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# Maintaining Trust Through Patient-centered Care and Collaboration: a Leadership Model for Hospitals

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# MAINTAINING TRUST THROUGH PATIENT-CENTERED CARE AND COLLABORATION: A LEADERSHIP MODEL FOR HOSPITALS

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## Dedication

To my father, the Rev. Dr. Mamy Ranaivoson, for pursuing his calling and passion to not only treat but also genuinely care about ill people throughout the world. Thank you for seeing patients as people, first and foremost. You are the standard to which I hold all doctors. Your knowledge is astounding, and your dedication and perseverance are magnificent examples.

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**Abstract**

Maintaining Trust Through Patient-Centered Care and Collaboration: A Leadership Model for Hospitals

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This study analyzes actions taken by hospital leaders throughout the United States to improve the services offered by their institutions. A review of studies by researchers on patient-centered care, doctor and nurse collaboration, and involvement of patients' families in the patients' experience revealed that increased focus on patient-centered care, doctor and nurse collaboration, and involvement of patients' families is necessary for trust to be attained by patients.

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## Introduction

At the age of 30, Dr. Mamy Ranaivoson left Madagascar, the only country he had called home, and moved across the world to Australia. There he would begin his life as a missionary doctor. After spending a few months in Australia learning English, "Dr. Mamy," as he had come to be known, moved with his wife and three daughters north to the island of Papua New Guinea. For three years, Dr. Mamy worked as the medical superintendent at Gaubin District Hospital on Kar Kar Island. Then they moved southwest onto the mainland to a small village called Yagaum where Dr. Mamy worked as the medical superintendent at Yagaum Rural Hospital. As the medical superintendent at both of these hospitals, he was in charge of the entire hospital as well as being the only doctor at these hospitals during his time there. Gaubin Hospital was equipped with approximately 215 beds for patients and Yagaum Hospital had 120 patient beds.

Though he was from a different country and culture, Dr. Mamy was received well by the patients at Kar Kar and Yagaum. He discovered soon after his arrival that the cultural gaps (such as the types of food, cultural greetings, and family hierarchy) between the people of Papua New Guinea and his home country of Madagascar were minimal, and he used that to his advantage. In order to build a relationship with his patients, he attended the meetings of the town and village elders and visited them weekly.

Because he was the only doctor, he saw many patients daily. Despite this, he did not rush through each patient. Dr. Mamy made it a point to build individual relationships with his patients. He would spend 10 to 15 minutes prior to examining a patient, talking with and getting to know them. "Building relationship

and trust was among my priorities," Dr. Mamy said, "[you need to show this to your patients] through your hard work, dedication, and openness" (M. Ranaivoson, personal communication, June 26, 2014).

Dr. Mamy also needed to heavily rely on his nurses. Being the only doctor at these hospitals meant that he was on call 24 hours a day, seven days a week for the many years he worked at the two hospitals. However, if he was tending to one patient's emergency, he could not be at another patient's. So he relied on his nurses and worked with them. In order to build relationships with his staff, Dr. Mamy held weekly Bible studies and gave hands-on teaching during rounds so that he could teach the nurses what they needed to know in case he was not available.

Dr. Kristi Leigh Kirschner is a physiatrist in Chicago, IL. Working with patients who were in the process of rebuilding their lives either from injury, trauma, or unexpected illness, Dr. Kirschner learned empathy early on in her career. "You tend to get a very intimate glimpse into the person's life and psyche," Dr. Kirschner stated (Magee, 1999).

Growing up, Dr. Kirschner's parents emphasized the concept of justice and fairness towards others and this idea stuck with her as she practiced medicine. She started the Rehabilitation Institute of Chicago (RIC) and worked to promote preventive health care among disabled women but found that despite the changes that were occurring due to the Americans with Disabilities Act, a lot of her female patients were not able to partake in preventive health care primarily because a majority of the facilities did not have wheelchair-accessible

instruments. After learning this, Dr. Kirschner constructed the RIC to be able to cater to the obstetric and gynecologic needs of disabled women. Her initiative has gained traction across the country and similar clinics are being formed (Magee, 1999).

Dr. Evan Loh is a cardiologist in Pennsylvania. Due to the nature of his specialty, he is more aware than others of how death is an imminent threat to his patients. One thing Dr. Loh is certain of is his commitment to providing exceptional care for his patients. "I believe that much of what we do is provide support and an ear to people when they are sick and scared," Dr. Loh states (Magee, 1999); "Building that relationship elicits confidence for them."

