

Decison Making

LEARNING OUTCOMES

After completing this chapter, the student should be able to understand:

- The difference between the rational and the bounded rationality approach to decision making.
 - The limitations of using intuitive decision making and the heuristics or biases approach.
 - How framing heuristics affects escalation of commitment.
 - The four basic styles of decision making.
 - The Vroom-Yetton Decision-Making Method and the relating factors.
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OVERVIEW

Managers face different types of problems (i.e., well-structured and poorly structured) and use different types of decision-making models. When managers confront a well-structured problem, defined as one that is straightforward, repetitive, familiar, and easily defined, they use a routine approach by relying on an organization's policies and procedures. For example, two employees request the same vacation period. Because the manager must ensure adequate coverage in the workplace, he or she follows company policy by granting the vacation request to the employee with the most seniority. However, middle and senior managers usually deal with poorly structured problems, those that are new and complex, where information is limited and incomplete.

In the context of behavioral decision making, there are various means that an individual can use to choose the optimal or most desired outcome. Individuals use the rational approach to decision making when there is sufficient time for an orderly, thoughtful process. However, because of time, resource, information constraints, and the complexity of today's health care organizations, managers are limited or "bounded" as to their rational decision making. The bounded rationality perspective takes into

consideration that managers, because of the complexity of problems, limited time, personal bias, and other factors, will not be able to weigh all possible alternatives to a problem and, therefore, must sometimes rely on intuitive decision making or the heuristics and biases approach.

Rational Approach

The rational approach to decision making, also referred to as the economic rationality model, is a systematic analysis of the problem followed by the choice and implementation of a solution in a logical, step-by-step sequence (Daft, 2004). The rational model is considered the “ideal” method of decision making. Daft (2004, pp. 449–450) explains the rational model using an eight-step approach, as illustrated in **Figure 13–1**.

1. *Monitor the Decision Environment:* In the first step, a manager monitors internal (within the organization) and external (outside the organization) information that will indicate deviations from planned or acceptable behavior. The manager talks with colleagues and reviews financial statements, performance evaluations, industry indices, competitors’ activities, and the like.
2. *Define the Decision Problem:* The manager responds to deviations by identifying essential details of the problems: where, when, who was involved, who was affected, and how current activities are influenced.
3. *Specify Decision Objectives:* The manager determines what performance outcomes should be achieved by a decision.
4. *Diagnose the Problem:* In this step, the manager digs below the surface to analyze the cause of the problem. Additional data might be generated to facilitate this diagnosis. Understanding the cause enables appropriate treatment.
5. *Develop Alternative Solutions:* Before a manager can move ahead with a decisive action plan, he or she must have a clear understanding of the various options available to achieve desired objectives. The manager may seek ideas and suggestions from other people.
6. *Evaluate Alternatives:* This step may involve the use of statistical techniques or personal experience to gauge the probability of success. The merits of each alternative are assessed, as is the probability that the alternative will reach the desired objectives.
7. *Choose the Best Alternative:* This step is the core of the decision process. The manager uses his or her analysis of the problem,

objectives, and alternatives to select a single alternative that has the best chance for success.

8. *Implement the Chosen Alternative:* Finally, the manager uses managerial, administrative, and persuasive abilities and gives directions to ensure that the decision is carried out. The monitoring activity (step 1) begins again as soon as the solution is implemented.

However, under most circumstances, managers do not possess complete information about a problem and/or all the plausible alternatives. In addition, managers are constrained by limited time and resources, personal bias, and other factors, which make rational decision making unrealistic. Therefore, managers are bounded or limited regarding their rational decision making. The concept of bounded rationality embraces the realism that evaluation of alternatives and decision making are constrained by human actions (Forest & Mehier, 2001).

