

## Leadership Development for Rural Health

Tim Size

Rural health has come a long way, but has a long way to go. With hindsight, some might minimize Jim Bernstein's leadership, now unaware that much of what he did for rural health was initially just an idea, a hope. It is this midwifing of a vision into reality that is the very essence of leadership. Henry David Thoreau described Jim's caliber of leadership when he wrote the oft repeated lines, "If a man does not keep pace with his companions, perhaps it is because he hears a different drummer. Let him step to the music which he hears, however measured or far away."<sup>1</sup> Jim Bernstein leaves a legacy that continues to challenge all of us to care and to achieve more than we first thought possible, whomever our drummer, whatever our position.

On July 15th, 2005, the National Advisory Committee on Rural Health and Human Services advisory to the Secretary of the United States Department of Health and Human Services, adopted a Special Resolution to honor James Bernstein, which concluded with the following: "The Committee believes that the best way to honor Jim is to consciously work to help develop the next generation of rural health leaders. Jim was a master of creating change by working within the existing policy framework and helping others to build sustainable programs that addressed long-standing problems. The Department should play a lead role by developing a program that identifies emerging leaders from and for rural communities and provides them with the training and resources to play a lead role in ensuring access to quality healthcare in their states and communities. This program warrants long-term support by the Department, and it should focus on rural needs within the larger policy context that affects us all. The Committee urges the Secretary to take the lead on this initiative, which will serve as a reminder of all of Jim Bernstein's fine work."<sup>2</sup>

While I can see/hear Jim wincing at the focused personal attention, I know he would put up with it to help further develop rural health, a process that must include understanding our past. I believe he would also be the first to remind us of the many people who are called to exercise leadership in both large and small ways.

This commentary is a personal statement without presuming to be writing the definitive word on what we need to know to further develop rural health leadership. My intent is to express belief as belief and not individual belief as universal truth, a convention too common today in our national "dialogue." The reader is invited to engage with what he or she reads here, taking what might be useful, and hesitating a moment to think through what might be useful, but doesn't immediately seem so. This is a "conversation," not a lecture.

### What Is Leadership Development and Why Do We Need It?

The weekend I received the opportunity to write this commentary, our church was celebrating those living or dead who made a contribution to our faith and various communities. That service brought forth the image that individuals who exercise leadership are like a river's current—a part past where we now stand, a part yet to come. We have an ongoing need to remember and to look toward the next "generation." Rural leaders will arrive without the assistance of any of us, but deliberative leadership development will foster more effective and diverse leadership. A key responsibility of those here now is to mentor and to create structures for mentoring, in order to maximize the flow and effectiveness of tomorrow's leaders.

Leadership is the capacity to help transform a vision of the future into reality. This commentary focuses on *leadership* development more than *leader* development to emphasize that throughout our organizations and communities, we have and need individuals who may not be formally designated as leaders, but who can and do exercise leadership. Leaders recognize that none of us are called

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to always lead, that sharing or conceding leadership to others is also a key role. None of us are called to lead on every issue; all are called to interact and support the vision and ideas brought by others.

We need to recognize that in addition to individuals having the potential to exercise leadership, the potential of leadership also exists “corporately,” in groups of individuals, whether they are teams, organizations, or communities. Individually and collectively, at all levels, we are called to lead in one place or another and are “born” with traits that can both enable and interfere with that opportunity and responsibility. Wherever the individual or group starts, learning and growth are possible. We need to structure leadership development for groups and communities as well as individual leaders.

Leadership development, formal or informal, is not just for the chronologically young. I have a friend who for many years has been a newspaper reporter and columnist as well as the chaplain for a mission that works with our city’s poor and addicted people. He has arrived at “retirement” age, but many of his readers are now seeing a columnist who speaks with a profoundly clearer voice. Some of the paper’s readers who disagree with him would undoubtedly welcome the news of his retirement; so be it, leadership necessarily brings out in good measure both supporters and detractors.

