
ARTICLES

Healthcare Leadership ‘Outliers’: An Analysis of Senior Administrators from the Top U.S. Hospitals

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ABSTRACT

Research on top performers across a variety of fields suggests that the strongest predictors of pinnacle attainment are (1) the availability of opportunities early in one’s career as well as (2) the cumulative effects of much greater-than-average practice. The present study assesses these factors as they relate to the attainment of top healthcare leadership positions. We defined our sample as the chief administrative officers for hospitals ranked in the 2007 *U.S. News & World Report* Best Hospitals list as our sample. Educational backgrounds were determined through assistance from Witt-Kieffer, an executive search firm with an extensive database of executive profiles, which was supplemented by web searches and telephone contacts to ensure data integrity and currency. Staff of the Commission on Accreditation of Healthcare Management Education (CAHME) verified whether the MHA/equivalent programs were accredited at the time the individuals graduated by cross-checking against historical records. An aggregate estimate of degree prevalence was used to assess the extent to which academic background appeared to have stronger-than-expected prevalence on the list. Results suggest that representation among the top executives was associated with (1) having a master’s degree in administration; (2) the degree being an MHA/equivalent; and (3) the degree being from a CAHME-accredited program. The implications of the results are discussed in relation to views of health administration as a profession as well as the accreditation of professional graduate degree programs.

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INTRODUCTION

In the book, *Outliers*, author Malcolm Gladwell summarizes several intriguing streams of research on the influence that talent, early opportunities, and sheer volume of practice have on who will eventually become the most successful in their careers (Gladwell, 2008). Citing examples as diverse as hockey leagues, software engineering, flight safety, and the turn-of-the-century garment industry, he concludes that outstanding success in any field requires a combination of all three. This conclusion has interesting implications for professional fields in general, and health administration in particular, where each of these elements may hold specific implications for the eventual pathways to success.

In the present study, we sought to provide some exploratory analyses of the 'outliers'—individuals who have achieved unusual levels of success—in healthcare management. We accomplish this by focusing on a single, high-profile group: individuals identified as the top-level administrator for each of the nationally ranked hospitals identified in 2007 by *U. S. News & World Report*. To place these results in some context, we will first provide a high-level overview of variables we examined.

TALENT VS. PRACTICE

Throughout history, virtuoso performance, like leadership, was often attributed to gifts people were born with. More recently, the role of innate talent has come into question. Research examining the relative effects of talent and practice suggest that it is the latter more so than the former that most reliably predicts who emerges at the top of their field (Ericsson, Krampe, & Tesch-Romer, 1993). In summarizing this research, Gladwell (2008) described the 10,000 hour rule—i.e., that expert performance typically required 10,000 hours of additional practice in the areas most closely associated with that expertise. He provides further support for this notion by analyzing the educational backgrounds of Nobel Prize winners. Through this analysis, he vividly demonstrates that attending the most competitive schools provides no apparent special advantage to receiving this top honor. Indeed, prize winners are as likely to come from less competitive state schools as from the ivy league.

EDUCATIONAL PREPARATION

Assuming this pattern holds true for healthcare management as well, it would imply that students are not necessarily advantaged by their academic pedigrees in pursuing the top leadership roles in the field, but rather by the practice opportunities their education affords them.

Leadership positions in healthcare are often considered to be a highly specialized subset of the broader management area and, as such, many of the broader debates about management education (e.g. Bennis & O'Toole, 2005; Pfeffer & Fong, 2003) have also been applied to healthcare management education. Indeed, although graduate education is generally recognized as important for success in healthcare management careers, there has been considerable divergence of opinion in terms of which type of graduate program provides the best preparation. The entry in the U.S. Bureau of Labor Statistics' *Occupational Outlook Handbook* (2006) is particularly telling: on the one hand it states that "A master's degree is the standard credential" for these jobs; on the other, it provides no guidance as to a specific type of degree program, suggesting instead that the master's degree could be in "...health services administration, long-term care administration, health sciences, public health, public administration, or business administration" (U.S. Bureau of Labor Statistics, 2008, 1). This heterogeneity of degree programs is also reflected in the accreditation of graduate healthcare management programs. Accreditation by the Commission on Accreditation of Healthcare Management Education (CAHME) is based on the nature of the masters program itself rather than the title of the degree; their list of accredited programs include a breadth of degree titles including MHA, MBA, MHSA, MS-HSM, MPH, MSPH, and MSPHM (CAHME, 2010).

