root-cause analysis; process analysis; workflows)	I, frankly, are more operational people in that role where we actually get to work on process issues. We get to set the fiscal targets, the financial targets; we get to work on efficiency, etc…	IQ5
	Data collection, measurement and analysis tools and techniques (e.g., root-cause analysis; process analysis; workflows)	analytics, which by the way is one of my favorite parts of my job	IQ6
	Data collection, measurement and analysis tools and techniques (e.g., root-cause analysis; process analysis; workflows)	do the analytical pieces as far as dissecting, whether it's something as simple as this ____ code analysis to something more in-depth, which is break-even analysis based on different product lines or subspecialty lines	IQ7
	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	set the fiscal targets, the financial targets; we get to work on efficiency, etc…	IQ5
	Fundamental productivity measures (e.g., hours per patient day; cost per patient day; units of service per man hour; PMPM)	Oversight of clinical operations	IQ5
	Management functions (e.g., planning; organizing; directing; controlling)	Oversight of clinical operations	IQ5
	Customer satisfaction principles and tools	Oversight of clinical operations	IQ5
	Comparative analysis strategies (e.g., indicators; benchmarks; systems; performance)	analytics, which by the way is one of my favorite parts of my job	IQ6
	Organizational mission, vision, objectives and priorities	From a business standpoint, it's a unique environment and understand that there are 3 missions	IQ6
	Organizational dynamics, political realities, and culture	negotiation outside the dept.	IQ6

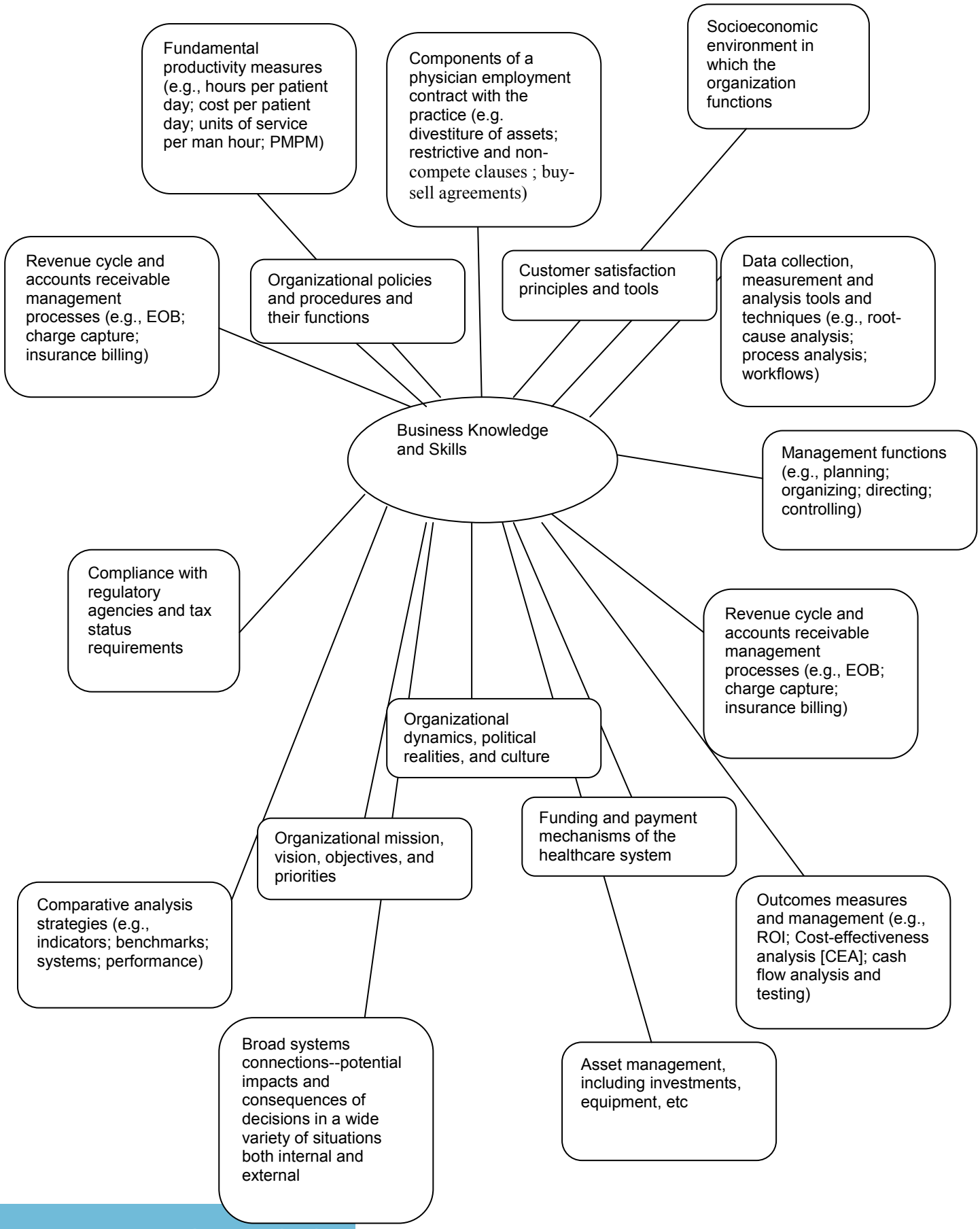
	Asset management, including investments, equipment, etc	revenue coming in, whether it's grant revenue, clinical revenue, endowments, interest earned on the endowments, giving it back to everyone so that they have a realistic picture of not what they want, right, but what they need. And then can we afford what they need. How do we go about doing that?	IQ6
	Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	Be creative in such a way that we're still fiscally prudent and responsible.	IQ6
	Outcomes measures and management (e.g., ROI; Cost-effectiveness analysis [CEA]; cash flow analysis and testing)	You have to understand contractual allowances versus gross charges	IQ10
	Funding and payment mechanisms of the healthcare system	grant funding, NOA process	IQ10
	Compliance with regulatory agencies and tax status requirements	You also have to understand a local environment and how to taxes are assessed and how that is going to produce the final bottom line	IQ10
	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	The net revenue that you have to pay for everything	IQ10
	Staffing methodologies and productivity management (e.g., acuity-based staffing; flexible staffing; fixed staffing)	monitor behavior	IQ10
	Organizational policies and procedures and their functions	An HR background would be helpful	IQ10
Emotional Intelligence	mood regulation and preservation of motivation in frustrating situations	You have to be a good listener, you have to be able to make sure you know it's not about you, it's not about being right or being wrong, it's about what's best for the dept.	IQ8
	Delay of immediate gratification	You have to be reflective	IQ8
	Remain in control of emotions while focusing on and accomplishing goals.	The intestinal fortitude to provide the consequences if the behavior does not match the pace and goals of the dept.	IQ10
Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	the ability to say, "job well done."	IQ10

Understanding of accepted social roles, norms, and scripts	The ultimate decision making is made by the chair, but you have an opportunity to collaborate with the chair on issues such as budget, issue such as personnel, etc…	IQ1
Management of one's behaviors that positively influence group member perceptions.	My role within the department is one of influence...That's both collaborative at the chair level and it's one of influence, not final decision making.	IQ1
Expression of oneself during social situations, reading, and comprehension of different types of social situations.	opinions are being sought	IQ2
Management of one's behaviors that positively influence group member perceptions.	We have an interesting mix of individuals where we have a few seasoned people on the staff side, but we have a lot of young people. If we push them too hard too fast, they'll leave. If we leave them without expectations, nothing will get done. I also say the ability to negotiate with the faculty members	IQ8
Skills necessary for task completion	the ability to set expectations	IQ10
Management of one's behaviors that positively influence group member perceptions.	you have to be able to articulate your message in such a way that various members of the audience aren't going to be offended and lose the message that you're trying to articulate.	IQ8
Ability to exercise complex social skills such as teamwork, communication, conflict resolution, harmony, consensus, multiculturalism etc."	Approachability. If you're seen as approachable, you'll always be seen as someone who can solve problems. If you're not approachable, you'll be seen, quite frankly, as someone who may be part of the problem.	IQ9
Attunement to complex social cues,	It's not really in this situation about hard and fast decision making. It's about seeing things clearly, being intuitive, being reflective and being able to give, for lack of better terminology, sound advice and sound council.	IQ7

Figure K5

Flow Chart of Competencies Expressed by P18





Participant 20

Table K6a

Summary of P20 Interview

Interview Question	Core Theme	Related Competency	Textual Descriptors
IQ1	Leadership	Leadership styles/techniques	"[Making] people believe in the changes that I'm making are for the better and for the good of the overall, not only of the mission of providing care but for those faculty for those staff that are here as well"
IQ2	Communication and Relationship Management	Public relations	I've really developed relationships externally as a liaison with other community hospitals, with other programs, whether they be for profit or not-for-profit.
	Knowledge of the Healthcare Environment	The interrelationships among access, quality, cost, resource allocation, accountability, and community	[Understanding the] integration between in an academic center is vital between the hospital, between the university, between the Dean's office
	Leadership	Personal journey disciplines	Building a reputation through positive past experiences
	Social Intelligence	Skills necessary for task completion,	serve on committees
	Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	When ideas are sequestered use tact to get one's ideas heard
IQ3	Business Skills	Marketing plan development	Developing departmental website to draw potential residents
	Business Skills	Organizational mission, vision, objectives and priorities	Supporting residency program vision and strategy
	Knowledge of the Healthcare Environment	Funding and payment mechanisms of the healthcare system	Understanding funding for residency slots
IQ4	Knowledge of the Healthcare Environment	Healthcare technological research and advancements	review all of the manuscripts before they go to the IRB to get a better understanding of what they're doing, what type of drugs they're bringing in, what they're trying to prove
IQ5	Knowledge of the Healthcare Environment	The interrelationships among access, quality, cost, resource allocation, accountability, and community	the clinical mission is to provide care for all, whether it be the indigent or otherwise because we're here to teach the residents and here to make sure that we have those complex cases for them to understand.
	Business Skills	Customer satisfaction principles and tools	keep patients satisfied with care
	Business Skills	Characteristics of administrative systems/programs (e.g., financial; scheduling; on-line purchasing; productivity; human resources)	my overall role with the hospital is minimum in nature unless it's some type of program driven.

IQ6	Business Skills	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	what I do is on a daily basis though is to look at the volumes that are flowing through the building and make sure that we are keeping at threshold of about 600 or so, of course everybody has vacations, but from the standpoint of down to the minute details
	Business Skills	Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	I've actually set up a great model for the floor that our clinics are on. The way that I've done that is develop a clinic manager who is superb and created a navigator who is a non-clinical individual who makes sure that the through-put is consistent and constant and therefore I don't have to worry about the day-to-day ops
	Business Skills	Customer satisfaction principles and tools	to assure, again, that we know what type of patients coming through and to assure that the patient is very satisfied in their experience here
IQ7	Business Skills	Organizational mission, vision, objectives and priorities	The first thing I think any administrator has to do is understand what the --- and mission is for the academic component. You know that and you try to make that as equal in your mind as possible that you're here for clinical research and education. And to assure that one doesn't step on the other.
IQ8	Emotional Intelligence	Empathy for others	From an emotional standpoint, you have to have your heart in believing in the people that you work with to make them feel that you care and to make them feel that you don't step over the fine line of what's authority and what is what will put you on the same level as them.
IQ9	Emotional Intelligence	Development of state-of-mind competency	communication, honesty, trust and respect.
	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	communication, honesty, trust and respect.
		Organizational business and personal ethics	I believe in four attributes. It's communication, honesty, trust and respect. And so therefore, I feel that if somebody has those attributes, they will be highly successful.
	Professionalism		

			New Perceived Competency Identified---Prior Experience	I've coached soccer when I was younger, I thoroughly taught that to those individuals who were very young that in order to be successful, that if you have those four elements in your, embedded in the back of your mind, and you cross over any one of those, like a lack of communication, there's disrespect, that you're not honest, that people will not believe in you.
		Professionalism Social Intelligence	New Theme--People oriented	
IQ10		Social Intelligence	Self-confidence	you have to have the confidence that you don't fear failure [in order to] win respect.
		Emotional Intelligence	Empathy for others	
				have that enthusiasm, to be patient with people, there's a value in a person, everybody has value to add in some way and you have to work toward those assets or towards that person's value and work to that strength and not be very chronicle in the weaknesses of that individual.
		Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	listen, that you care, that you recognize everyone as you are a leader, that you prepare for the worst and hope for the best, that you are industrialist
		Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	add [your] strength in order to build a [more successful] organization.
		Leadership	Personal journey disciplines	Strive for excellence
		Business Skills	Customer satisfaction principles and tools	[Striving for Excellence of service] People will understand you have an excellent product or service and therefore people want to come to see those individuals.

Table K6b

Summary of P20 Interview by Theme

Core Theme	Related Competency	Textual Descriptors	Interview Question
Communication and Relationship Management			
	Public relations	I've really developed relationships externally as a liaison with other community hospitals, with other programs, whether they be for profit or not-for-profit.	IQ2

	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	communication, honesty, trust and respect.	
Leadership			
	Leadership styles/techniques	"[Making] people believe in the changes that I'm making are for the better and for the good of the overall, not only of the mission of providing care but for those faculty for those staff that are here as well"	IQ1
	Personal journey disciplines	Building a reputation through positive past experiences	IQ2
	Personal journey disciplines	Strive for excellence	IQ10
Professionalism			
	Organizational business and personal ethics	I believe in four attributes. It's communication, honesty, trust and respect. And so therefore, I feel that if somebody has those attributes, they will be highly successful.	IQ9
	New Perceived Competency Identified---Prior Experience	I've coached soccer when I was younger, I thoroughly taught that to those individuals who were very young that in order to be successful, that if you have those four elements in your, embedded in the back of your mind, and you cross over any one of those, like a lack of communication, there's disrespect, that you're not honest, that people will not believe in you.	IQ9
Knowledge of the Healthcare Environment			
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	[Understanding the] integration between in an academic center is vital between the hospital, between the university, between the Dean's office	IQ2
	Funding and payment mechanisms of the healthcare system	Understanding funding for residency slots	IQ3
	Healthcare technological research and advancements	review all of the manuscripts before they go to the IRB to get a better understanding of what they're doing, what type of drugs they're bringing in, what they're trying to prove	IQ4
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	the clinical mission is to provide care for all, whether it be the indigent or otherwise because we're here to teach the residents and here to make sure that we have those complex cases for them to understand.	IQ5
Business Skills			
	Marketing plan development	Developing departmental website to draw potential residents	IQ3
	Organizational mission, vision, objectives and priorities	Supporting residency program vision and strategy	IQ3
	Customer satisfaction principles and tools	keep patients satisfied with care	IQ5

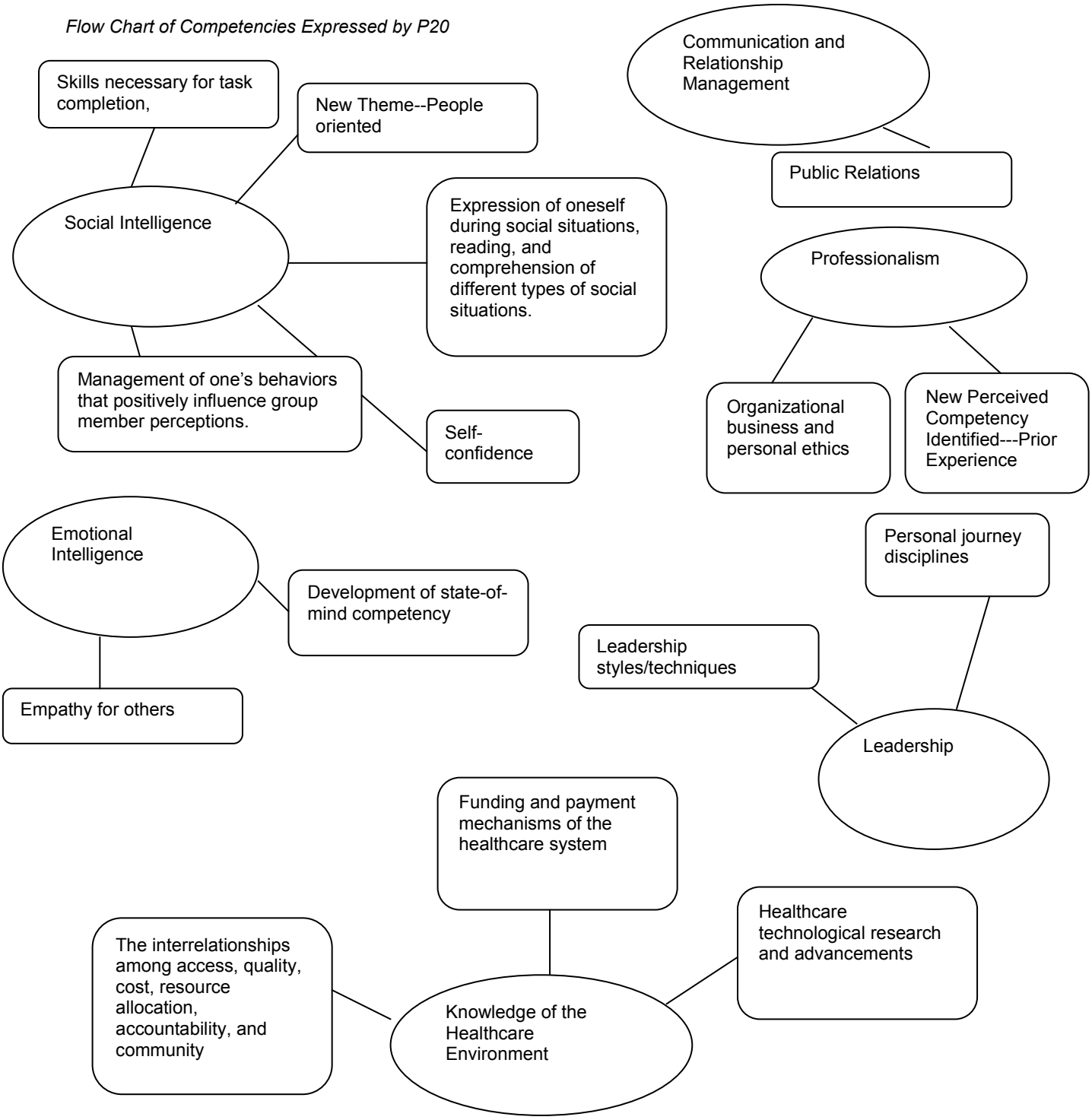
	Characteristics of administrative systems/programs (e.g., financial; scheduling; on-line purchasing; productivity; human resources)	my overall role with the hospital is minimum in nature unless it's some type of program driven.	IQ5
	Revenue cycle and accounts receivable management processes (e.g., EOB; charge capture; insurance billing)	what I do is on a daily basis though is to look at the volumes that are flowing through the building and make sure that we are keeping at threshold of about 600 or so, of course everybody has vacations, but from the standpoint of down to the minute details	IQ6
	Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	I've actually set up a great model for the floor that our clinics are on. The way that I've done that is develop a clinic manager who is superb and created a navigator who is a non-clinical individual who makes sure that the through-put is consistent and constant and therefore I don't have to worry about the day-to-day ops	IQ6
	Customer satisfaction principles and tools	to assure, again, that we know what type of patients coming through and to assure that the patient is very satisfied in their experience here	IQ6
	Organizational mission, vision, objectives and priorities	The first thing I think any administrator has to do is understand what the --- and mission is for the academic component. You know that and you try to make that as equal in your mind as possible that you're here for clinical research and education. And to assure that one doesn't step on the other.	IQ7
	Customer satisfaction principles and tools	[Striving for Excellence of service] People will understand you have an excellent product or service and therefore people want to come to see those individuals.	IQ10
Emotional Intelligence			
	Empathy for others	From an emotional standpoint, you have to have your heart in believing in the people that you work with to make them feel that you care and to make them feel that you don't step over the fine line of what's authority and what is what will put you on the same level as them.	IQ8
	Development of state-of-mind competency	communication, honesty, trust and respect.	IQ9
	Empathy for others	have that enthusiasm, to be patient with people, there's a value in a person, everybody has value to add in some way and you have to work toward those assets or towards that person's value and work to that strength and not be very chronicle in the weaknesses of that individual.	IQ10
Social Intelligence			
	Self-confidence	you have to have the confidence that you don't fear failure [in order to] win respect.	IQ10
	Skills necessary for task completion,	serve on committees	IQ2

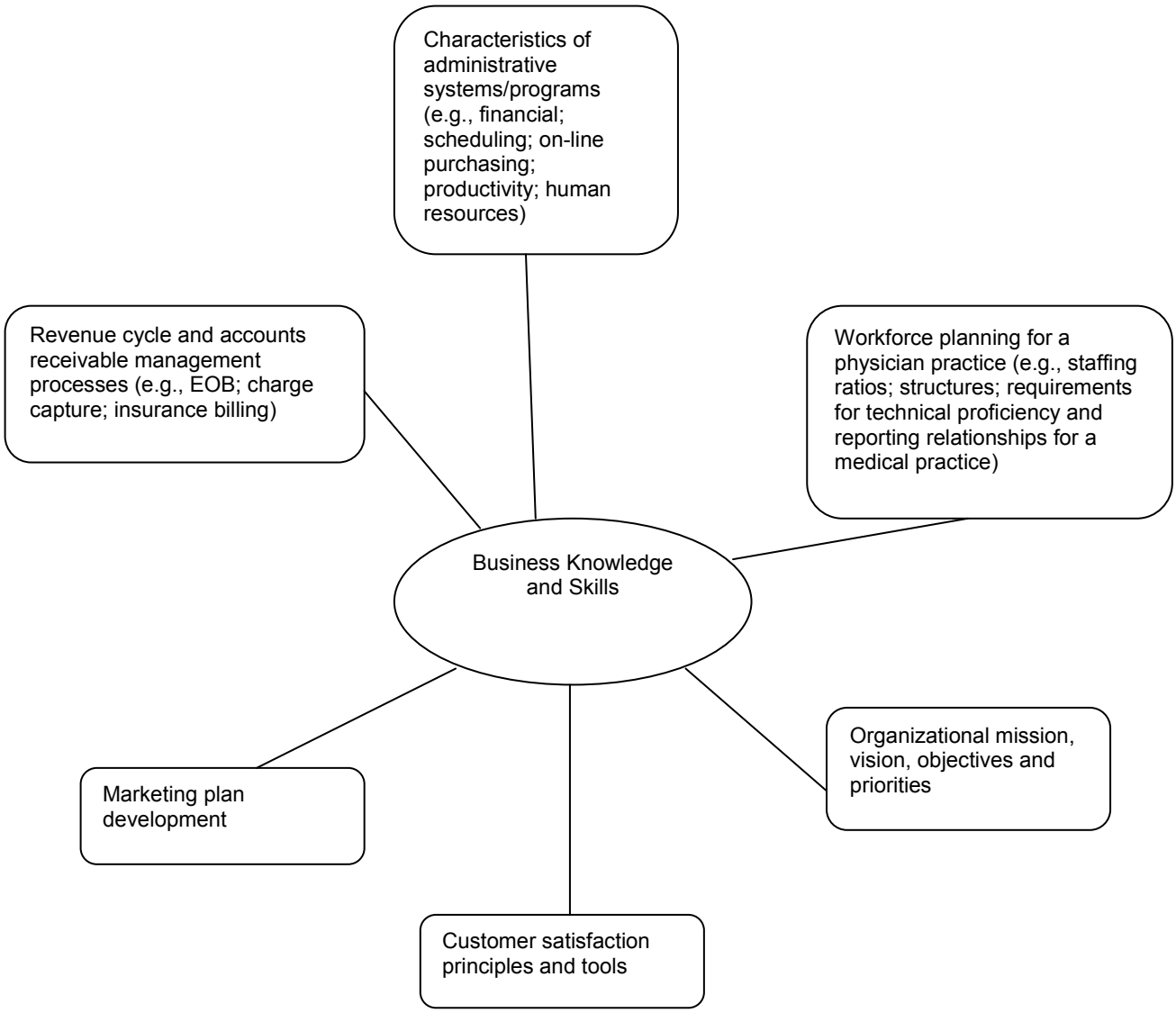
Management of one's behaviors that positively influence group member perceptions.	When ideas are sequestered use tact to get one's ideas heard	IQ2
New Theme--People oriented		IQ9
Expression of oneself during social situations, reading, and comprehension of different types of social situations.	listen, that you care, that you recognize everyone as you are a leader, that you prepare for the worst and hope for the best, that you are industrialist	IQ10
Management of one's behaviors that positively influence group member perceptions.	add [your] strength in order to build a [more successful] organization.	IQ10

Figure K6

Figure.