Dr. Loh is committed to building a relationship with each of his patients and making sure that there is as much consistency as possible for them because consistency in their relationship with him could be the only guarantee they have when their health is ubiquitous. "It's rewarding when they see you care as much about them as you do your own family," Dr. Loh stated (Magee, 1999).

Through compassion, empathy, and one-on-one care for their patients, these three doctors portray the type of leadership that hospitals use to maintain trust with patients. In his book *Positive Doctors in America*, Dr. Mike Magee (1999) set out to discover the personality traits and characteristics doctors would need to possess to be considered exemplary role models. Of the 50 doctors chosen to be featured in his book, they possessed a patient-centered focus, the desire to work as a team, an attitude of community servantship, a striving to be

the best in their performance and innovation, and a high regard for integrity and respect towards not only their patients but also their co-workers.

A hospital is a sacred place because people go there to seek healing. If trust in the leadership and methods used at the hospital is not present, patients would not return to that hospital. When patients enter a hospital because of illness, they expect to receive medical attention from professionals who are skilled in their knowledge and approach, be treated with care and respect, and receive the best care they can be given regardless of their situations. A patient trusts that everything will be done by the hospital staff to make them better. Hospitals are known to be high risk environments (Squires, Tourangeau, Laschinger, & Doran, 2010). Research has been done by organizations such as The Joint Commission, American Hospital Association, Healthgrades, and Hospitals in Pursuit of Excellence to discover just what it is that hospitals need to possess to have their patients consistently maintain trust in them.

This study will explore what successful acute care hospitals do to develop, promote, and sustain trust in what they do. An acute care hospital is one that treats patients for a brief but severe injury or illness including recovery from surgery ("Hospital Study," n.d.). Through an in-depth analysis of the current literature surrounding this topic, this study will provide a definition of what it means for patients to have "trust" in a healthcare provider such as an acute care hospital and the common approaches that have been found to be successful in sustaining that trust.

## Review of Literature

This literature review includes summaries and analyses of six research studies that were published between 2006 and 2013. These studies were chosen because their overall focus was on hospitals and the different dynamics that impact trust in the hospitals. Research done by Lown, Rosen, and Marttila (2011) and Ferguson, Ward, Card, Shephard, and McMurty (2013) focused on patient-centered care and why it is important for hospitals as leaders to focus on this concept in order to be the most impactful. A study by Sørlie, Torjuul, Ross, and Kihlgren (2006) looked into patients' experiences during their stay in a hospital, and a study by Bobrovitz, Santana, Ball, Kortbeek, and Stelfox (2012) went one step further to include patients' families and their experiences. Finally, research by Burns (2011) looks at what happens when doctors and nurses purposefully work together in their different roles, and research by Chang, Ma, Chiu, Lin, and Lee (2009) looks at how doctors and nurses' job satisfaction affects their quality of work.

All of these studies highlight the importance of how focus on patient-centered care, awareness and inclusion of patients' experiences, and doctor and nurse communication, or the lack of it, has a considerable impact on the hospitals and how their patients view them when it comes to trust. Current research also points towards the same conclusions of these six studies, and they were chosen because the researchers expressed their goals, research process, and objective conclusions most clearly and concisely.

**Studies on Patient-Centered Care**

*An Agenda For Improving Compassionate Care: A Survey Shows About Half Of Patients Say Such Care Is Missing,* Lown, Rosen, & Marttila (2011) define what patient-centered care is and then survey both medical professionals and patients on their opinions of whether patient-centered care was necessary. Patient-centered care, according to Lown, *et al.* (2011), is "respectful of and responsive to individual patients' preferences and needs, and ensures that patients' values guide all clinical decisions" (p 6). This is important because a medical professional's understanding or lack of understanding of patient-centered care affects how they treat their patients. The researchers surveyed 800 recently hospitalized patients and 510 physicians over a two-month period. Although the researchers rather problematically do not clarify their response rate, presenting the information in a way that made it appear as if they had a 100% response rate, a positive aspect with this study is that the survey was very concise in defining terms for the patients and physicians, such as "patient-centered care," "compassion," "empathy," and "compassionate health care" so that the participant was aware of what each term meant. In addition, both patients and physicians were given descriptions of certain things to keep in mind as they completed the survey. From their data, Lown *et al.* (2011) concluded compassionate care was vital to both the patient and the physician for successful medical treatment to occur. They further stated that clear communication and emotional support were important contributors to whether a patient lives or dies. The researchers stressed that "medical care without compassion cannot truly be patient-centered."

A study focusing on patient-centered care reached out to families of patients for their input as well (Ferguson, Ward, Card, Shephard, & McMurty 2013). In this study, the researchers were clear and concise in defining the terms they used, such as "patient," "patient experience," "professional relationships," and "professional communication."