ACCREDITATION AS A PROXY FOR PRACTICE

In the United States, most professions requiring higher education also have a profession-specific accreditation process for ensuring the quality of these programs. Accreditation is generally designed to serve the public interest, by promoting accountability as well as providing a mechanism for protection against fraud and abuse (Schray, 2006). Masters-level healthcare management programs have had a formal accreditation process since 1968, under the Accrediting Commission on Education for Health Services Administration (ACEHSA). In 2004, a Blue Ribbon task force was appointed to evaluate the accreditation process in response to the substantial changes and challenges the field was beginning to face. From this process ACEHSA evolved into its current structure as the Commission on Accreditation of Healthcare Management Education (CAHME), which is currently the sole organization formally recognized for this purpose in the United States and Canada (CAHME, 2008).

Throughout its history, the ACEHSA and CAHME accreditations have distinguished the programs bearing their designation in ways that are relevant to our study. Foremost among these is the emphasis they place

on ensuring that students have meaningful experiences applying their knowledge in real-world settings. Many accredited programs have strongly encouraged or required students to complete summer internships and/or an administrative fellowship, an intensive period of work under the supervision of senior leaders. Students completing these fellowships early in their careers distinguish themselves from their peers through this opportunity to develop "...an internal compass they can carry with them to their professional roles," (Garman, Butler, & Brinkmeyer, 2006, 361). Such experiences appear to fit the Gladwell model of expert-relevant practice.

METHODS

Ranked hospitals were identified using the online database provided by *U.S. News & World Report* (2007). The list, compiled annually as a guide for healthcare consumers, uses a combination of quality and reputation data to rank hospitals in 16 specialty areas (for a full overview of methods, see McFarlane, Murphy, Olmsted, Droz, & Hill, 2007). The 173 hospitals that received a national ranking in at least one specialty area represent a little over 3% of the 5,462 hospitals analyzed in their study.

For each of the 173 hospitals, the name of the senior administrator was identified from the *U.S. News* online database. Educational backgrounds of the administrators were then determined using a multi-method approach. The educational profiles of the majority of administrators were identified with the support of research assistants provided by Witt/Kieffer, the leading privately-held search firm for senior-level healthcare executives (Modern Healthcare, 2007). For individuals who were not represented in the Witt-Kieffer database, we identified educational backgrounds through a combination of phone contacts with the administrative offices of the hospitals, professional association database searches, and web searches.

Twenty of the administrators (12%) held more than one graduate degree, including three with PhDs. Given the small number of these cases, rather than developing a separate category for PhDs we categorized these administrators according to their masters or clinical degrees. Twelve of the remaining 17 administrators held either a clinical or an administrative degree as one of their graduate degrees, and we used this for their categorization. In cases where an administrator held a dual degree which included a healthcare administration degree (e.g. an MHA/MBA), they were categorized according to the healthcare administration degree. The remaining five administrators (3% of the total) held *both* clinical and administrative degrees; these five were categorized according to their administrative degree.

Once educational credentials had been identified for all administrators, a project assistant at the CAHME offices vetted terminal degrees against

historical accreditation records. If the program from which the terminal degree was earned was listed in the historical records as accredited at the time of the administrator's graduation date, then the administrator was categorized as having graduated from an accredited program.

To determine an 'expected' composition of educational degrees among the administrator group, relative base rates of the leading degrees in the sample (health administration, MBA, and MD) were estimated by reviewing *Digest of Annual Statistics* reports from the National Center for Education Statistics (NCES), Institute of Education Sciences, US Department of Education. The *Digest* provides an annual report of graduates of programs at various levels from major disciplines (*Digest of Education Statistics*, 2008). These data were compiled from the reports for each year beginning in 1970 and ending in 1991, representing the period spanning the first and ninth deciles of the graduation years of the sample. (We analyzed this period rather than the full range of graduation dates to control for the effect of statistical outliers in the data; additionally, since accreditation of graduate health administration programs did not exist prior to 1970, the period before this year would be less meaningful in terms of the research questions of interest.)