Flow Chart of Competencies Expressed by P20





Participant 21

Table K7a

Summary of P21 Interview by Question

Interview Question	Core Theme	Related Competency	Textual Descriptors
IQ1	Communication and Relationship Management	Organizational structure and relationships	"I really try to keep [the Chairman]abreast of what's going on and act as that advisor to him and … [direct] the staff
IQ1	Leadership	Leadership styles/techniques	Lead by example
IQ1	Professionalism	Professional roles, responsibility and accountability	Chief advisor to the Chairman; chief teacher to the staff
IQ2	Professionalism	Professional roles, responsibility and accountability	just trying to be a good advisor again to other people and how they might learn from that
IQ3	Knowledge of the Healthcare Environment	Role of non-clinical professionals in the healthcare system	Understanding and being able to do to perform the duties of the residency program coordinator
IQ3	Knowledge of the Healthcare Environment	Educational funding for healthcare personnel	Understanding funding for residency program
IQ3	Business Skills	Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	just because it's not a financial issue for an administrator, the educational piece, I think it's a really important piece to provide a good framework for the faculty to do their teaching so that your national prestige can be maintained, so that your funding doesn't get cut, so that you maintain that flow of teaching....
IQ4	Business Skills	Funding and payment mechanisms of the healthcare system	my leadership role to tell the faculty whether this is something that we can feasibly do without losing money or whether we can afford to lose money on something because they really want to do it.
IQ4	Business Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	I don't involve myself in trying to decide whether we should be doing [research] for any other reason except for financially

IQ5	Business Skills	Customer satisfaction principles and tools	patients have to be treated number one and then I'll deal with the research and the education because the patients are really very important and so I take a lot of time in trying to ensure that our practices in the department are good, that our customer service is good, that we're giving patient care the best that we can and that we make sure that the patients know that we're here.
IQ6	Knowledge of the Healthcare Environment	Nursing, physicians, and allied health professionals' roles and practice	faculty involvement
IQ6	Business Skills	Purchasing procurement	I deal with...purchasing equipment
IQ6	Business Skills	Fundamental productivity measures (e.g., hours per patient day; cost per patient day; units of service per man hour; PMPM)	I deal with hospital a considerable amount in allocation of OR time, giving up OR time,
IQ7	Professionalism	New Perceived Competency Identified--Prior Experience	I think that knowledge of the clinical practice world is absolutely necessary in a very busy clinical department.
IQ7	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	ability to be flexible and be able to communicate effectively with the physicians because I think that if they don't trust you then you have no relationship and therefore, you can't run their business.
IQ8	Emotional Intelligence	Mood regulation and preservation of motivation in frustrating situations	don't make decisions based on emotions...This isn't personal, this is business.
IQ8	Social Intelligence	Understanding of accepted social roles, norms, and scripts	I don't tend to focus on the emotional side of things and [I think my boss] appreciates looking like the bad guy but I'm really the bad guy
IQ9	Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	good manners, good etiquette, good grammar, and can adapt to situations as necessary.
IQ10	Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	synthesize a lot of information in a small amount of time without giving too many details and yet still make it effective so that the communication is clear.

Table K7b

Summary of P21 Interview by Theme

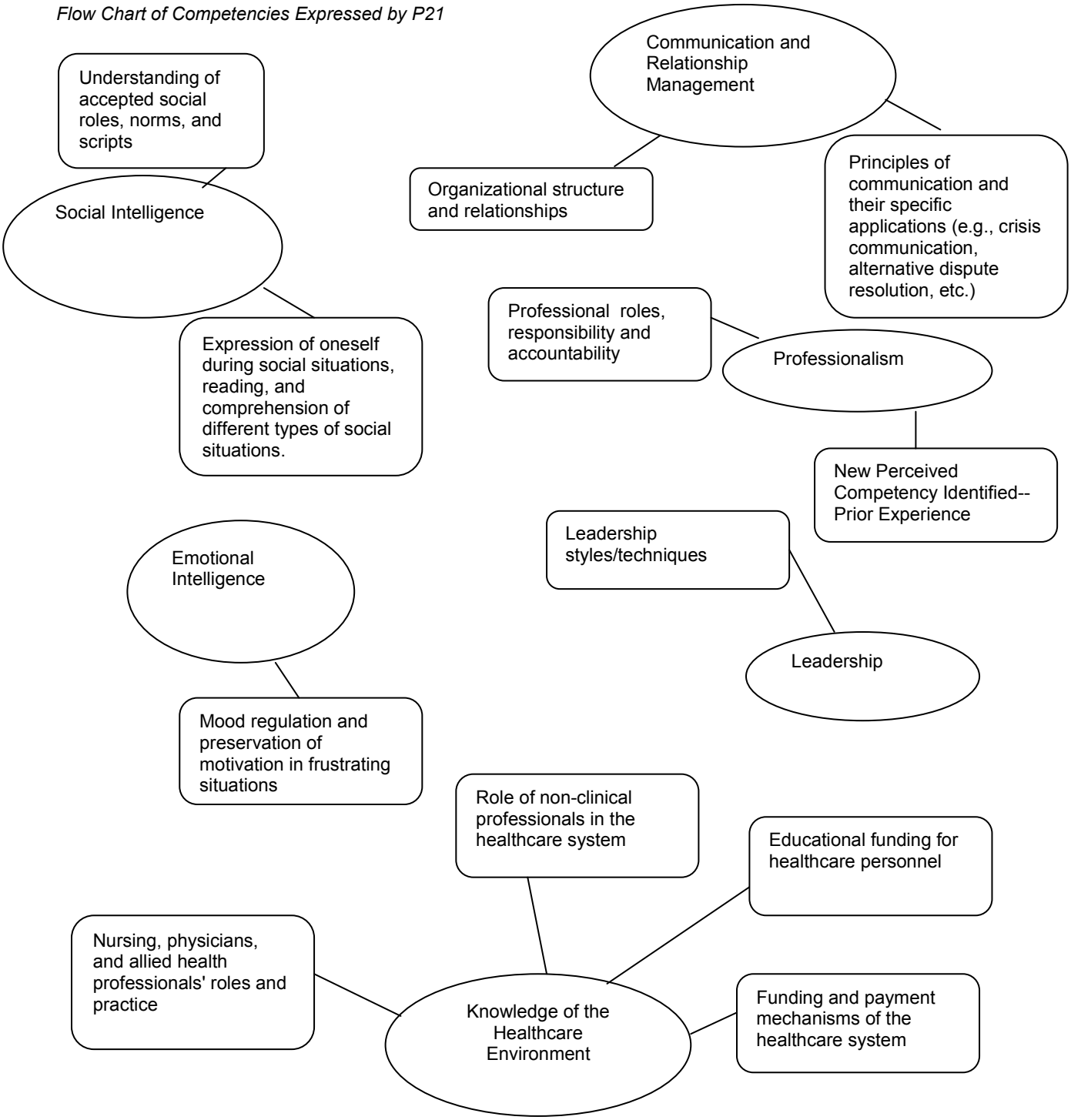
Core Theme	Related Competency	Textual Descriptors	Interview Question
Communication and Relationship Management			
	Organizational structure and relationships	"I really try to keep [the Chairman]abreast of what's going on and act as that advisor to him and … [direct] the staff	IQ1
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	ability to be flexible and be able to communicate effectively with the physicians because I think that if they don't trust you then you have no relationship and therefore, you can't run their business.	IQ7
Leadership			
	Leadership styles/techniques	Lead by example	IQ1
Professionalism			
	Professional roles, responsibility and accountability	Chief advisor to the Chairman; chief teacher to the staff	IQ1
	Professional roles, responsibility and accountability	just trying to be a good advisor again to other people and how they might learn from that	IQ2
	New Perceived Competency Identified--Prior Experience	I think that knowledge of the clinical practice world is absolutely necessary in a very busy clinical department.	IQ7
Knowledge of the Healthcare Environment			
	Role of non-clinical professionals in the healthcare system	Understanding and being able to do to perform the duties of the residency program coordinator	IQ3
	Educational funding for healthcare personnel	Understanding funding for residency program	IQ3
	Funding and payment mechanisms of the healthcare system	my leadership role to tell the faculty whether this is something that we can feasibly do without losing money or whether we can afford to lose money on something because they really want to do it.	IQ4
	Nursing, physicians, and allied health professionals' roles and practice	faculty involvement	IQ6
Business Skills			
	Workforce planning for a physician practice (e.g., staffing ratios; structures; requirements for technical proficiency and reporting relationships for a medical practice)	just because it's not a financial issue for an administrator, the educational piece, I think it's a really important piece to provide a good framework for the faculty to do their teaching so that your national prestige can be maintained, so that your funding doesn't get cut, so that you maintain that flow of teaching....	IQ3
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	I don't involve myself in trying to decide whether we should be doing [research] for any other reason except for financially	IQ4

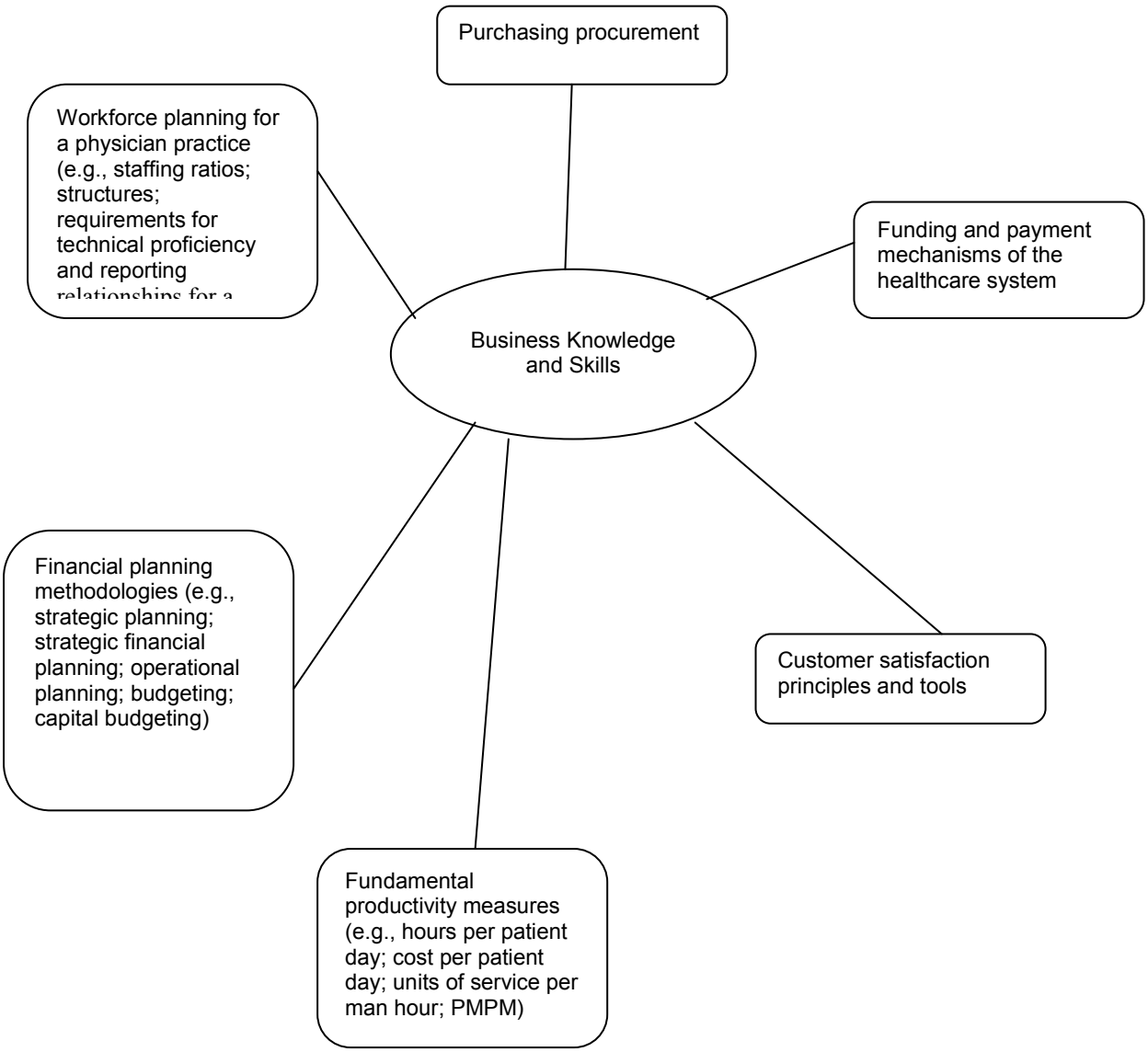
	Customer satisfaction principles and tools	patients have to be treated number one and then I'll deal with the research and the education because the patients are really very important and so I take a lot of time in trying to ensure that our practices in the department are good, that our customer service is good, that we're giving patient care the best that we can and that we make sure that the patients know that we're here.	IQ5
	Purchasing procurement	I deal with...purchasing equipment	IQ6
	Fundamental productivity measures (e.g., hours per patient day; cost per patient day; units of service per man hour; PMPM)	I deal with hospital a considerable amount in allocation of OR time, giving up OR time,	IQ6
Emotional Intelligence			
	Mood regulation and preservation of motivation in frustrating situations	don't make decisions based on emotions...This isn't personal, this is business.	IQ8
Social Intelligence			
	Understanding of accepted social roles, norms, and scripts	I don't tend to focus on the emotional side of things and [I think my boss] appreciates looking like the bad guy but I'm really the bad guy	IQ8
	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	good manners, good etiquette, good grammar, and can adapt to situations as necessary.	IQ9
	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	synthesize a lot of information in a small amount of time without giving too many details and yet still make it effective so that the communication is clear.	IQ10

Figure K7

Figure.

Flow Chart of Competencies Expressed by P21





Participant 22

Table K8a

Summary of P22 Interview by Question

Interview Question	Core Theme	Related Competency	Textual Descriptors
IQ1	Professionalism	Professional roles, responsibility and accountability	I think it varies depending on the different tasks that we have to do because sometimes I am an consultant, sometimes I am a visionary that kind of looks at where we're going and tries to inspire people to go along, sometimes I'm the enforcer and sometimes I am the whatever needs to be done person. It varies depending on the task.
IQ2	Business Knowledge and Skills	Organizational mission, vision, objectives and priorities	…college's task is to make sure the administrators understand what the goal is so we're all going towards the same direction. My job is to implement that vision if you will
	Business Knowledge and Skills	New Emerging Competency Identified- To integrate, merge, link, marry the department and hospital perspectives	...it's my job to take [the] macro vision [of top leadership within the AMC]and put it on a micro level [within the department].
	Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	[One duty is to] give feedback as I can to the top leadership on how it's going and where we might look at going another direction
IQ3	Business Knowledge and Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	I provide fiscal guidance primarily on …feasibility
	Business Knowledge and Skills	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	Balance the different missions so that no one mission is taking all the resources
	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	Negotiation
	Knowledge of the Healthcare Environment	Educational funding for healthcare personnel	Resident slot funding
	Business Knowledge and Skills	The interrelationships among access, quality, cost, resource allocation, accountability, and community	working with community agencies

IQ4	Business Knowledge and Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	Research is primarily a fiscal duty, keeping an eye on the finances, making sure that we have cash flow to support the research mission so we don't end up at some point with a deficit...
	Business Knowledge and Skills	Organizational policies and procedures and their functions	I help with polic[y development]
	Business Knowledge and Skills	Inventory control systems	It's making sure the books balance at the end of the day
	Business Knowledge and Skills	New Emerging Competency Identified--Support research, research personnel, and grants	...if you have a grant that ends in 6 months, you have to look forward and say, ok, when this grant is over, I have 3 people who are funded on this grant. What are we going to do with those 3 people? Where are they going to work after that?
IQ5	Professionalism	New Emerging Competency Identified--Prior Experience	I have a lot of clinical management experience
	Professionalism	Professional roles, responsibility and accountability	[I] act as more of a consultant…to the clinic
	Knowledge of the Healthcare Environment	Staff perspective in organizational settings (e.g., frame of reference by discipline and role; orientation)	have physicians working in the clinic on a day to day basis
	Leadership	Leadership styles/techniques	I think you get a better product when you do it as a team.
	Business Knowledge and Skills	Motivational techniques	I try to get my faculty involved [in clinical policy] so it's a team effort and not just one person saying this is what we have to do.
	Business Knowledge and Skills	Principles and practices of management and organizational behavior	...I'll go in the clinic and suggest things that we should do but if I see something outrageously wrong, I'll just tell the staff they have to fix it.
IQ6	Business Knowledge and Skills	Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	I watch the finances real closely and try to come up with ideas.
	Business Knowledge and Skills	Business plan development and implementation processes	looking at a business plan
	Business Knowledge and Skills	Organizational dynamics, political realities, and culture	once I get the plan finished, if it looks like it will be feasible, then I'll discuss it with the physician's and they'll tweak it and then we'll discuss it with the folks at Main Baylor and get everybody on board before we can move forward

IQ7	Business Knowledge and Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	I look for strong fiscal skills.
	Professionalism	Time and stress management techniques	Time management skills
	Social Intelligence	New Emerging Competency Identified--People oriented	Very good people skills
	Social Intelligence	Skills necessary for task completion	...very strong physician relations. No administrators can survive if they can't get along with physicians.
IQ8	Emotional Intelligence	Remain in control of emotions while focusing on and accomplishing goals.	I think you have to have an even keel so to speak, you can't get too excited or too frustrated because there are things that happen during the day that you just can't always control
	Emotional Intelligence	Mood regulation and preservation of motivation in frustrating situations	you have to be able to take some hits so to speak without losing your mind over it.
	Professionalism	New Emerging Competency Identified--Balance professional responsibilities and human skills	I also think you have to be able to go home and forget about it at some point and to have some things outside of work that take the stress off because it can be a real stressful job.
IQ9	Social Intelligence	Skills necessary for task completion	you have to be able to communicate with physicians
	Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	You have to be able to tell the physician's they're wrong when they're wrong but do it in a diplomatic way.
	Social Intelligence	Interpersonal problem-solving skills and social role-playing skills	Staff communication skills are huge, staff can make an administrator look terrible if they want to and so you've got to get the staff on board.
IQ10	Business Knowledge and Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	fiscal competencies
	Business Knowledge and Skills	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	have to be able to look at financial reports and see where you are and what's going on and also project where you're going.
	Social Intelligence	Interpersonal problem-solving skills and social role-playing skills	I think the interpersonal competencies are huge
	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute	being able to communicate with people.

		resolution, etc.)	
		The interrelationships among access, quality, cost, resource allocation, accountability, and community	you have to have some broad knowledge of the healthcare industry and how it works.
	Business Knowledge and Skills	Human resources laws and regulations (e.g., labor law; wage and hour; FMLA; FLSA; EEOC; ERISA; workers compensation)	I think a person needs to know about human resources and what you can and cannot do from a human resources perspective.
	Knowledge of the Healthcare Environment	Governmental, regulatory, professional, and accreditation agencies (e.g., CMS; JCAHO; NCQA) related to healthcare delivery	I think you have to have knowledge of clinics and how clinics operate and you know, what HIPAA is all about, those kinds of things.

