

The Pennsylvania State University

The Graduate School

College of Education

LEADERSHIP ILLUMINATED BY CRISIS: CHARACTERISTICS OF EFFECTIVE
HOSPITAL CEOS

A Dissertation in
Workforce Education and Development

by

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Submitted in Partial Fulfillment
of the Requirements for the Degree of

Doctor of Philosophy

August 2014

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Abstract

Eight characteristic categories were identified after interviews with three health care CEOs and three of their senior leaders who lead through a tornado, hurricane, and nursing strike at three U.S. hospitals: Let Leaders Lead, Leverages Resources, Doing What's Right, Crisis Adaptability, Partnering, Building Organizational Talent, Meaningful Visibility, and Strategic Foresight. These characteristics set the foundation to develop a theory of health care CEO competencies for leading in a crisis. Each leadership team, CEO and three senior subordinates, was asked to identify positive characteristics of the CEO as they lead through crisis. The case study protocol was crafted following Yin's (2009) case study model and Charmaz's (2006) analysis using strict coding process resulting in the identification of categories and then themes. Previous research in this area identify characteristics via self-report or through an analysis of secondary data. This study's findings provide first hand, triangulated data of actual crises and how both the CEO and senior subordinates viewed the behaviors displayed by the CEO. This study fills a gap in current research and sets the stage for future studies that build toward a competency model for health care CEO leadership competencies. This study's finding have applications for executive teams, executive search firms, hospital boards, human resource and organization development practitioners, and those aspiring to work in executive leadership. Attending to the characteristics identified in this research can help a hospital to find a leader who is a best fit, one that fulfills the individual organizational, as well as industry, needs for a health care CEO.

Table of Contents

List of Figures	viii
List of Tables	ix
Chapter One: Introduction	1
The Problem.....	4
Purpose of the Study	6
Research Questions.....	8
Significance of the Study	8
Definition of Key Terms.....	10
Chapter Two: Literature Review	14
Historical Perspectives on Leadership Selection	15
Person-Organization and Fit versus Misfit	19
Crisis Leadership	21
Leadership Competencies	23
Leadership Crisis Competencies.....	25
Decision-making.....	29
Upper Echelon and Bounded Rationality Theories	43
Chapter Three: Methodology.....	46

Study Questions	46
Site/Sample Selection	47
Propositions	48
Unit of Analysis	49
Limitations	50
Assumptions.....	50
Linking Data to Propositions and Criteria for Interpreting Findings.....	51
Judging the Quality of the Research Design.....	51
Memo-writing	52
Coding of data.....	53
Theoretical Validity and the Negative Case	54
Trustworthiness.....	57
Chapter Four: Findings	59
Within-Case Analysis Hospital A.....	59
Within Case Analysis Hospital B	74
Within Case Analysis Hospital C	88
Cross-Case Analysis	102
Chapter Five: Study Summaries, Conclusions, and Recommendations.....	116
Introduction.....	116

Data Collection and Analysis Summary	117
Triangulation.....	119
Conclusions.....	119
Strengths	129
Limitations	132
Practical Implications.....	136
Recommendations for Future Research	140
Crisis Leadership Implications	143
Managers/Leader Implications.....	144
Talent Management Consultants Implications.....	144
Executive Coaching Implications	144
Final Summary.....	145
References.....	146
Appendix A:.....	161
Pilot Study One	161
Trustworthiness.....	169
Pilot Study Two	173
Appendix B:.....	184
Case Study Protocol.....	184

APPENDIX C:	186
Leadership Traits for CEO Selection: Lessons from Three U.S. Hospital CEOs During Crisis	186
Introduction to the Study:	186
Sample:	186
Benefit:	186
Time Requirement:	186
APPENDIX D:	188
RESEARCH PARTICIPATION CONSENT FORM.....	188
APPENDIX E:	190
Health Care CEO Characteristics Displayed During Crisis, Behavioral Event Interviewing Guide	190

List of Figures

Figure 1 - Case Study Method; source: Yin (2009), p. 57 57

List of Tables

Table 1 - The Link between Research Questions and Interview Questions 51

Chapter One: Introduction

The selection of a new chief executive officer (CEO) for a hospital should follow a standardized process. Each time a new leader is needed to fill an upper-echelon vacancy, the board of directors and/or the contracted executive search firm (ESF) should utilize a standard set of characteristics when establishing selection criteria. Findings from a search of the literature and completion of two pilot studies involving interviews with individuals responsible for setting executive search criteria indicate that a standardized healthcare CEO characteristic checklist appears to be missing from the process of identifying the best candidate.

Chief executive officer selection can create success or turmoil depending on the fit of the candidate. The CEO is often pointed to by researchers as having a significant effect on the organization he/she leads (Finkelstein, Hamrick, & Cannella, 2009; Hutzschenreuter, Kleindienst, & Greger, 2010). Health care leaders must possess characteristics that allow them to adapt to change and crisis as they face a variety of tumultuous situations. Health care challenges include exigent financial situations with poor reimbursements and low admission rates which make resource predictions even more difficult. Some hospitals are struggling so mightily that they are shutting down entirely (Gold, Englander, & Seligman, 2008). Some other challenges for hospitals are massive changes in the types and amounts of reimbursements from private and government insurance programs, coupled with a dim financial picture for many Americans. As acute care hospitals cope with the various challenges of finances, staffing, and internal crises, hospital boards often choose to replace the chief executive officer as a way of sparking change and improvement in overall firm performance (Lieberson & O'Connor, 1972). Hospitals' boards provide varying degrees of governance for acute care facilities. One of their charges is to lead the selection committee that chooses a CEO and often other upper-echelon positions. The board

might choose to coordinate the selection process on its own or contract an executive search firm (ESF) to lead the search. The board members are ultimately responsible for final selection and will need an evidence-based set of characteristics when making the definitive choice. This decision-making process was the basis of this research.

Castrogiovanni, Baliga, and Kidwell (1992) evaluated the extent to which a CEO can help a business that is in financial trouble. The authors suggested that the selected CEO replacement must have “appropriate predispositions and skills” (p. 26) to be of benefit to the organization. Due to poor financial and/or clinical performance (return on investment, return on equity, customer satisfaction), hospital boards might find themselves under pressure to make sweeping change in the CEO position when financial stressors or overall drops in performance metrics continue regardless of improvement efforts. When the choice of successor is a good fit, the organization can overcome many factors such as a radically changing strategy or outside-the-industry selections (Chen & Hambrick, 2012; McCanna & Comte, 1986). Drucker wrote in the 1980s that hospitals are some of the most complex entities to manage (Drucker, 1985, p. 50). Board members have a responsibility to select new CEOs and should be matching organizational needs with the skills, abilities, and characteristics necessary to assure a good fit, a match of organization needs, and the CEO. The fit-drift/shift-refit model proposed by Finkelstein, Hambrick, and Cannella (2009, p. 210) attempts to draw attention to the ever-increasing need to assure that the CEO and the organization are suitable for each other. Finkelstein et al. (2009) offered a model that suggests a CEO is hired with competencies right for the position but over time the position requirements change and the CEO becomes a poor fit for the position. Health care is, at its core, an ever-shifting industry, such that the skills necessary to lead might also change in parallel. The CEO must be able to flex with the needs of the hospital. Finkelstein et al.

(2009) suggested that if the board does not scrutinize the match in skills and abilities with organization strategic plan and needs, then success is less likely. The authors also provided evidence that boards lack internal talent during replacement decisions and might pay more attention to non-evidenced based criteria (Finkelstein et al., 2009). Boatman and Erker (2012) confirmed this finding when they surveyed human resource professionals ($n = 250$) and new hires ($n = 2,000$) in 28 countries for their Global Selection Forecast study, and found that although human resource professionals said it was important to choose the best executive by utilizing tools and research-based criteria, at most 36% used a tool beyond the interview and resume screening when selecting a candidate. Seventy-one percent of participants reported that the competition for talent has increased over the last five years. The authors looked at organizations described as small to multinational businesses in 33 industries and found key issues related to CEO selection:

- growing leaders from inside works;
- new hires often do not understand the job responsibilities;
- hiring managers rely on personal judgment and miss “using the right mix or number of assessments to know more about candidates” (p. 4); and
- non-U.S. companies utilize assessment tools when choosing the next hire and rate their systems better than U.S companies, and even when a company uses an evidence-based tool they fail to use the data to improve processes for future selection.

The survey illustrates the need to choose wisely regardless of industry or company size and provides support for research that gives selection committees a guide when choosing a CEO.

The Problem

The need for research into this area has been documented by only a few researchers (Mitroff & Pearson, 1993; Seeger, Sellnow, & Ulmer, 2003; Wooten & James, 2008). Crisis competencies have been considered from a communications and a crisis response paradigm but not from a leadership competency perspective. Mitroff & Pearson investigated how an organization prepares and responds to a crisis but did not provide specific direction for required leadership competencies. In fact many articles have provided suggestions for crisis response, crisis preparation, and skills needed for emergency management. However, although the emergency manager and CEO will share some required job responsibilities during a crisis they do not have a similar enough job description for one set of competencies to be interchanged with the other. There has been little research to systematically identify crisis leadership competencies that are necessary in crisis management. Prior research has suggested that sense-making, managing the change process, taking risks, and fostering organizational agility during a crisis are required competencies for the leader (James & Wooten, 2005; Shaw & Harald, 2004).

Most hospital boards eventually face CEO replacement; the system counts on the board's expertise in selecting the best candidate for the position. Unfortunately, research-driven selection criteria are lacking in processes to choose the next successor. New hires might rise from within an organization or industry, or enter from a different industry. However they end up in the final candidate pool, it is imperative that they espouse the characteristics needed to lead in an ever-challenging health care industry. Research that supports the use of standardized criteria that yield more successful placements is lacking in healthcare and other industries. Replacement is a prominent issue for health care organizations, as evidenced in the annual Booz & Company survey (Favaro, Karlsson & Neilson, 2012) of 2,500 large, publicly traded companies and the

career success of their CEOs. Results showed a rise in CEO replacement to a rate of 14.2% during 2011, up from 11.6% in 2010. The reason for CEO departure was largely due to planned succession (9.8%) and the remainder came as a result of dismissals, mergers, or acquisitions. The authors suggested that companies are demanding that CEOs show positive outcomes earlier; in larger companies they are looking to outsiders to fill positions. This look outside the company underlines the need to utilize a standardized process for selection and be clear about the specific characteristics being sought for the healthcare sector. This trend would have boards, and in turn their executive search firms, look for the best and brightest candidates to make changes and hopefully improve performance. The vast majority of successors are insiders; they come from within the company ranks, but there has been a slight trend for smaller firms to look at outsiders (Favaro, Karlsson, & Neilson, 2012). Almost 90% of new CEOs have never held the position before (Favaro, Karlsson, & Neilson, 2012, p. 3) which annuls the possibility of looking to past performance as a measure of success. Considering that boards offer CEOs large compensation packages (Finkelstein, Hambrick, & Cannella, 2009; Harris & Helfat, 1997) and in turn require superior performance, it seems necessary to ensure that board selection committees utilize a standard set of characteristics based on what successful health care CEOs have demonstrated in the past. This characteristic list would then better fit the organizational needs and potentially lead to improved CEO-position fit. Currently the literature is devoid of research that provides healthcare organizations with identifiable characteristics for a successful CEO choice.

Organizations that do not use criteria in selecting the best candidate will see less overall success. “Organizations that make evidence-based hiring decisions gather a tremendous amount of data to improve workforce performance and to have a significant impact on the business” (Boatman & Erker, 2011, p.7). It also was found that U.S. managers in charge of selection do not follow a

consistent process for choosing talent and use fewer tools than their non-U.S. counterparts who rate themselves higher in all phases of selection as compared to the U.S. (Boatman & Erker, 2011). In two pilot studies (Jones, 2011, 2012), selection committee chairpersons ($n = 6$) were interviewed to identify what, if any, selection criteria were used when choosing a new CEO. None of the organizations utilized a set of competencies and abilities criteria based in research, a competency-based checklist or any other evidence-based process to choose the next leader. The selection chairpersons summarized the process used, indicating that choosing the next executive was driven by generalizations about the previous leader's inadequacies, and that picking a CEO that "doesn't look like the previous one" was a major criterion. Many organizations utilize the services of an executive search firm (ESF), an outside company dedicated to locating talent, and take their lead from the selection chair or committee. Often the guidelines provided to the ESF are not based on competencies but suggestions (Jones, 2011). Much has been written about finding the "right" CEO (Allen, Panian, & Lotz, 1979; Chen & Hambrick, 2012; Finkelstein, Hambrick, & Cannella, 2009; Guest, 1962) and much of that literature has yet to define exactly how to accomplish this crucial task.

Purpose of the Study

The purpose of this study was to identify characteristics found in health care CEOs who have led during a crisis. The crisis will have impacted multiple departments of the organization and required the CEO to engage senior leadership during the event. Health care organizations are changing at a rapid rate. New regulations, increasing technology, insurance processes, and staffing are among the stressors at almost every facility. Hospital CEOs find themselves in a variety of high-stress and potentially critical outcome situations on a daily basis. Sometimes, however, they face crisis situations that place considerable stress on the organization as a whole

and have the potential to create significantly negative outcomes. It is critical that the hospital CEO possess the appropriate leadership characteristics to lead this type of organization on a daily basis but also to direct the response to a crisis in the most efficient and successful manner. It is therefore essential that the board selection committee or ESF choose the candidate with the right fit that can handle the unique health care environment. A global talent management company (Boatman & Erker, 2011) found that poor selection practices have consequences beyond the negative blow to team performance, and that the financial bottom line feels every bit of the inconsistent protocol. Nadler and Spencer (2009) suggested that during a crisis “is the moment, more than any other, when the CEO must simultaneously fill the roles of strategist-in-chief and battlefield commander.”

Crisis situations ask much of every individual in the organization but the CEO serves a unique role as the face of the organization and the practical commander-in-chief. Therefore, they need to have the characteristics necessary for this role. The question of what makes a good leader has been studied thoroughly but the answer to what makes a good health care CEO remains uncertain.

The purpose of this multiple case study was to uncover the upper-echelon characteristics possessed by successful health care CEOs. The focus was on crisis situations and how the CEO and their subordinates described these qualities as experienced during a crisis. Any similarities identified across the three cases in this study became part of a set of characteristics that may be utilized by board selection committees and their outside search firms. One potential end product of this study would be the creation of a composite of successful CEOs that may be used by hospitals and other health care organizations as a more succinct selection process.

Research Questions

Since CEO selection has not been consistent, nor has research led to evidence-based criteria for this process, it is difficult for hospital boards to be confident that their hiring process selects for characteristics that have demonstrated association with organizational success. The upper-echelon characteristics and organizational fit are of utmost importance in CEO selection; however, precise selection criteria are currently undefined. Crisis gives us insight into how a CEO performs in the most difficult of situations. Engaging the CEO's leadership team could provide further insight into how their leadership characteristics impact those around them, leading to positive outcomes.

This study attempted to answer the following research questions (RQ):

1. What characteristics were displayed by the health care CEO during the crisis that the subordinates felt were beneficial?
2. What characteristics do successful health care CEOs demonstrate in a crisis that can inform the selection of a health care CEO?
3. What common set of competencies is inherent to successful health care CEOs across all cases?

Significance of the Study

This study was designed to look specifically at the characteristics of health care CEOs who direct acute care facilities which, as defined by the American Hospital Association (AHA), operate at least 25 licensed beds. While all CEOs likely share some similar job duties, this study attempted to uncover what health care CEOs share that is specific to health care. After identifying the specific characteristics, the researcher compared all of the cases in an attempt to

assemble a list of research-based characteristic criteria that could be utilized by boards and selection committees in locating the candidate with a superior fit for health care organizations. And although companies report selection is critical they still fail to follow best practices when engaging in the process: using appropriate evidence-based tools and knowing the type of candidate they need (Boatman & Erker, 2011). This study could provide a set of characteristics for health care CEO selection that would be utilized by both the board and the executive search firms they employ. The use of a consistent research-based tool should increase the “fit” between the candidate and organization. A strong fit should have an impact on firm performance metrics (Finkelstein et al., 2009) as well as team performance (Lencioni, 2002).

Specifically identifying those characteristics possessed by successful healthcare CEOs will fill a gap in our knowledge (RQ1). To date, successful healthcare CEO characteristics have received little study. Exploring the reasons for their success can provide the beginning of a characteristics checklist. Evaluating the same criteria from the subordinate’s view will help to validate demonstration of the CEO’s competencies and their impact on those serving with him/her and, how this translates into success at multiple levels (RQ1.1).

It is not enough for a CEO to think they are “successful”—this needs to be validated by a variety of sources. Some of this validation can come from the hospital board, subordinates’ experience in being led during the crisis, positive outcomes for infrastructure, avoidance of a negative outcome for patients and/or encouraging experiences for patients and/or families. This study explored how senior leaders experience the CEO’s leadership and those characteristics they identify as successful (RQ2).

With information on three different CEOs in three different crises events with three different sets of subordinate experiences, the researcher looked for similarities among the groups.

Although sites and situations were different, each case included a CEO and three commonly found subordinates (vice president, chief operating/administrative officer, chief nursing officer, or chief financial officer) at each site. Similarities or themes found in each case allowed preliminary suppositions about the types of competencies held by successful health care CEOs (RQ3). This set of competencies would be most beneficial to a hospital board and ESF when seeking talent to fill a health care CEO position. Identifying the best-fit CEO from the start could lead to better organization performance, with that performance measured by the organization.

Definition of Key Terms

Bounded rationality

“The theory that people can understand only a limited amount of information within a limited amount of time, and for this reason they do not always make the best decisions, especially in complicated situations” (Cambridge Dictionaries Online, 2014).

Characteristic

“Being a feature that helps to distinguish a person or thing; distinction, a feature that helps to identify, tell apart, or describe recognizably” (*The American Heritage Dictionary of the English Language*, 2009).

Chief Executive Officer (CEO)

“... In most organizations, the Chief Executive Officer (CEO) bears the final authority and responsibility for setting and maintaining its strategic course. Like the captain of a ship, the CEO is the organization’s substantive and symbolic leader whose roles include the gathering and dissemination of information, decision-making, and resource allocation. ...” (Thomas & Simerly, 1994, p. 960).

Cognitive dissonance

“The state of having inconsistent thoughts, beliefs, or attitudes, esp. as relating to behavioral decisions and attitude change.” (Retrieved from <https://www.google.com/#q=define+cognitive+dissonance>)

Competency

“A competency is the set of behaviour patterns that the incumbent needs to bring to a position in order to perform its tasks and functions with competence” (Woodruffe, 1993, p. 30)

Crisis

“An event that is an unpredictable, major threat that can have a negative effect on the organization, industry, or stakeholders if handled improperly” (Coombs, 199, p. 2).

The *Merriam Webster Dictionary* defines it as an unstable or crucial time or state of affairs in which a decisive change is impending; especially: one with the distinct possibility of a highly undesirable outcome (retrieved from: <http://www.merriam-webster.com/dictionary/crisis>).

Crisis Management

Pearson and Clair (1998) suggested that the definition of organizational crisis management should read: “a systematic attempt by organizational members with external stakeholders to avert crises or to effectively manage those that do occur.” (p. 61)

Grounded theory

“Grounded theory is defined as the discovery of theory from data systematically obtained from social research” (Glaser & Strauss, 1967, p. 2). Grounded theory involves a process in which hypotheses arise from the data during the course of the research.

Hospital boards

“The board of directors is the legal and accountable group responsible for all the corporation's actions and the results of those actions. It is elected by the shareholders and serves as trustee of the shareholder's interest... more and more publicly held companies do not have one dominant shareholder. This being so, boards of directors must, accordingly, act in essence as the owners of the business” (Louden, 1982, pp. 55–56).

Multiple case study

“In the proposed model of multiple-case study, individual cases, captured through intensive exploratory interviews, are brought into "conversation" with one another. This permits shared realities to be reconstructed out of individuals' perspectival images“ (Rosenwald, 1988, p. 239).

Semi-structured interview

“The defining characteristic of semi-structured interviews is that they have a flexible and fluid structure, unlike structured interviews, which contain a structured sequence of questions to be asked in the same way of all interviewees. The structure of a semi-structured interview is usually organized around an aide memo or interview guide. This contains topics, themes, or areas to be covered during the course of the interview, rather than a sequenced script of standardized questions. The aim is usually to ensure flexibility in how and in what sequence questions are asked, and in whether and how particular areas might be followed up and developed with different interviewees. This is so that the interview can be shaped by the interviewee's own understandings as well as the researcher's interests ...” (Mason (2004), as cited in Lewis-Beck, Byman, & Liao, 2004, p. 136).

Succession planning

“Succession planning is the process of pinpointing key needs for intellectual talent and leadership throughout the organization over time and preparing individuals for present and future work responsibilities needed by the organization. It emphasizes the internal development of people” (Rothwell, 2012, p. 6).

Shelter in place

“Shelter-in-place means selecting an interior room or rooms within your facility, or ones with no or few windows, and taking refuge there.” (Occupational Safety and Health Administration, 2014).

Triage

“The process of deciding which patients should be treated first based on how sick or seriously injured they are.” (Merriam Webster Dictionary online, 2014).

Chapter Two: Literature Review

The purpose of this chapter is to review the available literature related to CEO selection, specifically the selection of a CEO who is expected to lead in the crisis-laden health care environment. The issues surrounding the selection of the best CEO are complicated and require a review of multiple areas of research. First, a historical perspective on leadership selection and qualities is provided, followed by a look at person-organization fit or misfit as relates to leadership success. Next, the classic literature on decision-making, including strategic decision-making, is reviewed. Then, the issue of leadership competencies across several industries is examined, as there is a lack of research depth specific to the health care domain. Finally, the Upper Echelons (Hambrick & Mason, 1984) and crisis leadership theories are assessed in relation to the health care CEO. Each area adds a piece to the CEO selection in health care puzzle. What was not found was any significant research that provides a foundation for the types of characteristics a healthcare CEO should possess—an important omission considering that healthcare is a very crisis-oriented industry.

Many articles and related materials for review were obtained by searching academic and public search engines using several keywords (e.g., CEO selection, succession, succession process, selection criteria, board selection committees, decision-making, strategic decision-making, health care decision-making, leadership criteria, leadership selection, crisis, crisis leadership, CEO characteristics (skills, abilities), leader/leadership competencies, health care CEO/executive competencies, competency verification, executive search firm selection process). Each keyword was reviewed for relevant literature until the topic was exhausted.

Historical Perspectives on Leadership Selection

This section contains a review of the basic research and literature related to leadership selection overtime. Leadership selection has long been seen as a critical process for boards and their selection committees but not a consistent one due to the multiple foci emphasized in each study: insider versus outsider succession, industry insider versus outsider (Carroll, 1984; Guest, 1962; Harris & Helfat, 1997), state of organization performance (Boeker, 1992; Chen & Hambrick, 2012), environmental influences (Henderson et al., 2006; Wagner, Pfeffer, & O'Reilly, 1984; Wiersema & Zhang, 2011), CEO relevance (Finkelstein, Hambrick & Cannella, 2009, p. 16) and influence of the board (Fracassi & Tate, 2012; Zajac & Westphal, 1996).

In a replication of Gouldner's (1954) early work, Guest (1962) looked at two manufacturing plants and considered manager leadership style and the influence of the environment. Two successor managers were given the same task at the plant; there were two very different outcomes. Mr. Peele (manager 1) approached the new role with a "disciplinary" or strict rule-following philosophy while Mr. Coole (manager 2) led with a representative approach in that he included the workers in his early assessment of the plant. As the two managers proceeded, they made choices about how they led that had significant impacts on the two employee bases. Mr. Peele faced distrust and eventually a disjointed and unsettled employee group while Mr. Coole found success and validation when including his team in decisions. He admittedly looked at just two cases but brought to light that the leader's characteristics and qualities can have a significant impact on the team and overall performance of the organization. The critique offered in this article did not specifically mention competencies, yet both managers clearly had different sets of abilities that influenced how they proceeded and the performance of

their teams. This early work is a reminder of the need to assess the executive's competency base and match those features with the needs of the organization in order to enhance success.

Mintzberg's (1973) groundbreaking study of five CEOs uncovered the chaotic and fragmented work done in this top position and aligns with what is most often found in health care organizations. He called the manager the "folk hero of contemporary American society" (p. 3) because what is actually "done" by the manager is often unknown. Mintzberg (1973) sought to determine what job duties specifically are assigned to the manager. Some of his conclusions about the manager include the following: the work is challenging and lacks structure, managers work from an intuitive process, across industries the work is "remarkably alike, there is a tendency toward "superficiality" due to the vast amount of duties, and the work is complex and needs to be studied in depth to avoid oversimplification (p. 5). Mintzberg (1973) indicated that being an executive was multi-faceted and deserved special attention in research. This study attempted to uncover the complex nature of the CEO's competencies during crisis and shed light on their uniqueness.

Most companies have a CEO and will replace that CEO at some point. The importance of the CEO in an organization has received much attention—researchers have studied any number of concepts impacted by CEO succession choice and the influence of the CEO on the organization. Some have suggested that the manager is not very impactful either with subordinates or in relation to firm performance (Lieberson & O'Connor, 1972; Meindl, Erlich, & Dukerich, 1985). The impact on firm performance has been studied with a variety of metrics and situations and still there is no final determination of how exactly to characterize a successful CEO. How and why CEOs are selected and whether replacing the CEO is the best choice for an organization also are topics that have received considerable debate. Those issues were not

discussed or researched in this study. Instead, the focus was on what competencies the CEO, at the time of the crisis, utilized to successfully lead the organization through a challenging time period.

Research that provides evidence on essential competencies is lacking not only in the business sector but also in healthcare. During the extensive review of literature, many opinion articles were uncovered that provided suggestions for how to choose the best CEO (Blouin & McDonagh, 2006; Crowley, 2004; Font & Horn, 2001; O'Malley, 2004) and what boards often fail to do in the selection process (Gauss & Fairley, 2009; Khurana, 2001; Thompson & Thompson, 2003) but very few research-driven studies were found. Selection criteria vary from hospital to hospital and many authors have offered opinions for choosing the “right” one (O'Malley, 2004; Thompson & Thompson, 2003) but do not offer an evidence-based tool to help assure that the “right fit” occurs. Articles describing suggestions for CEO selection based on personal experience abound in trade journals. Practical advice articles on interviewing techniques (Thompson & Thompson, 2003) and best practice examples for how to manage talent (Berger & Berger, 2011) provide the reader with some intriguing ideas but no concrete indication that the methods are effective. These articles are not based in research, but rather in what each author feels is best practice or experience as learned by working in the field. This experience should not be discounted but also cannot be considered solid evidence for the creation of a health care CEO selection competency model.

Some authors have focused on executives' self-reports of necessary skills and abilities for future health care executives, with some of this based in military health care (Marty, 2006). Hudak, Brooke, Finstuen, and Riley (1993) completed a survey of 22 fellows of the American College of Healthcare Executives (ACHE). Each fellow was asked to identify the knowledge,

skills and abilities that they felt would be essential to future healthcare executives. Hudak et al. (1993) used the Delphi method, created by the RAND Corporation in the 1950s, in two survey waves to establish priorities and predict future trends that they felt would emerge for up-and-coming healthcare executives (p. 185). The authors' research centered on the link between what executives think are important qualities and what the higher education field can do to prepare them to lead. A focus on only the "qualitative" aspects that may leave the executive unprepared to work in collaborative teams and provide the visionary leadership necessary for the top managers was noted. The final list of domains, gathered from an analysis of the 102 identified skills and abilities, included cost/finance, leadership characteristics, professional staff, health care delivery concepts, accessibility, ethics, quality and risk management, technology, and marketing. This study only viewed the needed skills and abilities from the executive viewpoint. A one-sided evaluation that placed importance on a set of skills leaves the reader to wonder how subordinates' ranking might compare.

Marty's (2006) identification of executive competencies focused on Navy health care executives and also used the Delphi method. The first wave asked 133 senior Navy health care executives (Commanding Officers, Executive Officers, Directors for Administration, and other senior Navy health care leaders) to identify the five most important competencies over the next decade. Of the original sample of 133, 57 responded, for a 43% response rate. Then, a five-person expert panel, chosen for past successful leadership performance, sorted the competencies and associated Knowledge, Skills, and Abilities (KSA) into domains. From this process two surveys were created—one for senior leaders ($n = 64$) and one for junior leaders ($n = 130$). The results showed that "competencies surrounding interpersonal skills and understanding the environment emerged as most critical for Navy health care executives into the next decade"

(authors, year, p. 3). The expert panel identified six domain categories: Essential Resources (representing nearly 37% of all competencies), Leadership (25%), Environmental Analysis (15%), Knowledge/Experience Requirements (13%), Execution (8%), and Outcomes (2%) (p. 26). The researchers concluded that the real-world experience of senior executives explained their emphasis on the KSAs in the Leadership and Environmental Analysis domains. In contrast, the junior officers with mainly classroom experiences responded that Essential Resources and Knowledge/Experience Requirements domains held greater importance for them. A finding pertinent to the proposed study is the lack of agreement between the junior and senior leaders on the rank importance of the domains. Researching just one point of view may not provide the best overall understanding of the crucial competencies for the CEO position. Including other team members who work with the CEO can lead to a broader understanding of crucial competencies. The military sample in this study, while in a health care environment, may not provide the information needed for this study due to the very specialized nature of the military in comparison to a civilian hospital.

Person-Organization and Fit versus Misfit

Assuring that the chosen CEO fits the organization is seen as an essential and sometimes overlooked component of the selection process (Khurana, 2001). According to the Pittsburgh, PA-based accounting firm Alpern Rosenthal, the hard costs of hiring the wrong person have been estimated to cost 50–220% of the first year's salary (as cited in Grigoryev, 2006, p. 16). CEOs are chosen and replaced for a wide range of reasons but those reasons can influence the qualities on which the selection committee focuses. Finding the “right fit” also may be translated a few different ways, including strategic fit (Gupta & Govindarajan, 1984), personality fit, or avoiding long tenures (Miller, 1991), and board-CEO fit (Zajac & Westphal, 1996). Finkelstein et al.