The study was rather small and surveyed only eighteen patients - ten women and eight men - and eight family members in a large inpatient acute care hospital in Canada over a four-month period. Of the patients interviewed, twelve patients were over the age of 60 and six under 60, with several in their 20s and 30s. Because the survey group was small, the researchers were able to conduct face-to-face interviews in patients' rooms and received a 100% response rate. Having a small sample group was beneficial because it guaranteed a higher response rate, as seen in this research, but it is also disadvantageous because the small number of participants most likely does not represent the greater population.

One of the results from this research had participants stating that in their desire to be a part of and well-informed of their medical outcomes, 56% of the patients do research on their own prior to their hospital and physician visit. The researchers concluded that patients want to feel involved and have their opinions valued by their medical staff. Ferguson *et al.* (2013) also concluded that when the patients trust those they saw as leaders in the hospital and felt valued and genuinely cared for, they were more willing to engage and cooperate with the staff in their medical care.

**Patients and Their Families' Experience While in the Hospital**

A study that covers a patient's experience while they are in the hospital was done by researchers in Sweden. In this study, Sørlie, Torjuul, Ross, & Kihlgren (2006) through a "phenomenological hermeneutical" method, aimed to learn more about what it is like to be a patient in an acute care facility through a study of a small number of participants. These researchers interviewed ten patients aged 30 to 92 years old as a part of a comprehensive investigation for three different studies. The same ten patients were asked questions about five student nurses, five registered nurses, and ten other patients in the ward.

Sørlie *et al.* (2006) concluded that physicians and nurses need to continually strive for the best, even if they are told by their patients that the patients are satisfied with their work, care, and treatment.

This research carefully ensured that those being surveyed varied greatly by picking people who spanned in age across several decades. Additionally, the patients' illnesses were just as varied. Their diagnoses included "heart failure, cholangitis, pancreatitis, diverticulitis, paralyses, backache and headache" (Sørlie *et al.*, 2006). This meant the data collected ranged from patients who had spent as little as three days in the hospital to those that have spent several months in the hospital. However, the researchers stated the older patients being interviewed did not like to bother the staff and were more reluctant to ask for help. This can skew the results because if the older patients are not wanting to be a nuisance, they might just state to the researchers that everything is fine even when it is not. This definitely would affect the participants' responses to

their trust in hospital staff. This was a useful study because of the variation included. Those being studied varied in age and illness, and thus their responses were just as varied. The problematic piece of this study is the researchers surveyed such a small sample of people that they most likely would not be a great representation of the greater population.

Another study also looking at patients' experiences while they were in the hospital went one step further and surveyed the patients' families (Bobrovitz, Santana, Ball, Kortbeek, & Stelfox 2012). Prior to their study, these researchers found there were "no published surveys designed to capture the overall health care experiences of patients with major injuries" so they created one. Bobrovitz *et al.* (2012) surveyed two groups. The first group was the patients themselves and the second group consisted of family members. In total, they surveyed 170 people. The researchers had a 79% response rate from the patients and their families, which was a better response rate than they expected.

From their data, Bobrovitz *et al.* (2012) concluded one thing that was important for the family members was having clear communication about the patients' medication and care upon discharge. Both patients and their families agreed that in order for them to receive the best care, their caregiver's skills and qualities had to be the best. Both also agreed that communication and the way information was shared among the caregivers needed improvement.

One of the challenges Bobrovitz *et al.* (2012) ran into was collecting information from bereaved family members of patients. Of the 25 bereaved patients' family members they reached out to, only one responded. As they

researched more, they discovered that collecting information from families in similar situations would be difficult because family members who are grieving want to be left alone to grieve and not be bothered by the institutions where they lost their loved ones.

**Nurses' and Doctors' Job Satisfaction and Working Together**

A study looking at nurses and doctors, the very people perceived as the leaders in a hospital (Burns, 2011), focuses on the positive possibilities that would result if they purposefully worked together. Burns emphasizes a collaborative approach to patient care by doctors and nurses would improve the communication not only between doctors and nurses, but also with patients; reducing the errors committed by the medical staff, increasing efficiency, and enhancing a patient's view of their care. "Nurse-physician rounds have the potential to improve relationships between caregivers, and positively affect communication and perception of patient care [and] when both nurses and physicians talk with patients, teamwork creates a collaborative approach to safe, quality healthcare," Burns (2011) states.