Table K8b

Summary of P22 Interview by Theme

Core Theme	Related Competency	Textual Descriptors	Interview Question
Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	Negotiation	IQ3
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	being able to communicate with people.	IQ10
Leadership	Leadership styles/techniques	I think you get a better product when you do it as a team.	IQ5
Professionalism	Professional roles, responsibility and accountability	I think it varies depending on the different tasks that we have to do because sometimes I am an consultant, sometimes I am a visionary that kind of looks at where we're going and tries to inspire people to go along, sometimes I'm the enforcer and sometimes I am the whatever needs to be done person. It varies depending on the task.	IQ1
	New Emerging Competency Identified--Prior Experience	I have a lot of clinical management experience	IQ5

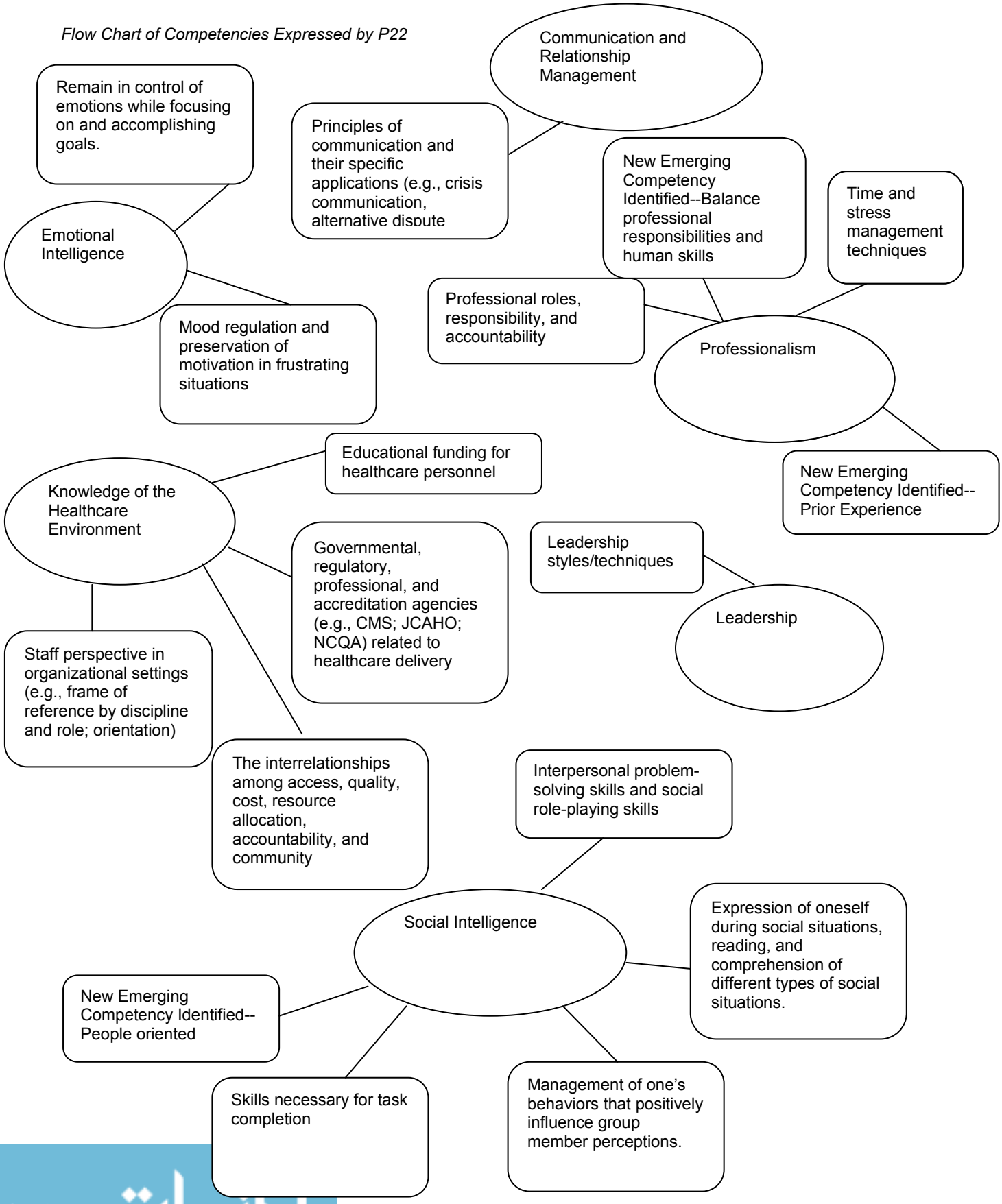
	Professional roles, responsibility and accountability	[I] act as more of a consultant…to the clinic	IQ5
	Time and stress management techniques	Time management skills	IQ7
	New Emerging Competency Identified--Balance professional responsibilities and human skills	I also think you have to be able to go home and forget about it at some point and to have some things outside of work that take the stress off because it can be a real stressful job.	IQ8
Knowledge of the Healthcare Environment	Educational funding for healthcare personnel	Resident slot funding	IQ3
	Staff perspective in organizational settings (e.g., frame of reference by discipline and role; orientation)	have physicians working in the clinic on a day to day basis	IQ5
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	you have to have some broad knowledge of the healthcare industry and how it works.	IQ10
	Governmental, regulatory, professional, and accreditation agencies (e.g., CMS; JCAHO; NCQA) related to healthcare delivery	I think you have to have knowledge of clinics and how clinics operate and you know, what HIPAA is all about, those kinds of things.	IQ10
Business Knowledge and Skills	Organizational mission, vision, objectives and priorities	college's task is to make sure the administrators understand what the goal is so we're all going towards the same direction. My job is to implement that vision if you will	IQ2
	New Emerging Competency Identified-To integrate, merge, link, marry the department and hospital perspectives	...it's my job to take [the] macro vision [of top leadership within the AMC]and put it on a micro level [within the department].	IQ2
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	I provide fiscal guidance primarily on …feasibility	IQ3
	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	Balance the different missions so that no one mission is taking all the resources	IQ3
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	working with community agencies	IQ3

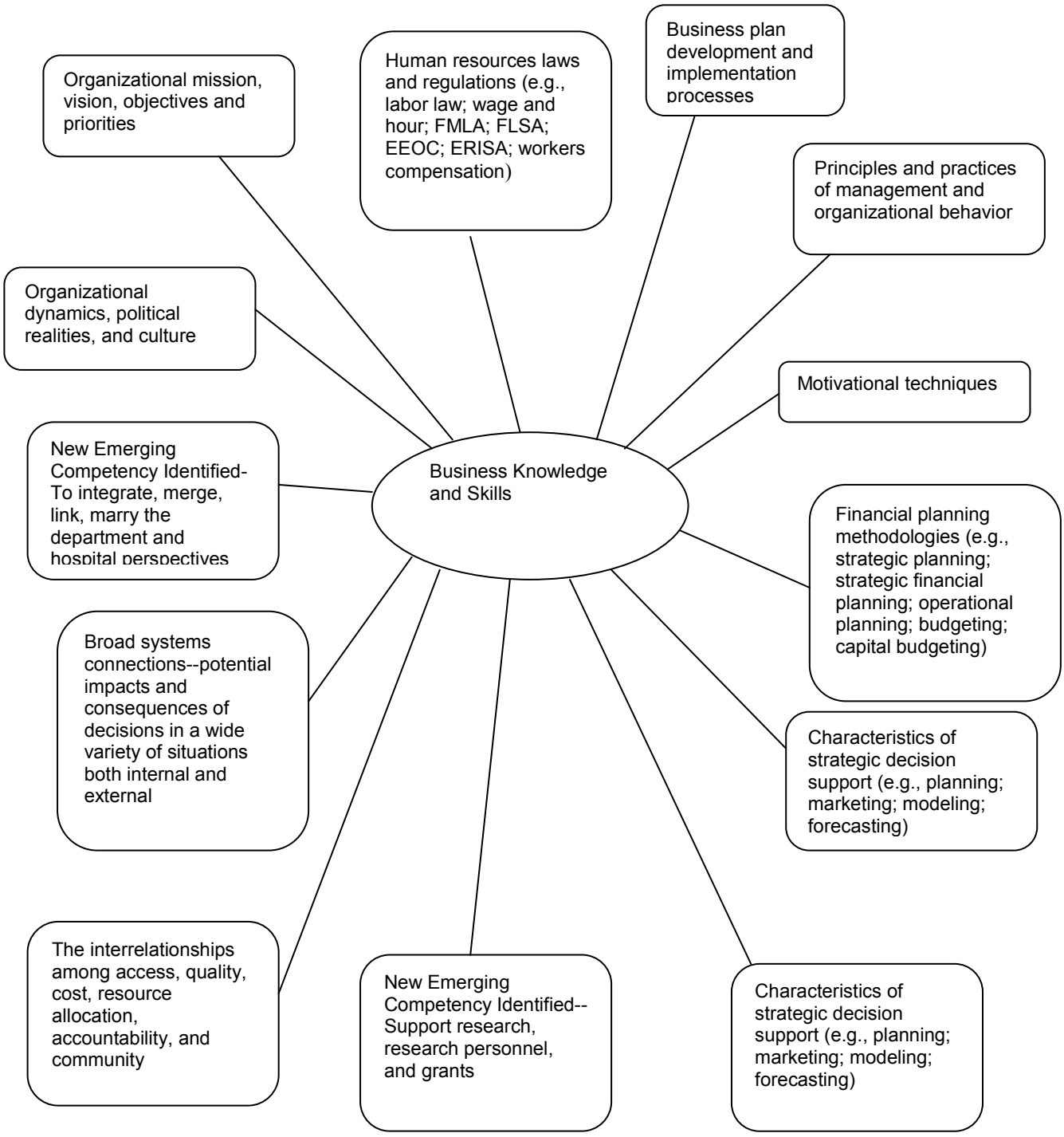
Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	Research is primarily a fiscal duty, keeping an eye on the finances, making sure that we have cash flow to support the research mission so we don't end up at some point with a deficit...	IQ4
Organizational policies and procedures and their functions	I help with polic[y development]	IQ4
Inventory control systems	It's making sure the books balance at the end of the day	IQ4
New Emerging Competency Identified--Support research, research personnel, and grants	...if you have a grant that ends in 6 months, you have to look forward and say, ok, when this grant is over, I have 3 people who are funded on this grant. What are we going to do with those 3 people? Where are they going to work after that?	IQ4
Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	fiscal competencies	IQ10
Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	have to be able to look at financial reports and see where you are and what's going on and also project where you're going.	IQ10
Human resources laws and regulations (e.g., labor law; wage and hour; FMLA; FLSA; EEOC; ERISA; workers compensation)	I think a person needs to know about human resources and what you can and cannot do from a human resources perspective.	IQ10
Motivational techniques	I try to get my faculty involved [in clinical policy] so it's a team effort and not just one person saying this is what we have to do.	IQ5
Principles and practices of management and organizational behavior	...I'll go in the clinic and suggest things that we should do but if I see something outrageously wrong, I'll just tell the staff they have to fix it.	IQ5
Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	I watch the finances real closely and try to come up with ideas.	IQ6
Business plan development and implementation processes	looking at a business plan	IQ6

	Organizational dynamics, political realities, and culture	once I get the plan finished, if it looks like it will be feasible, then I'll discuss it with the physician's and they'll tweak it and then we'll discuss it with the folks at Main Baylor and get everybody on board before we can move forward	IQ6
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	I look for strong fiscal skills.	IQ7
Emotional Intelligence	Remain in control of emotions while focusing on and accomplishing goals.	I think you have to have an even keel so to speak, you can't get too excited or too frustrated because there are things that happen during the day that you just can't always control	IQ8
	Mood regulation and preservation of motivation in frustrating situations	you have to be able to take some hits so to speak without losing your mind over it.	IQ8
Social Intelligence	Interpersonal problem-solving skills and social role-playing skills	I think the interpersonal competencies are huge	IQ10
	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	[One duty is to] give feedback as I can to the top leadership on how it's going and where we might look at going another direction	IQ2
	New Emerging Competency Identified--People oriented	Very good people skills	IQ7
	Skills necessary for task completion	...very strong physician relations. No administrators can survive if they can't get along with physicians.	IQ7
	Skills necessary for task completion	you have to be able to communicate with physicians	IQ9
	Management of one's behaviors that positively influence group member perceptions.	You have to be able to tell the physician's they're wrong when they're wrong but do it in a diplomatic way.	IQ9
	Interpersonal problem-solving skills and social role-playing skills	Staff communication skills are huge, staff can make an administrator look terrible if they want to and so you've got to get the staff on board.	IQ9

Figure K8

Flow Chart of Competencies Expressed by P22





Participant 24

Table K9a

Summary of P24 Interview by Question

Interview Question	Core Theme	Related Competency	Textual Descriptors
IQ1	Professionalism	Professional roles, responsibility and accountability	my leadership role is full accountability of both departments for all the missions of the college.
	Business Knowledge and Skills	Organizational mission, vision, objectives and priorities	There are three main missions of the college in research, education and clinical operations and I have to be accountable to all three of those in my three departments.
IQ2	Business Knowledge and Skills	Organizational dynamics, political realities, and culture	we have to play our part as a department in a much larger medical school in carrying out those missions. So we are each unit and we operate, hopefully, cohesively
	Knowledge of the Healthcare Environment	New Emerging Competency Identified--To integrate, merge, link, marry the department and hospital perspectives	Every department has things that make them unique in the overall academic medical center and it's our job to take care of that uniqueness and us it and it's what makes Baylor special.
	Business Knowledge and Skills	Organizational mission, vision, objectives and priorities	[Education] is the primary reason why we're here.
	Business Knowledge and Skills	Contingency planning (e.g., emergency preparedness)	we have to make allowances for education in our clinical operations, not allowances that ever cost us anything but we have to consider it.
	Knowledge of the Healthcare Environment	Nursing, physicians, and allied health professionals' roles and practice	Most time I think the faculty would say, it may take more time [to teach] at times but [teaching is] an enhancement for them as well.
IQ4	Knowledge of the Healthcare Environment	New Emerging Competency Identified--Support research, research personnel, and grants	We have to be able to support our research faculty and give them a little different administration. I mean they need assistance in other administrative areas than you would think of in day-to-day clinical operations. They're out getting the grants and trying to find funding and they're trying to complete studies and sometimes the studies are clinical and sometimes they're not and we need to incorporate that in our regular strategy for the department.
IQ5	Business Knowledge and Skills	Customer satisfaction principles and tools	we have to have great customer service in all areas of clinical operations and we need to be able to maintain good clinical operations day-today.
	Knowledge of the Healthcare Environment	The interrelationships among access, quality, cost, resource allocation, accountability, and community	key for having education for the students, you've got to have good clinic and surgery for the students to be able to participate in

IQ6	Leadership	Leadership styles/techniques	I think I'm very involved because clinical, there's operations to this department in all the missions of the college and so I'm not necessarily a hands-off manager.
	Business Knowledge and Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	The day-to-day operations...I have to be involved in them in order to make good leadership decisions.
	Knowledge of the Healthcare Environment	Role of non-clinical professionals in the healthcare system	I need to make sure that my staff who work in [clinical] areas, be it clinic manager or research manager or educational coordinator, that they are able to perform their duties
	Knowledge of the Healthcare Environment	Organization and delivery of healthcare (e.g., acute care, ambulatory care, medical practice, ancillary services)	I don't have the luxury or the time to be in every clinic every day, all day so I have to have good policies and staff to handle it when I'm not there every day.
IQ7	Business Knowledge and Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	I think that they have to have a good financial competency core.
IQ7	Professionalism	New Emerging Competency Identified--Prior Experience	I think they need to have operational experience [and]…management experience.
	Social Intelligence	Skills necessary for task completion	need to be able to multi-task
	Business Knowledge and Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	they need to be able to set goals and strategies for their department and see them through.
	Leadership	Leadership styles/techniques	they need to be able to have a level of leadership that allows the department to come together and be recognized as a leader.
IQ8	Social Intelligence	Self-confidence	would expect them to be confident, strong in their decision-making skills...When I say confidence, I think they need to be secure enough in themselves that they can makes decisions and take the good and the bad that comes with the decision
	Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	to be able to initiate some camaraderie
IQ9	Social Intelligence	Ability to exercise complex social skills such as teamwork, communication, conflict resolution, harmony,	have a team player personality

		consensus, multiculturalism etc."	
	Knowledge of the Healthcare Environment	Role of non-clinical professionals in the healthcare system	They need to be willing to understand all the staff in their departments and their jobs.
	Communication and Relationship Management	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	have the ability to communicate and speak
	Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	You need to be able….build relationships, it's very important to the success.
IQ10	Social Intelligence	Skills necessary for task completion	you need to be a flexible person
	Business Knowledge and Skills	Organizational mission, vision, objectives and priorities	[bring] together 3 unique missions that are all related but they all have whole different goals and strategies.
	Knowledge of the Healthcare Environment	New Emerging Competency Identified--To integrate, merge, link, marry the department and hospital perspectives	integrate those missions and make the department work as a whole.
	Social Intelligence	Interpersonal problem-solving skills and social role-playing skills	be able to make decisions
	Business Knowledge and Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	think at a higher level, go beyond what's happening today, think about a little bit in the future.
	Emotional Intelligence	Remain in control of emotions while focusing on and accomplishing goals.	be able to adjust.

Table K9b

Summary of P24 Interview by Theme

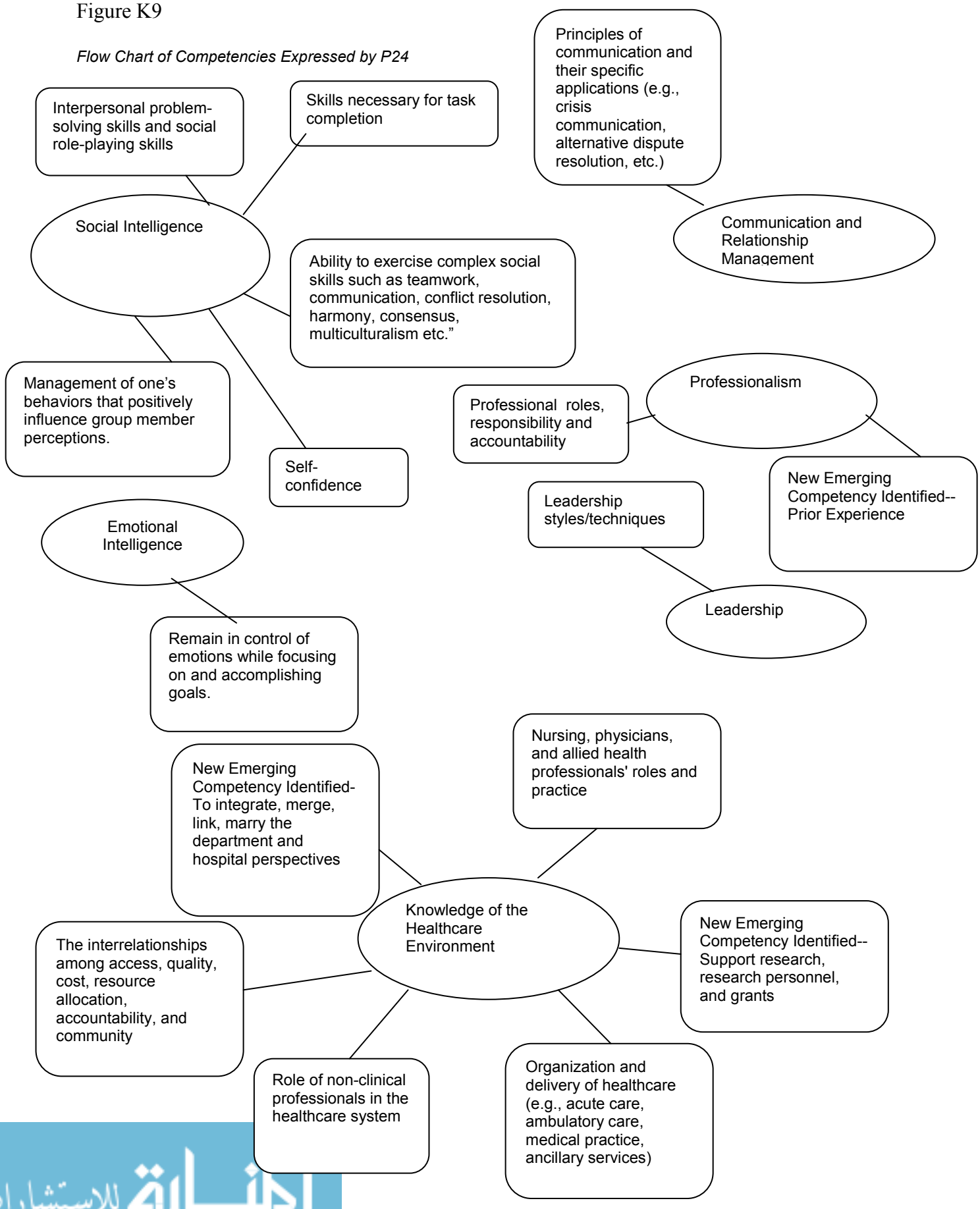
Core Theme	Related Competency	Textual Descriptors	Interview Question
Communication and Relationship Management			
	Principles of communication and their specific applications (e.g., crisis communication, alternative dispute resolution, etc.)	have the ability to communicate and speak	IQ9
Leadership			

