

VIRTUAL LEADERSHIP: CEOS AND C-LEVEL EXECUTIVES OF HEALTHCARE ORGANI- ZATIONS IN THE UNITED STATES REIMAGINED NEW ROLES AS VIRTUAL LEADERS

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CEOs and C-level executives of healthcare organizations in the United States reimaged their leadership roles during the COVID-19 pandemic. These leaders had to make decisions to positively impact their hospitals, communicate with their stakeholders, protect their employees, and offer urgently needed services to the community by utilizing virtual technology. In 2020, the COVID-19 crisis emphasized leadership in hospitals and other healthcare organizations as patients, clinicians, and staff sought clear direction in the face of uncertainty and stress. The second part of the problem was that hospitals and other healthcare leaders often arrived at their positions unprepared for

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their roles. The current research explored the transition CEOs, and C-level executives of healthcare organizations in the United States made to continue operations during the pandemic. The framework of the study was a quantitative survey with a descriptive design to explore the changes these leaders incorporated to become effective in a virtual environment during challenging times.

Introduction—Transition to Virtual Leadership

The impact of the pandemic on U.S. healthcare organizations inspired C-level executives to exponentially re-evaluate their roles and use their talents to empower people to adapt to new virtual environments. The current study defined a CEO or C-level healthcare executive as a senior leadership role of an organization responsible for making decisions that impact the overall operations and business. These leaders' new vision for business operations provided reorganized communication systems, adding a safer online environment for remote stakeholders, and improving quality patient care by accelerating virtual policies and procedures. A literature review highlighted the importance of critical communication skills as employees and patients transitioned from face-to-face to virtual communications. Additionally, the literature reported 7% of communications is in the words people use, 55% is body language, and 38% is the tone of voice (Harvey, 2020). The advent of Zoom, Microsoft Teams, Facetime, and Skype have overcome some of these obstacles to virtual communication.

In a COVID-19-related healthcare environment, virtual work settings present a growing opportunity for healthcare leaders to address complex problems through virtual interactions and operations. Virtual leadership has and will continue to revolutionize the healthcare industry by providing higher levels of responsiveness and flexibility (Mehtab et al., 2017).

Making the Transition to Virtual Leadership

Healthcare executives learned to conduct face-to-face interactions and communications with their stakeholders, including executive staff members, board members, third-party contractors, and others. Internally, these healthcare executives needed to evaluate

how to minimize front-line contact with patients and coordinate care with providers such as hospital patient representatives, representatives for hospice, home health, rehabilitation, skilled nursing representatives, as well as third-party vendors such as pharmaceuticals, medical equipment suppliers, and many more. The big question was, how does a leader communicate with stakeholders and coordinate services for patients in a virtual environment?

The two most frequently seen leadership styles in the healthcare setting are transformational and transactional. Transformational leaders focus on the organization's goals, whereas transactional leaders focus on rewards. Transformational leaders in the virtual environment encourage leadership and employee training via video platforms to enhance employee engagement and morale and boost the work environment (Pennington, 2019). Transactional leaders in the virtual environment focus on results of healthcare ratings and employees reaching their productivity goals. Employees receive promotions or monetary bonuses for such success (Pennington, 2019).

Transactional leaders are not focused on the long-term goal but on achieving monthly, quarterly, and annual plans. Employees see transactional leaders who focus on goals as micromanagers; however, during the pandemic and transition to virtual leadership, this leadership style had to trust their team and delegate more tasks evenly to accomplish the organization's goals (Pennington, 2019). A transactional leader who focuses on rewards may have difficulty adjusting to virtual leadership as they rely heavily on face-to-face interactions such as networking events, conferences, or business after-hours to reap the benefits of outcomes (Pennington, 2019). The transactional leader improved their leadership style when organizations started virtual networking events. Virtual events allowed more employees to attend such events (Pennington, 2019) and many companies saved money via

employee virtual participation. Cost savings resulted when companies did not have to reimburse employees for mileage and when actively engaging numerous healthcare peers.

From personal experience, one of our researchers works in a virtual environment in the hospice care setting. Her experience as a healthcare leader leading a team in a virtual environment was challenging initially but soon became rewarding. Trusting the employees to work anonymously and stay productive was a significant challenge; however, utilizing virtual platforms such as Microsoft Teams proved successful, with employees logging in from their assigned territories without having to travel to the office to host a face-to-face meeting. Employees who unscrupulously take advantage of independent working environments without being productive and meeting company expectations for personal gain do not retain their positions.

