An Analysis of Leadership Expectations in the Lebanese Healthcare Industry

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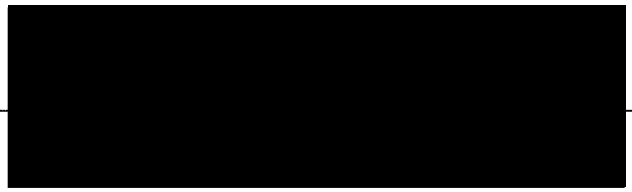

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ABSTRACT

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The purpose of this study was to explore the support for established leadership authority values among healthcare personnel and seek to develop a leadership model for the Lebanese healthcare industry. This study utilized an expanded version of Weber's "ideal types" of authority that was first advanced by Neal and Finlay (2004, 2005). The data were drawn from healthcare personnel (physicians, medical support "nurses", and administrators), and were subjected to an analysis of group and individual means on each of the questions, using the Scheffe option available in ANOVA. The analysis found evidence of common leadership authority values among the three groups whereby, they all favoured charismatic leadership. Physicians, meanwhile, were distinguished by significantly being much less supportive of traditional authority values than nurses and administrators. The results also showed evidence of nurses and administrators being marginally more supportive of rational legal authority values than physicians. This study is limited by the number of participants studied. It is thus anticipated that future comparative research will be extended to include more participants.

To my parents

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Chapter 1

General Introduction: Justification for the study

Built by local philanthropists, foreign or local missionaries, and foreign government agreements with the church, Lebanon pioneered modern healthcare in the Levant region in the late eighteenth century. These developmental years saw the creation of the Syrian Protestant College Hospital, now known as the American University Hospital, in 1867, the Saint George Hospital in 1878, and the Saint Joseph University of Medicine in 1883. Since that time, hospitals operating in Lebanon have progressed swiftly through strong associations with Western medical programs. Prior to Lebanon's independence in 1943, the country's healthcare sector was solely run, and owned by the non-governmental entities. In the early post-independence years, Lebanon established the Ministry of Public health to govern the healthcare sector as well as establish governmental healthcare agencies and hospitals. In addition, many other private hospitals opened and formed the syndicate of hospitals in 1946.

Up to1975, the marking of the start of the 16 year civil war, Lebanon boasted one of the region's most developed economies with its capital, Beirut, serving as the financial centre of the region. In addition, it was recognized as being among the region's leaders in healthcare services and medical institutions (Mundasad, 2003).

The Lebanese Civil war produced a significant decline in government-sponsored healthcare with only 700 out of 1870 national hospital beds available by the time the conflict ended. This gave rise to a dramatic period of growth in the private healthcare sector (W Van Lerberghe, Ammar, Rashidi, 1997). As a result of this lengthy internal conflict, Lebanon's public healthcare sector suffered enormously; buildings and equipment were destroyed, institutions were looted, and facilities were either severely damaged during occupation or simply taken over by militias as personal properties. Further damaging the effectiveness of Lebanese healthcare organizations was a decline in physicians, medical support "nurses", and trained employees as many left the country during this most-recent Lebanese Diaspora (Kronfol 1992). During this period of turmoil, the Ministry of Health (MOH) lacked both sufficient data to create a planned policy and the means to implement its programs with externally-sponsored healthcare programs, supported by international organizations such as UNICEF and WHO, partnering with local NGO's to sustain essential services. This insured that essential services such as emergency care and epidemic medicine continued to be provided throughout the war (Marseglia. 2004).

With public services being severely curtailed, the private medical sector experienced an unusual boom as the Ministry of Public Health (MOH) was forced to contract with private hospitals in order to carry out its role and deal with emergencies. This influx of government funding suddenly made private medical investment a lucrative alternative. Due to this change in the market structure, fifty-

six percent the present private hospital capacity in Lebanon can be directly traced to growth during the war years (W Van Lerberghe.1997).

The Lebanese healthcare sector that emerged from the war years was primarily dominated by private hospitals accompanied by a minimal contribution from non-governmental organizations that attend to the health needs of underdeveloped mainly poor communities (MDGR "Lebanon" 2003). The private sector investments are largely concentrated in urban areas with the hospitals being well-equipped with highly sophisticated equipment and providing a variety of services (Marseglia. 2004). MOH statistics for the year 1997 show that 75% of its budget was allocated to the Daman program which reimburses private hospitals for insurance purchased by the government covering citizens who do not hold private nor public insurance. Almost 50 percent of the population in Lebanon is dependent on private or public healthcare insurance with the remainder being dependent on the state to cover their healthcare bills through the MOH scheme known as Wizara (Mundasad 2003).