Steps in the Rational Approach to Decision-Making

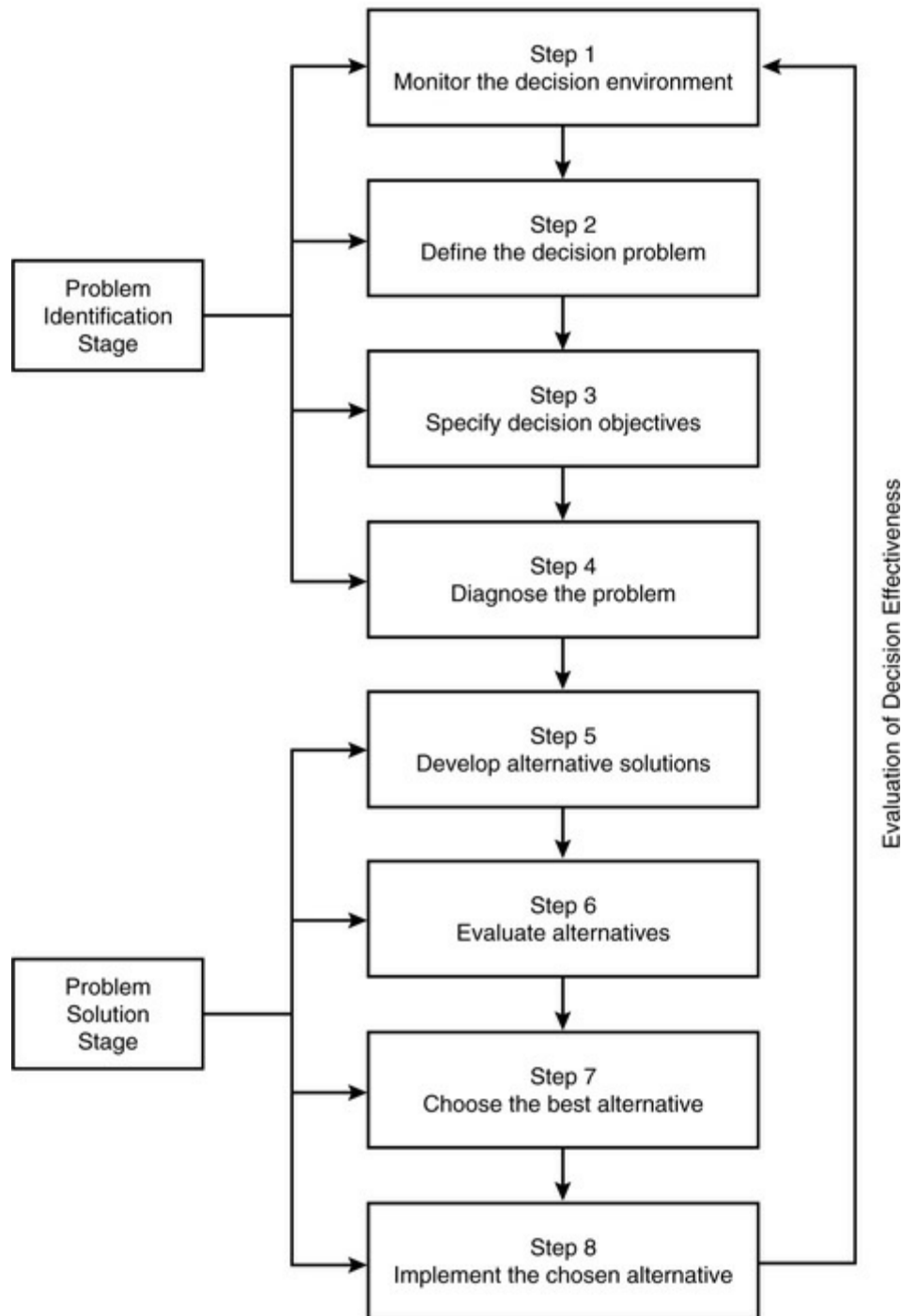


Figure 13–1 Steps in the Rational Approach to Decision Making

Source: Organization Theory and Design (8th ed., p. 449), by R. L. Daft, 2004, Mason, OH: South-Western. Used with permission.

Bounded Rationality Model

The bounded rationality model of decision making, proposed by Simon

(1957), recognizes that individuals have cognitive limitations, which prohibit the processing of all the necessary or optimal information necessary for decision making; as such, an individual will limit his or her search for information prior to decision making. Dequech (2001, p. 913) explains the concept of bounded rationality in the following manner:

1. Individuals often pursue multiple objectives, which may be conflicting. The alternatives from which to choose in order to pursue these objectives are not previously given to the decision maker, who thus needs to adopt a process for generating alternatives.
2. The limits in the decision maker's mental capacity compared with the complexity of the decision environment usually prevent him or her from considering all the alternatives. Those limits are also present when the decision maker has to consider the consequences of the alternatives, so that the decision maker employs some heuristic procedure for that purpose.
3. Finally, the decision maker adopts a "satisfying" rather than an optimizing strategy, searching for solutions that are "good enough" or satisfactory, given some aspiration levels.

The expression "bounded rationality" is used to denote the type of rationality that managers resort to when the environment in which they operate is too complex relative to their cognitive limitations. Because of these limitations, managers may employ the use of intuitive and/or heuristic strategies for decision making.

Intuition

Intuitive decision making can be understood as a cognitive "short-circuiting," where a decision is reached even though the reason for the decision cannot be easily described (Hall, 2002). In other words, intuitive decision making involves using one's professional judgment based on past experiences rather than sequential logic or explicit reasoning (Daft, 2004). Agor (1985, 1986a, 1986b) suggests that intuition is most useful to managers in situations of uncertainty. Agor advocates reliance on intuition when a high level of uncertainty exists, when there is little precedent, when variables are not scientifically predictable and analytical data are of little use, when facts are limited and don't clearly point the way to go, when several alternatives seem plausible, and when time is limited and there is pressure to come up with the right answer.