(2009, p. 210) posed a fit-drift/shift refit model to predict positive impact from CEO successions. The general premise was that although a CEO was selected with the specific competencies needed for the job, over time the environment gradually will shift and the CEO's competencies may no longer be relevant. They also suggested that the CEO who can adjust in step with firm changes is a rare find (Finkelstein, et al., 2009, p. 211). Literature that backs up their assumption that competencies are utilized during selection remains unknown. Health care research that connects selection with a "fit versus misfit" model is also unknown. Chen and Hambrick (2012) suggested that the choice of the best "fit" CEO will lead to improved firm performance; boards should define strategic needs and match the successor to that list. Chen and Hambrick's (2012) study looked at turnaround situations (a one-year swing from healthy profits to operating losses, p. 230) which are fraught with crisis and daily challenges and could be considered comparable to those that occur in the hospital environment. The authors challenged researchers to use the theory with a defined set of attributes that would guide the selection process. It was found that the replacement has little or no effect on firm performance and in turn may have uncovered the fact that the selection committee did not utilize evidence-based selection practices and brought on CEOs who did not match the needs of a company in crisis.

Consequences of poor fit include the CEO, board, employees and the financial bottom line. It seems that boards would find this quest for a fit to be priority number one. In Zhang's 2008 work he suggested that CEO dismissal was an outcome of "information asymmetry" at time of hire. Evaluating person-organization fit is tricky for the board. One method for finding fit, according to Vancil (1987, as cited in Zhang, 2008), is to have the board confirm needed competencies at time of hire but continue to evaluate over time and dismiss based on an observed lack of needed skills.

Crisis Leadership

This section defines crisis leadership and how it relates to this study. Much has been written about leaders “getting through” a crisis, as well as descriptions of the elements of a crisis, but most have been anecdotal and without a research foundation. After extensive searches on the web, no specific research was found that reports healthcare CEO competencies required for leading during a crisis. Crisis was the focus of this study because healthcare organizations experience a significant number of them, which means the health care executive must possess the appropriate competencies ahead of the event. According to Shewchuk et al. (2005), “rapid change in the healthcare environment has pressured healthcare organizations, health management professional associations, and educational institutions to begin examining more carefully what it means to be a fully competent healthcare executive” (p. 32). Hamblin (1958) identified the need to research the effects of a successful leader in a crisis. He determined that leaders had more influence during a crisis and that leaders who did not find a “solution to the problem” were ostensibly replaced. Hamblin created an experimental situation involving a shuffle board game with experimental and control groups. Each group included 12 three-person groups. Participants were told a red light would flash when a rule of the game was violated and a green light would show each time the group scored. Pre-game information included information about competencies needed to achieve scores higher than those for the high school students who had already completed the game. A crisis was created by changing the rules overall, and again each time they scored. Hamblin's results showed that persons who were found to influence the group during typical events were seen as more influential during the crisis. When the crisis was not handled satisfactorily, the current influential leader was replaced by the second most influential person and the initial leader lost influence. This has implications for any CEO because if they are

not ready to lead in a time of crisis, they are likely to be replaced at least in influence if not in actuality. With these factors in mind, the research proposed also paid attention to any comments made by case study participants that evidenced what a CEO does to prepare to be influential or remain influential.

Hesselbein (2002) wrote that “crisis management is not a discipline to be learned on the job, in the midst of the storm. It must be learned and practiced when there's not a cloud in the organizational sky.” She also suggested that there are too few examples of successful leadership in crisis and that a crisis is really a test of the quality of a leader, not their preparation. The ability to lead successfully during a crisis is essential to the future success of an organization and the CEO’s reputation. Pauchant and Mitroff (1992) said that a crisis has the potential to threaten an industry’s legitimacy and reverse strategic goals and missions. It is this threat that requires a CEO feel “comfortable” in a crisis. Companies that have plans for handling a crisis have been shown to fare better financially (Mitroff & Alpasian, 2003). Knowing that crisis is likely inevitable, it seems crucial that the CEO have a competency set that allows them to be flourish in crisis situations. Much has been written to help the reader learn from poorly managed events after the crisis but this study looked at a positive outcome in leadership, not necessarily the details of the crisis. There are models of crisis management rooted in experience (Caywood & Stocker, 1993; Nudell & Antokol, 1988; Pauchant & Mitroff, 1992), but this study was not about how the actual event was managed—it looked at what the CEO and subordinates felt about how the CEO led, not at specific organizational or event details unless they related to the research questions.

Leadership Competencies

The use of a defined competency model when evaluating new candidates could increase the likelihood of their success. This section reviews prior research that supports the inclusion of a competency model for executives. Competencies are “the knowledge, skills, attitudes and other characteristics essential to achieving good or outstanding results in a job while using culturally-appropriate behaviors” (Rothwell, 2012, p. 6). Competencies may differ by level or functional area on the organization chart. This study's focus was the assessment of competencies displayed during a crisis. Here, the type of crisis did not matter but the experience of going through the crisis and the requirements it placed on the CEO did.

The concept of competencies was made popular by McClelland (1973) when he posed that rather than using formal testing, a focus on practical application is more accurate. He suggested that only considering intelligence- would miss critical strengths unexplored by standardized testing. Some critics purport that the evidence to back up his claims has never been confirmed (Barrett & Depinet, 1991). Additionally Barrett and Depinet (1991) brought to light the fact that McClelland never defined the term competency until later work was published. The lack of a finite definition has plagued the conversation surrounding competency, competencies, and competency modeling (Rothwell, 1999). Woodruffe (1993) agreed that without a discrete definition, “...The person wanting to specify an organization's competencies has no clear idea what is being looked for. No technique for identifying competencies can be employed successfully amidst a general confusion over what a competency is and there can be no theoretical contribution to what causes individuals to have or to lack a competency and no theoretically based advice on whether they can be developed” (p. 30). He went on to delineate the distinction between what a person inherently brings to the situation and specific features of a

position that need to be performed competently (Woodruffe, 1993, p. 3). The definition of competency is offered in chapter 1 (see Definition of Key Terms).

Another critique of McClelland's proposition was how other researchers chose to test the validity of the concept. Specifically, work done by Boyatzis (1982) in which a Behavioral Event Interview Guide (BEIG), provided an interview that asks the participants to describe three situations in which they were successful and three unsuccessful situations, was held up as a content valid assessment method even though situations were not substantiated. This same sample then completed the Picture Story Exercise where subjects described pictures and looked for motives such as the need for achievement, need for affiliation, and need for power. Not surprisingly, people tended to include behaviors in their stories similar to the behaviors they described themselves using. Because this similarity was found, the competencies were declared to be criterion related. The possibility of mono-method bias (Cook & Campbell, 1979) was ignored” (Boyatzis, 1982, p. 1019). This critique was addressed in this study by validating the crisis described in the BEIG, triangulating the CEO's perceptions of their competencies by also interviewing subordinates who had worked with them during the crisis, defining competency for the study, avoiding labeling actions or behaviors during the interview to get the most unfettered responses, and including the researcher in the interview to probe answers that were unclear.

Health care executive positions are in an ever-changing state as they respond to new technology, regulatory compliance, customer service needs, and stakeholder demands. The candidates who fill the upper-echelon class may not have the skills, knowledge, or aptitude for the position (Stowe, Haefner, & Behling, 2010). Promotion often comes to the employee who has been on the job the longest or does a great job in their current position without considering whether the current skills, abilities, and aptitude fit the new position. Just because an executive is

functioning well as a vice president does not mean that they will thrive as the CEO (W. Rothwell, personal communication, September 2012).

Leadership Crisis Competencies

There are just a few research studies done that help to better understand what competencies are required when leading in a crisis (Roux-Dufort & Metais, 1999; Schein, 1992; Wooten & James, 2005; Wooten & James, 2008). Other work done on crisis competencies investigated requirements for security positions (Miller, 2012) and learning options to teach crisis competencies (Susnea, 2013). In 2002, Orr published an opinion article on required competencies for crisis management but did not provide evidence to support the associated behaviors. His competencies included personal resilience, calm, emotionally stable, and ability to maintain objectivity (Orr, 2002). Opinion pieces without theoretical or research support is an all too common finding when seeking evidenced-based competency studies. The lack of research driven articles provide additional support for the current study. Bolman and Deal (1997, as cited in Wooten & James, 2008) suggest leadership competencies “include activities such as decision making, communication, creating organizational capabilities, sustaining an effective organizational culture, managing multiple constituencies, and developing human capital (p. 354). To further the conversation, Wooten and James posed this question: “Do leaders actually enact these important competencies in a crisis situation?” (p. 354). This reveals the gap that this study will attempt to evaluate: what characteristics are displayed during a crisis by three health care CEOs.

Wooten and James (2008) completed a retrospective review of crises to identify competencies at each stage in the crisis management process by reviewing events within the

following categories: accidents, employee centered crisis, and product safety and health incident scandals. The sample was taken from the Institute for Crisis Management Database from 2000 to 2006. None of the crisis events included hospitals which are the context for this study; however they do explore attainment of competencies using a crisis lens. The authors (Wooten & James, 2008) suggest that although leaders understand the negative consequences of a poorly handled crisis they do not possess the skills to lead effectively during the event. Wooten and James (2008) report that leaders are not required obtaining crisis leadership competencies and therefore risking a potential 10% loss of stock value due to poor crisis management (p. 253). The lack of crisis competencies identification for leaders, according to the authors, comes from previous research being focused in communications research and the review of crisis management activities.

In order to identify these competencies the authors (Wooten & James, 2008) reviewed 500 pages of documents from both popular and business press and considered needed competencies within each of the five phases of a business crisis: signal detection, preparation and prevention, damage containment, recovery, and learning. They used ethnographic content analysis to explore and code the documents. At the conclusion of the qualitative analysis of documents the authors identified both beneficial and less helpful competencies within the five phases that represent a business crisis. Two competencies were identified within the signal detection category; sense-making and perspective taking. "Sense-making", according to Weick (1993) is the process through which the individual considers how something becomes an event, the meaning of the event, and their actions as a response to the event. Wooten & James (2008) suggest that it is essential for the leader to be able to take action after considering the answers to

these questions. The ability to consider others perspectives, empathize, and respond in a considerate way encompasses the competency of “perspective taking.”

Issue selling, organizational agility, and creativity were defined within the prevention and preparation category. Within a crisis context the competency of “issue selling” requires a leader to be able to convince upper level executives of the need to prepare for a crisis. Also within the prevention and preparation phase is the need to be responsive and flexible in a crisis. This “organizational agility” allows the leader to see both the more global scope and any necessary details. Creativity rounds out the competencies in this grouping and suggests a leader must be able to think outside the box when considering possible causes of crisis and potential responses.

Under the damage containment category the following competencies were delineated: decision making, communicating, and risk taking. A leader’s ability to “make decisions under pressure” is another competency which seems standard for an executive leader but in this case it is an ability to make a decision while seeing the crisis as an opportunity. A leader’s prior experiences with crisis or according to these authors (Wooten & James, 2008) their “learning orientation” is another required competency. Although they recognized that prior experience in a crisis provided a backdrop for organization learning the leaders did not see the crisis through to the end leaving them with an incomplete set of skills in this area. Business recovery included two competencies; promoting organizational resiliency and acting with integrity. The authors felt that those leaders who used the crisis to learn and promote an even better organization learned from the crisis. This “resiliency” allowed them to look ahead and bring the organization to an even better position than before the crisis. Additionally, they felt leaders needed integrity post crisis to assure the company did the right thing regardless of the type of crisis.

Another study involving crisis done by Van Wort and Kapucu (2011) explored necessary competencies for emergency managers in crisis.

According to Roux-Dufort & Metais (2008) even though crisis is unwanted and should only happen infrequently the corporate environment is changing and crisis is more the norm than the exception. Roux-Dufort and Metais explored the creation of competencies after experiencing a crisis and agree crisis is a rich environment for learning and exploration; “The corporate and competitive context in which today’s corporate strategies are formulated leads us to believe that organizations must integrate crises into the planning of their activities” (p. 113). They examined the French nuclear industry as they enhanced organization learning by using crisis experiences as a way to improve their own set of competencies. According to the authors the catastrophes of Three Mile Island in 1979 and Chernobyl in 1986 provided opportunities to add to their organization crisis competency over the last 22 years. They discovered three phases to the organization learning process: the technical phase (1977–1982), the human phase (1982–1989), and the cultural phase (1989–1995). The scope of the work was to look at the greater organization learning process however, it is pertinent for this research to consider how the competencies came to be. The authors (Roux-Dufort & Metais, 1999) suggested that “the existence of these crises” happening often lead to a process to review and revise organization protocol and in turn needed crisis competencies. Although specific competencies were not discussed it was revealed that the crises and re-learning had an impact on strategy and the organizational behavior of individuals, groups and communities. Roux-Dufort and Metais’s (1999) work provides some support for using crisis as a way to understand needed competencies and for this research the identification of characteristics that could lead to further research and competencies.

Decision-making

Decision-making is one of the most important job requirements for the healthcare CEO and his/her leaders in a crisis. Some decisions will be made solely by the CEO, others delegated, and some forced upon others by circumstance. The goal of this research was to identify how a health care leader's decision-making might affect the outcomes of a crisis. In the following section, the foundations of decision-making are explored, including some specific examples that helped to expand understanding of which heuristics influence those processes.

Zeleny et al. (1982) described a decision-making process that includes pre-decision, partial, final and post-decision stages as a looping process, with post-decision flowing into pre-decision for the next round of judgments. Their model was predicated by a conflict, a want for something better, causing the leader to initiate the decision-making process. A distinction is made between two procedural options: decision-making and measurement or search versus a process. The authors suggested that when one attribute and single options are available for measurement, then the most attractive option is selected. This, they asserted, is not decision-making. When many attributes exist and multiple variables and outcomes are in play, true decision-making is enacted by the leader. Although it is implied that there is structure to the decision-making process, the authors asserted that it cannot be constrained to a decision tree. Sole use of a decision tree places too many boundaries on the process. Instead, their work provided a decision flow diagram that they encouraged users to review, revise, and adjust during iterative uses.

At the "pre-decision stage", the attributes, qualities, or features are considered with alternatives and if no acceptable ones are found, a search ensues for more information, "the obvious and hidden" (Zeleny et al., 1982, p. 87). As the decision course moves along, the thinker

makes a series of choices—some more subjective, some discarded maybe even unconsciously—and information may be ignored or reinterpreted. In the “partial decision stage” options are cast off that can have a significant impact on the final outcome. It is here that cognitive dissonance, or inconsistent thoughts, might negatively impact the procedure. With cognitive dissonance at play attributes that were kept as part of the model become more prominent and those rejected become affirmed as such. The next stage, “final decision,” is influenced primarily by cognitive dissonance rather than the initial conflict, the element that prompted the need to make a change in the first place. The leader starts with a very objective evaluation of the options and ends with a much more subjective set; and preferences are cemented in the direction of the current chosen alternatives. The constant re-consideration of alternatives brings options to a few final choices. After the final decision is made the post-decision struggle begins. A reversal may occur as the dissonance fades and an increase in information gathering occurs to strengthen the decision and achieve a full commitment.

What Zeleny (1982) described can feasibly be utilized in a variety of settings when time exists and conflict is determined voluntarily. In a crisis, time is unpredictable and involvement is involuntary for leaders. The leader might attend to each step in this process but at a more rapid succession. In the health care industry crisis is more of a constant than an anomaly. Zeleny maintained, however, that “man is a reluctant decision maker, not a swiftly calculating machine” (Zeleny, 1982, p. 86). This model might explain some elements of a healthcare CEO’s decision-making. This study examined whether the healthcare CEO was reluctant to engage in or was naturally drawn to decision-making during a crisis.

Expanding on generic decision-making as described in Zeleny (1982), Bazerman (2002) provided a structure for managerial decision-making. Citing the numerous cases in which

prominent auditing firms made marked errors in verifying financial records, Bazerman pointed to factors that exist when the decision maker is influenced by a need to protect one's own interests. The author cited psychological research postulating that judgment is biased toward a person's self-interest and that this occurs subconsciously even in honest individuals. This self-centered bias exists because "people are imperfect information processors" (Bazerman, 2002, p. 2). The term "judgment" in the author's context refers to the "cognitive aspects of the decision-making process" (p. 2).

Bazerman (2002) structured rational decision-making into six steps: (1) define the problem, (2) identify the criteria, (3) weight the criteria, (4) generate alternatives, (5) rate each alternative on each criterion, and (6) compute the optimal decision. Underlying the steps is the concept of bounded rationality which sets the stage for examining the decision-making process based on what is actually occurring rather than what should occur. In his seminal work Simon (1957) proposed that a person's judgment is bounded by this rationality but that while trying to make a rational decision the decision maker lacks all the necessary data to do so objectively. The importance of attending to bounded-rationality is that often decision-makers lack information and details, transfer a limited number of variables to usable memory, and have a deficient perception and intelligence that may constrain their ability to find the optimal choice (Bazerman, 2002, p. 4). Understanding this premise becomes even more crucial as decisions are analyzed because the decision-maker will ignore the best choice in favor of one that is acceptable or reasonable (p. 5). They forgo contemplating all of the options and "satisfice" (p. 5), that is, end up with a solution that meets satisfactory criteria. This strategy could have a major impact on any decision-making process but certainly those decisions made in a crisis.

Bazerman (2002) reminded the reader that although rationality is one component of decision-making bias it does not fully explain how judgment is biased. To further explore this issue Tversky and Kahneman (1974), building on Simon's (1974) work, extended this concept with a dialogue about heuristics. Heuristics serve to reduce the complex task of making a decision into something more manageable for the individual and are specific to that individual. This process of simplifying "judgmental operations" (Tversky & Kahneman, 1974, p. 1124) is useful when ideas and decisions are complex and a definitive answer is needed such as a crisis scenario. However, these biases may lead to poor judgment and potential negative outcomes if they allow the personal bias to cloud their judgment. Within heuristics are three basic biases: representativeness, availability, and adjustment and anchoring. Within representativeness there are three probabilities: What is the probability that object A belongs to class B?; What is the probability that event A originates from process B?; and What is the probability that process B will generate event A? Individuals will rely on heuristics when deciding how much A is like B and how likely it is that B came from A. The concept of availability allows the individual to give credibility to something based on how easy it is to conjure instances of it happening. The last element of bias is that of adjustment and anchoring. In adjustment and anchoring the individual begins the decision process by approximating the first value so that it produces the final answer. Essentially the final result is biased by the choice of the starting value which is chosen with this purpose in mind. This original bias sets forth a trajectory that may or may not be accurate and could negatively affect the outcome. Bounded rationality is a complex matter; this discussion is intended to summarize the general concepts but not to fully explain how it serves to impact decision-making in all circumstances. An individual's cognitive preconceptions are dependent upon a set of judgmental heuristics and it is those heuristics that impact how they make a

decision and ultimately the solution that is chosen. This prevails in the face of warnings and directives to attend to more objective measures.

Thaler (2000, as cited in Bazerman & Moore, 2002) added two additional elements: bounded willpower and bounded self-interest. Bounded willpower suggests that the decision maker will “give greater weight to present concerns than to future concerns” (Bazerman, 2002, p. 5). Although both present and future issues must be considered, in a crisis present issues could hold more prominence in a decision-making model. The second concept of bounded self-interests submits that the individual cares about the outcomes of others, due to the influence of an ethos or social norm of fairness.

In comparison to the previously cited work, Zey (1992) suggested that there are alternatives to this rational thought and of focus only on the individual as governed by self-interests. She and her colleagues provided a series of thought pieces on differing explanations for how decision-making occurs. Delineating between problem-solving (fixing agendas, setting goals, designing activities) and actual decision-making, which included the evaluation and choice actions, Zey (1992) asked readers to consider a wide array of additional theories. She suggested that the individual and group are inexplicably intertwined—at any moment one affects the other and vice versa. Persons in the social context could restrict decisions; they could enact penalties for certain choices, and rewards for others playing a major role in the final solutions. This not only applies to the decision at hand but to future choices. This interesting consideration could affect this research. How does the leader behave within the group or social context and how do those behaviors affect the situation at hand?

Zey (1992) also questioned the use of rationality as a predictor of action and felt that preferences are used after the fact to support observed decision but do not really identify the

actual preferences. This hypothesis allows a rationalization for each action as having absolute utility in the situation because the person chose it. Too many other factors are left unexplained in this model. Behavior of the individual can only be judged as rational within the context in which it occurred so generalizing the choice to a different sequence of events is questionable (Zey, 1992, p. 15). Additionally, she argued that assessing solely the individual may miss the complexities of the social environment surrounding the decisions. In this same vein an individual's values should not be held up as iconic as they may not be regarded as a priority for the group. Arrow (as cited in Zey, 1992) also supported the idea that an individual is encumbered "by the social context in which it is embedded" (p. 63). This was an essential consideration when looking at the social context at each of the three hospitals studied and whether the CEO's characteristics impacted the atmosphere for decision-making.

Simon (1957, as cited in Zey, 1992) expanded the discussion to include the individual's "skills and abilities [as they] determine the quality of decisions" (p. 32). He said that it came down to strategy—how does one pare down a problem to a manageable size? The premise was that situations are complex and the human mind is unable to handle every piece of data, so it may be necessary to toss what the individual thinks is unnecessary from what is necessary in order to make the choice. In researching how this process is enacted Simon reported improvements in research (admittedly dated at this point) to consider more detailed and directed questions during interviews and attempts to gain understanding in real-life situations and not solely in a hypothetical laboratory. Additional work has scrutinized expert knowledge and the effects of intuition and judgment (Zey, 1992, p. 43). How does the expert use these elements in combination with a vast "indexed" (p. 43) store of knowledge in rapid succession to solve problems faster than the average person? The expert, according to Simon, has a wider array of

stored knowledge and is able to pull from that library when issues face them and only falls back on a slower analysis process when the original method fails them.

The next type of decision-making with an impact on health care crisis events is that of strategic decision-making. Strategic decision-making was investigated by Mintzberg, Raisinghani, and Theoret (1976) in their study of 25 decision processes. They created teams of four to five students who then spent three to six months observing a company. The student groups diagrammed the steps of one particular decision-making process within their company. Each company was asked a series of questions to aid the diagramming process, such as:

- What was the source of the initial stimulus?
- Were stimuli frequent and/or intense?
- Were specific constraints and objectives established early?
- Where did management seek solutions?
- Were many alternative solutions proposed or did management "satisfice" by taking and testing alternatives one at a time?
- To what extent was each step or subroutine programmed? (Mintzberg et al., 1976, p. 247).

Of the 25 processes studied, six were in manufacturing firms, nine in service firms, five in quasi-government institutions, and five in government agencies lasting from seven months to greater than four years. After an analysis of the steps, decisions were marked by novelty, complexity, and open-endedness (Mintzberg et al., 1976, p. 248). It was found that the decision-making process was arduous and uncertain until after much consideration a final decision is made. The processes were then categorized by four given, two ready-made, one custom made, and five modified solutions (Mintzberg et al., 1976, p. 251). The benefits of this research are

that although the route to a decision is overwhelming and seemingly chaotic, it fits into a model that could aid understanding of how the conclusion was reached. The authors found that the order is not precise and it may repeat, as well as shift, branch, cycle, and re-cycle (Eisenhardt & Zbaracki, 1992, p. 21).

The next group of literature was on decision-making in the health care-specific environment. Nutt (1984) investigated decision-making in service organizations including health-related organizations. He found parts of the rational model to be valid but it did not occur in a sequential manner. The organizations interviewed were involved in student internships. Two executives (CEO, CFO, or COO) were interviewed about a particular project. Nutt (1984) attempted to identify the phases of decision-making. He found that in health care much of the process was solution-driven, which decreased creativity. Nutt (1984) identified steps in the process that created a morphology of the decision, or representative diagram, which included search, synthesis, and analysis. In 66 of the 78 cases (84%) a solution-centered process was used and distinct ideas were demanded very early in the process. This inclination might limit the possibilities brought to the table.

Also looking at strategic decisions, Eisenhardt and Zbaracki (1992) reviewed literature related to the subject. For their review they defined strategic decision-making as “those infrequent decisions made by the top leaders of an organization that critically affect organizational health and survival” (p. 17). This type of decision-making was investigated in this research. Although healthcare experiences this type of decision-making more often than other industries it offers a suitable opportunity to consider how a successful CEO behaves. The key choice paradigms reviewed by Eisenhardt and Zbaracki (1992) included rationality, bounded rationality, politics and power, and garbage can. Thoughts on rationality and bounded rationality

were discussed earlier in this chapter, in work by Zeleny (1992) and Bazerman (2002).

Conflicting objectives and the influence of organizational politics can play a role in the choices that are made. The politics and power paradigm calls attention to the complex and competing nature of the players in a decision. The final option may change based on the constituents and be held to an overarching organization goal regardless of evidence that suggests otherwise. The garage can model, first described by Cohen, March, and Olsen in 1972 (as cited in Eisenhardt & Zbaracki, 1992, p. 27), involves decisions made as a result of accidental or random divergence. Those following this model value chance and allow for the individual to “wander in and out” with vague goals and preferences.

It is no secret that humans make mistakes but it is less known that they sometimes make predictable ones. Two of the seminal investigations on how individual heuristics impacted a series of decisions are the Cuban missile crisis, and the Challenger disaster. A brief consideration of the two cases is provided below.

The Cuban missile crisis occurred over a 13-day period in October 1962. Crisis might have been the only term that could be applied, but the potential crisis could have been of epic proportions. It is estimated that if this crisis had come to pass, over 200 million human beings would have been killed. The story began when U.S. spy planes made a shocking discovery and found nuclear missiles being built by the Soviet Union in Cuba, just 90 miles from the coast of Florida. The decision-making process began right away when President Kennedy kept this information close to the vest and initiated secret meetings with a special team of advisors. Next, Kennedy chose to surround Cuba with U. S. Naval ships. According to reports, Kennedy planned the “quarantine of ships” to stop all further shipments. He then demanded a stoppage of further missile development and the destruction of the sites. Shortly after the blockage was in place,

Soviet Ships entered close to the “quarantine of ships” area but chose to not engage the U.S. Navy in what would have been an armed conflict. Talks between the U.S. and the Soviet Union continued but another crisis occurred when a U.S. reconnaissance plane was shot down over Cuba, resulting in the only casualty of the crisis, Major Rudolph Anderson. The U.S. responded and readied military efforts in Florida as negotiations continued around the clock. The crisis ended when Kennedy and Soviet Premier Khrushchev came to an agreement on October 28th. The Soviet Union agreed to dismantle all missiles and the U. S. agreed to never invade Cuba.

Many potentially life-altering decisions were made over those thirteen days. Allison (1969) analyzed the complex set of circumstances at play during the crisis. In this situation large governmental processes were the focus—he pointed out that larger decisions are a result of many smaller ones and come from the “conceptual lenses” used to analyze the situation (Allison, 1969, p. 62). Allison argued that to improve our understanding of seminal events like the Cuban Missile Crisis the observer should consider the prior constraints that are brought to the analysis. He proposed three models set in terms of governmental functioning. Model I speaks to a single decision maker who utilizes the rational model to consider options and make a selection. Model II states that management follows a pre-set procedure toward an outcome. They still function as a single actor but within a group context. Model III suggests that the decisions an individual makes have much to do with what they do or their role. In a governmental situation the decisions are often compromises made across constituents. Using alternative frames of references could yield different outcomes. Anderson (1983) also supported this proposition and examined this concept using the high-level committee (ExCom) that advised President Kennedy during the crisis. He found that the committee considered relatively few alternative solutions and constituents played a role in the ultimate outcome. He also pointed out that organizational decision-making is not

solely the end result of one person's intellectual processing but social information processing is an integral part.

If, as Zeleny (1982) and Bazerman (2002) suggested, the decision maker tosses out the numerous other options to simplify the process, then they might be missing acceptable or even successful choices. He suggested that the rational model is flawed and that what an organization has done in the past will tend to predict what they do in the future, even in light of information that would suggest a direct course of action. The analysis of the Cuban Missile crisis was crucial to why certain decisions are made—in this case although Kennedy was the main actor there were constituents and an entire country to consider. Allison's (1969) work did less to explain the crisis but more importantly he drew attention to the possibility of alternative views and the need to attend to underlying assumptions during the practice of decision-making.

Next, decision-making is explored through a complicated series of authority and miscommunications. The Challenger Disaster exemplifies the varied layers of group decision-making, arguably at its worst. On January 28, 1986 the space shuttle Challenger lifted off from the Kennedy Space Center in what the U.S. hoped was a history-making trip that included the first teacher in space. Unfortunately at 73 seconds into the mission the unthinkable happened—it exploded and killed all seven crew-members aboard. According to news reports no one saw it coming, or did they? This would be the focus of the Rogers Commission investigation and many other articles and books in the years to follow. What is relevant to this research is how the persons involved in the decision to launch the Challenger made this choice knowing that one of the parts was suspect and could fail. This section contains a brief review of the issues faced by the members of National Aeronautics and Space Administration (NASA) and contractors who developed the parts for the Challenger, including Morton Thiokol and Rockwell engineering

firms. This is not a discussion of the cause of the explosion but what influences surrounded the final approval for launch.

The Rogers Commission determined that part of the issue was flawed decision-making. The approval for the launch process began at Level IV where the principal contractor confirmed the “readiness for launch” (Hirokawa, Gouran, & Martz, 1988, p. 413) and communicated that to Level III. Once Level III managers completed their recommendation it too was communicated to the next level, II. As with the previous levels the Level II managers completed pre-flight readiness checks and made a recommendation to Level I. At Level I the managers have the final say for launch, which is largely based on the recommendations of the three previous levels. The Level I team was the final safeguard in an intentionally complex approval process set up to decrease any risk to crew and mission.

In two of the analyses on the Challenger, Gouran (1987) and Hirokawa et al. (1988) each considered the findings of the Commission, and specifically the complex set of variables found within the recommendations at Level IV to Level III. Hirokawa et al. (1988) determined that psychological and social influences were at play and made the final determination on where the breakdown in decision-making occurred a bit more complex than it appears. Members of Levels IV and III felt perceived pressure and had a presumptive shift that allowed them to move ahead with a recommendation to launch (Hirokawa et al., 1988, p. 422–425), even though members at both levels were concerned. According to the commission reports, the pressure at play for the contractors came from managers at Level III. When Thiokol shared concerns about proceeding and suggested a postponement of the launch, the feedback was that NASA was “appalled” and challenged the analysis methods used to come to such a conclusion. The engineers reported to the commission that they felt pressured to approve based on strong questioning from NASA.