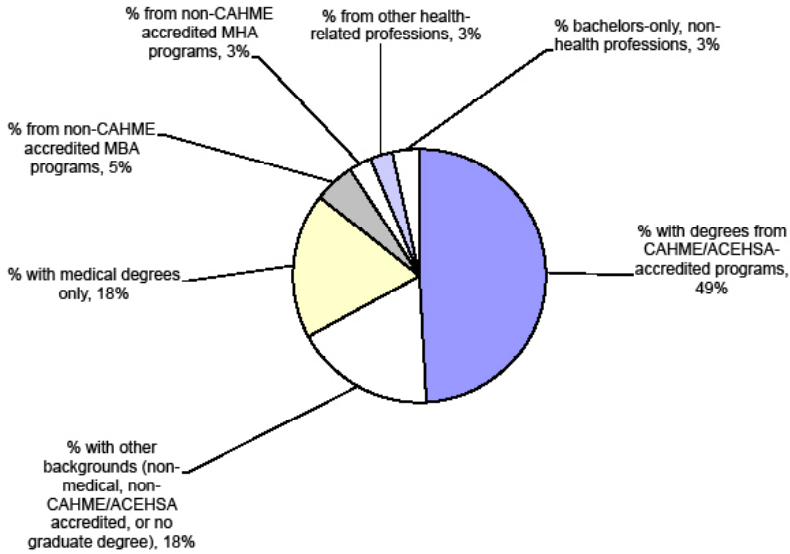
The final step in our data preparation involved estimating the base rate of graduates from accredited health administration graduate programs, as a function of total graduate health administration graduates. Since we were unable to identify any repository or analysis of historical data that would allow us to straightforwardly estimate the breakdown of graduates from accredited vs. non-accredited programs, we constructed the estimate using program descriptions from *Peterson's Guide to Graduate Programs in Business, Education, Health & Law*, an annual publication that is widely regarded as an authoritative guide for graduate education in the United States (U.S. Department of State, 2008). Analysis proceeded as follows: First, sections of *Peterson's Guide* pertaining to graduate health administration programs were obtained from each of three intervals during the study period (1976, 1984, and 1988). Next, all master's level graduate programs described in each guide were coded as either accredited or non-accredited, and total counts for each category were calculated. A linear regression model was then created to extrapolate these data points to create trend estimates for the in-between years.

RESULTS

Figure 1 graphically represents the composition of healthcare administrators from the nationally ranked hospitals, according to the graduate degrees they held. As this figure illustrates, the largest proportion of administrators