Since 1991, the Lebanese healthcare industry has been making strides in a variety of technological and managerial areas. The government has already begun addressing these issues by renovating old public hospitals and establishing new technologically-advanced hospitals both in the capital and in rural areas. The MOH has taken the initiative to address quality management in all its dimensions by driving the establishment on an accreditation system for both

private and public hospitals (Ammar 2000). To accomplish its goals in this area, the MOH contracted consultants to complete an accreditation manual for hospitals in Lebanon and required all hospitals to undergo annual inspection in order to confirm the hospital's compliance with set accreditation standards. This accreditation process addresses care deficiencies as well as harmful and wasteful practices while serving to stimulate debate between public, private providers, policy makers, and consumers on which practices conform to the latest reliable approaches and techniques. As a result, this process strives to ensure that hospitals achieve improved quality standards that will eventually benefit the consumer.

We are living in dynamic times, and these advances in the Lebanese healthcare industry requires leaders who are capable of guiding healthcare personnel through the many challenges arising from adopting new technologies and obtaining accreditation. This study will explore the support for established leadership authority values among healthcare personnel and seek to develop a leadership model for the Lebanese healthcare industry.

Chapter 2

Literature Review

2.1 Leadership and hospitals

Byham, Nelson, and Paese (2000) challenged the thought that hospital leadership differed significantly from leadership in other organizations. Their analysis concluded that even though healthcare organizations employ individuals from a widely-differentiated professional backgrounds (i.e. physicians, administrators, technicians, and nurses) the characteristics for successful leadership in healthcare bear a strong similarity those in other types of organizations.

2.2 Physicians and Leadership

No other profession has a greater responsibility for placing the consumer at the forefront of all its initiatives than the healthcare industry. The simple reason being that healthcare providers are charged with the responsibility for upholding the highest principles of competence, integrity, and knowledge as they focus on the well being of its patients (Crosson, Weilnad, & Berenson 2004). This tradition dates back more than 2500 years and is deeply embedded in the profession; it is the origin for the time-honoured social contract on which the medical profession has traditionally succeeded in gaining its special status in society and its special say over leadership in healthcare (Crosson, Weilnad, & Berenson 2004).

At times in the past, Physicians have enjoyed an almost complete autonomy in their work (Colby 1997), reporting to no one and holding a nearly "god-like" sway

over the healthcare universe. With the early focus being on private practice, physicians tended to the needs of hundreds of individual patients on an individual basis. Within this intimate relationship between physicians and patients, it was the physician who held all the knowledge, power and authority with the primary focus being on the relationship were the physician and the patient. (Crosson, Weilnad, & Berenson 2004). Even in the relationships between physicians, nurses, and hospital administrators it was the physicians who held the authority to set policies and to determine the cost for services rendered. The stature ensured that this right was rarely challenged.

The working environment within which physicians operate is moving at a remarkably fast pace with technological advancement largely shaping the quality and precision on healthcare services. Huge increases in demand for healthcare services have resulted in rising costs and a movement from an emphasis on private practice toward large complex organizations which in addition of physicians, employ individuals from a variety of supporting professions including technicians, nurses, and administrators. This evolution has resulted in the obliteration of most of the authorities that physicians used to hold (Lupton D.1997). McKinlay and Arches (1985) and McKinlay and Stoeckle (1988) partially attributed this erosion of the absolute authority and complete autonomy of physicians to the rise in bureaucratic organization and the fragmentation of the health industry into an increasing number of subspecialty societies. Along with these direct changes in the profession, these authors point to the over-supply of

medical practitioners and the emergence of the patient consumerist movement, and better education among common people as factors that have led to the decline in the level of power that physician have traditionally enjoyed.

This erosion of physician authority has meant that the leadership styles employed in the past are inconsistent with the healthcare demands of the 21st century. Some authors suggest that by recognizing that traditional leadership styles are insufficient to support physicians in delivering their professional obligations of competence, knowledge, and best practice, the industry has moved toward a new leadership paradigm that focuses on group practice (Crosson, Weilnad, Berenson, 2004).

Other researchers (Crosson, Weilnad, & Berenson 2004).have suggested that the typical leadership attitudes and behaviours that physicians were previously taught in medical school and during their residency are only applicable in the clinical environment and the operating room.

> "Physicians are taught to think and act as independent and individually accountable leaders; they all perceive themselves as leaders, and all are trained to make life and death decisions and to be held accountable to them and are not necessarily effective outside that special setting"

Indeed, at those times when a physician is required to act as a strategist, administrative, or a managerial leader; the traditional physician leadership skills may result in counter productivity. What is required are leadership skills which

incorporate delegating authority, collaborating rather than acting solely, holding group responsibility "groupness", and acting proactively rather than reactively (Kutra, Curry 1994).