After that conversation Thiokol changed its recommendation and likely fell prey to what was real or perceived pressure from a superior.

As background, NASA is bound by the “launch commit criterion” that suggests launches should be cancelled if there is any doubt of its safety. However, the psychological pressure asserted here was due to an adjustment in that criterion and most of the Level III managers felt a launch was a go unless there was “conclusive evidence that it is unsafe...” to launch (Hirokawa, et al., 1988, p. 423). So instead of honoring the doubt Thiokol felt, the engineers believed they had to prove it was unsafe, a new experience for them at that time. They accepted this presumptive shift and, knowing they could not prove it was unsafe, recommended for launch. One of the social influences that affected the group was Thiokol’s inability to persuade Level III of the possibility the O-rings would fail because they did not have proof. In the process of trying to prove it was unsafe they used language that was ambiguous and left managers to assume no evidence existed to halt the launch. The messages were not concise and clear enough for the Level III managers. Since they were in the “prove it” mode they provided voluminous writings to defend a position and what got lost in the message and what was never said was “do not launch”. Instead, according to transcripts, the language seemed so vague that it was difficult for the Level III managers to discern where they stood.

Another analysis of the Challenger disaster was presented by Gouran (1987), who recognized another element of decision-making confusion. The concern related to how NASA deemed the functionality of their parts, that is, how one part’s potential failure would be absorbed by another part. This seemingly overused and intricate labeling practice might have played an unwitting part in the disaster. The o-rings had a Critical 1R rating, which meant “the component was part of a redundant system and that its failure, while serious, would be offset by

another component serving the same function that would not fail” (Gouran, 1987, p. 440). A C1 classification should have automatically created a launch constraint. However, in all, over 900 components on the Challenger had a C1 rating and this tremendous number might have led managers to be complacent about this type of rating and the potentially dangerous issues surrounding it. Gouran pointed out that it may have been a suspect situation from the start as Thiokol was chosen even though other firm’s designs were rated higher but Thiokol’s plans were chosen anyway. Additional issues surfaced, including comments made by NASA officials that the launch was not desirable but acceptable. This reversal in logic flew in the face of what was standard. Remember the motto was to hold a launch if anyone had concerns but in this instance just the opposite was perceived as true: launch unless you can find absolute evidence not to do so. The factual evidence was there and communicated but when questioned, managers testified that they thought the possible failure rate of the rocket booster was one in 100,000 when the Air Force had already identified the risk as one in 35. Information they knew but chose to ignore at the time included the fact that NASA had already ordered new casings for the solid rocket booster, suggesting that it knew there were issues and chose not to wait for their arrival. Gouran (1987) also noted that one person is not likely to stand alone in the disagreement, especially as a subordinate. If the lone dissenter feels even a little push back they will often retreat to group consensus. Another interesting influence was that of historical context. Since the equipment had never failed before they believed that it would not fail now. An overall decrease in sensitivity, the idea that if I am not affected then it will be alright, also might have prevailed.

In all, the Challenger disaster provides an impactful insight into why decisions are made and why leaders stick with a decision even when evidence suggests they should not. Were the managers putting business goals over safety or did they just feel they had to stick with the

decision they made (Gouran, 1987, p. 445)? This confounding set of factors is a warning for anyone who makes decisions or is a leader of others who do. So much has been learned from this very disastrous outcome.

The previous discussion of literature could possibly lend itself well to a conversation about how current health care CEOs make decisions that affect their senior leadership team and their organization. Healthcare leaders make an enormous number of decisions daily and the complexity of these decisions continues to grow. The underlying influences on decision-making might help to explain decisions made by the health care CEOs interviewed for this study.

Upper Echelon and Bounded Rationality Theories

Hambrick and Mason (1984) proposed a theory about top management that sought to pull extant literature at the time into a cohesive concept about how organizational outcomes come about. According to the authors, “both strategies and effectiveness are viewed as reflections of the values and cognitive bases of powerful actors in the organization” (1984, p. 193). One of the stated possible benefits of the theory was that it would benefit organizations when selecting upper-level executives. Hambrick and Mason felt it could expose how particular candidates might shape an organization based on their characteristics. The theory is built on a basic assumption that “top executives matter” (Hambrick & Mason, 1984, p. 194), a belief that is not consistent throughout the literature. Another guiding principle was taken from the Carnegie School and suggests that executives make decisions due to behavioral factors (multiple and conflicting goals, options, varying aspiration levels).

In the follow-up to the original article Hambrick (2007) summarized the theory to suggest that “executives act on the basis of their personalized interpretations of the strategic situations

they face and these personalized construal are a function of the executives' experiences, values, and personalities" (Hambrick, 2007, p. 334). The upper echelons theory is built on the idea that situations which require complex information processing are not objectively "knowable" (Hambrick, 2007, p. 334) but are instead interpretable. This foundation is seated in the bounded rationality research from Cyert and March (1963). Bounded rationality in turn was built on Simon's (1957) theory and created the basis for the "Carnegie School" of thought. Simon's suggestion was revolutionary at the time in providing the following understanding of how theory should be generated:

"The capacity of the human mind for formulating and solving complex problems is very small compared with the size of the problems whose solution is required for objectively rational behavior in the real world—or even for a reasonable approximation to such objective rationality" (Simon, 1957, p. 198).

Simon (1957) was suggesting that the currently accepted understanding was that all decisions, regardless of the situation, are reached in a very rational way. His work broke from that era's philosophy because he believed that certain factors made it impossible to be rational, such as constrained resources, complexity of the situation that outweighs the mental capabilities, and the overall complexity of the situation (Mukdad, 2009). These propositions help frame a connection among the bounded rationality, upper echelons and the research proposed in this study. A successful CEO who leads an organization in a crisis will cognitively process a voluminous amount of information and make decisions based on some method. The plan for this study involves interviewing the CEO and his/her subordinates about how the CEO completed this process. The hope is that the resulting information will lead to a clear set of competencies that will form the basis for selecting successful health care CEOs.

Hambrick (2007) advocated future research in the area of upper echelon theory. He suggested that a “proverbial black box” (Hambrick, 2007, p. 337) could be created from the lack of research that confirms executive characteristics (experiences, values, and personalities) and their effect on their: (1) field of vision (the directions they look and listen), (2) selective perception (what they actually see and hear), and (3) interpretation (how they attach meaning to what they see and hear) (p. 337). Admittedly it would be difficult to assess this process during the crisis, which is why this type of analysis has yet to be broached. One of the issues Hambrick (2007) put forth is the question of a form of reverse causality: does the CEO make decisions because the hospital board has set forth a change mandate and it chose “this” CEO because he/she had the qualities necessary to enact such a change? In this domain this research may offer some delineation between an inherent set of competencies and potential intrusion of board will. The situation explored was a spontaneous, non-scripted crisis that, after the fact, should allow an uncontaminated process and help to advance this theory in the health care industry.

Chapter Three: Methodology

There has been a call for more qualitative research surrounding the selection of CEOs, since much of the past research has relied on quantitative and archival data that may not have been an effective approach for an exploration of why a CEO is successful beyond performance metrics. Kesner and Sebor (1994) suggested that qualitative work in this arena would strengthen what is known about the subject. Surveys can be helpful in exploring the surface of an issue; however, in order to understand the specific characteristics of the successful health care CEO, the qualitative method could unearth elements a survey could not. Interviewing subjects allows a deeper sense of why the CEO is successful. Information gathered through interviews will provide details on why a particular CEO is effective when a simple Likert-scale would be incomplete.

Case study research design has five components according to Yin (2009): study questions, propositions, unit of analysis, the logic linking the data to the propositions, and criteria for interpreting the findings. This chapter describes how this study addressed each element of the design process. A plan was shared to address the quality of the chosen design utilizing construct validity, internal validity, external validity, and reliability (Yin, 2009, p. 41).

Study Questions

This study identified characteristics displayed by health care CEO during a crisis event from the perspective of the CEO and three of his/her senior leader subordinates. This study specifically asked the following questions:

1. What characteristics were displayed by the health care CEO during the crisis that the subordinates felt were beneficial?

2. What characteristics did successful health care CEOs demonstrate in a crisis that could inform a selection committee when choosing a health care CEO?
3. What were the common sets of characteristics inherent to successful health care CEOs in crisis across all cases?

This multi-case study explored “how” successful health care CEOs behave in a crisis and how those actions impacted their leaders during the crisis. The case study method allowed the researcher to ask questions and follow-up questions to delve deep into the specific characteristics. Case studies are well suited to look at these types of questions (Yin, 2009, p. 27). The CEO’s perceptions of the particular characteristics they exhibited during crisis events were coupled with insights from their subordinates, enabling a triangulation of a series of successful characteristics.

Site/Sample Selection

The process of gathering sites for this research began by reviewing newspapers and online media articles for crises that occurred in different parts of the country. Careful review of multiple sources was conducted to identify hospital crises that appeared to impact multiple levels of the hospital, and there by necessitating the CEO’s and subordinates’ involvement in the event. Many sites were rejected because the crisis did not affect multiple levels or multiple departments at the facility. No particular event, geographic location, or type of hospital was sought. The sampling of subjects for interviews was done by identifying the first informant and asking them to connect the author to the hospital CEO. In two instances a contact offered to help make introductions to an additional contact at various hospitals. Once the introduction to the CEO was accomplished, requests were made for interviews with the CEO and three senior leaders who were working for the CEO at the time of the crisis. An in-person or email conversation ensued to

assure that the crisis impacted multiple departments and many layers of employees. An introduction to the study (Appendix C) and consent to participate in this research were emailed to each CEO or their assistant. An email or phone meeting with the CEO allowed them to identify which of the senior leadership would be most appropriate to participate in the study. The CEO was asked to choose subordinates who had been heavily involved in the crisis.

Propositions

To ensure that the interviews were assessing the concepts set forth by the study, a set of propositions were put forward. “Only if you are forced to state some propositions will you move in the right directions” (Yin, 2009, p 28). The intent of this study was to assess the CEO’s leadership characteristics in a crisis situation so each case selected must include a “crisis” or event that caused “an unstable or crucial time or state of affairs in which a decisive change is impending; one with the distinct possibility of a highly undesirable outcome” (Retrieved from <http://www.merriam-webster.com/dictionary/crisis>). A second proposition was to identify subordinates who had the opportunity to observe and be impacted by the CEO during the crisis. Therefore, pre-screening of both CEO and subordinates was a must.

Another proposition was that the interviews focus specifically on the crisis event. Although informants were allowed to share antidotal information the researcher employed an evidence-based Behavioral Event Interview Guide (BEIG) to focus the informants on the specific crisis event. A CEO who had time to find a comfort level, get to know their staff, and function in the most natural way had been in their position for at least one year. Therefore, the researcher only interviewed CEOs who have been in the current position for over a year. Similarly, the subordinates needed to have been working for the CEO at the time of the event.

The final proposition was that the crisis event affected multiple layers of the organization in order to capture how the CEO interacted with and displayed individual characteristics with a variety of reporting levels. Multiple layers included different units of the hospital and multiple layers of management, and utilized internal and external resources. Although many elements of a crisis are intriguing, these propositions set forth a foundation that allowed a look at particular characteristics displayed by the CEO during the crisis.

Unit of Analysis

Defining what the unit of analysis or the “case” will include has been a challenge for researchers in the past (Yin, 2009, p. 29). For this study the case was defined as a multiple-case study that included the CEO and three subordinates from three different hospitals that had experienced a crisis. A “case” included one CEO and three subordinates. The multiple case study was made up of a total of three cases from three different hospitals. As such, this case study was designed as a collective case study in which “one issue or concern is...selected, but the inquirer selects multiple case studies to illustrate the issue” (Creswell, 2007, p. 74). Yin (2009) suggested that a collective case study should use replication—the case study procedure (Appendix B) is replicated in each instance in order to develop the best results.

Multiple sources of information-gathering are acceptable for a case study. After the interviews were completed using the Behavioral Event Interview Guide, a holistic analysis or embedded analysis of the data was performed. “When multiple cases are chosen, a typical format is to first provide a detailed description of each case and themes within the case, called a within-case analysis, followed by a thematic analysis across the cases, called a cross-case analysis, as well as assertions or an interpretation the meaning of the case” (Creswell, 2007, p. 75).

Limitations

The collective case study was based on interviews with the CEO and multiple subordinates in order to triangulate the responses and identify consistent themes (Charmaz, 2009, p. 42). Some critiques suggest that the case study method has inherent bias due to researcher involvement and a willingness of the subject to answer questions the “right way”. This researcher employed a semi-structured interview protocol, or a set of questions that created a structure for the interview but also included follow-up questions and opportunities for the subject to add appropriate information. Asking each participant the same set of questions, assuming they all will answer, helped to ensure that the same core group of answers would be evaluated. The goal was to create a characteristic checklist for use by selection committees and executive search firms when searching for a new candidate. Seeking three different crises in three different parts of the country added to the probability that this tool would be used.

Assumptions

Using the case study method, it was assumed that the information provided during interviews was accurate and free from bias to the best of the interviewees’ ability. It also was assumed that each participant had provided a comprehensive look at the characteristics needed to head a health care organization and successfully lead during crisis. It also was assumed that because of the job descriptions for CEO, vice president, chief executive officer, chief administrative officer, chief financial officer, director of emergency medical services, and communications coordinator these individuals possessed the requisite knowledge to explain the characteristics displayed by the CEO during the event in question or how it had affected a senior leader.

Linking Data to Propositions and Criteria for Interpreting Findings

The Behavioral Event Interview Guide (BEIG) was adapted to match the research questions for this study (Table 1). The BEIG served as the “structure” for the interview questions but follow-up and probing questions also were asked to obtain the detail necessary to answer the research questions. This guide asked the participant what they were thinking, feeling, and doing during the event.

Research Questions	Interview Questions
1. 1. What characteristics were displayed by the health care CEO during the crisis that the subordinates felt were beneficial?	Q3, 4, 5
2. What characteristics did successful health care CEOs demonstrate in a crisis that could inform a selection committee when choosing a health care CEO?	Q3, 4, 5
3. What is the common set of characteristics inherent to successful health care CEOs across all cases?	Q3, 4, 5

Table 1 - The Link between Research Questions and Interview Questions

Judging the Quality of the Research Design

The case study method is a form of social research and as such was judged by four tests that establish the quality of empirical work (Yin, 2009, p. 40). Yin provided a guide for addressing each of the four tests: construct validity, internal validity, external validity, and reliability. This section describes how the researcher attended to each test during this work.

Construct validity has been met when the researcher has identified correct operational measures for the concepts being studied (Yin, 2009, p. 40). Yin suggested that multiple sources of evidence, chain of evidence, and review of the draft case study by key informants during data collection and composition provides construct validity (Yin, 2009, p. 41). The concept of CEO skills, abilities, and characteristics was determined by not only the CEO but a series of subordinates. The CEO and their subordinates reviewed the transcripts and assumptions to assure accuracy.

Internal validity should be founded on pattern matching, explanation building, addressing rival explanations and the use of logic models (Yin, 2009, p. 41). Memo-writing, coding, and negative case analysis were utilized to support the internal validity of the study.

Memo-writing

After each interview and then each case the author stopped to consider the interview, the responses, or any other relevant data related to the research questions and wrote down observations, concepts needing further investigation, follow-up questions needed, and interesting trends. This process is called memo-writing and allows the researcher to stop and analyze ideas about the codes in any-and every-way that occurs during the moment (Charmaz, 2006, p. 72; Glaser, 1998). It was used in this study to stop and reflect on the interview, the informant's responses, information missed and how to adjust interview questions for the next case, and finally what needed to occur next. This practice can clear the mind of the researcher, giving them an opportunity to add notes forgotten during the interview or process possible categories as the coding continues. A memo-writing event also may help break through challenging periods in creating the semantic relationships. As Maxwell (1996) asserted, memos can serve to "convert

thought into a form that allows examination and further manipulation” (p. 11). Memo-writing was utilized at every stage of this project.

Coding of data

The transcripts were coded and kept open with no preconceived ideas of categories or conclusions (Charmaz, 2006). Memo writing was employed after each interview to summarize and consider what had been discussed. Then, initial open coding was done line by line to identify phrases and meanings from the transcript (Charmaz, 2006, p. 53). Remaining true to the data, the phrases were allowed to accumulate and a secondary process commenced with more focused coding to create categories or themes. Next, categorized portions of data were given a short name to account for their meaning (Charmaz, 2006, p. 43). In the third part of the coding process the categories were taken and reassembled to enable deeper delving into each dimension of the categories. This process is called axial coding and is the phase in which “concepts and categories that begin to stand out are refined and relationships among them are pursued systematically” (Strauss & Corbin, 1998, p. 52). This attention to one category at a time, Axial coding, allows for synthesizing and organizing the data and bringing it back to a whole (Strauss & Corbin, 1990). Axial coding categories are related to their subcategories; Glaser and Strauss (1990) recommended looking at the data to consider conditions (circumstance or situations that form structure), actions/interactions (routine response to issues, and consequences (outcomes – what happens from the actions).

The axial codes were created to define those characteristics displayed by the CEO during the crisis as experienced by the CEO and his/her subordinates. Finally, theoretical categories were pondered during the final stage of coding—these could lead to the discovery of action dilemmas (Charmaz, 2006).

Member Checks

The transcripts were shared with a subject matter expert (SME), Dr. Catherine Baumgardner who has extensive experience in the healthcare industry and specifically in health care administration. Dr. Baumgardner, the SME, and the researcher completed the same coding process. She also served as an advisor in the review of the findings. Each transcript was thoroughly read and reviewed, looking for phrases and then themes to emerge. No a-priori categories were provided to the SME in advance of the data review. The themes identified by the SME were compared to the themes identified by the researcher. During a conversation between the SME and the researcher, any different theme labels were explained to uncover the definition of the theme. Then, one main list was created from the two lists. Similarities and differences were identified; when a difference existed a conversation occurred to review how the theme had been identified. The SME or the researcher provided support for the theme in question and if both could not agree on its acceptance, the theme was removed from the main list. The removed theme was then placed on a future research list. If additional research is conducted, the author will revisit this theme for further evaluation.

Theoretical Validity and the Negative Case

The next test in judging research quality involved creating theoretical validity. At the conclusion of the coding process the subsequent semantic relationships create the foundation for the theoretical representation. According to Charmaz (2006), the theoretical integration will assemble the bones (codes) into a skeleton (diagram). The researcher attempted to translate the thick descriptions into categories and then into relationships, and further extrapolated them to an abstract level for understanding by others. Each category was defined and elaborated using the

informant's descriptions of the process. Each part of the Grounded Theory coding was used to create the final model.

A significant attempt was made to avoid “commonsense theorizing” that would result in substituting the researcher's voice for that of the informants. Throughout the evaluative activities the researcher followed a reflexive process (Corbin & Strauss, 2008; Cunliffe, 2004; Denzin & Lincoln, 2008) in examining how the researcher and inter-subjective elements impinge on and even transform research. The researcher was cognizant that her 20 years of experience in health care could have had an impact on the informants' answers as well as rapport-building (Corbin & Strauss, 2008; Spradley, 1979). The impact of the researcher's background on informants varied, with some not offering explanations for a comment or concept because they assumed that the researcher already understood the issue. This assumption might lead the informant to offer less information when answering questions. To avoid this presumptive process and gain as much from the informant as possible, the researcher asked each participant to provide detailed answers and reminded them the researcher has not experienced their event so the more detail the better. The researcher also asked participants to define all concepts or events to be sure the true description was included in the transcripts. There might also be a positive influence from my prior work in that it might have led to enhanced rapport building making informants more comfortable and increase participation or information gathering. For these reasons, the researcher decided to disclose to each informant her 20 years of experience in health care, working in management and education. Each informant was urged to share all thoughts regardless of what might already be known by the researcher.

An inductive and analytic process guided the study (Glaser & Strauss, 1967). The study researcher used inductive reasoning to make adjustments in the semantic relationship and create

the most representative reality for those that stemmed from leadership during the crisis in the health care setting (Charmaz, 2006, p. 96). The process also was left open for the inclusion of negative case analysis which “may be regarded as a process of revising hypothesis with hindsight or ... refining until it accounts for all known cases without exception” (Lincoln & Guba, 1985, p. 309). For each of the three cases, each was compared to the next to ensure that the majority of the elements fit within the theoretical presumptions. To provide case-wise consistency the researcher ruled that at least one participant from two of the three cases needed to use the same phases or meanings in order to be included in the phases of coding. The goal of this comparison was to keep checking until no more meaning could be interpreted or found and each case was represented by the eventual model. Charmaz (2006) spoke of the emergence of saturated theoretical categories when gathering fresh data—saturation occurs when new theoretical insights and properties no longer spark core theoretical categories; in other words, patterns begin to recur (Charmaz, 2006, p. 113). The evaluation proceeded, acknowledging that three cases could not suggest complete representation of all cases.

The eternal validity for a multiple or collective case study was evaluated via replication logic (Yin, 2009, p. 41). The researcher chose to include three hospitals in this study to increase the chance that this study’s findings would be generalizable beyond the immediate case study (Yin, 2009, p. 43). “Case studies (as with experiments) rely on analytic generalization and in analytic generalization; the investigator is striving to generalize a particular set of results to some broader theory” (Yin, 2009, p. 43). Since replication is not automatic, the first case study was compared to each of the subsequent cases in hopes that direct replication would provide support for the eventual theory.

The final test of the study design was reliability—Yin (2009) suggested using a protocol and developing a case study database (Yin, 2009, p. 41). Reliability strives to “minimize the errors and biases in the study” (Yin, 2009, p. 45). The researcher created and adhered to an interview and analysis protocol as well as documentation of the protocol, since doing so ensured the study’s reliability and made it possible for future researchers to replicate and outside reviewers to confirm a strict process.

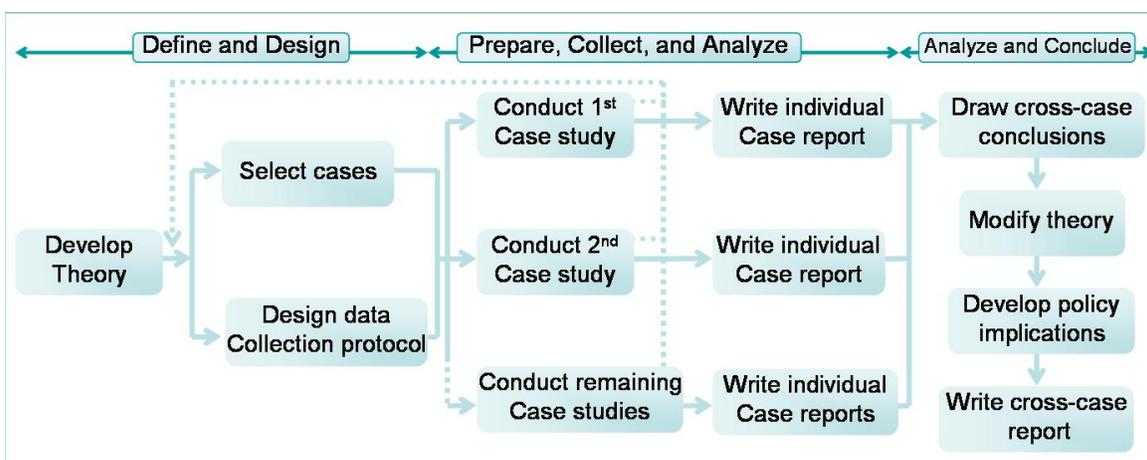


Figure 1 - Case Study Method; source: Yin (2009), p. 57

Trustworthiness

In order to enhance trustworthiness in this research the researcher examined credibility, transferability, dependability and confirmability for this study (Lincoln & Guba, 1985). Although prolonged engagement and persistent observation were not possible, credibility was enhanced by triangulation of the data across the three research sites. In addition to having three sites, the researcher interviewed three subordinates in addition to the CEO. Adding three additional perspectives moved the research from sole self-report to a broader research model. Furthermore, the researcher had each participant provide a member check; further, a cross-case analysis was

conducted to provide a holistic analysis of all data. A “disinterested peer’ and subject matter expert (Lincoln & Guba, 1985, p. 308) was engaged to review the transcripts; this person coded without the benefit of a priori codes. Negative cases were considered as mentioned above to allow for unique findings within the data.

Then, member checks were completed with each informant, who were asked to review the transcripts, codes and diagram. Their feedback was included; only minimal changes were requested to some of the wording within the transcript. The concept of transferability was evaluated by providing thick descriptions of the informants’ words. Complete dependability remained incomplete with this sample size.

Finally, the researcher acknowledges researcher bias, since she shared her prior experience with each participant prior to the interview. She reminded them that although she had significant experience in the field she wanted them to describe their experience, terms, and issues in as much detail as possible, as though the interviewer/research had no health care experience. Many participants asked the researcher to explain her reasons for selecting this topic. She shared her interest in how leaders are chosen in the healthcare industry which is what led her to explore this area initially. This bias was reflected upon during each step of the process, to make every effort to avoid significant impact on the coding and subsequent interpretations.

Chapter Four: Findings

This study interviewed three leadership teams who were involved in a crisis from three different hospitals in the United States. The researcher interviewed three health care CEOs and three senior leader subordinates who had experienced a crisis in order to identify and examine characteristics displayed by the CEO during the crisis. In all, 12 participants were interviewed for this study. This chapter is divided into five sections. Parts one, two, and three offer information of interview participants, event history, hospital demographics, background on the crisis from the informant's perspective, and then a within case analysis will be share that includes quotes from each participant that support research question one. Part four is an across-case analysis of all three hospital cases that addresses research questions two and three.

The research questions were as follows:

1. What characteristics were displayed by the health care CEO during the crisis that the subordinates felt were beneficial?
2. What characteristics did successful health care CEOs demonstrate in a crisis that could inform a selection committee when choosing a health care CEO?
3. What is the common set of characteristics inherent to health care CEOs who successfully handled a crisis, across all cases?

Within-Case Analysis Hospital A

Interview Participants, Event History, Hospital Demographics and Background on the Crisis

Interview Participants

Four interviews were completed with hospital A informants. The interviews included the CEO (Chief Executive Officer), CFO (Chief Financial Officer), CAO (Chief Administrative

Officer) and CNO (Chief Nursing Officer). Utilizing the Behavioral Event Interview Guide, adjusted for this study's research questions, each member of the senior leadership team shared the story of the crisis; a summary of that story telling is imparted below, including quotes from different members of the group to showcase the characteristics of the CEO.

Event History

Hospital A became a pile of rubble when an EF5 tornado hit the building more than a year ago. A tornado is “a rotating column of air, in contact with the surface, pendant from a cumuliform cloud, and often visible as a funnel cloud and/or circulating debris/dust at the ground” (AMS, 2013). According to the American Meteorology Society (AMS) the tornado is the most intense of all atmospheric circulations at a local level (2013). They can occur at any time of the year and any time of day. On average a 1,000 tornados occur each year with many of them affecting the central plains and southeastern United States (AMS, 2013). Many of them touch down in Tornado Alley which is a “term often used by the media to denote a zone in the Great Plains region of the central United States, often a north–south oriented region centered on north Texas, Oklahoma, Kansas, and Nebraska, where tornadoes are most frequent” (AMS, 2013). This tornado is just the 59th EF5 class to hit the United States since 1950 (NOAA, 2013). Since February, 2007 tornados are classified using the Enhanced Fujita Scale (EF) which uses a three second gust in miles per hour (mph) assessment to assign numbers from zero to five (NOAA, 2013). The scale was adjusted slightly in 2007 to the “enhanced” scale with changes in overall winds speeds. Tornados classified prior to 2007 would be designated with an “F” and those after February 2007 will be designated with an “EF” (NOAA, 2013). The wind speeds are subjective estimates based on damages seen during a three-second gust of wind. The assessors use eight levels of damage and use 28 indicators including damage to barns, apartments, motels,

strip malls, school, metal buildings, and trees to name a few. Wind speeds (mph) of 65- 85 are classified as EF0, 86-110 are classified as EF1, 111-135 are classified as EF2, 136-165 are classified as EF3, 166-200 are classified as EF4, and over 200 are classified as EF5 (NOAA, 2013).

The tornado all but leveled the building with cement and cars strewn about the campus. Although it was a “direct hit” all of the patients, staff, and community members, which sought out the hospital for shelter, made it out with just minor injuries (Grenoble, 2013). The area had just 15 minutes to prepare for the impact. The hospital was unable to provide any care after the event as none of its departments were left intact. Any current patients were transferred to other facilities or stabilized and sent home. Many community members lost their homes, cars, and businesses. This tornado left twenty-four people dead after ripping through two elementary schools and dozens of homes in a 17-mile tirade through the county (Katz, 2013). Although all hospitals practice for these types of events each tornado is different and each outcome uncertain.

Hospital Demographics

Hospital A is part of a three-hospital system that originally began as an American Legion hospital (Norman Regional, 2013). The system offers a wide range of services, including emergency care at each location, but each facility is focused on a specialty group of services. At the time of the crisis this facility housed 50 beds, employed over 300 staff members and was accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). The CEO had oversight for all three sites and reported to a board of directors. As a result of the tornado this particular facility is no longer functioning as it was prior to the event but the health system still has a presence in the town offering an outpatient facility. The new facility has

outpatient services and a women's and children's focus. The health system recently dedicated a new facility this year where the damaged hospital had once been and is again serving patients.

This Mid-West leadership team is no stranger to weather alerts. In this area of the country the staff and management at hospitals pay attention to the weather more often than the average health care facility. On this particular day the television was on in the background just to "keep an eye on things" while the leadership team gathered for its weekly coordination meeting. Keeping watch over the three facilities in their system were the CEO, CNO, CFO, and CAO. As is standard in tornado country, the team had already been in touch with the National Weather Service to check on storm progress and location. From the reports they received they "knew things were building up and we were going to have an exciting afternoon" . . . "It was our third major tornado since 1999 and so we were aware of the weather situation, the storm build up, and had been tracking it" (Oklahoma CEO, 2014). The meeting participants moved through agenda items but the storm was ever-present in the minds of all four leaders. In fact, the team found itself "unable to concentrate on the agenda" and eventually turned all of its "attention to the television" (Oklahoma CAO, 2014).