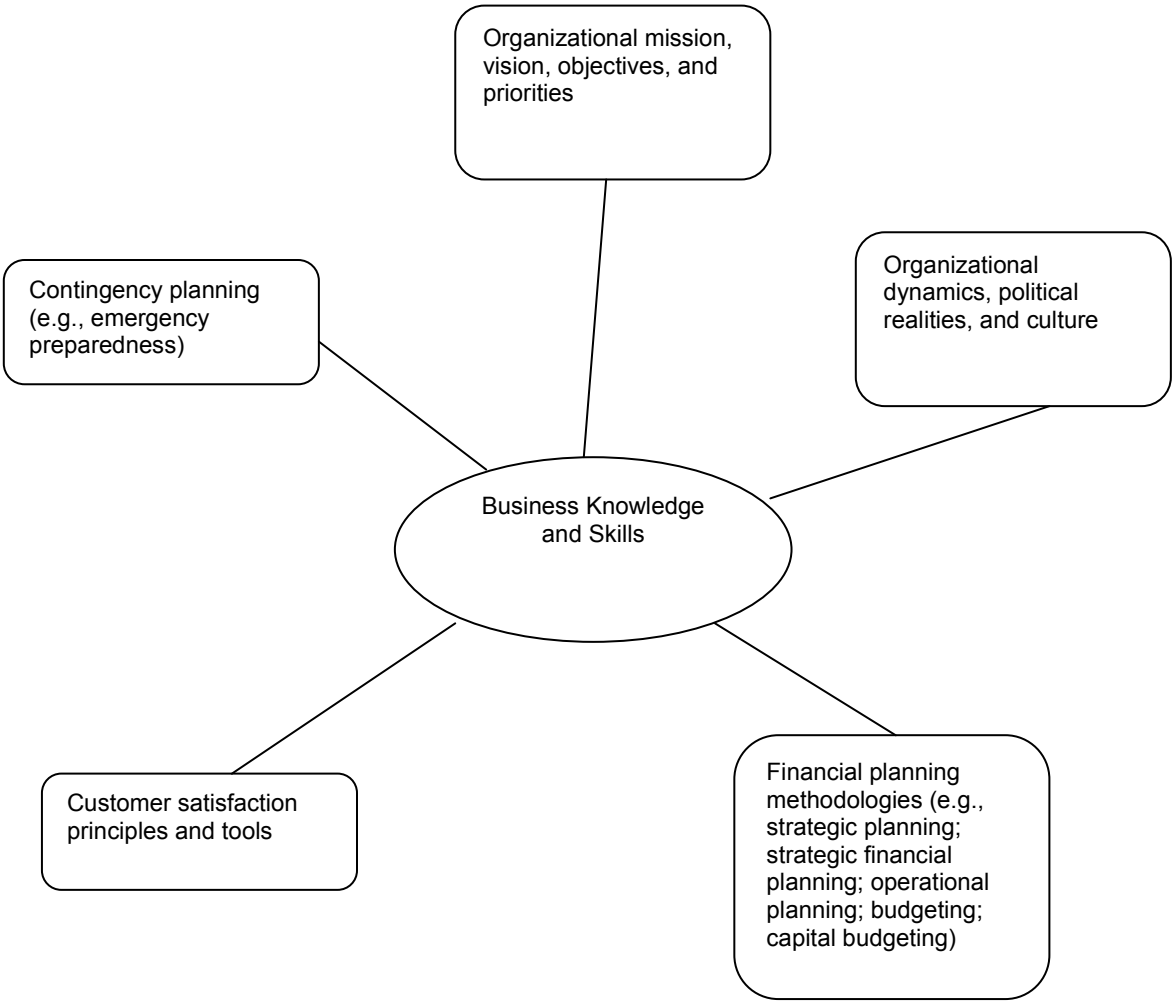
	Leadership styles/techniques	they need to be able to have a level of leadership that allows the department to come together and be recognized as a leader.	IQ7
	Leadership styles/techniques	I think I'm very involved because clinical, there's operations to this department in all the missions of the college and so I'm not necessarily a hands-off manager.	IQ6
Professionalism			
	Professional roles, responsibility and accountability	my leadership role is full accountability of both departments for all the missions of the college.	IQ1
	New Emerging Competency Identified--Prior Experience	I think they need to have operational experience [and]…management experience.	IQ7
Knowledge of the Healthcare Environment			
	New Emerging Competency Identified--To integrate, merge, link, marry the department and hospital perspectives	Every department has things that make them unique in the overall academic medical center and it's our job to take care of that uniqueness and us it and it's what makes Baylor special.	IQ2
	Nursing, physicians, and allied health professionals' roles and practice	Most time I think the faculty would say, it may take more time [to teach] at times but [teaching is] an enhancement for them as well.	IQ3
	New Emerging Competency Identified--Support research, research personnel, and grants	We have to be able to support our research faculty and give them a little different administration. I mean they need assistance in other administrative areas than you would think of in day-to-day clinical operations. They're out getting the grants and trying to find funding and they're trying to complete studies and sometimes the studies are clinical and sometimes they're not and we need to incorporate that in our regular strategy for the department.	IQ4
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	key for having education for the students, you've got to have good clinic and surgery for the students to be able to participate in	IQ5
	Role of non-clinical professionals in the healthcare system	I need to make sure that my staff who work in [clinical] areas, be it clinic manager or research manager or educational coordinator, that they are able to perform their duties	IQ6
	Organization and delivery of healthcare (e.g., acute care, ambulatory care, medical practice, ancillary services)	I don't have the luxury or the time to be in every clinic every day, all day so I have to have good policies and staff to handle it when I'm not there every day.	IQ6
	Role of non-clinical professionals in the healthcare system	They need to be willing to understand all the staff in their departments and their jobs.	IQ9
	New Emerging Competency Identified--To integrate, merge, link, marry the department and hospital perspectives	integrate those missions and make the department work as a whole.	IQ10
Business Knowledge and Skills			
	Organizational mission, vision, objectives and priorities	There are three main missions of the college in research, education and clinical operations and I have to be accountable to all three of those in my three departments.	IQ1
	Organizational dynamics, political realities, and culture	we have to play our part as a department in a much larger medical school in carrying out those missions. So we are each unit and we operate, hopefully, cohesively	IQ2
	Organizational mission, vision, objectives and priorities	[Education] is the primary reason why we're here.	IQ3

	Contingency planning (e.g., emergency preparedness)	we have to make allowances for education in our clinical operations, not allowances that ever cost us anything but we have to consider it.	IQ3
	Customer satisfaction principles and tools	we have to have great customer service in all areas of clinical operations and we need to be able to maintain good clinical operations day-today.	IQ5
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	The day-to-day operations...I have to be involved in them in order to make good leadership decisions.	IQ6
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	I think that they have to have a good financial competency core.	IQ7
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	they need to be able to set goals and strategies for their department and see them through.	IQ7
	Organizational mission, vision, objectives and priorities	[bring] together 3 unique missions that are all related but they all have whole different goals and strategies.	IQ10
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	think at a higher level, go beyond what's happening today, think about a little bit in the future.	IQ10
Emotional Intelligence			
	Remain in control of emotions while focusing on and accomplishing goals.	be able to adjust.	IQ10
Social Intelligence			
	Self-confidence	I would expect them to be confident, strong in their decision-making skills...When I say confidence, I think they need to be secure enough in themselves that they can makes decisions and take the good and the bad that comes with the decision	IQ8
	Skills necessary for task completion	need to be able to multi-task	IQ7
	Management of one's behaviors that positively influence group member perceptions.	to be able to initiate some camaraderie	IQ8
	Ability to exercise complex social skills such as teamwork, communication, conflict resolution, harmony, consensus, multiculturalism etc."	have a team player personality	IQ9
	Management of one's behaviors that positively influence group member perceptions.	You need to be able….build relationships, it's very important to the success.	IQ9
	Skills necessary for task completion	you need to be a flexible person	IQ10
	Interpersonal problem-solving skills and social role-playing skills	be able to make decisions	IQ10

Figure K9

Flow Chart of Competencies Expressed by P24





Participant 26

Table K10a

Summary of P26 Interview by Question

Interview Question	Core Theme	Related Competency	Textual Descriptors
IQ1	Business Knowledge and Skills	Organizational mission, vision, objectives and priorities	you have to understand how all the missions of an academic department at a medical school or college are intertwined.
	Business Knowledge and Skills	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	recruit the right kind of faculty that can not only provide the teaching so you can attract the best students but then those faculty also have to, they might be doing undergraduate medical education, but they're also potentially doing graduate medical education and then they're providing, in many cases the same faculty, clinical service at a hospital.
	Knowledge of the Healthcare Environment	Nursing, physicians, and allied health professionals' roles and practice	developing who are the personalities and how did they fit together
	Knowledge of the Healthcare Environment	Organization and delivery of healthcare (e.g., acute care, ambulatory care, medical practice, ancillary services)	the leadership role in the department is trying to find people that are interested in fulfilling each one of the academic missions and hopefully you'll find somebody who also fulfills the third mission, research.
	Professionalism	Professional roles, responsibility and accountability	working with your chairman or chairwoman and understanding what their vision is of the department and how they want to grow it and change it and make it better and improve it and working with them in kind of a joint leadership arrangement.
IQ2	Leadership	Personal journey disciplines	number 1 department [excellence]
	Business Knowledge and Skills	Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	we have managed to make the most money for the college, the most surplus.
	Leadership	Personal journey disciplines	I see [the ability to get and retain grant funding, make the biggest profit for the College of Medicine, and be a desirable location for residency education] as the leadership role because people come to our department and they want to know how are we doing it.
IQ3	Business Knowledge and Skills	Organizational mission, vision, objectives and priorities	being a medical school, the primary educational duty is to teach the undergraduate medical students
IQ3	Business Knowledge and Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	we have ...6 or 7 committees that we pull together every month and we talk about the teaching and who's going to be teaching what courses, and do we have the right people in the right places. What were their course evaluations for the last year, were they well received by the students or would there be a better spot?

	Business Knowledge and Skills	Comparative analysis strategies (e.g., indicators; benchmarks; systems; performance)	we have ...6 or 7 committees that we pull together every month and we talk about the teaching and who's going to be teaching what courses, and do we have the right people in the right places. What were their course evaluations for the last year, were they well received by the students or would there be a better spot?
IQ4	Business Knowledge and Skills	Quality planning and management	I see the primary research duty as recruiting the right faculty
	Social Intelligence	Interpersonal problem-solving skills and social role-playing skills	working with them and listening to what their interests are
	Business Knowledge and Skills	Asset management, including investments, equipment, etc	invest [money] in our research enterprise
IQ5	Communication and Relationship Management	Public relations	I had an idea about 15, 16, 17 years ago and pitched an idea to the college of growing, of community hospital based practice.
	Communication and Relationship Management	The interrelationships among access, quality, cost, resource allocation, accountability, and community	I pitched an idea to create a community hospital-based practice and now we have 29 community hospitals where we have good general and sub-specialty [physicians] out in the community
IQ7	Social Intelligence	Skills necessary for task completion	I think somebody has to be able to handle lots of different things at a time because you can be working on one agreement with a doctor or with a hospital and you could get interrupted and you might have to take a residency question or you might…
	Emotional Intelligence	Remain in control of emotions while focusing on and accomplishing goals.	Someone that can triage lots of different things and keep reprioritizing throughout a day or throughout a week
	Business Knowledge and Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	good financial skills
	Knowledge of the Healthcare Environment	Educational funding for healthcare personnel	How the residency slots are funded
	Knowledge of the Healthcare Environment	New Emerging Competency Identified--Support research, research personnel, and grants	how the grant funding works
	Social Intelligence	Interpersonal problem-solving skills and social role-playing skills	able to deal with lots of different types of people
IQ8	Emotional Intelligence	Remain in control of emotions while focusing on and accomplishing goals.	I think somebody has to be relatively calm because there's just so much, so many interruptions that happen throughout a day you just have to be able to have a lot hit you
	Emotional Intelligence	Mood regulation and preservation of motivation in frustrating situations	

	Social Intelligence	Management of one's behaviors that positively influence group member perceptions.	It's not all good news all the time, so how can you take it and triage everything that comes at you and still have a positive attitude when you're walking down the hall, no matter what person you run in to.
IQ9	Social Intelligence	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	somebody that can really fit in in almost any type of social situation.
IQ10	Social Intelligence	Skills necessary for task completion	Good organizational skills
	Professionalism	Time and stress management techniques	good time management skills
	Business Knowledge and Skills	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	a basic understanding and knowledge of finances, financial performance, financial spreadsheets
	Business Knowledge and Skills	cost accounting	a little bit of accounting
	Social Intelligence	New Emerging Competency Identified--People oriented	good people skills.
	Leadership	Leadership styles/techniques	I think you can enhance people's careers by just pulling them and moving them and teaching them different skills and then watching them grow.

Table K10b

Summary of P26 Interview by Theme

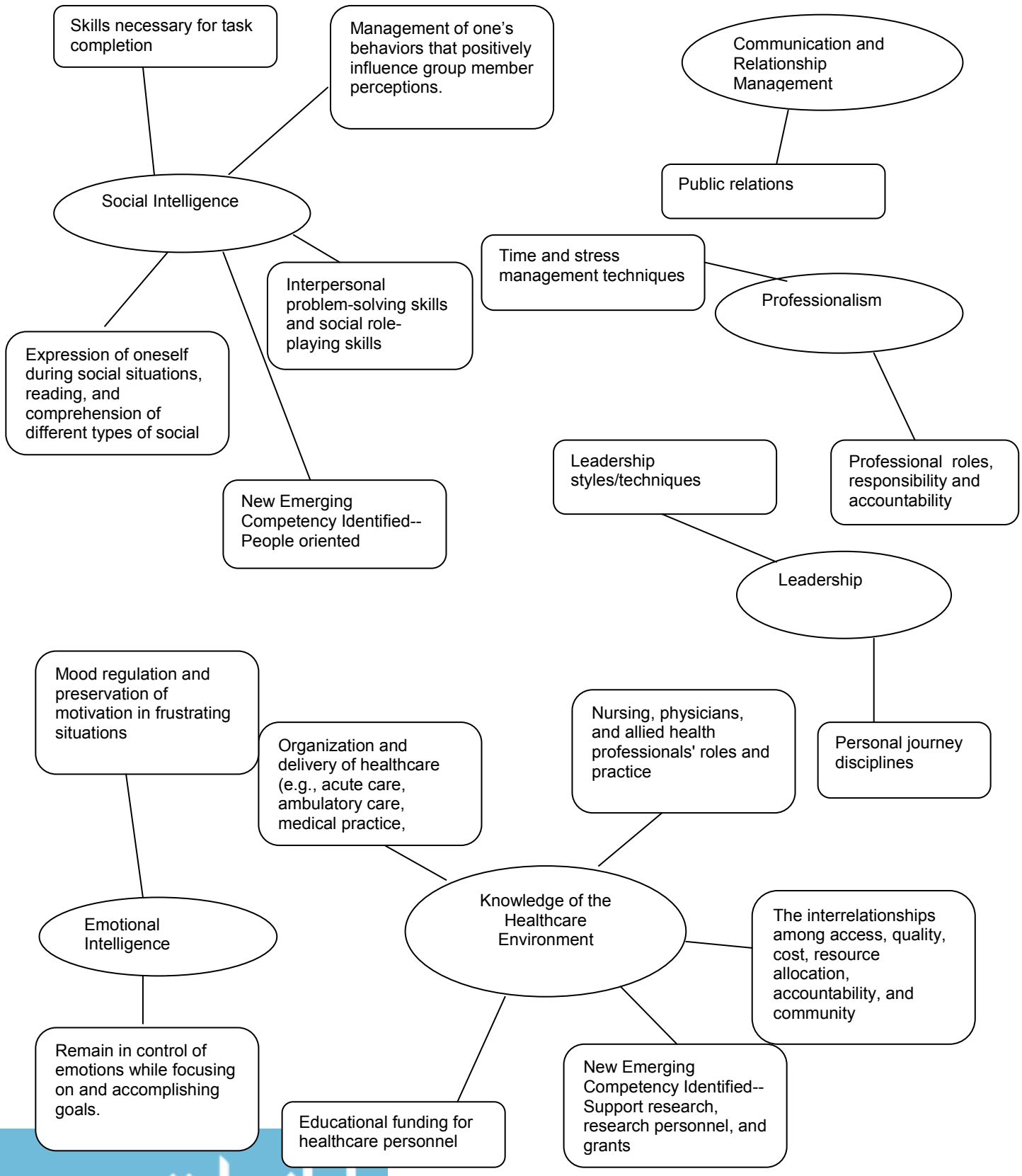
Core Theme	Related Competency	Textual Descriptors	Interview Question
Communication and Relationship Management			
	Public relations	I had an idea about 15, 16, 17 years ago and pitched an idea to the college of growing, of community hospital based practice.	IQ5
Leadership			
	Leadership styles/techniques	I think you can enhance people's careers by just pulling them and moving them and teaching them different skills and then watching them grow.	IQ10
	Personal journey disciplines	number 1 department [excellence]	IQ2
	Personal journey disciplines	I see [the ability to get and retain grant funding, make the biggest profit for the College of Medicine, and be a desirable location for residency education] as the leadership role because people come to our department and they want to know how are we doing it.	IQ2
Professionalism			

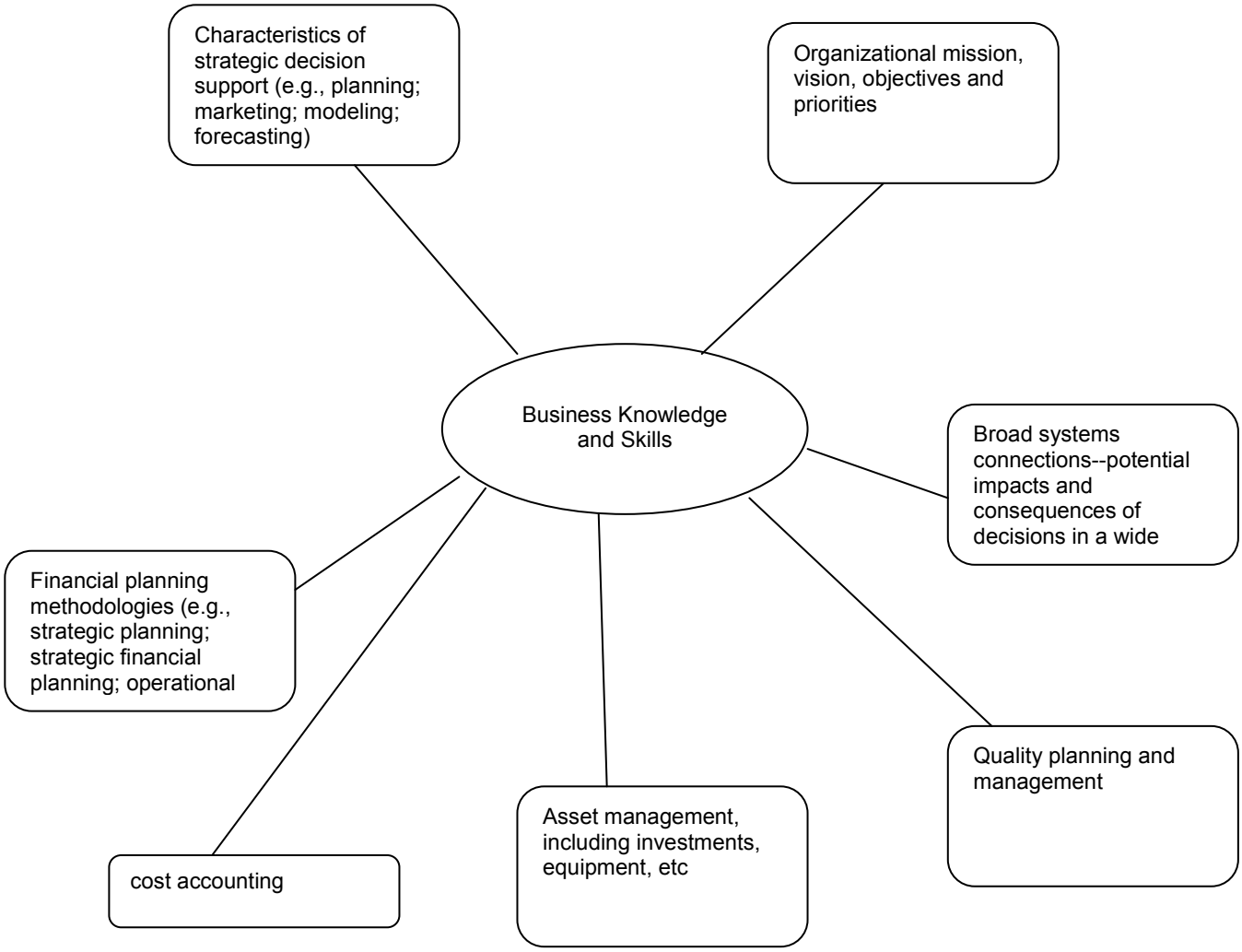
	Professional roles, responsibility and accountability	working with your chairman or chairwoman and understanding what their vision is of the department and how they want to grow it and change it and make it better and improve it and working with them in kind of a joint leadership arrangement.	IQ1
	Time and stress management techniques	good time management skills	IQ10
Knowledge of the Healthcare Environment			
	Nursing, physicians, and allied health professionals' roles and practice	developing who are the personalities and how did they fit together	IQ1
	Organization and delivery of healthcare (e.g., acute care, ambulatory care, medical practice, ancillary services)	the leadership role in the department is trying to find people that are interested in fulfilling each one of the academic missions and hopefully you'll find somebody who also fulfills the third mission, research.	IQ1
	The interrelationships among access, quality, cost, resource allocation, accountability, and community	I pitched an idea to create a community hospital-based practice and now we have 29 community hospitals where we have good general and sub-specialty [physicians] out in the community	IQ5
	Educational funding for healthcare personnel	How the residency slots are funded	IQ7
	New Emerging Competency Identified--Support research, research personnel, and grants	how the grant funding works	IQ7
Business Knowledge and Skills			
	Organizational mission, vision, objectives and priorities	you have to understand how all the missions of an academic department at a medical school or college are intertwined.	IQ1
	Characteristics of strategic decision support (e.g., planning; marketing; modeling; forecasting)	recruit the right kind of faculty that can not only provide the teaching so you can attract the best students but then those faculty also have to, they might be doing undergraduate medical education, but they're also potentially doing graduate medical education and then they're providing, in many cases the same faculty, clinical service at a hospital.	IQ1
	Broad systems connections--potential impacts and consequences of decisions in a wide variety of situations both internal and external	we have managed to make the most money for the college, the most surplus.	IQ2
	Organizational mission, vision, objectives and priorities	being a medical school, the primary educational duty is to teach the undergraduate medical students	IQ3
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	we have ...6 or 7 committees that we pull together every month and we talk about the teaching and who's going to be teaching what courses, and do we have the right people in the right places. What were their course evaluations for the last year, were they well received by the students or would there be a better spot?	IQ3
	Comparative analysis strategies (e.g., indicators; benchmarks; systems; performance)	we have ...6 or 7 committees that we pull together every month and we talk about the teaching and who's going to be teaching what courses, and do we have the right people in the right places. What were their course evaluations for the last year, were they well received by the students or	