Crosson, Weilnad, and Berenson (2004) and Philip J (2003) emphasized the importance of leading through vision, whereby leaders would work on a motivation vision that would result in a better way of working and living. The vision should also serve as the source for setting principles and values capable of guiding the everyday activities of the group. The visionary leader is, in most cases, charismatic, energetic, pragmatic, driven, and committed to the realization of his or her vision.

Philip J (2003) attributed the success of physician leader to their emotional intelligence. He considered that empathetic leaders are experts in reading body language, interacting with colleagues, good listeners, and responding appropriately to concerns expressed by other people. These leadership attributes are in turn key to retaining talented individuals in a medical group.

Physician leaders should also be able to scan current environmental trends and use them to propose future directions while staying up to date with medical advancements. According to Crosson, Weilnad, and Berenson (2004),

> "medicine has changed more in the last 50 years than in the previous 500 years, and it will change more in the next ten years than in the last 50 years"

2.3 Medical support "Nurses" and Physicians relationship

The research of Raz (1994) and May (1993, 1995) shed light on the authority relationships between physicians and nurses.

> "We must recognize that the nurse-physician relationship exhibits the structure of "rational authority". By "rational authority" I mean authority which imposes an obligation (to obey) because there are "reasons for an action". [*Rational authority refers to rational-legal*]

2.4 Nurses and Leadership

According to the International Council of Nurses, nurses have the responsibility for: promoting health, preventing illness, restoring health, and alleviating suffering. According to the Council, the Nurses' mission is:

> "the respect of life, dignity, and the rights of man. It is unrestricted by considerations of nationality, race, creed, color, age, sex, politics or social status. Nurses render health services to individuals, the family and the community and coordinate their services with those related groups" (Esther Lucile Brown, 1971).

Prior to the nineteenth century, the nursing profession lacked guidelines or official procedures regarding the precise role of nurses and who was proficient enough to take on that role. The nursing profession first existed during the early years of Christianity in the form of monasteries for women who took in the sick and the needy in accordance with their religious teachings (Brian Abel. Smith. 1975). For several centuries thereafter, the spread of healthcare evolved slowly. During the Crusades, heath care was incorporated into the military by establishing subunits

in charge of maintaining health and caring for the wounded. This incorporation marked the beginning of the hierarchical healthcare organization.

In 1854 Florence Nightingale was asked by the British of State at War to address the 50% fatality rates among the wounded in Turkey, and her efforts reduced the rates of non-battlefield deaths to 2.2%. As a result of her efforts, she received a government grant of 45,000 British Pounds which she is over £3.5 million in today's value and used it to establish the first school of nursing at St. Thomas's Hospital in London in 1860 (Baly 1986) (Woodham, Woodham-Smith 1951).

Florence Nightingale's work set the principles for the nursing profession based upon her belief that, nursing should be an independent career for capable; trained women; nursing services should be administered by those with special preparation; relationships between physicians and nurses should be professional0 (Baly 1986) (Woodham, Woodham-Smith 1951).

By the end of the nineteenth century, most of the Western world had adopted Nightingale's approach to developing nurses and the profession itself had become more independent of religious institutions. Still, the leadership model continued to be similar to the monastic approach which the military had adopted (Walsh 1994). This was characterized by a top down chain of command with all personnel following strict rules and procedures (Walsh, 1994). Max Weber would have immediately recognized this as "rational-legal" authority. The end of the Second World War marked a major turning point for the nursing profession,

whereby nurses had to learn new skills, extend their field of expertise, and become more specialized thus gaining more independence and authority in their working environment (Morgan 1998).

In recent decades, many researchers have delved into the world of nurses and have reported the threats surrounding the profession. Baby boomers which is the title given to people born post-World War Two increased birth rates, were the main suppliers of the nursing workforce during the 1960s and as such, this workforce is rapidly aging with 40 to 60 percent of these nurses expected to retire within the next ten years (Cordeniz 2002). Life expectancy is ever increasing, the percentage of people over age 65 and over in the general population is expected to double in the upcoming 20 years (Henrich 2001). Lastly, the US Department of Health and Human services has projected a 29 percent nurse's shortage by 2020 due to a 40 percent increase in demand. In addition to the points above, the medical profession is experiencing advances and hospitals are becoming ever more complex. This has focused attention on the need for nursing workforce leadership to address the challenges relating to employee recruitment and retention.