Background on the Crisis

As the CEO recalled the story in his memory it was as clear as if it had just happened, and as clear as his memory was about an event in the late 1970's which he would later share with the staff. It wasn't long before the first tornado warning was issued and the team proceeded with the disaster center protocol. Each state and local region has a protocol for disasters. Additionally, the federal government has protocol guidance available at the Federal Emergency Management Agency. Hospitals also have a site specific protocol that will provide guidance in the event of a crisis. In this case the crisis is a tornado and the hospital participates in drills during the year to

assure that each member of the hospital knows what their role will be in case a tornado warning is issued or if bad weather is suspected. The disaster plan is a part of the protocol and includes preparation, proactive drills, resources, response prior, during, and after the event as well as communications provisions. Depending on the time frame this protocol enactment can take just minutes. This was something they have trained for and is something every hospital is required to practice to comply with regulations from the JCAHO, the organization that governs hospital accreditation in the United States (U.S.). Every report coming from the experts predicted that the storm would hit very near one of their three facilities. The reports had the storm touching down 200 yards across from their facility, a little too close for comfort. The team knowingly looked at each other and mobilized to get over to the target area right away. Prior to leaving they phoned their respective managers on site and checked in on preparations. Questions flowed easily; “How’s the house (hospital)?”, “How many patients in-house?”, “How are the patients?” Each area provided reports on the efforts taken to safeguard patients, families, and staff. As was protocol, the “shelter in place” process was in full swing, meaning they would stay at their location, selecting interior rooms with no or few windows, and come as close to the center of the building as possible. “The nursing team who was on duty at the site started moving patients...based on our shelter-in-place program, and quite frankly at the last minute based on weather service information about the wind speeds two of the nurse managers made the decision to change where they placed patients that day (Oklahoma CEO, 2014). “I [CEO] give all of our leadership team the ability to be adaptable” (Oklahoma CEO, 2014). According to the informants reports this support for autonomy and critical thinking starts with the senior leaders and is translated through all staff lines.

The CEO stayed at the main campus to run the incident command center. Incident command functions as the heart of the operation—filtering communication, accessing resources, and networking with agencies to provide the necessary supplies and support. Meanwhile, the CNO and CAO moved quickly toward their car, picking up the chief pharmacist along the way, and left for the potential primary target of the storm. Each of the senior leaders noted feeling uncomfortable about remaining at the main campus and away from their “people” (Oklahoma CAO, 2014). Once they left, the communications stopped and no one had cell phone coverage. All they could do was drive, hoping they could get there in time to help. On the way they “were watching this big black rain cloud wrapped tornado moving across the landscape in the distance” and “they were driving right toward it (Oklahoma CAO, 2014).” The CAO talked about the unsettling quiet in the car and so he “... intentionally left the music on low just as a filler” (Oklahoma CAO, 2014). Although the drive would normally take just 20 minutes, this trek was down a traffic-packed two-lane road where cars were inching along too slow for this crew. Driving toward the black cloud became even more ominous when it “disappeared and this beautiful, if you can call it that – beautiful funnel cloud appeared”. Then, suddenly “it spins up in two little pigtales and disappears” (Oklahoma CAO, 2014). The CAO saw an ambulance coming and tucked in behind it, following it all the way to the facility. The scene was overwhelming and the team took in the landscape littered with debris, “across the streets, along the buildings, you just can’t imagine the devastation” (Oklahoma CAO, 2014). Then it became clear, in the distance, their facility was missing floors. The CNO said “it looked like a bomb had gone off (Oklahoma, 2014).” They parked as close as they could and jumped out. The CNO, wearing a white jacket and scrubs, was immediately flagged down to help. “Are you a nurse? Yes, I am”, “I need you to help this man” (Oklahoma CNO, 2014). This type of interaction with the CNO

continued for some time. While she was helping victims, the CAO took two pictures to capture as best he could the visual impact of this shocking event. One photo showed the cars tossed on the roof and the unrecognizable hospital entrance. The second picture showed cars piled three-deep surrounding the campus. Those would be the only two pictures he would take until the next morning—the rest of the day was a blur yet he worked in crisp detail, attending to the needs of as many staff as he could. When the three caught up they tried to discern the number of injured and found minor injuries and no fatalities. Once they confirmed triage was up and running they proceeded to what was left of their hospital and planned to support the staff as they relocated patients.

What the team could not know was that while they were driving to the facility the managers on the floor had diverted from their typical protocol of sheltering-in-place and moved patients to the ground-floor cafeteria and chapel. Later, the staff said that they felt this situation was different from the others, more “ominous and scarily serious” (Oklahoma CEO, 2014). That decision to follow their instincts, combined with the senior leadership team’s encouragement to make changes if necessary, saved lives—many lives. That day an excited couple arrived to have their first baby but had no idea just how exciting the day would be. As the rest of the hospital staff moved patients, the Labor and Delivery staff were deliberating about the best placement of their laboring mom and her unborn child. She was too far into her labor to move her as she needed to stay on the fetal monitor. At first they moved her into the hallway and then decided to move her to a C-section room, an operating room specially equipped for the birth of a child. In preparation the three nurses plugged her monitor and pumps into generator power, and piled pillows, blankets, and anything else they could to protect everyone. As the storm came barreling down on the town the labor and delivery staff closed their eyes laid on top of her, “held hands;

they knelt beside her bed and they prayed” (Oklahoma CEO, 2014). Once the noise turned into silence they opened their eyes and “the wall at the foot of the bed was gone” (Oklahoma CEO, 2014). The CNO and CAO caught a glimpse of the expecting mom as she was transferred into an ambulance and transported to another facility, where she had a healthy baby boy.

Triage, a process of determining which patients should be treated first based on their injuries, was up and running, ambulances were arriving to move patients to their other facilities, and staff members were assisting community members who had come in for shelter. The team was thankful not to have injured patients, but felt overwhelmed by the damage from the 200 plus mile/hour tornado that directly hit the building—the second floor was almost completely gone, there was no front entrance, and in the end over 300 employees had no place to work the next day. Now that the main event was over the next steps focused on people and thoughts shifted to “how do we recover from this?” and staff, who were in shock, wondered, “what do we do next?” The senior leaders remembered “hugging them and telling them it will be okay, we will be okay” (Oklahoma CAO, 2014). At the height of the storm the 300 employees kept approximately 150 patients, family members, and community members safe when “almost no place is safe in an F5 tornado that roamed the landscape for about 15 minutes” (Oklahoma CEO, 2104).

Once the immediate needs were secured the senior leaders began to secure the building. Next, the fire department checked out the structure, secured equipment and made arrangements to lock down any medications left in the building. Tents were set up as a mobile emergency department as people found their way back to their homes and families. Sometime in the middle of the night the CAO caught a ride out of town and to his home. The next morning the senior leaders returned early to connect with staff, assess further damage, and just “be visible” (Oklahoma CEO, 2104). The CEO was present the next morning as well and “made himself

available, talking with them and giving hugs” (Oklahoma CAO, 2014). The CAO said he felt the staff so appreciated the CEO sitting and “letting them talk about their experiences, just talk out loud” and being reassured they had a job, you may not be doing what you did yesterday but you have a job” (Oklahoma CAO, 2104). They “cried a little, laughed a little, and healed together” (Oklahoma CAO, 2104).

Today, this hospital and its town are still rebuilding. Losing multiple community members during the tornado traumatized everyone. The hospital continues to be a leader in rebuilding the health care system in the region. The leadership team remains together and remembers this day “like it just happened”. The participants in this case study provided many comments that helped to answer RQ 1:

CEO

During the interview the CEO was asked to describe the event in detail and share the types of things he did to lead the team and the organization through the crisis. He was asked to provide examples of the leadership characteristics. He shared how he allowed his staff to make decisions and be autonomous when they saw fit during this crisis and in general. He also made expectations clear and reported that he feels this is crucial for team success. Additionally, he shared the importance of role modeling for his direct reports so that they will do the same with their leadership team:

So folks there when the tornado warning did go out they started as they had been trained to do, we do a lot of training, a lot of preparation for not just tornados but lots of different challenges that we could face. So we were prepared. The nursing team who was on duty at Moore started the moving of the patients based on our shelter and place program and quite frankly at the last minute based on weather service information about the wind speeds in turn of the tornado two of the nurse managers there made the decision [to divert from shelter-in-place]. **I give all of our leadership team, the ability to be adaptable. They just felt like they had a bad feeling about the shelter and place plan on the second floor and they made the decision . . .** got employees together and they moved nine of the patients from a particular area on the second floor down to the first floor and got them into a secure area on the first floor. And then it hit.

And then you know at the same time **give your employees the, the leeway to at the last, to make the last minute decisions at hand based on what they think is going to be best for patients** that they're taking care of. And the perfect example of that is those student nurse managers who felt uncomfortable with the shelter in place plan based on the internal wind speeds that we were feeding to them. You know we were telling them what to expect, and, and **they made that quick decision on their own.**

I think my staff understands that that's what I expect of them. I am giving them that power, authority to make a decision and don't be indecisive. If you feel strongly and you think it's the best thing for your patients particularly in, in a crisis situation like this then make that decision and follow through on it. And in this case, this instance, it, it saved lives. There's no doubt in my mind.

My senior leadership understands that I have expectations and we agree on those expectations and, and I give them the authority and the resources to produce. **And it's the same way that they deal with their directors and managers at the middle management level. And that's where the real success of the organization will occur.** If the director and manager level are successful and effective then your organization is going to move forward.

If it's a tough decision to make and you're going to wait for the person one step above you to make the decision for you, that's just not good for an organization. **You can't thrive and you can't grow and that's not a way to prepare leaders to take our place.**

Another area this CEO seemed to be adept at was networking and accessing resources.

Shortly after he was hired, he began the process of connecting with his community, local experts, and businesses where a mutually beneficial relationship could be achieved:

We've got a temporary modular emergency department set up. Part of that modular unit is what was in Joplin, Missouri. **We were on the phone the day after the tornado with our colleagues in Joplin and picked up a lot of information from them** and lot of hints on what you need to do moving forward. So that's the other thing from the leadership perspective you got . . . **don't be afraid to ask for help.**

That's what leadership is all about, right? Just **trying to figure out how you remove the immediate crisis.**

What are the issues that might involve outside agencies, government, whatever that we **need to make contacts to coordinate care** with . . . and the local politicians, the fire departments, [and] the police departments.

Mentoring and coaching is another area that he sees as a priority for this leadership team.

He spoke about the importance for those who are already successful but those who need some assistance as well. He reaches out to those who are struggling and this is one example of his philosophy:

That's when you, that's when the mentoring, being a leader, that mentoring responsibility comes into play . . . and you work with those leaders to get them to the place where they need to be where they can grow. And their growth makes the organization grow. And so you don't, **you don't give up on them** because it may be the first time that they've work in an environment like that. And that's where being a mentor, and preparing people to be the leaders is such a critical role for, for particularly people in the senior leadership positions cause we all know although some of my colleagues may not admit to it, but **we are only as good and successful as the people that we have in place that, that work with the supports. And if they're not successful and not effective then quite frankly the senior leader is not going to be very effective either.**

Building a strong and functional team also seems to be a crucial element for this hospital.

Choosing team members that have similar expectations for work ethic and who also have a willingness to learn:

My expectation is when someone comes to work with me in this organization that they're there to lead a defined function or a group of people, that they're going to model their behavior based on my expectations. That's a question I ask before I even bring someone on board with us.

This CEO had previous experience in situations like this so he knew some of the things that would happen and that might have helped him prepare for this event:

I was in Wichita Falls, Texas in 1979 at the Catholic hospital when a big . . . this is before they rated tornados on the Fujita scale. So there was no F5 or 4 gradings at that time. April 10, 1979, three storms came together on the southwest part of town and created a huge tornado. It destroyed 20% of Wichita Falls, which at that time had a population of about 120,000 people. I was a brand new healthcare executive; had been on the job there at the _____ hospital for just a year. I lost my, my home, which was an apartment at that time.

The CEO stated several times throughout the interview that the leadership team's mission was to protect patients and ensure that all staff members were taking the right steps on patients' behalf. Despite the time and labor involved:

We never thought about how much money this is going to cost me.

Communication was a top priority during the crisis and he made an effort to assure he was seen and listening to the needs of the staff and the leaders. When he heard about how many employees lost everything his team set up a store at the hospital so they could access toiletries and other basic needs. He was already comfortable that his staff was out making the best decisions so he was sure to be anywhere they needed him to be:

... in the aggressive situation it's **not just your reactions, but it's also your communications**. You know we had 2,800 employees within our organization. Two hundred of those basically lost their homes or had major damage. Every employee at Moore Medical Center that day lost their vehicle. **You have to give people updates constantly**. They want to know what's going on not only with themselves you know what about my job you know? The place that I work every day, it's gone. What, what's next for me? **And that was one of the first things that, that I wanted to do as, as the leader of Norman Regional was, was make those employees understand that you know your job is protected.**

It's not going to be the same. But you still have this family. You've got 2,700 brothers and sisters you know that **is here to support you**.

COO

The CEO played a supporting role both during the crisis and on the leadership team. The COO shared his perception of the CEO's actions during the crisis and what specific experiences he felt were beneficial. He commented on the constant communication from the CEO's office:

There were **update meetings** that we had in essence basically **daily where everybody was reporting** ... what were the issues, what could we run into, what, **what are the priorities** for the day or for the, for the coming hours type thing?

The CFO also spoke to the CEO's abilities to access resources and provide pre-planning:

You know our biggest role is prior to an event ...that is **making sure that we have organized correctly**, that we have put the **appropriate resources into planning, training** and having professionals on staff that can handle those types of situations and understand site security, those types of scenarios.

A testament to the CEO's comments earlier that he sets expectations and the leaders roll that out in their actions and to their teams is that the CFO used the similar words as the CEO:

I think our role during the event itself iswhat can I do to remove barriers?

How can I make sure they can **do their jobs effectively**?

In regards to the CEO's abilities to be collaborative the CFO spoke to his "genuineness" and that he takes the team approach when working with his senior leaders. This speaks to his

willingness to allow his leaders do their job and that he trusts them to make decisions. When asked what he does to make the team approach happen the CFO shared:

Again I think it's just the **team approach** ... he's a CEO but **he is also part of the team**. There are **very few edicts** that are passed. I think he's realized that you know you **allow people to come to the decision**. They're, they're generally going to make the same decision you would be. But there will be **more buy-in if they feel like they were part of that decision** as opposed to here's the memo of what, how we're going to handle the situation.

The CFO reinforced the sentiment shared by the CEO that is important to be visible and with the staff after such a significant tragedy:

Yeah and you know the first thing you know the one good thing that the CEO did was you know the day or day after the event basically **assured everybody you don't have to worry about your job**. You will be paid during the ... anybody that was an employee at the time is going to be paid and is going to be paid in the same stance they were before this occurred.

CNO

According to the CNO, the CEO's role included working with the media during and after the event as well as being present with the staff. She felt he was adept at talking and listening to the staff as well as reassuring them in the height of uncertainty:

Acting as the voice of calm and reason.

He's been more the **media presence** I guess.

Well, ... **he has that ability to touch** and, and you know speak to the staff and **engender a kind of a coaching type atmosphere**. You know get the job done. Everybody is in it together and **everybody is working for the same cause**.

When asked how the CEO works with his team and what does he do to add to the success of the team the CNO said:

He **gave us the ability to have a lot of autonomy** in doing the things that we needed to do.

He was **running obstacles** for any kind of needs that we had to, to **make sure that we were able to do the things that we needed** to do in the immediacy of the storm and also long-term.

He acted as a sort of coach, working with those newly **empowered** to engage in decision making during the crisis, and as a **sounding board**.

CAO

The CAO reported that the CEO was visible often and made himself available to the team and others:

I do know that **he made himself visible** in our emergency rooms and throughout the hospital... We didn't have much control but we knew what we were dealing with. **He made himself available** to the staff. He went down and, and **visited and gave them hugs, talked, talked with families**. He did all of that stuff. And **I'd heard later how important that was for them to hear his voice and to see him** in the area and that was very reassuring for them.

On Wednesday morning we had planned, just a **time to come together, a time to debrief and talk about our shared experience or the experience overall**. So staff came in to the auditorium at our Porter Campus, our main campus, and _____ just wanted to say a few words and **let them know that he was there**, that we were all there and **available to them and he gave them the opportunity to talk**. Talk about their experiences just to talk out loud. And I think very importantly to say to them hey don't worry about your job. You have your job. You may not be doing what you were doing on Monday, but you are going to have a job. And I think that was a **very clear message, a very important message, and staff responded**. And so we, we cried a little, we laughed a little and we, we healed together.

The CAO also spoke to the CEO's ability to be clam in the face of uncertainty, to critically think, and the staff's overall comfort level with him:

His demeanor, **his calmness**. He is that type of leader. He **does not get overly excitable**. He's, he's not unshakable but he is a **very strong and even keeled and consistent**. **He's compassionate** when it comes to this system and the people we have and the work that we do, the care that we provide.

Again, this member of the team spoke to being allowed to lead and hearing that he would be supported along the way:

I just felt very comfortable from the beginning that **he was allowing me to be that leader**. He was **allowing us as a team to be a unified front** about what we were going to do.... It was very important to me. I remember having that feeling.

He's really **allowed me to come to him or, or to the group and say here's an idea I have**. So, and I have some pretty crazy ideas at times but I **feel very comfortable sharing that with them**. So when this tornado took away our building I said I think it's important we, we have a remembrance ceremony. Let's do it.

Within Case Analysis Hospital B

Interview Participants, Event History, Hospital Demographics and Background on the Crisis

Interview Participants

Four interviews were completed with hospital B. The interviews were conducted with the CEO, CNO, the Director of Emergency Medical Services (DEMS), and the Communications Coordinator (CC). Utilizing the Behavioral Event Interview Guide, adjusted for this study's research questions, each member of the senior leadership team shared the story of the crisis; a summary of that story is imparted below. Within the summary, quotes from different members of the group are included to showcase the characteristics of the CEO.

Event History

Hurricane Sandy was officially a tropical cyclone and the 18th named one in 2011 (National Weather Service, 2014). Prior to tracking up the east coast Hurricane Sandy formed in the Caribbean. It became a post-tropical cyclone just prior to entering land in New Jersey. A post-tropical cyclone is when a tropical cyclone no longer has the characteristics of a tropical cyclone. A tropical cyclone is defined as "a warm-core non-frontal synoptic-scale cyclone,

originating over tropical or subtropical waters, with organized deep convection and a closed surface wind circulation about a well-defined center (National Weather Service, 2014). Along the way to New Jersey this storm was classified as a tropical depression, tropical storm, minor hurricane, and a major hurricane, record high tide levels were recorded as it has the unfortunate luck of peaking during high tide affecting New York, Connecticut, and New Jersey (National Weather Service, 2014). During the storm wind speeds of up to 96 miles per hour were observed as it hit the east coast of the United States (National Weather Service, 2014). To provide additional exemplars on the weightiness of this storm the National Weather Service recorded the highest wave heights ever recorded at buoys along the coast (National Weather Service, 2014). Weather alerts for Hurricane Sandy began almost a week prior to landfall and during the height of the storm watches and warnings were posted for fresh water flooding (watch only), high winds, and coastal flooding. According to the Federal Emergency Management Administration (FEMA) the timeline for alerts follows as such:

- Oct. 22 Tropical Storm Sandy forms.
- Oct. 24 Storm strengthens to Category 1 Hurricane.
- Oct. 27 Sandy weakens to Tropical Storm.
- Oct. 28 Re-intensifies to Category 1 Hurricane.
- Oct. 28 The President declares an emergency for the state of New Jersey.
- Oct. 29 Sandy briefly strengthens to Category 2 hurricane. From Oct. 30 to Nov. 5, twenty-four states from Florida to Maine and as far west as Michigan and Wisconsin are impacted.
- Oct. 29 Sandy makes landfall as a tropical storm near Brigantine, New Jersey (2014).

The storm was so powerful that New Jersey experienced a total of 2.7 million power outages (FEMA, 2014). Major disruptions were felt across the New York, New Jersey and Connecticut regions including interruptions at two oil refineries, 11 petroleum terminals and two petroleum pipelines, 37,000 primary and 9,300 rental properties received major damage, \$382 million dollars of commercial property loss in New Jersey, and 8.5 million cubic yards of debris that included 2.5 million cubic yards of sand and silt were left on the streets of New Jersey causing transportation and environmental impacts for millions of people (FEMA, 2014). Responders rushed to the area to assist communities. Immediately after the storm 113 emergency shelters were opened, 480 volunteer agencies, and teams from FEMA went neighborhood to neighborhood to offer assistance. Families were displaced for weeks and months from their homes. The enormity of the aftermath is apparent as FEMA provided 195,000 hotel nights and provided temporary housing to over 5,500 survivors of this massive storm (FEMA, 2014). New Jersey lost its historic boardwalk, amusement parks, businesses, private homes, tourism income, and transportation infrastructure as a result of Hurricane Sandy.

The impact was felt in every corner of the state including its hospitals. Jersey City Medical Center remained open during the storm but had to divert patients for a period of time as they operated on generator power. They opened back up to all but trauma patients very quickly when electricity services were secured. The emergency room was quieter than normal possibly due to patient's inability to get to the hospital due to poor road conditions and a transportation system crippled by the storm. Jersey City's first floor completely flooded by over four feet of water in just 12 minutes at the height of the storm surge. The entire emergency department was a loss in addition to 60 employee cars and six ambulances. The staff experienced some extraordinary events during the storm including over 30 patients from a fire that broke out and

staff working on critical patients as water rose over their shoes (McCaffrey, 2012). It took almost two months after the storm to get the temporary emergency department up and running (McCaffrey, 2012).

Hospital Demographics

Hospital B was built in 1882 as a part of the city's plan to provide health care to its constituents. It now houses over 200 beds and it is the "state's designated trauma center" and has teaching affiliations with multiple schools of medicine (Liberty Health, 2014). The hospital is accredited by the JCAHO and has a full slate of general and specialty services, including heart surgery, pediatrics, psychiatry, and emergency services. It is located in an urban environment and is close to major metropolitan areas. The facility is governed by a board of directors and is part of a larger health system that serves communities in the state.

Background on the Crisis

It is mid-October—for the Caribbean and southern states, hurricanes are a common threat. However, a storm was making lots of news as it looked to hit the Northeast like no other had in the past. Originating between Jamaica and Cuba, it was categorized as a Category 3 and 2 at different periods and slowly moved up the coast. When it hit New Jersey the National Hurricane Center (NHC) reported extreme low pressures and categorized it as a post-tropical cyclone and it hit land approximately five miles above Atlantic City, New Jersey. Sandy made the record books for many reasons but in the New Jersey and New York areas the storm surge had the greatest impact. Records were set in New York when a buoy recorded a 32.5-foot wave (Blake, 2013). Peak tides of over 13 feet were recorded in Sandy Hook, New Jersey. Since this was not a typical path (uncommon to move so far up the coast), most had no idea what to expect.

Sitting “dead in the center of the seven most dangerous miles in America” (Jersey DEMS, 2013), this hospital was going to need each leader to be present and ready to handle anything that came their way. This unpredictability caused this leadership team to begin talking to their staff about 48 hours before the storm was to hit: “They are talking about a storm surge but nobody can tell us what this surge will look like or how it will impact our area” (Jersey CNO, 2013). The team reached out to weather experts but “nobody [could] tell us what this surge [would] look like or how it [would] impact our area” (Jersey CEO, 2013). Since this CEO had worked in the South and had experience with large storms, he began to brainstorm about preparations that they would need to execute. The CEO was thinking about his facility but mostly about the people. The team “started sending people home making sure that their homes were secure and that they were making preparations to either be here or immediately after the storm”(Jersey CEO, 2013). All they could do was wait so the CEO, CNO, DEMS, and CC used this prep time to brainstorm issues that might arise and tried to predict what they would need if the worst predictions came true. Would they need a daycare so parents felt comfortable being on site during the storm, or gas in case shortages occurred, or generators and maybe even food supplies? In addition to these products and services, they might need the team to make a schedule for administrative coverage so someone would always be there. At the same time they “started looking at our staffing and who was local and who wasn’t and how many we could house” (Jersey CNO, 2013). They even thought about moving cars out of their lot to a higher location but guessed it wouldn’t be an issue, having never had the problem in the past. The CNO remarked that she felt “he [CEO] was very forward thinking and proactive in the planning” and was “just being front and center in the entire plan” (Jersey DEMS, 2014). There was a command center with a sleeping area for those who lived too far away to leave. As preparations continued

to the best of their ability this CEO reached out to his community. This facility also served as the county command center so its responsibilities extended outside its walls to the community. Every team member remarked how connected the CEO was to the community: “he has been doing this since his arrival, reaching out and making lasting connections” (Jersey DEMS, 2013). These efforts proved very helpful during and after the storm as many of his connections provided supplies, advice, and support.

As the storm started, it was windy and raining hard but no one knew what impact the rain or storm surge would have. All they could do was watch and wait: “As time [suspected time of storm surge] got closer and it became more evident that it wasn’t looking good for us, we stepped up our efforts”. The group was told to expect the surge by 9:30 p.m. and when 9:30 came and went they collectively felt relieved. “Sure there was flooding but everything was accessible” and no water had entered the building. What they weren’t expecting was what happened at 9:38 pm and ended at 9:50 p.m.—water overtook all of downtown. In “just twelve short minutes the water was seven feet deep and the Hudson River overtook our campus” (Jersey DEMS, 2013). The CEO felt his mission was clear: “we just had to protect the patients... we had to do things right for our patients” (Jersey CEO, 2013).

According to the CNO “As the sun came through and the damage became evident things really got put into perspective.” The team pulled together: “we really all got together not only as a facility and not only with administration but just as a family. It didn’t matter who you were, where you were, whether you were a patient or a visitor or an employee we were all in it for the long haul.” On site they lost 65 employee cars. But as they looked around they were not alone—over 120 people were putting up drywall and bringing the first floor of the hospital back to life within hours of daybreak. This particular hurricane tracked all the way up the coast and made

landfall in the Northeast, causing over \$50 billion in damages (Blake, 2013). Along with the devastation to homes, businesses, and the environment, this storm took the lives of 72 people in the U.S. and 104 in other countries.

In the aftermath of the storm the CEO made people his priority. The CC remarked that “he [CEO] didn’t even think for a moment, there wasn’t a bottom line, there wasn’t a cost, it was just do what needs to be done and compassion was very evident.” The team continued to switch gears from disaster reaction to support. Even as people began to panic the CEO kept the team focused on recovery—he “went out and anyone that had lost their home, he arranged to have local developers build new buildings” and asked to use new construction to house employees. The hospital paid for cars, housing, and assured employment. “And as word got out about that everyone kind of took a deep breath”. The team made things work when the outlook seemed dim. One leader commented that “he [the CEO] never lost sight of those little things that make a difference.” Over 18 months later the area is still recovering. This hospital has been rebuilt and began to provide full service six months post-event, including continuing to serve as the 9/11 medical care center for all those service providers affected during that tragedy. This thriving medical center is still taking the lead helping the community bounce back from a devastating natural disaster.

The participants in this case study provided many comments that helped to answer RQ 1: What actions were taken by the CEO that impacted how the subordinates performed during the crisis?

The following phrases and words were excerpted from transcripts to provide insight for research question one:

CEO

Again, the CEO's main concerns were ensuring the safety of the patients and staff; continuing to serve the community; and bringing the hospital through the storm as intact as possible. With regard to the latter, he had some previous experience with them and understood hurricane preparedness. When word came that one was on its way, he made sure the staff were informed and that they could get home safely. Those who could not, were urged to remain at the hospital:

So we got our separation process. We informed the staff that you know there was a hurricane coming. It may be difficult to get around once the hurricane hit. So **48 hours out we start sending people home making sure that their homes were secure.** And that they're **making preparations to either be here before or during I mean during the storm or immediately after the storm.** And so we started the whole **staffing and planning process.** We're also the command center for Hunton County so that was another important thing. **We started coordinating with other hospitals and local officials to figure out what our next steps were.**

About **12 hours before the storm arrived** one of the things I say to our staff is you know they're talking about a storm surge although nobody can tell us what this surge will look like or how it will impact our area. And so I said you know let's see if we can't . . . using these cars on our lot are going to be safe.

And I don't know **having been through this process before down in Florida,** you know it was just the fact that **we had to do things right for our patients.** You know that immediate infiltration of water and . . . around the whole city was shocking but I knew that it was eventually going away and that we would be okay and **we just did what was right to protect the patients.**

I think the smart thing in the crisis I think we never thought about how much money is this going to cost me? **I just thought about what's the best thing for everyone involved.** So for example **we paid every employee time and a half for any time that they were there at the hospital.** I mean if you were there for 48 hours and you were doing patient care or you were sleeping even we paid you. I just didn't worry about that. I just knew that was kind of the right thing do. And it would alleviate much of the fear that . . . cause our employees are in crisis too, right? And **I think that's what leadership is all about, right? Just trying to figure out how you remove the immediate crisis.**

So I think that was a really good thing that, that came out of that. But my sense if **you're really good leader you, you just don't worry about the day-to-day things in a crisis.** You think about what's the best thing that's going to stabilize things in the short term, right. And it's all about trying to get people back to normal.

The focus on doing right by patients and staff continued during the conversation:

I think as long as you kind of **keep your focus on what needs to happen to the people you're serving**, I think that's the most important thing.

Although when he was first brought on board they were in a challenging situation so he began with a strategic plan and started making strategic long term plans right away. His ability to see the future and plan was an asset during the crisis:

I knew that there was an opportunity **to set the direction** and the most important thing was I had a board that wanted nothing but for this hospital to be successful. You know as a CEO you can't pay to have that happen. And, and they were totally supportive of me in terms of really understanding what needed to happen.

CNO

The CNO reported that the CEO played a critical role in engaging in proactive planning and resource-gathering/networking to ensure the hospital had the resources needed to look after residents before, during, and after the storm:

I thought very forward thinking and proactive in the planning for this disaster. So he of course **reached out to a lot of our resources in the community** just as communication, really just **being front and center** in the entire plan. **We met days in advance** and of course I knew operationally what was going on and where we were with staffing because you know he did a lot of briefings, very, **very protocol driven** almost on we'll meet at this time, we'll meet at this time, we'll meet at this time so that everybody kind of had absolute time to prepare and a real timeline for when we would have things in place whether it's fuel for the generators or food or you know supplies and, and that I thought was just a very organized approach. So you know he always comes across as the **front line leader**—he just does. He's out there and he's very knowledgeable about what goes on in hospitals and, and **he's the face and kind of the rudder**. So, so he you know **he brought even more expertise to this because he'd been through it so many times.**

He was on the phone with the state several times so you know he was very good at that external communication.