Figure 1

Administrators of U.S. News-ranked hospitals, by type of graduate degree

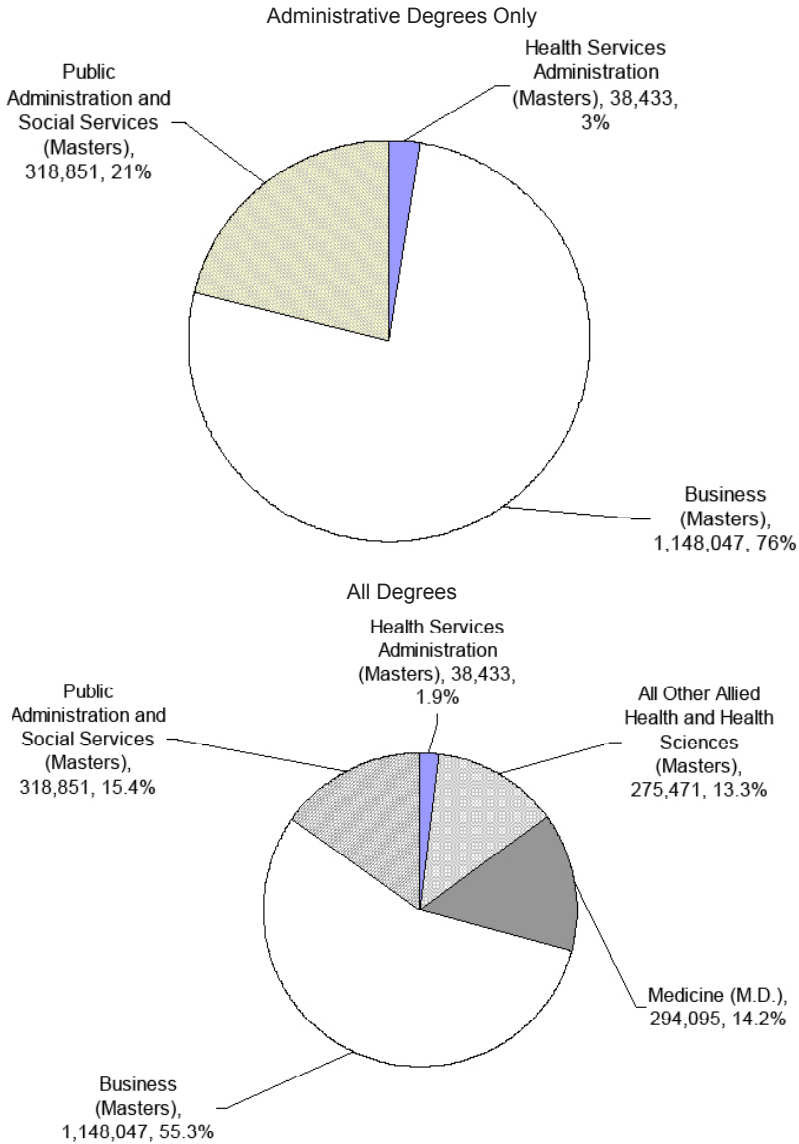


(49%) were from programs that were accredited as health services management graduate degree programs. The MD was the second most frequently held degree among the group, comprising 18% of the total. Graduates of non-CAHME accredited MBA and MHA programs comprised a relatively small proportion of the total (5% and 3%, respectively), as did other health-related professions (3%). Another 3% of the total did not have graduate degrees. The remaining 18% were categorized "other," which included degrees in areas such as special education, law, political science, liberal arts, urban planning, and (non-CAHME-accredited) public health/public administration.

If we assume that type of graduate education has no effect on career attainment for the sample at hand, then we would expect the composition of Figure 1 to reflect the distribution of the total population of graduate degree holders in the United States. So, for comparison purposes, Figure 2 graphically represents the base rate of graduate degrees conferred in the United States during the period under study, in the categories most frequently represented by the educational backgrounds of the administrators under study. As these graphs illustrate, business masters degrees represented the largest number of total degrees granted across the major disciplines analyzed, comprising 76% of the total administrative degrees and 55% of all degrees under study. Public administration and social services comprised

Figure 2

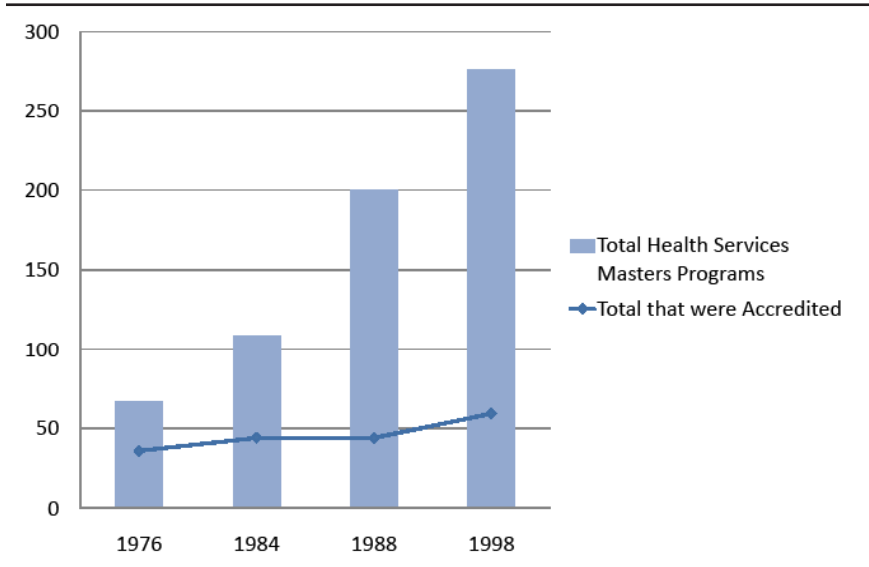
Estimated population of graduates with educational backgrounds similar to those of the U.S. News list administrators, 1970-1991



the next largest grouping, with 21% of the total for administrative-only and 15% for administrative and health sciences degrees. The MD degree comprised 14% of the total, and master's-level health sciences degrees

Figure 3

Trends in accredited and unaccredited healthcare management masters programs over time



comprised 13% of the total. Health services administration, in contrast, accounted for just 3% of the administrative degrees awarded, and less than 2% of total degrees awarded.