There is some debate as to the degree to which an individual's intuitive

ability can be developed and improved (Bennett, 1998). Some argue intuitive abilities are closely related to personality types (Myers, 1980). Others claim that job characteristics or situational factors encourage managers to develop and improve their intuitive abilities (Agor, 1986a, 1986b; Behling & Eckel, 1991; Wally & Baum, 1994). In top-level decision-making environments, this ability is certainly an asset and has been shown to be a benefit to senior managers (Agor, 1986a, 1986b; Eisenhardt & Bourgeois, 1988; Hayashi, 2001; Simon, 1987). For example, Agor (1985, 1986a, 1986b) conducted a series of studies and found that senior managers always score higher than middle- and lower-level managers in their abilities to use intuition to make decisions on the job. In Maidique's (2011) study of CEO decision making, he found that intuition was a major or determining factor in 85 percent of the 36 key decisions that were studied. Therefore, it is not surprising that Peters and Waterman (1984) relate that the 10 best-run companies in America encouraged the use of intuitive skills. In addition, business schools are designing courses to help develop MBA students' intuitive skills for decision making (Agor, 1985, 1986b).

Heuristics or Biases Approach

In addition to using intuition to deal with the problems of uncertainty and complexity, managers use judgmental heuristics strategies to simplify their decision making. Heuristics are guidelines or "rules of thumb" that help make our world manageable by simplifying complex tasks (Kahneman, Slovic, & Tversky, 1982; Tversky & Kahneman, 1974). Heuristic processing strategies enable managers to cut through overwhelming data by applying simplifying assumptions to the information. Although the use of heuristics may result in accurate predictions by managers, it also can give rise to an array of errors and biases. Tversky and Kahneman (1974) describe three commonly used heuristics: (1) availability, (2) representativeness, and (3) anchoring and adjustment.

Availability bias is an intuitive technique where the perceived probability of an event is influenced by the ease of recollection. More easily recalled events are given a higher probability. More frequent events are often the most easily recalled, but the most easily recalled are not necessarily the most frequent (Hall, 2002). Ease of recall is also affected by salience (i.e., the degree to which some information is perceived as being more relevant to the decision being made) related to the emotional strength of a memory, with memories associated with strong emotions being recalled more easily. For example, performance appraisals of staff are affected by the use of

availability heuristics by managers while evaluating them. It is common to find the most recent and vividly etched event—positive or negative—influencing the appraisal. (See **Case Study 13-1: A Case of Abuse or Neglect?**)

Representativeness bias is an intuitive technique where probabilities are evaluated by the degree to which the given sample matches, or is representative of, a class of samples or populations. In the workplace, representativeness heuristics can be traced as the reason behind many cases of employee discrimination. (See **Case Study 13-1: A Case of Abuse or Neglect?**)

Anchoring and adjustment bias is an intuitive technique used when a series of estimates is used to obtain a “proposed” answer to a current problem. People create the preliminary solution on the basis of initial information (anchoring), and thereafter modify the answer when more information becomes available (adjustment). For example, when the salary of a new employee is being set, the anchoring and adjustment heuristic is used. The employee’s starting salary is invariably set close to the last paid salary, without regard to what the new job description may entail. In other words, the initial value significantly influences the process of the adjustment toward the new value, irrespective of the rationality in the choice of the initial value. (See **Case Study 13-2: A Case of Abuse or Dependency?**)

Case Study 13-1 A Case of Abuse or Neglect?

A significant portion of Dr. Smith’s private practice comprised clients who had been referred to him from a psychiatric hospital. These included a former inpatient at the hospital, Ms. Sarah Jacobson. During the initial 20 minutes of the intake session, Sarah reported that she was 15 years old and was in her sophomore year in high school. Sarah told Dr. Smith that her parents were divorced and that her mother had custody of her and her two younger sisters. The client reported that her mother repeatedly said that she was tired of taking care of her and her sisters and that she thought that her mother wanted the children out of the home. Sarah went on to say that she had been placed in the hospital because of her aggressive and defiant behavior toward her mother. In addition, Sarah stated that she thought that her mother had become involved with another man prior to the divorce and that her mother liked him more than she liked her children. Sarah expressed considerable anger toward her mother and the belief that her mother was trying to “get rid of her.”

Dr. Smith’s case notes indicated that Sarah seemed agitated and felt persecuted by her mother. As he was conceptualizing the case, he recognized the similarity between this case and previous referrals from the hospital and recalled that the diagnosis in those cases had been paranoid schizophrenia. The case notes indicated that Sarah seemed to be functioning at an adequate level to be treated as an outpatient and that Dr. Smith regarded her as suffering from paranoid schizophrenia.

Sarah attended only one other session, as she failed to keep subsequent appointments.

Approximately three weeks after his last meeting with Sarah, Dr. Smith received information from the Division of Family Services that Sarah's mother had been charged with neglect and abandonment of Sarah and her two younger siblings. Two weeks after Sarah had been released from the hospital, her mother had failed to pick up the younger children from day care and had left the city with her male friend.

Discussion

Dr. Smith used the availability heuristic when formulating his diagnosis. Symptoms of psychopathology were very salient and accessible to Dr. Smith, because many of his cases were referrals from the psychiatric hospital. Dr. Smith also used the representativeness heuristic by comparing Sarah to former clients. Had Dr. Smith referred to DSM-III-R (American Psychiatric Association, 1987) criteria when forming his diagnosis in addition to relying on his previous experience, he would have realized that Sarah's symptoms did not meet the criteria for schizophrenia.