According to the CNO the CEO is always thinking ahead and planning for the future of the organization:

Well certainly a comfort level. I mean any of us can run this place right. I don't want it to sound like we depend on him to run things because **[CEO] typically is never an in the weeds leader**. So he's **visionary** . . . if I were to describe [CEO], above all **he's a visionary**.

Another skill asset of the CEO according to the CNO was how in-touch he is with the entire staff and how often he makes an effort to be on the floors. So when asked what another positive characteristic would be she quickly added communication:

Communication. Every level. He knows every housekeeper's name. They feel perfectly comfortable talking to him about their kids or anything else up to you know the state level folks. He just has a **tremendous insight** when it comes to **how to communicate with people** from this organization, from the board, to you know to the floor. So that's very good when it comes to working through disasters.

The CNO also commented on his adaptability and critical thinking skills in the crisis environment as well as in every day functions:

I think it's his **knowledge**, it's **his relationships** and it's his **communication**. I mean he's also **very incisive**. He can get to the, the heart of the issue immediately. There's no dithering back and forth. And **he has the ability in all situations, not just in disasters, to really take in a lot of information and sift it through** . . . you see it going through his head. You can see it in his eyes. I've come to plan. And he'll say well what about this? Let's do this. And then you say oh well . . . okay. Let's, let's alter this plan and do, do it this way, oaky let's move, which is why we accomplish so much in such a short time. So that, that **ability to synthesize information on the spot and to come up with a workable plan**. It stands you on good stead when you're in a disaster. And he's really good about that. He doesn't sit around deliberative. **Takes it in quickly, analyzes it, plan it.**

He seems to have set in place a very collaborative environment from the senior leadership team to the physicians to the nursing staff. He role models collaboration and it has trickled down:

I start my day with the CMO (chief medical officer) in my office and you know **nobody does anything here without coming in and saying should we do this?** What, I want to do that. What do you think? Or **let's talk about that.** Or I need you on this steering committee because . . . or you know it's just, there's just such a partnership. You know I can pop in their office at any time and say what are they doing with this? Or we have to do something with that or let's change the model. Or you know they're just really good about that. Not that we don't have the same [issues] that everyplace else has. But there's just you know **we all share the issue.**

Communications Coordinator (CC)

According to the CC at hospital B the CEO relies on his team and utilizes their knowledge base. He takes input and knows the group is very talented. He demonstrated during this crisis his willingness to seek out those with greater expertise and knowledge than he had, when circumstances warranted consultation. He also made a point of checking with staff to ensure that they had the resources needed to do their jobs:

So one of the key things I think with, with any leadership position is, is taking input from those who know the subject matter experts if you will. One of the lines that I use a lot when I talk about our administration here at the medical center is we've got an **incredibly talented group of administrators who can run a hospital like I've never seen,** especially if you know anything about (inaudible) the last five years. But something that they're not is, is emergency managers. But they're **not so proud that they won't reach out to the subject matter experts and say hey, I can do this great but what should I do here?** And they, they're **not afraid to ask for help.** And that's I think such a positive trait where I see in many other hospitals that I've been exposed to where the boss just thinks he's the boss . . . well he is the boss but, but he won't listen to anyone else cause he's the boss and situations can go horribly wrong when, when that happens. So **the number one thing you need is someone that listens and someone that respects the work that's done on a daily basis** and _____ is absolutely [that person] . . . you know aces in both of those categories.

Communication and preparation were also characteristics the CC felt the CEO did well before and during the crisis:

And we started pushing information out and saying hey this is what it looks like. This is what could happen. This is what might happen. And **keeping everyone informed**.

Being calm in the in the face of the storm. I'll never forget we were at one point we were on the phone and giving him an update. He was on the other side of the hospital and we're you know we're telling him never seen the water coming up and he said 20 feet away from the hospital. And then literally 30, 40 seconds later like okay you know five feet away from the building. Wait you said it was 20 feet away. Yeah [CEO] it's now five feet. It's coming pretty fast. We're not even sure what's going on here. **But he stayed calm.**

The CC relayed how compassionate and centered on doing what the employees and patients needed above all else:

Quite frankly **the number one trait** if I had to pick one over the course of the entire . . . that would be **compassion**. We had employees who, who lost everything. And he didn't even think for a moment. You know **we just have to do whatever we have to do to fix this and make this right. There wasn't a bottom line there wasn't a cost; it was just do what needs to be done and compassion was very evident.**

The CC also provided numerous accolades about the CEO's characteristics including his respect for the leaders and that it creates a sense of trust. He does not just focus on his senior leaders he is a global leader connecting with all the departments. When asked how the CEOs characteristics made him feel during the storm he said:

It made me feel **reassured**. When he needed something from our area emergency management and emergency medical services, he would ask us you know whatever your opinions. Not just hey this is what we're going to do. **He'd ask us you know look for, for input** and say what, what, what do you need? What do you . . . you know and **then he'd go to x-ray and radiology and do the same thing**. He'd go to ED and what do you need? And get all the inputs and he'd basically **think about what everyone's needs were and then just sort of triage through them and figure out how to best handle it and then direct the right people** to make you know make repairs or ready general ideas.

Director of Emergency Medical Services (DEMS)

The DEMS was a unique perspective in this case study and an important one in this particular crisis, for this hospital. Due to his role as the coordinator he had a unique view on the CEO's characteristics during this crisis. He reported that the CEO had made a point of getting to know all of the staff, so that when this crisis arose, he had a good idea of their needs, concerns, and how he could help as well as their skills:

He was known to lead and you know when you think of ____ you know one of the things you think of is a very, **very gregarious guy**, very **friendly**. **He was an individual who truly knows all of the staff and really, really cares about his staff**. And I would say that you know . . . actually ____ said that one of the things that really stood out about [CEO] was you know throughout the event he was **always thinking about you know what's the impact on everybody?** You know it's **not what's the impact on my life**. But what's the impact on the employee's life? And as things started to escalate you know he was constantly trying to say you know how are our staff doing?

You know certainly this is over his level of expertise. And he said . . . I'm going to go you know do a quick round and make sure everybody is doing okay . . . **be willing to let other people take charge and take a leadership role when he knew it was the appropriate time**. He is a friendly, gregarious guy who's always out there and you know kind of being a jokester and you know, tries to make people feel comfortable at the same time you know **you saw him step up when the time was appropriate**.

The CC also identified that the CEO allowed them to lead and stepped in only when necessary. He let the leaders do their jobs but did not leave them stranded:

He was a lot of you know when we kind of start to spin our wheels a little bit you know he'd be the first one to stand up and say guys we all need to focus in here you know let's go around the room. What are the lead issues? What, what do we need to do next? But at the same time, when the world was running a little bit smoothly he'd step back and say okay let's check on the staff, let's see where the . . . let's figure out what's going on. And I think that was a really a true testament to his character that he has the ability to do that you know despite when things were going you k now becoming a real issue, so long as things were moving smoothly he wasn't necessarily always stepping in to try and figure . . . to take charge. He let people do it. But the moment that the wheels started to come off the, come off the vehicle he would say woah a minute you guys. Let's stop a minute and think. And you could see that. He could, he could sit there and see when things were starting to fall off track and he could bring everybody back on to the same page.

You know I, I remember sitting in his office one day about some issue and I was trying to tell him how to do something and I was trying to very diplomatic and political about it and he looked at me and, and he said to me, he goes ' ____ '. And I said what? He goes for God sake, he goes, **am I doing the right thing or am I doing the wrong thing? And he looked at me and said if I'm doing the wrong thing just tell me you wouldn't do it this way. I said I wouldn't do it that way. He said okay then I won't do it.** And we moved on. And I was okay all right, that wasn't so bad.

The CEO kept the focus on everyone else and doing what was needed for the community:

Like just constantly bringing them back to ground zero and saying **how are we doing for the patients?** You know, how is the staff doing? And **what can we do for the community?**

You know what he did . . .after Hurricane Sandy, when we were still living out of the hospital for many of us. You know guys there's not going to be a holiday party . . . immediately **take that money.... and we're going to start you know using it to help people out.**

You know he went out and anyone that lost their home he arranged to have local developers, cause there were a lot of development here in Jersey City and he called them up and said heyDo you got any extra space? I'm going to . . . **the hospital will pay to house these people. And as word got out about that everyone kind of took a deep breath and said it's all going to be okay.** You know there's a lot going on but it's all going to be okay because we know that Joe's watching out for us.

You know he never lost sight of those little things that make a difference that usually the employees just get through it.

Within Case Analysis Hospital C

Interview Participants, Event History, Hospital Demographics and Background on the Crisis

Interview Participants

Four interviews were completed with hospital C. The interviews were conducted with the CEO, CFO, COO and CNO. Utilizing the Behavioral Event Interview Guide, adjusted for this study's research questions, each member of the senior leadership team shared the story of the crisis; a summary of that story is imparted below. Summary quotes from different members of the group are offered to showcase the characteristics of the CEO.

Event History

After an 18-month negotiation the nurses from a community hospital in Oregon vote to walk out for a one-day strike to protest nursing staffing guidelines. The following is a summary of the events surrounding the unionization and strike. All of the media reports appear to present the nurses view and there were very few comments recorded from the hospital administration therefore this report is a mostly one-sided account. The nurses from this community hospital in Oregon voted to unionize in 2001 but at the time the hospital and the union could not agree on what type of "shop", or hospital, would be operated by the union organizers. In general there are two options: open and closed. In a closed shop every nurse is required to join the union and an open shop gives the individual nurses the option to join or opt-out. In 2003 the nurses won an Unfair Labor Practice suit against the hospital requiring changes in the staffing patterns and decision making process for numbers of staff persons needed based on acuity rather than census (Sewell, 2003). In media reports the nurses went on strike because they felt the hospital

administration had not done enough to address the issues brought forth in the law suit (Moody, 2003; Nurses.com, 2003; Sewell, 2003). Some nurses spoke to the media and provided their experiences with the staffing process. One labor and delivery nurse shared:

“I’ve watched [the hospital administration] systematically chop my feet out from under me...I don’t mind working hard, but you cut the nursing staff to a certain level and people start to die” (Sewell, 2003).

Another nurse relayed the following sequence of events to an internet media site The Portland Alliance (2003):

“Tina Clark, an RN who works on the floor, related a typical experience at the hospital. One night, she was at home on call; meanwhile, the supervisor who was working felt that the floor was overstaffed and sent the nurse’s aide home. However, the nurses on the floor felt that they needed some back-up and asked the supervisor to call Clark in at 4 p.m. The supervisor refused. At 7:30, a new supervisor came on, and the charge nurse again asked that Clark be called in, and again the supervisor refused. In the meantime, two staff members had been injured, needy patients had gone without their bedpans being changed, the nurses themselves had been unable to eat or take bathroom breaks, and they were exhausted. By 9 p.m., when Clark was finally called in, she said, “The nurses were so far behind, because they were doing the job of a nurse’s aide as well as their own. The hospital had someone scheduled to come in, and they cancelled. That’s against staffing guidelines” (Sewell, 2003).

Prior to the strike there was a rally in which, according to published reports, nurses from other local hospitals and the Oregon AFL-CIO came out to support the Providence nurses (Sewell, 2003; Nurses.com, 2003). The Oregon AFL-CIO got even more direct when it suggested that the next move would be to consider: “If the hospital forces our members out on the street, we may be forced to take Providence Hospital off our health care options for our members.” One report quotes a hospital spokesperson who denies hearing about the concerns:

"It is our intent to honor that [February] agreement," said Providence Milwaukie spokeswoman Renee King. "We have not heard from the union that they have been concerned about staffing. If they have concerns, they haven't brought them to the bargaining table" (Nurses.com, 2003).

Reports suggest that the nurses rallied to bring attention to the larger issue of nurses leaving the profession due to high patient loads and the potential nursing shortage in the future created by this departure (Sewell, 2003). The strike was the culminating event in an 18-month discussion in which 89% of the nurses voted to ratify the strike notice and walked out for a one-day strike (Nurses.com, 2003). The contract was eventually ratified with a 75-1 in favor of the union according to The Portland Business Journal (Moody, 2003). The agreement reached included a "cap of 144 hours placed on "mandatory days off," in which nurses report to work but are sent home because of a low hospital census and a change from a merit-based to a step-based pay scale, which will boost nurse's salaries significantly, according to OFNHP internal organizer Alan Moore" (Moody, 2003). In an effort to be sure the communication channels remained open the hospital agreed to "establish a nurse practice committee, which will allow nurses and management to directly discuss quality-of-care issues" (Moody, 2003). The strike ended in 24 hours with no reported impact on patients and the union is still in place.

Hospital Demographics

Hospital C is located in the northwest region of the country and is run by a larger health system. Accredited by the JCAHO, this hospital is one of 30 facilities in its parent health care network. They all operate under a Catholic-based mission and service five surrounding states (Providence, 2014). The crisis took place at a facility in Oregon; the CEO, CFO, CNO, and COO were interviewed for this research. This particular hospital opened in 1968 near a metropolitan area and houses 77 licensed beds. Due to the enormity of the system the CEO reported to a

regional board that then reported to the health system board. The facility offered a complete slate of medical services, including emergency and outpatient services.

The final case study does not deal with a natural crisis but a people crisis. This leadership team, similar to the other two cases, was mainly put together by the CEO. This CEO was brought in after the law suit had occurred and in the height on the labor unrest. After conducting a survey with current staff to identify leadership gaps, the CEO took the result and began the process of getting “the right people in those chairs with the skill to do the job, but also the people skills to do the job” (Oregon CEO, 2014). Meeting with each leader one-on-one to begin the relationship-building experience included sharing expectations because the CEO practiced “respectful truth telling so there’s nothing hidden” (Oregon CEO, 2014). The team reported experiencing equal exchanges of ideas and a trust in their abilities. The CEO felt so strongly about the team functioning as one that retreats would often be accompanied by skits and other opportunities that let each leader feel vulnerable in an effort to connect with others. This crew would come to lean on each other during the coming 18-month crisis.

A leadership team sometimes is so busy doing their jobs that rumblings about concerns occur without making enough of a noise to get noticed. A leadership team that is connected to its staff and encourages information sharing might hear more than the average management group. This case had just such a team, one that began to hear “rumblings” of a plan to unionize the nursing staff. A union can be a positive process at some facilities and might even be seen by some as needed in certain cases. However, most successful leaders would say that hearing union rumblings means there is a perceived lack of a relationship between leadership and employees. This was the only hospital in the system that did not have a union.

This team inherited much of the unrest that led to staff seeking union representation. It was a long process of growing support that was occurring even before the CEO took office. None of the participants could pinpoint exactly why the staff felt the need for the union but it did not seem to be going away and “there was a growing sense of tension”. It came to a head when one day “a group of nurses marched into the CEO’s office, kind of stormed in without even being announced” (Oregon CFO, 2104). The CFO felt that “they were trying to trick the CEO into basically accepting this (union) without a full vote” (Oregon CFO, 2104) and without hesitating [the CEO] shut them down, reminding them that everyone needed a vote, everyone needed to be represented. At that point it was clear they needed a team of experts to be sure this process would be fair and followed all legal guidelines. So the CEO “leveraged the experts and got a really good team of people together who dealt with the procedural pieces” (Oregon CFO, 2014). This knowledge was then passed down to the entire leadership crew, as some had never experienced or worked with a union.

Now that a union vote seemed inevitable, the team swirled into motion. In an effort to maintain transparency and visibility they “had a war room between my (CEO) office and the conference room” (Oregon CEO, 2014). This center controlled communications for the team. They considered carefully what was being shared with the staff and wanted each person on the same page so “flip charts” chronicled progress and messages coming and going. Negotiations took place over many months and the team tried to rebuild and strengthen trust not just among the nurses but the physicians and support staff. The CEO interacted with the media, keeping the community connected as well. The team worked hard to get accurate and respectful communications to the entire employee base. The CNO represented the team during negotiations. She and the team were aware that they not only needed to work with the staff interested in

unionizing but those who were not on board with the union. They wanted to “ensure the other staff were represented and felt safe” (Oregon CNO, 2014).

According to the CNO, “They did actually strike” and “we stayed, working nights and the CNO worked the floors”. The leadership team felt that because communication was always open and honest that many of the nurses crossed the lines and worked during the strike. And as with any strike each person has to pitch in and do what they know best. The CFO was involved to be sure budgets could support the very expensive process of bringing in locum tenens nursing staff, or contract workers, to take over for striking nurses. The COO worked closely with physicians as they “can get drawn onto some of this stuff” (Oregon COO, 2104). Again, keeping the messages clear and accurate was a priority not only with the staff, and the union, but also physicians and ancillary staff members. Another commitment to making a transparent administration was to have one member of the team in-house 24 hours a day, accessible to anyone. Accessibility went beyond the staff. While the CNO was working with the union the CEO interfaced with press, physicians, and the community. According to the CNO the CEO had a sense of how to communicate and she told “the story of the hospital, in a clear and transparent manner without negative impact on neither the organizing union that was coming in nor the nurses who wanted to organize” (Oregon CFO, 2014). To be accurate with information and stand true to their mission, this deliberate process was repeated over and over by each member interviewed.

The strike did not last long because the team felt it “negotiated honestly and with fairness and ...kept those lines of communication open” (Oregon COO, 2014). In the end though the nurses did unionize but the team felt its attention to communicating openly and expressing genuine concern for the staff and hospital set a strong collaborative foundation for future dealings with the union.

The participants in this case study provided many comments that helped to answer RQ 1: What actions were taken by the CEO that impacted how the subordinates performed during the crisis?

CEO

The CEO brought a variety of management skills to this position according to her senior leaders but when asked what she thought she brought to the role she shared many of the same elements. One thing she felt was important was clear communication and expectations. A part of the effort she made was also to be very visible:

“One of the lessons that I learned right from the beginning is that you **have to be respectful, truth telling**. And, to **maintain as much transparency** as possible.”

So, so basically we sort of had a, how can I say, a war room between my office and the conference room, we had a war room in the suite. We had flip charts up about what communication moved on out to whoever what was you know **we were visible**.

The CEO made multiple comments during the interview about the importance of building a team. She also spoke to creating a sense of team and assisting in bonding the team together:

I'm truly, **firmly believe in skill**. You know that you have to have the **right people sitting in those chairs** with the skill to do the job, but also the people skills to do the job. Strong communication skills and the willingness to be a **team player**. And not sort of being autocratic.

I met with my leaders individually to develop those one-on-one relationships. But also on a team basis we met. They knew what to expect because like I said I do respect practice, respectful truth telling so there's nothing hidden up my sleeve. They know exactly what my expectations are and then you know it's an equal exchange [be]cause I always believe I've learned from them too. You know so it's not about . . . I don't have a big ego so it's not about me, me, me. It's really about what we can accomplish together. And so my you know the thing is the last time the bonding has to do with and the, the reason that I look for bright people who you know have a good balance in their approach. And because what I'm looking for, to do the best in my role as a CEO.

She also reports being committed to building and developing her team of leaders. Part of the development is allowing them to be the leader while she stays back and is there if she is needed:

My number one job is to move organizational results. How I do that is not by [CEO] do, but it's by **facilitating the best of the people that work with you**. So one, you are counted as the best you know people who have that same mindset to **develop their people and not be about, all about them**. And then people who are driven for results.

And that I'm the last man in.

You know the teams that I've put together and the people that work with me, the reason that I feel like I've been successful is because that's one of **the key attributes I look for in people and hunger**. But then you have the other levels like that are really basics. Like for instance **communicating with impact**. People have to **be able to take command**. They have to **have presence**.

When asked about what she brought to the position to assist in being successful she pointed to her past experience and how it prepared her for this crisis:

You know so I think part of the, the success for me and particularly related to this crisis, absolutely had to do with **past experiences that were in my toolbox** way ahead of coming to that organization.

This CEO has comments on what a senior needs to lead their organization and get results.

Additionally she reports that building internal talent is a priority:

So for senior leader competencies. It includes **visionary leadership**, sort of the ability to set direction and gain commitment. That is a skill that nobody talks about a lot but, but you have to be able to do that in order to . . . it's executive disposition. And that's what we just were talking about. And that's sort of like the way you see yourself. And how you view yourself. **Ego is not what you want**.

I think you're also looking at **project and program management**, which again is a skill. I think they also have to be cognizant about **facilitating change**.

What are you doing to motivate them on both the group or that team level but also on an individual level so that you're **maximizing the potential of the whole organization**. Do, do your employees have a **personal development plan**? You know or, or is it just their annual eval? You know that really does not really talk about their personal development.

CNO

The CNO in this case felt the CEO brought a valuable set of skills to their position, including her ability to communicate and do so effectively, be thoughtful and respectful of others, be organized, work collaboratively, and be committed to transparency:

So what I saw prior to that was just her **sense of communications and the right communication**, telling the story of the hospital if you will in a **very clear and transparent** manner without negative impact on the organizing union that was coming in nor the nurses who wanted to organize. So that was impressive to me.

It's all about **building trust and confidence and it's about communication**. And I believe that's what [CEO] really **instilled in her leadership style** whether prior to or during or after.

So that's about you know the, **the transparency of communication**, not belittling the other person, but making sure that the staff had all of the facts in order to make their decision.

So we almost had a little mini command center if you will. So that **someone would be present and be visible and be available**. So I believe that was a huge key, not so much for the organizing entity or for the nurses but for the other staff who had really felt disenfranchised.

“Well one of the things was you know **someone was there 24 hours a day**. I remember you know she slept in her office one night. We would take different shifts so that there would be somebody from administration in the administrative suite. So that was, that was one thing. Secondly we believed in **leadership rounding. So we were out and about rounding our units and within departments**, those that we were responsible for and those that you know we worked with. **So that was going on far before the union organization sort of organizing took place.**

The CNO felt the CEO was open to questions from her staff. She worked closely with the leaders on their own development and created a sense of support and reassurance. She also saw the need to collaborate with her experts:

Well [CEO] style and I believe it's probably her style to this day, she is **very much of a team player**. She leads . . . I think she's very much of an **authentic leader**. She allows, she was a nurse herself and I was impressed that she never sort of drew that nursing card on the decisions that I was recommending related to nursing practice. **She allowed me to gather information on proposals or, or different initiatives I wanted to undertake**. So that was . . . very much appreciative.

You could ask her anything at any time. **So very open. Very genuine** and for me I mean **she was my mentor**.

You know she believed in me and she saw strength in myself that often I couldn't see. So I think she had that ability to draw out the strength of others in order to benefit the team.

She was **able to really pull that team together**. So I think she probably **knew what she needed** and then was able to make it happen in a very . . . even the replacement of whom I replaced she was a very thoughtful and careful.

I was never fearful or hesitant to have those discussions with Jackie either in an admin team meeting with you know the core group or whether just with her one-on-one.

This CEO also had previous experiences that benefitted her in this crisis. She was regarded as very detail-oriented and sought guidance from others when she was not familiar with a situation or did not have all of the answers and information needed to resolve something. She was open to constructive criticism and willing to be challenged if people felt she was wrong. All in all, interviewees said that “people gravitate naturally to her because of her enthusiasm and that energy and that positivity.”

She had been in a similar instance in the past in one of her former roles. So I think that sort of blended with her love and passion for our organization and our, our staff and people in general really did allow her to be a successful leader through this time and other times as well.

COO

The COO conveyed that the CEO brought some of the same and some other valuable skills to the leadership team. These included being fearless, having and maintaining integrity, being willing to compromise, commitment to the truth, courage, the ability to network and communicate effectively, and having keen insights into situations:

And one of those things you know when [CEO] began to really assess, she does her homework. And so she's assessing all the different keys, stakeholders, physicians, other you know other folks within the organization, within the hospital itself. But also regionally because providence is a, is a fully integrated health, health system. There's lots of I would say direct and indirect lines of reporting.

She created a task force and it included not only us, the senior leaders at the hospital, but it also included some, some **regional folks** as well that, that were again **key stakeholders** in all this.

And so that was one of the first things that she did was to ensure that we were all adequately prepared to, to lead our own perspective areas throughout all of this.

She was pretty **fearless** quite honestly.

Going to **maintain integrity** and **we will tell the truth** and we're not going to you know we're not going to shy away from opportunities to do just that. But one of the things that she said repeatedly was **we will not compromise our, our personal integrity.**

The COO noted she had a significant amount of integrity and courage not just throughout the crisis but it was a part of her core values. When asked how this affected her during the crisis she felt it helped to reassure her as well:

Well **it gave us courage**. **She modeled** quite literally. **She modeled the behavior that she wanted** . . . she wanted exemplified throughout the organization. And **she just didn't waver**. That was . . . it was just astounding.

Another priority was to build and maintain a clear mission for the team and the organization was a top priority:

The quality that comes to mind about her specifically is she has you know **stellar manager courage**. But also **keen insight into what was actually happening** and also had, seemingly a pulse on what could ultimately happen if this thing went one way or the other.

She **will not tolerate any lack of collegiality** among, among disciplines and if she caught wind of any of that, people would be held accountable to whatever degree.

When asked to describe the CEO's communication skills the COO just simply said:

Superb. Just superb.

When asked about whether she allowed her leaders to lead and if so how she did it the COO replied:

She **gave you the latitude and the autonomy** to do what you felt you know was in the best interest of your area. But, but you wanted her ... if you said something to [CEO], what do you want? What, what should I do here? **I mean she would step up** and she you know she'd give her opinion.

When asked if there was anything else that made the CEO stand out as a leader he mentioned the following:

She's very insightful, very **empathic**, she is just . . . she's so **damn smart**. There's no other way to say it. Her **business acumen is, is off the charts**.

She really is very much into mentoring others and to giving back to others....one of the things that she said to me was whatever you do in this pathway make sure that you always reach back and bring somebody else along because that's going to keep you . . . the balance is going to keep you humble. It's going to keep your perspective. It's going to keep you based in reality. And it keeps you from you know from getting full of yourself. And, and that is so true because you know I took that to heart. And, and I've been doing that ever since.

CFO

Finally, the CFO shared that the CEO was regarded as another role model/mentor, due to her positive qualities and experiences. She was considered to be a very well-rounded senior leader with a strong commitment to the organization. He felt she was always considering her resources:

There's a lot of federal lawsso you know **she garnered a group of experts** that are going to deal with this you know that's kind of part of their core competencies. And she also really orchestrated us through that process educating the rest of us.... I mean most of us who worked there had never really dealt, worked in that kind of environment. . . it was just very different—an organized shop versus an non-unionized organization.

It's **leverage the accessing resources** maybe beyond what you kind of normally have, I think an important thing. And plus she was able to . . . for example **get help for security at our other facilities** and bring those over and in fact everybody had their **contingency plan and organizing** you know through that.

The CFO reported he felt that he respected his expertise and utilized the expertise she had on her team:

I really enjoyed working with her for a number of reasons. One is that **she made me feel like you know my opinion was valid**. And that you know I think that . . . a good, strong leadership trait is to **let people do their jobs**. And you know she was, **she kept bringing me into stuff and you know I really appreciate that**.

So also I really appreciated the fact that she was, **she was very affirming**. And you know not just me but you know for, for the rest of the management staff ... she would always make you feel like you know **really appreciated you**, you know, for doing your job. ... you know I think that's, that also just **gained her a lot of loyalty** as well, as well as ... that whole trust thing. I think that's, that's a very important aspect of CEO leadership and I have to say I think I really liked that aspect of it. **I feel like I could tell her anything**.

Relying on her experts and you know kind of **bringing the team close together** so it would be like we're all working on the same strategy instead of individually flailing you know.

She also served as a mentor for the CFO. He mentions that because of her abilities, to mentor and coach and all of the other positive qualities he shared, he followed her to other facilities after this experience:

I felt like she, she was **very mentoring and nurturing** you know to a lot of the folks she worked with. And, and sometimes folks that didn't even know they needed nurturing and mentoring got, got it anyway, which is what ... and, and then after the fact. I mean people really appreciated.

She's kind of just a **natural leader**.

We all want just to feel like we belong as part of our team and we make a difference and know our opinion is valued and so you know ...some of her natural behaviors. I think we're you know we're definitely facilitated you know as a group you know becoming a team. **I always loved the fact that I knew where I stood with her**.

He added that she was open to question and willing to listen by sharing this example:

I'll give you an example of one you know one time where we were in a meeting and we were going one direction and I felt strongly that direction was not the right way to go. And so I went and asked her privately afterwards and I'd like permission to kind of speak frankly and she was like absolutely. Then I told her my concern and, and she actually agreed and we went a little different direction on the item. But and that **meant a lot to me**. I mean some leaders are so caught up in their own ego that they can't you know, you know, they can't take a different perspective.

She modeled the behavior she wanted . . . what she wanted, she exemplified throughout the organization.

This concludes the within-case analysis of each hospital and the informant's comments that support RQ1. The next section will provide a cross-case analysis of all twelve interviews as they relate to RQ2 and RQ3.

Cross-Case Analysis

This section shares the results of the axial coding process that resulted in the identification of themes. Each interview was analyzed for phrases and words that supported the research questions for this study. "As a form of validation, triangulation follows a classic strategy – seeing whether new ideas are consistent with what is already well known about the Case" (Stake, 2006, p. 77.) Each case was compared to other cases to look for common characteristics and negative case characteristics. As the cases were transcribed they were read and re-read to consider how to clarify the current interview protocol to gather deeper explanations, and identify consistencies and inconsistencies among participants. This process occurred for all 12 interviews and as a result minor changes were made to the Behavioral Event Interview Guide (Appendix C to enhance the possibility of eliciting "thick descriptions" (Charmaz, 2006). It is these descriptions that yield intricate information about the case that help in answering the research questions.