		would there be a better spot?	
	Quality planning and management	I see the primary research duty as recruiting the right faculty	IQ4
	Asset management, including investments, equipment, etc	invest [money] in our research enterprise	IQ4
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	good financial skills	IQ7
	Financial planning methodologies (e.g., strategic planning; strategic financial planning; operational planning; budgeting; capital budgeting)	a basic understanding and knowledge of finances, financial performance, financial spreadsheets	IQ9
	cost accounting	a little bit of accounting	IQ10
Emotional Intelligence			
	Remain in control of emotions while focusing on and accomplishing goals.	Someone that can triage lots of different things and keep reprioritizing throughout a day or throughout a week	IQ7
	Remain in control of emotions while focusing on and accomplishing goals.	I think somebody has to be relatively calm because there's just so much, so many interruptions that happen throughout a day	IQ8
	Mood regulation and preservation of motivation in frustrating situations	you just have to be able to have a lot hit you	IQ8
Social Intelligence			
	Interpersonal problem-solving skills and social role-playing skills	working with them and listening to what their interests are	IQ4
	Skills necessary for task completion	I think somebody has to be able to handle lots of different things at a time because you can be working on one agreement with a doctor or with a hospital and you could get interrupted and you might have to take a residency question or you might…	IQ7
	Interpersonal problem-solving skills and social role-playing skills	able to deal with lots of different types of people	IQ7
	Management of one's behaviors that positively influence group member perceptions.	It's not all good news all the time, so how can you take it and triage everything that comes at you and still have a positive attitude when you're walking down the hall, no matter what person you run in to.	IQ8
	Expression of oneself during social situations, reading, and comprehension of different types of social situations.	somebody that can really fit in almost any type of social situation.	IQ9
	Skills necessary for task completion	Good organizational skills	IQ10
	New Emerging Competency Identified--People oriented	good people skills.	IQ10

Figure K10

Flow Chart of Competencies Expressed by P26





APPENDIX L: INDIVIDUAL PARTICIPANT INTERVIEWS

P02 Interview

1. How do you perceive your leadership role within the department?

My theory on this is that, as an equal partner with some of the more senior faculty members. I think the business of medicine is truly that, a business these days, it's not a… Just like we have a director of clinical affairs, director of education affairs and research, I think you have, you need a director of business affairs or finances or however you want to phrase it. I look at is being an equal partner with the senior leadership. In my perfect world, you have the chair and then you have maybe 4 people at an equal level who would share the responsibilities for the 4 main missions or maybe 5. Research, education, clinical, service I'm not too sure, you know, that's a little different, then admin would be the other one is the view I take and the responsibility I take.

2. What do you perceive as your leadership role within the administration of the academic medical center?

Well I'll address that specifically for my position in the sense that we're fairly active in the clinical operating room, inpatient environment. Not only that we manage the day to day operations at the outpatient surgery center and we have fairly substantial influence at the children's surgical center, which was Ayers before. Having said that, I think that gives us a little bit more engagement or involvement in the operations of the main inpatient facility. Unlike maybe something, like, say, dermatology that practices primarily in a clinic. We have no clinics and so we have very little influence in that environment but much more in the inpatient, primarily or in the surgical theatre and I guess my involvement there is to try to make sure that we have the right mix of providers and by that I mean the right mix is not only right aggregate number but you have to have the right people on the right days. For instance, if I have a

cardiovascular guy show up on Tuesday and none of them on Wednesday, we have a problem, so I spend a good bit of my time doing long range planning and recruiting or at least saying we need to recruit somebody cause Bob's leaving in December and we need two more pediatric anesthesiologists, that type of thing. I think there we do get very involved in that, in the operations of the inpatient surgical arena.

3. What do you perceive as your leadership duties to the educational mission of the organization and department?

Not much. Ok, um, you know, we have a pretty set education environment. We have a didactic session every morning that starts are 6:30 in the morning. I'm really not involved in that; I lecture about 4 or 5 times a year on the business of anesthesia, whether it's the billing basics for the new guys coming in or some of the other things, um, so besides that 4-5 time a year, I really don't get that involved in it. We don't spend a, my activities are driven by money, and we don't spend a lot of money on education in the sense that we do most of it in real time while we're there taking care of the patient, having this morning session is relatively inexpensive. You know we do tape it, we do send it to our two outpatient areas and to the VA hospital so our residents that are rotating. Once we invest in the infrastructure for that, it's really not all that expensive. We do have a visiting professor program, I do get involved, very limited, in trying raise some money for that so we can bring in folks from around the country, experts. That's all part of the education. Um, we obviously try to motivate our residents and fellows especially try to do some national presentations, so that's a little bit along the educational line but in the big scheme of things, I would say it's probably 5% my time and effort.

4. What do you perceive as your leadership duties to the research mission of the organization and department?

Research I think is very important and research right now makes up about 5-6% of our total budget, so it's not much. It's maybe $2million or $2.5million depending on what we get in the next couple of months but it's very important because, um, if we have to assign people, if people get research money, we have to take them out of the clinical environment and so that's doubly expensive. One, I'm paying the person I'm taking out and two; I have to pay somebody to be there, so we have got to watch that. I think we're in an environment in academic medicine where sometimes it's very important to separate fact from fiction. In other words, it's, I'm very happy and very proud that doc x got a grant, I can't do anything until we get the NOA, until it gets here; Oh, by the way, he didn't really get a grant but somebody in that company said they thought maybe they could fund it. So again, it's that's important. I think the other important part of my role in research is to make sure we are following policies and procedures whether they be federal or the state or an organization and funding agency. As you know, there are certain things that are not allowed in certain granting agencies so I try to guide, especially some of the young researchers. The other thing I think, an important role is to help them develop a budget, a realistic budget so they have an opportunity to get the grant. You know,vetting these applications and everything I think sometimes we actually as a department we vastly back and forth, from somebody asking not enough to do the work, because they think, "oh, good. If I ask for $25,000, I'll get it." When they need $35,000 to do it. So I try to correct that. Then we have the other side of the coin where they ask for $50,000 even though they only need $35,000 and I say, you know, how are you going to justify $5,000 in travel in 1 year and you don't even have anything to present. I think that's an important part of it, following the policies and procedures and if you think about it, 2million, 2.5 million dollar enterprise is, it needs some attention to make sure that we are not going in the wrong direction. I've also said and I'll, the end on this one is that

probably for every dollar we get in on research money extramurally, we spend a dollar from the dept or the organization, so the 2 mil becomes 4 mil or 4.5 mil. So it's an important enterprise. It needs an eyeball on it.

5. What do you perceive as your leadership duties to the clinical mission of the organization and department?

Well, you know, as I've already stated, if for instance the research dynamic, you take somebody out of a clinical enterprise, you have to backfill, the same with education. If we do all day seminars, which we usually do when we get our brand new residents, they're obviously are not ready to undertake a lot of clinical work. We do simulation and stuff like that, so this is probably the biggest mission the biggest and responsibility I have is in the clinical arena, which is what you'd expect from a department that's hospital based that's very engaged in clinical work. If you take out the research component, which I feel we wouldn't spend the money if we didn't have the research, about 97% of our dollars come from the clinical environment. Obviously, that's very important. For us, salaries are basically our clinical work is driven by labor and labor translates to salaries, which are very expensive, which we have to be good managers of the expenditures, etc… so um I think the other thing is to look at when you think about budgets and new enterprises for instance, one of the things that the anesthesia world does is they often times get involved in critical care. That's a bit side-service, that's more like a medical service. What is that going to yield? In other words, how many, if we do a lot of modeling, like how many beds do we need to take care of to cover the workload. The same with pain, pain's a big component of anesthesiology and you can run it in a clinic environment or you can run it on an inpatient hospital environment, two different types of it. My job from what I perceive is to model those things so that I can give the chair insight, is it worth engaging in this

kind of business. Now, having said that, we do things in the clinical arena that are not financially sustainable but we do it because we have to educate, so there's also this mixing of pure business outcomes versus what our teaching and education mission is. I kind of go back and forth there but kind of into your question, in the clinical environment, it's kind of looking at making sure we're staff correctly because all we are is facilitators, we don't generate business, we facilitate the ability for others to do new business and then, is, so you have to have the right mix of people and then we need to do some long term planning because when you have 65-70 clinicians, you have a constant coming and going. Some leaving, some retiring, some moving, promoting to other places, etc… So, it's, I keep my hand on that wheel a lot.

6. What do you perceive as your role as business manager in the operation of a clinical practice?

Well kind of what I just said. I mean, first of all, I think as I think about it the first thing I look at from the clinical business perspective would be the monthly results of what we did. How much did we bill how much did we bring in and I'm maybe a little different than some of my colleagues. I'm not wedded strictly to monthly, I'm more of a year to date guy. I want to see trends and I want to see, well, six months have gone by, we're 5% behind. That means we've got to do 55% of the business with 50% of the time of the year. Not necessarily, gee December was a wonderful month but the other 5 months were terrible. You need to… so I think the first part, the business part of a clinical enterprise is the kind of the return on our investment or on our labor and that's the revenue cycle and it's kind of appropriately named because I do the same things every month. In that, we then break down various business units within the anesthesia whole and look at what we're doing. Are we doing more cardiovascular cases or are we doing more OB, are we doing more peds, all of those have to go into the mix. Again, as I just said in the last question, a lot of the time and effort that I see myself in the clinical arena is doing staffing or projecting for

staff and the other thing which I failed to mention which is a big component right now for this department is that we've gone to a staffing model of what we call an anesthesia care team, where we now have about 40 CRNA's. We used to be completely resident based in terms of extenders and now we have a combo of, any day in the OR, we have actually gone the other way. We have about 40 CRNA's and 26, 27 residents there so to cover the aggregate about 50 rooms or 50 locations is a better way of putting it so that's kind of changes. The recruiting and the retention of these folks is a little different. Residents come here and expect to do3, 4 or 5 years in training, you pretty much point them in the direction and its hands off. Managing 40-50 nurses is a little different, so and you know they're more of an employee where residents are more of a trainee obviously and the management needs are different in that environment

7. If you were interviewing someone for your position what knowledge, skills and abilities would you look for?

I think I would like to say I would look for the bright eyes. I want to see enthusiasm in any level of recruiting. I think that if the person is qualified on paper and that our job is to narrow the position down so that we get a good description of what we want. If they're qualified most likely they have the skills set so then I would look for like I said enthusiasm, I think the ability to communicate well I think the obviously writing, written communication but that's kind of hard to tell in an interview but sometimes you can tell from the cover letters you get or how the CV or the bibliography or the resume is constructed. Again I think enthusiasm is a big thing I'm going to step out and say that people are coming and interviewing for the position with certain skill sets already that somebody has vetted that so um probably the next thing would be the be current in terms of what academic medicine is doing. At least have a good idea about that also be current about your labor pool. I think that's one of the big things that we are faced with

as we go forward lifestyle dictates more than work style. Some of the older folks kind of grew up in that environment and that applies I think not only to our professional staff, our nurses, our physicians our teachers, etc…but also to support staff and the research staff. So I think you want somebody who is somewhat in tune I think that if they coming from or having the experience in an academic medical center is probably a number 2. Being enthusiastic number 1 and maybe having some experience in this environment given that I assume they come with the toolbox that they can do word processing and understand spreadsheets and kind of MBA type stuff .

8. If you were interviewing someone for your position what emotional skills would you look for?

Well I guess enthusiasm is an emotional skill. I think level-headedness I you know we work in a dynamic environment and often times under pressure so maybe some of that is self-generated but I think that some of that is internally, or externally I should say, deadlines etc…I would look for somebody who has enough confidence in themselves that they don't get all that flustered by that. That they can keep their focus on the task at hand and not being overwhelmed by the task at hand. Kind of like the catch 22 and chasing your tail instead of actually getting production because at the end of the day I think the people we answer to are expecting a certain amount of production. How we do that, whether we do it in by amassing data from the people underneath us or we do a lot of thought process ourselves, they really don't care but they want to product to deliver, so

9. If you were interviewing someone for your position what social skills would you look for?

I kind of I saw that question I'm not sure, you know its kind like how do you build the perfect beast. I don't know, it's a good question. Can we differentiate between social and emotional? Probably not because I would think emotional drives it gives your social signature, if you will. If you're a high strung, loud and boisterous and stuff like that versus the low-key

person, I guess the big thing would be is to be able to be engaged at all levels. That the full professor who's been here 20 years should be treated no differently than the new trainee you're bringing in or the person who's doing an internship over the summer. I mean, they all have value and our emotional or social ability ought to be to draw that value out and try to help regardless, you know the mentoring type thing.

10. What competencies are essential for effective leadership of an academic medical center clinical department administrator?

Um, I think maybe one of the most essential one is the ability to listen and to have patience. You may know the answer but you may have to wait a while until the person finishes the question or the statement. We have, one of the things that makes things enjoyable to work in this environment is we work with a lot of bright people. A lot of these bright people have a, shall we say, a bias. There's nothing wrong with that, I have a bias I'd like to see more operations being done. Somebody in the clinic may want to see better parking for the clinic, I, you know. So what I have to do if I'm working with colleges is to kind of put myself in their place and at least listen fairly to their statements and their desires and their needs. And vise-a vie they should do the same for me or at least try to, I don't want to be corny and to say to walk in someone's shoes but at least look because we have to much so many competing interests within the one confine of the building if you want to call it that that I think that skill you need is a little bit of patience to listen, understanding of other peoples position, you can't be shy or you'll get run over I think in this environment but that doesn't mean that you have to, certainly that doesn't mean that you have to be obnoxious and rude cause we have enough of those folks sometimes. And I think some of that's old school. I think some of the, I think some of the newer leaders that we have understand it's a business and we really are in it for the long run and want to try to improve.

They look at it, I look at it as anesthesia's my little cottage industry here and so yes, I'm going to protect it and think of it first but then I need to also think of the other dynamics at work in this environment that we're in and try to see if I can actually help others to succeed. Because usually if they succeed, then we're going to succeed so there's that connected centered focus that one has to have to be sure the thing works. That's what I would say.

P04 Interview

1. How do you perceive your leadership role within the department?

It's changed over time and I've been with the department since before it was a department. It was a division that was very fletching and not highly functional. When I got here it was part of anesthesiology, which is highly unusual in the specialty and so in the time that I've been involved in emergency medicine here, the role has changed and so for better and worse, I'm somewhat of an institutional library to this department. And so my role has transitioned from simply kind of establishing process and procedure and policy to an extent to now really assisting the chair as a member of the senior leadership team and thinking in terms both operationally and trying to be mindful of details and working with staff but also trying to think strategically, think ahead and really get a view of what where we should be going, what are the trends in healthcare and emergency medicine in particular, locally and nationally and then make sure I'm on the same page with the chair and at least understand where our differences are.

2. What do you perceive as your leadership role within the administration of the academic medical center?

That is also changing but much, much more modestly, so what I think that have done is over time I've either become less concerned with appearances or just old enough to not give a damn as much, so I will certainly offer opinions and suggestions if I see things on a more macro

level that could affect the college and try to assist there. But I've also participated in some of the programs that have been introduced the past couple of years as opportunities to, perhaps you could define it as exercises in leadership. So for instance, I've participated in both cycles of the mentoring program at the college has introduced. I've participated in all the management book clubs that have been offered. Just opportunities like that to be present to lend a hand and hopefully make some of that voice that we were just talking about that isn't there a regular part of the staff, help communicate that.

3. What do you perceive as your leadership duties to the educational mission of the organization and department?

Probably easier to answer again on the department level and then to the extent that that manifests out to the organization. I guess it does for the department again because it started as a division with virtually no role in the education mission and then grew slowly that we developed a mandatory 4-th year student clerkship and then evolve to now where we have our own Gainesville base residency program that began about 6 years ago – we'll graduate our 3rd class this year. So I was very intricately involved in a lot of that set- up and helping just to administer the process and get the stuff out the door and some of that kind of stuff. I won't claim that I helped author, just you know the detail work that goes into organizing those things and getting them out the door, so hiring the staff. We had no program coordinator; we had no clerkship coordinator, so getting those things actually established was a key point. As our faculty have expanded and assumed the roles of program directors, associate directors, we have our coordinator in place now for several years, my role is more tangential. I think I perceive the educational functions in the department as almost not a separate entity per say, but they have very much their own agendas, their own directives, they have to follow from external

organizations like the accrediting bodies, so I'm involved in seeing how the education functions fit with the rest of the department.

4. What do you perceive as your leadership duties to the research mission of the organization and department?

Research is probably our least well developed mission, but it has come a long way as well. And that, right now, as of today is probably also in a very unstable situation. We've had some excellent leadership and personnel that we've hired but the roles are changing so right now I see my role as helping very much to lead the development of the critical research infrastructure we'll need to continue to grow that effort and grow the number of contracts and grants that we have as well as to establish, really fundamentally what our policies and procedures for administering our research mission are, so that's a lot of where the leadership focus is as well as provide a lot council to the chair. We have a lot of very involved discussions about how proceed there.

5. What do you perceive as your leadership duties to the clinical mission of the organization and department?

That is something again that has evolved over time and as with a lot of the clinical spaces in this organization, the alignment and facile working relationships between the hospital staff and the medical staff in the emergency department have often been incongruent and incompatible, frankly. As so over time, that has attenuated a lot. There's been a coming together and so my involvement has grown and I now attend a weekly emergency department operations meeting where there's just a constant review of the real clinical policies and procedures and issues that have come up and getting more involved. And I really foresee a good chance that the model we were talking about earlier in terms of the department admin and chairs having a direct

administrative responsibility for the clinic area; I just think it's a matter of time before someone sees that as a similar model to be applied to the emergency department, so helping to bridge the hospital perspective in the clinical arena and with the medical staff. My background, I was trained and started my career as a hospital administrator in another academic center and I had received the report of my counterpart at that institution, so I have worked early in my career from the hospital administration perspective, specifically in emergency department and now I've been working for many years with the medical staff and so I kind of see the opportunity to understand at least those mindsets and try to help bring them together to the degree that I can.

6.What do you perceive as your role as business manager in the operation of a clinical practice?

It's very limited so far. There has been limited degree of influence that I could truly affect over the real expense and revenue cycles for the hospital component of the emergency department. That said, as we both know, the physician influence over hospital expenditures and revenues is tremendous and probably 70-80% of expenditures are physician driven through orders and other behavior, so that extent, very mindful of those things. We've been encouraging a look at the emergency medicine, emergency department service line so you could really look at the whole spectrum of not a physician and separate hospital component but they are truly integrated. They function together so I have spent a lot of time thinking about these things, discussing these things with my chair and getting that orientation and then to the extent that we can have been, we again started with nothing so I've established all of the accounting procedures, actually created two different accounting systems that we've evolved to for this department and very heavily, heavily involved in trying to examine, analyze, learn and enhance the revenue cycle management.

