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Research Article

The Modified Democratic Management Model: Conferral of Optimal Leadership in Present-Day Health Care

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Abstract

The ideal model for management/leadership structure in health care is that of a modified democratic management model with a transformational leader at the helmet. This model is not the result of one single theory, but a mix of many existing motivational and organizational behavior theories including the theories of Mc Gregor, Taylor, Hawthorne, and de Vroom. In addition, components of trait and behavioral theories of leadership including Lewin's and Blake and Mouton's are discussed and incorporated. Functional participation and team approaches determine the management style of the modified democratic management model. To avoid functional areas from becoming 'silos', a horizontal communication style between divisions is endorsed. Within the different specialty areas, a combination of participative and collaborative management styles prevails among the workforce while managers exert coaching and transformational management styles. The democratic management model is modified to retain components of an authoritative management style in the relatively rare cases of unexpected crises which require fast decision-making to avert organizational detriment. Authority is bestowed on managers due to their hierarchical position within the organization. The modified management model should apply to all different employment levels to provide a fair, transparent, and accountable management system for all and to maximally motivate employees to excel in their respective specialty areas.

Keywords: Modified democratic management model in health care and transformational leadership; Modified democratic leadership style in health care; Transformational leadership

Introduction

Health care is not only the largest but arguably also the most complex and unique industry in the U.S. There are several reasons for it. The health care business itself is not a uniform industry but made up of different segments: from hospitals to nursing homes, rehabilitation centers, home health care, ambulatory centers, and health administration. These components cover hospital, emergency, primary, palliative, preventative, rehabilitative, long-term, and home care. And they do not even account for health care related businesses such as health care technology, pharmaceutical industry, health insurance, health promotion or health care marketing. The modern health care industry comprises three key branches: services, products, and finance, all of which are subclassified into many related sectors and categories. The health care system itself comes down to four essential constituents: the patients, providers, insurers, and government. Different economic structures (e.g., for-profit, not-for-profit, governmental) determine the financial makeup. Aside from organizational and financial aspects, the complexity of health care is further corroborated by a very different mix of occupations, ranging from highly skilled

medical professionals (e.g., physicians and nurses) in the core business of medicine over pharmacists, occupational and rehab specialists, social workers, financial specialists, support staff, human resources and quality assurance specialists to administrators and hospital managers [1,2].

It is obvious that due to all these complexities in health care, a successful management structure is pivotal. Yet any organizational management structure in health care is as complex as the field itself. Among the most common leadership structures in health care are the autocratic, conflict, democratic, and laissez-faire management styles, but other classifications including transformational, transactional, servant, charismatic, task-oriented, and relationship-oriented leadership complicate matters further [3]. Hence, any management/leadership model in health care should be based on the prevalent motivational and organizational behavior theories that have evolved over time and provide a variety of different choices as to management model and style, manager-employee relationship, personal traits of managers, differences according to specialty area and much more. Herein, the democratic management structure dating back to Kurt Lewin's theory from the 1930s and 1940s is recommended with modifications as the best model to successfully address current health care issues [4,5]. The democratic management structure with a transformational leader at the helmet is proposed with modifications in the context of existing motivational and organizational behavior theories.

Background and Methods

The evolution of motivational and organizational behavior theories is key to a modern understanding and development of an ideal contemporary management/leadership model in healthcare. In this context, it is best to start with Douglas Murray Mc Gregor (1906-1964) who published his highly influential Theory X and Theory Y axiom in 1960. Historically, it is not the first motivational theory, but it remains, due to its simple classification, one of the most relevant ones with implications to modern times [6,7]. Notably, Mc Gregor was a student of Abraham Maslow, both of whom were important contributors to the development of motivational and management theories. However, Maslow's 1943 pyramid of human needs focuses mainly on human motives as based on innate and universal predispositions [8]. The Theory X and Theory Y axiom details two contrasting models of work motivation. According to this model, Theory X focuses on the importance of heightened supervision with external rewards and penalties. Employees' motivation is based on managers' authoritative direction and control. In contrast, Theory Y focuses on employees' motivation through job enlargement, greater responsibility, self-control, and integration. These employees require much less supervision [4].

However, numerous studies have shown that not all employees do neatly fit into the Mc Gregor classification. The workplace is simply not a 'one or two size(s) fit all' environment. Hence, Mc Gregor's tenet is regarded as an over-simplification of the workplace environment. Other important management theories regarding employee motivation, behavior and communication have evolved since. An aspect that goes beyond Mc Gregor's theories had already been published by Frederick Taylor in his 1911 'The Principles of Scientific Management' textbook. Therein he proposed the importance of a personal consideration for, and friendly contact with, one's employees. Such manager sentiments should stem from a germane and kind interest in the welfare of one's employees. Taylor also found that it takes special inducement to get the initiative of one's employees [9]. Yet the cognizance of the relevance of human relations and behavioral movements in management started with the Hawthorne studies. One of the key findings was that, when improved working conditions that had increased the workers' productivity, were removed, the workers' productivity remained at the previous high level. This result was accredited to group dynamics: the group was allowed to develop social interactions. The workers derived satisfaction from their social participation with both co-workers and managers [10]. Mc Gregor, Taylor, and Hawthorne laid the basis of managerial thinking as it concerns perceptions and attitudes toward employees. The next step in the evolution of organizational behavior theories was managerial insight into one's own behavior to better motivate employees. This included for some managers a necessary change from an authoritative to a participating and empathetic leadership style. This is where motivational theories come into play.