Below, each theme is identified, followed by quotes from the participants to provide thick descriptions of the themes. Themes were created if all three cases had at least one participant who shared content that fit into that theme. Themes are listed in the order that they were populated. In all, eight themes were identified:

- Let Leaders Lead

- Leverages Resources
- Doing What's Right
- Crisis Adaptability
- Partnering
- Building Organizational Talent
- Meaningful Visibility
- Strategic Foresight

The cross-case analysis in this section provides evidence, via themes, for research questions two and three combined: RQ 2: What characteristics did successful health care CEOs demonstrate in a crisis that could inform selection committee when choosing a health care CEO? RQ 3: What is the common set of characteristics inherent to successful health care CEOs in crisis across all cases?

Let Leaders Lead

It may be inferred that every CEO applies for that type of position because they enjoy the leadership opportunity. This theme draws attention to the CEO's ability to allow other members of the team to lead while they themselves step back or take care of other needs. This ability does hinge on a few other necessary skills: talent management and collaboration. If they have found a best fit team and fulfilled their role of collaborator, then facilitating leadership among others seems like a natural progression for this group. Letting his/her leaders take charge, make decisions, and function autonomously reaps rewards for the organization, the CEO, and personally for the leader. The leaders sounded excited when discussing this area of the CEO's characteristics. They shared how it impacted them in their work and personally. They shared that the faith the CEO placed in them, and backed up with actions, improved their loyalty and

enthusiasm about their work. This translates to those they lead and would follow this leader professionally.

- He gave us the ability to have a lot of **autonomy** in doing the things that we needed to do (Oklahoma CNO, 2014)
- I give them all of our leadership team, the ability to **be adaptable**. They just felt like they had a bad feeling about the shelter and place plan on the second floor and **they made the decision** (Oklahoma CEO, 2014).
- You know not only **does he let you run with it and do your own thing but if he is running with something and you realize that your subject matter you know as your you know area of expertise that he's doing something wrong, it's okay to go to him and say stop**. You know this is not the right answer. And he'll look at you and say okay what should we do then? (Jersey COO, 2013)
- I was **never fearful or hesitant** to have those discussions with [CEO] either in an administrative team meeting with you know the core group or whether just with her one-on-one, she is **open to discussion** (Oregon CNO, 2014)
- She was very **supportive**. I don't know any other way to say it (Oregon COO, 2014)
- Once we established the plan for how we were going to run the show internally he as you would expect probably just **let us run it** and you know he was there if we got into something that was beyond the plan (Jersey CNO, 2013).
- **Seeking consensus** of the group, not being so . . . and **not being dictatorial** at all (Oregon CNO, 2014)
- She is very much of a **team player** (Oregon CNO, 2014)

- She never drew that nursing card on the decisions that I was recommending related to nursing practice. **She allowed me to gather information on proposals on different initiatives I wanted to undertake.** And she would look at them through the eyes of a CEO and **not question my thought process** (Oregon CNO, 2014)
- He **listens** and is someone that **respects** the work that's done on a daily basis (Jersey COO< 2013)

Leverages Resources

The ability to network, connect with internal and external stakeholders, know resources, and critically think in advance about what resources might be needed was a strong theme in the interviews. CEOs in all three cases had a strong ability to identify, assess, and utilize human, material, and technical resources. The senior leaders noted the CEOs' ability to propose needs for resources that others had not yet considered. They also knew when they did not own the expertise. They worked diligently year-round to create a network of potential resources both within the health care organization and with community members. Comments shared by the informants, offered below, lend support to this theme:

- **Utilizing internal and external expertise** (all)
- Willing to **ask for help** (all)
- **Removes bureaucracy** (all)
- **Knows who to call** on for resources and they know him (Jersey CNO, 2013)
- They [Staff] know him personally and he has **built tremendous relationships**, and that stands you in good stead (Jersey CNO, 2013)
- **Leverage and accessing resources** beyond what you normally have (COO, Oregon, 2014)

- **Accessed all resources** and make connections with outside agencies (Oklahoma CFO, 2014)
- She **created a task force** and it included not only us, the senior leaders at the hospital, but it also included some regional folks as well as key stakeholders in, in, in all this, one being an attorney (Oregon COO, 2014).
- She **accessed training** for the leaders about the unionization process and how we need to lead during this event.... none of us had that kind of great training (Oregon COO, 2014)
- Was able to **garner support** from, from himself and the board to, to **provide us with whatever things that we needed** to do at the time, like getting the freestanding ED back and running and keeping a presence in that area (Oklahoma CNO, 2014).
- **Running obstacles** for any kind of needs that we had and to make sure that we were able to do the things that we needed to do in the immediacy of the storm and also **long-term** (Oklahoma CNO, 2014).
- He had truly **embedded himself in the community** (Jersey CNO, 2013).
- We met . . . in **the three days leading up to it**. We at least **had a plan** as to when we would all be in the building. He was actually very good about knowing that these disasters aren't over when it's over. You need to have people rested. So **he started early**... (Jersey CNO, 2013).
- We had a **store that was set up** for two weeks to provide supplies to employees who lost their homes (Jersey, CNO, 2013).
- They pull up two days later in a 45 foot semi and this trailer is packed from the floor to the ceiling, side-to-side with just huge supplies for, for daily living (Oklahoma CEO, 2014).

Doing What's Right

Keeping the employee and patient at the forefront of every decision is the basis for this theme: “doing what’s right”. Not every CEO does the right thing by their employees—just ask the investors with ENRON or any other company that has been selfish at the expense of hard-working staff. Sometimes leaders make gestures in support of employees but this group of CEOs certainly was beyond thoughtful. Every business has a financial bottom-line and the board gives the CEO ultimate responsibility. In each of the crises discussed here, the CEO reached out to employees at every level to provide support, allay fears, provide resources, consider the extended employee family, and often broke budgets to make it happen. In many of the scenarios their refined sense of duty to others created a deep sense of loyalty. Quotes that support this theme are shared below:

- You know the first thing the CEO did was the day after the event he basically **assured everybody you don’t have to worry** about your job, you will be paid during the rebuilding. . . anybody that was an employee at the time is going to be paid and is going to be paid in the same as they were before (Oklahoma CFO, 2014)
- They (employees) were going through employee program and making sure that they were **talking to counselors, people lost their cars, their, their job, cars and all that stuff.** So we made sure we got rentals and new phones for people who lost cell phones (Oklahoma CNO, 2014)
- **Very insightful, very empathic** (Oregon COO, 2014)
- We just had to **protect patients**, we had **to do things right for our patients**, we just did what was right to **protect the patients** (Jersey CEO, 2013)

- **You will have your job. You may not be doing what you were doing on Monday, but you are going to have a job.** And I think that was a very clear message, a very important message, and staff responded (Oklahoma CAO, 2014)

Crisis Adaptability

The theme of a CEO's ability to be crisis-adaptable arose from informant remarks about that individual's confident, calm handling of whatever came at them. The CEO is able to work the big picture, then move to minute details, and then shift back to the next smaller crisis. They understand when to provide input, when to pause, and how to switch gears while keeping the global scene in sight. All three CEOs had significant seniority in the industry and had experienced crises in the past. While each undoubtedly pulled from those experiences, each one remarked that not one crisis was identical to others. Being adaptable to an ever-changing environment is a crucial skill. Each CEO seemed to have the aptitude to avoid getting caught up in small details when it was not critical for them to attend every meeting and personally handle every situation.

- **"I was in Wichita Falls in 1979 at the Catholic Hospital when a big...this was before they rated tornadoes on the Fujita Scale... I was a brand new health care executive..."** (Oklahoma CEO, 2014))
- His **calmness**, he is that type of leader. He **does not get overly excitable**. He's, he's not unshakable but he is a very **strong and even keeled and consistent**. He's **compassionate** when it comes to this system and the people we have and the work that we do, the care that we provide (Oklahoma CAO, 2014)

- She does her homework and she's **assessing all the different keys**, stakeholders, physicians, other you know other folks within the organization, within the hospital itself and regionally (Oregon COO, 2014)
- You saw him step up when the time was appropriate and he **found the right moment for everything** (Jersey COO, 2013)
- **When we would start to spin our wheels a little bit he'd be the first one to stand up and say guys we all need to focus in here you know let's go around the room.** What are the lead issues? What, what do we need to do next? But at the same time, when the world was running a little bit smoothly he'd step back (Jersey COO, 2013)
- **Not afraid to ask for help** and that's I think such a positive trait (Jersey COO, 2013)
- **He's not ashamed, afraid or unwilling to say well what if.** What's possible? (Oklahoma CAO, 2014)
- Very **incisive**. He can get to the, the heart of the issue immediately. There's no dithering back and forth and he has the ability in all situations, not just in disasters, to really **take in a lot of information and sift it through** (Jersey CNO, 2013)
- He moved right to looking at rebuilding, a bigger, taller building, jumping to the recovery stage right away (Oklahoma, CAO, 2014)
- **He's really good at doing things and modifying things and changing things on the fly** (Jersey COO, 2013)

Partnering

Speaking with the senior leaders brought to light a common compliment for each CEO—that is, the CEOs were “open to question” and worked with others in decision making. They both asked for advice and sought expertise from their leaders. When making decisions the CEOs collaborated with their leaders and stepped in only when they felt they “were spinning their wheels”. And when it was a decision they could make but about which they were not the subject matter expert, the collaboration was a natural process. In addition to partnering with their internal team the CEOs all made an effort to do the same with outside stakeholders, benefitting them in times of crisis. To further clarify, one COO remarked

- “Every time I see him I have no problem looking at him and saying don’t do that. Or you shouldn’t have done that. ...He goes all right then, **then lesson learned for me** (Jersey COO, 2013)
- **Don’t be afraid to ask for help** (Oklahoma CFO, 2014)
- Afterwards how can **we critique**, critique ourselves in terms of what could we have done better? What other resources should we make sure are on the table? What unexpected things did we run into (Oklahoma CFO, 2014)?
- Made me **feel like you know my opinion was valid** (Oregon CFO, 2014)
- **Kept bringing me into stuff** and you know I really appreciate that (Oregon CFO, 2014)
- **Not so proud that they won’t reach out to the subject matter experts** and say hey, I can do this great but what should I do here (Jersey COO, 2013)
- **Taking input** from those who know the subject matter experts (Jersey COO, 2013)
- **Delegating responsibility, a proactive leadership** style (Oregon CNO, 2014)

Building Organizational Talent

For this study, “building organizational talent” encompassed a few CEO actions: building a team, coaching/mentoring, and fit vs misfit. Building a team took on a few configurations. First, the CEOs assessed gaps in the leadership team with future needs in mind and then, when choosing team members, selected leaders with the potential to handle crises in the future and disseminate expectations in this arena to their subordinates.

- And so my you know the thing is the last time the **bonding** has to do with and the, the reason that **I look for bright people** who you know have a good balance in their approach.
- Very **proactive in your leadership** style and how to build a successful leadership team
- **Maximizing the potential of the whole organization**
- Do your employees have a personal development plan?
- Able to really **pull that team together**. So I think she probably knew what she needed and then was able to make it happen in a very (Oregon COO, 2014)

Team building starts with competencies and skills of the leaders then moves down to the middle managers and they really drive results so you need to build the entire team (Oregon CEO, 2014). Coaching and mentoring were mentioned frequently as a CEO goal and a benefit of being led by the CEO as identified by the leaders:

- That’s when you, that’s when the **mentoring**, being a leader, that **mentoring responsibility** comes into play and you . . . and, and you work with, with those leaders to get them to the place where they need to be **where they can grow** (Jersey CEO, 2013)
- **Mentoring and nurturing** (Oklahoma CEO, 2014)

- Although some of my colleagues may not admit to it, but **we are only as good and successful as the people that we have in place. And if they're not successful and not effective then quite frankly the senior leader is not going to be very effective either** (Jersey CEO, 2013)
- Rather than confront me and call me out on it they simply made it a part of my development (Oregon CNO, 2014)
- **Don't give up on them** (Oklahoma CEO, 2014)
- **Mentoring**, being a leader, that mentoring responsibility comes into play
- **A coaching type atmosphere** (Oklahoma CAO, 2014)

Fit versus misfit was discussed in chapter two, in the discussion of work by Chen and Hambrick (2012). The CEO must “fit” the organization’s needs; further, this fit might shift over time and become less of a fit. It is possible that the CEOs interviewed for this study performed very well due to their fit with their organization.

- I'm a firm believer in the **right person in the right job** at the right time (Jersey CNO, 2013)
- They were **really the best fit** and everyone knew it right away (Jersey EM, 2013)

Meaningful Visibility

Informants often said during interviews that the CEO was “visible” and not just attending a meeting or showing up for a celebration, but genuinely visible. The term meaningful visibility grows from a multitude of comments that evidenced CEOs sitting with employees, hugging them, knowing about their kids or home situations, reaching out to help with personal issues after a crisis, and giving of themselves when no one was looking. The meaning lies in how it impacts

the employees with whom they are connected. It seems to create a sense of loyalty, pride, enthusiasm, and increased dedication to their role. This connectivity appears to be a natural one, not rehearsed and not forced. The following quotes support the “meaningful visibility” theme:

- **Communicating with impact** (Oregon CEO, 2014)
- **Transparency of communication** (Oregon, CNO, 2014)
- Typically is never an in the weeds leader, he is **out there with the people** (Jersey CNO, 2013)
- **Out there in front** making it possible (Oklahoma CAO, 2014)
- **Humble** (Oklahoma CAO, 2014)
- **Sincerity** and to be that face, to be out there was very important for who we are as an organization (Oklahoma CAO, 2014)
- He made himself **visible** in our emergency rooms and throughout the hospital (Oklahoma CAO, 2014)
- Made himself **available** to the staff (Jersey EM, 2013)
- He went down, visited and gave them hugs, talked, talked with families. He did all of that stuff and **I’d heard later how important that was for them to hear his voice** and to see him in the area and that was very reassuring for them (Oklahoma CAO, 2014)
- **Visible and available** to us and the staff (Oregon CNO, 2014)

Strategic Foresight

Every CEO and senior leader team is responsible for strategic goals and the overall business strategy of their organization. However, this theme extends beyond that role or possibly deeper into those responsibilities. The CEO with strategic foresight is not just planning for the

next budget cycle—they are encompassing a massive picture. This leader looks for strategic planning opportunities in their direct report line, in departments, and in the community; considers long- and short-term possibilities; and contemplates what could be needed in the event of a crisis. Informants spoke to all of these areas and an uncanny ability to plan for a multitude of contingencies, far beyond the everyday functioning of the hospital.

- She's got this ability to not only **envision** but . . . she's a rare entity that has a very strong skillset in **creating vision** but then they also know the day-to-day implementation and the oversight (Oregon COO, 2014)
- She's so damn smart. Her **business acumen** is off the charts (Oregon COO, 2014)
- **Leadership** and their ability to not only provide us as leaders but she provided us with certainly **insight** and **wisdom about how we need to govern ourselves** and govern you know govern our respective campus (Oregon COO, 2014)
- He's much more the **visionary** and thinking about all the needs now and for the future (Jersey CNO, 2013)
- You have to show a lot of **heart and courage** and **preparation** – get your employees ready. Preparation over and over with drills and the courage shown because of that saved lives (Oklahoma CEO, 2014)
- My leaders are **motivated to excel** and not just them but their middle managers and we need to think about how that works its way down to the middle managers. Be a **pace setter and they are encouraged to make decisions to thrive and grow**, need to prepare leaders (Oklahoma CEO, 2014).

Chapter Summary

This chapter has provided support for each of the research questions posed for this study. Each set of leaders shared rich descriptions of the CEO characteristics that allowed the reader to understand how the CEO's characteristics were displayed during the crisis. This deeper look into what characteristics the CEO displayed during crisis will help to better inform an executive search firm or board selection committee when they are selecting a new CEO. A summary of finding, recommendations for future research, and implications for practice will be shared in chapter five: **Study Summaries, Conclusions, and Recommendations.**

Chapter Five: Study Summaries, Conclusions, and Recommendations

Introduction

Study findings are discussed in this chapter. In section one, the purpose of the study is reviewed; section two, data collection and analysis procedures; section three, conclusions; section four, study strengths and limitations; section five, implications for practice; and section six, suggestions for future research.

The purpose of this study was to identify the characteristics of successful health care chief executive officers (CEOs) in three United States (U.S.) hospitals that had experienced a crisis and discuss ways in which this information could help inform the CEO selection process. According to Anderson (1983), research should be conducted outside the laboratory and should include a look at symbols, signs, and meanings that are not artificial but real. This researcher interviewed various individuals who constituted leadership teams that had experienced a real crisis. The events were real; the responses from the CEO and subsequent actions by his/her leadership team were unscripted. Their sentiments and actions were captured, and coded into themes.

The following research questions were addressed:

1. What characteristics were displayed by the health care CEO during the crisis that the subordinates felt were beneficial?
2. What characteristics did successful health care CEOs demonstrate in a crisis that could inform a selection committee when choosing a health care CEO?
3. What is the common set of characteristics inherent to successful health care CEOs in crisis across all cases?

Data Collection and Analysis Summary

Interviews with three health care CEO's and three subordinates each were conducted over a one-month period. All interviews were conducted by telephone. Each lasted 40 to 90 minutes. The Interviews were recorded and then transcribed. Each participant was sent a copy of the interview transcript for review. No additions or changes were received from the participants. Some follow-up questions were asked of participants by e-mail / telephone, and answers were added to the coding process for inclusion as appropriate in the themes. The transcripts were coded and kept open with no preconceived ideas of categories or conclusions (Charmaz, 2006).

The coding process consisted of three stages: initial, focused and axial. The initial open coding, using all data, was completed line-by-line to identify phrases, words, and meanings from the transcript (Charmaz, 2006, p. 53). The researcher asked four questions during the initial coding phase:

- What is the data of this study?
- What does the data suggest?
- From whose point of view?
- What theoretical category does this datum indicate? (Charmaz, 2006).

No pre-existing assumptions were made in this phase. The researcher evaluated the transcripts for actions while remaining grounded in the data, using only the data to evaluate the actions. The line-by-line analysis of each individual transcript allowed the researcher to pay attention to specific details provided by the informants. While reviewing the data the following codes guided this phase:

- Remain open

- Stay close to the data
- Keep your codes simple and precise
- Construct short codes
- Preserve actions
- Compare data with data

After initial coding was complete focused coding commenced. Remaining true to the data, the phrases were allowed to accumulate and a secondary process was then undertaken with more focused coding to identify categories or themes. During focused coding all the line-by-line data is reviewed, considered, and connections are made. The line-by-line was done interview by interview and this phase considered all the interviews together. A constant comparison of the codes occurred. The final phase was axial coding and is the phase in which “concepts and categories that begin to stand out are refined, and relationships among them are pursued systematically” (Strauss & Corbin, 1998, p. 52). Next, categorized portions of data were given names to account for their meaning (Charmaz, 2006, p. 43). This part of the coding process took the categories and reassembled them, delving deeper into each of their dimensions. The attention to one category at a time in axial coding allows for data to be synthesized and organized and then brought back to form an overall picture of the data. (Strauss & Corbin, 1990). Axial coding categories are related to their subcategories; Glaser and Strauss (1990) suggested that the researcher contemplate the meaning of the data and consider conditions, (circumstances, or situations for structure), actions/interactions (routine response to issues, consequences), and outcomes (what happens from the actions).

Triangulation

“Triangulation is an effort to ensure that the right information and interpretations have been obtained” (Stake, 2006, p. 35) from the qualitative data. Triangulation is an attempt to get the most complete and evidence supported data available that helps to answer the research questions. It also reduces the risk that the study conclusions will reflect only the limitations of the researcher and/or informants, reducing but not eliminating threats to validity (Maxwell, 2005). Triangulation was performed in this study because the data being evaluated were “critical to the main assertion” and descriptions could “potentially be debatable” (Stake, 2006, p. 35). Denzin (1989) suggested one method for achieving triangulation utilized in this study: inclusion of multiple views of the same event; using second and third perspectives. This was achieved by interviewing the CEO and three of his/her subordinates. It was important to hear how others experienced the CEO and assess whether the CEO and subordinate perspectives were congruent. Utilizing a multiple case study method, three CEOs from three hospitals and three each of their senior leaders ($n=12$) were interviewed between December 2013 and January 2014. In addition to interviews, the researcher reviewed each health care system’s website for additional details about each facility and sought media articles related to the crisis. A review of the hospital website and a multitude of news and media reports offered information which was used to verify the participants’ comments about their hospital and the events that had transpired during the crisis. Multiple cases, document review, and a coding by an outside SME were completed in an effort to achieve triangulation.

Conclusions

I have identified eight themes of characteristics in common among the CEO’s who have successfully led a health care organization through a crisis: (1) Let Leaders Lead, (2) Leverages

Resources, (3) Doing What's Right, (4) Crisis Adaptability, (5) Partnering, (6) Building Organizational Talent, (7) Meaningful Visibility, and (8) Strategic Foresight. These characteristic groupings create the developing theory of competencies of health care CEOs leading in crisis.

Crisis is the focus because hospitals and the CEOs who run them function in turbulent environments. As one CEO commented, "I mean on a daily basis you have crisis in a hospital" and "what you do as the CEO toward your senior leaders trickle down to the staff" (Jersey CEO, 2013). This comment draws attention to the importance of this study. How the CEO leads has implications in almost every aspect of the hospital and in a crisis, this impact is heightened. Their ability to lead impacts their senior leaders and in turn should continue a positive cascading effect throughout the management core.

Selection of the CEO should center on organizational fit (Chen & Hambrick, 2012) and what qualifies a candidate should certainly be built around the needs of the organization, but also the industry-centric requirements. This study suggests that one of the best-fit qualifications for a health care CEO candidate could be their crisis leadership skills. The researcher's experience with the lack of consistency in how health care CEOs are selected, the increasing number of CEO replacements (Green & Hymowitz, 2014), and potential for a lack of "best fit" candidates due to absent criteria were the researcher's impetus for completing this study.

Executive search firms and boards are facing this issue on a regular basis; this research provides timely guidance. For example, to expose the critical issue of CEO departure, Equilar Inc. conducted a three-year study of CEO turnover. They found that 348 of 361 companies (96%) in their study sample had replaced their CEO at least once during the three-year study period (Equilar, 2013). Twenty-three of the 348 companies that replaced their CEO had replaced

their leader twice during the same time period. CEO replacement occurred most commonly within the service industry ($n=88$) but technology ($n=58$) and health care ($n = 55$) were not far behind. The next closest rates for industries with CEO turnover were basic materials and industrial goods—both experiencing 36 turnovers from 2009 to 2012. More recently, at least 43 companies listed in the top 500 on the Standard and Poor's Top 500 Index had replaced their CEO by the end of the third quarter of 2013 (Equilar, 2013).

Health care is not far behind with an average health care CEO tenure of less than 3.5 years (Gearon, 2014). According to search firm executive vice president, Paul Essleman, the expectations for health care CEO have tightened and hospital boards are expecting results (Gearon, 2014). It will be essential for selection committees and search firms to choose the best candidate and this study has provided the development of a theory for competencies of CEOs who have lead through crisis.

Identifying the preliminary set of CEO characteristics required was the intended outcome. The researcher suggested that executive search firms, board selection committees, and/or selection committee chairpersons would benefit from a standardized list of characteristics when choosing a new CEO. Two pilot studies (Jones, 2011; Jones, 2012) found that none of the study participants used a standardized list of characteristics that included questions about previous experience leading through crisis. According the pilot study participants, the selection process for the candidate includes conversations about “what they were looking for,” and the meaning of this varied for each group. However, the selection chairpersons did not use a formal checklist, scenarios that would showcase the candidate's ability to critically think, or consider what characteristics a health care CEO would need to lead. When using an executive search firm (ESF), boards via the chairperson met with the ESF consultant to share what they felt was

needed in a new candidate. When asked how they chose the criteria, all said it was just a “gut” feeling or opposite to the characteristics of the current CEO. These criteria did not appear to promote a consistent or reliable method to choose CEO candidates. The availability of a list such as that proposed could help committees concentrate efforts during resume review, when narrowing selection options, and/or during the selection process itself.

The researcher has over 20 years of experience in health care as a medical practitioner, educator, internal consultant, and mid-level manager. During my tenure it was clear that not every CEO or senior leader had the requisite skills to lead an ever-evolving and crisis-oriented industry. Hospitals encounter crises that have significant impacts on multiple levels of the organization on a recurring basis, and although the CEO may not be directly involved, the leaders they have chosen often will be impactful. Observations over the years have revealed that when a CEO is a poor fit, the entire organization feels the consequences. As a result of this CEO misfit, the researcher has witnessed leaders who lack talent management skills, communication skills, an inability to adapt to crisis, inability to plan for future needs of the organization, and an inability to energize their leaders and communicate a shared vision with all levels of the organization. These deficits lead to poor morale, lack of trust, lack of shared vision, miscommunications that lead to misinformation, and overall job dissatisfaction. These issues then translate into overall poor performance as an organization. The importance of a leader who understands how they impact the entirety of a health care institution cannot be understated. Employees feel disconnected to an organization whose leaders cannot grasp the need to be well rounded, and performance suffers. Having a better selection process that vets a candidate’s abilities prior to hiring could help to avoid these challenges. It is not enough to think the

candidate is a fit; the selection process owes to the organization a rigorous review and serious contemplation of each candidate.

In this study, the first research question was designed to collect information about which CEO actions the subordinates felt were beneficial during the crisis. According to comments described in chapter four, each CEO had done a variety of things perceived by subordinates to be helpful, such as leveraging resources, letting them do their jobs, trusting them, using them as the expert, communicating honestly and transparently, setting expectations, being open to being challenged, planning with vision, and coaching them to better performance. Those data combined to provide support for RQ1 and RQ2:

2. What characteristics do successful health care CEOs demonstrate in a crisis that can inform the selection of a health care CEO?
3. What common set of competencies is inherent to successful health care CEOs across all cases?

The participants provided rich descriptions of those characteristics possessed by a successful health care CEO. Eight themes were identified from those descriptions. This study's findings suggest that when hospitals search for a CEO the candidates should have the following qualities (shown with the theme labels assigned and described in chapter four):

- Let Leaders Lead - Allow their senior leaders to lead
- Doing What's Right - Do what's right for the entire organization
- Crisis Adaptability - Adapt in crisis situations
- Partnering - Collaborate with their team and a variety of stakeholders, mentor, and coach

- Building Organization Talent - Recruit, retain, develop, and promote the best talent within the organization
- Meaningful Visibility - Be visible during and after the crisis and display superior communication skills
- Strategic Foresight - Provide strategic foresight
- Leveraging Resources - Understand and access resources

The interviews revealed details about the CEO's actions and specific examples of what they said or did during the crisis that was beneficial to the organization (See details in Chapter Four). Informants shared many accounts where the CEO trusted the informants' expertise for making decisions at various scales. The leaders imparted specific experiences where they were called upon for critical information and then given the autonomy to make decisions. They also commented that although an initial plan had been devised, the CEO gave them the latitude to make alterations to that plan. It was the support they received after the change in plans that added to an experience of support. It was made clear through the responses to interview questions that being allowed to run with ideas, make independent decisions, and review both public and private assessments of their actions had a positive impact on the overall management of the crisis, and on the individual leaders themselves. All of these elements combined to create the theme of "Letting Leaders Lead". Informants disclosed that being allowed to do their job and get support from the CEO increased their effectiveness in the crisis because of the support and encouragement they knew was there from the CEO. Knowing the leaders felt empowered and role modeled the same with their direct reports is an important message to CEOs. So, the cycle could provide a "circle of support" that improves overall performance. According to the interviews it appears this is happening at each of the three facilities investigated.

Over and over again, stories centered on “doing the right things” by the employees and the communities served by these CEOs. Anecdotal evidence piled up about replacing employees’ cars that were lost in the tornado and hurricane, a store that was created to help employees get toiletries, making sure employees got to loved ones, and looking at long term effects of each event on hospital employees. It did not appear that the CEOs had to intentionally plan these events; they were unscripted. In one case the leader gave their car to a couple so they could get to their children with no regard for how the leader would themselves get home. One CEO canceled unnecessary events at the hospital and donated money to an employee fund. One site replaced all employees’ cars destroyed by the tragedy. In yet another story every employee got paid time and a half and was assured a job even though the hospital where they worked at had disappeared into a pile of rubble. There were so many stories that supported this theme it appears these CEOs believed in doing the right thing and then actually did it. It is not clear how often this happens in less crisis-driven situations.

The theme of ‘Crisis Adaptability’ came through with all three sites. Crisis does not bring out the best in all people, however this group of CEOs seems to be able to adapt to it very well. The need to be flexible, to move quickly, make and then change decisions quickly, as well as being comfortable with uncertainty, came through in many of the interviews, and at each location. Informants commented often that the CEOs were flexible and very “in tune” to the quick changes needed during the crisis, and did not get overly invested in any one idea. They were open and able to critically think through many issues and ideas rapidly and if needed, they stepped in to make a decision but only after allowing their team to lead first. Being skillful in this area is a characteristic that is very useful in running a health care organization. The variables, rules, and requirements in health care change all the time. Requirements for accreditation and

insurance regulations are just two examples of reasons CEOs would need to flex often and with skill.

As a result the CEO's willingness to be questioned, offer mentoring advice, and seek out input, the theme of "Partnering" was developed. Almost every organization requires its leaders to have the ability to collaborate at some level. This is also true in health care. The level of collaboration, though, is different for each person depending on how they see their role and the need to take input and create a two-way conversation. Each one of the CEOs received compliments on their ability to collaborate across departments, authority levels, and with the greater community. A part of this skill set seems to be a willingness to see other's needs, whether that was a leader's gaps in skill sets, or how decisions might impact a community member. Each CEO was vocal when identifying areas of weakness but also as vocal when sharing a willingness to help the leaders achieve success in that area. The comfort level with coaching and mentoring was evident and seemed to be appreciated by most of the informants.

The theme "Building Organizational Talent" was identified and explored. Talent management or workforce development responsibilities are often solely housed in the human resource department. This is not true for the institutions studied here. Each of the CEOs considers developing talent as part of their role. Although none of them used those exact words, they actively participate in these activities according to their senior leaders. Every CEO spoke to their role in building the team. Building the team considerations occurred during the evaluation of the already in-place talent upon their arrival, and then in regard to recruiting new leaders, during the hiring phase, in performance reviews, and even in some informal meetings. The CEOs also mentioned that they role-modeled what they wanted the senior leaders to do, and expected them to do the same for their subordinates. Leaders commented that they felt the CEO was

looking for ways to enhance each of their skill sets. Attention was also paid to what skills their staff might need during a crisis and that, too, was made a priority long before any crisis ever occurred.