Virtual communication and the utilization of technology allow all parties to effectively communicate and provide clinical care to patients in need of hospice services. Families can access clinical team members via Facetime, phone calls, and emails for patient updates versus waiting for face-to-face interaction. Due to COVID-19 visitor restrictions, caregivers and family members could not visit their loved ones in the hospital. These essential stakeholders were able to receive updates virtually through Facetime and Zoom meetings with hospital staff and were able to document their required signatures through electronic signature portals. The implementation of virtual communication was fast, simple, and easy to receive and send documents.

MANAGING VIRTUAL TEAMS IN THE HEALTHCARE

One assumption of the study was that healthcare executives had to determine the benefits and challenges of leading a healthcare team virtually. Over time, technological advances have allowed virtual communication using the Internet through video conferencing, virtual teams, emails, and groupware systems by moving stakeholders to a virtual environment for improved virtual communications.

Looking at the benefits of working in a remote environment, virtual leadership allows for effective com-

munication between multiple stakeholders, with many forms providing real time interactions. When travel or coordination of face-to-face interactions is a barrier to communications, technology offers the flexibility to meet anywhere and at any time during the day.

Healthcare executives face several new leadership challenges in establishing and maintaining relationships with stakeholders in a virtual environment built earlier from face-to-face interactions. One of the critical challenges for healthcare executives is their ability to gain the trust of their stakeholders in a virtual environment. Healthcare leaders face challenges in building trust with their teams, constrained by a culture of face-to-face interactions (Kligler, 2017). Face-to-face interactions for healthcare leaders allow the leader to communicate through subtle communication skills (i.e., body language, nonverbal cues, facial expressions), which may diminish over time in a virtual environment.

More challenges occur when virtual leaders must determine which stakeholders will function appropriately in a remote environment. Additional challenges include employees who are not self-starters and often require guidance and hands-on management to ensure accountability; clear communication and the tone of emails or voice calls; organizational skills, and discipline to stay on task to meet deadlines (Kligler, 2017).

The evidence suggests leaders need to be their best consistently if they are to have teams and communities deliver excellent performance while working virtually (Mawson, 2020). Leaders, remaining compelling and inspired, hold expectations to improve their virtual communication skills. In a virtual environment, leaders may miss non-verbal cues, lack the opportunity for impromptu chats, and find messages easily misconstrued. Virtual communication requires more extraordinary thoughtfulness than in-person communication (Harvey, 2020).

EMPLOYEE RELATIONSHIPS THROUGH VIRTUAL LEADERSHIP

During the literature review, it was found that healthcare executives' concerns about the ability to hire, recruit, or manage healthcare employees in a remote setting were a new phenomenon. Kligler (2017) found

that one of the benefits healthcare leaders discovered is that they could recruit higher-level talent by allowing employees to work from home or an off-site office for employees unable to relocate to a particular region. Kligler (2017) posited that employees could have higher productivity levels due to fewer distractions from onsite operations, and healthcare leaders can give attention to the daily operations and oversight of stakeholders more effectively and efficiently.

When physically working in an office or other healthcare settings, employees have access to colleagues through breakroom chats, coffee chats, or water fountain conversations. Transitioning to a virtual office challenged the development of person-to-person relationships, social interactions, and informal communication. The lack of interaction could lead to dysfunction when healthcare leaders do not correctly transition their team to virtual interactions.

TEAMS CREATED IN VIRTUAL LEADERSHIP

Creating effective and well-functioning teams in a virtual environment is challenging for healthcare leaders. Team members who feel excluded often express having difficulty adapting to working alone or transitioning from a shared office space. Three phases leading to virtual teams include welcoming, working, and wrapping-up phases (Zander et al., 2013). As noted by Clouner (2018), the transition to virtual teams must provide focus on goal alignment, knowledge transfer, and motivation. During the virtual team members' welcoming phase, each member learns of goals and objectives (Clouner, 2018). Goal alignment, task definition, and building relationships are encouraged during the welcoming phase. The welcoming phase often leads to teams with strong communication skills and building trust among team members (Zander et al., 2013). The working phase focuses on roles and processes (Clouner, 2018). As healthcare leaders transition to virtual leadership, healthcare leaders must remain aware of each stakeholder's ability to perform specific tasks. Virtual leaders facilitate team processes and coordination to ensure effective team performance. Potential conflicts may arise during the working phase, leading to the need for conflict resolution skills (Zander et al., 2013).