Several studies have shown that following the traditional methods in working with nurses will not solve the problems of de-motivation, employee turnover, and encouraging new entrants. On the contrary it will result in even greater setbacks. As Swearingen and Liberman (2004) put it,

> "quick fixes are not enough, hospitals can raise salaries if possible, offer bonuses, scour other countries, or introduce new diploma

> programs to improve the capabilities of their current staff, but nothing can retain nurses if drastic changes to how business is conducted are introduced"

The Academy of Canadian Executive Nurses points out that the standard approach to leadership is yielding to a newer model based on teamwork, taking initiatives, involving others in decision making, and allowing nurses at all levels to exercise some degree of leadership. Swearingen and Liberman (2004) describe this as servant-leadership.

Their study (2004) titled "Nursing leadership: serving those who serve others" demonstrated that nurses who feel they contribute to the work environment experience job satisfaction, whereas management styles which prevent nurses from achieving personal goals result in poor job satisfaction and high employee turnover.

Kouzes and Posner (2002) describe the role of nursing leadership as "a process ordinary people use when they are bringing forth the best from themselves and others". This importance of collaboration was echoed by Havens and Aiken (1999) who stressed the importance of maintaining high levels of interaction between team members as best approach to nursing practice and problem solving. In the same manner Studer (2004) highlighted the importance of participative forms of leadership in the nursing environment as a means of

achieving unit cohesiveness and increasing job satisfaction. In his words,

> "Nurses who feel a part of a valued team and participate in leadership activities are less likely to leave the organization."

Weik, Prydum, and Walsh (2002) revealed that young nurses preferred leaders who were honest, motivating, receptive to people, had a positive outlook on life, and had good communication skills. Similarly, nurses with longer years of experience preferred leaders who exhibited integrity, fairness, and empowered others.

2.5 Administration and leadership

In earlier times, healthcare services were rendered by physicians, who were known to be independent thinkers and self-reliant professionals. They could lead and manage small operation in ordinary, as well as emergency situations without having the required training on the techniques of management (Hepner 1997).

As the structures of healthcare organizations and hospitals grew, they began to be run by non-medical executives. These leaders had the undesirable task of coordinating the work of different hospital departments including human resources, finance, archives, nursing, laboratory, and surgery. These administrators had to work twice as hard to win the hearts, minds and respect of headstrong medical professionals (Henochowicz, Hetherington 2004).

Numerous studies have shown a positive relation between leadership and employee satisfaction in the healthcare industry, Aronson, Sieveking,

Laurenceau, and Bellet (2003) defined leadership as the ability to influence subordinates to perform at their best. They added that this trait was driven by

> "the extent that management respects workers, operates with honesty, integrity, promotes efficiency, and has open lines of communication with employees."

Spinelli's study (2006) applied Bass's model of transformational, transactional, and laissez-faire leadership in the hospital administrative environment. The study verified that subordinates preferred leaders who followed a transformational leadership style. Bass (1985) described a transformational/charismatic leader as someone who is capable of getting followers to transcend their self-interest while raising the importance of the desired outcomes.

> "Charismatic or transformational leadership whose aspects are strongly and universally endorsed across cultures articulate a realistic vision of the future that can be shared, stimulate subordinates intellectually, and pay attention to the differences among the subordinates" (GLOBE)

He added that transformational leadership differs from transactional leadership which is based on an exchange reward system. In the latter from, the leader ties support and reward structures to performance (Bass, 1985).

2.6 Weber and Authority

This is a study of healthcare authority values; and Max Weber's work on authority is thus of high relevance to it. In his book *The Theory of Social and Economic Organization*, Weber identified three fundamental types of authority, "traditional", "rational-legal", and "charismatic".

(1) *Traditional authority*, according to Weber is mainly continued through the historically-endorsed use of power. This category is not challenged by time, does not encourage social change, and supports the status quo

> "The creation of a new law opposite traditional norms is deemed impossible in principle". (Weber 1974)

This category incorporates the sub-category, "paternalistic", which refers to a systematic relationship in which authority is sustained by subordinates' expectations of fair treatment, and material or symbolic gains from the leader. Traditional systems usually involve the centralization of power in a single individual who becomes the focus on political lobbying. (Neal and Finlay, 2005).

(2) *Rational-legal authority* is embedded in technocracy where roles are clearly defined by strict rules and procedures. Rational-legal systems are noted for their impartiality, a lack of concern for individual goals, and a focus on the rationality and efficiency of the organizational system's operations. (Neal and Finlay 2005)

> "Weber observed that this form of authority was reflexively related to what he called zweckrational action: the impersonal, rational pursuit of goals that are themselves rationally determined". (Neal and Finlay 2006)

(3) *Charismatic authority* is rooted in the perceived extraordinary characteristics of the leader. Weber defined the charismatic leader as:

> "he is set apart from ordinary men and treated as endowed with supernatural, superhuman, or at least specifically exceptional powers or qualities. These are such as are not accessible to the ordinary person, but are regarded as of divine origin or as exemplary, and on the basis of them the individual concerned is treated as a leader " (Weber 1974)

Neal and Finlay (2005) noted out that *Charismatic authority* might take the shape of a simple leader-follower relationship but does not necessarily involve interactive skills.