Leadership comes in many contexts. Jim Bernstein and I talked more than once about the similarities and differences in our vocational situations. We held in common that we were born and raised “elsewhere,” but became deeply rooted in our adopted home states. I work with mid-western rural communities facing relatively more racial homogeneity and less extreme poverty. These communities have a strong tradition of agricultural cooperatives that enabled our development of a cooperative of community hospitals—hospitals that work with and challenge both our state and our universities. Jim worked with southern rural communities facing more racial diversity and often extreme, community-wide poverty. He was able to be innovative from a position inside of government. Jim was notable in the respect and understanding he offered those working in a variety of circumstances.

A friend recently shared with me a few of the leadership challenges she faces, which are unique to her role as the chief executive officer of a hospital in a rural community. This commentary will not catalog such challenges, but her comments serve as a reminder for the “in the trenches” reality that rural health leadership development initiatives must address. “It is easy to become isolated, I am the only person doing what I do in our community. We are much smaller than most of our urban counterparts, so I need to juggle the crunch of many required ‘dos’ without the luxury of additional staff who can take the ball from start to finish. And when first arriving, it was not unusual to have a ‘new gal/guy in our community trying to tell us what to do’ type greeting. ‘She or he will be gone and never give us another thought.’ ”

## The Role of Nature and Nurture

At one time, people tended to believe that leaders were born, not made. Now we tend to see leadership as a set of traits that can be nurtured. But what about nature, the traits we are born with? A while back, I was asked when I became an advocate. The answer was that we all receive some traits at birth, or shortly thereafter. “One of my most vivid memories of home in the late 1950s is the endless kitchen argument with my devout Baptist mother on the theory of evolution. Her particular tenacity on this issue may be traced to her childhood memories of her guardian’s friend, William Jennings Bryan, the famed attorney on the then winning side of the ‘Scopes Monkey Trial.’ But like many women of her generation raised in the shadow of the old south, she had a finely tuned nature of smiling and cajoling while not giving an inch.”<sup>3</sup> On the way to the rest of my life, I realized that what we did have in common was an innate passion to talk, and to never concede. Yes, nature matters, but it need not be determinative. Subsequently, with the help of a very well-financed Kellogg leadership program, others were able to teach me not to use a rhetorical cannon when a rifle was sufficient, and that once in a while, a concession wouldn’t kill me.

America has a complex heritage when it comes to how it thinks about leaders—accepting contradictory leadership styles. We call the strong, individualistic characters, such as played by John Wayne, classic American leaders. Democrats and Republicans honor Jimmy Carter’s leadership, whose less autocratic emphasis on partnership makes him a contender for “the country’s most successful ex-President.” We understand that leadership is not limited to the classically cinema-charismatic or those holding formal power, as Rosa Park’s “simple” act of saying “no” will forever testify.

How our culture holds these apparent contradictions is not well understood. Robert Frost’s poem “Mending Wall” set on a New England farm is most famous for the line “Good fences make good neighbors,” a frequent citation of American individualism. But it is a better example of not reading a whole poem. Frost goes on to say, “I let my neighbor know beyond the hill, and on a day we meet to walk the line and set the wall between us once again....” Even this icon to self-sufficiency is expressed within the cultural context of selective cooperation.<sup>4</sup>

To develop as a leader, we must understand how leadership has unfolded in our own lives. A key initial transition is to recognize and accept “for better, for worse” what characteristics one has “hard wired” and then begin to see how one can develop further. This is also a precondition for those intending to take on the role of leader recruiter or mentor.

In my own development, a key step forward happened in my mid-20s while working as an “assistant superintendent” at a university hospital. As quickly as a light switch is turned on, I was lucky one day to realize that maximizing program successes was not the same as minimizing program failures. This eventually led to a transition from state government, which I experienced as being risk adverse, to an organization in the non-profit sector, which has allowed calculated risk taking. The operative word is

“I experienced.” Jim Bernstein is the obvious counter example, having taken many risks and had many successes from a base within state government.