The final stage of virtual leadership is the wrapping-up phase. In wrapping-up phase, teams and virtual leaders should self-evaluate the success of their virtual team and determine if goals and objectives are being achieved (Clouner, 2018). Finalizing the virtual leadership phase forces the virtual leader to address the team's shortcomings, missed opportunities, and organizational dysfunction to meet goals and objectives. Evidence suggests leaders need to be consistently aware of the team's progress and interactions if they are to have their teams deliver excellent performance while working at a distance (Mawson, 2020).

STAGES OF GROUP DEVELOPMENT

Tuckman and Jensen (1977) proposed five stages to team formation: forming, storming, norming, performing, and adjourning. The model for team formation explains that as a team matures and establishes a stronger relationship, the leadership style changes to a more collaborative or shared leadership (Tuckman & Jensen, 1977). Virtual and in-person leaders must recognize which stage their team is in so the developmental stage process and assisting the team can be consistent to make the team productive. A group may function in various stages and introducing a new team member or leader can change the team's morale. Team morale can take place in both virtual and in-person settings.

The first stage, forming, focuses on observable behaviors (i.e., avoiding controversy, problem-solving, politeness); feelings and thoughts (i.e., expectations, attendance, fear, excitement); team needs (i.e., mission and vision, effective class meetings, operational guidelines); and leadership required (i.e., active involvement, project guides and instructors, communication).

The second stage, storming, forms as an organizing task to handle interpersonal conflicts, causing leadership and power to be more dominant in this phase. The storming stage focuses on observable behaviors (i.e., arguing among members, lack of role clarity, lack of progress); feelings and thoughts (i.e., feeling defensive, resistant to tasks, loss of interest); team needs (i.e., effective listening, conflict resolution, constructive feedback); and leadership required (i.e., active team engagement, support and praise, team conflict resolu-

tion). To move forward to stage three, a team must shift from a testing and proving mentality to a problem-solving mentality (Tuckman & Jensen, 1977).

The third stage, norming, allows team members to create new ways of doing and being together (Tuckman & Jensen, 1977). The stage focuses on observable behaviors (i.e., focusing on energy, developing team routines); feelings and thoughts (i.e., a sense of belonging, a general sense of trust); team needs (i.e., decision making, constructive feedback); and leadership required (i.e., shared leadership, team interaction). Collaboration between the team and the leader emerges during this stage, allowing creativity to be high through shared success. The only drawback in the stage is that team members may begin to fear the future of how the team will function if there are any interruptions.

In the fourth stage, performing allows the team to be flexible and adapt to meet the team's needs (Tuckman & Jensen, 1977). The stage focuses on observable behaviors (i.e., fully functional teams' roles are clear); feelings and thoughts (i.e., empathy for one another, fun, and excitement); team needs (i.e., maintaining team flexibility, providing the information); and leadership required (i.e., share new information, little management). All groups do not reach the performing stage because all team members need to function independently for total unity to be successful (Tuckman & Jensen, 1977).

The fifth and final stage of small-group development is adjourning. In adjourning stage, teams are ready to leave due to a significant change in the team's structure and conflict with others (Tuckman & Jensen, 1977). The stage focuses on observable behaviors (i.e., visible signs of grief, restless behavior), feelings and thoughts (i.e., sadness, humor), team needs (i.e., recognizing and rewarding team efforts), and leadership required (i.e., good listening). The final stage of adjourning is the regressive termination of a group from giving up control to giving up inclusion in the group (Tuckman & Jensen, 1977).

Leaders of healthcare organizations must hone their virtual communication skills when leading a virtual organization. Virtual communication requires more thoughtfulness than in-person communication. Leaders

tend to miss non-verbal cues, lose the opportunity for impromptu chats, and the listener more easily misconstrues messages (Harvey, 2020).