> "One can be aloof and non-participative and still have high levels of charismatic authority". (Neal and Finlay 2005)

In our modern world, charismatic authority is viewed differently from what Weber envisioned. In his research, Bass (1997) illustrated that management structures are leaning nowadays more towards charismatic/transformational authority which is more a combination of charisma and interactive skills, than rational-legal authority. This difference in how charismatic authority is viewed today drove Neal and Finlay to create a fourth type of authority which they called "Interactive authority"

(4) *Interactive authority* as envisioned by Neal and Finlay (2005) is closely related to participative management. In present day practice, it is used to describe interactions between leaders and subordinates that are typified by informal relationships, delegation on authority, and consultative decision making.

> "Interactive authority is primarily rooted in the embedded interactive activities of the leader. In conditions of interactive authority, the relationship between leader and subordinate is characterized by high levels of informality, trust, delegation, negotiation, and consultation." (Neal and Finlay 2005).

Chapter 3

Research Methodology

3.1 Research Design

This research inquiry is an extension of previous studies reported by Neal and Finlay (2002, 2005). Whereas their study measured the attitudes of female business students towards implicit leadership authority, this project sought to improve on their research design by including both male and female subjects and obtaining information and specifically focusing on healthcare employees. Since this research study deals with leadership authority values, the instrument used required respondents to rate statements concerning the characteristics, actions, and background of an ideal effective leader. The instrument used in this study is similar in content and scope to that employed in the leadership research of Neal and Finlay (2004, 2005). However, it was modified so as to be more discriminating in terms of leadership authority values, particularly where personnel working in the healthcare industry are concerned. This was accomplished by employing a seven-point scale, ranging from "strongly agree" to "strongly disagree", as opposed to the five-point scale foil used by Neal and Finlay (2004, 2005). In addition, six additional statements were included, primarily associated with *rational-legal* leadership, bringing the total number of statements to 39, with each of these being clearly associated with one of the four ideal types of leadership authority*: interactive*, *rational-legal*, *traditional*, and *charismatic*. [see Appendix 1]

3.2 Data Collection

Given that this study was exploratory in nature and that the author did not intend to generalize his findings to the entire Lebanese population, convenience samples of Physicians, nurses, technicians, administrators, and lab technicians were used. For analysis purposes, demographic information was collected from the respondents, including gender, religion, highest degree earned, and whether hey had prior direct supervisory experience over subordinates. A complete listing of the demographic characteristics of the respondents is provided in **Table 1**.

Table 1
Overall Demographic Characteristics of Respondent Groups

Demographic Characteristic	%
Gender	
Female	54.50%
Male	45.50%
Religion	
Muslim	10.50%
Christian	5.50%
Druze	4.70%
NA	79.30%
Supervisory responsibility	
Yes	55.50%
No	44.50%
Primary responsibility	
Physician	40.60%
Medical support	35.60%
Administration	23.80%

The sample was drawn from six hospitals operating in different areas of Lebanon. The medical facilities included two of the major hospitals in Beirut, a hospital in the Beqaa Valley (Zahle), a hospital in the Shouf area, two midsize hospitals in Mount Lebanon, and a major hospital in the South of Lebanon (Saida). The sample was drawn from persons of both subordinate and managerial ranks within their hospitals. The respondents were "self-selecting" in that they completed the instrument on a voluntary basis. In order to ensure that no over-representation of one of the professions occurred, questionnaires where distributed to the respondents in accordance to degree to which each of the professions was represented in each hospital.

Distribution of questionnaires was accomplished either by gaining the written approval of the hospital administrators in order for the researcher to distribute the questionnaires individually, or in other cases when the hospital administrations cooperated by taking on the role of distributing the questionnaires to their staff. In all cases, it is important to make clear that participation was voluntary, anonymous, and not subject to any form of reward mechanism.

Due to the fact that respondents were all volunteers, a response rate could not be computed. The number of usable questionnaires received was 261; they were divided in terms of independent variables in the following manner: 106 Physicians, 93 medical support, 62 administrators, 140 females, 121 males. The group of respondents provides a fair representation of the full-time workforce in the Lebanese healthcare workforce.