Burns (2011) mentions that over the years, the idea that nurses are inferior to doctors has become dominant in the medical community, thus placing them lower on the hierarchy of who is in charge. If that concept was removed and doctors and nurses, along with pharmacists and physical and occupational therapy professionals, worked together to improve patient care, hospitals would be successful in giving patients the best care possible. Burns states "nurse-physician rounds allow nurses to know more about what is happening to our

patients and what the course of treatment will be first hand. The key ... is to implement a strategy that focuses on compliance."

Burns (2011) was able to do an action research where over a four-week period, he had nurses and doctors do collaborative rounds and monitored the outcome. By the end of the four-week period, his results stated "doctors and nurses were able to anticipate each other's steps" and "staff nurses needed fewer reminders from nurse leaders to complete rounds." In the end, instead of nurses and doctors vying for power and contradicting each other in front of patients, they were viewed as a collaborative leadership team.

Another study focused on how doctors and nurses' job satisfaction impacts the quality of their work. Chang, Ma, Chiu, Lin, & Lee (2009) conducted a study to see how job satisfaction impacts a doctor or nurse's quality of patient care and their teamwork with each other. The research took place in four hospitals in Taiwan. A cross-sectional survey was sent out to 2,828 health care professionals, but they only achieved a 52.2% response rate with answers from 180 physicians, 1,019 nurses, and 276 other healthcare professionals. The results revealed a poor relationship between physicians and nurses affects the quality of work both exhibit, which could be detrimental to patient care and result in a higher rate of medical errors. Additionally, it can cause stress, frustration, and anger, which then impacts communication, a vital aspect to their jobs. Chang *et al.* (2009) further states that there is a "correlation between negative nurse–physician relationships and patient outcomes such as the 30-day mortality rates, medical errors, and length of hospital stays."

The researchers' results stated physicians were more satisfied with their jobs than the nurses and other medical professionals. The researchers attributed their findings partially to the fact that physicians get paid more (Chang *et al.*, 2009). Also, the stereotype that nurses were the helpers and physicians were the team leaders contributed to the nurses' dissatisfaction and negative image of teamwork because they were treated differently, more negatively. Chang *et al.* (2009) concluded it is pivotal to build collaboration and teamwork among medical professionals so they are not competing within their jobs and can treat patients more effectively.

This research, however, had a low response rate from physicians which "may have skewed the results" (Chang *et al.*, 2009). Of the 768 surveys sent out to physicians, only 180 were returned, a 23.4% response rate. Though it had a low response rate from the physicians, this research study was chosen because the higher response rate of 63.3% from nurses. Nurses were less inclined to participate in many studies because they feared losing their jobs if they spoke too honestly about the negativity in their work situations.

In summary, this literature presents evidence that there are different dynamics that impact trust in the hospitals. As Lown *et al.* (2011) and Ferguson *et al.* (2013) suggest, professions should re-focus on the concept of patient-centered care. When patients feel they are valued and their opinions matter, they will be more willing to cooperate with hospital professionals. Sørlie *et al.* (2006) and Bobrovitz *et al.* (2012) concur that getting the patients' families engaged in their treatment plan will be beneficial to all involved. Burns (2011) and Chang *et*

*al.* (2009) agree that when doctors and nurses purposefully collaborate, it builds a positive work atmosphere, enables clear communication, and portrays positive leadership to the patients. Additionally, it improves the quality of work by both doctors and nurses and can lead to increased job satisfaction. Each of these findings has a considerable outcome on the hospitals and how patients trust the hospital leadership.

## Research Findings

### The History of Hospitals

Present-day hospitals do not resemble the first hospitals from centuries ago. Greek and Egyptian history records the earliest hospitals as temples dedicated to healing gods. It was in these areas that offerings were given up to deities. Simple procedures such as setting broken bones and stitching up wounds also occurred in these places (Gormley, 2010). Though known to be the founders of medicine, Greeks did not have hospitals. Instead, physicians would make the rounds, visiting sick people in their homes. This practice has continued to present day.

Surprisingly, even though they were not the founders of medicine, it was the Romans who generated the word "hospital" from the Latin word "hospes" or "hospitium" meaning host or a place to entertain (Gormley, 2010). There are early documentations of the Romans having the best military hospitals of their time. One of the hospitals, which still stands in Switzerland, was built with a courtyard in the center and each room contained a space big enough for three beds. As the Roman Empire adopted Christianity as their official religion, the

Church became more involved in these hospitals. No longer were they just for the rich and upper class, but monasteries were created where the poor or those traveling could seek refuge. It was even mandated by Emperor Charlemagne during the 6th century that every church that was created needed to have a hospital built onto it. Over the years, each hospital building was built to be able to accommodate multiple patients (Gormley, 2010).