Methods and Research Design

The current study was a quantitative study. Data derived from a Qualtrics Survey instrument surveyed persons in CEO and different C-level positions within healthcare organizations across the United States. Before 2020, few U.S. healthcare organizations were conducting business virtually. The 2020 global pandemic required these U.S. healthcare leaders to introduce hospital stakeholders to virtual work (Alberts et al., 2021).

The 12-question survey asked C-level healthcare executives to respond to issues they may have experienced during the year 2020 to meet the needs to interact virtually with stakeholders. The quantitative questions sought agreement or disagreement to answer the research question by addressing changes in the efficiency of service to patients,

1. increased monitoring of employees,
2. the effectiveness of emotional intelligence,
3. knowledge of technology,
4. employee skills,
5. the effectiveness of communications,
6. quality of care, employee motivation, and
7. trust among stakeholders.

RESEARCH QUESTION

The research question was: *What transition did the CEOs and C-level executives of healthcare organizations in the United States make during the COVID-19 pandemic as virtual leaders reimaged their roles?*

DATA COLLECTION METHODS

The survey defined participants as a CEO, or C-level healthcare executive who was responsible for organizing and overseeing the health services and daily activities of a healthcare organization within the United States. The goal of the survey was to receive responses from 100 C-level healthcare executives (President/Chief Executive Officer [CEO], Chief

Operating Officer [COO], Chief Financial Officer [CFO], Chief Nursing Officer [CNO], Hospital Administrator, Associate Executive Director) of healthcare organizations within the United States.

Researchers, who have developed similar survey instruments in the past, designed the survey instrument. Two of the three researchers have extensive experience in the healthcare industry. All three researchers have extensive experience in leadership and hold advanced degrees in Organizational Leadership. The survey consisted of six (6) multiple-choice questions, five (5) questions measured on a 5- and 7-point Likert scale, and one (1) open-ended question. The Qualtrics survey creation tool and B2B (Business-2-Business) database system were used to conduct the survey. Qualtrics implemented the survey through Qualtrics online survey platform (Qualtrics, 2021).

PARTICIPANTS IN THE SURVEY

Responses to the survey were received between August 25, 2021, through October 5, 2021, from 32 C-level leaders of U.S. healthcare organizations. During a review of the surveys, one survey was unusable, leaving a survey size of 31. The preponderance of respondents held positions of Chief Executive Officers of Community and Specialized Hospitals. The participants were: Chief Executive Officers (CEOs), Chief Nursing Officers (CNOs), and other C-level positions.

The study included healthcare executives who were CEOs (59%) of leading hospitals with experience ranging from 6 to 10 years. Participants reported education levels of master's degrees (74%) and professional

and academic doctoral degrees (22.5%). Of the 31 participants, 19 said they were leading healthcare organizations with over 100 employees (62.5%). Table 1 depicts the demographic distribution of the participants.

The researchers analyzed 31 participants' responses in the analysis. One response was unreliable and deleted as most responses on that survey were "prefer not to answer." The remaining 31 responses explored how senior leaders in U.S. healthcare organizations reimagined their leadership roles as virtual leaders as the COVID-19 pandemic forced the use of virtual technology to keep stakeholders safe while maintaining the efficient and effective application of needed healthcare services.

SIGNIFICANT FINDINGS

The research showed that moving to a virtualized leadership environment challenged most C-level executive leadership skills. The results from the survey questions showed:

1. C-level executives (61.3%) of healthcare organizations agreed that communications in a virtual environment are difficult.
2. CEOs (78.9%) found leading in a virtual environment to be easier or the same as face-to-face interactions.
3. C-level executives (89.4%) surveyed agreed or somewhat agreed, virtual teams have been more efficient at providing service than face-to-face interaction.

Table 1 Demographics of Survey Participants

Participants					
Position title	%	Count	Organizational affiliation	%	Count
Chief Executive Officer (CEO)	61.30	19	Community Hospital	31.25	10
Chief Nursing Officer (CNO)	19.35	6	Specialty Hospital	15.63	5
Other senior leadership	19.35	6	Physician Office	12.50	4
Total	100	31	Specialists' office or clinics	9.38	3
			Nursing homes and/or assisted living facilities	9.38	3
			Other healthcare organizations	21.88	6

Note: Distribution of the participants in the survey.