Risk taking requires comfort with failure, one of life’s most powerful teachers. A while ago, I was asked to address how I maintain energy in the face of so many failures. I was taken off guard because I didn’t think of myself as having had that many failures. Upon reflection, I was able to easily come up with a list of ten failures, many of which in less charitable circumstances would have involuntarily led me to “pursue a new career opportunity.” I just hadn’t been keeping a tally, and I still don’t.

For us to have integrity as leaders, we have to continue to work to know who we are as we relate to our work. A timeless illustration is found in Chinese philosopher Chuang Tzu’s “Woodcarver,” written about 2,300 years ago:

Khing, the master carver, made a bell stand  
Of precious wood. When it was finished,  
All who saw it were astounded. They said it must be  
The work of spirits.  
The Prince of Lu said to the master carver:  
“What is your secret?”

Khing replied: ...  
“What happened?  
My own collected thought  
Encountered the hidden potential in the wood;  
From this live encounter came the work  
Which you ascribe to the spirits.”

The best explanation of this poem I know is in Parker Palmer’s renowned work on vocation, an *Active Life*.<sup>5</sup>

...we both act and are acted upon, and reality as we know it is the outcome of an infinitely complex encounter between ourselves and our environment. In this encounter we do some shaping, to be sure, but we are also shaped by the relational reality of which we are a part. We are part, and only part, of the great community of creation. If we can act in ways that embrace this fact, ways that honor the gifts we receive through our membership in this community, we can move beyond the despair that comes when we believe that our act is the only act in town.... When authentic action replaces unconscious reaction, the active life becomes not (in the words of Chuang Tzu) ‘a pity’ but a vital and creative power.

As noted by Parker Palmer, how we choose to frame or understand our relationship with others and our environment is critical to our growth as leaders. My best example occurred in graduate school, or more specifically in the dormitory elevator in graduate school. It was Chicago’s oldest and slowest Otis elevator—it took an “eternity” to go the 12 stories to my room. One day it hit me that my frustration wasn’t the result of the elevator, but my unrealistic expectation of its behavior. Subsequently, I still thought it was slow, but I didn’t worry

about it. So how do we frame rural health leadership? What kind of elevator is it? If we make the right investments, what kind of elevator can it become?

## Servant Leadership and Rural Health

The concept of “servant leadership” is a perspective held by many throughout the rural health community, and I believe is a major frame for understanding the attributes of leadership we need in rural health. Robert Greenleaf, the man who coined the phrase servant-leadership described it as “the servant-leader is servant first.... It begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead.”<sup>6</sup> I don’t believe he is saying “natural” as in the sense “natural athlete,” but that at some point in life, the feeling arises to serve, which in turn leads to a decision to exercise leadership. What are the attributes of servant leadership; what characteristics or skills must we look for when we recruit a leader or should we look for when we learn, teach, and reinforce? For me, a good start to that question is to compare the attributes of “servant” and “traditional” leaders. Cooper McGee and Duane Trammell do just this in “Hero as Leader to Servant as Leader.”<sup>7</sup>

### Examples of Traditional Leadership Skills

- Highly competitive; independent mindset; seeking personal credit.
- Understands internal politics and uses them to win personally.
- Focuses on fast action.
- Controls information in order to maintain power.
- Accountability is more often about who is to blame.
- Uses humor to control others.

### Examples of Servant Leadership Skills

- Highly cooperative, interdependent; gives credit to others generously.
- Sensitive to what motivates others to win with shared goals and vision.
- Focuses on gaining understanding, input, buy-in from all parties.
- Shares big-picture information generously.
- Most likely listens first, values others’ input.
- Accountability is about making it safe to learn from mistakes.
- Uses humor to lift others up.

## Our Health Needs Collaborative Leaders

I had the opportunity to serve on the national Institute of Medicine’s (IOM) Committee on the Future of Rural Health Care. For me, the major breakthrough in the Committee’s work as documented in the report, *Quality Through Collaboration: the Future of Rural Health*,<sup>8</sup> was that the IOM’s Six Quality Aims (originally constructed for the healthcare of the individual) apply equally well to a population health perspective, or said another way, “the community as patient.”

