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Necessity of Leadership Development in Allied Health Education Programs

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INTRODUCTION

Why should educational programs teach leadership, and why should universities and colleges who offer allied health care programs be concerned with training future clinicians to be leaders? Leadership development is a topic wrought with passion among business professionals and educators alike. Leadership is something everybody needs and it remains vague and ambiguous. Leadership is a mystical, almost ethereal, quality that you cannot define, yet know when you see. Advancing the allied health care professions and the members of the allied health care community is proving to be difficult without the necessary leadership skills. More and more clinicians and students are looking to and expecting educational programs to help in their leadership development.

Success and promotion of the allied health sciences and the individual practitioners from various disciplines depends highly on leadership ability. In allied health care, like many other organizations, the way leadership is taught, passed on and evaluated is critical. Leadership development is an important issue that every organization and every institution must address to ensure survival. It is no secret that strong intentional leadership is highly valued in our society. This value raises the question all organizations ask, how is leadership developed? Is leadership developed through mentoring, curricular activities, co-curricular, extra-curricular, didactic education, or the proverbial "school of hard knocks?" These and similar questions must be answered if leadership development within our educational programs is to be successful.

WHAT TO TEACH?

A survey of the popular literature reveals a consensus that leadership skills and abilities can be learned and developed, while many agree that some people have natural leadership ability while many aspects of leadership can be learned through skill development, competencies and experience. How people come to learn leadership is of key consequence in leadership development. Densten and Gray[5] state that, "teachers face many challenges in designing programs to enhance the leadership capabilities of their students."

Educators face many obstacles and confounding variables when designing practical leadership experiences and implementing pragmatic instructional methods. Organizational leaders everywhere (church, corporate, educational, health care) must ask, how is leadership learned best? Are there leadership competencies that are "universal" and what are they, and what leadership competencies are discipline specific? Within the context of allied health educators and professionals must investigate the same questions. Once each discipline determines what to teach, then how to teach it becomes relevant.

INSTRUCTION METHODS, WHERE TO BEGIN?

Traditionally there are three sources of how people learn to lead; the first is "trial and error", the second "observation of others" and lastly, "education."[3] Closely related to these "three sources" other longitudinal studies found three categories of how managers learn to manage: 1) job experience and assignments; 2) relationships; and 3) formal education/training3. Implementing these three instructional methods is critical for successful leadership development. Through clinical education and

clinical experiences much of allied health care education already includes these two sources, “trial and error” and “observations of other.” It is the “educational” method of leadership development where the struggles begin. One other potentially significant issue observed in the literature is the difference between “observations of others” and “relationships”, identified by Brown.[3] While these two have similarities, intrinsic in the terminology are key differences.

Many leadership development programs include an aspect of mentoring, but does that mentoring include developing relationship or are they merely observation. Although not explicitly stated, it is apparent from other of Brown’s[3] statements such as, “people learn to respond to who and what we are,” and “leading is a dynamic process of human interaction,” and “what was missing from this context [leadership development] was attention to people” that her idea of relationship is more than mere “observation,” tag-a-long or watch-and-do. Leadership development involves aspects of relationship between mentor and student that requires intentional investment of time and resources. Ideally one manages work and leads people.[3]

Cress, Astin, Zimmerman-Oster, and Burkhardt4 state that, “many educational institutions only give minimal attention to developing student leaders in terms of specific leadership programs and/or curricula.” There is no shortage of opinions on leadership, the literature is replete with differing opinions and findings of how leadership is defined, instructed, identified and evaluated. Other authors suggest that leadership development is “sporadic”, “haphazard” and “illogical”; and that the word leadership is a “nebulous” term[1]. For example, students commonly perceived to have leadership skills tend to “shine” by being less shy, better students (i.e., grasping concepts and application of knowledge), motivated, and articulate. These students are dubbed to have “leadership potential” and as a result have higher expectations placed on them. This typically is the extent of our leadership preparation or education. These students’ failure or success is now dependent on their effort in light of these new or higher expectations.

Leadership is initially recognized by the instructor, and depending on the disposition of the instructor may or may not be facilitated. This can only mean that if leadership is to be taught then those in faculty and instructor positions, must increase and fine tune their own leadership ability, activity, and awareness! Leadership development within Allied Health education is often coincidental and left to extra-curricular and co-curricular activities, such as clinical rotations/education, clinical observations, and peer teaching experiences.

INTENTIONAL LEADERSHIP DEVELOPMENT

Those competencies that do exist in Allied Health education (within specific disciplines) typically address management, organizational and administration skills, and lack identification and instruction of leadership competencies. Leadership development in allied heath care should be intentional. Intentional leadership assumes everyone has the ability to lead, at least circumstantially, and therefore can be taught in its simplest form as a set of attitudes, behaviors, characteristics, and desires that successful leaders often exhibit. By identifying ahead of time what constitutes leadership and what competencies and skills one can posses or learn specific to Allied Health can provide a more favorable climate for leadership training. By teaching students how to lead, rather than just how to manage or administrate, our professions can reach into many other areas of our communities, ideally leaving good impressions of our specific professions and individual members.

MANAGING AND LEADING

Allied Health educators need to ask, “What leadership skills are required?" “What are necessary leadership behaviors?” “What are the specific leadership competencies?" Finally, “How can leadership be evaluated?” Outside of individual disciplines or academic programs, any literature on leadership development in Allied Health as a whole is virtually non-existent. So a grass roots examination needs to be conducted to determine what leadership behaviors and skills are necessary to our professions. This is no small task. Adding to the difficulty of defining leadership performance standards or competencies within allied health is the diversity of work settings and job duties. This wide diversity makes it very difficult to develop universally accepted competencies for leadership. While some authors have attempted to address “predictors of success” these are not necessarily leadership outcomes.