SOURCE: "Bias in the Counseling Process: How to Recognize and Avoid It," by K. A. Morrow and C. T. Deidan, 1992, *Journal of Counseling and Development*, 70(5), pp. 571–577. Reprinted with permission.

Case Study 13–2 A Case of Abuse or Dependency?

Mr. Larson was a counselor employed by a community health clinic that offered both medical and psychological care. Mr. Larson made a practice of reviewing all records on file at the center before seeing each new client. Prior to the initial session with Ms. Irma Busse, Mr. Larson reviewed her file, which indicated no health problems and no previous visits for psychiatric reasons. The only remarkable entries were a broken arm sustained six months earlier and an indication that the attending physician suspected abuse. The physician's notes indicated that Irma's husband always accompanied her during examinations and that she deferred to him to answer the physician's questions.

During the initial session, Mr. Larson noticed that Irma had her collar buttoned to her neck, was slightly stooped when she walked, and did not make immediate eye contact when she spoke. She had a quiet voice and indicated that she had come to counseling because she was having marital problems. During this interview, Irma discussed how important her marriage was to her and how difficult it was for her to do things on her own, and indicated that all she wanted was to make her husband happy. After the session, Mr. Larson reviewed the interview and concluded that the client was a victim of spouse abuse and was unable at this time to recognize the need to leave her husband. He decided that the course of counseling would be to help Irma become aware of the dangerous nature of the situation, provide information about the shelter for battered women, and attempt to convince Irma that she needed to leave her husband for her own safety.

As counseling progressed, Irma made other statements such as "I'm afraid to go anywhere without my husband" and "I just don't know if I could get along without him." These seemed to support both his and the physician's earlier conclusions that Irma was a battered wife. After speaking to several family members, it became apparent that Irma had not been abused. Rather, it seems as though she was a very dependent person and that her needs were directed primarily toward her husband, although others had experienced her dependency as well.

Discussion

Mr. Larson's perceptions seem to have been skewed by the physician's notes (anchor), which suggested that Irma may have been abused. Because of the dangerous nature of abusive situations, Mr. Larson focused on assisting the client to prepare to move out of her home and into a shelter. He

failed, however, to recognize that this client, through her verbal and nonverbal behavior, was reflecting strong dependency. Mr. Larson maintained his initial impression of Irma (i.e., the “battered wife” label) until much later in the counseling process when he obtained substantial contradictory information from family members (adjustment).

SOURCE: “Bias in the Counseling Process: How to Recognize and Avoid It,” by K. A. Morrow and C. T. Deidan, 1992, *Journal of Counseling and Development*, 70(5), pp. 571–577. Reprinted with permission.

As illustrated by these two case studies, there are many similarities between clinical decision making and managerial decision making. Extensive literature exists regarding the use of intuition and heuristics in medical decision making because of the high degree of uncertainty within the practice of medicine. As Sox et al. (1988, p. 17) point out, “medicine is the art of making decisions without adequate information.” As such, decisions made by clinicians through the use of intuition or heuristics can have a tremendous impact on health care managers. Clinicians make the decisions as to the commitment of scarce resources to patients and the associated care and treatment plans (Hall, 2002; C. Thompson, 2003). However, it is the responsibility of health care managers to provide the resources for clinicians to perform their work, and their health systems are “judged” on the clinical outcomes of the patient populations they serve. As such, health care managers need to appreciate not only how intuition and heuristics play a part in their own decision making but also how they affect the decision making of clinicians because both impact the achievement of organizational goals. (See **Case Study 13–3: Cognitive Errors in Clinical Decision Making.**)

Case Study 13–3 Cognitive Errors in Clinical Decision Making

Heuristic processing strategies enable individuals to cut through overwhelming data by applying simplifying assumptions to information. Heuristics are guidelines or “rules of thumb” that help make our world manageable by simplifying complex tasks (Kahneman, Slovic, & Tversky, 1982; Tversky & Kahneman, 1974). As health care managers use heuristics strategies to simplify their decision making, so do clinicians. Although the use of heuristics may result in accurate predictions by individuals, it also can give rise to an array of errors and biases. Tversky and Kahneman (1974) describe three commonly used heuristics: (1) availability, (2) representativeness, and (3) anchoring.

Consider the following clinical examples illustrating commonly used heuristics:

Availability error occurs when clinicians misestimate the prior probability of disease because of recent experience. Experience often leads to overestimation of probability when there is memory of a case that was dramatic or that involved a patient who fared poorly or a lawsuit. For example, a clinician who recently missed the diagnosis of pulmonary embolism in a healthy young woman who had vague chest discomfort but no other findings or apparent risk factors might then overestimate the risk in similar patients and become more likely to do chest CT angiography for similar patients

despite the very small probability of disease. Experience can also lead to underestimation. For example, a junior resident who has seen only a few patients with chest pain, all of whom turned out to have benign causes, may begin to do cursory evaluations of that complaint even among populations in which disease prevalence is high.