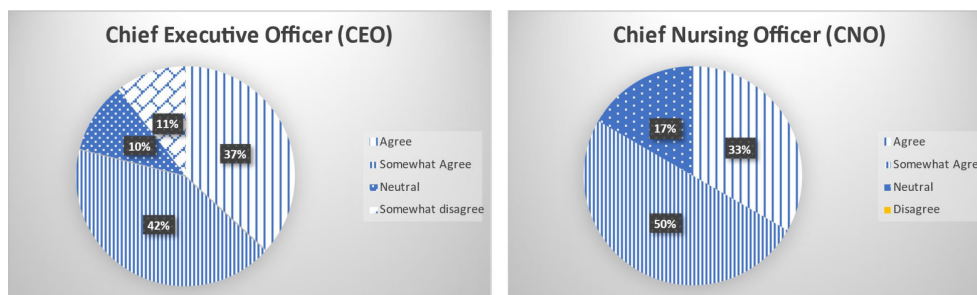


Figure 1 Communications

Note: Communications between C-level executives and employees

These C-level executives (84.2%) summarized; the virtual leader needed to monitor their employees more closely than in a physically present environment. There was a split between CEOs (47.4%) and other C-level executives (25%) in their agreement on whether the quality of work in a virtual environment can be diminished.

HIGHLIGHTS OF SURVEY RESPONSES

There were significant findings regarding C-level executives implementation of their role as virtual leaders. The findings for additional leadership responsibilities in a virtual environment were the following.

In the questions related to implementing virtual communications, it was found approximately one-quarter of the respondents answered the additional responsibilities of their leadership increased and included:

1. CEOs (Chief Executive Officers) agreed their communication improved with employees in a virtual environment—79% (see Figure 1)
2. CNOs (Chief Nursing Officers) disagreed communications with employees improved in a virtual environment—35% (see Figure 1).

One of the most interesting findings related to operations in a virtual environment was in the operation and decision-making related to working with and supervising virtual teams. When asked to clarify their experience with the need to monitor virtual teams, the survey participants had varied responses to the need to monitor virtual teams more closely.

As seen in Figure 2.

- 17% of the CEOs agreed virtual teams needed more monitoring.
- 77% of the CNO agreed the virtual teams needed more monitoring.
- 34% of the C-level leaders agreed virtual teams needed more mentoring.

Throughout the survey, it became clear the Chief Executive Officers (CEOs) held a more positive attitude toward the reinvention of the workplace as a virtual organization than other C-level executives. The latter expressed less favorable responses to the survey questions. Such a finding of reinvention in the workplace was supported by responses to survey questions by Chief Executive Officers (CEOs) and, to a lesser degree, by other C-level executives.

Discussion

Throughout the analysis of past research and the data obtained in the current survey of CEOs and other C-level leaders of healthcare organizations, the following key findings may affect current and future leaders of healthcare organizations. Specifically, compared to operating face-to-face, communicating in a virtual environment is more challenging, operating in a virtual environment is easier, and greater efficiency of virtual teams occurs in a virtual environment.

As noted earlier, the additional monitoring of virtual teams suggested a differing opinion depending on the level of monitoring needed for virtual teams. CEOs did not see a need for more monitoring of virtual teams (17%) compared to CNOs (77%). The difference