3.3 Development of Hypothesis

The working environment of physicians has dramatically changed over the past Century. Historically, physicians enjoyed complete autonomy at their working environment making them the sole decision maker, but as healthcare evolved their environment moved from one which was physician-controlled to a more collaborative interactive environment. The healthcare industry has moved to a new leadership paradigm that encourages group practice and responsibility (see Crosson, Weilnad, & Berenson 2004; Kutra &Curry 1994; Crosson, Weilnad, & Berenson R 2004). Given the current decision-making environment, it would not then be surprising if physicians were to adopt an interactive approach to authority rather than a traditional one.

Next, we considered the possibility the nature of their work play a role in shaping the attitudes of nurses toward leadership authority. Nurses have traditionally followed a more rational-legal approach to authority (Walsh, 1994) but as the nursing profession evolved and the demand for nurses has drastically risen, there is evidence that they have become more supportive of a participative approach. According to a variety of authors (see Havens, Aiken 1999; Studer 2004) the participative approach enhances unit cohesiveness, increases job satisfaction, and give away to better ways of solving problems. While nurses may be highly interactive within their own work environment, they are still subject to strict rules and procedures that are imposed by physicians in order to ensure the well being

of the patients (see May & Raz 1993)]. These findings lead to the development of the following hypothesis:

Hypothesis 1: Nurses will be more supportive of traditional authority values than physicians.

Hypothesis 2: Administrators will be more supportive of traditional authority values than physicians.

As Spinelli (2006) observes, hospital administrators preferred a transformational, transactional leader who is capable of getting followers to transcend their self-interest while raising the importance of the desired outcomes (Bass 1985). Weber (1978, pp.956-1005) also indicated that roles and duties that require plenty of paperwork, and bureaucracy were associated with rational-legal authority. This led the author to draw of the following hypothesis.

Hypothesis 3: Nurses will be more supportive of rational-legal authority values than physicians.

Hypothesis 4: Administrators will be more supportive of rational-legal authority values than physicians.

3.4 Statistical Analysis

The statements were written so that a rating of "strongly agree" would correspond to a high level of support for a specific authority type, referred to as "construct". The original 39 variables were expanded by summing all of the responses under each of the authority types and computing a mean for the total value of each. The end result was the development of four "Prototype" variables representing the four types of leadership authority values.

For the purpose of statistical analysis, the data was subjected to an analysis of individual variables and group means using the Scheffe' option available in ANOVA. One of the strengths of Scheffe' test is its tendency to declare a lack of significance when the standard ANOVA does not (Hair, Anderson & Tatham, 1995). The authors point out that this approach is generally considered to be more appropriate for exploratory studies since it guards against the occurrences of Type 1 error (i.e. the risk of declaring a significant relationship when one does not actually exist) (Hair, Anderson &Tatham, 1995).

Chapter 4

Research Results and Findings

4.1 Evaluation of Individual and Group Means:

Table 2 which summarizes the Sheffe' tests for the individual statement means, shows a high level agreement among the three employee classes with respect to the underlying authority values. Of the 39 individual statements included on the instrument, only eight were associated with significant physicians, medical support "nurses", and administrators.

Table 2

Sheffe' tests for the Means of the Prototype Variables

My idea of an effective leader is one who . . .	Construct	Physician	Admin	Medical Support	Sig. Level
is from a rich or powerful family	Traditional	1.9	2.69	2.88	0.00
practices strong religious values	Traditional	2.29	2.71	3.39	0.00
is primarily concerned about his/her own personal success	Traditional	3.38	3.95	4.22	0.015
likes routine and habit	Rational-legal	2.67	3.19	3.54	0.003
is better educated than the other members of the organization	Rational-legal	5.25	5.79	5.96	0.002
is the most capable individual in their field of study	Rational-legal	5.36	5.92	5.92	0.004
has received the most external recognition for their accomplishments	Rational-legal	5.21	5.73	5.81	0.006
is the most qualified person in their particular area	Rational-legal	5.53	6.02	6.05	0.008

4.2 Authority prototypes of Leadership

In addition to evaluating the means of each of the individual questions, the author sought to test the strength of constructs when viewed as a whole. Utilizing the revised prototype of authority variables (PI-P4) in Table 3, the author first made comparisons based on their absolute values.