This perspective that we need to “balance and integrate personal healthcare with broader communitywide initiatives that target the entire population,”<sup>9</sup> developed after the committee applied the IOM report, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*,<sup>9</sup> to rural health. Examples of applying the IOM’s Six Quality Aims for a population health perspective include:

- *Safety*: Road construction designed to reduce auto accidents.
- *Effectiveness*: Public schools act to reduce risk of obesity/diabetes.
- *Community-centered*: Regional provider networks respect community preferences.
- *Timeliness*: Timely identification of epidemics.
- *Efficiency*: Public reporting of population-based measures of health status.
- *Equity*: Developing, maintaining rural jobs.

The Committee on the Future of Rural Health Care synthesis was that “rural communities must build a population health focus into decision-making within the healthcare sector, as well as in other key areas that influence population health. Most important, rural communities must reorient their quality improvement strategies from an exclusively patient- and provider-centric approach to one that also addresses the problems and needs of rural communities and populations.”<sup>8</sup> This vision constitutes a major opportunity for rural health leaders to lead the health of our country, all of it. The “central thesis” of the recently published compendium *Reinventing Public Health, Policies and Practices for a Healthy Nation* makes the same point “to effectively improve population health and reduce health disparities, policy making in a variety of domains must take into account policies that address the fundamental social, economic, and ecological determinants of health.”<sup>10</sup>

As an example, in Wisconsin, a voluntary coalition has developed a Strong Rural Communities Initiative (SRCI) to support the state’s health plan by implementing sustainable rural models for medical, public health, and business collaboration to enhance preventive health services in rural Wisconsin. In *Wisconsin County Health Rankings 2005*,<sup>11</sup> a report by the Wisconsin Public Health and Health Policy Institute at the University of Wisconsin-Madison, 52% of metro counties in Wisconsin are in the top (best) quartile for Health Outcomes compared to only 11% of non-metro counties; 30% of non-metro counties are in the bottom (worst) quartile compared to 16% of metro counties. The specific purpose of SRCI is to improve health indicators for selected rural communities in Wisconsin and significantly accelerate establishing collaboration for prevention as the norm, not the exception, in rural Wisconsin.

The complexity of creating a healthy state requires a higher level of cooperation than any of us have yet experienced. This requires a significant expansion in our commitment and ability to develop collaborative leadership. Again, from *Quality Through Collaboration: the Future of Rural Health*:<sup>8</sup>

Strong leadership will be needed to achieve significant

improvements in health and healthcare in rural communities. Comprehensive community-based efforts will require extensive collaboration, both between stakeholders within the healthcare sector, and between healthcare and other sectors. It will be necessary to mobilize all types of institutions (e.g., healthcare, educational, social, and faith-based) to both augment and support the contributions of health professionals. Rural communities engaged in health system redesign would likely benefit from leadership training programs.<sup>8</sup>

## Principles of Collaborative Leadership

The significant challenges we face today in healthcare require a form of leadership that is less authoritative and more collaborative. Ronald Heifetz and colleagues at the Stanford Graduate School of Business say it very well. These “problems require innovation and learning among the interested parties, and, even when a solution is discovered, no single entity has the authority to impose it on the others. The stakeholders themselves must create and put the solution into effect since the problem is rooted in *their* attitudes, priorities, or behavior. And until the stakeholders change their outlook, a solution cannot emerge.”<sup>12</sup> It is important to not confuse being collaborative with endless stanzas of singing “Kum By Ya;” collaboration frequently requires strong external catalytic action.

Max DePree, in *Leadership Is an Art*,<sup>13</sup> offers a model for employer-to-employee relationships based on his experience that productivity is maximized by designing work to meet basic employee needs. His vision of the art of corporate leadership brought employees into the decision-making process. DePree’s experience is primarily within the world of the Fortune 500, but many have found him to offer a useful framework for non-profit and public sectors.