Representation error occurs when clinicians judge the probability of disease based on how closely the patient's findings fit classic manifestations of a disease without taking into account disease prevalence. For example, although several hours of vague chest discomfort in a thin, athletic, healthy-appearing 60-year-old man who has no known medical problems and who now looks and feels well does not match the typical profile of a myocardial infarction (MI), it would be unwise to dismiss that possibility because MI is common among men of that age and has highly variable manifestations. Conversely, a healthy 20-year-old man with sudden onset of severe, sharp chest pain and back pain may be suspected of having a dissecting thoracic aortic aneurysm because those clinical features are common in aortic dissection. The cognitive error is not taking into account the fact that aortic dissections are exceptionally rare in a 20-year-old, otherwise healthy patient; that disorder can be dismissed out of hand and other, more likely causes (e.g., pneumothorax, pleuritis) should be considered. Representation error is also involved when clinicians fail to recognize that positive test results in a population where the tested disease is rare are more likely to be false positive than true positive.

Anchoring errors occur when clinicians steadfastly cling to an initial impression even as conflicting and contradictory data accumulate. For example, a working diagnosis of acute pancreatitis is quite reasonable in a 60-year-old man who has epigastric pain and nausea, who is sitting forward clutching his abdomen, and who has a history of several bouts of alcoholic pancreatitis that he states have felt similar to what he is currently feeling. However, if the patient states that he has had no alcohol in many years and has normal blood levels of pancreatic enzymes, clinicians who simply dismiss or excuse (e.g., the patient is lying, his pancreas is burned out, the laboratory made a mistake) these conflicting data are committing an anchoring error. Clinicians should regard conflicting data as evidence of the need to continue to seek the true diagnosis (acute MI) rather than as anomalies to be disregarded. There may be no supporting evidence (i.e., for the misdiagnosis) in some cases in which anchoring errors are committed.

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Escalation of Commitment and Framing Heuristic

In addition to Tversky and Kahneman's (1974) three commonly used heuristics, there is another area that may cause low-quality decision making—escalation of commitment. Staw (1981) defines the problem of escalation of commitment as when a manager continues to allocate more resources to a losing proposition. One reason escalation of commitment may occur is because a manager does not want to admit that he or she has made a mistake (Staw & Ross, 1987). Research finds that if a manager feels personally responsible for an initial decision that is failing, he or she is more likely to allocate additional resources than another person who was not responsible for the initial decision (Staw, 1981). The expression “throwing good money after bad” describes escalation of commitment, in a decision.

For example, one of the main reasons for the bankruptcy of the Allegheny Health System in Pennsylvania was the unwillingness of the top leaders of the organization to make midcourse corrections in their grand plans on the basis of what was and was not working in hospitals and office practices in Philadelphia and Pittsburgh (Bottles, 2001). Examples from the public sector (Staw & Ross, 1987) include the city of Vancouver's commitment to Expo '86, Chicago's Deep Tunnel project, and the Washington Public Supply System.

In the case of the World Exposition on Transportation and Communication, or Expo '86, the fair was supposed to operate close to financial breakeven. But as the plans moved forward, the expected losses burgeoned. The planners continued because politically it was too late to stop due to various stakeholders. British Columbia had to create a lottery to cope with the \$300 million deficit. The good news is that the fair did open as scheduled.

Another reason escalation of commitment may occur is due to framing heuristic. Framing heuristic is a tendency to make a decision based on the form or manner in which information is presented. For example, Levin, Schnittjer, and Thee (1988) conducted a study where one group was given a description of an experimental cancer treatment that was shown to have a 40 percent success rate; the other group was told that the procedure had a 60 percent failure rate. Although both statements are true, the way the researchers worded the statements affected a person's opinion of its effectiveness and whether or not he or she would recommend the treatment to a family member. The participants were more optimistic about the treatment when its success rate was emphasized and less optimistic when the failure rate was emphasized.

Staw and Ross (1987) suggest that to avoid escalation of commitment, managers can: (1) recognize that they may be biased toward escalation, (2) see escalation for what it is (i.e., an overcommitment to a strategy by defining failure ambiguously, or by ignoring others' concerns), and (3) avoid overcommitment by looking at the strategy from an outsider's perspective.

Decision-Style Model

Managers have different styles when it comes to making decisions and solving problems. Rowe and Boulgarides (1983, 1998) developed a decision-style model that proposes that managers differ along two dimensions in the way they approach decision making: value orientation and tolerance for ambiguity. Value orientation reflects the extent to which an individual

focuses on either task and technical concerns or people and social concerns when making decisions. Tolerance for ambiguity reflects the extent to which a person has a high need for structure or control in his or her life.