7. If you were interviewing someone for your position what knowledge, skills and abilities would you look for?

Probably the intelligence that that person would run as fast as they could. Probably first, the sense of commitment or passion. You have to have some desire, drive to want to be in a setting like this. Just as we were taking earlier about our faculty having opportunity in other settings, we without backgrounds, or least mine, I'm pretty certain I could go elsewhere, even outside of academia perhaps. So, you have to want to be in academic medicine and you have to want to probably have some at least interest in, if not a real affinity, for specialty you're working in. I think one thing I've really learned is that while you can kind of be just a general administrator, I've known people who have worked in different specialties like you but I think you'll probably know better than I that if you don't really have an interest in urology, in your case, even though you working in medicine, you have to have some interest in what your faculty are doing and what the missions of the department are so I would look for that. Then I would look for a good amount of technical skill set in terms of, my, I'd suggest at least master's degree training and so that they understand that level of management and the kind of the technical and analytical skills and an ability to really, you know, we have to multitask so much and you have to be able to just cover the spectrum, even in the span of a day from some very mundane kinds of duties to even you know, thinking strategically. So I think that about covers it in terms of the types of things I look for. So to summarize, it'd be a desire to truly be doing this job, some understanding of what it is they're doing, some professional level training and hopefully experience and the ability to work both in a detailed work environment as well as thinking more locally and more of a macro level.

8. If you were interviewing someone for your position what emotional skills would you look for?

Probably first and foremost, somebody that can differentiate professional or job-related things from personal. I don't mean balancing work and outside life issues although that's also important. But as I've hopefully matured, one thing that I have recognized is that I think especially in men, we have so much of our identity tied to our jobs and our titles and if you don't recognize that phenomenon and you get caught up in the things that happen. For instance, as an example, if you own too much, the finances of your department and you are concerned whether your department is going to receive it's fair share of the resources of the college and what the faculty will be eligible for certain year end incentives, that really is there's a line where our responsibilities and our abilities to influence stops and whether those things happen really isn't of our concern after we've done our job to try to prove the information and analysis that will assist the chair in making whatever arguments they need to but I know a lot of times, I in the past, and my colleagues will get very caught up in those types of things so I would look for that ability for someone to emotionally differentiate and to maintain a perspective to be able to passionate about their work involved but to maintain a healthy perspective.

9. If you were interviewing someone for your position what social skills would you look for?

They'd have to have communication skills which you know it's almost cliché at this point but its critical both for verbal and written they need to be able to communicate intelligently, articulately and effectively. They need to be able to especially, in the specialty I work with, I say it somewhat sarcastically, but I really do believe truly that there is match between emergency medicine and folks who tend toward difficulties with attention and you need to be able to appreciate that. The medical staff that you're working with is not trained nor oriented in an administrative mindset, so you need to get your points made clearly, empirically if possible and try to appreciate that that's what is a key part of the job, so communication is a huge part. And I

guess the other social skills would be to, there's a fine balance. I think you've probably seen this over and over again in your job, too where hospital administrators, especially I know in my training, and I've heard many admissions over the years they view physicians as a stereotype group. They tend to paint them with a broad brushstroke and in our job, I think we need to always be mindful of tolerance and appreciation for the medical staff we work with as people and as family members and those types of things but lines can be crossed so they need to also be reminded of those things, if they do actually misbehave.

10. What competencies are essential for effective leadership of an academic medical center clinical department administrator?

Hopefully I've touched on many of them and as again we were talking before the formal interview started and in mentoring some people, I have at an earlier stage thought that professional credentials were important and so did pursue and receive the American College of Medical Practice Executives certification and they have identified what I still believe is a very good list of credentials. That's a little bit of a copout but there are some key competencies that they would look at in terms of, again, leadership skills, management basics like understanding basic software programs, understanding how to do some data analysis, understanding your governing structures, understanding some IT types of aspects of the job so I refer really to the ACMPE standards as kind of, I believe that is a good guide for the competencies that someone managing any kind of medical practice would need. In an academic health center, it helps also really I think to appreciate that despite the stresses, the strains, and changes in resource allocation, there are three missions and we are not simply patient care enterprise, we're not simply the training enterprise but research is critical and I think it is important for those of us in administration to understand that. Last thing I guess that I would look for across some of these

questions is, “what is the person’s general orientation?” Now, I’ve tried to cling to an ideal that we only are employed because of the faculty and the trainees that are here. And we are here really to provide a service to facilitate those fundamental missions. I think too often administration turns that upside down and they believe that the medical staff and students and the residents are at their behest and I don’t think it’s quite an accurate perspective, so.

P10 Interview

1. How do you perceive your leadership role within the department?

Leadership role – Serve as a resource, facilitator and decision making party supporting all faculty and staff to the best of my abilities on key operational, financial, research administrative issues and initiatives.

2. What do you perceive as your leadership role within the administration of the academic medical center?

Well, an academic medical center is a complex hierarchical organization that is at the department administrator role and then in that scale is to balance the core missions of the academic department within the college of medicine. So, the core mission to patient care research, education, research and philanthropy are the things that come to mind, so for me, patient care will cross pollinate with the university hospital and our overarching patient care mission. The teaching, the residency, the educating of fellows and the philanthropy role would be obviously philanthropic and then research. Those four core missions I believe that the administrator has a role in each one of those to various degrees as it pertains to the academic medical center as a whole.

3. What do you perceive as your leadership duties to the educational mission of the organization and department?

Well that's a great question. I am, from a leadership standpoint, with the education mission is to make sure we procure the highest quality medical students into our residency program, that we abide by the rules of the work hours and we provide the resources for the residents to have the most fruitful and rewarding and educational experience they can during their tenure of the residency. Same thing for our fellows, who come in for a year of intensive focus training, that we make sure that we, the training the next generation of physicians, in this case in orthopedic surgery is fulfilled. So to whatever degree that it's appropriate, that I can have a role in helping with that, the residency coordinator reports to me, we are involved in the match. I also gather philanthropic funds to do unique things like, every incoming resident gets an ipad from us and they will keep it and take in on with them, beyond the completion of their training. So, those are the first things that come to mind.

4. What do you perceive as your leadership duties to the research mission of the organization and department?

Those are our less, not less but my role is leadership in that is to make sure we do our best to become a research center of excellence. But to be honest with you, we have a dedicated research administrator, who I work in tandem with and really I view my role as a support mechanism for her to advance research throughout the department and institute. But it's much less than the other areas.

5. What do you perceive as your leadership duties to the clinical mission of the organization and department?

I may have answered your question in question 2 and so we, these next two or three questions are re-hashing those and that is the perception leadership duties to the clinical mission. Well, as I was sharing with you, I believe that a department administrator has a varied role in

each of those four core areas and I'll use the ball analogy to patient care, balance research, teaching and philanthropy. I think it's fair and I hope you'd agree with me that patient care is the biggest ball in that but if the ball becomes too big and over takes over the other missions then we've become a private practice offering without fulfilling our other obligations. So regarding the clinical mission, It is to make sure that we have department in our subspecialties and that we have good access and that we provide evidence based medicine, really the best, you know the latest and best _____, treatments and care that we can provide to our core community, our core service area, which in this case is a tertiary group. It can be as broad as half of the US several counties around us.

6. What do you perceive as your role as business manager in the operation of a clinical practice?

Well there is the operation budget that can be challenging to both plan for on a fiscal year and also the challenge of fulfilling that obligation, meaning that budget and I think the bus man role is really making sure that the financial resources are there to meet our year to year goals on our operational budget and then our capital goals on our long term objective and those can be naming of professorships, preserve time for researchers and how to fund that. And new equipment, what have you, depending. As a business manager I perceive my role to I think I have a very important role in that regard and ultimately the buck starts and stops with the department administrator.

7. If you were interviewing someone for your position what knowledge, skills and abilities would you look for?

Great hair. I would look for I believe there's a balance between being very tactically strong admin and also having good human skills and so I've been I would try to find somebody who is knowledgeable but also has good interpersonal skills. I find that administrators sometime

think excel in one or the other. Either they're good in interpersonal skills and fostering a trusting environment and the faculty like him or her and they're very popular with the staff, but they may be weaker technically and not be well-versed in the revenue cycle, human resources regulations, the regulations that might go with the accounting system of that organization in our case, you is PeopleSoft. Then I find individuals who are technically very strong but bury themselves in the office and never are engaged with the residents and the faculty and the staff and thus don't have the deeper relationship. So if I was interviewing someone for my position, I would look for somebody who has balance in those two skills sets. Personality that would be reflective of those things I already reference to you and validation of some department of technical knowhow.

8. If you were interviewing someone for your position what emotional skills would you look for?

I think the first thing that comes to mind with emotional skills is I've often said that the administrator's office is like the priests quarter. It is the lawyer's room and so with that comes a certain amount of accountability and trust. You have to be able to listen and not pass judgment right away. Listen to what the issue is, there is always two sides in an argument or in a problem. And so the emotional skills is sense of maturity, discretion, trustworthiness, great listening skills and high ethics

9. If you were interviewing someone for your position what social skills would you look for?

Again, I think I may have answered this partially in question 7 and that is the two biggest attributes we're looking for and somebody in my role would be one of my peers in another department would be for them to not be socially inept. For that to be, they don't necessarily have to be charismatic, you know the shining star, often we would like the chair of the department and individual faculty to be that role. I think they have to be trustworthy and visible and socially engaging. And there's a skill set that goes with it. The interest level of one the housekeepers for

social conversation versus one of the surgeons reciprocally might find it easier to talk to the housekeeper than the surgeon, might find it easier to talk to the surgeon than the housekeeper. I think a good administrator learns how to engage both of them.

10. What competencies are essential for effective leadership of an academic medical center clinical department administrator?

What competencies? The academic medical center, I'm going to say to you is a complex and this is my 4th academic medical center I've been at and there are basic structures that are the same. But there is a lot of differences and so the competencies are an academic leader at an academic medical center are a knowledge of the complexities of what makes an academic medical center unique versus a private hospital. The education requirements as a part of the educational mission some validation of technical competencies. In our industry, that's often validated with a certification from a medical group management association, a certification from the American College of Healthcare Associates or ambulatory surgery center administration certification. So there is quite an array of certifications out there. I would submit that that would provide validation of competency at a certain level. But I think I can probably reference my feedback to you on the prior questions. An effective leader would balance technical skills with a good personality to listen, be a facilitator and a resource. That changes from day to day.

P12 Interview

1. How do you perceive your leadership role within the department?

Um, with the leadership in an academic center I think is always changing. I see my role as helping facilitate whatever the mission is of the department. And you know we have the three general missions of education, research, and clinical but then we also have little projects at each of those and so when we have a project such as ours, we have an outreach lab here, I get right

involved in that. When there's a personnel issue that's not directly reporting to me, I get involved in that as well. So, I think leadership in academic medicine kind of encompasses the entire whatever's happening in the department or even in the college, getting in there and representing the department's best interest.

2. What do you perceive as your leadership role within the administration of the academic medical center?

I think it's an influx right now; there's been some changes as far as structure and integrating departmental administrators into group practice more, which I think is long overdue. We're probably decades behind other academic health centers in that. Beyond that, there's also mentoring programs here which I've been involved in so I think there's definitely a leadership role that each departmental administrator takes. I fell that in my role I'm a little, well, first I'm new and pathology has been here less than two years. And I'm a good but younger than a lot of my colleagues, so I don't take the lead in those meetings as much, but one-on-one I think I'm good report with a number of them.

3. What do you perceive as your leadership duties to the educational mission of the organization and department?

Well I think in academic medical centers, education tends to be the lowest on the totem pole of the three missions, and it's unfortunate but it's because there's not a whole lot of money in education. I don't have as much involvement in that mission as the others, mostly that's faculty driven. There've been kind of the, my role in that is helping it run smoothly, just like I help the rest of the department run smoothly. Make sure they have the equipment they need, the personnel the need, when there's conflicts help resolve the, those types of things. Well, we haven't really had a comprehensive education survey done of our hours in a number of years. We

used to do that every year here at UF but that's been broken and it's still broken, so no, I don't get involved in that because I'm not sure that is really happening at any level. If it has to do with getting the course into the registrar's office, those types of things, that's done either at the faculty or we have a staff member that handles that for us. No direct involvement.

4. What do you perceive as your leadership duties to the research mission of the organization and department?

Well, one of my main duties is for the financial health of the organization and that relates heavily to research. We have to fund research, it doesn't fund itself. So, from a leadership prospective in a department, we need to plan for when we will have funding and when we won't have funding. Keep end dates for grants firmly in mind, have a conversation with our PI's about their research programs, the health of their research programs, what's available to them as far as bridge funding when necessary, managing their accounts, so there's quite a bit of leadership in that realm, because it's, it also, in these different missions, education changes the least. Grants and clinical work change the most, and so where there's change, there's definitely a need for more leadership, so that certainly comes into play. Beyond that, there's also the general management of the grants staff, uh the administrative staff that needs to be in place.

5. What do you perceive as your leadership duties to the clinical mission of the organization and department?

Well, it's um it's probably the most complex of the three areas as an administrator; you need to understand the business from a purely clinical standpoint understand the politics from a faculty standpoint and uh, help the chair navigate those areas effectively. Beyond that, constantly watching to make sure that the clinical work is getting billed correctly, watching you're A/R and keeping your fingers on the pulse of that. In research grants, you have an end date for the grant

and you can circle on your calendar, but in clinical realm, every day is different and we have a very large outreach program that I'm involved in quite a bit, that can change on a day to day basis and can be a 500,000 a year swing if you either land a new client or lose a client, so it's a higher, there's higher variability and it's also I think, that's where there are fewer people available to really assist in that strategic planning and management. We have people who perform the clinical work, but the actual planning and evaluation of the work, of the business plan, there are not a lot of people out there that do that. On the research side, we have grants administrators who can say, all right well, "this grant that we're putting forth, we want to have 30% of a PI's salary on this, plus we're going to have to cover any salary over the cap." So you can have a staff member who can really evaluate the grants without any supervision and on the clinical side, I think there's a big gap there, that the administrator of the department is pretty much the responsible party for that.

6. What do you perceive as your role as business manager in the operation of a clinical practice?

Um, I don't see myself as the business manager. I think that's, it's more speaking to the people and more coordinating the people that are the business managers of their little areas. We have a lab, an outreach lab, has a manager there, making sure that that manager is managing that lab effectively from a personnel standpoint, from a fiscal standpoint and coordinating those efforts with our other areas. That's how I see the role; it's not on the day to day operations as much as it is the overall picture and coordination.

7. If you were interviewing someone for your position what knowledge, skills and abilities would you look for?

Um, in this area, I've always approached those leadership roles in that you have to have one or two of about 3 things. You need to have managerial experience, you need to have clinical

experience, or you need to have research experience. You have to have two of those three. And you also need to have the skills that are hard to quantify. The ability to dissemble situation and read the mood of the faculty and the staff and help maneuver through what can sometimes be, with the wrong words, a very volatile situation. With the right words and the right presence, you can come to a pretty quick and not always easy but at least acceptable solution to problems. Out of the three things I think are the most important, the research, clinical or management, I think, you can learn research fairly quickly. If you don't have it, you don't really need. At the director level, you really do need to have the other two. You really need to understand clinical practice and understand management at a fairly high level. Now, with that said, I don't think you need to have experience in that particular specialty.

8. If you were interviewing someone for your position what emotional skills would you look for?

I would try to evaluate the person's ability to stay calm under stress and under, when dealing with angry people, in particular, angry faculty. Not that there's a big problem with anger management in faculty. I don't think that's the case, but when it happens, you really have to know how to handle it. The wrong moves in those situations can really damage your credibility across the board, so from that standpoint, I think that being able to remain calm and try to bring people together to see a common goal. As you establish that common goal, it's much easier than to gain agreement on this is the goal. Then you can have a discussion on how to best reach the goal instead of focusing on the conflict area. I think that's one of the harder things to find in a manager.

9. If you were interviewing someone for your position what social skills would you look for?

I think that you can have a few different kinds of social abilities and types in this role. You have to be comfortable talking to people and talking to people that you don't know. You can

be completely introverted to succeed in this role but you don't have to be completely extroverted either. I think it's good to have kind of a mix of the two, right around the border line where you can reach out to people when you need to but you can also aren't just spending your time going from one person to the other, talking to them because, you know, you're really not accomplishing much. So, it's a balance in that.

10. What competencies are essential for effective leadership of an academic medical center clinical department administrator?

There's some basic skills that you need as far as financial; those aren't the hardest skills to come by. There's beyond that, there's the understanding of just general management of people. But then going back to the theme of what I've talked about is being able to read the situations, being able to read between the lines when you're in a big meeting where and the college is telling you what the next new thing is so you understand where it's coming from and where the pitfalls could happen for the department and for the faculty. But also, getting a feel for people you don't' see that faculty necessarily on a day to day basis in a large department like this but when you do, you really need to quickly determine how they're doing. You can ask them and they'll say something but then you read between the lines and find out you know what's the real feeling here. Because I think that's the, that's where the biggest problems can occur, you have personnel conflicts between the faculty and that's where it can really submarine your department. the other areas, being able to logically evaluate options and propose new options because, you know, there's, where there's a conflict, there's got to be another option because you're not getting agreement. So I think those are the areas where it's important to have those skills in this role.

P18 Interview

1. How do you perceive your leadership role within the department?

My role within the department is one of influence. The ultimate decision making is made by the chair, but you have an opportunity to collaborate with the chair on issues such as budget, issue such as personnel, etc… That's both collaborative at the chair level and it's one of influence, not final decision making.

2. What do you perceive as your leadership role within the administration of the academic medical center?

One of a number and I see within this institution in that our opinions are being sought more frequently. For more operation issues, we're in the midst of great change; how do we got about implementing. I think that there's less influence the farther you get away from your department, though. So you have the ability essentially to be a voice for your dept. but other that, decisions will be made with input of outside the dept. per say

3. What do you perceive as your leadership duties to the educational mission of the organization and department?

For me, I think I'm a little unique in that as a previous hospital CEO, I've been able to carve out niche for myself with physician contacting. I've done hundreds of physician contracts. I believe that resident physicians are ill-equipped, if you will to negotiate on their own behalf. They don't know the difference between level 1 hit and pick and level 2 hit and pick, how working at a critical access hospital builds up a provider base can negatively impact how revenue is recorded and subsequently, how they get paid. So for me, as far as education goes, it's in and around the business of medicine and preparing physicians to negotiate their first contract and how to assess opportunities.

4. What do you perceive as your leadership duties to the research mission of the organization and department?

Research mission, for me in particular, I feel it's more of a support role per say in that we support the ability to get grants done, we support the ability to provide realistic financial snapshots of where the researchers stand relative to budget. I really see it again as a support role versus more of a direct role, like we have in the clinical side.

5. What do you perceive as your leadership duties to the clinical mission of the organization and department?

I feel like you and I, frankly, are more operational people in that role where we actually get to work on process issues. We get to set the fiscal targets, the financial targets; we get to work on efficiency, etc…so that's more of an operational role for the clinic. In that, I think, here, in this environment anyway, has changed rapidly recently. I think before it was more of a collaborative role and bow we get to play more of an oversight role, a direct oversight role.

6. What do you perceive as your role as business manager in the operation of a clinical practice?

Well, I'm in a unique situation, where you and I get to collaborate frequently on analytics, which by the way is one of my favorite parts of my job, let me just tell you that right now and get it on camera. From a business standpoint, it's a unique environment and understand that there are 3 missions. I think, from my perspective and having grown up in essentially a MedCaid hospital, I'm learning that there's more of a negotiation outside the dept. maybe not all, but certainly a young dept is not going to break even from operations relatively quickly. We don't have endowments to back us up, so it's really juggling the different pieces of revenue coming in, whether it's grant revenue, clinical revenue, endowments, interest earned on the endowments, and actually giving it back to everyone so that they have a realistic picture of not

what they want, right, but what they need. And then can we afford what they need. How do we go about doing that? Be creative in such a way that we're still fiscally prudent and responsible.

7. If you were interviewing someone for your position what knowledge, skills and abilities would you look for?

I think there are certain things that are a given. I would definitely say they'd have to, from my standpoint, have an advanced degree, an MBA or an MHA, my preference always is somebody with experience on top of the MBA or MHA because that's when you get into the softer skills. Of course you want individuals who can do the analytical pieces as far as dissecting, whether it's something as simple as this ____ code analysis to something more in-depth, which is break-even analysis based on different product lines or subspecialty lines, but really what you have to have in this position is some of the softer skills, so what I mean by that is that everything in this environment is in negotiation. So you may be negotiating between a chairman and faculty; you may be negotiating between staff and a faculty member; you may be negotiating between the dean and the chairman, per say and just providing insight and influence. It's not really in this situation about hard and fast decision making. It's about seeing things clearly, being intuitive, being reflective and being able to give, for lack of better terminology, sound advice and sound council.

8. If you were interviewing someone for your position what emotional skills would you look for?

Emotional skills. Well, first and foremost, you have to learn, you have to know how to talk to people, especially in this environment. We have an interesting mix of individuals where we have a few seasoned people on the staff side, but we have a lot of young people. If we push them too hard too fast, they'll leave. If we leave them without expectations, nothing will get done. I also say the ability to negotiate with the faculty members. You have to be a good listener,

you have to be able to make sure you know it's not about you, it's not about being right or being wrong, it's about what's best for the dept. You have to be reflective, you have to be able to articulate your message in such a way that various members of the audience aren't going to be offended and lose the message that you're trying to articulate. So, there are a number of soft skills involved, such as this. And there are probably, frankly, and I think you would agree with me, at times, if not a preponderance of the time, they're actually more important than the hard and fast skills of finance, operations, etc…

9. If you were interviewing someone for your position what social skills would you look for?

Social skills, approachability, approachability. I think is the key one. Whether its staff or faculty, even residents, you want to be approachable. If you're seen as approachable, you'll always be seen as someone who can solve problems. If you're not approachable, you'll be seen, quite frankly, as someone who may be part of the problem.

10. What competencies are essential for effective leadership of an academic medical center clinical department administrator?