Table 3

Sheffe' for Authority Prototypes

	Interactive Mean		Charismatic Mean	Traditional Mean		Rational legal Mean
Primary responsibility	N	Subset for alpha = .05	Subset for alpha = .05	Subset for alpha = .05		Subset for alpha = .05
		1	1	1	2	1
Physician/Surgeon	106	5.5385	6.2688	3.767		5.6624
Admin	62	5.4973	6.1129		4.1645	5.7811
Medical Support	93	5.7276	6.3082		4.2366	5.9101
Sig.		0.142	0.348	1	0.887	0.1

Physicians:

In absolute terms, the rankings of the authority prototypes of leadership scores for physicians were as follows:

P4: Charismatic 6.31
P3: Rational legal 5.66
P1: Interactive 5.54
P2: Traditional 3.77

Physician leadership authority values were strongly charismatic, rational-legal, and interactive. What stands out in terms of this analysis is the lack of clear leadership prototype for physicians. While the mean value for charismatic was the highest, the physician respondents also evidenced strong support for rational-

legal, and interactive as compared to the traditional approach to authority in leadership.

Medical Support "Nurses":

In absolute terms, the rankings of leadership prototype scores for medical support personnel [i.e. nurses] were as follows:

P4: Charismatic	6.27
P3: Rational legal	5.91
P1: Interactive	5.50
P2: Traditional	4.24

Again the data showed similar levels of support for Charismatic, Rational-Legal and Interactive authority. The medical support personnel had similar levels of support to physicians in terms of all four authority in leadership prototypes with charismatic receiving the highest means rating followed closely by rational-legal and interactive. The only difference between these two groups was a relatively higher degree of acceptance of traditional authority among the medical support "nurses" respondents that may be attributable to their relatively lower status in the overall decision-making hierarchy.

Administrators:

In absolute terms, the rankings of leadership prototypes scores for administrators were as follows:

P4: Charismatic	6.11
P3: Rational legal	5.78
P1: Interactive	5.73
P2: Traditional	4.16

The administrators overall means mirrored those of both physicians and medical support personnel with Charismatic being the most favored followed closely by Rational-legal and Interactive. As with the other groups, Traditional received the lowest degree of support, slight lower that the mean for the medical support personnel.

The consistency of these results show that traditional authority, while once the norm in health care is now the least favored form of leadership (Crosson, Weilnad , Berenson, 2004). It is clear that there is no disagreement among the three employee categories with respect to the absolute values of the prototype variables. In all cases, Charismatic leadership was ranked highest followed by rational-legal, interactive, and traditional. This high degree of similarity is confirmed by the ANOVA tests in Table 3 which reveal levels of significance below (alpha .10).

4.3 Hypothesis Testing:

The Scheffe' results in Table 4 show that significant variances exist between the three groups with respect to at least two of the authority of leadership prototypes. The level of variation is greatest in terms of Traditional leadership [alpha .001] but is also marginally significant for Rational-legal leadership [.068].

Table 4
One Way ANOVA for the four authority prototypes

		Sum of Squares	df	Mean Square	F	Sig.
Interactive Mean	Between Groups	2.565	2	1.282	2.306	.102
	Within Groups	143.448	258	.556		
	Total	146.013	260			
Traditional Mean	Between Groups	12.422	2	6.211	6.966	.001
	Within Groups	230.052	258	.892		
	Total	242.474	260			
Rational-legal Mean	Between Groups	3.041	2	1.520	2.789	.063
	Within Groups	140.656	258	.545		
	Total	143.697	260			
Charismatic Mean	Between Groups	1.556	2	.778	1.047	.353
	Within Groups	191.755	258	.743		
	Total	193.311	260			

Traditional Authority Values:

The low ratings for the Traditional authority statements among physicians were very interesting, and enough to distinguish them from the other two groups. This was particularly evident in statements 2, [*My idea of an effective leader is one who] "is from a rich or powerful family"*, statement 7,*"is primarily concerned about his/her own personal success"*. In both cases, the medical support "nurses" and administrators, showed more support for traditional authority systems than physicians with significance level of (0.00) and (0.015) respectively. Statement 3, *"practices strong religious values"* showed that Medical support "nurses" were more supportive of traditional type of authority than physicians with significance level of (0.00) (see table 2). These results support the acceptance of hypotheses stating that physicians are less supportive of traditional authority than medical support "nurses" and administrators.

Separate Scheffe tests on the Traditional prototype variable were conducted to test the individual hypotheses relating to this mode of leadership [*H1: Nurses will be more supportive traditional authority values than physicians*] and [*H2:* Administrators will be more supportive of traditional authority values than physicians]. Both are supported by the Scheffe comparisons of the prototype variable for Traditional authority at the .001 alpha level [see Table 4]. Given that there was no significant variance between the medical support personnel and the administrators with respect to traditional authority, both H1 and H2 were accepted and it was concluded that physicians are significantly less likely to support traditional authority than medical support personnel and administrators. This finding is extremely important since it shows a complete reversal in the approach that physicians now take to medical decision making as compared to the approach they had adopted historically.