Unfortunately, due to poor building structure and a rise in the number of people becoming sick from diseases, hospitals became very dangerous places. Some wards had over 100 beds and at times, more than one patient to a bed. Other problems arose due to very poor ventilation throughout the buildings. Patients who were infectious were often placed among other patients who were not infectious, who then contracted those diseases. Additionally, the equipment used on patients was not sterilized. During the Crimean War in Turkey from 1853 to 1856, a military hospital held a mortality rate of 42% (Gormley, 2010), higher than it had been up to that point.

In order to create change so hospitals could once again become safe and a place of sanctuary for the sick, the Pavilion Plan was adopted. The Hôpital Lariboisiere in France was the first to take on this new plan which had simple changes like opening up the layout of the hospital to allow fresh air to pass through the wards and limiting the number of beds in a ward. With the Pavilion Plan, mortality rates dropped and the concept was adapted to each hospital building (Adams, 1998). A famous hospital in the United States, Johns Hopkins in Baltimore, MD incorporated the Pavilion Plan when it was built.

When settlers arrived in North America, they carried over the concept of wards and hospitals with them. Bellevue Hospital in New York was the first hospital built in the 13 colonies in 1743 (Gormley, 2010). Prior to that, when sick or giving birth, Americans stayed in their homes. If they happened to live in a community with a physician, that physician would travel to the homes to tend to the sick ("America's Essential Hospitals," n.d.). When hospitals were created, however, they carried on the custom of being a place that tended to the less fortunate instead of being a place solely for the rich. Hospitals became the place where the care of strangers took precedence and from there, it has expanded into an institution that covers a broad spectrum.

**Classifications of Hospitals in the United States**

According to the American Hospital Association (2014), there are 5,723 hospitals in the United States of America. Of these registered hospitals, 2,903 are non-profit hospitals while 1,025 are for-profit. The remainder are owned by state or local government entities. Of all the hospitals registered in the United States, 35% of them are considered rural hospitals because they serve a rural community (Dunn, 2013). Of the total number of registered hospitals in the United States, 4,500 are acute care hospitals. An acute care hospital is one that treats patients for a brief but severe injury or illness including recovery from surgery ("Hospital Study," n.d.). The focus of this study is placed on acute care hospitals in the United States.

**Present-Day Hospitals in the United States**

It has taken many years for hospitals in the United States to reach the high standards that they presently have in cleanliness, work efficiency, state-of-the-art equipment, and well-schooled staff. In their 2007 Annual Report on Quality and Safety of Hospitals, the Joint Commission, an independent, non-profit organization that accredits and certifies more than 20,500 health care organizations, stated that up to that year, hospitals had their biggest increase on 19 different measures of quality between the years of 2002 and 2006 (Joint Commission, 2008). For example, in those five years of data collection, heart attack care, pneumonia care, and surgical care were drastically improved. Often, it was by doing something simple. Of the more than 3,000 hospitals who contributed data to the 2007 annual report, 70.3% of them stated that to improve quality, they did simple things such as providing discharge information to their heart failure patients. This was up from the 30.9% in 2002. In 2013, 97.1% stated they provide discharge information to their heart failure patients (Joint Commission, 2013). In 2002, discharging patients in an orderly manner meant a hospital was good. Today, not only having a discharge plan but providing appropriate information to the patients before discharging them gives a hospital a higher rating.

**Patient-Centered Care**

More emphasis is being placed on the patient today than in previous years. When originally proposed in the 1970s, the concept of patient-centered care was deposed as "trivial, superficial, [and] unrealistic" ("Patient Centered Care," 2008). Hospitals felt threatened by ideas of allowing healthcare providers

and patients to be on common ground regarding the patient's illnesses. Over the years, hospitals focused on numbers and getting through as many patients as possible without considering tasks like involving patients' loved ones, spirituality, and physical environment. This often contributed to readmissions and higher mortality rates ("Patient Centered Care," 2008).

In recent years, patient-centered care has become a focus for many hospitals across the United States. In their 2001 seminal report, The Institute of Medicine declared that patient-centered care is "an essential foundation for quality and patient safety" ("Patient Centered Care," 2008). This theory has been reinforced by other researchers. For example, Lown, Rosen, & Marttila (2011) at the Schwartz Center for Compassionate Healthcare in Boston, MA stated that compassionate care was very important to both the patients and physicians for a successful medical treatment to occur, and factors such as clear communication and emotional support were important contributors to whether a patient lives or dies.