Staying visible long after the media departs seemed to have a long-lasting effect on the leaders and the employees therefore the theme of “Meaningful Visibility” was developed. It is common to find the organization’s leader at a press conference after a crisis or a fundraising event when re-building, but this set of leaders took the idea of being visible much more seriously and in an unscripted manner. The CEOs were said to be in cafeterias, hugging employees, telling stories, helping to debrief, and checking in many days and months after the crisis. Before the crisis this was already in place as they knew the names of employees with whom they do not interact daily, and had details about staff that only a leader who stops to ask would know. It seems that this natural and meaningful (to others) visibility builds trust, dedication, loyalty, and a willingness to do whatever was needed during the crisis. The leader could experience an easier time making changes or getting employees to take on new challenges because they see and know this CEO and understand and share their mission.

A benefit seen during the crisis was the CEO’s “Strategic Foresight”. Even though they had no specific foresight of when or how a crisis would come, it seemed they were always looking ahead and contemplating needs for the long run. This happened over and over according to the informants and with a variety of focus areas: crisis training and disaster drills, strategic benchmarking, long term business acumen, staffing, and goal setting. This skill was also taught to their leaders and seemed to provide a very prepared set of leaders and workforce. The ability of this group of CEOs to advance-plan and look into the future drove the development of the theme of “Strategic Foresight”.

The final theme is that of “Leveraging Resources”. As a complement to their ability to have strategic foresight, each of the CEOs interviewed paid close attention to the types of internal and external resources they would need. This was not at all central to impending crisis, but day-to-day as well as long term needs were assessed. They reached out to community businesses, community stakeholders, legislators, peers in other areas – even other states, specific employee skill sets, and internal leaders. One outcome of this ability to reach out was that each hospital had their pick of folks who offered and provided help before, during and/or after the event. This keen sense of never being too shy to ask for help or get advice benefitted the entire organization.

To guide the study of this topic, literature related to person–organization fit, fit versus misfit, decision making, and upper echelon theory was discussed in chapter two. This study’s intent was to provide a list of characteristics that could be used by executive search firms and/or health care organization boards in selecting the best CEO for their facility. The researcher believed that interviewing a health care CEO and their subordinates about a crisis they experienced together would uncover characteristics useful in identifying and choosing selection criteria. The proposition was that health care is in constant crisis and the best selection criteria would include a candidate who thrives under crisis situations. Finding the “right fit” also may be translated a few different ways, including strategic fit (Gupta & Govindarajan, 1984), personality fit, or avoiding long tenures (Miller, 1991), and board-CEO fit (Zajac & Westphal, 1996). This study did not specify which type of fit was evaluated—participants were asked whether the CEO’s actions and words were helpful during the crisis. Chen and Hambrick’s (2012) work suggested that a CEO could initially fit an organization’s needs at one point in time and then become less of a fit at a later date. This study’s findings could positively affect the original quest

for a right-fit leader. If health care organizations tend to function in crisis mode, then the leaders selected by search committees must have the qualities identified here to ensure a better fit and avoid the potentially negative outcomes of a poor fit and yet another search for a new CEO

Strengths

One of this study's strengths is that the findings partially fill a gap in the research surrounding identification of CEO characteristics necessary to successfully/effectively lead a health care organization. Where guidance was lacking on those characteristics that could offer direction to a search for the best "fit" candidate, now a foundational list is available for ESF and board selection committees. The identification of themes lays the theoretical groundwork for additional research to measure these draft competencies as will be discussed later in this chapter. Looking at crisis-specific situations brings a different perspective to leadership skills in health care. This is not to say that selection is a completely unstructured event, but there is a difference between what is "thought" to be a needed characteristic and one that can be shown to be effective. The data found in this study suggests that the eight themes occur on a regular basis with these three effective CEOs, as reported by their subordinates. It is no longer merely a "gut" feeling or the CEO's opinion that the characteristics matter. Leaders were able to identify specific instances of how the characteristics benefited themselves, employees, or the organization as a whole.

The CEOs interviewed for this project indicated they, too felt this study was a worthwhile effort and were willing to engage in further efforts to advance the work started here. For example, one CEO shared this statement about the study: "I think the topic is so very unique. I think you've hit on something" (Oklahoma CEO, 2014). All of the CEOs offered comments similar to this, providing support for continuing study into these themes. The CEOs could see the

need to identify these characteristics within a crisis context. They were in agreement that the health care industry survived in a crisis orientation making this research timely and important.

The inclusion of three cases afforded the researcher the opportunity to evaluate data from three different parts of the country, on three different types of crises, with three different sets of senior leader combinations, and with CEOs from diverse cultural backgrounds. Of course three cases will not allow for full generalization to all health care organizations, health care CEO's nor leadership team experiences. It is however a richer data collection and analysis process than a single case study approach as it expands and allows for the beginnings of saturation. Saturation "has become the gold standard by which purposive sample sizes are determined in health science research" (Guest, 2006, p.60). According to Glaser and Strauss (1967) there is no particular number of interviews required but the researcher needs to reach theoretical saturation. In this study saturation has begun but is not complete. The diversity of settings allows the findings to be applied to not just one situation but to consider that because similar characteristics were found across three different scenarios it might be applicable across health care. Because it is a foundational study there are opportunities for additional research and this will be discussed later in this chapter. The additional views of the crisis and the CEO's actions bring a deeper understanding to what characteristics made an impact on the subordinates and avoided a one-sided story from the CEO. Because this technique has been successful here it should be considered for additional future studies to validate its continued effectiveness.

Diversity among CEOs is limited. In fact, according to Diversity Inc.'s 2013 survey, only six of the Fortune 500 CEOs are black and only 28 are women (Diversity Inc., 2014). In this study's sample there were two African American leaders, one female CEO, and three female senior leaders. Within the health care executive ranks the Institute for Diversity in Health

Management, an affiliate of the American Hospital Association, reports that as of 2012 minorities compose 14% of upper level executive positions (Selvam, 2013). According to the study this is a positive swing from 9% in 2011. In fact, in the first year of the survey, 1994, minority leaders held just 2% upper echelon positions. Minority chief operating officers hold 14%, chief nursing officers hold 10% and chief financial officers hold just 7% of the nation's health care executive positions (Selvam, 2013).

For a sample size of 12 this is a generally representative sample. The perspectives of two men and a woman helped to provide a diverse lens on what both men and women CEOs can offer their leadership teams. This work revealed only minor differences between the men and woman studied. The female leader received some additional comments that spoke to her caretaking behaviors but other than that there were no significant differences in the actions of CEOs of either gender

Another noted strength of this study was its expansion on CEO self-report. Not only was the CEO interviewed but input from three other members of their leadership team was obtained. This increased the impact of triangulation of the data (Yin, 2009). To a great extent, it also eliminated the potential that the CEO's comments would be taken at face value and not verified with other informants. Importantly this study did not just report what the CEO "thought" or "hoped" they were displaying but instead compared what they thought with three other members who had direct knowledge of the events.

The researcher was able to identify eight themes that could be used by an executive search firm or board selection committee when selecting a new health care CEO. Since no checklist currently exists, this list forms the foundation of an objective set of qualities to grade

prospective CEO's against. Additionally, this list can be researched further to expand and continue to validate these findings.

Limitations

“Mature is the researcher who rejoices in finding a mistake” (Stake, 2006, p. 77).

Interviews are a valid and credible method of conducting case study research (Yin, 2009). However, it is helpful to have additional sources of evidence to support findings. In this research additional evidence was provided by interviewing three subordinates of the CEO—this strategy provided an excellent source of information and lent support to the triangulation of the data. One limitation was that only interviews and a review of media related to the crisis were conducted. Additional observations of the CEOs' characteristics and their impact on the crisis would have been beneficial to the understanding of this topic. Unfortunately, due to the nature of crisis situations, it would have been virtually impossible to get to the scene in adequate time to complete the observation. This is why it was very important to add the views and observations of the CEO's senior leaders to this study. Adding additional sources of evidence has the advantage of “the development of converging lines of inquiry” (Stake, 2006, p. 56).

Of course, future work can build on expanding the diversity and eventually the generalizability of the findings. An additional possible limitation could be that of memory error. “Tapping the memories of the decision makers could introduce two forms of error, distortion and memory failure” (Mintzberg et al., 1976, p. 101). Mintzberg's team also asserted that multiple interviewing could reduce that error. Each participant was only interviewed once for this study; however, because these events were so significant, participants' memory seemed to be crisp. The researcher chose crises that were significant either in intensity or impact and therefore memory

overall was clear. One crisis occurred less than a year ago, one about 2 years ago and one almost 10 years ago. This study seems to have been minimally impacted by memory failure but that does not mean each informant was able to remember every detail.

An area of interest identified after the interviews was social context. The social context of each facility can be different and a variety of variables might be at play that influences how the CEO interacts with the team and anyone else involved in the crisis and vice versa. For example employees and leaders might act differently if an organization is doing well financially or struggling with a hiring freeze. The researcher did not ask or complete observations that focused on issues of social context within this study. Observation would have helped to identify whether social context had an impact on CEO characteristics or senior leaders' behavior as a result of the CEO's characteristics. Zey (1992) suggested in his research on decision making that social context can have a positive or negative impact.

In order to increase any possibility of generalization and because a single case cannot provide enough detail for this topic, the researcher chose to engage in a three-case study. When determining the number of cases necessary for a multiple case study, the researcher should not use "sampling logic" since "the typical criteria regarding sample size" are not appropriate in qualitative methodology (Yin, 2009 p. 58). Yin (2009) suggested that the researcher consider how many cases would be necessary in relation to the complexity of the topic. Interviewing subjects from three different hospitals was very helpful to seeing a variety of experiences and finding common themes. However, interviewing more groups of CEO and senior leaders in the future would provide a stronger case for the themes identified in this study. Although, the researcher noted partial saturation as a strength it also can be seen as a limitation of the study. This introductory study gained significant insight into the research questions but more can

be done to expand on its findings. The researcher used grand tour, example, experience, and native-language questions (Spradley, 1979, p. 86). The grand tour questions allowed the researcher to describe the overall event and give details about what happened during the crisis. The example questions asked the informants to delve deeper into the actions of the CEO (or themselves) prior to, during, and after the crisis and to give examples of the actions. Experience questions were sometimes asked along with the native-language questions to gain a better understanding of what a particular term meant for that informant. Often, probes were used to get richer understanding of how an objective was accomplished by the CEO or how it impacted the subordinate or other parts of the organization. It was a limitation, though, and in future studies the questions could focus more on crisis-specific meanings, implications, and characteristics specific to the crisis environment.

Each crisis event that was studied encompassed a very complex set of tasks for the CEO and the leadership team. Larger events might differ from smaller ones, and this study looked at three large-scale events. All three crises seemed to depict similar characteristics. It is still unknown if this study can represent smaller-scale crises. In a smaller-scale crisis, the CEO might rely on additional characteristics to lead the team. Additional purposive sampling would be necessary to uncover whether a difference exists or not.

The location of the three cases studies was similar in this study. Each of the hospitals was located near or in a large city environment. It is unclear what impact that location had on the informant's responses. The more metropolitan area could provide access to resources and allow for a different experience in regards to accessing and leveraging resources. Resources, networking, communication options, types of leaders, and prior leader experience could vary significantly in more rural locations. Another limitation is that this study did not explore

potential differences is how rural hospitals process a crisis. There could be a range of variances with urban, suburban, and rural locations.

This study included leaders with whom the CEO would commonly interact during a crisis and on a regular basis. The design was purposeful because the researcher wanted input from leaders that intimately interacted with the CEO in hopes they would be able to give pieces of minutiae that a distant manager might be unable to provide. It was designed in that manner to be sure participants had firsthand knowledge of the CEO characteristics. However, interviews could have included middle management roles to ascertain whether the impact was evident at a layer beyond the senior leader. The inclusion of the next layer down could shed even more light on the impact of the CEO's actions within the organization. It also could uncover characteristics that only that level of management would experience.

Although this participant group included both men and women and represented at least two ethnic groups, it did not include all ethnic or age groups. Since only three CEOs were interviewed, not all cultural backgrounds could be represented. Additional participants with a purposeful sampling technique would allow for comparisons on CEO characteristics in different ethnic or age categories as well as inside and outside industry experience, different clinical backgrounds, prior crisis experience, or educational background. This additional demographic investigation could add a quantitative component to the study and although not necessary it could be beneficial.

Each of the CEOs had been in the industry and working as an upper echelon leader for a number of years at the time of the crisis. Since all of the CEOs were experienced leaders, they might react, act, mentor, and display certain characteristics that a less senior leader might not. The researcher did not purposefully sample CEOs with a wide range of leadership experience.

The lack of CEOs at the beginning, toward the middle, and those at the end of their career trajectories might have provided a wider scope and could have added to the types of actions seen by subordinates. There is some discussion about the impact of a CEO's tenure with a company. Some say that the longer a CEO stays the less effective they are when it comes to customer and strategic initiative but it might benefit employee relations (Miller, 1991). Luo, Kanuri, and Andrews (2013) found something similar when they studied 356 U.S. companies from 2000-2010) and measured the impact of CEO tenure on customers and employees. Their performance indicators were the magnitude and volatility of stock returns and their employee dynamic indicators included retirements, layoffs, quality and safety outcomes (Luo et al., 2013). They suggest that a longer stay as CEO has a positive impact on the "firm-employee dynamic" but an abbreviated impact on customer connect and that impacts overall firm performance. The longer a CEO serves, the more the firm-employee dynamic improves. But an extended term strengthens customer ties only for a time, after which the relationship weakens and the company's performance diminishes, no matter how united and committed the workforce is. How long a CEO has been in place might impact what skills they select in particular crises or what characteristics have been acquired by a certain experience level. What impact tenure would have played in this study is unclear. Did the longer tenures of the informants in this study increase their ability to relate to employees and/or did they have better employee centric skills? Thus is unclear, and worth consideration in future studies.

Practical Implications

Information collected in this research led to the discovery of eight characteristic themes from three very different stories provided by a group of skilled and innovative leader groups.

There is so much more to learn about the topic. Below are additional streams of research revealed after completing this study.

Chief Executive Officers

CEOs can learn from information offered from this study as well. CEOs who participated in this study provided a significant amount of autonomy for their leaders by selecting the best team and then “letting them lead”. Many comments suggested the senior leaders appreciated being seen as the expert and then allowed to make decisions. This autonomy caused the leaders to feel empowered and trusted, which trickled down to their managers. The CEO in a health care setting can utilize the information in this report to identify behaviors that they should look for when hiring new senior leaders.

Another area for interest might be the process of communication during crisis. Frandsen and Johansen (2011) explored internal versus external communication during a crisis and found that each stakeholder had differing needs as well as interpretations of the communications provided during the event. Although this work did not delve into issues specific to communication the informants did provide information about positive communication skills. CEOs would benefit from looking at how and when communication is provided and its impact on senior leadership and overall management of the organization. What does connect from this study is that each leader, department, and employee has differing needs during a crisis with regard to communication. This study’s CEO participants seem to skillfully consider those needs and act accordingly.

Management & Leadership Teams

The participant's accounts of each crisis can provide clarity about how a senior team functions successfully as well as what to expect from a CEO. These successful CEOs provided their senior leaders with an assortment of mentoring and coaching opportunities. A senior leader also needs to "fit" an organization and its CEO. If this checklist also was used in selecting upper-echelon leaders, a better fit might occur between CEO and team.

The decision-making process in a crisis is very important. Research done on decision making after the Cuban Missile Crisis (Allison, 1971) and Challenger Space Shuttle crash (Gouran, 1987) revealed that social context, perception of authority, and changes in mission or purpose impact the manner in which decisions are made. During the emergency, leaders might be influenced by any one of these elements; the characteristics inherent to the person might mitigate the effectiveness of their performance. The CEO's "conceptual lens" explains and describes how they process issues and decisions. A conceptual lens defines how someone interprets situations, responds to situation, and analyzes outcomes. In the context of this study this conceptual lens can be affected by prior crisis experience, previous experiences with each member of the team, details from other leaders whom they trust, and if the leaders trust the CEO. All of these things, combined with the evidence presented and attended to help them make a decision. However, if the leaders do not trust the CEO, and if the CEO is not suited to engagement in the crisis environment, they may not get accurate evidence or trusted advice—situations that may alter the decision-making process.

Executive Search Firms and Hospital Boards

The list of themes obtained from this research offers insight into characteristics that executive search firms and hospital board selection committees can use when searching for their

next CEO. This initial list is a foundation for the initial stages of a search, or may be used in narrowing down the field or deciding between final candidates. One of the benefits from this qualitative study and the rich descriptions provided by the participants is that ESF and boards can begin using this characteristic list right away. Because of the pressure to find the right CEO boards should pay attention to this research utilizing it as a beginning theory of competencies for CEOs leading through crisis. Choosing the wrong CEO could be a high stakes gamble for the hospital, patients, and board members. It also causes disruption in the functioning of the health care system so care to choose the very best fit should be a priority. Although additional research is required to make these characteristics measurable hospital boards and executive search firms could participate in the next phase of this research as it would benefit their processes as well.

Human Resource Development Practitioners

This study has provided a list of health care CEO characteristics that would be beneficial in a crisis. Because hospitals function in a crisis mode these characteristics could be used as a foundation when looking to hire the next CEO. Human resource practitioners can benefit from this study in two ways. The first benefit is providing an initial guide for evaluating candidates. Human resource practitioners are often involved in assisting the selection committee or working with the executive search firm as they develop a set of criteria for candidates. Currently, it is unclear what if any criteria are used for selection and this study's findings provide a beginning step on the way to identifying a full set of competencies.

Secondly, this research can assist human resource practitioners when creating development programs for current and future leaders. Opportunities for development could be identified and matched with many of the characteristics outline in this study. The role of human resources is often to set the agenda for organization learning. Learning opportunities that allow

leaders to develop these skills or allow upper level leaders to assess up and coming leaders also would be helpful. The list of characteristics could also be incorporated into a watch list or used for assessment during succession planning. Another possible benefit would be to utilize this list of characteristics when assessing high potentials. High potentials, or those employees that the companies have identified as top talent, are on their way to upper level executive positions and should also either have or obtain these characteristics along the way. Additional research is needed to advance this list to competencies but human resources could then be involved in developing ways to assess for the characteristics such as scenarios, stretch opportunities, or next level up opportunities. Human resource professionals have a focus on organization learning and development and the characteristics could hone their focus for future executive talent.

Recommendations for Future Research

Researchers

This study is a launching pad for future researchers. There are many opportunities to expand on this work, including potential expansion, diversification, and additional triangulation. More cases would allow the researcher to confirm reoccurring themes and additional saturation (Charmaz, 2006; Strauss & Corbin, year). One other option would be to expand the current demographic group to include other industries such as service industries. This industry was found to have the highest CEO replacement rate (Equilar, 2013) and would be a good place to replicate this study. The financial industry has experienced a series of crises in recent years and might be another appropriate place to reproduce this work.

Another opportunity for future research is to look for sites similar to that used in the pilot study (Jones, 2012). That study examined an internal crisis and the impact of a computer

shutdown. Other internal crises might deepen knowledge in this area. The pilot study findings are congruent with those for the main study.

Expanding sites to additional geographical locations such as rural hospitals could provide a different perspective on how CEOs behave and display characteristics in a crisis. As mentioned earlier in this chapter a new environment might offer different challenges with resources, staff expertise, and networking. For example, how a rural environment might impact the findings, if at all.

Since the ethnic make-up of this study's sample was 33% non-White, future researchers should consider sampling other ethnic groups and additional female representatives within the CEO and senior leader group. Diversity is very important to understanding or uncovering even slight differences in how different groups lead during crises. Leaders who might have held positions in other countries and then came to the U.S. might also provide a new perspective. Adding to the diversity of the CEO group would increase the generalizability of this study's findings to foreign country scenarios.

Workforce Education Practitioners

Developing a competency model for health care CEOs would be a logical research next step. The current research provides draft competencies for health care CEOs but does not make them measurable. This is a multi-step process and can be approached in three ways according to Rothwell and Kazanas (1986, as cited in Rothwell & Lindholm, 1999) the borrowed approach, the borrowed and tailored approach, and the tailored approach" (p. 97). The borrowed approach consists of finding a ready-made set of competencies. This is quick and less expensive but may not truly match what is needed. The next approach borrowed and tailored means the practitioner would take the packaged competency model but tweak it to fit the needs of the client. The final

option is to create a model that is specific to that industry or client need from scratch. This method is more time-consuming but is the most rigorous and complete. This option is expensive because the process is detailed and requires multiple steps but can build an excellent model.

This last approach would be well suited for future research using this study as its foundation. The current research identified exemplary health care CEOs and gathered data to create a list of characteristics displayed while the CEO performed essential job functions. The next step would be to fully explore what is needed for a health care CEO competency assessment. Rothwell and Kazanas (1986, as cited in Rothwell & Lindholm, 1999) suggest that the “process-driven approach” focuses on the work that is performed by the “exemplary” performers (p. 98). There are three steps in the “process-driven approach” (Dubois, 1993, as cited in Rothwell & Lindholm, 1999, p. 97). Step one is to examine the work responsibilities of the exemplary performer, in this case it would be the CEO, by surveying or interviewing large numbers of CEOs and their leadership teams. In this stage the original eight themes would be explored further using the Behavioral Event Incident form to ask participants how they know each of the themes are being performed. For example the theme “leveraging resources” would be explored by asking the informant to give specific ways in which they saw the CEO “leverage resources”. This would be done for each theme leaving room for identification and inclusion of new themes. The snowball approach (Goodman, 1961) would work to have successful CEOs identify other high performing CEOs to interview or include in focus groups and allow the sample to grow by referrals. The next step requires that the characteristics of the performer be isolated. This could be achieved by sharing the list with other decision makers to assess whether or not the items identified would match with strategic plan. The final step would be to verify what was found during steps one and two. The model would then be used in actual selection

processes to see if it actually provides solid guidance when choosing the next CEO. It would be important to gain feedback from ESF and board selection committees. This step could also help to identify when the tool would be useful. It may have uses outside the selection process such as recruitment, development, performance management, and/or on-boarding (Personal communication, Rothwell, March 24, 2013). One evaluation of whether the tool has been developed well is to find out if it is being used. If the tool meets the needs of the situation and measures what it is intended to then it will be used. However, if it is not being used all is not lost. Going back to the end user to assess why the tool is not being used and then revising is also an important step. This research is a good first step in the competency modeling process and the themes identified can serve as the basis for the “process-driven approach” (Dubois, 1993, as cited in Rothwell & Lindholm, 1999, p. 97).

Crisis Leadership Implications

While this study has provided a solid initial list of health care CEO characteristics, subsequent work could delve deeper into which characteristics are specific to crisis response. Crisis was chosen as the setting for this study because of its sense of urgency and potential for loss and high risk. Increasingly, crises are more widely reported and can be more impactful due to the ever-expanding and interconnected nature of business and industry (Seeger, Sellnow, & Ulmer, 2003). The crisis itself was not under investigation so theories related to organizational crisis, such as chaos theory (Murphy, 1996), sensemaking (Weick, 1993), or organizational learning theory (Cohen & Sproull, 1996), were not employed or discussed. Since crisis often impacts hospital settings, selecting those sites provided an opportunity to focus the informant’s attention on a specific set of circumstances so that CEO characteristics could be revealed. The crisis setting was a ripe one for uncovering a set of characteristics displayed by CEOs as they

lead. The eight identified themes can be developed into a selection checklist. Additional interview questions that might be included in future competency modeling would contain inquiries that isolate crisis specific skills and abilities at an even deeper level than the current researcher completed. The current interview questions would be expanded with additional probes and follow-ups that uncover potential additional characteristics.

Managers/Leader Implications

This research could be viewed as a pilot study for a full study that delves further down the chain of command to determine the impact of CEO characteristics. Sharing the CEOs' expectations, interrelations with senior leaders, feelings of autonomy, and lower-level management's perceptions of leader support were not confirmed in this study. For that type of study it could be helpful to be embedded in the hospital system to observe the stream of leadership over a longer period of time.

Talent Management Consultants Implications

An additional area of potential research would involve considering a reversal of the process used in this work. The CEO would use the list of characteristics to choose up-and-coming leaders for promotion. This could impact the succession planning program at hospitals as well as coaching and mentoring. In the current research CEOs made it clear that they carefully consider whom they add to the group when building a team. Although none of the CEOs mentioned looking for people "like them", this is an obvious possibility.

Executive Coaching Implications

The information gained in this research also supports the role of the CEO as a coach and mentor. Many participants commented that the CEO's ability to identify performance gaps and

weaknesses was very helpful. Additionally, informants reported that they respected the CEO very much when they chose to share feedback in a private setting. The role of coach is part of the talent management role and reaps rewards in many areas. The leaders viewed the role modeling as effective and favorable and then said they did the same with their direct reports. This trickle-down effect was helpful because during a crisis the employees need to access these skills quickly. Therefore CEOs should continue this behavior on a daily basis but also in crisis as it appears CEOs are able to process multitudes of information even in crisis mode.

Final Summary

This study interviewed three United States health care CEOs and three of their senior leaders who lead through a tornado, hurricane, and nursing strike. Each leadership team was asked to identify positive characteristics of the CEO as they lead through crisis. The CEO was asked to describe what characteristics they thought made them successful as a CEO and leader in crisis. The three case study protocols were crafted following Yin's (2009) case study model and Charmaz's (2006) analysis using strict coding process resulting in the identification of categories and then themes. The current study set out to develop a theory of competencies of a health care CEO during a crisis situation. The study provides eight themes that identify characteristics displayed by three CEOs at three different hospitals in the U. S.: Let Leaders Lead, Leverages Resources, Doing What's Right, Crisis Adaptability, Partnering, Building Organizational Talent, Meaningful Visibility, and Strategic Foresight

As only step one in the competency modeling process these themes focus the selection process for a new health care CEO to a closer best fit. This research is just the beginning—there is more to learn and explore.

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doi: 10.1002/smj.689

Appendix A:

Pilot Study One

The author has completed two pilot studies to inform this proposal. The first pilot study was conducted in late 2011 under the direction of Dr. Barbara Gray which explored the selection process for hospitals and academic medical centers. Three upper echelon level administrators were interviewed about the selection process for other upper echelon positions. The research project was approved by the Pennsylvania State University Institutional Review Board (Approval #38222). Participants (n = 3) were asked about criteria for selection, interview process, evaluation or prior crisis leadership experience, interview questions that would evaluate current skills and abilities beyond resume specifics. A grounded theory method was utilized to explore and evaluate the data. The following section describes pilot study one.

Conceptual Framework

Selection committees are faced with an overwhelming task. Selecting the next leader is important, but few analytic techniques have been suggested to aid directors in making complex CEO selection decisions (Hoffman, Schniederjans, & Sebor, 2004). Finding a good fit requires a complex but specific process in order to be successful. CEO selection occurs “relatively infrequently and involves ambiguous data and possible disagreement about which data are relevant” (Schwenk, 1984). It stands to reason that with such important work, companies would employ standard methods that are known to yield successful results. Crowley (2004) reports that search committee face two distinct challenges: Identify criteria and then apply effectively. Successful committees are expanding search criteria to include integrity, professional ethics,

emotional intelligence, qualities that may be more significant than candidate's ability to drive financial and operational and developmental initiatives.

Research Questions

This study asked three questions about the executive leadership process and selection criteria:

1. What is the process medical centers move through when choosing new executives?
2. According to selection committees, what qualities are necessary in a new executive?
3. How is prior ability to lead through chaos and crisis evaluated?

The questions were developed with a reminder that in qualitative research ideas emerge, grow, and die (Stake, 1995, p. 21) and therefore the research questions may also be adapted. Stake suggests - a suggestion followed in this study - that researchers make a flexible list of questions, progressively redefine issues, and seize opportunities of learn unexpected (p. 29). The final questions were revised and reimagined to better define the goal of the interviews.

Methods

The author conducted and analyzed this study from an interpretivist paradigm (Burrell & Morgan, 1967). It is the author's opinion that engaging in the interview made an impact and that there is no way to remain separated from the reality surrounding the situation. The author was aware during the entire process that her own previous work and life experiences made an impact, regardless of how small, on the types of questions asked and how the data was interpreted. In reporting the study's findings, every effort was made to use the informant's voice and stay true to the data collected however the relationship between reality and the author was one of interdependence. It is this awareness through the process that helped the author to focus on the

information being provided and not to privilege personal opinions or feelings in the interpretation.

Data Collection

Identification of the first informant was provided by a colleague of the author, a convenience sample. After interviewing the first informant, the sample technique changed and became that of snowball sampling. For this study the definition of snowball sampling, as described in the work done by Trow in 1957, is when a few members of a rare population are asked to identify other members of the population, those so identified are asked to identify others, and soon, for the purpose of obtaining a nonprobability sample or for constructing a frame from which to sample (as cited in Handcock & Gile, 2011). The first informant identified the second and third informants. The informants lead selection committees at either an academic medical center or hospital without an associated academic medical center. By choosing two different types of facilities it was the hope of the author to identify if both facilities approached the selection process in the same manner. Two of the facilities can be described as large academic medical centers attached to large medial facilities with approximately 500 beds and full medical education programs (medical students, residents, and fellows). One facility was a free-standing hospital with approximately 250 beds that also supports medical education (medial students, fellows, nursing students) but does not have an academic medical center campus. The methodology followed a grounded theory (GT) approach as described by Charmaz (2006) but built on the work done by Glaser and Strauss (1967). The grounded theory method was used as a set of guiding principles and practice but not as a prescription (Charmaz, 2006, p. 9). The process of GT is not linear and encourages adding new pieces of data or focus as the researcher moves through the process. The research questions shaped the methods used in this study (Charmaz,

2006). Interviews were chosen to get at a deeper understanding of the process as a survey would yield only surface information. The Grounded Theory method allows the researcher to contemplate the fit between beginning research focus and the data that emerges.

After the first interview the initial questions in the protocol were adjusted to discover additional descriptions. This was done during each interview and each informant provided additional information to inform the eventual theoretical representation.