As illustrated in **Figure 13-2**, the decision-style model encompasses four basic styles: directive, analytic, conceptual, and behavioral. Boulgarides and Cohen (2001, pp. 59–60) describe the four basic styles as follows:

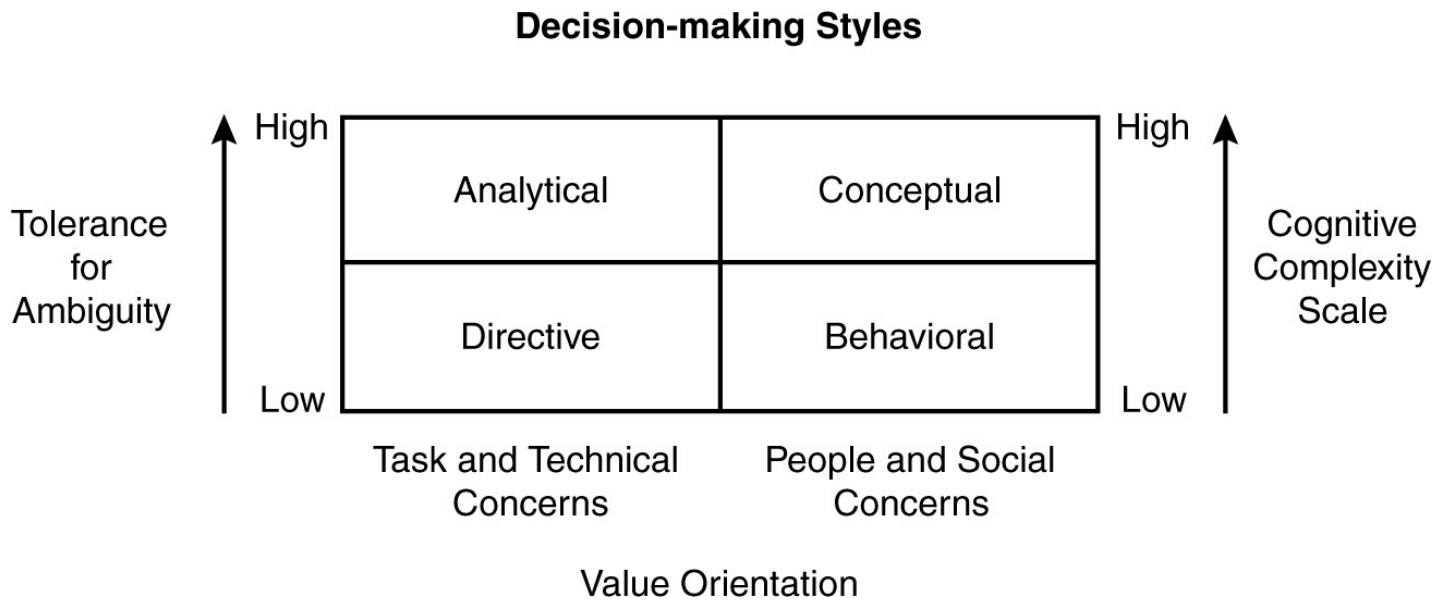


Figure 13-2 Decision-Making Styles

1. *Directive*: Low tolerance for ambiguity and low cognitive complexity. The focus is on technical decisions, and this style is generally autocratic. The decision maker may adopt this style because of a high need for power. Because of the use of little information and few alternatives, speed and satisfactory solutions are typical. The decision makers tend to be focused and are frequently aggressive. Generally they prefer structure and specific information, which is given verbally. Their orientation is internal to the organization and short range. They tend to operate with tight controls. Although they are efficient, these decision makers have a high need for security and status. They have the drive required to achieve results, but they also want to dominate others.
2. *Analytic*: This decision maker has a much greater tolerance for ambiguity than the directive-style manager and also has a more cognitively complex personality that leads to the desire for more information and the consideration of many alternatives. Because of

the focus on technical decisions and the need for control, the analytic style contains an autocratic bent. The analytic style is typified by the ability to cope with new situations (but in a structured manner) and problem solving. Position and ego are important to individuals who use an analytic decision-making style. As such, these individuals often reach top positions within an organization or start their own companies. They are not particularly quick in their decision making, and they enjoy variety and prefer written reports. They also enjoy challenges and examine every detail in a situation.

3. *Conceptual*: Including both high cognitive complexity and people orientation, this decision-making style tends to use data from multiple sources and considers many alternatives. Similar to individuals using the behavioral decision-making style, conceptual-style decision makers share goals with subordinates in trusting and open relationships. These individuals tend to be idealists who may emphasize ethics and values in their behavior. They generally are creative and can readily understand complex relationships. Their focus is long range with high organizational commitment. They are achievement-oriented and value praise, recognition, and independence. They prefer loose control over power and will frequently encourage the participation of those they lead. They may be characterized as thinkers rather than doers.
4. *Behavioral*: Although low on the cognitive complexity scale, this leader has a deep concern for the organization and the development of people. Behavioral-style managers tend to be supportive and are concerned with subordinates' well-being. They provide counseling, are receptive to suggestions, communicate easily, show warmth, are empathetic, are persuasive, and are willing to compromise and accept a looser style of control. With low data input, this style tends toward a short-range focus and uses meetings primarily for communicating. These managers avoid conflict, seek acceptance, and tend to be more people-oriented, but sometimes are insecure.