While DePree was a successful leader of a Fortune 500 Company, some may describe him as impractical, a common descriptor thrown by the “pragmatists” at “collaborators.” Robert Greenleaf offers a suggestion that may be helpful in thinking through this dilemma: “For optimal performance, a large institution needs administration for order and consistency, and leadership so as to mitigate the effects of administration on initiative and creativity and to build team effort to give these qualities extraordinary encouragement.”<sup>14</sup>

As the executive director of a cooperative of rural hospitals for more than 25 years, it is easier for me than for many to see rural health through the lenses of collaboration, the opportunities it creates, and the threats it endures as a model for organization and community work. We have adopted and adapted DePree’s eight leadership principles as a guide for both our internal and external relationships. To illustrate these leadership principles, the following is as described in the article “Managing Partnerships: The Perspective of a Rural Hospital Cooperative.”<sup>15</sup>

*There Is Mutual Trust*—Develop relationships based primarily on mutual trust so that the cooperative go beyond the minimum performance inherent in written agreements. “While responding

to a rapidly changing market in 1984, the implementation in six months, 'from scratch,' of a rural-based health insurance company in Wisconsin was only possible due to the prior existence of a basic level of trust among the key actors."

*Commitment Makes Sense*—Participants may join a cooperative to explore its potential; they remain only if they perceive that they are receiving a good return on their investment of time and money. "RWHC offers a broad array of shared services from which hospitals pick and choose according to their individual needs; commitments are made because they have been structured in a way that attempts to maximize the 'fit' for each individual participant."

*Participants Needed*—Each organization must know that it is needed for the success of the cooperative. "It is a major mistake to ever take for granted the participation or commitment of any member. The RWHC communication budget is ample testimony to the importance of early and frequent communication and consultation."

*All Involved in Planning*—The planning is interactive, with the plan for the Cooperative being the result of, and feeding into, the plans of the individual participants. "One theatrical but powerful example of ignoring the need for local input and preferences involved the Cooperative within months of its incorporation in 1979. Two regional health planners were practically driven from the bare wood stage of Wisconsin's historic Al Ringling Theater after their presentation of a unilaterally developed plan for local consolidations and closures. The plan was not implemented and did not contribute to further discussion of how rural healthcare in southern Wisconsin could be improved."

*Big Picture Understood*—Participants need to know where the organization is headed and where they are going within the organization. "RWHC has a motto: 'say it early and keep saying it.' A number of RWHC's more significant initiatives, such as improving rural hospital access to capital, various quality improvement projects, and advocacy for major education reform within the University of Wisconsin's health professional schools has been multiyear if not indefinitely long efforts."

*Participants Affect Their Own Future*—The desire for local autonomy needs to be made to work for the Cooperative through the promotion of collaborative solutions that enhance self-interest. "When RWHC began operations, many observers were highly skeptical about whether or not it would last, let alone make any real contribution—that rural hospitals' traditional need for autonomy would prevent any meaningful joint activity. Some shared services have been undersubscribed as hospitals have chosen local options when, at least from the perspective of RWHC staff, a cooperative approach offers a better service at a lower cost."

*Accountability Up Front*—Participants must always know up front what the rules are and what is expected of them. "Discussions at RWHC board meetings are frequently comparable to customer focus groups and equally valuable. Participation in all Cooperative shared services requires a signed contract, not so much as to permit legal enforcement, but to ensure that all parties in the partnership have thought through upfront the expectations of all the participants."

*Decisions Can Be Appealed*—A clear non-threatening appeal mechanism is needed to ensure individual rights against arbitrary actions. "The use of the cooperative strength of RWHC hospitals has been used to enforce an appeals process in a variety of circumstances, including a potential breach of contract by a large health insurer; individually, few could have justified the necessary prolonged legal challenge to enforce the contract but through concerted joint inquiry into the legal options available, further legal action became unnecessary."