Rational-Legal Authority Values:

Five of the rational-legal variables showed significant differences among the three groups and the mean ratings for both medical support "nurses" and administrators were significantly greater than for the physicians. In all five cases, the levels of agreement with the individual statements were consistent. This is evident in the following statements, Statement 13, *"likes routine and habit"*, Statement 34, *"is better educated than the other members of the organization"*, Statement 35, *"is the most qualified person in their particular area"*, Statement 37,

"has received the most external recognition for their accomplishments", Statement 38, *"is the most capable individual in their field of study"* with significance levels of (0.003), (0.002), (0.004), (0.008), and (0.006) respectively (see table 2). These results also support the findings of the rational-legal authority prototype.

In terms of the prototype variable, separate tests for significance in terms of Rational-legal leadership authority were also conducted for [H3*: Nurses will be more supportive of rational-legal authority values than physicians*] and [H4: *Administrators will be more supportive of rational-legal authority values than physicians*.] Since rational-Legal authority is associated with bureaucracy, and the obligation to follow strict rules and procedures (Weber 1978), those at lower levels of responsibility often lack the authority to make key decisions. The author hypothesized that the nature of the work that medical support teams "nurses" and administrators do, would result in a significantly higher support for rational-legal authority than physicians. The Sheffe' comparisons again show commonality between the medical support personnel and the administrators but marginally different from the physicians [alpha .063]. While this level of significance is not sufficient to accept the hypothesis, it is worth noting. As a result, it was concluded that H3 and H4 were only marginally supported by the data. This finding is still important since it is consistent with the relatively lower level of decision-making authority that these groups possess.

Chapter 5

Conclusion:

This study has attempted to explore the support for established leadership authority values among healthcare personnel and to develop a leadership model for the Lebanese healthcare industry. Doing so has uncovered evidence that charismatic authority is the most preferred form of leadership among the healthcare personnel in Lebanon. While clear similarities are evident in terms of common preference for charismatic authority, we can also identify important differences, particularly the low preference of traditional authority among physicians.

The data from this study revealed very striking information in regards to physician leadership whereby the data shows a complete reversal in the leadership approach that physicians historically followed. Physician' responses clearly show that traditional authority is the least favorite nowadays and that charismatic authority is the preferred authority. The data also reinforces the notion that medical support units "nurses" are marginally more likely to support a rational-legal leadership style.

While these findings are by no means conclusive, they do suggest the existence of significant differences in the work place expectations, between the three

healthcare groups that can be attributed to the nature of the work that each of the groups play and are responsible for.

In order to reach a more certain ruling in terms of the preference to a single form of leadership and the impact that the nature of the work may play in this preference, the author feels that future further research should be conducted with a larger sample and a wider geographical representation of the Lebanese healthcare industry.

Appendix 1
Data Collection Instrument

My idea of an effective leader is one who . . .	**Leadership Type**
changes his/her behavior to suit different situations	interactive
is from a rich or powerful family	traditional
practices strong religious values	traditional
is willing to show anger with and punish employees when needed	traditional
has a clear strategic vision of the future	rational-legal
is willing to accept team decision-making when it is appropriate	interactive
is primarily concerned about his/her own personal success	traditional
treats all subordinates equally	rational-legal
is careful not to upset people	interactive
considers the personal welfare of all employees	interactive
promotes colleagues based on their loyalty	traditional
embraces change	interactive
likes routine and habit	rational-legal
advances subordinates based upon their performance	rational-legal
has great charisma and personal presence	charismatic
consults with his/her staff before taking action	interactive
demands that all rules are followed	rational-legal
is willing to make unpopular decisions	traditional
has a sense of humor and smiles a lot	interactive
takes ruthless actions with his/her enemies when necessary	traditional
makes firm decisions and sticks with them	traditional
can be persuaded to change his/her mind	interactive
regularly walks around talking to staff	interactive
keeps subordinates informed of any activity which could affect them	interactive
maintains a formal distance from subordinates	traditional
is always truthful with employees	rational-legal
is more concerned about organization goals than individual goals	rational-legal
inspires colleagues with a vision of the future	charismatic
is enthusiastic about work	charismatic
treats men and women equally	rational-legal
is open with information	interactive
provides subordinates with clear targets and goals	rational-legal
accepts disagreement from subordinates	participative
is better educated than the other members of the organization	rational-legal
is the most capable individual in their field of study	rational-legal
attains their position based on their professional success	rational-legal
has received the most external recognition for their accomplishments	rational-legal
is the most qualified person in their particular area	rational-legal
has strong political connections	traditional

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