Of the four decision-making styles, individuals have a tendency to resort to a single, dominant style (i.e., default mode of decision making). However, with training, managers can use all four styles effectively as different situations are presented.

VROOM-YETTON DECISION-MAKING MODEL

A good decision-making method under one set of circumstances may not be considered so under other conditions. A classic contingency model for decision making was first described by Vroom and Yetton (1973). Fifteen years later, Vroom and Jago (1988) replaced the decision tree system of the original model (see **Figure 13-3**) with an expert system based on mathematics. As such, you will see the model referred to as Vroom-Yetton, Vroom-Jago, and Vroom-Yetton-Jago. The contingency model for decision making suggests that individuals should consider choosing from five types of decision processes based upon a number of factors. Two are autocratic (AI and AII), two are consultative (CI and CII), and one is group-based (GII). As such, this decision-making model can be used to choose between individual and group decision-making strategies.

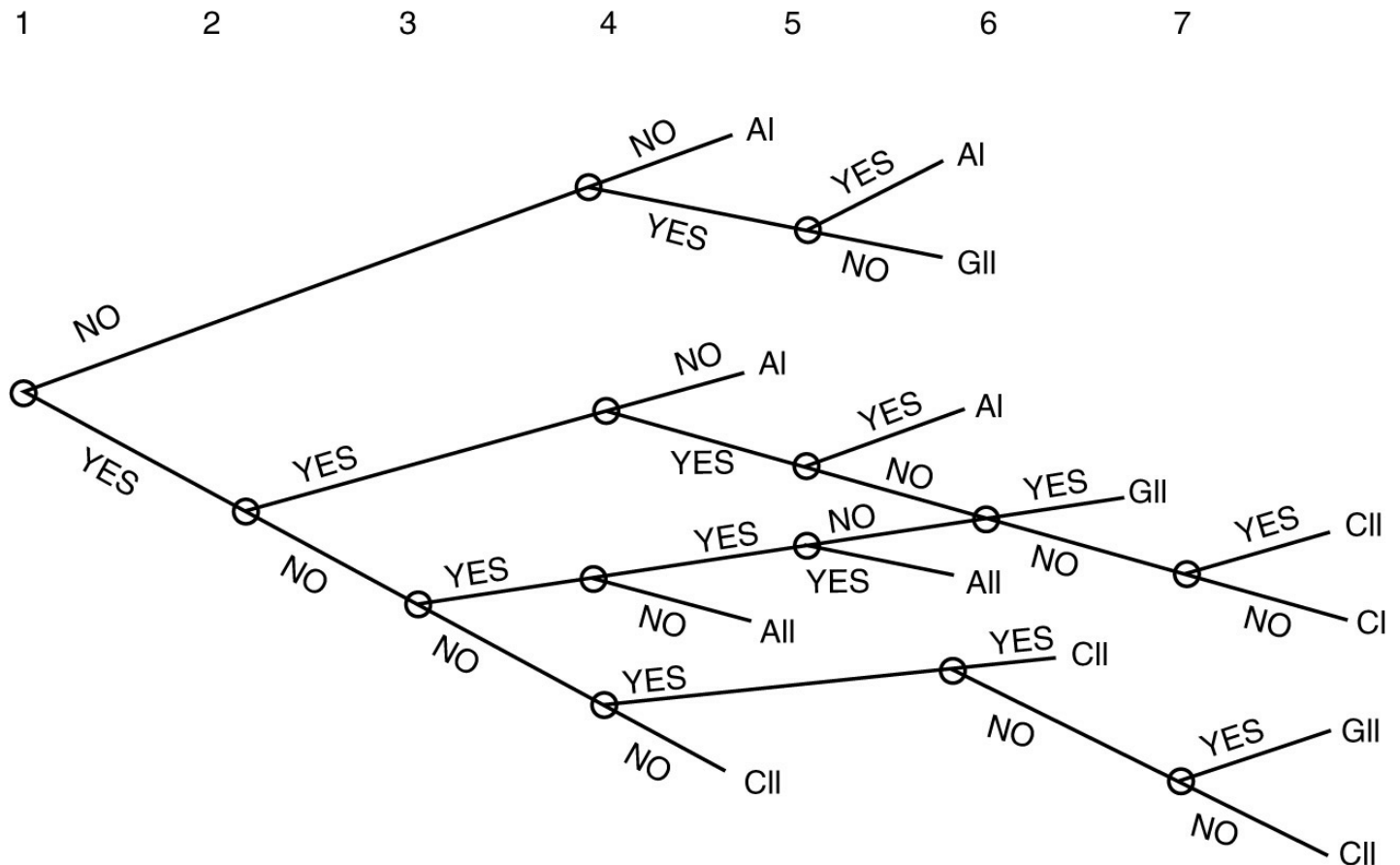


Figure 13-3 Vroom-Yetton Decision-Making Method

Modified from Vroom, V. H. and Yetton, P. W. (1973). Leadership and decision-making. Pittsburgh: University of Pittsburgh Press.