## Recruiting Rural Health Leaders

When recruiting organizational leaders, the recruitment and interview process must seek individuals who in addition to technical competence, also have demonstrated leadership in their prior work and activities. John Gardner, in his classic work, *On Leadership*,<sup>16</sup> notes six characteristics common to individuals who exercise organizational leadership. These characteristics are exhibited in many roles, for example, as the head of an organization, as a manager, or in a volunteer position:

- They think longer term—beyond the day's crises, beyond the current fiscal year.
- In thinking about the program or organization they are heading, they grasp its relationship to the larger organization or community—conditions external to the organization.
- They reach and influence constituents beyond their immediate area of responsibility.
- They emphasize the intangibles of vision, values, and motivation and understand intuitively the non-rational and unconscious elements in their relationship with their constituents.
- They have the political skills to cope with the conflicting requirements of multiple constituents and expectations.
- They think in terms of renewal. The leader or leader/manager seeks procedural and structural change consistent with an ever-changing reality.

In addition, as argued throughout this commentary, collaboration needs to be a core competency for leadership of those organizations claiming to work in or with rural communities. The following are a few examples of principles relevant to collaboration to keep in mind or discuss when recruiting or developing a leader.

*Collaborative Leadership Isn't Always Traditional*—If leadership is serious about maintaining and developing collaborative relationships, the following must be kept in mind:

- Management practices necessary for successful collaboration are not commonly seen in traditional, vertically organized institutions.
- Most administrators have had little experience, and even less training, regarding leadership within the context of collaborative models.
- The "natural" administrative response will frequently come out of traditions that may be inconsistent with the actions needed to support networking.

- The development of collaborative relationships has a different timescale than those based on authority—more time on the front end paid off later with less participant resistance.

*Personal Attributes of a Collaborative Leader*—A partial list of the personal attributes relevant to seeking or developing a collaborative leader include:

- Experience/potential for leading collaborative enterprises or networks, cultural competence across diverse communities and populations.
- When looking at alternative investments: the objectivity of an academic, the pragmatism of a businessman or woman, and the creativity of an artist.
- Appreciation for the dualities inherent in American culture—individualism and community, competition and collaboration; a realistic understanding of the health system challenges we face balanced by an “irrational” optimism and faith that we each can make a difference.
- A vision that leadership needs to be simultaneously top down and bottom up within organizations, as addressed by Max DePree.

*Collaborative Leadership Skills and Experience*—Below are a set of general questions intended to stimulate conversation regarding an individual’s collaborative leadership skills and experience.

- What is the role of “trust” in your work with colleagues or partners? What examples can you offer of your ability developing trust in these “partnerships”? How did you do it? How was the relationship affected?
- How have you been able to make your collaborative partners feel useful?
- How have community partners been invited into your organization? What did you see as benefits and challenges in these instances? How would you do it differently today?

- In what ways have you worked to promote collaborative solutions that have enhanced the self-interest of both internal and external partners?

## Summary

Leadership is the capacity to help transform a vision of the future into reality. Individuals who can and will exercise leadership are like a river’s current—a part past where we now stand, a part yet to come. We have an ongoing need to remember and to look toward the next “generation.” A key responsibility of those here now, is to mentor and to create structures for mentoring, in order to maximize the flow and effectiveness of tomorrow’s leaders. When recruiting organizational leaders, the recruitment and interview process must seek individuals who in addition to technical competence, also have demonstrated leadership in their prior work and activities.

To exercise effective leadership, we must work to know who we are, how we relate to others, and the environment around us. “Servant leadership” is a perspective held by many throughout the rural health community and offers a key set attributes of leadership useful to rural health. To implement the Institute of Medicine’s recommendations in *Through Collaboration: the Future of Rural Health*, we must develop leaders skilled in collaboration, both internal to their organization and across organizations.

The National Advisory Committee on Rural Health and Human Services had it right when they said to the Secretary and to the rest of us, “the best way to honor Jim is to consciously work to help develop the next generation of rural health leaders.” There are, of course, a multitude of leadership institutes, programs, and courses throughout America; this is not a call for yet another separate entity. But it is a call to each of us in rural health to assure that we are deliberate in how we identify “emerging leaders from and for rural communities and provide them with the training and resources to play a lead role in ensuring access to quality healthcare in their states and communities.”<sup>17</sup> Let’s get started. **NCMedJ**

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