Our final analysis compares the proportion of graduates of CAHME-accredited programs to those of non-accredited healthcare management programs, as extrapolated from the *Peterson's Guide* reviews described in the methods section. Results of this review are shown in Figure 3. Extrapolating from this review across the period of the study, we estimated that 37% of alumni with these degrees graduated from accredited programs, versus 63% from unaccredited programs. Once again, this contrasted sharply with the *U.S. News* sample, in which 95% of the administrators who had masters of healthcare management degrees were from CAHME-accredited programs, and 5% from unaccredited programs.

In summary, it appears that there is an association between graduate education and composition of the administrators under study. The strongest effect for degree type appears to be associated with health services management degree programs; although they comprised only 2% of the degrees in the underlying distribution, they represented 52% of the administrators in the sample. A Chi-square analysis of this effect yields a X^2 of 11.33 ($p < .001$). In comparison to the effect for degree type, the effect for CAHME ac-

creditation was even stronger; our estimates suggested that approximately 37% of health services management graduates during the study period were from CAHME-accredited programs, but comprised more than 95% of the administrators who held health services management degrees ($X^2 = 144.3, p < .001$). Finally, a positive association was also found for the MD degree, with 14% of the degrees awarded but representing 18% of the administrator group; however this result did not reach statistical significance ($X^2 = 1.19, p = .28$).

DISCUSSION

The goal of our study was to examine the extent to which educational background and early career opportunities had an association with the attainment of top administration positions in leading hospitals. If there truly were no effects, then the leadership of the *U.S. News*-ranked hospitals should have represented, at least roughly, the broader population of degree graduates from which these leaders were drawn. The data we analyzed suggested that education did have an association, in that graduates from health services management programs generally, and ACEHSA/CAHME accredited programs in particular, were significantly overrepresented among this group of healthcare leaders. The sizes of the associations found in this study are compelling. In terms of degree program, at the population level, graduates of healthcare management programs represented less than 3% of the administrative master's degree graduates for the study period, but comprised 49% of those who became the top administrator in one of the ranked hospitals, producing an overall advantage better than 16:1 for graduates of these programs. In terms of graduates from CAHME accredited programs, our estimates suggested an even more pronounced effect—as much as 80:1—favoring graduates of healthcare management programs with vs. without this accreditation.

Although the strength of these associations is compelling, they also raise important additional questions about these career pathways. Of particular note is the potential role of administrative fellowships, which can offer their participants greater relative access to the experience and perspectives of senior executives at a formative early career stage, as well as mentoring opportunities and a substantial jump-start on one's professional network. It is conceivable that a properly structured post-graduate practicum, six to twelve months in duration, may have as much to do with ultimate career success as the preceding didactic experience. Some key questions which were beyond the scope of the present study include: are the senior leaders of top-ranked hospitals more likely to have fellowships in their history?

If so, in what types of settings, for what lengths of time, and with what kinds of operating models? Another set of influential factors might be the pre-graduate school life experiences of the study population, including post-baccalaureate years of employment and/or such diverse leadership opportunities as team captaincies, student government positions, and club/fraternity/sorority officerships. For this particular cohort of CEOs, another common life experience prior to graduate school might be the draft-era military.

Although more detail on career pathways could have enriched the results considerably, a more fundamental concern stems from the absence of more basic demographic data concerning the extent to which these leaders 'looked like' the pools from which they were drawn. There is a well-documented lack of diversity among healthcare CEOs (e.g. American College of Healthcare Executives, 2006, 2008; Garman & Tyler, 2004, 2006); it would be useful to know the extent to which demographics is associated with preferential treatment and/or better access to key social networks and, in turn, career trajectories.

These limitations notwithstanding, it remains clear that for these types of roles, graduate education in health services management matters, and CAHME accreditation matters even more. If we can assume that individuals are *called* to healthcare management in part due to their talents and in part due to early career interests, then it appears that Gladwell's (2008) outliers model holds explanatory power for the field of healthcare management as well.

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