Interviews

The initial phase in the interview process is to establish rapport as described in Spradley (1979). The four phases of rapport building were attended to during the interviewing process: apprehension, exploration, cooperation, participation. Once the informant and researcher moved through each stage the informant understood their role in this study and participated fully in the interview (Spradley, 1979, p. 44). An interview protocol was created to guide the interviews and included descriptive questions that included grand tour, mini tour, example, and experience questions to elicit rich responses from the informants. It was important to elicit the participant's definition of terms, meanings and not the researcher's perspective (Charmaz, 2006). Each potential informant was contacted by phone and a verbal consent was obtained. Then a written consent was sent, signed, and returned prior to the second contact. Each informant agreed to be audio taped. Tapes and notes from the interviews were transcribed by the author, verbatim.

Several questions were considered when evaluating data (Charmaz, 2006):

- How does the observed process emerge? How do participant's actions construct them?
Who exerts control, under what conditions?

- What do they emphasize? What do they leave out?
- How and when do their meanings and actions concerning the process change?
- What are the conditions under which specific action, and processes emerged?
- What specific words and phrases used by the informants seem to carry particular meanings?

Coding of data

The transcripts were coded and kept open with no preconceived ideas of categories or conclusions (Charmaz, 2006). Memo writing was employed after each interview to summarize and consider what was discussed. Initial coding was done line by line to identify phrases and meanings from the transcript (p. 53). Remaining true to the data, these phrases were accumulated and a secondary process commenced with a more focused coding to create categories. Categorized portions of data were given a short name to account for its meaning (Charmaz, p. 43). The third part of the coding process created Axial coding that allowed for synthesizing and organizing the data and brought it back to a whole (Strauss & Corbin, 1990). Strauss and Glaser (1990) suggest looking at the data to consider conditions (circumstance or situations), actions/interactions (routine response to issues, consequences), and outcomes (what happens from the actions).

The axial codes created an attempt to define what happened during each selection process for each facility. Theoretical categories were pondered during this final stage of coding. At times the codes revealed action dilemmas (Charmaz, 2006).

Table 1. Initial Coding and Subsequent Categories

Initial coding	Categories
Part of a group - ** “Progressive” – Good rapport - *** “Ability to work in ambiguity” ** “Needs to be able to work in chaos” ** “Needs to meet our value structure” - ** Looking for someone with same values as organization - *** “Needs previous experience that links to future plans” - ** Needs experience that is linked to strategic plan” - **	Non-resume elements
“Find a search firm - *** Always use a search firm - *** Charge the committee - *** Provide requirements needed - **	Selection of Search Firm Charge Committee
Create a job description specific for the job - *** For each position we consider what it takes for that job-**	Creation of Specific Job Description
“Choose representative group for committee” *** “Need to be committed” - **	Selection of Committee
Really good judge of character - ** Provide invaluable input - *** A second perspective - **	Outsider Input

Note: Number of asterisks denotes number of informants that mentioned code

These thick descriptions allowed for a sequential representation of the selection and evaluating process for potential candidates. In the tradition of the grounded theory method a return to the interview protocol to add additional questions brought to light in interview number one and two also allowed me to get fuller explanations.

Memo-writing

Memo-writing allows you to stop and analyze the ideas about the codes in any-and every-way that occurs to you during the moment (Charmaz, 2006, p. 72; Glaser, 1998). It was used in this study to stop and reflect on the interview, the informant's responses, what information I missed and how to adjust interview questions in the future, and finally what needed to occur next. This practice can clear the mind of the researcher giving them an opportunity to add notes forgotten during the interview or process possible categories as the coding continues. I used the memos to help break through challenging periods in creating the semantic relationships. As Maxwell (1996) asserts, memos can "convert thought into a form that allows examination and further manipulation" (p. 11).

Theoretical Validity and The Negative Case

At the conclusion of coding the subsequent semantic relationships created the foundation for the theoretical representation (See Figure 2, below). According to Charmaz (2006) the theoretical integration will assemble the bones (codes) into a skeleton (diagram). The author attempts to take the thick descriptions, translate into categories, then relationship and further extrapolate to an abstract level for understanding by others. Each category was defined and elaborated using the informant's descriptions of the process. Each part of the Grounded theory coding was used to create the final model.

A significant attempt was made to avoid "commonsense theorizing" that would result in substituting the researcher's voice for that of the informants. Throughout the evaluative activities the author followed a reflexive process (Cunliffe, 2004; Denzin & Lincoln, 2008; Corbin & Strauss, 2008) in examining how the researcher and intersubjective elements impinge on and even transform research. The researcher's was cognizant that her 20 years of experience in

nursing may have an impact on the informants' answers as well as rapport building (Spradley, 1979; Corbin & Strauss, 2008). Her prior work may lead to enhanced rapport building or a potential for the informant to not fully explain or expand on ideas making assumptions about her knowledge base. This resulted in the decision to disclose to each informant that the author was a nurse with 20 years of experience who had worked in management and education at various levels. Each informant was urged, through the introduction and interview questions, to share all of their thoughts regardless of what they think may already be known.

An inductive and analytic process guided the Grounded Theory method (Glaser & Strauss, 1967). The study author proceeded using inductive reasoning which allowed for adjustments in the semantic relationship to create the most representative reality for leadership selection (Charmaz, 2006, p. 96). This included negative case analysis which “maybe regarded as a process of revising hypothesis with hindsight or ... refining until it accounts for all known cases without exception (Lincoln & Guba, 1985, p. 309). For the three cases gathered here each case was compared to the next to be sure the majority of the elements fit within the theoretical presumptions. I made a rule that two of the three cases needed to use the same phases or meaning in order to include in a phases of coding. The goal for this comparison was to keep checking until I was sure no more meaning could be interpreted or found and that each case was represented by the eventual model. Charmaz (2006) speaks of saturated theoretical categories occurring when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of you core theoretical categories – keep finding the same patterns (p. 113). The final charge was to create a diagram (Strauss, 1979) to offer a concrete image of the ideas that evolved in this preliminary project.

Emergent Theory

The emergent theory was created from the coding as interpretations (Figure 1) were made about how each category was related to the others either in causal, sequential, reason for, part of, or kind relationships (Spradley, 1979).

Trustworthiness

In order to enhance trustworthiness in this research the author provides an examination of credibility, transferability, dependability and confirmability for this study (Lincoln & Guba, 1985). Although prolonged engagement and persistent observation was not possible for this study credibility was enhanced by triangulation of the data across the three research sites.. In addition to interviews the job descriptions for each position were reviewed and peer-debriefing, member checks and case analysis were employed. A “disinterested peer” (Lincoln & Guba, 1985, p. 308) was engaged to review the transcripts and was asked to code without the benefit of a prior codes. Negative cases were considered as mentioned above. Finally member checks were completed with each informant. They were asked to review the transcripts, codes and diagram. Their feedback was included and only minimal changes were requested in some of the wording within the transcript. The concept of transferability was evaluated by providing thick descriptions of the informants’ words. Dependability remains incomplete with this sample size.

Additionally the author would like to acknowledge researcher bias. I was clear about my concerns about how leaders are chosen in the healthcare industry which is what lead me to want to explore this area initially. This bias was reflected upon during each step of the process to make every effort to avoid significant impact on the coding and subsequent interpretations.

Results

The study provides the reader with “thick descriptions” (Geertz, 1960) of the process involved in choosing the next executive leader in healthcare. The descriptions yielded four intriguing categories: non-resume elements, leadership evaluation elements, leading through crisis evaluative measures, and outsider input. In the category on “non-resume elements” informant one shared “we expected a high level of emotionally intelligence...committed to the same values as the organization and we were explicit in our offers stating that”. Informant three shared that “We have defined values here...we are looking for someone who has respect for diversity, excellence...working well with others, being a part of a group, not just on your own, so that is what needs to be looked when you interview”. When sharing their thoughts on leadership evaluation elements, informant two reports “needing a risk-taker, decisive, outgoing, decision maker”. When asked how to evaluate the candidates’ ability to lead through crisis, each informant originally said they did not evaluate this quality. An additional probe question prompted each one to then share they do this but in very different ways, and certainly do not label it in the same way. Informant two mentions “gave them real word scenarios, things actually happening here to see what they would tell us, can they make decisions...” and informant one suggested “each one of them had to be able to navigate through permanent white water and we tested that by role playing”. Lastly, the informants were provided with a category of outsider input. Each informant used persons outside the committee to evaluate the “non-resume elements”. This was a formal part of the selection process in that it occurred at meal times during the interview days. Every informant took potential candidates out for meals and invited “outsiders” to observe and provide feedback on initial impressions and those elements that are not written on the application or resume. Informant two said of the outsiders “they have lots of

years in another business and are really good judge of character so their input was crucial”. Informant three said of the “outsider” “I rely on this feedback because if they cannot relate to others and especially those they work with they are...frankly dead in the water”.

While comparing case to case it was clear that one of the cases did not match the other two. In the original decision on which type of facilities to choose the author felt any institution that had students at their facility would work like an academic medical center. This assumption was not supported by the data. Informant three came from a medical center that is not designated as an academic medical center and their process was different in a few ways: they did not seek diversity in the slate of candidates, they did not consider prior academic experiences as needed, they used the board of directors instead of a dean or department chair to lead the selection committee, and they considered outside influences such as the public and benefactors in their initial decision making. AS future work on this study progresses it will be important to decide to increase this sample or to delete it all together.

Implications for practice and future research

This study is clearly just an introduction to the leadership selection process and explores the surface when considering a standard set of elements for evaluating potential candidate’s ability to lead through crisis. Future research has a burden to further evaluate the entirety non-resume characteristic with more depth by interviewing many more selection committee chairpersons. In this vein it seems as though to triangulate the information provided by those chairs interviews of other members may be helpful as a check of trustworthiness.

Another intriguing aspect is to consider if future interviews will reveal that many more organizations consider “outsider” input when making decisions on the slate of candidates or even the final choose. This inquisition will require an additional set of interview questions. It will be

important to uncover if this is a standard process or an anomaly for the three organizations reviewed for this study.

In the future I would adjust the interview protocol and send a survey or complete a precursor phone interview in advance of the interview to ask about personal and facility demographics. This procedural change would decrease the time spent on these topics in the interview. In turn this would open up more time to delve into the other questions and potentially yield deeper explanations. In the original interview protocol I reviewed job descriptions for each new position but due to the specificity for each job this may not be important or necessary in the future. Each committee created the job description and then brought in and interviewed candidates that met the criteria for the position.

Of course, with such a small sample this study was not able to reach theoretical saturation (Charmaz, 2006, p. 113). Considering it was such a small sample there were only six original categories that were not confirmed by two or more informants. It is the author's feelings that the current study lacks a robust evaluation of the research questions due to only three interviews. Charmaz (2006) prompts the researcher to ask: "Have I collected enough background data about persons, processes, and settings to have ready recall (p. 18)? She also suggests considering if you have gathered enough data to make comparisons and develop analytic categories (p. 18). I feel these questions were met with minimal success for the situation. Having only viewed the process through the chairperson's perspective and not interviewed other elements I feel it provides the starting point for future investigations.

Implications for Practice

Academic medical centers and hospitals have the need to choose new executives on a fairly frequent basis (Crowley, 2004; Kesner & Sebor, 1994). This process is important to the

strategic success of the institution. Therefore, a consistent and evidence-based plan should be utilized when creating the selection committee through the final selection. It is clear that although committees consider leading through crisis and non-resume elements they do not do so consistently or with a proven plan. If this research continues it is hoped it would be of help to facilities in making the best choice each time for such influential positions as CEO and executive leaders. Further exploration may be able to uncover what tools will provide the best evaluative benefit when considering the “soft” characteristics needed to do any of these positions well/.

Pilot Study Two

The purpose of the second pilot study was to explore and identify how the executive health care leader displays their leadership style, qualities and abilities and to how upper and middle management leadership process is altered as a result. This study was informed by pilot study one (Jones, 2011). Pilot study one made clear that the best method would be qualitative interviews and that it needed to start with the CEO rather than the selection chair or committees. Pilot study one uncovered that the selection process is not guided by competencies or evidence-based research. In fact, each of the sites used different and often nebulous criteria for selection. This study was guided by three research questions: How do healthcare executives lead their subordinates through crisis situations?; How do the subordinates of health care executives describe the qualities necessary to be a “successful” leader during crisis?; How does upper or middle management’s describe their ability to lead after experiencing the CEO leadership style?

This case study explored how one organization and three leaders worked through a crisis situation and how the leadership of the CEO impacted the subordinate’s actions. This paper proceeds as follows. In the next section, a literature-based overview of the typical issues facing

selection committees is provided as a background on leadership selection. This section is followed by a review of the research methodology. Then, an initial line-by-line coding reflecting the informant's perspectives (Charmaz, 2006) is presented; followed by focused coding. Although grounded theory is normally presented at the end of a study it is provided at this point as to guide the reader to understand the semantic relationships (Spradley, 1979). The paper concludes with recommendations for future research in the area and implications for health care selection committees.

Methods

This study follows a case study model and is limited in the fact that it explores just one locale and one crisis. Typically case studies will employ four analytic techniques: pattern-matching, explanation-building, time-series analysis, and program logic models (Yin, 1994, p. 102). This author relied on theoretical proposition that because there was a crisis there would be some differing experiences by management based on how the CEO handled the situation (Yin, 1994). That proposition guided the process and interviews were chosen as the data collection method to get to individual experiences. Because the author is a novice in case study analysis the main tenants of Yin's (1994) work that provided a framework for this study was to assure the analysis relied on all the relevant evidence, include all major rival interpretations, address the most significant aspect found in the study, and bring the authors prior, expert knowledge to the case (p. 133-134). Because this case included but three interviews it would be difficult to say it adhered to Yin's (1994) process in its entirety but future work in this area would maintain that strict compliance more effectively.

Site Selection

The site for this study was a middle sized (between 150-300 beds) hospital in a rural/suburban location. The facility has no trauma designation but has a full operating suite, emergency and outpatient services, medical-surgical, oncology, mother-baby, intensive care and pediatric based units. The hospital is governed by a board of directors and then a chief operating officer. The upper management has four senior vice presidents and five vice presidents supported by a group of department directors and clinical supervisor in each unit. It employs over 1,400 staff and credentials over 200 physicians in 40 subspecialties. This site was chosen because it had recently gone through a large scale internal crisis event and was willing to participate in this study. The author has contacts at this location and had previously worked there prior to 2010.

Sampling

The sampling of subjects for interviews was done by first identifying the first informant and a middle management level and then identifying during the interview who they felt was the leader they looked to during the crisis. The first informant mentioned interviewee number two by name many times in the first few minutes and it was clear. However, the author also objectively asked them to identify that person and my estimation and theirs matched. Therefore that person was then contacted for an interview. I also allowed the second interviewee to identify who they felt who their leader in the crisis was and they clearly chose the CEO. This was also my assumption but the choice needed to come from the informant and not from my assumptions. Finally, then the CEO was contacted to complete the loop and plan for triangulation of the data.

Interviews

The initial phase in the interview process is to establish rapport as described in Spradley (1979). The four phases of rapport building were attended to during the interviewing process: apprehension, exploration, cooperation, participation. Once the informant and researcher moved through each stage the informant understood their role in this study and participated fully in the interview (Spradley, 1979, 44). An interview protocol was created to guide the interviews and included descriptive questions that included grand tour, mini tour, example, and experience questions to elicit. It was important to elicit the participant's definition of terms, meanings and not the researcher's perspective (Charmaz, 2006). Each potential informant was contacted by phone and a verbal consent was obtained. Then a written consent was sent, signed, and returned prior to the second contact. Each informant agreed to be audio taped. Tapes and notes from the interviews were transcribed by the author, verbatim and returned to them for member checks.

Tools

The interviews were conducted utilizing an interview protocol. After each interview the questions were adjusted slightly and a final group of questions were applied to the CEO interview (see below). The interview tool was a guide for gathering information but during the interview the author allowed the informant to open up new questions. Interview protocol (See Appendix.....)

Coding of data

The transcripts were coded and kept open with no preconceived ideas of categories or conclusions (Charmaz, 2006). Memo writing was employed after each interview to summarize and consider what was discussed. Initial coding was done line by line to identify phrases and meanings from the transcript (p. 53). Remaining true to the data, these phrases were accumulated

and a secondary process commenced with a more focused coding to create categories. Categorized portions of data were given a short name to account for its meaning (Charmaz, p. 43). The third part of the coding process created Axial coding that allowed for synthesizing and organizing the data and brought it back to a whole (Strauss & Corbin, 1990). Strauss and Glaser (1990) suggest looking at the data to consider conditions (circumstance or situations that for structure), actions/interactions (routine response to issues, consequences (outcomes – what happens from the actions).

The axial codes created attempt to define what happened during each selection process for each facility. Theoretical categories were pondered during this final stage of coding. At times the codes revealed action dilemmas (Charmaz, 2006).

Memo-writing

Memo-writing allows you to stop and analyze the ideas about the codes in any-and every-way that occurs to you during the moment (Charmaz, 2006, p 72; Glaser, 1998). It was used in this study to stop and reflect on the interview, the informant's responses, what information I missed and how to adjust interview questions in the future, and finally what needed to occur next. This practice can clear the mind of the researcher giving them an opportunity to add notes forgotten during the interview or process possible categories as the coding continues. I used the memos to help break through challenging periods in creating the semantic relationships. As Maxwell (1996) asserts, memos can “convert thought into a form that allows examination and further manipulation” (p. 11). This process also yielded changes in the interview guide after each interview because the information was ever changing and required inclusion of information gathered in the previous interview.

Theoretical Validity and The Negative case

The author attempts to take the thick descriptions, translate into categories, then relationship and further extrapolate to an abstract level for understanding by others. Each category was defined and elaborated using the informant's descriptions of the process. Each part of the Grounded theory coding was used to create the final model.

A significant attempt was made to avoid "commonsense theorizing" that would result in substituting the researcher's voice for that of the informants. Throughout the evaluative activities the author followed a reflexive process (Cunliffe, 2004, Denzin & Lincoln, 2008, Corbin & Strauss, 2008) in examining how the researcher and inter-subjective elements impinge on and even transform research. The researcher's was cognizant that her 20 years of experience in nursing may have an impact on the informants' answers as well as rapport building (Spradley, 1979, Corbin & Strauss, 2008). Her prior work may lead to enhanced rapport building or a potential for the informant to not fully explain or expand on ideas making an assumptions about her knowledge base. This resulted in the decision to disclose to each informant that the author was a nurse with 20 years of experience who had worked in management and education at various levels. Each informant was urged, through the introduction and interview questions, to share all of their thoughts regardless of what they think may already be known.

An inductive and analytic process guided the Grounded Theory method (Glaser & Strauss, 1967). The study author proceeded using inductive reasoning which allowed for adjustments in the semantic relationship to create the most representative reality for leadership selection (Charmaz, 2006, p. 96). This included negative case analysis which "maybe regarded as a process of revising hypothesis with hindsight or ... refining until it accounts for all known cases without exception (Lincoln & Guba, 1985, p. 309). For the three interviews gathered here

each one was compared to the next to be sure the majority of the elements fit within the theoretical presumptions. I made a rule that two of the three cases needed to use the same phrases or meaning in order to include in a phases of coding. The goal for this comparison was to keep checking until I was sure no more meaning could be interpreted or found and that each case was represented by the eventual model. Charmaz (2006) speaks of saturated theoretical categories occurring when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of you core theoretical categories – keep finding the same patterns (p. 113). In this small study no negative case was identified.

Trustworthiness

In order to enhance trustworthiness in this research the author provides an examination of credibility, transferability, dependability and confirmability for this study (Lincoln & Guba, 1985). Although prolonged engagement and persistent observation was not possible for this study credibility was enhanced by triangulation of the data. In addition to interviews the job descriptions for each position were reviewed and peer-debriefing, member checks and case analysis were employed. A “disinterested peer” (Lincoln & Guba, 1985, p. 308) was engaged to review the transcripts and was asked to code without the benefit of a prior codes. Negative cases were considered as mentioned above. Finally member checks were completed with each informant. They were asked to review the transcripts and codes. Their feedback was included and only minimal changes were requested in some of the wording within the transcript. The concept of transferability was evaluated by providing thick descriptions of the informants’ words. Dependability remains incomplete with this sample size.

Additionally, the author would like to acknowledge researcher bias. I was clear about my concerns about how leaders are chosen in the healthcare industry which is what lead me to want

to explore this area initially. This bias was reflected upon during each step of the process to make every effort to avoid significant impact on the coding and subsequent interpretations.

Findings

Three interviews with members of the management team were conducted at the hospital after what was described by all as a large and complicated “internal disaster”. The event had occurred within the last six months so it was in recent memory. The event consisted of an entire shut down of services within the building and it affected almost every facet of the organization. This type of event has never happened before at this hospital. None of the members on the executive team have ever handled this but two of the informants had been in other crisis events. Each of the transcripts analyzed revealed very similar details about leadership during this time of stress and challenge. Each of the informants shared feeling of worry, stress, and accomplishment. The ‘crisis’ was difficult but as interviewee two shared “we have practiced for this and we knew what to do, well most of us did, but we got through it and it was alright”. In fact each of the informants shared a sense of teamwork and struggle through adversity which seems to have left them with a stronger sense of themselves as evidenced by “I didn’t think I belonged” and later added they now know they can do it.

The experience inside the facility was different with each encounter. The informants included a clinical supervisor, vice president and the CEO. I interviewed them in their offices so I could observe “their” environment. The author wished to view what the walls, desk, shelves and setting looked like for each of them. It was thought that this may add to what is said or not said in the interview. Each office was comfortable and adorned by personal photos and some awards. The CEO had more personal effects that related to connections outside their position at

the hospital. Because I am known to them interviewee one and two were at ease and the conversation starters flowed easily.

The study provides the reader with “thick descriptions” (Geertz, 1960) of the situation surrounding the crisis and how leaders and their actions play a part in leading through crisis. In the analysis four overall categories emerged: empowering behaviors, creation of trust, creation of control, and transparency. In the first category of empowering behaviors each informant used this word and gave examples of how they felt or shared empowering behaviors. The vice president discussed that the CEO empowers him by “defining the responsibility then removes himself and lets me work”. The clinical manager said they too felt empowered after the “command center” meetings and that allowed her to come back to her staff and be effective. They also shared that “I know my boss trust me enough to make the right decisions. I knew that they would be OK with all of it... would back me up - if I could say I did this and this is why, I knew would back me up”. It was this sense of empowerment that was shared over and over by both the middle and upper level managers. In turn, the CEO commented “I want them to feel empowered”, “If they feel empowered they will do good work” and “They are good at what they do, I want people to do what they do well”. This category needs to be looked into with more informants and with different situations to fully understand how it affects others. The vice president may have said it best when they commented “I feel like I can go and do because they tell me I am good at what I do”.

Within the category of Creation of Trust each informant shared that the CEO created a sense of trust by how they speak to them “You have made some great decision can’t fix this but I am here, not that you’ll need me”. Both managers said that this creation of trust was not started during the event but was strengthened and confirmed. They both felt it before this time and had

heard comments similar but being in a situation that was so intense that it really became apparent. This revelation is something to consider including in future interviews, to tease out what is done in a crisis that is different than the everyday that makes it so imprintable for the recipient.

Another category was that the CEO created a controlled environment. The two managers mentioned early on in the interview that they felt the situation was under “control” even though they knew the end was not in sight it was a controlled crisis. The CEO described that the creation of this control was deliberate; “In order to make it clear we were under control I contacted the media, the board, and senior management and made it clear what the process was going to be so everyone knew there is a plan”. The vice president shared almost an identical set of comments about what needed to happen in the first few hours. They also provided a similar process for those who reported to them – it really mimicked what the CEO did for them.

The final obvious category was that of Transparency. The CEO was quite clear in this respect; “Everyone needs to know how I think, I don’t think they were very used to that here”, “I want there to be no surprises for my staff and they know they can ask me anything”, “If you work here you need to know what I expect and I need to know what you need so we all need to talk and understand. The managers felt like there was transparency in the crisis and the communication was so very clear” “they kept us informed all the time, even coming up to the floor to update us, it felt so good to be included and in the know”, “I needed to make it clear to all what I knew and that is what I did”.

Each of the areas was really confirmed by each informant, sometimes in different ways that is inevitable by the general nature of their positions. Every person shared similar comments

and there were really no outliers in this instance. Of course, with such a small sample this study was not able to reach theoretical saturation (Charmaz, 2006, p. 113). Further research is essential to fully understand the extent to which the CEO's leadership abilities, skills and behaviors are experienced by their management team.

Pilot Studies Summary

Both studies allowed the researcher to refine the process. Each pilot study was very helpful in narrowing and at the same time expanding the specifics of the interview questions. It was clear from pilot study one that only speaking to the head of the selection committee would not provide the needed information for what criteria are the most effective. None of the institutions used evidence-based criteria and that spurred the final research design. The multi-layered interviews at each site will validate through triangulation that the competencies are not just felt by the CEO but a series of layers below the CEO.

Appendix B:

Case Study Protocol

The following protocol was adapted from Yin, 2003, p. 69.

- I. Overview of the case study project
 - a. The purpose of this study is to investigate the characteristics displayed by health care CEOs when leading through crisis at three U.S. hospitals
- II. Field procedures
 - a. Email /call potential participant from each university:
 - i. Norman Regional Medical Center, Moore Oklahoma
 - ii. Liberty Health System, Jersey City Hospital, Jersey City, New Jersey
 - iii. Providence Health System, Milwaukie, Oregon
 - b. Self-introduction / presentation of credentials, explain the purpose and goals of the study, discuss research questions, and advise as to why the participant has been invited to join the study
 - c. Explain human subjects requirement and attain necessary consents
 - d. Begin interview, using Behavioral Event Interview Guide
 - e. Answer any questions that may arise from participant during interview
 - f. Thank participant for his/her participation in the research
 - g. Ask for permission for future follow-up if necessary
 - h. Obtain contact email for future follow-up
- III. Case study questions
 - a. For full interview guide, see Appendix D
 - b. What should be answered at from each interview regarding each research question:
 - i. Research Question 1: What characteristics were displayed by the health care CEO during the crisis that the subordinates felt were beneficial?
 - ii. Research Question 2: What characteristics did successful health care CEOs demonstrate in a crisis that could inform a selection committee when choosing a health care CEO?
 - iii. Research question 3: What is the common set of characteristics inherent to health care CEOs who successfully handled a crisis, across all cases?
- IV. Guide for the case study report
 - a. Overview
 - b. With-in case analysis for each case
 - i. Description of interview subjects
 - ii. Description of event history
 - iii. Description of hospital demographics
 - iv. Description of background on the crisis
 - c. Cross-case analysis
 - i. Compare and contrast discoveries from each of the three cases

- ii. Discuss common lessons learned
- iii. Discuss common issues encountered

APPENDIX C:

Leadership Traits for CEO Selection: Lessons from Three U.S. Hospital CEOs During Crisis

Introduction to the Study:

Choosing a new CEO should be a standardized process. Each time a new leader is needed to fill an upper-echelon vacancy, the board of directors and/or the contracted executive search firm should follow a predefined procedure when establishing selection criteria. After a search of the literature and completion of two pilot studies involving interviews with individuals responsible for setting executive search criteria, there does not appear to be any standardized competency-based process for identifying the best candidate.

Sample:

CEOs

- Who have lead through a crisis
- Have been in the position for at least 1 year at the time of the crisis

Subordinates (3)

- Three that have worked for the CEO at the time of the crisis and were there during the crisis – interacting with the CEO

Benefit:

- Results of study could provide a guideline for boards and executive search firms when hiring a health care CEO
- I will share study results
- All identifying information will be kept confidential

Time Requirement:

- 1 hour interview (In-person, telephone, GoToMeeting, or skype)
- I will be very respectful of your time

Additional Rationale for the Study:

Chief executive officer (CEO) selection can create success or turmoil depending on the fit of the candidate. The CEO has been often noted by researchers as having a significant effect on the organization he/she leads (Hutzschenreuter, Kleindienst, & Greger, 2010; Finkelstein, Hamrick, & Cannella, 2009). The leaders of healthcare organizations face a very tumultuous scene. An increasing number of hospitals are facing challenging financial situations with poor

reimbursements and low admission rates. Some are shutting down entirely (Gold, Englander, & Seligman, 2008). Hospitals are encountering massive changes in the types and amounts of reimbursements from private and government insurance programs that are coupled with a dim financial picture for many Americans. As acute care hospitals cope with the various challenges of finances, staffing, and internal crises, hospital boards often choose to replace the chief executive officer as a way of sparking change and improvement in overall firm performance (Lieberson & O'Connor, 1972). Hospitals' boards provide varying degrees of governance for acute care facilities. The board president, and frequently a selection committee, is charged with choosing a CEO and possibly other upper echelon positions.

APPENDIX E:

Health Care CEO Characteristics Displayed During Crisis, Behavioral Event Interviewing Guide

The following information will be obtained with each interview:

- Researcher Name
- Date of Interview
- Name of Informant Interviewed:
- Informant contact information (email address, phone)
- Title of Informant
- Years in current position

Questions:

1. Tell me about your work requirements?
 - a. Tell me about your work duties
2. Please describe the crisis from beginning to end. It is important that you describe the situation in detail. Tell me what you were thinking, feeling, and doing during the crisis.
 - a. First, provide an overview of the situation.
 - b. Background questions:
 - i. When did this occur (approximate dates)?
 - ii. Who was involved (give job titles and but not names)?
 - iii. Where did this occur (give approximate location)?
3. Tell me how you (the CEO) performed in this situation. Be as specific as possible, describing what happened in the sequence that it happened. Be sure to explain
 - a. what was happening, what you were doing
 - b. what you were thinking (When the CEO was doing_____)
 - c. what you were feeling as events unfolded
 - d. What did you/the CEO do that made a positive impact – on individuals, the team, and the hospital?
4. What CEO characteristics do you feel were critical in this crisis?
5. What do you do/does this CEO do that makes him/her successful when leading in a crisis
6. Is there anything I forgot to ask you about the CEO characteristics required for leading in a crisis?

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Rothwell, W. J., **Jones, M. C.**, Kirby, M., & Loomis, F.
(2012). Talent Management: A step-by-step action-oriented
guide based on best practice. HRD Press

Presentations

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Assessing and Developing High Potentials, Pre-conference
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Course Development

Eight courses: created and implemented: Emergency care,
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Professional Experiences

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Faculty, Course Coordinator, Instructor
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