To ensure patient-centered care is practiced throughout hospitals in the United States, The American Board of Internal Medicine has created patient experience surveys focusing on this aspect (Cassel, 2010). Many patients in institutions across the country are selected to participate in this survey. Following the American Board of Internal Medicine's footsteps is the American Board of Medical Specialties, and more recently, The Patient Protection and Affordable Care Act. A website was created so patients can review and compare physicians based on other patients' accounts.

In a lecture given at The American Board of Internal Medicine's 2008 Forum titled "What 'Patient-Centered' Should Mean: Confessions of an Extremist," Dr. Don Berwick, the former President and Chief Executive Officer of the Institute for Healthcare Improvement stated:

> For better or worse, I have come to believe that we—patients, families, clinicians, and the health care system as a whole—would all be far better off if we professionals recalibrated our work such that we behaved with patients and families not as hosts in the care system, but as guests in their lives. I suggest that we should without equivocation make patient-centeredness a primary quality dimension all its own, even when it does not contribute to the technical safety and effectiveness of care. (Berwick, 2008)

Dr. Christine Cassel, President and CEO of National Quality Forum, a non-profit organization that works to reduce readmissions of patients to hospitals, states, "truly patient-centered care health reform has the potential to achieve the 'Triple Aim' - improving patients' experience, bettering the health of our nation as a whole, and reducing healthcare costs" (Cassel, 2010). Patient-centered care should be at the forefront of every hospital if they want to sustain their patients' trust.

## Leadership in Hospitals

In a typical organization there are two groups of leaders: the governing body, as well as the chief executive officer and other senior managers (Schyve, 2009). In hospitals, there might be some confusion as to who leaders are

because not only do hospitals have these two groups of leaders, they also have a third group who are more visible to the patients than the other two groups: the doctors and nurses. In some instances, when the groups do not overlap, the doctors and nurses who belong in this third group are more powerful than the leaders in the other two groups because they make the final decisions on a patient's diagnosis.

As in any organization, good leadership is necessary, even crucial in a hospital's success (Schyve, 2009). The Joint Commission, an independent, non-profit organization that accredits and certifies more than 20,500 health care organizations, began their research in 1994 to answer what good hospital leadership looks like. Prior to this research, good leadership included standards such as "management, governance, medical staff, and nursing services" (Schyve, 2009). It was not until they interviewed top ranked healthcare management officials that they were told to "stop thinking of the healthcare organization as a conglomerate of units and think of it as a 'system,' ...a combination of processes, people, and other resources that, working together, achieve an end" (Schyve, 2009).

Recent studies have agreed with The Joint Commission's conclusions. Doctors and nurses working together to treat their patients would ensure clear communication not only among staff members, but also with the patient they are treating. It would also vastly minimize the number of errors the staff make, improve how efficient the staff are, and give the patient a more positive attitude towards the care that they are receiving (Burns, 2011). If a hospital is to succeed,

the different systems, especially the leaders - the doctors and nurses - need to work together for that success. The new approach to leadership in a hospital is:

> A collaborative approach by the doctors and the nurses [that] would improve the communication not only between the doctors and the nurses but also with the patients, reduce the errors committed by the medical staff, increase efficiency, and enhance a patient's view of their care. (Schyve, 2009)

Due to the numerous, areas within a hospital, it is not probable for the different personnel in leadership to be successful in separately accomplishing the goals of a hospital system which are "safe, high-quality care... community service, and ethical behavior" (Schyve, 2009). In order to be successful, they need to work together. If they see themselves as separate entities, jealousy, discontentment in their positions and titles, and poor relationships develop, causing higher medical errors and anger, stress, and frustration (Chang, Ma, Chiu, Lin, & Lee, 2009).

## Leadership Theories for Medical Personnel

Some doctors and nurses might not have chosen their professions with the goal of being a leader, but inevitably, they are leaders precisely because of what they do. Whether they work in a large hospital or a small practice, doctors and nurses are viewed as leaders in the healthcare industry ("Core Leadership Theory," n.d.). It has been a struggle over the years to define specific leadership theories for medical personnel because most theories were developed for the business world, then applied to those in the healthcare industry (Al-Sawai, 2013)

but several doctors are working at merging the two and making leadership theories relevant for the medical field.

Mere decades ago, doctors were taught they had to be autocratic leaders. Of the four core leadership theory groups - trait theories, behavioral theories, contingency theories, and power and influence theories - autocratic leadership falls under the category of behavioral leadership theories which focus on a leader's behavior. Autocratic leaders are ones more keen on making decisions on their own without getting others' inputs. Though beneficial in times when a quick decision needs to be made, it does not work well for a team environment because it does not require discussion in order for an agreement to be made ("Core Leadership Theory," n.d.). Medical personnel can no longer afford to be autocratic leaders because in the health care industry, teamwork is necessary and not all patients can be treated the same (Chaudry *et al.*, 2008).