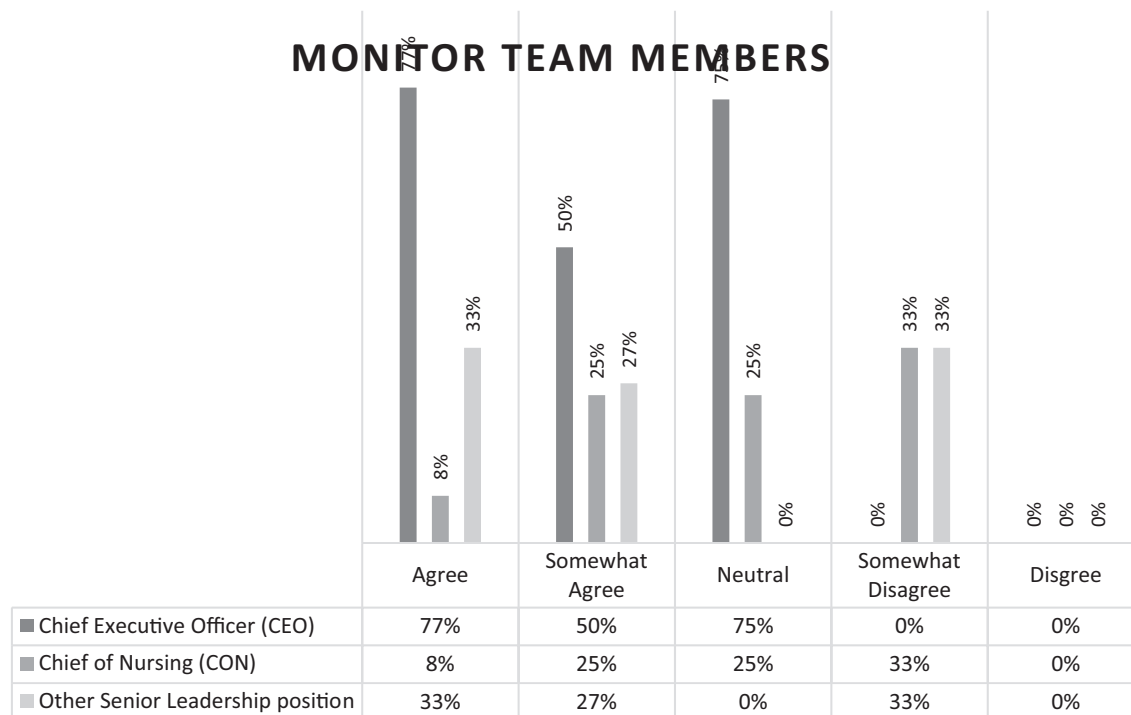


Figure 2 Need to Monitor Virtual Teams More Closely

Note: CNOs—dark; CEOs—mild; and other leaders—light

between CEOs and CNOs may be directly related to the daily interaction between the leader and the led, with CNOs working more closely with virtual team members on a more frequent basis.

Limitations and Recommendations for Future Research

LIMITATIONS

Several factors limited this research.

1. Research was limited in the number of respondents ($N = 32$).
2. The survey instrument was quantifiable and could be improved by adding qualifiable discussion with respondents.
3. Time to gather data and analyze the information provided by the respondents was restricted to meet imposed deadlines.
4. The research question: What transition did the CEOs and C-level executives of healthcare organizations in the United States make during the COVID-19 pandemic as their roles were re-

imagined as virtual leaders? limited the depth and breadth of the study.

RECOMMENDATIONS

Virtual leadership in healthcare organizations within the United States are still in its infancy. Consideration for future research,

1. Duplicate the current quantitative study with a larger sample size maintaining the qualifications of survey participants to CEOs and other C-level leaders working in the Healthcare Industry.
2. Expand the research to include a qualitative aspect to the questions to allow respondents to clarify their interpretation of the questions in their own words.
3. While the focus of this study is on leaders of healthcare organizations, the research should be expanded to include other members of the team who must interact with the C-level leadership.
4. Separate research is suggested for measuring changes in productivity while working in a virtual

environment understanding the team dynamics in a virtual environment in the healthcare industry.

Conclusion

The current study explored the reimagined leadership styles of CEOs and C-level executives in healthcare organizations throughout the U.S. during the COVID-19 pandemic. The primary research question addressed by the research was: *What transition did the CEOs and C-level executives of healthcare organizations in the United States make during the COVID-19 pandemic as their roles were reimagined as virtual leaders?* Virtual leadership became an emerging answer to effective communications between leaders of healthcare organizations and other stakeholders. Virtual leaders learned new skills and implemented new technology to manage the day-to-day business through virtual communications, virtual team building, and conducting patient care coordinated through remote workers.

The current study adds to the body of knowledge of the leadership of healthcare organizations identifying the future having been forever reimagined. Leaders of healthcare organizations are finding new ways to conduct business in U.S. healthcare organizations through implementing virtual leadership. Virtual leaders at U.S. community hospitals have reimagined their roles and the roles of technology during the COVID-19 pandemic. Community hospitals will forever see and experience the evolution of virtual leadership. The demand for global integration, cost reduction, advanced communication, and technology will fundamentally shift the transition of virtual leadership (Zander et al., 2013).

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