Allied Health education seems to be behind the leadership curve. During the last decade there has been a shift from management development to leadership development.[3] In spite of this “shift” Allied Health Care education continues to focus on managerial skills and fails to differentiate between management and leadership. As an example, Richard Ray[8] states in his textbook on athletic training management [an allied health care profession] that, “this book is devoted primarily to principles and techniques intended to improve the athletic trainer’s ability to be a transactional leader.” Transactional leadership is commonly thought of as a trade off between superiors and subordinates (i.e., management). For example, the trade of money for compliance can be seen as transactional leadership, no real skill is required by the “leader” it is positional authority or power only.

On the other hand, there is transformational leadership which is more akin to current leadership ideas, which encourages subordinates to maximize their potential even if it means "showing up" the boss. Transformational leadership promotes individuals and organizations by transforming current commitment to a set of higher ideals and values versus self-preservation. One can view the difference between transactional and transformational leadership as similar to the differences between management and leadership. As mentioned earlier, we come back to the idea that management is positional and based on title while leadership is based on influence.

While teaching management and administration is important and a large part of what many allied health practitioners do in clinical practice, it is remiss not to establish a difference between what is done as a manger and what is done as a leader. Admittedly management can be easer to teach than leadership. John Kotter[3] described it best, "most organizations are over-managed and under-led." Allied health and our specific disciplines need to address issues of leadership with the students in our programs. In spite of this need, Brown[3] reports that, "leadership development is an underutilized strategy at most universities." This can relate to the issue stated earlier that is difficult to succinctly define, yet much easier to identify when you see it expressed in others.

LEADERSHIP COMPETENCIES: A STARTING POINT

In 1997 the Association of Schools of Allied Health Professions (ASAHP) set forth as one of their strategic plans, item 1.2.10 which states, "Cooperate with the National Network of Health Career Programs in Two-Year Colleges and the Health Professions Network to implement an allied health leadership program." This strategy resulted in the Coalition of Allied Health Leadership which hosts annual "workshops" on leadership issues. The September 2003 workshop states on the application the "workshop goals" which include:

- define aspects of leadership as it relates to allied health education and practice,
- identify personal leadership strengths and weaknesses,
- develop mentoring skills,
- explore how to lead in a time of change in health care systems and higher education,
- develop the ability to forge relationships with linkages in allied health education and practice.

The dialogue of this workshop and the semantics of these goals can serve as a starting point in identifying competencies for leadership in our diverse work settings. While, in Athletic Training[7] for example, the competency matrix and teaching outcomes cover such things as communication, establishing relationships and other "crossover" leadership skills, leadership remains primarily an indirect result of education. Most students' leadership abilities are developed via non-curricular or extra-curricular events. In spite of the fact that leadership skills are a sought after commodity these "supporting experience[s]" are given little importance in the hiring of entry level athletic trainers.[6] Because many leadership competencies are specific to a discipline some leadership experiences should be gained through Allied Health educational programming and not rely solely on extra-curricular activities.

Another place to serve as a starting point is in Anderson's and Pulich's[2] summary on management competencies in the health care environment. They outline four competencies with several sub-points as important competencies in health care. These competencies include: 1) Planning, a) goal setting, b) decision making; 2) Organizing, a) cooperating, b) coordinating; 3) Leading, a) communicating, b) conflict management, c) professionalism; 4) Controlling, a) empowering. These certainly overlap and include management ideals, but serve as a starting point for intentional instruction of students to be leaders in their communities, places of employment and within their profession. Teaching leadership as a competency and its related skills (#3 above) outside the context of management or as a stand alone curriculum is something worth considering.

Allied Health faculty and instructors need to address issues specific to leadership and not merely those of management and administration. Many authors offer theoretical differences between leadership and management that are based on assumptions, while some offer differences based on reviews and analysis of empirical research. Whatever the source it is a relatively accepted ideal that leadership and management are different. For example: leadership challenges the status quo and management protects the status quo; leadership creates vision and management implements vision, also part of the difference is that management can be seen as positional or a title where leadership is influence and not necessarily based on hierarchical position or title. To further explain this difference it has been reported that, "management focuses on structuring goals, tasks and roles, whereas leadership focuses on influencing direction and change, developing quality relations, and bringing out the best in oneself and others."[3]

CONCLUSIONS & DISCUSSION

There has always been dialogue about promoting allied health care. One way to be proactive on this front is to teach Allied Health Care students to lead. The question now is, "is leadership an entry-level competency" that needs to be taught at the entry-level, or is this something to hold off till graduate school or advanced studies? Surveying the literature available on leadership one can conclude that leadership transcends position and rank. If this is true then all indications can be, yes, it can be an entry-level competency.

Many of our health science program's clinical experiences have strong hands on/trial-and-error aspects, which is one way leadership is developed, but in allied healthcare disciplines leadership is rarely intentionally taught and according to the literature education is also one of three prominent ways leadership can be developed.

The challenge to Allied Health Care educators is to enhance our own leadership abilities and make it a priority to teach leadership. Promoting student's leadership ability indirectly promotes and advances allied health care professions even if the leadership outlet is somewhere other than in Allied Health Care. Graduates and practitioners getting involved in leadership positions outside of Allied Health Care enhances credibility in the eyes of the community and other professions.

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