Another leadership theory that no longer works well in the medical field is the Great Man Theory. The Great Man Theory, popular in the 19th century, stated that great leaders were born that way and it was not possible for anyone to become a great leader through his or her own effort. This theory was flawed because those who created it based their results off of leaders who were born into the aristocratic class. Those who were of a lower class had fewer opportunities to become great leaders and that is why this theory thrived back then ("Great Man Theory," 2014). In today's society, we see the opposite of this theory taking place and notably so within the medical field. An example is seen in world-renown neurosurgeon Dr. Ben Carson. Born into poverty and raised in a

single-parent home, Carson received poor grades in school and had a quick temper. Despite this, his mother encouraged and challenged him to greatness and he became a successful pediatric neurosurgeon at Johns Hopkins, one of the best hospitals in the United States (Hallowell, 2013). Carson is one of many in the medical field who have proved that the Great Man Theory of leadership is no longer relevant.

A leadership theory that does work well for doctors and nurses is Emotional Intelligence. Emotional Intelligence (EI) plays a big role in doctors' and nurses' careers. Being Emotionally Intelligent is a great asset to a leader and often distinguishes the outstanding leaders from their peers. Emotional Intelligence includes four domains: self-awareness, self-management, social awareness, and relationship management (Boyatzis & McKee, 2005). An Emotionally Intelligent leader is not only attuned to his or her emotions, but also to the emotions of those they lead, and in order for a doctor or nurse to be impactful in their line of work, they need to be Emotionally Intelligent. Doctors and nurses work in environments that are emotionally charged, so having a deep understanding of their emotions and the emotions of those they lead will only prove more beneficial to them because they will be better able to lead and provide the best care for their patients while creating a caring and resonant environment (Chaudry *et al.*, 2008).

If in a particular hospital the doctors and nurses are not seen as a team and the doctor is to take charge, the transformational leadership style should be put into motion by the doctor. Transformational leadership calls on the leader to

inspire positive changes in those who follow them so they go above and beyond what is expected of them. This will cause the followers to forego their individual self-interests and instead allow them to focus on the overall good of the organization (Avolio, Walumbwa, & Weber 2009).

Transformational leadership includes four components: idealized influence, inspirational motivation, individualized consideration, and intellectual stimulation. Idealized influence means that not only does the leader talk the talk, but he or she also walks the walk. What they are calling their followers to do is modeled by their actions. Inspirational motivation means that like any leader, transformational leaders have the ability to inspire and motivate those they lead. A unique concept about transformational leadership is its individualized consideration aspect, where leaders display a genuine concern for not only the needs, but also the feelings of those they lead. Because of this, a transformational leader may mentor or coach their followers in order to give them support. And finally, a transformational leader holds very high hopes for their followers and believes they are intelligent and capable of bringing about change. Therefore, the leader challenges their followers to be innovative and creative through intellectual stimulation (Riggio, 2009). Doctors who are transformational leaders are better able to lead and support their staff, creating excitement and a better sense of unity behind the staff.

A leadership theory that works effectively when medical personnel are required to work together is the collaborative leadership theory. With patient-centered care in mind, doctors and nurses work together with the goal of helping

a patient get healthy. With this mutual goal in mind, the collaborative leadership theory distributes information to all parties involved so they can make an informed decision. This theory works well in healthcare settings because it inspires communication between doctors and nurses and requires them to share their knowledge and experiences with each other. If changes are required along the way, more dialogue will need to take place, which further encourages communication and working together. With the nurses and doctors involved, both claim responsibility for the results of their decisions. They are dependent on each other, creating a more unified front (Al-Sawai, 2013). The collaborative leadership theory ties into Burns' (2011) theory that the better nurses and doctors were at working together and anticipating each other, the better they were at serving their patients.

There are many other leadership theories that could be applicable to doctors and nurses but those mentioned have proven to be the most effective (Al-Sawai, 2013). History has taught that autocratic leadership and the Great Man Theory of leadership are no longer relevant in the medical field. Leadership theories that are successful, however, include: Emotional Intelligence - being able to distinguish not only your emotions but also the emotions of those you lead; transformational leadership, which calls leaders to create personal relationships with their followers and challenge their followers to be better and work; and collaborative leadership theory, which calls for doctors and nurses to work together to achieve patient-centered care.

## Mayo Clinic

Mayo Clinic, located in Rochester, Minnesota, is the largest, non-profit group practice in the world. Mayo boasts a wide array of doctors with various medical specialties who join together to uphold the philosophy that "the needs of the patient come first" ("Mayo Clinic," 2014).