In that context, the Expectancy Theory is important as it focuses on the employee's behavior [11]. Victor Vroom's 1964 interpretation professes that employee motivation is an inter-dependable mix of effort, performance and reward. De Vroom summarized his theory in a formula comprising valence (strength of need/want for reward), instrumentality (higher work effort necessary to receive reward), and expectancy (increased effort results in increased performance) as multiplicators. This formula requires attentive managers to engage in the following: they must discover what employees value; they must provide a task that the employee believes is achievable in order to put effort into it; and only then will employees perform well in anticipation of the reward. Insights into de Vroom expectancy maxims led to Newsom's assessment of the 'Nine Cs'. The manager has to assess if challenge, criteria, compensation, capability, confidence, credibility, consistency, cost and communication are all aligned in such a way that the employee can be successful. Motivation and communication are of particular relevance in that regard as an employee evaluates his or her outcomes and inputs by comparing them with those of others, according to Stacy Adams' 1965 Equity Theory [12]. The employee's input/output assessment is a key criterion for job satisfaction or dissatisfaction. Based on these theories it is important to acknowledge that only if managers understand what motivates their employees, they can help them to reach their fullest potential. Managers can have a positive impact on both the employee's extrinsic factors (e.g., salary, working conditions, interpersonal relationships) and intrinsic factors (e.g., need for recognition, achievement). By successfully providing such infrastructure, managers can be instrumental in employees achieving the organization's goals. This also requires managers to be knowledgeable about both the Content and Process Theories of Motivation and how they relate to Maslow's human motivation theory [13].

Results and the Modified Democratic Management Model

Utilization of the relevant existing theories

The existing motivational and organizational behavior theories have a major impact on the modified democratic management model with a transformational leader at the helmet as the ideal leadership style in present day health care. This management/leadership model includes the following components of the various theories:

a. The recognition that different motivational types of employees exist, but not separated just into the two extremes as described in Mc Gregor's Theory X and Theory [6,7];

b. The necessity for managers to engage in direct contact with employees and to explore their desire for incentives as proposed by Taylor [9];

c. Support of social interactions between employees and both co-workers and managers to increase job satisfaction as suggested by Hawthorne [10];

d. Incorporation of the motivational elements of valence, instrumentality and expectancy as submitted by de Vroom [11];

e. Inclusion of the Process and Content Theories for delineation of specific factors that motivate employees (Content Theory) and the cognitive processes underlying an employee's level of motivation (Process Theory) [14].

The utilization of these theories allows health care leaders to better manage their employees [1-14]. When used in practice, these theories have shown that they assist health care managers to deal with staff more fairly, make jobs more interesting and satisfying, and motivate employees to higher levels of productivity. Application of these theories also help managers understand that they should not set unrealistic expectations about productivity, avoid a hostile work environment, steer clear of miscommunication, and avert inconsistency and ambiguity.

The ideal management structure of the organization

Based on the above theories, the ideal management structure in present day health care is a modified democratic management model with a transformational leader at the helmet in extension of Kurt Lewin's theory. Lewin found that "participative leadership, also known as democratic leadership, is typically the most effective leadership style. Democratic leaders offer guidance to group members, but they also participate in the group and allow input from other group members [13,15]."

In essence, the democratic management/leadership model in health care is defined through functional and team approaches determine the democratic management style. The organization is grouped according to functional specialty (e.g., patient care, finance, human resources, marketing, etc.) with team leaders and team members. To avoid functional areas from becoming 'silos', a horizontal communication style between divisions is endorsed. Within the different specialty areas, a combination of participative and collaborative management styles prevails among the workforce while managers exert coaching and transformational (see below) management styles. The most important disadvantage of a purely democratic management model is its slow (and time-consuming) decision-making process which makes it potentially less effective in a crisis. This is why the democratic management style is modified with elements of an authoritative management style based on the managers' hierarchical positions when quick decisions are required [4,5,16]. This modified democratic management style model versus purely autocratic, conflict, and laissez-faire management style models is best suited to achieve the many diverging goals of a health care organization [4,5,16]. The modified management model should apply to all different employment levels (i.e., physicians, RNs, LPNs, CNAs, administrators etc.) to provide a fair, transparent, and accountable management system to all.