The five decision processes are:

1. Autocratic I (AI): Completely autocratic. You solve the problem or make the decision yourself using the information available to you at the present time.
2. Autocratic II (AII): Request specific information. You obtain any necessary information from team members/subordinates, and then decide on the solution to the problem yourself. You may or may not tell subordinates the purpose of your questions or give information about the problem or decision you are working on. The input provided by them is clearly in response to your request for special information. They do not play a role in the definition of the problem nor in generating or evaluating alternative solutions.
3. Consultative I (CI): One-on-one discussion. You share the problem with the relevant team members/subordinates individually, getting their ideas and suggestions without bringing them together as a group. Then you make the decision. This decision may or may not reflect your subordinates' influence.
4. Consultative II (CII): Group discussion. You share the problem with your team members in a group meeting. In this meeting you obtain their ideas and suggestions. Then, you make a decision that may or may not reflect your subordinates' influence.
5. Group (GII): Consensual group decision making. You share the problem with your team members/subordinates as a group. Together you generate and evaluate alternatives and attempt to reach agreement (i.e., consensus) on a solution. Your role is much like that of facilitator, coordinating the discussion, keeping it focused on the problem, and making sure that the critical issues are discussed. You can provide the group with information or ideas that you have, yet you do not try to "press" them to adopt your solution and are willing to accept and implement any solution that has the support of the entire group.

Many people find this contingency model for decision making helpful when the following seven yes/no questions are answered in relation to the tree diagram, as shown in [Figure 13–3](#). The seven questions must be answered in order from 1 to 7 and followed across the tree diagram from left to right:

1. Is there a quality requirement? Is the nature of the solution critical? Are there technical or rational grounds for selecting among possible solutions?

2. Do I have sufficient information to make a high-quality decision?
3. Is the problem structured? Are the alternative courses of action and methods for their evaluation known?
4. Is acceptance of the decision by subordinates critical to its implementation?
5. If I were to make the decision by myself, is it reasonably certain that it would be accepted by my subordinates?
6. Do subordinates share the organizational goals to be obtained in solving this problem?
7. Is conflict among subordinates likely in obtaining the preferred solution?

For example, in the case where the quality requirement is low (e.g., the nature of the solution is not critical), you would choose the upper branch at point 1. If you then consider, in reference to question 4, that acceptance of this decision by subordinates is also not critical, the method suggests that you should make the decision on your own (i.e., choose method AI). Alternatively, at point 4, if acceptance is critical, you would consider question 5 regarding certainty of acceptance if you made the decision on your own. If people are likely to accept your decision, the method suggests once again making the decision on your own (i.e., AI). If, however, acceptance of your decision is not reasonably certain, the method suggests a consensual group method (i.e., GII) to help overcome this.

Situational factors that may influence the model are:

- When decision quality is important and followers possess useful information, then AI and AII are not the best methods.
- When the leader sees decision quality as important but followers do not, then GII is inappropriate.
- When decision quality is important, the problem is unstructured, and the leader lacks information/skill to make the decision alone, then GII is best.
- When decision acceptance is important and followers are unlikely to accept an autocratic decision, then AI and AII are inappropriate.
- When decision acceptance is important but followers are likely to disagree with one another, then AI, AII, and CI are not appropriate, because they do not give opportunity for differences to be resolved.
- When decision quality is not important but decision acceptance is critical, then GII is the best method.
- When decision quality is important, all agree with this, and the decision

is not likely to result from an autocratic decision, then GII is best.

Some researchers relate that the model works best when there are clear and accessible opinions about the decision quality importance and decision acceptance factors. However, these are not always known with any significant confidence.

SUMMARY

In this chapter, we have discussed the various methods used by managers in their decision making processes. The rational approach is used when there is sufficient time for an orderly, thoughtful process. However, due to limited resources, such as time and information, managers may be limited in their rational decision making and will rely on intuitive or the heuristics and biases approach.

DISCUSSION QUESTIONS

1. Explain the difference between the rational and bounded rationality approaches to decision making.
 2. Explain the limitations of using intuitive and the heuristics or biases approach to decision making.
 3. Describe how framing heuristics affects a manager's escalation of commitment.
 4. Discuss the four basic styles of decision making.
 5. Explain the various situational factors that may influence the Vroom-Yetton decision making model.
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EXERCISE 13-1

There are times when you have made good decisions. At the time of the decision making you knew it was a good decision, when you look back on it you recognize that, yes, that was a good decision, and even now you still think it was a good decision.

There are also times when you have made poor decisions. At the time of the decision making you may have felt uneasy about it, and when you look back on it you recognize that it was a poor decision.

Analyze the factors that you think contributed to both your good and poor

decisions.

EXERCISE 13-2

You have 100 doses of a vaccine against a deadly strain of influenza that is sweeping the country, with no prospect of obtaining more. Standing in line are 100 school children and 100 elderly people. The elderly are more likely to die if they catch the flu than the school children are. But the elderly have fewer years left to live as compared with the school children, who have their whole lives ahead of them. Which group do you vaccinate?

Describe each step in your decision-making process.

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