In July of 2014, *U.S. News and World Report* ranked Mayo Clinic the number one best hospital overall in the United States. When considering which hospitals it would deem number one, *U.S. News and World Report* takes into consideration aspects such as "patient survival rates, adequate nursing staff, reputation with specialist physicians, and patient safety" (Cheshire, 2014).

*U.S. News and World Report* sends the same survey to patients in approximately 4,000 hospitals in the United States asking them questions such as how they would rate the hospital overall, would they recommend the hospital to friends and family, and about the staff at the hospital ("Mayo Clinic Patient Satisfaction," 2013). When asked how they would rate Mayo Clinic overall, 84% of patients gave Mayo a "highest or very high" rating, 14% above the national average. Only 3% of patients gave Mayo a "low" score. When asked if patients would recommend Mayo to their friends and family, 87% of patients stated "definitely," 16% above the national average ("Mayo Clinic Patient Satisfaction," 2013). Mayo Clinic clearly towered over their competitors.

Regarding the medical personnel at Mayo Clinic, when asked if "nurses were courteous and respectful, listened carefully, and explained things clearly," 80% of patients said "always." When asked if "doctors were courteous and respectful, listened carefully, and explained things clearly," 83% of patients said

"always" ("Mayo Clinic Patient Satisfaction," 2013). These high ratings do not come without hard work. Mayo focuses on achieving the best for their patients. Dr. John Noseworthy, president and CEO of Mayo, attests to their goals: "We have a deep commitment to delivering high-value health care that best meets patients' needs. We owe our success to truly dedicated staff that provide a seamless patient experience and the care that each individual needs" (Eisenman, 2014).

So what makes Mayo Clinic successful? One aspect is that their "model of care is defined by teamwork" (Hanson, 2012). Mayo's staff reaffirms Burns' (2011) emphasis that great things can be achieved when doctors and nurses work together, including improved communication between the employees, reduced number of errors occurring, increased efficiency, and an enhanced view of health care by the patient. The Mayo staff also "focus their expertise on one patient at a time" (Hanson, 2012) which Lown *et al.* (2011) deem to be patient-centered care, which is being "respectful of and responsive to each individual patient" and the most effective way to care for a patient.

There were many reasons why Mayo Clinic was chosen as the number one hospital in the United States and those listed above are only a few of them. With 150 years of existence in the medical field and this most recent recognition, Mayo Clinic is a hospital many hospital leaders nationwide should follow. Mayo Clinic sets a great example for other hospitals in the way they apply patient-centered care, in the way the doctors involve patients and their families, and in the way the doctors and nurses collaborate and communicate. The responses

from the survey came directly from the patients from whom Mayo Clinic leadership desire to gain and maintain trust. Other hospitals and their leadership can also gain and maintain trust from their patients by applying the methods Mayo Clinic uses.

## Conclusion

When patients are admitted to a hospital, they trust they will be endowed with the best care and medical treatments possible. When this is not the case, the responsibility falls on the leadership of the hospital. A lack of funds, a lack of up-to-date medical equipment, or a lack of services certainly can contribute to less-than-desired patient outcomes, but these hospitals should also consider how those in leadership could maintain their patients' trust in themselves.

First, they need to establish or re-establish their focus on patient-centered care. Research shows that patient-centered care is vital to the success of the hospital. This means that medical professionals have to be compassionate towards their patients, getting to know them as people while they get to know them as patients. This also allows doctors and nurses to involve their patients in decision-making and allows the patient's opinions to be heard (Lown *et al.*, 2011).

Second, they need to ensure collaboration between the doctors and the nurses. They might have different ways of training, but when doctors and nurses work together, not only do they combine a wealth of knowledge, they also improve communication amongst themselves. They reduce the amount of errors occurring, they increase efficiency, and they present a better view of healthcare

to their patients. Having doctors and nurses collaborate ensures positive results for the hospitals (Burns, 2011).

Third, in order to maintain trust in themselves, hospitals need to teach and apply certain leadership skills to their staff. Staff members need to learn the transformational leadership theory which calls on leaders to expect more from their followers and challenge their followers to bigger and better things, and the collaborative leadership theory, which again, encourages medical personnel to work together for the greater good of the hospital. Antithetically, if the Great Man Theory or the autocratic leadership theory exists and is practiced by a hospital, it needs to be re-examined as potentially weakening the bonds of communication between doctors, nurses, and patients.

Every hospital has the potential to maintain trust by their patients. Patients' trust is an extremely important factor in developing and maintaining a hospital environment where patients feel compassionately cared for, heard, and understood.

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