Competencies. You have to know the business of medicine. You have to know what a hit pick is, you have to know what a CPT code is, you have understand what RVU's are, you have to know how it all rolls up into a budget. You have to understand contractual allowances versus gross charges, you have to understand as ____, frankly, now coming from this environment the research side, grant funding, NOA process, etc.. You also have to understand a local environment and how to taxes are assessed and how that is going to produce the final bottom line, or the net revenue that you have to pay for everything, so those are the hard and fast skills that you need. An HR background would be helpful, we mentioned multiple people in an organization of this size, there's multiple opportunities, so inevitably, you're always going to

lost employees, so you have to have the ability to hire, you have to have the ability to set expectations, monitor behavior and the intestinal fortitude to provide the consequences if the behavior does not match the pace and goals of the dept. If it does, you also have to have the softer skills and the ability to say, "job well done."

P20 Interview

1. How do you perceive your leadership role within the department?

So I just want to quantify the question, so um how I personally or how I feel others perceive it? I feel based off my history that I had at Hopkins, and the way I was mentored as an administrator, people look at me as a very strong leader. I lead by example, I believe in management being all about people, not necessarily knowledge per say, so when I walk around the building, now not only as an administrator but as the director for the South Tampa center, which is this building, people believe in the changes that I'm making are for the better and for the good of the overall, not only of the mission of providing care but for those faculty for those staff that are here as well. So I feel very strongly that I have a very, my reputation as a leader here has been strong and especially with my chair, with Dr. David Smith. He believes in my skill set and my leadership and utilizes that to fullest extent to take forward as part of the executive management committee here.

2. What do you perceive as your leadership role within the administration of the academic medical center?

When I came on board, I was highly regarded, I was asked to serve on many committees, which shows a very keen leadership role when the Dean's office requests you to serve on those committees. The problem that I've developed over the past few years and Renee has the same issue is that, integration between in an academic center is vital between the hospital, between the

university, between the Dean's office. the dean's office doesn't look at their strength as in the clinical departments but within so therefore, many of the leadership qualities that Renee and I could and would provide are pretty much, not only sequestered but squelched in terms of moving those forward because we have to tactfully get them to understand that it's their idea before it will move forward because our ideas are basically nonexistent. Very different model than Hopkins, but here from the standpoint of what the dean's office looks at my leadership, they still look to me for some ideas. I've really gone outside the box of surgery; I've really developed relationships externally as a liaison with other community hospitals, with other programs, whether they be for profit or not-for-profit. And that's been rare within this college of medicine, so I think they think very highly of me based not only off where I can from but what I've done for them so far in my time here.

3. What do you perceive as your leadership duties to the educational mission of the organization and department?

Well, the educational mission is basically to provide the education for the resident and the medical students. I think the role as an administrator is to be pretty stand-offish with education to allow the program directors and the program coordinators to run the program and be there to support whatever their vision is or whatever the strategy may be. The one concern I had through the department of surgery is the match that we had on a yearly basis would be very low. In other words, we would have to go down to the 34th slot or…this year because of the way that we have changed the way we interview, put a little more emphasis into the website for those applicants who are looking here. We've actually come down to the 12th position to match. That's the way I help support them. I didn't help them in terms of the creation, I helped them when it came to me to say I'll be here to help you and move whatever initiatives or whatever

ideas they had to move forward. We have 26 residency slots of which we fill 6 each year. They are all funded by the hospital and if we go over that number then we look for alternative funding sources. If we go outside the quota, we look for the alternatives. There are alternatives that we do have but we bring those individuals in not as categorical but preliminaries. So if say we have two additional slots out at the VA and we have one additional slot that serves for the transplant program and they're supported by outside concerns.

4. What do you perceive as your leadership duties to the research mission of the organization and department?

Again, being at Hopkins, it was all about research and the education model. You know, when I left there, it was if your residency does well, everything else will follow because the residents actually go out into the world and they talk about their experience. The problem with research here at USF is that it's very limited in the department I'm in. therefore, most of the research is not federally funded… There is some industry funded, there is strong emphasis on the clinical research activity, so the infrastructure isn't as great. I do review all of the manuscripts before they go to the IRB to get a better understanding of what they're doing, what type of drugs they're bringing in, what they're trying to prove in terms of…But from the standpoint of true bench research, and outcomes research, there really isn't much here, so therefore I don't have as much of a need in regards to the research component as I did up at Hopkins.

5. What do you perceive as your leadership duties to the clinical mission of the organization and department?

Oh, huge. I think that's with all administrators. Here we're very productivity driven; the clinical mission is to provide care for all, whether it be the indigent or otherwise because we're here to teach the residents and here to make sure that we have those complex cases for them to

understand. But we're very driven by the bottom line here at USF to assure that the productivity it met by each of the faculty members as assigned on a yearly basis. I make sure that the physician's follow, to maintain patient satisfaction. So I'm on top of all the physicians to make sure that those physicians are not running behind, that we do get the patients that we don't have the pressing surveys here at the hospital but we do have, we do get feedback from patients that are very unhappy. But the administrators here are very clinically driven in terms of what the need is down here at USF. If I had my way, I'd try to get restructured so that a percent of time was either protected and if they were able to obtain funding to help them in research funding or some other mechanism of funding, but the problem is, is that because the majority of income that comes in to the school is through the clinical mission that we have to be involved probably 80% of our time to make sure that that's followed through with. I do have some involvement with the operating rooms and the surgeries that are done in the hospital arena. The problem is because we're an affiliate hospital, I mean we're affiliated with a hospital and not integrated with a hospital, we have pretty much again the model and I will use my Hopkins standard is that the way they invest into their administrators and to their assistant administrators and their chair is because they have a hospital, not an affiliation but an integration is that half of their salary is supported by hospital and half by the university. All the way down through executive levels. Therefore, they have to understand that they're, a portion of their responsibilities are hospital driven and they assure that there's a protected interest there as well as on the university side or through the COM. Here, administrators are driven 100% on the academic side with limited input on the hospital side. So, my overall role with the hospital is minimum in nature unless it's some type of program driven. Therefore, we don't have much in terms of, it was very hard to get used to not have any type of oversight in a hospital because it was, they're very controlling.

6. What do you perceive as your role as business manager in the operation of a clinical practice?

My role in the operations of the clinic or clinics is like I've actually set up a great model for the floor that our clinics are on. The way that I've done that is develop a clinic manager who is superb and created a navigator who is a non-clinical individual who makes sure that the through-put is consistent and constant and therefore I don't have to worry about the day-to-day ops because I confide and believe in those two individuals. what I do is on a daily basis though is to look at the volumes that are flowing through the building and make sure that we are keeping at threshold of about 600 or so, of course everybody has vacations, but from the standpoint of down to the minute details, the faculty will come to me if there's a concern, they want to start a procedure or some type of clinical care within the setting and then I'll filter that down to Kim, who's the clinic manager and Connie, who's the navigator to assure, again, that we know what type of patients coming through and to assure that the patient is very satisfied in their experience here.

7. If you were interviewing someone for your position what knowledge, skills and abilities would you look for?

You know, I let me think of what I put. The first thing I think any administrator has to do is understand what the --- and mission is for the academic component. You know that and you try to make that as equal in your mind as possible that you're here for clinical research and education. And to assure that one doesn't step on the other. It's unfortunate down here, I feel there is an imbalance there, I've tried to get it as balanced as I could through the clinical care component. It's definitely there on the inpatient side. It's very from a university or academic center; I think it's very imbalanced, that the physician doesn't understand how to fulfill the mission of what we're here for. Research is secondary, education they say is a primary concern

but they don't treat the residents as if they're teaching them, they treat them like scribes, they treat them like they're not going to be out in the world more. I think that if you understand that value of what the important is and do your homework, and understand to try and figure out a way to balance that, that's the type of person that will come in and if I interviewed them and they would really focus on a way to make those things balance is the type of person that I would want to fill my shoes if they came in here.

8. If you were interviewing someone for your position what emotional skills would you look for?

People love to feel comfortable with the individual and I have found that if you wear your heart on your sleeve, you're very honest with individuals, that you will earn the respect of those individuals as you move forward. From an emotional standpoint, you have to have your heart in believing in the people that you work with to make them feel that you care and to make them feel that you don't step over the fine line of what's authority and what is what will put you on the same level as them. I always say, you know people always say, I shouldn't say people always say; a lot of manager's always say, well, this person worked for me and I always say, I work with them. And I always go to this and I'll talk about the pyramid of success but if you go to a pyramid of success, and you're at the top and John Wooden's the believer of this and you remove one of those bottom layers of the success story, you come crumbling down faster than it took to build up that point. That's what people have to understand, it's those people down there are making you look good and not necessarily that's all about me. It's about all them.

9. If you were interviewing someone for your position what social skills would you look for?

I believe in four attributes. It's communication, honesty, trust and respect. And so therefore, I feel that if somebody has those attributes, they will be highly successful. I've coached soccer when I was younger, I thoroughly taught that to those individuals who were very

young that in order to be successful, that if you have those four elements in your, embedded in the back of your mind, and you cross over any one of those, like a lack of communication, there's disrespect, that you're not honest, that people will not believe in you. All you have to do is cross over that and so therefore, they are the type of social skills that I think. If an individual has that, you know, and they just have to be very very people oriented. They really do and have those attributes.

10. What competencies are essential for effective leadership of an academic medical center clinical department administrator?

Well define competencies, because there could be core, there could be...., the core competencies, they're all the different types of competencies you can think of, anything that you perceive that would be for effective leadership, let's say that. What are the leadership competencies, what makes for an effective leader? Well there are two things that i can say to that. The first is, and we were taught this at Hopkins, is there's one word we should always strive for and that's excellence. You strive for nothing else. That doesn't mean that you'll always be considered excellent, but if you're striving for that excellence, eventually it will come. People will understand you have an excellent product or service and therefore people want to come to see those individuals. If it's mediocre, then you're not going to be able to, it gives people other options, rather than wanting to see those individuals. The other think i believe in and I brought it here is the ten points of --- success by John Wooden and I'll read those to you and I hate to read off paper because I don't remember them. That is that you listen, that you care, that you recognize everyone as you are a leader, that you prepare for the worst and hope for the best, that you are industrialist, and what that means is that you can't accomplish anything without hard work; without the hard work, you're not adding strength, you're not building. So, to have that

enthusiasm, to be patient with people, there's a value in a person, everybody has value to add in some way and you have to work toward those assets or towards that person's value and work to that strength and not be very chronicle in the weaknesses of that individual. So you have to have the confidence that you don't fear failure, which i never have and you do earn and win respect. And I think that if anybody follows that in academic medicine, you not only have the faculty, the staff, your colleagues, people in the external when you're working with other people. They feel that right away and I think if one's missing, that's fine. If you have more than that, people catch, you know they learn about that.

P21 Interview

1. How do you perceive your leadership role within the department?

I perceive my leadership role to be sort of the chief advisor to the chairman and the faculty and probably the chief teacher to the staff. I mean I think that's concise but I can elaborate if you'd like...my, in my particular department, I have a very busy chair who has very little time for administration and I know that varies among, depending on the kind of department you have but in neurosurgery, it's such that the chair spends very little time on admin duties, so he needs a synopsis in a very short period of time. What's on the, what's on the slate right now, what's happening? And sort of guidance as to what I think should happen, where I think we're going. Generally, I tend to think things over as opposed to just giving the decision right away because it gives him some time away from the office to go over those things. So, I really try to keep him abreast of what's going on and act as that advisor to him and then with regard to the staff, I think that I have to, at least in the areas where I maybe know more than they do, which isn't everything, I really want to lead by example. I want to know how to do the things that they do, I want them to understand why I do things as opposed to just making arbitrary decisions and

thinking that I'm making those things up as opposed to teaching them what is important in our workplace.

2. What do you perceive as your leadership role within the administration of the academic medical center?

I think my leadership roles is to try to bring good ideas, try to bring some experience from previous locations where many of our administrators here have never worked in another university and don't have any idea that things may be done similarly or differently at other places. so I think that probably just trying to be a good advisor again to other people and how they might learn from that

3. What do you perceive as your leadership duties to the educational mission of the organization and department?

I think that's an interesting question because having been in, again more than one department, It seems almost sometimes that the educational mission is away from the administrators purview because it's deemed to be the job of the faculty to deal with this, but if you, as you well know, if you don't maintain that part of your business, you could get in trouble very quickly and then you realize that has a financial impact as well. And so, just because it's not a financial issue for an administrator, the educational piece, I think it's a really important piece to provide a good framework for the faculty to do their teaching so that your national prestige can be maintained, so that your funding doesn't get cut, so that you maintain that flow of teaching but you're sort of really a step back from it. From a match standpoint - I actually at one point lost an employee who was in charge of our program coordination, so I actually scheduled and set up interviews with residents one year, which was really interesting. I took on duties and it was a good learning experience for me because I hadn't ever touched that part of the business before

but other than to say, I am interested in the match and I hear the results of the match, and I occasionally provide data back to the faculty about where our matches have gone over time. So, say we got two of our ten matches last year, sometimes I provide them with data just so they can see that we believe our program has increased. I've never actually been physically in to the computer program that does that match. I haven't done that. Our positions are funded by various hospitals. Because we, different than other universities, we don't have a teaching hospital per say. We have a primary hospital that's a teaching hospital but we also have multiple others, so the majority of them are funded by Tampa General and then a couple by all Children's Hospital, the VA, so yes, they are all funded by a hospital.

4. What do you perceive as your leadership duties to the research mission of the organization and department?

Again I think this is interesting because depending on what kind of department you have, that role can be very different. In the department of neurosurgery, the vast majority of the research is of course clinical research and I think in that role, for clinical research, my job is, my leadership role to tell the faculty whether this is something that we can feasibly do without losing money or whether we can afford to lose money on something because they really want to do it. And so I generally I don't involve myself in trying to decide whether we should be doing it for any other reason except for financially and I leave that to their discretion as to whether the level of importance they place on any individual item of research.

5. What do you perceive as your leadership duties to the clinical mission of the organization and department?

I think probably this is probably, again, in my particular situation, the most important thing I do on any given day. Even though the education mission is equally important, we

couldn't teach the residents if we didn't have the patients, and so our duty to treat patients is sort of like, you know I think about how Marines say, "God, Country, Family." This is my God, Country, Family, the patients have to be treated number one and then I'll deal with the research and the education because the patients are really very important and so I take a lot of time in trying to ensure that our practices in the department are good, that our customer service is good, that we're giving patient care the best that we can and that we make sure that the patients know that we're here.

6. What do you perceive as your role as business manager in the operation of a clinical practice?

I'd like to have more. I welcome being involved in the clinic and we also have a clinic manager. I don't want to necessarily run my own clinic because as neurosurgery, being as small as we are, it makes some sense to share that business with another dept. for example, we share space with surgery and that way we can have a bigger space with better employees who are cross-trained and so it's good to have a little bit of separation but I'm always happy to be involved and I think that in our organization at USF, that sometimes that distance is a little too much. That they think you don't need to be involved in this and I just get involved whether they like it or not. I deal with hospital a considerable amount in allocation of OR time, giving up OR time, purchasing equipment and usually some level of faculty involvement would be, happen at the same time but yes. In a surgical department, it's the biggest resource you have, it's the most important resource you have, so you can't make your clinic schedules unless you have your OR schedules and those things are interdependent. And so, people who don't have a surgical practice don't realize how much is dependent on getting that time allocated from the hospital or hospitals. Our OR schedulers - we do that in that in the department. It's all done in the department. In fact, the department schedules all the patient visits as well so as much as I say I'm not in the clinic,

the only patient visits that are scheduled in the clinic are follow-up. So a patient is already there and the doctor says I want to see this person in 6 weeks – the clinic handles that and my office, all the phone calls come in where the scheduling takes place for new and return patients and they screen all the patients, they get whatever the doc requires up front and so we're intimately involved in day-to-day schedules of the doctor's whether it's in the clinic or in the OR.

7. If you were interviewing someone for your position what knowledge, skills and abilities would you look for?

I think that knowledge of the clinical practice world is absolutely necessary in a very busy clinical department. It might be that if I were running the department of pathology, that I'd say knowledge of NIH Grants is integral to running the department but I think it's different for different specialties. I think more importantly is an ability to be flexible and be able to communicate effectively with the physicians because I think that if they don't trust you then you have no relationship and therefore, you can't run their business.

8. If you were interviewing someone for your position what emotional skills would you look for?

I'm told from a number of people that I am very not emotional and I believe that is probably one of the keys to my success is that I don't make decisions based on emotions and I would think the key to success emotionally in this environment is being able to leave it, take it off the emotional side when you're at work. This isn't personal, this is business. People say that, my boss calls me all kinds of names and calls me aggressive and says that I'm not a typical women and I'm sure he's probably right in the sense that I don't tend to focus on the emotional side of things and he thinks that I'm kind of harsh sometimes but I think he appreciates looking like the bad guy but I'm really the bad guy.

9. If you were interviewing someone for your position what social skills would you look for?

I would look for someone who has good manners, good etiquette, good grammar, and can adapt to situations as necessary. So again, more flexibility.

10. What competencies are essential for effective leadership of an academic medical center clinical department administrator?

I think that's an interesting question. That's challenging in the sense that I believe you have to have the ability to process a lot of information and be able to narrow it down to a small number of items to present to the faculty, because you don't have their attention for 40 hours a week. I have them for maybe an hour or two and in order to communicate with them, in order to make the business run correctly, I need to be able to synthesize a lot of information in a small amount of time without giving too many details and yet still make it effective so that the communication is clear.

P22 Interview

1. How do you perceive your leadership role within the department?

I think it varies depending on the different tasks that we have to do because sometimes I am an consultant, sometimes I am a visionary that kind of looks at where we're going and tries to inspire people to go along, sometimes I'm the enforcer and sometimes I am the whatever needs to be done person. It varies depending on the task.

2. What do you perceive as your leadership role within the administration of the academic medical center?

Well a college has certain goals and objectives. Right now we have a lot of fiscal goals that we're trying to reach and so the college's task is to make sure the administrators understand what the goal is so we're all going towards the same direction. My job is to implement that vision if you will, and to also give feedback as I can to the top leadership on how it's going and

where we might look at going another direction, that sort of thing. Mostly it's the top administrative folks have a vision and it's my job to take that macro vision and put it on a micro level.

3. What do you perceive as your leadership duties to the educational mission of the organization and department?

It's sort of consultancy realm. I obviously don't teach medical students much, if at all. But the education has certain goals and I provide fiscal guidance primarily to them on what's feasible and what isn't and try to balance the different missions so that no one mission is taking all the resources. Sometimes there's a lot of negotiation that has to go on about who gets what resources and how we're going to divide things up and where do we need to invest more and where do we need to cut back? That sort of thing.

a. We have a little over 50 residents and a handful of fellows on top of that, so it's a pretty big program

i. And it's all funded by the hospital?

b. No, we have 1.5 that are funded by us and they work in our clinic here, so I have to make sure that we bring enough revenue to support those folks. An then we have affiliations with some community agencies. In Psychiatry, it's not all hospital work, it's agency work too, so we have community agencies that we work with

i. And you said you have a fellowships, too?

c. We have child fellowships, we're starting an addictions fellowship, we're trying to get a geriatrics fellowship going. The biggest one is child. I think we have 8 child fellows right now

4. What do you perceive as your leadership duties to the research mission of the organization and department?

Research is primarily a fiscal duty, keeping an eye on the finances, making sure that we have cash flow to support the research mission so we don't end up at some point with a deficit or whatever. Sometimes I help with the policies, right now we're looking at how we deal with private pharmaceutical studies. We have a pharmaceutical study and they study is over and there's retained earnings, then how do you dispose of those retained earnings? Does it stay in the apartment? Does the researcher have access to those retained earnings so they can, sort of use it as feed money for the next project they're on. That sort of thing and so I help with making the policies for that. But most of it is a fiscal function. It's making sure the books balance at the end of the day and that we know, if you have a grant that ends in 6 months, you have to look forward and say, ok, when this grant is over, I have 3 people who are funded on this grant. What are we going to do with those 3 people? Where are they going to work after that? What other grants do you have in the **pock line** that sort of thing.

a. Do you expect your PI's to be fully funded or ------ is there a guideline of what you want your PI's to be funded by?

i. That's a good question. In this department, there, it depends on how you define fully funded. For example, we have some chairs, so you could have a person who has a chair that pays a part of their salary and the grants cover the rest. So if the chair plus the grants mean fully funded, than yeah, I expect them to be fully funded. In this part, we have a lot of PI's that are work at the VA. The VA picks up part of their salary. The rest of the salary that they ---- is all funded by grants. Sometimes we have one researcher that we have a contract for, he does some contract work and that covers part of his salary. Essentially they are fully covered and another department I work in, they were awful at coverage. We just did 100% grants and if we didn't have it, we just didn't have it. Hopefully we don't ever get to that point here because it's really hard on folks.

5. What do you perceive as your leadership duties to the clinical mission of the organization and department?

I have a lot of clinical management experience and so I act as more of a consultant I guess, to the clinic. It's a ----- thing to go into the clinic and say we need to do this, this, this and this, but we have physicians working in the clinic on a day to day basis that also see how things should be done. And so I'll go in the clinic and suggest things that we should do but if I see something outrageously wrong, I'll just tell the staff they have to fix it. I try to get my faculty involved so it's a team effort and not just one person saying this is what we have to do. I think you get a better product when you do it as a team.

6. What do you perceive as your role as business manager in the operation of a clinical practice?

I watch the finances real closely and try to come up with ideas. Like right now, I'm about to start looking at a business plan for a different clinic model that we may go to, once I get the plan finished, if it looks like it will be feasible, then I'll discuss it with the physician's and they'll tweak it and then we'll discuss it with the folks at Main Baylor and get everybody on board before we can move forward.