The ideal characteristics of the CEO

The 19th century 'Great Man Theory' introduced by Thomas Carlyle has been replaced or complemented by contemporary leadership models [17,18]. However, some the five 'Great Man' traits still hold true, specifically traits of self-confidence, extraversion, energy level, courage, and charm although some of them are worded differently today [18]. In contrast, aggressiveness, and strong physical attributes such as height and appearance do no longer apply. Importantly, innate personality traits are enhanced by acquired characteristics such knowledge, skills, values, and vision to effectively influence employees and improve individual and organizational performance. Some of the five 'Great Man' traits have been replaced in modern times by these 'Big Five' personality characteristics: extroversion, agreeableness, conscientiousness, emotional stability, and openness to experience [18]. However, the emergence of new traits just adds to already existing traits for the leadership personality that remains difficult to exactly define. And another new trait is receiving lots of attention: emotional intelligence that involves the ability to monitor the manager's own as well as the employees' feelings and emotions.

The ideal CEO of this proposed modified democratic management model should be a transformational leader directed toward organizational change and innovation through incorporating emotions, values, and a strong vision to motivate employees [19]. Changing the status quo and moving the organization to the next performance level is the aspired goal of such value-driven change agents. Their reward is that employees go beyond self-interest for the good of the organization [18]. Through their inspirational and intellectual charisma, transformational leaders encourage their employees to question and to improve their own way of doing things for the better of the organization. A transformational leader must also be able to anticipate and quickly address essential changes in response to an ever-changing, globally competitive health care environment. This trait goes along with a strong focus on excellent results, high performance and quality outcomes while reducing costs amid decreasing revenues [19].

Other aspects of the organizational structure

The CEO should surround himself/herself with a cadre of high-quality 'lieutenants' (COO, CMO, CFO, CNO, etc.) who share the same vision. Since the CEO is a transformational leader, his lieutenants would preferable be transactional managers directed toward task accomplishment and maintenance of good relations between employees and managers through consideration of performance and reward [20]. The task of the managers is to hire/recruit employees that can be identified with Mc Gregor's Theory Y to achieve a high level of production, motivation, and job satisfaction among the employees.

Facilitators and barriers to implementing this management model

Facilitators of the modified democratic management model are the transformational CEO, his/her transactional lieutenants, and a highly motivated workforce of Theory Y employees. Barriers to successful implementation of the proposed model are both internal (e.g., worsening work conditions, unrealistic production goals) and external (e.g., changing federal/state regulations, reimbursement changes). The onus is on the transformational CEO to predict and solve these impending threats through application and expansion of existing motivational theories (internal factors) and appropriate administrative changes (external factors).

Discussion

Any model of management structure in health care must take advantage of the different existing theories of motivation and organizational behavior. The proposed model presented herein is a mix of elements found in the seminal theories by Mc Gregor, (Maslow), Taylor, Hawthorne, de Vroom, and others. It is important to re-emphasize the fact that the proposed model is the result of not one but many theories that exist in organizational behavior and are applied to the current health care environment. The proposed management structure is a modified democratic management model, as originally and broadly described by Kurt Lewin, and with a transformational leader at the helmet. Its elements include participation and collaboration between managers and employees across all divisions of healthcare organizations. Employee motivation and rewards as well as teamwork and job satisfaction are some of the driving forces of this model. The democratic management model with a transformational leader at the helmet is modified to retain components of an authoritative management style in relatively rare cases of unexpected crises which require fast decision-making to avert organizational detriment. Authority is bestowed on managers due to their hierarchical position within the organization. This modified democratic management model combines both horizontal and vertical reporting structures.

The key position of the proposed management structure is that of the CEO. He/she must be a transformational leader with the unique skill set of highly motivating his employees and presenting the right solutions to workplace issues at the right time to make the organization successful. Excellent communication skills, a germane ability to set the right motivational goals for employees, and broadly accepted leadership performance are all vital ingredients to modern health care leaders. This leads directly into the field of organizational behavior theories. Transformational health care leaders must have a grasp on the causes of workplace problems, such as low performance, conflict, stress, and turnover and must possess an ability to minimize negative developments and outcomes. Managers with a deep knowledge and understanding of organizational behavior theories are better prepared to predict and influence employees' behavior in the best interest of achieving organizational goals [2-20].

Conclusions

The proposed model for management structure in health care presented herein is that of a modified democratic management model and a transformational leader at the helmet. This model is not the result of one single theory, but of a mix of many existing motivational and organizational behavior theories including the theories of Mc Gregor, Taylor, Hawthorne, and de Vroom. Although hierarchy and vertical reporting in this health care management model still exist, functional and team approaches determine the management style. To avoid functional areas from becoming 'silos', a horizontal communication style between divisions is endorsed. Within the different specialty areas, a combination of participative and collaborative management styles prevails among the workforce while managers exert coaching and transformational management styles. The democratic management model is modified to retain components of an authoritative management style in cases of unexpected crises which require fast decision-making to avert organizational detriment. The modified management model should apply to all different employment levels to provide a fair, transparent, and accountable management system for all. It is expected that the components of the proposed management model motivate employees to excel in their respective specialty areas to the organization's overall benefit.

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Conflict of Interest

No Conflict of interest.

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