7. If you were interviewing someone for your position what knowledge, skills and abilities would you look for?

I look for very strong fiscal skills. I would look for someone with very good time management skills and very good people skills and very strong physician relations. No administrators can survive if they can't get along with physicians.

8. If you were interviewing someone for your position what emotional skills would you look for?

I think you have to have an even keel so to speak, you can't get too excited or too frustrated because there are things that happen during the day that you just can't always control and so you have to be able to take some hits so to speak without losing your mind over it. I also think you have to be able to go home and forget about it at some point and to have some things outside of work that take the stress off because it can be a real stressful job.

9. If you were interviewing someone for your position what social skills would you look for?

I think you have to be able to communicate with physicians. No administrator is successful if they can't communicate well with physicians. And that doesn't always mean telling the physicians what they want to hear or that they're always right. You have to be able to tell the physician's they're wrong when they're wrong but do it in a diplomatic way. So physician skills are huge. Staff communication skills are huge, staff can make an administrator look terrible if they want to and so you've got to get the staff on board.

10. What competencies are essential for effective leadership of an academic medical center clinical department administrator?

I think fiscal competencies. You have to be able to look at financial reports and see where you are and what's going on and also project where you're going. I think the interpersonal competencies are huge, being able to communicate with people. People skills, fiscal skills, you have to have some broad knowledge of the healthcare industry and how it works. I think a person needs to know about human resources and what you can and cannot do from a human resources perspective. I think you have to have knowledge of clinics and how clinics operate and you know, what HIPAA is all about, those kinds of things. There's a lot.

P24 Interview

1. How do you perceive your leadership role within the department?

Well, I'm a little unique in ----department, so I'll kind of answer most of these questions as a general ---and I do think they're very similar. I would perceive that my leadership role is full accountability of both departments for all the missions of the college. There are three main missions of the college in research, education and clinical operations and I have to be accountable to all three of those in my three departments. So, whatever it takes to be accountable for that as a leader of the department is how I perceive my role.

2. What do you perceive as your leadership role within the administration of the academic medical center?

As a department, we have to carry out the missions of the college. It's very important in academics that it's an emphasis as well in research and education, so we have to play our part as a department in a much larger medical school in carrying out those missions. So we are each unit and we operate, hopefully, cohesively. We do have things that makes us unique as a department. Every department has things that make them unique in the overall academic medical center and it's our job to take care of that uniqueness and us it and it's what makes Baylor special. Each of the departments can take their strengths and weaknesses and that's what makes a medical school with a great curriculum.

3. What do you perceive as your leadership duties to the educational mission of the organization and department?

Well in everything that we do, education is a very important part. It's the primary reason why we're here. Baylor is a medical school, a very well know medical school. So we have to make allowances for education in our clinical operations, not allowances that ever cost us anything but we have to consider it. You know, we have to remember what would be a better educational opportunity for our students, residents fellows, medical students and the physicians

understand that this is part of their regular operations. Most time I think the faculty would say, it may take more time at times but it's an enhancement for them as well. They learn from each other and every time we have students, we want to, we send them off and they are a speaking ground out in the community. We always have to get consideration that we want to teach and how, how do we make that teaching experience for our faculty and our students.

4. What do you perceive as your leadership duties to the research mission of the organization and department?

Research is something that you have to make, it's a mission and we have researchers and it's a different business than clinical operations and it's a different business than education and you have to acknowledge that and you have to have good, strong clinical operations so that you can support research initiatives. We have to be able to support our research faculty and give them a little different administration. I mean they need assistance in other administrative areas than you would think of in day-to-day clinical operations. They're out getting the grants and trying to find funding and they're trying to complete studies and sometimes the studies are clinical and sometimes they're not and we need to incorporate that in our regular strategy for the department.

5. What do you perceive as your leadership duties to the clinical mission of the organization and department?

Well so have clinical mission both on the adult and the pediatric private side as well as a clinical mission on the non-private side as well and so we have to have great customer service in all areas of clinical operations and we need to be able to maintain good clinical operations day-today. So it's very important that our faculty are successful in both areas because that is what's key for having education for the students, you've got to have good clinic and surgery for the students to be able to participate in as well as you have to have good data and good opportunity

to see patients that you can learn something from and so that's very important, the first driver that starts everything for them.

6. What do you perceive as your role as business manager in the operation of a clinical practice?

I think I'm very involved because clinical, there's operations to this department in all the missions of the college and so I'm not necessarily a hands-off manager. I prefer to be involved in that. I want to have staff that can help me and I want them to do what they need to do. The day-to-day operations are just part of who we are and they have to be run well and so I can't, I have to be involved in them in order to make good leadership decisions. I have to be aware of them to make good leadership positions. I need to make sure that my staff who work in those areas, be it clinic manager or research manager or educational coordinator, that they are able to perform their duties and if they perform them at the same level that I have for the whole department, that they complete my expectations. You can't do that if you're not involved in it. I don't have the luxury or the time to be in every clinic every day, all day so I have to have good policies and staff to handle it when I'm not there every day.

7. If you were interviewing someone for your position what knowledge, skills and abilities would you look for?

I think that have to have a good financial competency core. I think they need to have operational experience. I think they need to be able to multi-task, both in financial and the operations tasks. I think they need to be able to set goals and strategies for their department and see them through. You have a lot of folks who can set goal and they can't see them through. I think they need to have management experience. If they've never manages staff, it's going to be a hard job and I do think they need to be able to have a level of leadership that allows the

department to come together and be recognized as a leader. If they don't perceive you as a leader, they won't be part of the policy and ----of the department.

8. If you were interviewing someone for your position what emotional skills would you look for?

I would expect them to be confident, strong in their decision-making skills, which I think is very important. I would expect them to be able to initiate some camaraderie with those in their department, where they're not hands-off or unaware of the camaraderie in their own department. When I say confidence, I think they need to be secure enough in themselves that they can makes decisions and take the good and the bad that comes with the decision and they also probably need to recognize that being a great leader might mean that you make decisions that aren't popular sometimes but it's how you present things. I would look for them to have the ability to present things in an objective as well as professional manner.

9. If you were interviewing someone for your position what social skills would you look for?

I think I touched on that a little bit. I think they need to have a team player personality. I think they need to be willing to understand all the staff in their departments and their jobs. I think they need to want to participate in all the jobs in their department. It's hard to expect things from those if you don't understand all aspects of their job. I personally think they need to have the ability to communicate and speak, so I say that because there are some that are just too reserved. You need to have a communication style that you can carry out and for everybody that's different; for every leader that's different. You need to be able to write and speak and build relationships, it's very important to the success. Especially in an academic environment where you have so much going on in your department. Research, education, you have all these areas going on with different personalities, you need someone who can communicate at those very different levels and get the message across.

10.What competencies are essential for effective leadership of an academic medical center clinical department administrator?

I think you need to be a flexible person because you are bringing together 3 unique missions that are all related but they all have whole different goals and strategies. I think you need to be flexible enough to integrate those missions and make the department work as a whole. I think you need to be able to make decisions because if you can't set goals and make decision and be confident in those decisions, then the department doesn't flourish, it doesn't develop, it doesn't grow, it doesn't maximize itself. You need someone who has the competency to think at a higher level, go beyond what's happening today, think about a little bit in the future. At the same time, still keep day-to-day going. It's a little bit of a balance act. That's why I say flexibility. You have to think ahead and you also have to adjust for your environment. You know, nationally speaking, healthcare legislation has a lot of challenges right now, economically we have a lot of challenges right now. So you have to be flexible enough to adjust to all that in your leadership style in your department. It's effective healthcare, so it's important that they're confident enough, competent enough in all their skills to be able to adjust.

P26 Interview

1. How do you perceive your leadership role within the department?

Well I think a leader of any academic department has to understand, I don't think you initially totally understand, that when you step into the role, you have to understand how all the missions of an academic department at a medical school or college are intertwined. You have faculty that come and they have a certain, you're trying to recruit the right kind of faculty that can not only provide the teaching so you can attract the best students but then those faculty also have to, they might be doing undergraduate medical education, but they're also potentially doing

graduate medical education and then they're providing, in many cases the same faculty, clinical service at a hospital. So a lot of it has to do with just developing who are the personalities and how did they fit together? So I really think the leadership role in the department is trying to find people that are interested in fulfilling each one of the academic missions and hopefully you'll find somebody who also fulfills the third mission, research. A lot of what you do is working with your chairman or chairwoman and understanding what their vision is of the department and how they want to grow it and change it and make it better and improve it and working with them in kind of a joint leadership arrangement.

2. What do you perceive as your leadership role within the administration of the academic medical center?

Well, we talked about it briefly earlier, but I not only provide this role for the department of pathology, I'm also involved in the leadership of the department of radiology and leading the radiology group and I'm involved in the leadership of the anesthesiology department and the anesthesiology group. I've been involved in pathology for 16 years, radiology is much newer; it's about 6 years that we've been working together and myself and the chair and the administrator. I do not hold the administrator title in radiology. I hold the President and CEO title of the Baylor Radiology Associates group. I don't have a formal title at all in Anesthesiology yet, it's probably forthcoming later this year but that doesn't really matter. And then one of the things that we've done with pathology is we've been the number 1 department for the last 13 years in academic, in our ranking going down and NIH ranking, which you probably know is the grants that our researchers have gotten and part of that is us supporting young researchers with start-up money until they got grant support. So we, our ranking is continually going down whereas we have managed to make the most money for the college, the most surplus. I see that as the

leadership role because people come to our department and they want to know how are we doing it. I don't really have any other role in the dean's department or throughout the college, at least not at this time.

3. What do you perceive as your leadership duties to the educational mission of the organization and department?

Well, being a medical school, the primary educational duty is to teach the undergraduate medical students so we have I guess 6 or 7 committees that we pull together every month and we talk about the teaching and who's going to be teaching what courses, and do we have the right people in the right places. What were their course evaluations for the last year, were they well received by the students or would there be a better spot? And so then you have that role and then you have the role of the graduate medical education where we have graduate students and post-doc's and so on that involved in projects and then you have another tier which is the fellowship and residency programs, so all of those have certain committees that I don't sit on every one of them but I attend as many of the committee meetings as possible to make sure that our course evaluations are as strong as they can be year after year and we have the right faculty educators in the right place.

4. What do you perceive as your leadership duties to the research mission of the organization and department?

I see the primary research duty as recruiting the right faculty, that there are synergistic opportunities for them to work together on research or on program grants and so on. But then how do you support them? How do you support them in ongoing education, for them to go and travel and become a national presence, giving talks at meetings. Do you support them with

additional unfunded research money to take on new projects and try new things to establish a new grant? Just working with them and listening to what their interests are and then how, with the money we create in surplus, how can we invest that in our research enterprise? To me that's the leadership portion of the research part of the department.

5. What do you perceive as your leadership duties to the clinical mission of the organization and department?

We talked briefly offline. I had an idea about 15, 16, 17 years ago and pitched an idea to the college of growing, of community hospital based practice. We have all these very knowledgeable, smart pathologists that are such specialized in all the fields. They were doing the teaching and the training. Out in the community hospitals, you have good general pathologists for when they come across a difficult case, they're not sure where to refer it, and sometimes there are delays in referring it to big institutions other than our group, there's additional cost to a patient. So I pitched an idea to create a community hospital-based practice and now we have 29 community hospitals where we have good general and sub-specialty pathologists out in the community and then they refer difficult cases back into the medical center for teaching and training and for consultation. So it fits into the multiple missions and also the research component and it has grown our clinical practice to this year, we'll do close to $45,000,000 per year in clinical practice, which throws off a substantial margin to fund the other missions. And that's really kind of the overarching leadership that holds all the components together.

a. I'm overseeing all of the components.

6. (P26 did not answer IQ6, What do you perceive as your role as business manager in the operation of a clinical practice?)

Although P26 is administrator for a clinical department, the department does not have a formal clinic.

7. If you were interviewing someone for your position what knowledge, skills and abilities would you look for?

I think somebody has to be able to handle lots of different things at a time because you can be working on one agreement with a doctor or with a hospital and you could get interrupted and you might have to take a residency question or you might…and you're not going to know all of it. I mean, unless somebody has had, you know 5+ years as an administrator. Someone that can triage lots of different things and keep reprioritizing throughout a day or throughout a week and somebody that has, you know, good financial skills because you have to understand lots of different complex things of how they fit together. How the residency slots are funded through the hospitals or are they funded with state money, how fellowship works, how the grant funding works, so somebody might come to you with one piece or multiple pieces of the equation. Certainly their personality and how they're able to deal with lots of different types of people. You might have a Chinese-born post-doc, you might have, in our department we have a researcher, a really top notch researched but he's Italian and he's really outspoken and, but once you get to know him you realize that's just who he is. So there's, and there's softspoken pathologists who are used to pretty much just being in their office all the time and how do morph throughout the day to be able to work with all those different kinds of people. Whether it's a research tech or a histology tech or and administrative person. I think that's what I would look for in somebody if I was interviewing them.

8. If you were interviewing someone for your position what emotional skills would you look for?

I think somebody has to be relatively calm because there's just so much, so many interruptions that happen throughout a day, you just have to be able to have a lot hit you. I mean I think that's a, you've got to, somebody that has a personality that's positive, that's outwardly positive. It's not all good news all the time, so how can you take it and triage everything that comes at you and still have a positive attitude when you're walking down the hall, no matter what person you run in to.

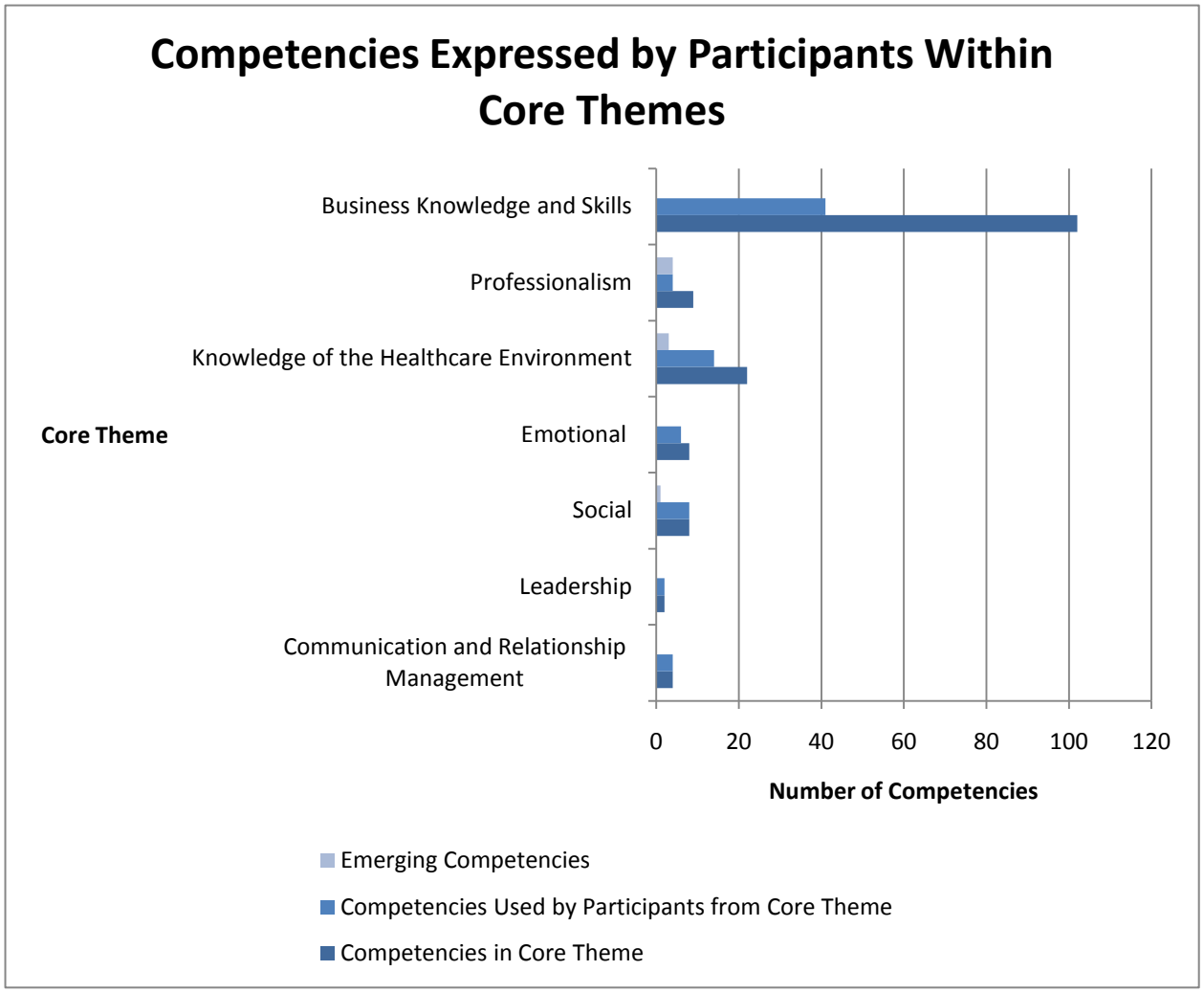
9. If you were interviewing someone for your position what social skills would you look for?

I think as I said earlier, in an earlier answer, I think it's somebody that can really fit in in almost any type of social situation. Whether you're going the president's office and you put on your jacket and you're all buttoned up and you're sitting and you're listening and you interject when you need to versus, you know sitting with folks in the lunch room and visiting with your couriers and your administrative staff and people that take interest in other people.

10. What competencies are essential for effective leadership of an academic medical center clinical department administrator?

Good organizational skills, good time management skills, a basic understanding and knowledge of finances, financial performance, financial spreadsheets. Might know a little bit of accounting. I think a person can come from any background as long as they had good people skills. Then always a positive mental outlook would be somebody that I would, you know I'm one of those people that I hire people that I think have a good people skills and a good outlook on life. You can teach them almost anything. Certainly you would love to get all of these skills together in one person but I think you can enhance people's careers by just pulling them and moving them and teaching them different skills and then watching them grow.

APPENDIX M: EMERGING COMPETENCIES AS COMPARED TO HLA COMPETENCIES



APPENDIX N: PERMISSION TO USE PREMISES

University of South Florida

DIVISION OF RESEARCH INTEGRITY AND COMPLIANCE

Institutional Review Boards, FWA No. 00001669

12901 Bruce B. Downs Blvd., MDC035 .. Tampa, FL 33612-4799

(813) 974-5638 .. FAX (813) 974-5618

March 4, 2011

Ron Dearinger

Administrator

Department of Urology

College of Medicine

University of Florida

RE: A Phenomenological Study: Leadership Competencies of Academic Medical Center Clinical Department
Administrators Study

Dear Mr. Dearinger:

This is in response to your email dated February 25, 2011 addressed to Ms. Anna Davis.

You have permission to ask University of South Florida Clinical Department Administrators to participate in your
study.

From the information you have provided to us, it does not appear that the University of South Florida is "engaged"
in this research project except that USF Clinical Department Administrators will be asked to be participants. There
is no USF Investigator and no study data will be stored at USF. Also, the study has been reviewed and approved by
the University of Phoenix Institutional Review Board so there will be an IRB following the progress of this study. A
copy of the University of Phoenix's Institutional Review Board has been provided.

According to the Office for Human Subjects Protection (OHRP) Guidance on "Engagement of Institutions in
Research" (Section B.5), an institution is not engaged in research if their involvement is limited to the following:

"Institutions (e.g., schools, nursing homes, businesses) that permit use of their facilities for intervention or
interaction with subjects by investigators from another institution."

Unless there is a change in the status of this project, the University of South Florida Institutional Review Board will
not review this study for the reasons given above and no further submission to the USF IRB is required.

Please keep this letter with your correspondence for this project. A copy of this letter will be placed in the USF IRB
correspondence file along with the items submitted by you. If you have any questions about this matter, please do
not hesitate to contact me at 813-974-5638.

Sincerely,

cid:image001.png@01CB542A.FA703B90

John Schinka, PhD, Chairperson

USF Institutional Review Board

Cc: Anna Davis, USF IRB Professional Staff

University of Florida

From: Mahoney, Michael P

Sent: Tuesday, January 11, 2011 2:49 PM

To: Dearinger, Ronald L

Subject: RE: Pending

Ah – response received!

You are hereby granted access to staff to request their participation in your survey. Please let me know if you need anything else.

Michael Mahoney

Asst. Director

Institutional Review Boards

University of Florida

(352) 273-9601 direct

(352) 273-9600 secretary

(352) 273-9614 fax

http://irb.ufl.edu/

Baylor University

From: Castaneda, Tiffany Holden [mailto:tyholden@bcm.edu]

Sent: Thursday, April 14, 2011 1:30 PM

To: Dearinger,Ronald L

Subject: RE: Request to use premises

Hi Ron,

below are the contact information for the administrators:

wgaupp@bcm.edu

gayleenb@bcm.edu

menge@bcm.edu

dvenker@bcm.edu

From what my supervisor explained to me, you would just contact the administrator to see if they were able to do the interview (based on their department's own policies). Please let me know if I can help further

-Tiffany

Tiffany Holden Castaneda |Administrator, Institutional Review Board (IRB) | Baylor College of Medicine | Office of Sr. VP & Dean of Research | One Baylor Plaza, Suite 713DD, Mail Stop BCM310, Houston, TX 77030 | T: 713.798.6995 | F: 713.798.2721 | tyholden@bcm.edu | bcm.edu